TOBACCO ENDGAME
NHMRC Centre of Research Excellence

Submission to the National Tobacco Strategy

2022-2030

24 March 2022

The NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame (Tobacco Endgame CRE) aims to develop the evidence base for tobacco control policies and to identify the optimal policy mix to achieve a smokefree Australia. Please visit **our website** for more details.

About the NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame

Established in November 2020, the NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame (Tobacco Endgame CRE) conducts research on a wide range of interventions to reduce tobacco-related disease.

Our research generates evidence on the feasibility, effectiveness and acceptability of tobacco endgame policies and interventions.

The Tobacco Endgame CRE is led by a multidisciplinary team of international experts in health policy, behavioural science, epidemiology, biostatistics, law, environmental health, psychology, Aboriginal and Torres Strait Islander Health, and priority populations, from nine universities across Australia, New Zealand and Canada.

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Consultation Submission National Tobacco Strategy 2022–2030

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Thank you for the opportunity to make a submission on the Draft National Tobacco Strategy 2022-2030. This submission is made on behalf of the NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame (Tobacco Endgame CRE; https://tobacco-endgame.centre.uq.edu.au/). Commencing in November 2020, our CRE brings together an international multidisciplinary team of experts to develop the evidence base for tobacco endgame strategies and identify the most promising policies that could end the cigarette epidemic in Australia, and beyond. As such, our team of researchers represent global experts on various aspects of tobacco control policy. Our contact details are provided at the

end of this submission, should any further information or clarification about any issues raised in our submission be needed.

We welcome the target that has been set to reach 5% or less smoking prevalence by 2030. Reducing tobacco smoking to extremely low levels or eliminating it will reduce tobacco-related illness, death, and the associated suffering in Australia. However, we believe the current goal of 5% by 2030 should not be seen as the end goal, but the beginning of the end. We believe the 5% goal will only be achievable within the period of the Strategy if:

- innovative new policies are implemented
- clear timeframes are specified for implementing each proposed action
- governance and responsibility for implementing each action is clear
- regular monitoring and reporting of progress concerning smoking prevalence and policy implementation is specified supported by funding at least biennial national data collections.

Australia has been a global leader in tobacco control, in policies such as plain packaging and increasing taxes on tobacco products. However, Australia is at risk of not reaching the prevalence targets outlined in the National Tobacco Strategy if the focus stays only with existing policies, without continuing to innovate and introduce new policies that have the greatest potential to reduce smoking rapidly and permanently to minimal levels.

Other countries are moving ahead with such policies. For example, New Zealand's Smokefree Aotearoa 2025 Action Plan includes the proposal to allow only very low nicotine content smoked tobacco products to be sold in the country, to substantially reduce the number of tobacco retail outlets, and to prohibit the sale of smoked tobacco products to people born after a certain date (creating a smokefree generation).[1] Malaysia announced an intention to introduce a bill to implement a smokefree generation law,[2] as has Denmark.[3] The Irish government has announced an intention to start public consultation on a range of innovative strategies to achieve an 'endgame' for cigarette smoking, including ending all tobacco product sales, implementing a smokefree generation law, reducing the number of tobacco retail outlets to a small number of licensed outlets only or restricted to pharmacy only sales, banning tobacco sales near schools and universities or a complete ban on the sale of tobacco, year on year tax increases of up to 20 per cent a year, reducing the nicotine content of cigarettes, banning filters, adding warnings to the cigarette rod, and requiring tobacco companies to pay the costs of treating tobacco-related diseases.[4] The European Union has already banned all "characterising flavours" from tobacco products and Brazil introduced legislation to ban all additives from tobacco products. Canada banned all flavours in cigarettes in 2010, other than menthol, which was also banned in 2017, leading to a significant increase in quitting among people who smoked these products.[5]

We applaud inclusion of consideration of new policies that have the potential to substantially reduce tobacco smoking as a major cause of death and disability within the

Draft National Tobacco Strategy 2022-2030, however we believe the text and level of commitment to these could be strengthened with specific timeframes for reviewing the evidence for the policy, and clearer statements to support their implementation. We recognise that the details concerning how some policies should be implemented may require additional research evidence to inform, but clearer commitment to the policies of supply reduction and product regulation to reduce addictiveness would show a strong commitment to implementing the types of policies that will be needed to achieve the prevalence target in the NTS. We strongly recommend that every action listed in the National Tobacco Strategy have a timeframe attached and a clear implementation plan developed. At a minimum, a timeframe for reviewing the evidence for the novel policies should be included.

Below, we provide feedback on specific elements of the Draft National Tobacco Strategy 2022-2030 document.

Comment on the Introduction

This section should note that tobacco use is the leading cause of the gaps in death and disease between Indigenous and non-Indigenous people,[6] and people experiencing mental illness versus those who do not experience mental illness.[7]

We believe that acknowledgement of the adverse impacts of colonisation on Aboriginal and Torres Strait Islander peoples and that the high prevalence of commercial tobacco use among these peoples is a legacy of colonisation is needed in the introduction when discussing tobacco use among Aboriginal and Torres Strait Islander peoples (e.g., page 6 of the draft strategy). This is important context that should not be omitted. We would like to highlight the following relevant publications:

> Colonna. E., Maddox, R., Cohen, R., Marmor, A., Doery, K., Thurber, K. A., Thomas, D., Guthrie, J., Wells, S., Lovett R. Review of tobacco use among Aboriginal and Torres Strait Islander peoples. Australian Indigenous Health Bulletin. 2020;20(2). Retrieved from https://aodknowledgecentre.ecu.edu.au/learn/specific-drugs/tobacco/
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> Maddox R, Bovill M, Waa A, et al. Reflections on Indigenous commercial tobacco control: 'The dolphins will always take us home' Tobacco Control 2022;31:348-351.
>
> Maddox R, Waa A, Lee K, Nez Henderson P, Blais G, Reading J, Lovett R. Commercial tobacco and indigenous peoples: a stock take on Framework Convention on Tobacco Control progress. Tobacco Control. 2019;28(5):574-581.

In terms of other populations with high smoking prevalence and at greater risk of tobacco-related disease, we would like to highlight the community of people living with HIV and Hepatitis C Virus, and highlight the following publication:

Edwards SK, Dean J, Power J, Baker P, Gartner C. Understanding the Prevalence of Smoking Among People Living with HIV (PLHIV) in Australia and Factors Associated with Smoking and Quitting. AIDS and Behavior. 2020;24(4):1056-1063.

Gartner C, Miller A, Bonevski B. Extending survival for people with hepatitis C using tobacco dependence treatment. Lancet. 2017;390(10107):2033.

When noting remaining challenges (section 1.3, page 7), we strongly support the emphasis on the tobacco industry as the root cause of the tobacco epidemic. We suggest that the NTS should go further and acknowledge that the primary product produced by this commercial industry does not meet modern expectations for consumer product safety. Other industries are expected to ensure their products are safe to use, and the tobacco industry should not be given preferential treatment by being permitted to continue marketing an addictive and lethal product as a consumer good indefinitely. We believe the NTS should signal that this is a legacy industry that does not contribute to the benefit of Australian society, that there is no role for continuation of this commercial industry within a smokefree society, and that all commercial actors involved in the manufacture and supply of tobacco products need to prepare for Australia becoming a smokefree country. Relevant publications we would like to highlight are:

Gartner C, Wright A, Hefler M, Perusco A, Hoek J. It is time for governments to support retailers in the transition to a smoke-free society. Medical Journal of Australia. 2021;15;215(10):446-448.

Smith EA, Malone RE. An argument for phasing out sales of cigarettes. Tobacco Control. 2020;29:703-708.

Hefler M, Bostic C. 'Commit to quit': a goal for all, not only individual tobacco users. Tobacco Control. 2021;30:239-240.

On a minor note, the legend for Figure 4 appears to have the wrong labels for age and for smoking status. We have checked this with the original source document (Figure 3.1 in that document) and can confirm that the labels have been incorrectly applied. Firstly, the older age group (16-17) should be the lines with the higher prevalence (dark green and yellow). And 'weekly smoking' should be the higher prevalence figure (and may be better described as 'at least weekly smoking'), i.e., the dark green and light green lines. Committed smoking is a subset of 'weekly smoking' and represents smoking on at least three out of the last 7 days.

Comment on the goals and smoking prevalence targets

We strongly agree with the approach of setting a goal for rapidly reducing smoking prevalence and that the specified smoking prevalence targets are reasonable (<5% overall prevalence by 2030). However, the 2030 target could be strengthened by stating that the aim is to achieve as close to 0% as possible with smoking prevalence by 2030 at 5% being

the upper level of acceptable prevalence by that date. We recommend rephrasing the overarching goal from "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" to "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 **inequities** it causes," as this better incorporates the unfairness and injustice aspects of the currently unequal distribution of smoking in Australia.

Furthermore, a major omission in the Strategy is a clear stated commitment to eliminate current inequities in tobacco use and tobacco-related harms among sub-groups of the Australian population, such as Aboriginal and Torres Strait Islander people, people with physical and mental co-morbidities, and people who experience social and financial disadvantage ('priority populations'), compared to the general community. For example, compared to the Australian general population's daily smoking rate of 13.7%, 37% of people who identify as Aboriginal and Torres Strait Islander,[8] 24.2% of people who experience mental illness,[9] between 77% and 93% of people who experience homelessness,[9] 74% of people diagnosed with substance use disorders,[10] and 75% of people entering prison[11] smoke tobacco daily. We note that if the rate of decline in smoking prevalence from 2012/13 to 2018/19 among Aboriginal and Torres Strait Islander peoples continued, <5% prevalence will not be achieved until beyond 2050; this is not acceptable. To achieve <5% smoking prevalence by 2030 overall, and preferably among all population groups, innovative policies that will assist and support these priority population groups are crucial.[12] While more intensive and routinely provided smoking cessation assistance is needed, targeted individual-based approaches will not be enough to facilitate the level of smoking cessation that will be needed. Ensuring that policies aimed at Aboriginal and Torres Strait Islander peoples are determined and led by Aboriginal and Torres Strait Islander people is also essential.

As such, it is crucial that the Australian NTS adopts a similar approach to the New Zealand (NZ) Government's Smokefree Aotearoa 2025 Action Plan, which lists "Eliminate inequities in smoking rates and smoking-related illnesses" as the very first outcome. As stated in the NZ Government's 2025 Action Plan: "This outcome acknowledges the marked inequities in health caused by higher smoking prevalence among Māori, Pacific peoples, and those living in the most deprived areas of New Zealand. This action plan is an essential step towards…achieving equitable health outcomes for Māori." We thus strongly suggest that the goal of eliminating smoking for all population groups should be specified along with specific interim targets for smoking prevalence reduction overall and separately among priority populations such as Aboriginal and Torres Strait Islander peoples by 2030. Reducing current tobacco-related inequities among Aboriginal and Torres Strait Islander people and other priority populations, should be considered of the highest priority.

Comment on the objectives

We agree that the objectives are broadly appropriate. We recommend specifying targeting commercial tobacco use rather than tobacco use in general among Aboriginal and Torres Strait Islander peoples, to acknowledge the traditional use among some peoples. The great harms of tobacco use experienced by Aboriginal and Torres Strait Islander peoples is a legacy of the impacts of colonisation which has promoted the habitual use of commercial tobacco products. As noted above, it is crucial that the objectives both prioritise minimising commercial tobacco use among Aboriginal and Torres Strait Islander peoples but also to strengthen Aboriginal and Torres Strait Islander governance and leadership over efforts to reduce commercial tobacco use among Aboriginal and Torres Strait Islander peoples.

The background correctly acknowledges the environmental and economic impacts of the tobacco industry, and its role as the root cause of the tobacco epidemic. In addition to protecting tobacco control policy from commercial interests, we believe that the NTS should also include objectives related to recovering the costs of the environmental impacts of their industry (e.g., the costs of clean up and disposal of tobacco product waste, and offsetting the CO2 emissions this industry generates), the health care costs of treating tobacco-related diseases, and the other economic and social costs that are outlined on page 7. In addition to denormalisation of the tobacco industry, this industry needs to be explicitly considered as a sunset industry with a time-limited future, because eliminating tobacco use is inconsistent with continued commercial viability of tobacco manufacturers and tobacco product suppliers. Therefore, we also believe the NTS should include an objective to support Australian businesses (particularly small business) to end their reliance on tobacco product sales to ensure their businesses are prepared for a smokefree country. Relevant publications we would like to highlight are:

> Gartner CE, Wright A, Hefler M, Perusco A, Hoek J. It is time for governments to support retailers in the transition to a smoke-free society. Medical Journal of Australia. 2021;15;215(10):446-448.
>
> Hefler M, Bostic C. 'Commit to quit': a goal for all, not only individual tobacco users. Tobacco Control. 2021;30(3):239-240.
>
> Bostic C, Hefler M, Muller G, Assunta M. FCTC Article 2.1 and the next horizon in tobacco policy: Phasing out commercial sales. Tobacco Induced Diseases. 2020;18:98.

Comment on the guiding principles

We agree that the four guiding principles are appropriate.

However, we suggest that the ‘Working in partnership’ principle should be strengthened to acknowledge the need for governance structures to ensure that Aboriginal and Torres Strait Islander leadership contributes at National, State, local and community levels. A similar

commitment to Māori leadership and governance was included in the NZ Smokefree Aotearoa 2025 Action Plan. This acknowledged the status of Māori as the Indigenous peoples of Aotearoa, the leadership of Māori in developing the smokefree (Tupeka Kore) vision and advocating for the adoption of a national smokefree Aotearoa goal, and the disproportionate impact of smoking on the health of Māori peoples. The Australian NTS should aim for similar acknowledgements for Aboriginal and Torres Strait Islander peoples and enshrining Aboriginal and Torres Strait Islander governance over tobacco control strategies that aim to reduce smoking among Aboriginal and Torres Strait Islander peoples.

As described above, we also strongly recommend that the guiding principles include a clear and actionable commitment to addressing and eliminating inequity in smoking reductions between population groups, including Aboriginal and Torres Strait Islander peoples and other priority populations, recognising that previous approaches to reducing smoking have had greatest success among the most advantaged people in society.

In addition to partnership with specific populations, we suggest the addition of partnership with the research community be added to the guiding principles. Particularly for new policy areas, such as regulating the contents and emissions of tobacco products and reducing the supply and availability of tobacco, a robust evidence base developed by independent researchers is needed to support implementation. Therefore, we recommend including partnership with academia and acknowledgement of the important contribution of Australian universities and research institutes to the NTS and in supporting its implementation through generation of evidence. An action item that could be added in this regard is "Strengthen the science and surveillance by increasing research funding to examine novel and ambitious approaches to end tobacco use (or achieve the stated objective)."

While we **strongly agree** with the guiding principle of "Protection from all commercial and other vested interests", we also recommend that tobacco products should be treated exactly like other addictive and dangerous substances, for which general retail sales would not be considered appropriate. We believe treating the tobacco industry as a sunset industry should also be adopted 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. This needs to be explicitly recognised and publicly communicated so that businesses involved in the commercial tobacco supply chain are prepared. Phasing out tobacco products from the retail sector should be considered in a similar light to phasing out other harmful products, such as those containing asbestos.

However, we suggest that it is not sufficient to restrict these principles to explicit interference by the tobacco companies themselves, and that consideration should be given to extending the draft principles and actions to recognise the implicit or hidden influence that the tobacco industry uses to circumvent and undermine public health policy. Industry

peak bodies or trade associations who receive funding from tobacco companies have actively advocated to undermine tobacco control policy. They should be explicitly recognised as acting as part of the tobacco industry, and relevant guidelines and policies such as the *Guidance Note for Public Officials on Interacting with the Tobacco Industry* applied to their interactions with legislators and officials.[13]

Furthermore, considering that opposing policies that aim to improve public health for the purposes of increasing or maintaining commercial profits is highly unethical, consideration of ways to make tobacco companies, their executives and employees, who engage in such activities criminally liable for the impacts of tobacco use should be explored. Executives of other industries are held responsible and subject to potential criminal proceedings when their activities result in death, particularly when those deaths are foreseeable as a potential consequence of such action. Hence, we believe there is a case for imposing similar liability on executives and employees of tobacco companies who attempt to obstruct or delay the implementation of public health regulations that aim to reduce smoking, since such actions will result in avoidable deaths that could be prevented through public health interventions. This is consistent with FCTC Article 5.3 of not giving preferential treatment to the tobacco industry, by holding tobacco companies responsible for actions that result in avoidable deaths, like other industries.

Comment on the priority areas and the actions listed under each priority area

We agree that the 11 priority areas cover a good range of priority topics for further enhancing tobacco control in Australia and achieving <5% smoking prevalence by 2030. We provide suggestions for further strengthening the NTS in the sections below.

We particularly commend the inclusion of priority areas 1 and 4 of protecting tobacco control policy from tobacco industry interference and expanding efforts to reduce tobacco use among Aboriginal and Torres Strait Islander Peoples.

The strategy, as it currently stands would benefit from strengthening up commitments to action items, to make accountability, governance, responsibility, and timelines for implementation clearer.

We believe that for some of the key intervention areas, a clear commitment should be made to implementing that actions that are needed to achieve desired outcomes, such as minimising the appeal and addictiveness of smoked tobacco products and restricting the supply and availability of these products. A firm commitment to implementing controls on the constituents and emissions of tobacco products is consistent with expectations under Article 9 of the WHO FCTC. We note that reducing nicotine content in tobacco products is listed under Priority 8 (Action 8.10), however it fits better under Priority Area 7. Currently, the text for these action items is unclear as to what action will be taken, what level of commitment there is to the policy, or which level of government will lead and be responsible for developing and implementing the policy, and what the timeline for

implementation is. The actions will be more likely to be implemented if these factors are clearly specified.

The recently released Smokefree Aotearoa 2025 Action Plan is an example that included more firm commitments to, and timeframes outlined for the types of policies that will be needed to achieve a <5% smoking prevalence goal by 2030 in Australia, such as:

- restricting sales to a reduced number of authorised retailers
- prohibiting sale and supply of smoked tobacco products to people born after specified date – to create a smokefree generation
- legislating to mandate only very low nicotine content smoked tobacco products are available for sale
- introducing other measures to restrict product design features that enhance appeal and addictiveness
- working across Government to minimise the health and environmental impacts of filters

Below we provide specific comment on several priority areas, and the listed actions, and provide additional suggestions for areas that could be further strengthened.

Priority Area 1: Protect public health policy, including tobacco control policies, from tobacco industry interference

Regarding Action 1.4, we recommend the removal of the phrase "or to require full disclosures of such contributions," as these donations should be banned outright 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 strongly support **Action 1.5**, and support the implementation of substantial fines for non-compliance, and a mechanism for investigating compliance.

Regarding Action 1.6, the voluntary content disclosures submitted by the tobacco industry should be replaced with mandatory disclosures in a prescribed form that is more useful to understanding how much of each ingredient is added to cigarettes. This could be modelled on Canada's Tobacco Reporting Regulations.[14]

Regarding Action 1.7, we support action to increase the transparency of tobacco industry use of corporate social responsibility claims and to prevent the tobacco industry from using corporate social responsibility promotions and rhetoric to promote their industry and products. The tobacco industry uses "human rights," "sustainable development" and "sustainability" rhetoric interchangeably throughout its public-facing corporate reporting and Environmental and Social Governance (ESG) documentation to propose it is comprehensively meeting its Corporate Social Responsibility obligations. Often in such

documentation, the tobacco industry emphasises that human rights mandates and sustainability principles are central to their supply chain and procurement practices.

If tobacco control researchers, Australian consumers and ESG compliance regulators are to robustly examine these claims to ensure their accuracy for genuine ESG accountability and governance purposes, then it is important that the packaging of tobacco products sold in Australia not only name where that product is made, but where the tobacco within that product originates from. This is crucial for two reasons. First, to ensure that tobacco companies operating in Australia are not in breach of the Modern Slavery Act 2018 (Commonwealth), which aims to create transparent supply chain processes and practices that uphold human rights (including extra-territorial, cross-border processes and practices). The International Labour Organization (ILO) estimates that the agricultural sector accounts for 11% of all incidents of forced labour and over 70% of all child labour globally[15,16]; and the role tobacco farming and production plays in all global regions on forced labour, human trafficking, and human rights protection and promotion remains a tremendous concern.[17] The second key reason it is important that tobacco company's identify not only where their products are made but which country (or countries) the tobacco is sourced from is to ensure that the environmental policies of and in those countries are consistent with the Paris Climate Agreement and Sustainable Development Goal 2030 Agenda, and that tobacco farming and production is also consistent.

Philip Morris International (PMI) Australia is also a signatory of the Australian Packaging Covenant, which is a national regulatory framework under the National Environment Protection (Used Packaging Materials) Measure (NEPM) that sets out how government and businesses across Australia share the responsibility for managing the environmental impacts of packaging.[18] PMI Australia also won an Industry Sector Award in 2020 for sustainable packaging excellence.[19] Finalists are assessed based on Members' Annual Reporting scores and their performance against the Packaging Sustainability Framework criteria. It is indeed concerning that PMI Australia can win a sustainability award considering the enormous environmental damage caused throughout the entire life-cycle of cigarettes.

Regarding Action 1.9, this action should include exploration of making tobacco companies responsible for the full impact of tobacco on health, the value of years of life lost, and on the true and full costs of the environmental impact of tobacco product litter and carbon emissions. Currently, the community (e.g., local governments and volunteer environmental groups) bear the costs of cleaning up and disposing of tobacco product waste, while the tobacco industry profit from the sale of a product that is highly littered. We also believe that such financial liability should be applied retrospectively, to cover historical damage, not just future impacts. There should also be exploration of the possibility of imposing a Corporate Death Sentence on tobacco companies, considering the disproportionate, unacceptable, and improper harmful impacts of this industry. No other consumer product results in death when used exactly as intended. The appropriateness of allowing tobacco companies to

continue operating indefinitely on a commercial 'for profit' basis, considering the nature of the product they produce, needs to be examined. Serious consideration should be given to potential alternative models of tobacco supply that do not incentivise the maintenance of smoking for commercial gain. Imposing corporate criminal responsibility for tobacco company actions that are likely to lead to avoidable tobacco-related deaths through obstructing tobacco control policies could be consistent with the corporate criminal responsibility reforms proposed by The Australian Law Reform Commission and should be explored as a way to protect against tobacco company 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

We strongly support this Priority Area.

The Strategy notes the increase in the use of digital media during the life of the previous Strategy, and the importance of continued monitoring of the effectiveness of various types of media for promoting smoking cessation. Research by Tobacco Endgame CRE researchers[20] and others[21] shows that social media platforms are one of the main channels that young people regularly receive information from, and that an abundance of e-cigarette and tobacco related content is available online without meaningful age-restrictions. As such, mass media campaigns and tighter regulation on social media platforms are needed to counteract the marketing of tobacco and alternative non-therapeutic nicotine products, particularly via channels that are highly accessed by youth.[20] We would like to highlight the following publication:

> Sun T, Lim CCW, Chung J, Cheng B, Davidson L, Tisdale C, Leung J, Gartner CE, Connor J, Hall WD, Chan GCK. Vaping on TikTok: a systematic thematic analysis. Tobacco Control. 2021;tobaccocontrol-2021-056619.

We agree that including information about the toxic constituents of cigarette smoke could be a promising way to increase awareness of the risks of smoking. We also caution that this information needs to be presented in a way that also conveys the origin of these toxic constituents. Other research found that some people have misinterpreted information on health promotion materials about the toxic constituents of tobacco smoke as implying these are deliberately added to the tobacco cigarette, rather than arising as a natural consequence of burning tobacco leaves.[22] The implication of this research is that some people mistakenly interpret these messages as implying that 'additive-free', 'natural', 'organic' or 'high quality' cigarettes will contain fewer of these harmful chemicals. Lack of understanding that these harmful constituents are present in all cigarette smoke because

they are generated from the combustion of tobacco leaves, not from added ingredients, can lead consumers to switch to brands that are marketed as low in additives, rather than making a quit attempt.

Other studies have found that people also misattribute the harms of smoking to nicotine instead of combustion products.[21-23] This misunderstanding can discourage consumers from using evidence-based smoking cessation aids, such as nicotine replacement therapy or lead to ineffective use, such as under-dosing. As such, it is crucial that health warnings and mass media campaigns provide clear, consistent, and accurate messages about the relative harms of nicotine products, and that these messages are consumer tested, to ensure that the messaging is understandable, accepted by consumers, and effective in reducing harms.[21-23]

We believe that education efforts should also aim to increase the practical knowledge of consumers to enable them to make informed choices. The US Food and Drug Administration Center for Tobacco Products has produced some educational materials that take consumers through the origin of the chemicals in tobacco smoke from the tobacco plant, manufacturing, and combustion ('Chemicals in Cigarettes: From Plant to Product to Puff' campaign). We believe examples such as this, alongside warning labels that convey similar information in a shortened form, may hold promise for empowering consumers with the knowledge to be able to make informed choices.[23] Research on educational campaigns such as the FDA's 'Chemicals in Cigarettes: From Plant to Product to Puff' campaign should be researched for effectiveness among Australian consumers. Publications we would like to highlight include:

> King B, Borland R, Morphett K, Gartner C, Fielding K, O'Connor R, Romijnders K, Talhout R. 'It's all the other stuff!' How smokers understand (and misunderstand) chemicals in cigarettes and cigarette smoke. Public Understanding of Science. 2021;30(6);777–796.

Related to Actions 2.4 and 2.6, we support rigorous developmental research to inform education campaigns and to evaluate them; we also support sharing campaign material with the global tobacco control community, but also to consider reusing or adapting materials that have been developed by other countries, such as the FDA's 'Chemicals in Cigarettes: From Plant to Product to Puff' campaign.

Regarding Action 2.7, we also encourage research into the development of new graphic health warnings that develop a deeper understanding of where the chemicals in tobacco smoke come from to empower consumers to make informed choices, such as quitting rather than switching to additive free cigarettes on the mistaken belief that these are less harmful.

Regarding Action 2.8, we support developing health warnings and other messages that encourage consumers to rethink the normalcy of tobacco as a consumer product and to think about it in terms of how other products are regulated. We believe that packaging

inserts could be used to inform consumers of proposed regulatory changes to tobacco products to communicate to consumers why such changes are appropriate and beneficial for society and for people who smoke. We also believe that messages that encourage people to reflect upon whether their smoking is a 'free choice' or one that is driven by addiction to smoking would be useful for challenging tobacco industry messages that seek to hide the role of addiction in smoking. Furthermore, the effectiveness of messages that emphasise the tobacco industry's role in addicting young people, the profits they make for each person who dies from smoking, and the lack of concern for customers' health and well-being are worth exploring.

Priority area 3: Continue to reduce the affordability of tobacco products

We support Priority Area 3- "continue to reduce the affordability of tobacco products". Research by Tobacco Endgame CRE researchers (Ms Ara Cho, Dr Gary Chan and Assoc Prof Coral Gartner) that is currently under review with a journal found that since 2013, the cost of smoking became the most cited motivator to change smoking behaviour in Australia (e.g., quitting, cutting down), replacing health concerns, which dominated between 2007 to 2010. Financial concerns were particularly cited by those who live in low socioeconomic areas, smoke more cigarettes per day, drink alcohol, and experience high/very high psychological distress. This research shows the vital role that price measures have for motivating behaviour change. We are happy to share a copy of the manuscript confidentially before publication, or more freely once published.

Relevant to **Actions 3.4, 3.5, and 3.6**, we emphasise that increases in tobacco product prices should also be accompanied by additional support to quit smoking. This support should be proactively offered and supplied free of charge. We believe that there should be a commitment to use tobacco tax revenue to fund these support services, particularly for low-income populations. This is not only a fair use of these funds, but also increases the public acceptability of applying high rates of tobacco taxation. We discuss smoking cessation assistance further in comments related to Priority area 11.

Tobacco harm reduction with lower risk non-smoked nicotine products may also have a role to play in countering potential unintended adverse impacts of high tobacco taxation for people who smoke who are not ready to quit nicotine use. Behavioural economic research has previously found that the availability of lower priced nicotine products is likely to generate greater reductions in smoking from increasing tobacco tax on cigarettes, than if the tax increases are implemented on their own.[24] Differential tax rates on products based on differential risks (with cigarettes taxed at the highest rate) is also recommended by leading tobacco control economists.[25] This would result in taxes on tobacco products being higher than any tax rates on non-smoked nicotine products, including e-cigarettes. This acknowledges evidence showing significantly reduced harm associated with non-smoked

nicotine product use compared to combustible tobacco use.[26] Publications we wish to highlight are:

> Gartner C, Jimenez-Soto E, Borland R, O'Connor R, Hall W. Are Australian smokers interested in using low-nitrosamine smokeless tobacco for harm reduction? Tobacco Control. 2010;19(6):451-6.
>
> Chaloupka F, Sweanor D, Warner K. Differential Taxes for Differential Risks—Toward Reduced Harm from Nicotine-Yielding Products. New England Journal of Medicine. 2015;373;595-597.

Regarding **Action 3.4**, we support careful examination of the impacts of the effects of tobacco excise increases, including on young people and in low-income populations. Furthermore, while we agree that real price increases used in tandem with mass-media advertising campaigns are effective in promoting quitting among the general population and among priority populations, research by Tobacco Endgame CRE authors highlights the unique needs of people from priority populations when quitting smoking, and the need for targeted mass media campaigns.[27-30] Publications we would like to highlight include:

> Guillaumier A, Bonevski B, Paul C. 'Cigarettes are priority': a qualitative study of how Australian socioeconomically disadvantaged smokers respond to rising cigarette prices. Health Education Research. 2015;30(4):599-608.
>
> Guillaumier A, Bonevski B, Paul C. Tobacco health warning messages on plain cigarette packs and in television campaigns: a qualitative study with Australian socioeconomically disadvantaged smokers. Health Education Research. 2015;30(1):57-66.
>
> Guillaumier A, Bonevski B, Paul C, D'Este C, Doran C, Siahpush M. Paying the price: a cross-sectional survey of Australian socioeconomically disadvantaged smokers' responses to hypothetical cigarette price rises. Drug and Alcohol Review. 2014;33(2):177-85.
>
> Puljević C, Snoswell A, Rivas L, Ali MM, de Greef W, Ferris J, Gartner C. 'Money up in smoke': The financial benefits of smoking cessation may be more motivating to people who are homeless than potential health gains. Drug and Alcohol Review. 2021;40(7):1308-1314.

Regarding Action 3.6, we strongly support increasing efforts to prevent and minimise the illicit tobacco trade, and recommend research on how best to monitor both the illicit supply and the consumer demand for illicit products. The recently completed Parliamentary Inquiry into illicit tobacco in Australia concluded that "to tackle illicit tobacco, the first step is to develop an understanding of the scope of the problem… and what is driving supply and demand."[31] However, no substantive research has explored the factors driving demand for

illicit tobacco in Australia in over 15 years. An Australian study conducted in 2002 found that the primary driver for illicit tobacco use was its cheaper price compared to licit tobacco.[32] In contrast, a 2007 nationally representative survey found that price did not influence most consumers' decision to use illicit tobacco.[33] We also note that there is little research on how to reduce consumer demand for illicit tobacco. Considering these contradictory findings, and that the 2007 study is the most recent Australian study exploring consumer perspectives on illicit tobacco, there is a clear need for further research on this topic. Insight into why people do or do not buy illicit tobacco is critically important to inform the design of appropriate policies to deter this criminal behaviour.

Regarding Action 3.7, we support further action on reducing the affordability of tobacco products, such as by introducing a minimum floor price and once-only price changes after each excise increase. We also suggest requiring the tobacco industry to pay for the health, environmental and social impacts of tobacco products via taxes such as via a super tax applied directly on the industry rather than via excise applied directly to the products.

Priority area 4: Continue and expand efforts and partnerships to reduce tobacco use among Aboriginal and Torres Strait Islander People

We support the actions outlined under priority area 4, however we recommend including action to strengthen Aboriginal and Torres Strait Islander leadership and governance over tobacco control interventions that target these populations. Many of the actions listed focus on individual support to quit smoking. While this is critical, as is greater investment in these services and culturally safe educational programs, such as mass media campaigns and health education delivered through brief interventions, a role for wider environmental changes that support communities to become smokefree should be considered in partnership with Aboriginal and Torres Strait Islander community leaders. It is essential that such interventions are determined by Aboriginal and Torres Strait Islander People. In Aotearoa, Māori leadership was instrumental in driving an action plan to achieve a smokefree nation that includes population-based policies that have greater potential to reduce inequity in tobacco related disease, such as by reducing the nicotine content of cigarettes to reduce their addictiveness and reducing retail availability of tobacco products. Further research is needed on whether such policies could also have support among Aboriginal and Torres Strait Islander Peoples. We would like to highlight the following relevant publications:

> Colonna E, Maddox R, Cohen R, Marmor A, Doery K, Thurber K, Thomas D, Guthrie J, Wells S, Lovett R. Review of tobacco use among Aboriginal and Torres Strait Islander peoples. Australian Indigenous Health Bulletin. 2020;20(2). Retrieved from https://aodknowledgecentre.ecu.edu.au/learn/specific-drugs/tobacco/

Maddox R, Bovill M, Waa A, Gifford H, Martinez S, Clark H, Bradbrook S, Calma T. Reflections on Indigenous commercial tobacco control: 'The dolphins will always take us home.' Tobacco Control. 2022;31:348-351.

Maddox R, Waa A, Lee K, Nez Henderson P, Blais G, Reading J, Lovett R. Commercial tobacco and Indigenous Peoples: a stocktake on Framework Convention on Tobacco Control progress. Tobacco Control. 2019;28(5):574-581.

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 agree with the inclusion of this priority area. Research by Tobacco Endgame CRE researchers provides a description of these populations (i.e., people who experience low socioeconomic status, severe mental illness, incarceration, identify as Aboriginal or Torres Strait Islander, or live in remote areas) and highlights the urgent need to address the disproportionate rates of tobacco use among these populations compared to the general community.[12] While there is a common misperception that people from these populations are not interested in quitting, research by Tobacco Endgame CRE researchers has found a high level of interest in quitting among these populations, including among people who experience socioeconomic disadvantage,[34,35] incarceration,[36] and homelessness.[34,35,37]

A systematic review and meta-analysis of the effectiveness of behavioural smoking cessation interventions among these priority populations by Tobacco Endgame CRE researcher Prof Billie Bonevski and colleagues found a significant increase in cessation for behavioural support interventions targeted at low-income women at short-term follow-up, and behavioural support interventions targeted at individuals with a mental illness at long-term follow-up.[38] They also noted that two approaches (a self-help Cognitive Behavioural Therapy program and brief advice integrated in dental care) targeting low-income individuals from deprived areas demonstrated significant increases in smoking abstinence rates, and that the addition of NRT to behavioural support for pregnant women who smoke more than five cigarettes per day may increase cessation rates.[38] We encourage the consideration of this research and other similar research when considering specific efforts to reduce tobacco use among these high-risk populations.

We note that the NTS mentions that "governments or other organisations" are not limited from targeting populations with high rates of tobacco use. Here it is important to consider research from CRE researcher Prof Billie Bonevski and colleagues that found that 93% of a sample of senior staff in Australian non-government social and community service organisations indicated that their organisation did not provide smoking cessation support for clients, and 78% indicated that client smoking status was not recorded on case notes.[39]

These findings demonstrate that Australian non-government social and community service organisations require further support to integrate smoking cessation support into usual care, with particular focus on education, training and support for staff to enable them to help their clients quit smoking.[39] Additional resourcing of staff time could also assist these organisations to allocate more assistance to clients to support quitting.

Regarding Actions 5.1 to 5.8, we strongly agree that additional support via targeted programs are needed. Furthermore, better integration, tailoring and promotion of existing smoking cessation support should be funded, with active referral to quit support embedded into routine contact with services. We wish to highlight three existing programs with demonstrated effectiveness that should be expanded: Queensland Quitline's Intensive Quit Support Program (IQSP), Central Queensland's 10,000 Lives Initiative, and the Queensland Public Mental Health Services implementation of the Smoking Cessation Clinical Pathway: SCCP.

First, Quitline's IQSP is a free Queensland government-funded smoking cessation program that provides 12 weeks of nicotine replacement therapy and weekly telephone counselling to people who smoke from identified priority groups.[37,40] The populations eligible for the IQSP are those recognised as having a higher smoking prevalence than the overall Queensland population or are at higher risk of adverse smoking outcomes. These populations include pregnant women, people released from prison, or people experiencing homelessness, unemployment, or economic stress, and people living in region, rural and remote areas with a smoking prevalence that is higher than the state average. The program generally relies on organisations who work with the target populations to refer their eligible clients to the program rather than using widespread advertising.[37] Wider publicity of the program and expansion of the eligibility criteria, could address the current under use of Quitline[40]; for example, fewer than 2% of Australians who smoke used a Quitline service in 2019.[41] However, the program's current resourcing caps the number of people able to access the program each year. A 2021 cross-sectional study of 66 men experiencing homelessness in Brisbane conducted by Tobacco Endgame CRE researchers found a low level of awareness (35.3% of participants) but moderate interest (56% of participants) in the program.[37] This program represents a valuable opportunity to link people from priority populations who smoke to a free and existing evidence-based service; we thus strongly recommend further funding and expansion of the IQSP program to other populations and states.[37,40]

Second, the "10,000 Lives" initiative is an existing health promotion campaign run by the Central Queensland (CQ) Public Health Unit, in partnership with the CQ Hospital and Health Service (CQHHS).[40,42] In response to the higher than state-average smoking prevalence in Central Queensland, the CQHHS set a goal of reducing the daily smoking rate in CQ from 16.7% in 2015-2016 to 9.5% by 2030. Achieving this target is equal to reducing the number of people who smoke by 20,000, resulting in saving "10,000 Lives" from premature smoking-

related mortality, based on the estimate that half of all people who smoke without quitting will die prematurely. The “10,000 Lives” initiative promotes existing smoking cessation support services, particularly Quitline’s IQSP, to clinical populations and the wider community in CQ using multiple strategies.[40] Briefly, “10,000 Lives” is coordinated by a Senior Project Officer, who identifies potential champions from CQHHS who are encouraged to implement smoking cessation activities. Clinicians are encouraged to identify patients who smoke and to refer them to Quitline either through the Smoking Cessation Clinical Pathway (SCCP), the Quitline on-line referral form, or encouraging the client to contact Quitline themselves via telephone or the website (https://quithq.initiatives.qld.gov.au/). Tobacco Endgame CRE researchers conducted a time series analysis to measure the impact of 10,000 Lives on monthly referrals to, and use of Quitline services (counselling sessions and nicotine replacement therapy (NRT) dispatched by Quitline), in CQ compared to other areas in the state (control population).[40] The research team found that there was a 238.5% increase for the monthly rate of referrals to Quitline per 1,000 smoking population, and a 248.6% increase in the monthly rate of initial counselling sessions completed per 1,000 smoking population.[40] These findings show that a locally coordinated health promotion program can promote and boost referrals to, and use of Quitline smoking cessation services, and we recommend the expansion of this program into other jurisdictions.[40,42]

Queensland Public Mental Health Services used a service improvement approach to introduce routine screening and delivery of an evidence-based brief intervention to adult public mental health services statewide (Smoking Cessation Clinical Pathway: SCCP).[43] This approach commenced in 2015 and has resulted in significant statewide improvements in the recording of smoking and delivery of the brief intervention in inpatient units.[44] In 2017, this approach was extended to include community mental health services and combined with the introduction of a mandatory smoking screening question in the mental health statewide clinical information system and a Queensland Health Quality Improvement payment (QIP) has also resulted in improvements in reporting of smoking and delivery of a brief smoking cessation intervention (SCCP). Notably, unpublished results indicate that these improvements have been sustained for over five years in inpatient services and, following conclusion of the QIP, community mental health services. Further, the Queensland public community mental health smoking rate has shown a decline from 51.6% in 2018 to 50.2% 2021.

Publications we would like to highlight include:

> Khan A, Green K, Khandaker G, Lawler S, Gartner C. How can a coordinated regional smoking cessation initiative be developed and implemented? A programme logic model to evaluate the '10,000 Lives' health promotion initiative in Central Queensland, Australia. BMJ Open. 2021;11(3):e044649.
>
> Khan A, Green K, Khandaker G, Lawler S, Gartner C. The impact of a regional smoking cessation program on referrals and use of Quitline services in Queensland, Australia:

a controlled interrupted time series analysis. Lancet Regional Health Western Pacific. 2021;14:100210.

Plever S, McCarthy I, Anzolin M, Emmerson B, Allan J, Hay K. Queensland smoking care in adult acute mental health inpatient units: Supporting practice change. Australian and New Zealand Journal of Psychiatry. 2020;54(9);919-927.

Plever S, Gartner C. Smoking cessation support should be free, accessible and proactively offered. Medical Journal of Australia. 2022;216(7): https://doi.org/10.5694/mja2.51468.

De Guzman K, Snoswell C, Puljevic C, Gupta D. Evaluating the utility of a Smoking Cessation Clinical Pathway tool to promote nicotine prescribing and use among inpatients of a tertiary hospital in Brisbane, Australia. Journal of Smoking Cessation. 2020;15(4):214-218.

Puljević C, Snoswell A, Rivas L, Ali MM, de Greef W, Ferris J, Gartner C. 'Money up in smoke': The financial benefits of smoking cessation may be more motivating to people who are homeless than potential health gains. Drug and Alcohol Review. 2021;40(7):1308-1314.

Webb AR, Coward L, Meanger D, Leong S, White S, Borland R. Offering mailed nicotine replacement therapy and Quitline support before elective surgery: a randomised controlled trial. Medical Journal of Australia 2022; 216(7): https://doi.org/10.5694/mja2.51453.

Regarding Action 5.5, we agree with this Action, however we also emphasise the need for continuity of care across settings. For example, supplies of NRT should align with evidence-based guidelines, such as ensuring the amount supplied is consistent with a treatment duration that is sufficient to support a quit attempt (i.e., not only enough supply for a few days). Quitline services and additional smoking cessation support should be integrated into longer term residential settings, such as community care units.

Regarding Action 5.6, we strongly support this Action, but feel that this Action would benefit from further detail, such as the type of cessation support that would be most effective, the ideal time for this support to be provided, and which organisation(s) should be responsible for providing this support.

First, there is evidence for the provision of nicotine replacement therapy, especially nicotine lozenges, in Australian prisons, at no cost. Australians entering prison smoke tobacco at a rate of six times the general community,[11] and people who experience incarceration experience significantly higher rates of smoking-related illness compared to the general population.[45] When prison smoke-free policies were first introduced in Australia, prisons in many states (e.g., Queensland and the Northern Territory) offered nicotine replacement

therapy in the form of nicotine patches to people entering prison to assist with nicotine withdrawal. However, following reports of people making cigarettes from diverted nicotine patches (known as "teabacco"),[46] correctional authorities removed all nicotine patches from their facilities.[45] Instead, nicotine lozenges were available for purchase. While research by a Tobacco Endgame CRE researcher found that some people then made cigarettes from nicotine lozenges instead,[47] a forensic analysis of this form of teabacco found that it still represented a harm reduction intervention even when misused because it would be less harmful than smoking teabacco made from nicotine patches or smoking traditional tobacco cigarettes.[48] As such, considering the lower potential health harm of smoking teabacco made from lozenges,[48] and strong evidence showing the clear role of nicotine lozenges in assisting people to quit,[49] overcoming nicotine withdrawal (which may result in irritability, anger, and frustration, among other symptoms[50]) and maintaining long-term smoking cessation,[49] we recommend that nicotine lozenges, at a minimum, be provided in prisons, at no cost. A report by Western Australia's Office of The Inspector of Custodial Services also recommended the provision of nicotine lozenges in smoke-free prisons.[51] Furthermore, as explained below, people in prison should be able to access government-subsidised tobacco cessation pharmacotherapies (i.e., varenicline, bupropion or nicotine replacement therapy) to assist with the symptoms of forced cessation through the Pharmaceutical Benefits Scheme (PBS). This low-cost and highly effective[52] means of smoking cessation support is available in the general community, yet people in prison are not able to access smoking cessation pharmacotherapy through the PBS, in direct contradiction of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).[53,54]

There is also evidence for the effectiveness of behavioural counselling promoting smoking cessation among this population.[55] For example, a randomised controlled trial of an intervention consisting of six weekly sessions of motivational interviewing and cognitive behavioural therapy delivered just before release from prison found significantly increased rates of tobacco abstinence three months after release from a smoke-free prison.[56] Research by Tobacco Endgame CRE researchers strongly suggests that behavioural counselling in this setting would benefit from promoting social support for smoking cessation among the individual's friends and family, strengthening motivation to remain abstinent post-release from smoke-free prisons, promoting engagement with treatment for other substance use, and providing strategies for coping with the stress typically encountered by those recently released.[57]

In terms of the ideal timing for the provision of this support, we strongly recommend that smoking cessation support is provided in prison, at the time of release, and immediately following release from prison. While support in prison assists with quitting and overcoming nicotine withdrawal (as described above), support provided at the time of release and immediately following release (ideally though an integrated program that engages with people just before release and assists with transition into the community) will help people to maintain their hard-won abstinence following release from smoke-free prisons. This is

important because evidence from Tobacco Endgame CRE researchers shows high rates of smoking relapse upon release from smoke-free prisons,[57] including evidence from a cross-sectional study, which found that 94% of a sample of 114 people released from smoke-free prisons in Queensland resumed smoking within two months of release (72% on the day of release).[36] Despite this, there are currently no formal programs offered to people being released from smoke-free prisons to maintain their hard-won smoking abstinence after release. People released from smoke-free prisons have a head-start on smoking cessation,[58] as most have been abstinent past the duration of nicotine withdrawal.[59] The lack of programs promoting the maintenance of smoking abstinence among people leaving smoke-free prisons represents a clear missed opportunity for multiple reasons. First, there are clear health benefits of continued smoking abstinence for people who cycle through prison, who demonstrate markedly higher rates of smoking-related illness compared to the general population.[45] Second, high rates of smoking relapse (combined with high rates of recidivism) are likely to result in higher costs related to treating smoking-related illnesses for both prison- and state-level healthcare agencies, and compound the financial hardship typically experienced by individuals recently released from prison. Finally, the provision of smoking cessation interventions for people who experience incarceration is justified on equity grounds,[54] as the principle of equivalence outlined in international human rights conventions dictates that people in prison are entitled to healthcare equivalent in standard to that of people living in the community. However, in direct contradiction of these conventions,[53] people who smoke who enter prison in Queensland are only able to purchase nicotine lozenges (at a cost of approximately $12 for 20 lozenges in 2017) in some prisons and are currently prohibited from accessing government-subsidised tobacco cessation pharmacotherapies to assist with the symptoms of forced cessation, barring them from accessing a low-cost and highly effective[52,57] means of smoking cessation support available to members of the community.[60] Furthermore, research found that only 8.9% of a sample of 971 smokers released from prison in Queensland accessed government-subsidised smoking cessation prescription medication (varenicline or bupropion) or nicotine patches in the two years following release.[60] This shows that despite a very high rate of tobacco use among people cycling through prison, and the very low cost of (subsidised) smoking cessation pharmacotherapy in Australia, few people obtain pharmaceutical assistance with quitting smoking following release from prison, and that there is a clear need to support this population to access smoking cessation pharmacotherapy, to reduce the high rate of tobacco-related morbidity and mortality in this profoundly marginalised population.

There is clear benefit in embedding routine referral to smoking cessation support in probation and parole settings.[61] For example, individuals who indicate that they use tobacco could receive an immediate and automated referral to Quitline's Intensive Quit Support Program.[37,40] As part of this program, people released from prison are eligible for a free program consisting of weekly behavioural counselling calls from Quitline, and 12 weeks of nicotine replacement therapy. However, awareness of this free and evidence-based service

is low; for example, as of 2018, this program had only been advertised to Queensland's probation and parole staff via one email, resulting in only a handful of referrals.

In summary, we recommend the provision of free nicotine lozenges in prison settings (at a minimum), and a formal program consisting of behavioural counselling and pharmacotherapy offered just before and after release from prison. At a minimum, people being released from prison should be offered information on how to access government-subsidised smoking cessation therapy,[60] or the evidence-based Intensive Quit Support program (offered through Quitline)[37] following their release from prison.[60] Referral to smoking cessation support should be embedded as part of routine care[61] for all people presenting at Probation and Parole services who indicate tobacco use. Enforced tobacco abstinence does not address the behavioural or social triggers that influence smoking in a way that can sustain abstinence after release from smoke-free prisons. Hence, rates of smoking and smoking-related illness among people who experience incarceration will continue to be high until smoking cessation support becomes routine for this population.

Publications we wish to highlight include:

Puljevic C, de Andrade D, Coomber R, Kinner SA. Relapse to smoking following release from smoke-free correctional facilities in Queensland, Australia. Drug and Alcohol Dependence. 2018;187:127-133.

Puljevic C, Segan CJ. Systematic Review of Factors Influencing Smoking Following Release from Smoke-Free Prisons. Nicotine and Tobacco Research. 2019;21(8):1011-1020.

Puljevic C, de Andrade D, Carroll M, Spittal MJ, Kinner SA. Use of prescribed smoking cessation pharmacotherapy following release from prison: a prospective data linkage study. Tobacco Control. 2018;27(4):474-478.

Hefler M, Hopkins R, Thomas D. Successes and unintended consequences of the Northern Territory's smoke-free prisons policy: results from a process evaluation. Public Health Research and Practice. 2016;26(2).

Puljevic C, Coomber R, Kinner SA, et al. 'Teabacco': Smoking of nicotine-infused tea as an unintended consequence of prison smoking bans. Drug and Alcohol Review. 2018;37(7):912-921.

Mitchell C, Puljevic C, Coomber R, White A, Cresswell S, Bowman J, Kinner S. Constituents of "teabacco": A forensic analysis of cigarettes made from diverted nicotine replacement therapy lozenges in smoke-free prisons. Drug Testing and Analysis. 2019;11(1):140-156.

Concerning Action 5.7, we strongly agree with this Action, and refer to the examples of the Intensive Quit Support program (IQSP), 10,000 Lives program and Public Mental Health

Services in Queensland as examples of existing collaborations between services that successfully promote smoking cessation and the health system. As described above, limited funding caps the number of people able to access the IQSP each year, thus limiting the number of people able to seek support from the program to quit smoking. We recommend that further research on the program's effectiveness is conducted to establish the value in increased funding and expansion of this program.

Queensland Public Mental Health Services have developed a partnership with Queensland Quitline to deliver a Ready to Quit Program for the priority group of public community mental health consumers. This provides four support phone calls, three evaluation calls, and 12 weeks of free NRT. A proactive referral process enables public community mental health clinicians to refer consumers directly to the program. Results from this program have demonstrated consistent results in terms of 3, 6 and 12 month quit rates. Despite this, a yearly cap has been placed on all priority group programs. The cap is under the number of places community mental health consumers have used over the 4 years prior. This means that many public community mental health consumers will not be able to access this program. More concerningly, those that would like to access the program will be turned away. This places mental health clinicians in a difficult position where they risk referring consumers for support to have them declined because the cap has been reached. Increasing resourcing of this program is needed to be able to support all those who would benefit from access to it.

Regarding Action 5.9, We strongly support this recommendation, and further recommend that such census questions are paired and linked with questions about alcohol use considering associations between alcohol and tobacco use; for example, many individuals who use alcohol at risky levels are more likely to smoke heavily and vice versa.[62] Given the enormous impacts of tobacco use on health, economic, and social well-being, we believe that adding a question to the Census on this issue is warranted. Furthermore, this would assist with calibrating other population-based surveys, such as the National Drug Strategy Household Survey, the ABS National Health Survey, and the International Tobacco Control Policy Evaluation Project Survey. This would also link with the National Wastewater Drug Monitoring Program, which conducts an extensive wastewater sampling campaign to coincide with the Census, to obtain the most accurate population figures for each sampled catchment. Tobacco Endgame CRE Researchers (Assoc Prof Coral Gartner and Assoc Prof Kathryn Steadman) are currently conducting biomarker research to refine the use of wastewater analysis to estimate the quantity of tobacco that has been smoked in a catchment. Linking this data to sales data can help to refine the estimation of the illegal market, which is valuable for tax gap analysis and monitoring of the size of criminal activity. Addition of this question to the Census would also be extremely valuable for monitoring if the the NTS is successful in reducing smoking among priority populations, among whom obtaining a sufficiently representative sample is often extremely challenging. Indeed, a

Census question on smoking may be the only practical way to measure smoking among some hard-to-reach populations.

We would like to highlight the following publications by Tobacco Endgame CRE researchers:

> Thomas D. & Scollo M. Should a smoking question be added to the Australian 2021 census? Australian and New Zealand Journal of Public Health. 2018;42(3);225-226.
>
> O'Brien J, Grant S, Banks A, Bruno R, Carter S, Choi P, Covaci A, Crosbie N, Gartner C, Hall W, Jiang G. A National Wastewater Monitoring Program for a better understanding of public health: A case study using the Australian Census. Environment International. 2019;122:400-411.
>
> Gartner C. Flushing out smoking: Measuring population tobacco use via wastewater analysis. Tobacco Control 2015; 24:1-2.

Priority area 6: Eliminate remaining tobacco-related advertising, promotion and sponsorship.

We support further action to eliminate remaining avenues of tobacco-related advertising, promotion and sponsorship.

Regarding Action 6.2 we strongly support prohibiting other forms of tobacco promotion. Advertising of price specials and displays of tobacco products at point of sale should be prohibited. Tobacco products should not be included in any type of reward or loyalty program/s for receiving or redeeming points. Tobacco retailers and proprietors of hospitality venues should not receive incentives or rebates by tobacco manufacturers, importers, or wholesalers, including support to meet the costs of retail compliance with tobacco control regulation. As a minimum requirement, all incentives and rebates should be reported and be publicly available.

Regarding Action 6.6 we strongly support monitoring, identifying and acting to prohibit the promotion of tobacco products on current and emerging platforms. Many media platforms have taken steps to control and report the spread of health misinformation in relation to COVID-19 for the health and safety of people who use the platforms, and there would be benefit in extending this to information on tobacco. Further, brief interventions embedded within the platforms have been shown to reduce the sharing of misinformation.[63] For Action 6.6 this would require support from media platform organisations as well as users for reporting of tobacco advertising, promotion and sponsorship seen on the media platforms.

Regarding Action 6.4, we strongly recommend requiring tobacco companies, importers, and wholesalers of tobacco products in Australia to report details and expenditure on any form of tobacco promotion and marketing activity, including contributions to third parties.

Furthermore, we support prohibiting such activities. For further examples of actions we support to restrict tobacco marketing and promotion see comments provided related to priority area 1.

Here we highlight the following publication:

> Jahanbakhsh F, Zhang A, Berinsky A, Pennycook G, Rand D, Karger D. Exploring Lightweight Interventions at Posting Time to Reduce the Sharing of Misinformation on Social Media. Proceedings of the ACM on Human-Computer Interaction, 2021;5(CSCW1):1-42.

Priority area 7: Further regulate the contents and product disclosures pertaining to tobacco products.

Australia is falling behind on regulating the design and content of tobacco products. Industry documents show that tobacco companies manipulate ingredients and design features of cigarettes, to increase their addictiveness and appeal,[64] making smoking difficult to quit and addicting new generations. In Australia, there is little regulation of the contents and design features that make cigarettes addictive and appealing, despite other countries progressing these policies. Regulating cigarette contents and design could substantially increase quitting and protect future generations from tobacco addiction while fulfilling Australia's international obligations as a signatory to the WHO's Framework Convention on Tobacco Control (FCTC).

There are three main content and design aspects of tobacco products that we recommend regulating:

1. *Reducing nicotine content to non-addictive levels*

Nicotine is the primary addictive component in tobacco. Evidence reviews and modelling from the USA suggests that reducing nicotine by at least 95% of typical cigarette levels could save millions of lives and billions of dollars in health expenditure.[65] [66] Reviews of randomised trials have concluded that use of Very Low Nicotine Content Cigarettes (VLNCs), compared to standard nicotine content cigarettes, leads to a reduced number of cigarettes smoked per day, a reduction in nicotine dependence, and is likely to increase smoking cessation.[67] Mandating a VLNC standard for all cigarettes in New Zealand is a critical policy component of the country's Action Plan to reduce smoking to less than 5% for all population groups by 2025 and has also been proposed in the United States.[68] Implementing a VLNC mandate in Australia could prevent a new generation of young people from becoming addicted to smoking and lead to an increase in quitting among current smokers. Our scoping review of evidence syntheses found many review articles that summarise the evidence for VLNC cigarettes on a wide range of research questions. We determined that there is a substantial evidence base available for this policy.

Puljevic C, Morphett K, Hefler M, et al. Closing the gaps in tobacco endgame evidence: a scoping review. Tobacco Control. 2022;31(2):365-375.

2. *Regulating flavours and additives that increase the palatability of tobacco products*

Research shows that flavoured tobacco products especially appeal to children and young people.[69] Additives can reduce perceptions of the harshness of cigarette smoke, make the flavour more appealing and palatable.[70] While additives directly contribute only a small amount of the health harms of tobacco smoking, their masking of unpleasant sensory experiences associated with smoking may increase uptake and reduce quitting. Australia has prohibited the sale of tobacco products with fruit or confectionary flavours, but this still allows other flavoured cigarettes to be sold. The term "characterising flavour" has been used to refer to "a noticeable smell or taste other than one of tobacco." Several countries worldwide are implementing flavour bans for smoked tobacco products[71] and we agree with the **Action 7.5** to prohibit all additives and flavourings, including menthol, in smoked tobacco products in Australia.

3. *Regulating cigarette filters*

Filters remain a major way for tobacco companies to innovate and differentiate their products, particularly since plain packaging was introduced. There are cigarette brands with recessed or firm filters,[72] and ones with flavour capsules in the filter, which are designed to be crushed to release flavour. Although banned in other countries, sales of cigarettes with flavour capsules are increasing in Australia.[73] These products are likely to especially appeal to youth. Filters make cigarettes more palatable by preventing tobacco flakes falling into the mouth during smoking and they also make the smoke seem less harsh, which smokers interpret as being less harmful.[74] Cigarette filters also cause an enormous amount of toxic litter, and some jurisdictions overseas have proposed legislation to ban them altogether to protect the environment.[75] Research to investigate the health and environmental impacts of prohibiting the sale of cigarettes with cellulose acetate filters in Australia should be prioritised to determine whether they should be banned. We recommend that cigarettes with flavour capsules are banned from sale in Australia, and that consideration is given to banning cigarettes that have filters from sale altogether. We highlight the following article on the issue of the environmental impact of cigarettes with filters:

Morphett K, Gartner C. Making the tobacco industry pay for cigarette litter could stop 4.5 billion butts polluting the Australian environment. The Conversation. December 6, 2021. https://theconversation.com/making-the-tobacco-industry-pay-for-cigarette-litter-could-stop-4-5-billion-butts-polluting-the-australian-environment-171831.

We also agree with **Action 7.4** to require manufactures to disclose all additives used in each individual tobacco product and the purpose for their inclusion. However, further detail is required about who this information is going to be disclosed to (government only or the public?), how it will be presented, and how often this data will need to be provided. Will

there be penalties for the tobacco companies if they do not provide this information within the timeframes or in the format required? There is research showing that many people who smoke hold misunderstandings about the mechanisms of tobacco-related harm, and the role of additives in tobacco products.[22,76,77] Any means of disclosure to the public of the constituents of tobacco products will require pre-implementation evaluation in order to ensure that the information is understandable and does not increase misperceptions about the causes of tobacco-related harm.

Priority area 8: Strengthen regulation to reduce the supply, availability and accessibility of tobacco products

We strongly support Priority area 8.[78]

We support **Actions 8.1 to 8.6**, with further comments provided below.

Regarding Actions 8.5 and 8.6, we support further regulation of where tobacco products are sold, including regulatory approaches to control or restrict the number, type and location of tobacco outlets.

We believe that tobacco products are too addictive and dangerous to be supplied as a general consumer product. Hence, these products need to be phased out of the general retail market. Alternative supply options, such as pharmacy-based supply, or supply via smoking cessation kiosks that can provide advice on the health impacts of smoking, and cessation advice and support should be investigated as to their feasibility and potential effectiveness.

In the interim, a national tobacco wholesale and retail licensing scheme should be implemented with a capped number of licences that are then reduced. Reducing the number of retail outlets is a policy that is supported by the Aotearoa Smokefree 2025 action plan, with expectations that the percentage of reduction in retail outlets will be substantial under this proposed policy. Small businesses involved in the current commercial supply chain, such as smaller retailers, may require assistance to remove tobacco from their product lines. A publication we wish to highlight is:

> Gartner CE, Wright A, Hefler M, Perusco A, Hoek J. It is time for governments to support retailers in the transition to a smoke-free society. Medical Journal of Australia. 2021;15;215(10):446-448.

Furthermore, we recommend strengthening regulatory frameworks to reduce or eliminate inconsistencies in the regulation of retail sales and public consumption of tobacco products such as licensed venues where tobacco may be sold, but not easily consumed, or in places where tobacco smoking is already strongly restricted such as health settings or surrounding

educational settings. Research has demonstrated that there is a significant positive association between tobacco outlet density and daily tobacco use, particularly among young people and populations who have a high prevalence of daily tobacco use.[79] Similarly, retail exposure can hamper cessation attempts and trigger relapse, particularly among people who recently quit smoking. Therefore, addressing the incongruity would support cessation efforts.[80]

Regarding Action 8.7, we support requiring wholesalers (and retailers) to supply sales data for all tobacco products to allow monitoring of these sales, and to better monitor illicit supply. We highlight the following publication:

> Gartner C, Chapman S, Hall W, Wakefield M. Why we need tobacco sales data for good tobacco control. Medical Journal of Australia 2010;192(1):3-4.

Regarding Action 8.8 and 8.9, we encourage the Australian government to become a signatory to the WHO Protocol to Eliminate Illicit Trade in Tobacco Products. Additional action to combat illicit trade in tobacco products is warranted, including expanding current monitoring efforts to include sentinel populations. Wastewater analysis is also a promising method to assist with improving estimates of the quantity of tobacco products used in a community, which can be compared with sales data (see response to Action 5.9).

Regarding Action 8.10, we support implementing a mandatory very low nicotine content standard for tobacco products. See comments under Action Area 7. This policy (mandatory VLNC standard) is one that is under consideration in the USA,[81] and has been announced also for New Zealand as a key policy of the Smokefree 2025 Action Plan. Modelling by Tobacco Endgame CRE researchers of the Aotearoa Action Plan policies suggests that this policy is expected to be the most impactful and will be essential to achieving that country's smokefree goal.[82] Ireland is also currently considering this policy.[4] We believe that the commitment of the New Zealand government to this policy makes this an ideal time for Australia to also implement the same policy.

Here we highlight the following publication:

> Wilson, N., Hoek, J., Nghiem, N., Summers, J., Grout, L., & Edwards, R. (2022). Modelling the impacts of tobacco denicotinisation on achieving the Smokefree 2025 goal in Aotearoa New Zealand. New Zealand Medical Journal, 135(1548), 65-76.

Regarding Action 8.11, we support raising the minimum purchase age for tobaccco. Furthermore, we support the introduction of a tobacco-free generation law (TFG). This policy for reducing the accessibility of tobacco products is gaining momentum worldwide. For example, this is another policy included in the Smokefree Aotearoa 2025 Action Plan, with the New Zealand Government recognising that stopping children and young people from ever being able to purchase tobacco will reduce future smoking rates and related harm. The TFG policy is also under consideration in Denmark and Malaysia.[2] A recent

scoping review by Tobacco Endgame CRE researchers reviewed the evidence for this policy, concluding that the policy has potential to achieve substantial population-level health improvements, although additional policies would be needed to achieve a 5% smoking prevalence goal by 2030, because it is a policy that takes a long time to have full impact.[78] Nevertheless, this policy is likely to have strong community support because it is targeted at people who do not currently smoke to phase out smoking, while 'grandfathering' people who already smoke. It also provides a powerful signal to retailers that commercial tobacco products are being phased out. As such, we strongly recommend the inclusion of this policy in Australia's National Tobacco Strategy.

The TFG policy and other restrictions on tobacco product supply should also be coupled with development of a replacement model of tobacco supply that can provide tobacco products for those who continue to smoke, but in a way that does not incentivise maintaining smoking, and that is more appropriate for an addictive and lethal product than the current commercial supply model.

Priority area 9: Strengthen regulations for novel and emerging products

While we agree that strategies are required to prevent uptake of novel and emerging products by young people, we highlight the need for increased enforcement of existing laws, which already prohibit the supply of vaping products to youth, and the restrictions on marketing of nicotine vaping products generally. Further regulation of novel and emerging products needs to consider any evaluation of the TGA regulatory changes that were implemented in 2021 and consider the effects these regulations have had.

Proposed Action 9.1 is not clear as to what this would involve and what level of restriction is planned. We believe that regulation that restricts access to these products should also consider regulation to restrict access to smoked tobacco products as outlined in our recommendation und Action 9.3.

Regarding Action 9.2, there is currently limited evidence to inform the long-term impacts on individual and population health of e-cigarettes, which makes science communication on this issue challenging. Modelling by Tobacco Endgame CRE researchers and colleagues have estimated the population health impacts of e-cigarettes,[83,84] however more research is needed to refine the estimates of health risk to reduce uncertainty in the estimates. We recommend including information about the risks of smoking whenever the risks of vaping are discussed to ensure that people do not switch from vaping to smoking due to mistaken relative risk perceptions that can occur when the risks of one product are discussed in isolation.

Currently, there are no requirements or standards for e-cigarettes supplied in Australia to carry product warnings, apart from generic warning statements such as 'keep out of reach

of children' and 'avoid contact with eyes, and skin'. Within the context of minimising vaping uptake among youth and non-smokers, it would be worth considering mandating a nicotine addiction warning (and perhaps battery related injuries), such as are used in other countries (e.g., USA and Israel). Israel also requires plain packaging of e-cigarette products.

Regarding Action 9.3, we support developing and implementing a comprehensive regulatory framework for all nicotine and tobacco products, including smoked tobacco products. Currently, there is a regulatory imbalance, whereby greater restrictions have been placed on many non-smoked nicotine and tobacco products compared to cigarettes,[85] despite the greater risk associated with cigarette smoking. Regulating all nicotine and tobacco products together rather than each product in isolation will produce more rational and coherent regulation. We support research into how best to increase the restrictions on smoked tobacco products to reduce this regulatory imbalance. Another consideration is that measures that reduce the appeal and availability of smoked tobacco products may be easier to justify, more feasible to implement, and may have greater impact in encouraging people to stop smoking, if people who smoke who cannot or do not want to quit using nicotine have acceptable alternative products available. Hence, considering the regulation of the entire nicotine and tobacco market together makes most sense.[86]

The use of nicotine vaping products to support quitting and harm reduction purposes should be acknowledged, given the TGA regulations that came into effect in October 2021 to facilitate the supply of these products via pharmacies on prescription. However, these changes are not mentioned in the NTS. The stated goal of the TGA regulations is to: "balance the need to prevent adolescents and young adults from taking-up nicotine vaping products while allowing current smokers to access these products for smoking cessation with appropriate medical advice." (https://www.tga.gov.au/nicotine-vaping-product-access). The Royal Australian College of General Practitioners includes e-cigarettes in their smoking cessation guidelines,[87] stating that:

"For people who have tried to achieve smoking cessation with first-line therapy (combination of behavioural support and TGA-approved pharmacotherapy) but failed and are still motivated to quit smoking, NVPs may be a reasonable intervention to recommend along with behavioural support. However, this needs to be preceded by an evidence-informed shared-decision making process, whereby the patient is aware of the following caveats:

- *Due to the lack of available evidence, the long-term health effects of NVPs are unknown.*
- *NVPs are not registered therapeutic goods in Australia and therefore their safety, efficacy and quality have not been established.*
- *There is a lack of uniformity in vaping devices and NVPs, which increases the uncertainties associated with their use.*
- *To maximise possible benefit and minimise risk of harms, dual use should be avoided and long-term use should be minimised.*
- *It is important for the patient to return for regular review and monitoring."*

Regarding Action 9.5, we agree with tightening promotion and advertising restrictions of all non-therapeutic nicotine vaping products, and other alternative tobacco products to ensure there are no loopholes that allow promotion to young people, such as via social media.[20]

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

We strongly agree with the introduction of smoke-free policies in apartment buildings; research by CRE researchers and colleagues notes the need for the tightening of legislation of smoking restrictions in multi-unit housing based on evidence that allowing smoking in multi-unit housing leads to inequities in second-hand smoke exposure.[88] We also recognise the challenges in implementing and enforcing this policy and the need to ensure that people who may already have limited housing options are not made homeless through this policy. We recommend that proactive smoking cessation assistance, such as active referrals to Quitline and provision of free smoking cessation pharmacotherapy is provided to every tenant of public housing or resident of private multi-unit housing in low-income areas.

A further setting worthy of consideration for this priority area is prisons in Western Australia and Australian Capital Territory (ACT). While prisons in all other states have introduced smoke-free policies that prohibit smoking on prison grounds, Western Australia and the ACT have not yet introduced this policy. With 75% of people entering Australian prisons smoking tobacco daily (including approximately 80% of people entering Western Australian prisons), a high percentage of people who live and work in these prisons are either using tobacco daily or are exposed to dangerous second-hand smoke. There is a clear need to introduce smoke-free policies in these settings to protect the public health of residents and staff, but it is imperative that such policies include the provision of evidence-based support (e.g., nicotine replacement therapy, especially lozenges[48,51]) as recommended in action 5.6., to ameliorate nicotine withdrawal and promote long-term smoking cessation that extends beyond release. A 2021 report by the Western Australian Office of the Inspector of Custodial Services found that “there is ample evidence to support the case for a smoking ban” in Western Australian prisons.[51]

We also note the current challenges to enforcement of smokefree 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, research from CRE researchers shows that use of the Smoking Cessation Clinical Pathway, a brief intervention tool used in Queensland hospitals, is effective at promoting uptake and acceptance of nicotine replacement therapy.[89] Furthermore, no one should be fined for smoking in these locations without being offered nicotine replacement therapy 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

We strongly agree with this priority area. Research by CRE Deputy Director Prof Billie Bonevski highlights the need for the integration of smoking cessation support into routine care in health settings.[61] There is also evidence that online smoking cessation interventions are effective (and can reach a lot of smokers, low cost), particularly if they incorporate behaviour change techniques.[90]

Here we wish to highlight these two publications:

> Thomas D, Abramson M, Bonevski B, George J. System change interventions for smoking cessation. Cochrane Database of Systematic Reviews 2017;2: CD010742.
>
> McCrabb S, Baker A, Attia J, Skelton E, Twyman L, Palazzi K, McCarter K, Ku D, Bonevski B. Internet-Based Programs Incorporating Behavior Change Techniques are Associated with Increased Smoking Cessation in the General Population: A Systematic Review and Meta-analysis. Annals of Behavioral Medicine 2019;53(2):180-195.

With regards to Action 11.1 we fully support an evaluation of the smoking cessation services available in Australia. Australia is fortunate to have an array of evidence-based support services available, yet often uptake of and referral to these services is suboptimal. As such, we would recommend an evaluation of the reach and uptake of these smoking cessation services and where referrals come from. This approach would identify gaps in the referral networks, as well as to understand whether healthcare professionals and community members are aware of the cessation services. A recent initiative in Central Queensland, called the 10,000 Lives Campaign, aimed to promote available support services, including Quitline, to increase smoking cessation in CQ. It works as a catalyst to bring all smoking cessation activities together and identifying champions for increasing smoking cessation in partnership with multiple stakeholders from government, non-government organisations, and the community. An evaluation found this initiative increased referrals to, and use of Quitline.[40]

We also support **Action 11.9**. Here we wish to highlight the following article by members of the Society for Research on Nicotine & Tobacco Treatment Network:

> Palmer A, Toll B, Carpenter M, Donny E, Hatsukami D, Rojewski A, Smith T, Sofuoglu M, Thrul J, Benowitz N. Reappraising Choice in Addiction: Novel Conceptualizations and Treatments for Tobacco Use Disorder. Nicotine & Tobacco Research. 2022;24(1):3-9.

Briefly, the article highlights that strategies used for combustible product cessation need to be adapted for novel products (i.e., e-cigarettes and other novel products), and that

“treatment recommendations for tobacco use disorder should be made within the context of the existence a harm reduction framework wherein alternative product use” (and not complete abstinence from nicotine) may be the desired outcome.[91] We wish to highlight the following quote from the article: "The ultimate goal for medical providers should be to improve the health of their patients. Regarding tobacco treatment, this can be accomplished through promotion of abstinence from combustible smoking. For combustible tobacco product users who cannot quit nicotine entirely, switching to less risky modes of delivery might be an alternative goal, with an eventual aim of stopping use of the nicotine product. Despite some products lying lower on the continuum of risk, they are not completely harmless. Therefore, if patients wish to continue use of alternative products, they should be counselled about known and unknown long-term consequences, including the potential for dependence on a new product. For most individuals, quitting cigarettes is difficult due to nicotine addiction, and therefore, shifting to products lower along the continuum of risk might be a way to reduce risk and eventually lead to quitting nicotine altogether; although to date, evidence on how to achieve the latter outcome is less clear." [91]

CRE researchers authored a commentary on this research, highlighting that “providing access to less harmful forms of nicotine increases the choice for individuals who find abstinence from nicotine difficult.”[92]

Morphett, K., & Gartner, C. (2022). Informed Choice in the Context of Tobacco Use Disorder. Nicotine & Tobacco Research, 24(1), 1-2.

Additional comments including Priority Areas not currently (or adequately) addressed

While priority areas 1-2 and 6-9 are compatible with transforming tobacco supply in Australia from one focused on commercial profits to one focused on maximising health and social outcomes, we believe that the NTS should go further and include this as an explicit priority area. This would acknowledge the incompatibility between the commercial viability of the tobacco industry in its current form, and the achievement of the NTS goals and the ambition for Australia to become a smokefree society. Importantly, this would address the root cause of the tobacco epidemic. We believe that a government framework and government-managed process for transforming the tobacco supply system in Australia is needed to ensure that businesses are fully informed and prepared for the anticipated reduction of smoking to minimal levels. Research shows that assurances from the tobacco industry and voluntary undertakings to ‘transform’ their commercial product lines to reduce harms are not effective. Hence, voluntary industry-run initiatives will not achieve this goal. Publications we would like to highlight include:

Edwards R, Hoek J, Karreman N, Gilmore A. Evaluating tobacco industry 'transformation': a proposed rubric and analysis. Tobacco Control. 2022;31(2):313-321.

Gartner C, Wright A, Hefler M, Perusco A, Hoek J. It is time for governments to support retailers in the transition to a smoke-free society. Medical Journal of Australia. 2021;15;215(10):446-448.

Hefler M, Bostic C. 'Commit to quit': a goal for all, not only individual tobacco users. Tobacco Control. 2021;30(3):239-240.

Bostic C, Hefler M, Muller G, Assunta M. FCTC Article 2.1 and the next horizon in tobacco policy: Phasing out commercial sales. Tobacco Induced Diseases. 2020;18:98.

We have a few final additional comments.

First, we believe that the section on governance would benefit from more detail about the governance structure, how priority groups and communities such as Aboriginal and Torres Strait Islander Peoples are represented, and how in practice a whole of government approach is implemented.

Similarly, we believe that the monitoring and evaluation component would benefit from more detail. We suggest that this component includes a commitment to develop a clear evaluation framework, and comprehensive monitoring and research infrastructure. For example, collection of national data on smoking prevalence (currently at 3 yearly intervals) is not currently frequent enough to inform a truly comprehensive picture of trends in tobacco use. As we have noted at the beginning of our submission, we recommend more detail is provided, with firmer commitments, clearer responsibilities, and timeframes for implementation for each of the actions listed in the NTS. This will increase the likelihood of a successful NTS.

Concluding comments

Thank you for this opportunity to comment on the draft National Tobacco Strategy 2022-2030. The NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame is the only NHMRC-funded CRE dedicated to generating knowledge on tobacco control policy. Our research program and expertise can assist government to fill evidence gaps related to the new policies included in the NTS to facilitate policymaking and implementation. Our investigators have conducted simulation modelling for the New Zealand government on the novel and traditional policies that were included in the Smokefree Aotearoa 2025 Action Plan to enable evaluation of the impacts of these policies on their own and as a package.

Similar modelling can be performed for Australia by adapting this model. Additionally, our New Zealand Investigators from the ASPIRE2025 research group have made a collection of articles and blog posts that summarise the research that informed the Smokefree Aotearoa 2025 Action Plan available for use: https://aspire2025.org.nz/category/findings-and-views/.

The Tobacco Endgame 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. This survey will collect data from Australians in 2022 that will be of high relevance to the NTS, including views on policies such as reducing the nicotine content of cigarettes, and banning cigarette filters.

If you would like further information on any of the points mentioned above, please contact us on create@uq.edu.au or 07 33465475.

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