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VICHEALTH LETTER

TOBACCO

VICHEALTH'S POSITION ON TOBACCO

THE TOBACCO PROBLEM IN 2000

NATIONAL TOBACCO CAMPAIGN SUCCESS STORY

WHY THE TOBACCO FARCE IS SUCH A TRAGEDY

TAKING SMOKING OUT OF KOORI CULTURE

VicHealth

Tobacco

VicHealth's origins provide us with a unique position from which to examine the tobacco issue, publish our position on it and advocate for redoubled pressure on the single largest cause of preventable death and disease in Australia today.

In 1987, led by Dr Nigel Gray and Dr David Hill, Victorians from all sectors—the arts, advertising, sport, church, community groups and both sides of Parliament—supported the passing of Victoria's *Tobacco Act 1987* that established VicHealth. The Act set the standard for international best practice in tobacco control legislation by banning outdoor tobacco advertising, restricting promotions and providing the mechanism to buy out tobacco sponsorship.

Reflecting on those early years one must recognise the enormous contribution of Ron Casey as a founding board member and great contributor to VicHealth over the first 13 years of our existence. Ron will be remembered for helping to break the nexus between sport and tobacco. We are saddened by his loss and we will certainly miss his guidance and experience.

Since VicHealth was established we have seen some enormous changes. With a few exceptions, tobacco sponsorship has been banned, outdoor and print advertising have disappeared and there are now widespread restrictions on smoking in workplaces and public places. The legal age for selling cigarettes has risen from 16 to 18 years and the recent amendments to the Tobacco Act will ensure greater attention is paid to the sale of tobacco to children. Smoking rates in Victoria dropped from 33% for men and 29% for women in 1986 down to 27% for men and 22% for women in 1997. We can confidently predict that today's statistics will be even lower given the positive results of the National Tobacco Campaign. We certainly have much to be proud of.

Now it is time to explore some of the complexities of the tobacco issue in the 21st Century. In this edition some of the world's most respected experts in the field examine the product, the politics, the industry, the harms and the success stories. We hear about the work of the new VicHealth Centre for Tobacco Control and report on some of the many projects working with the SmokeFree message.

In this the second of our published position statements (the first was on illicit drugs), we recognise tobacco as our single biggest preventable killer. Tobacco use and/or exposure to tobacco smoke is so injurious to the health of smokers and non-smokers that it warrants particular attention and a wide range of initiatives.

Tobacco smoking and tobacco-related deaths are not simple problems, ones that can be treated once and disappear. The tobacco issue is a lethal conspiracy with three dangerous elements that work together. We have an addictive product, where the addiction starts in the teen years. We have a product that contains 43 known carcinogens, therefore the addiction is responsible for the dose of carcinogens over a long period of time. And we have a tobacco industry that fights hard to continue to market its 'legal' product which, when used as intended, kills one in two of its lifetime users. Of particular concern for VicHealth is the fact that tobacco is also a product that discriminates on the basis of education and socioeconomic status.

The Australian Medical Association and the Australian Council on Smoking and Health's Dirty Ash-tray Awards, announced on World No Tobacco Day (31 May), placed Victoria fourth, in comparison to other states, for its record in tobacco control. We must do better next year.

If there is one key theme apparent in this newsletter, it is the continued need for vigilance. It is the need to maintain the pressure to drive down smoking rates and to strive for the regulatory and legal precedents that we have started to see in the United States, where at last the industry is being held accountable for its actions.

Consider that smoking prevention costs, per life-year gained, less than one five hundredth of the costs of treating lung cancer. Consider that Massachusetts has achieved a 35% decline in smoking rates with money, patience and a comprehensive approach. With appropriate funding, we have the expertise and the infrastructure to achieve similar results here. When VicHealth was first set up, Victoria was the place that both the tobacco industry *and* the anti-smoking advocates looked to for a view of the future in tobacco control. It's time to once again earn this formidable reputation.

Dr Rob Moodie
Chief Executive Officer

Rob Moodie and Robert Doyle, Victoria's Shadow Health Minister, point out the use of our national symbol in overseas tobacco advertisements on a recent study tour of drug facilities.
Photo courtesy of Bruce Mildenhall, Parliamentary Secretary Assisting the Premier.

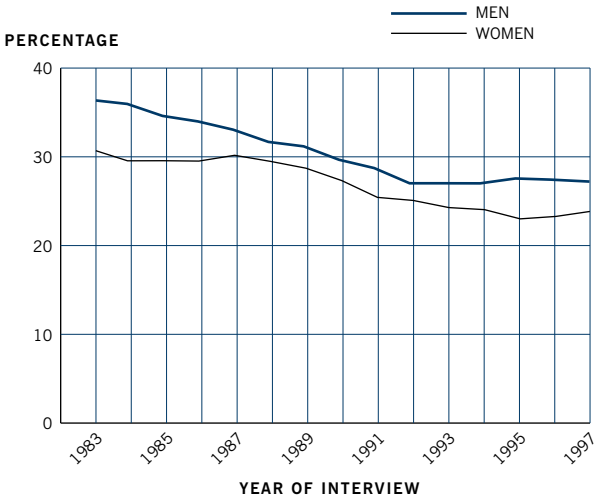
Tobacco

Overview

Smoking prevalence

Victoria's smoking prevalence declined between 1986 and 1991 at the rate of 1% per year from 31.5% to 25.6%. Between 1991 and 1997, declines in prevalence slowed and Australian prevalence as a whole reached a plateau.[1] Earlier gains Victoria had made over other states were also lost. Total smoking prevalence in Victoria in 1996 and 1997 was 27% for men and 22% for women. However, the latest National Tobacco Campaign evaluation indicates a reduction of 1.4% in smoking prevalence (representing 190,000 people quitting smoking) in the first six months of the Campaign (1997) Australia-wide. These results suggest the current prevalence in Victoria is likely to now be lower.

Percentage of Victorian smokers over 18—men and women 1983–1997 (three year moving average).



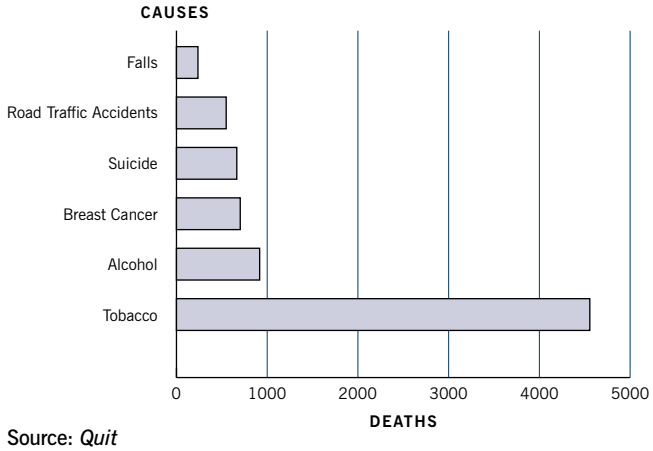
Source: *Quit*

Smoking prevalence is inversely related to education and socioeconomic status.[2] In Victoria, those with a university education are least likely to smoke (17%) and smoking prevalence is highest at the low end of the occupational scale. People from lower blue-collar homes have the highest smoking prevalence (32%) and the lowest proportion of ex-smokers among the occupational groups (25%). People from upper white-collar households have both the lowest smoking prevalence (18%) and the highest proportion of never-smokers (52%). This indicates they are less likely to take up smoking than other groups. Most of the difference in prevalence seems to be as a result of variation in uptake of smoking. Those who are unemployed or not working are much more likely to smoke (45%) than any other demographic group and the percentage of ex-smokers in this group is low (19%).

Morbidity and mortality

Tobacco smoking is the leading cause of drug death and the major preventable cause of disease in Victoria. Between 1950 and the start of the new millennium, 170,000 Victorians lost their lives as a result of tobacco smoking.[3] Based on current estimates, 13 smokers die every day.[4]

Deaths by various causes—Victoria 1997



Source: *Quit*

In 1995 in Victoria, over 4,672 deaths were caused by smoking.[5] If we compare this to other causes of death, on average:

- illicit drugs killed fewer than 4 Victorian every week;[6]
- road accidents killed 8 Victorians every week;[7]
- alcohol killed 12 Victorians every week[8]; and
- tobacco killed 90 Victorians every week, around 13 per day.[9]

The true impact of a lifetime of smoking is clear. Half of those who smoke throughout their life will die as a direct result of their habit. Half of these deaths will occur in middle age, with an average of 21 years of life lost. The rest will occur in old age, with around eight years lost.[10]

Tobacco Overview (cont.)

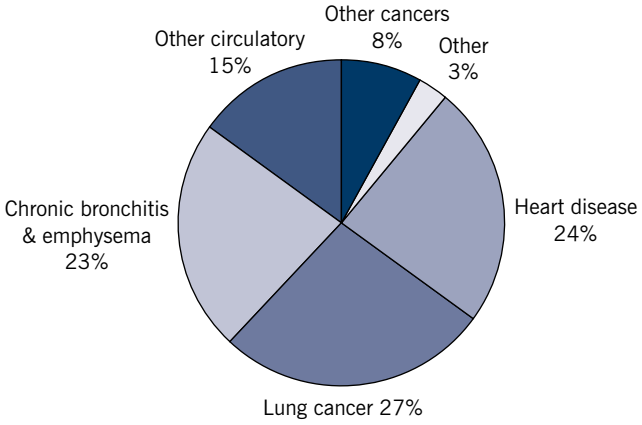
The Victorian Burden of Disease Mortality study has identified tobacco as the risk factor associated with the greatest health problems, responsible for 16.7% of mortality burden in men and 9.3% in women.[11] More than half this burden is due to tobacco-related cancer mortality and much of the rest is due to chronic obstructive lung disease and ischaemic heart disease.

Australian and British research has shown that mortality rates for smoking-related diseases are highest among individuals in lower socioeconomic groups, and have been for at least two decades.[12] This trend is evident for all the major smoking-related diseases: lung cancer, heart disease and lung disease (emphysema and chronic bronchitis). These groups are also more likely to have occupational exposure to carcinogens and have other risk factors making them more susceptible to diseases such as cardiovascular disease.

Diseases caused by smoking

Cigarette smoking is a major cause of heart disease, stroke and peripheral vascular disease. Nearly 40% of smoking deaths are due to heart and blood vessel disease. Stroke resulting from smoking is most evident in younger age groups. Around 40% of all strokes in people under 65 are caused by smoking.[14]

Proportion of deaths from smoking by disease group



Source: *Tobacco in Australia: Facts & Issues*

Around 21% of all cancer deaths can be attributed to smoking.[15] Lung cancer and other cancers cause almost half of the tobacco burden, responsible for 75% of disability-adjusted life-years lost. Most of this is due to premature death. Lung cancer, a disease mostly caused by smoking, is the overall leading cancer killer.

Almost all smokers who smoke over 20 cigarettes a day will develop some form of emphysema. The severity will increase with the number of cigarettes smoked per day and the number of years the person has smoked. This disease is rare in non-smokers.[16]

Smoking is also a risk factor associated with a number of other health problems including blindness, asthma, cancers of the stomach, cervix and kidney, male and female fertility problems, impotence, miscarriage, still birth, low birth-weight and death in early infancy, osteoporosis, peptic ulcer and back pain.

Passive smoking

Environmental tobacco smoke (ETS), responsible for passive smoking, is a combination of exhaled smoke and smoke that drifts from the burning end of a cigarette. ETS contains many chemical carcinogens and other toxic substances. While active smoking is more dangerous to health than passive smoking, there are a number of diseases related to passive smoking. These include lung cancer and heart disease in adults and ear infections and respiratory illnesses in children.[17]

Cost of tobacco use

Tobacco use cost the Victorian community $3.2 billion in 1992. This comprised intangible costs of $1.7 billion and tangible costs of around $1.5 billion. Around 45% of these costs, or $1.44 billion, was avoidable,[18] which means that with appropriate public policies costs could be reduced.

Intangible costs are all borne by the individual and include pain, suffering, loss of enjoyment of life and loss of enjoyment of consumption. Tangible costs include costs to business and net costs to government for the provision of extra medical services. Of the tangible costs, individuals bear a large proportion (60%), businesses around 35% and governments around 5%.

These estimates do not include the costs of pharmaceuticals, domiciliary care and allied health professionals as these data were unavailable. They also exclude the cost of treating diseases associated with passive smoking, the cost of absenteeism due to smoking and the costs of tobacco-caused fires.

Tobacco control initiatives

The National Tobacco Strategy 1999 to 2002-03 highlights the need for a comprehensive and multi-variate approach, together with a national collaborative effort, to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms.[19]

Victoria's Tobacco Act, enacted in 1987, set the standard for international best practice in tobacco control legislation by banning outdoor tobacco advertising, restricting promotions and providing the mechanism to buy out tobacco company sponsorship. This year the Victorian Government introduced a Tobacco Amendment Bill to further improve tobacco control measures. On 25 May 2000, the Legislative Assembly unanimously supported the reforms. The new measures will reduce exposure of the community to the harmful effects of environmental tobacco smoke, increase penalties for sales to young people and reduce the marketing of tobacco products.

The Victorian Smoking and Health Program (Quit Campaign), a joint initiative of VicHealth, the Anti-Cancer Council of Victoria, the Department of Human Services and the National Heart Foundation of Australia, has been a major contributor to the reduction in smoking rates in Victoria since its inception in 1985.

The VicHealth Centre for Tobacco Control, established in January 2000, focuses on legal, economic and social research to strengthen and broaden current tobacco control initiatives. The Centre will be a focal point for research, development and information on tobacco control within Victoria, Australia and the rest of the world.

Photo courtesy of *The Age.*

Bags of chopped unmanufactured tobacco (chop-chop).

[1]Centre for Behavioural Research in Cancer 1986, 1988, 1989, 1990, 1991, 1992, 1995, 1996, *Quit Evaluation Studies Volumes 1 to 9*, Victorian Smoking and Health Program, Melbourne, 1998. Also in the press.

[2]Centre for Behavioural Research in Cancer, *1996-97 Quit Evaluation Studies Volume 9*, Victorian Smoking and Health Program, Melbourne, 1998.

[3]R Peto, A Lopez, J Boreham, M Thun & C Heath, *Mortality From Smoking in Developed Countries 1950-2000*, Imperial Cancer Research Fund, World Health Organization, Oxford University Press, NY, 1994.

[4]DR English, SDJ Holman et al., *The Quantification of Drug-caused Morbidity and Mortality in Australia, 1995 edition*, Commonwealth Department of Human Services and Health, Canberra, 1995. Updated for 1995 by the Australian Institute of Health and Welfare (Williams 1999).

[5]AIHW unpublished data in P Williams, *Progress of the National Drug Strategy: Key National Indicators. Evaluation of the National Drug Strategy 1993 – 97*: Statistical Supplement. Department of Health and Family Services, Canberra, 1997.

[6]ibid.

[7]Federal Office of Road Safety, *Road Fatalities – Australia: Statistical Summary 1996*, Federal Office of Road Safety, Canberra, 1997.

[8]AIHW, op. cit.

[9]ibid.

[10]Peto et al., op. cit.

[11]Department of Human Services, *The Victorian Burden of Disease Study: Mortality*, Department of Human Services, Melbourne, Victoria, 1999.

[12]M Winstanley, N Walker & S Woodward, *Tobacco in Australia – Facts and Issues*, Victorian Smoking and Health Program, Melbourne, 1995.

[13]Department of Human Services, op. cit. and Department of Human Services, *The Victorian Burden of Disease Study: Morbidity*, Department of Human Services, Melbourne, Victoria, 1999.

[14]English et al., op. cit.

[15]AIHW, *Tobacco Use and its Impact in Australia*, AIHW cat. no. CVD 1. AIHW, Canberra, 1996.

Data calculated from 1992 deaths (English et al.).

[16]US Department of Health and Human Services, *The Health Consequence of Smoking: Chronic Obstructive Lung Disease. A Report of the Surgeon General*, US Department of Health and Human Services, Public Health Service, Office on Smoking and Health, Rockville, Maryland, 1984.

[17]US Department of Health and Human Services, *The Health Consequences of Involuntary Smoking: A Report of the Surgeon General*, US Department of Health and Human Services, Public Health Service, Office of Smoking and Health, Rockville, Maryland, 1986.

[18]D Collins & H Lapsley, *The Social Costs of Tobacco in Victoria and the Social Benefits of Quit Victoria*, Victorian Smoking and Health Program, 1999.

[19]Commonwealth Department of Health and Aged Care, *National Tobacco Strategy 1999 to 2002-03: A Framework for Action*, Canberra, June 1999.

VicHealth gratefully acknowledges the assistance of Jane Martin and Carolyn Ford from Quit in compiling these statistics.

VicHealth's Position on Tobacco

VicHealth's *Strategic Directions 1999-2002* reasserts the importance of tobacco control as a priority health promotion area. VicHealth continues to make the largest contribution to the total State Government investment in tobacco control initiatives.

VicHealth complements the activities of government and other non-government organisations by supporting research and innovations in health promotion to contribute to an evidence base that will ultimately lead to improved population health.

VicHealth incorporates the social, environmental and biological determinants of health and wellbeing in its approach to promoting health. The goal is to implement a range of processes within social structures, communities and in individuals to enable people to increase control over their lives in ways that achieve and maintain health.

VicHealth's approach is guided by the following principles.

VicHealth principles

Tobacco use and/or exposure to tobacco smoke is so injurious to the health of smokers and non-smokers as to warrant appropriate restrictive legislation and regulation of tobacco products and their use.

VicHealth supports the comprehensive tobacco control approach as outlined in the National Tobacco Strategy 1999 to 2002-03. VicHealth aligns its contributions to the Strategy and strongly supports:

- preventing the uptake of tobacco use in non-smokers, particularly children;
- encouraging young and adult smokers to stop smoking and to remain non-smokers;
- identifying and eliminating the disparities related to tobacco use and its effects among different groups;
- reducing the exposure of users and non-users to the harmful components of tobacco smoke; and
- legislating and regulating the content, manufacture, supply, promotion, sale and price of tobacco products.

VicHealth acknowledges tobacco is used regularly by approximately 25% of Victorian adults. Therefore to ban it completely would be impractical.

There are a number of identified population groups, such as people with low income and low education levels, children and young people under 18 years of age, Kooris, people from culturally and linguistically diverse backgrounds, and pregnant women, that require tailored programs to reduce initiation and increase cessation rates.

National and/or state level policy frameworks provide an essential foundation for modifying current strategies or developing new strategies to minimise the adverse health, social and economic impacts of tobacco use.

Partnerships and networks at local, state, national and international levels are important mechanisms for supporting tobacco control initiatives. The significant groups that can assist change include policy makers, opinion leaders, journalists, health professionals, teachers, youth workers, parents, retailers, sporting administrators and restaurateurs.

[1]The WHO recently developed the Tobacco Free Initiative to decrease the prevalence of global tobacco use. The project goals include stimulating global support for evidence-based control policies and actions; building new and strengthening existing partnerships for action; and accelerating implementation of national, regional and global strategies.

VicHealth will:

- contribute to improving the health of all Victorians by supporting current tobacco control initiatives and the further development of dynamic evidence-based programs to reduce harms associated with the supply of and demand for tobacco products, with particular attention to the reduction of disparities between population groups;
- work and/or develop new alliances with the health sector and other sector organisations to support the ongoing improvement of the comprehensive tobacco control strategy in Victoria;
- advocate and support efforts for increasing the financial resources available for tobacco control to be commensurate with the burden of the diseases attributable to smoking;
- ensure all organisations in receipt of VicHealth funds declare they are not receiving any support from the Australian Tobacco Research Foundation or tobacco companies and their affiliates;
- encourage all organisations to develop a 100 per cent smoke-free policy for workplaces and other indoor environments;
- be consistent with the objectives of the World Health Organization's Tobacco Free Initiative[1] and complement the National Tobacco Strategy 1999 to 2002-03; and
- maintain a high level of advocacy for the range of tobacco control initiatives.

The Tobacco Problem in 2000

Dr Nigel Gray, European Institute of Oncology, Patron of VicHealth

Marlboro man Michael Schumacher at the Australian Formula One Grand Prix, Melbourne 2000.
Photo courtesy of *The Age*.

The tobacco issue simply will not go away. A quarter of the population still smokes and recruitment still occurs despite considerable control over what the tobacco industry does. Given that many controls are recent, we should not expect the image of the Marlboro man, even if he now looks like Michael Schumacher, to disappear immediately.

The recent addition of chop-chop tobacco to the list of problems is a reminder that the price of peace (and public health) is eternal vigilance. Chopped unmanufactured tobacco is a way of life in countries such as India, where various forms of it are used widely. Burning it produces (almost) exactly the same list of carcinogens and toxins that smoking well-known brands produces.

The public still, in 2000, does not know what they are getting in their smoke. Recent information, only some of which is in the public arena, shows that the composition of tobacco smoke varies considerably. Not many smokers know their cigarette smoke contains lead, arsenic, formaldehyde, ammonia and mercury in addition to such well-known carcinogens as benz(a)pyrene and a galaxy of tobacco-specific nitrosamines, of which 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (better known as NNK) is perhaps the most important. Further, neither the smokers nor, so far as I know, the Government, know that the variation between brands in the levels of these substances may be between three and nine-fold.

The tar and nicotine labelling printed on the packet has become misleading as the component mix of tar has changed over time, and nicotine dose varies according to how hard the smoker inhales and on the bio-availability of the nicotine. A smoker who thinks their daily dose is 20 cigarettes multiplied by the tar content is misled. They may be getting 5 or 10 times the dose of NNK depending on the brand chosen, however this information will not be on the packet.

The tobacco industry knows all this but relevant information leaks into the public arena so slowly that regulatory efforts by governments have so far missed out on the cigarette itself. Although advertising is controlled, the content of the smoke is not. This is surprising in this decade when even the manufacturers of pretzels tell their customers what is in them.

The problem is not intrinsically very different to the one faced years ago by car manufacturers who were required to reduce levels of various toxins in their exhaust smoke (including lead). They successfully did this with the active cooperation of petrol refiners.

Given that cigarette smoke contains some 4,000-odd substances, controlling it requires selectivity. This would not be unduly difficult if manufacturers were compelled to declare yields of the 40 or so major carcinogens/toxins in their smoke, as they currently are in Massachusetts and British Columbia. However, what these two advanced states have not yet achieved is the right to tell the public this information **by brand**, so smokers can make informed choices.

Controlling smoke content is feasible and the principle involved simple. Analysis of the range of, say, NNK and benz(a)pyrene in the top 20 brands would show the degree of variation. Setting the median level of those so discovered as the upper limit allowable in 12 months time would be a simple way to start. The median is in the middle, so that immediately allows half of the brands to remain as they are, while the other half would have to change.

If the industry chose not to comply, half their brands would go off the market—not exactly a tragedy with the plethora currently available.

The industry might squeal like a stuck pig, but this is certainly where the future lies for them. It is time we got down to work and cleaned up some of the unnecessary rubbish which is allowed to get into cigarette smoke. The nitrosamines are controllable in various ways, one of which is by controlling the amount of nitrate in the fertiliser put on the plant; another is by a clever system of semi-microwaving the tobacco, which has been recently patented. Somehow we got the lead out of petrol, but not out of cigarette smoke. So the industry could no doubt achieve it, if required to.

What I am forecasting is that the industry will have to change its procedures and reduce both the carcinogenicity and toxicity of its product as much as possible, something it has escaped so far. The result of the lack of regulation has been a somewhat casual approach to the customers' welfare, which does not happen with toothpaste or, as stated, the humble pretzel.

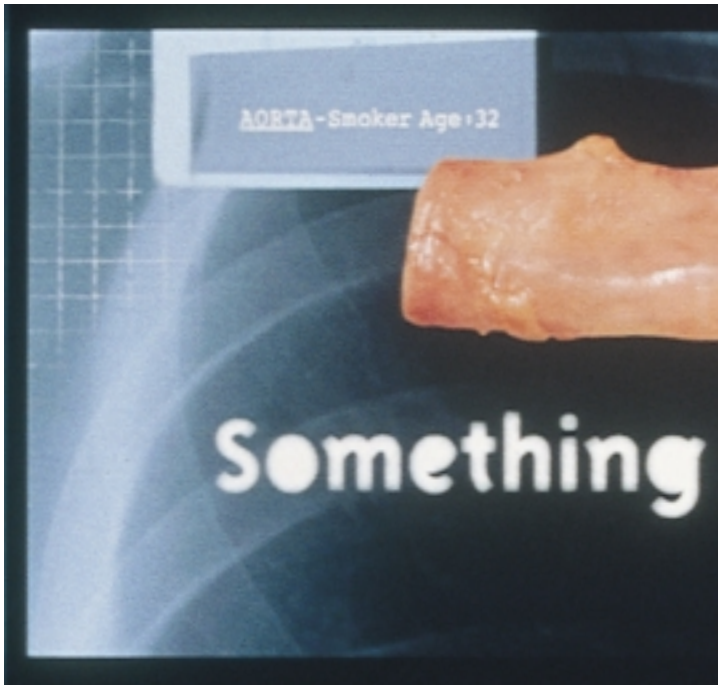
The tobacco industry in Australia presumably has the same information currently given to Massachusetts for US brands and could make it available, by brand, in a television interview if they were willing to, and to government if required to.

It is time to stop fiddling with this important element of tobacco control. Persuading people to stop smoking is the prime objective. Cleaning up the product is simply good housekeeping, as the product, while never capable of being safe, is unnecessarily dangerous.

The smoker is entitled to know, by brand, what the levels of the substances named above actually are. They can then go shopping for the lower end of the market.

As for chop-chop, of course it should be controlled, and some major penalties might do this. But, in light of the information given to smokers in the year 2000, the carcinogen/toxin content of the major brands cannot be compared with chop-chop, or even each other.

Response to the Campaign continues to be very positive. Evaluation results show recognition of the Campaign remains high and the Campaign television commercials continue to be seen as 'relevant', 'believable', and 'thought-provoking'.



Australia's National Tobacco Campaign Success Story

Dr David Hill, Director, Centre for Behavioural Research in Cancer, Cancer Control Research Institute, Anti-Cancer Council of Victoria

National Tobacco Campaign results show that the combination of behavioural theory, health effects information, support services and mass media advertising has been cost-effective in targeting 18 to 40-year-old smokers.

Since the National Tobacco Campaign began three years ago, the *Every Cigarette is Doing You Damage* message is clearly being heard, with a significant number of Australian smokers' lives either saved or prolonged.

An evaluation that tracked the Campaign's effects through to the end of 1998 showed that in the first six months smoking prevalence declined by 1.4%, resulting in 190,000 fewer smokers. This is enormously cost-effective as a public health strategy and represents a health cost saving of $24 million.

During the three-year life of the advertising campaign, the behavioural theory and health effects approach has remained consistent, even in the face of reduced media buys. It has also been carefully monitored and is probably the most comprehensively evaluated national health promotion campaign mounted in Australia to date. Support for the Campaign has come from many areas, and the value of the cash and in-kind contributions from government and non-government health organisations has been substantial. The collaborative effort of the Federal Government and State and Territory Governments, together with non-government and community organisations, has also ensured one of the most cooperative, intense and sustainable anti-smoking campaigns ever seen in Australia.

In developing the overall strategy, behavioural theory was translated into an advertising agency brief for phase one of the television campaign. The idea was to prompt smokers to put the issue of quitting on their 'today agenda'. Initially, three health effects advertisements were used, focusing on *Artery, Lung* and *Tumour*. In phase two, another health effect advertisement focusing on stroke *(Brain)* and an advertisement modelling the behaviour of someone calling the Quitline *(Call for Help)* were introduced.

The health effects advertisements were visceral and confronting. Previous research indicated smokers reported this is what they needed. It was intended the smoker's reaction would be: 'I can't bear to think I am doing that to myself'. At the end of each advertisement the national Quitline number was displayed. Each smoker calling this number had access to trained smoking cessation counsellors.

There were large numbers of calls to the Quitline in phase one (June–December 1997). The number of calls per week were similar in phase two, when the *Call for Help* advertisement was introduced to build on earlier successes. In addition, there were significant increases in the proportion of children encouraging their parents to quit smoking and of people obtaining information about quitting and using nicotine replacement therapy.

Response to the Campaign continues to be very positive. Evaluation results show recognition of the Campaign remains high and the Campaign television commercials continue to be seen as 'relevant', 'believable', and 'thought-provoking'.

The Campaign was not designed for, nor targeted toward, young people at risk of taking up smoking. However, it was recognised that young people's attitudes toward smoking could potentially be affected through exposure to Campaign advertising. Before launching phase one, it was established that this advertising would not be counter-productive among young people. Eighteen months after the Campaign began, a survey of 14 to 17-year-olds showed there was almost universal recognition of the Campaign. Young smokers within the survey sample found the Campaign at least as relevant to them as did their adult counterparts. If anything, the teenage smokers reported being more influenced by the Campaign than adults in a number of key ways. Although the data we have on teenagers' responses to the Campaign is not strong enough to claim any impact on reducing teenage smoking prevalence, the findings are encouraging. Some health promotion specialists recognise the uptake of smoking among teenagers is unlikely to be reduced unless and until adult smoking rates decline. They also see significant risks in attempting to create 'cool' teen-specific campaigns that miss the mark, are seen to be patronising, and therefore backfire.[1] The effects of the National Tobacco Campaign among teenagers is consistent with these views.

The economic outcomes are the most encouraging part of the National Tobacco Campaign evaluation. A cost-benefit analysis formed the basis of the economic study. All jurisdictions and organisations involved in tobacco control contributed information on their activities and costs. The benefit side was drawn from survey data indicating a reduction in prevalence of about 1.4% for the first six months of the Campaign. The analysis showed that the National Tobacco Campaign has been excellent value for money from a variety of perspectives, confirming the desirability of continuing. On the basis of the assumptions used, phase one of the Campaign (June–December 1997) should have prevented 922 premature deaths and achieved an additional 3,338 person-years of life up to the age of 75. In monetary terms, the Campaign proved excellent value for money, as it is expected to have averted costs to the health system of $24 million, far in excess of the estimated $9 million expended by the Federal Government and the State and Territory Governments and partner organisations combined.

At least up to the end of phase two, the National Tobacco Campaign has delivered important health and economic benefits to the nation. The results vindicate the Commonwealth Health Minister's 1996 substantial funding allocation for an intensive six-month Campaign to restart a downward trend in the prevalence of smoking in Australia. Despite its success, there are signs of a slowing down in the key indicators of impact on smoking behaviour, and this is not surprising given the reduced expenditure, particularly on advertising. Campaign strategies, target groups and advertising themes need to be kept under review, refreshed and re-funded on an ongoing basis.

Importantly, the significant reduction in overall prevalence reported to the end of phase one was sustained through the following year. Nevertheless, this result is no cause for complacency, since prevalence did not continue to decrease at the same rate as in phase one and there was no further movement of smokers through the stages-of-change for smoking cessation. The important thing now is to keep up the pressure and sustain the original momentum of success. To achieve this momentum it is crucial to have the necessary resources and support.

[1]D Hill, 'Why should we tackle adult smoking first?', *Tobacco Control*, vol. 8, pp. 333-335, 1999.

Exposure to passive smoking used to be an accepted annoyance, part of the price of socialising with smokers or going into public places. This standard has changed and non-smokers (and, indeed, many smokers) now expect smoke-free environments.

Passive Smoking

Changing Attitudes and Responses in Victoria

Dr Ron Borland, Director, VicHealth Centre for Tobacco Control, Cancer Control Research Institute

We are experiencing a revolution in the way Victorians think about and respond to passive smoking. This shift in community thinking has taken nearly 15 years. In this paper I try to make sense of this shift. The data is Victorian, but parallel activity is occurring in the rest of Australia and other parts of the world.

This is a story of how knowledge of a harm and the dissemination of that knowledge have empowered entire communities to rethink their relationship with a behaviour and socially marginalise it in the interests of the public good.

In the 1980s, scientific evidence of the harms of passive smoking began to accumulate, with the first authoritative reviews published in 1986.[1,2] This process of collating data continues, with a growing list of harms and even more convincing evidence of their linkages with passive smoking.[3] The Victorian public's acknowledgment of these risks plateaued at high levels by around 1987.[4]

In 1988, the first major move to introduce workplace smoking bans occurred with Telecom (now Telstra) and the Australian Public Service going smoke-free. The majority of Victoria's indoor workers have been protected since 1991. It is notable that support of bans in workplaces by smokers is higher after their introduction.[5] This phenomenon also occurs in recreational venues, such as indoor areas of racecourses.[6] This pattern clearly shows that people experience benefits from having bans, and this may explain why those having bans at work are more likely to have them at home.[7]

In 1989, we started to look at passive smoking in the home, with a focus on non-smokers. In that year, 37% of Victoria's non-smoking households reported they discouraged visitors from smoking inside. This compared to 3% of homes where all the adults smoked. By 1997, these figures increased to 63% and 21% respectively.[8] In 1995, the focus shifted to asking smoking households if they go outside to smoke. In 20% of smoker homes, smokers reported always smoking outside. This increased to 28% in 1997. Not surprisingly, this practice was more common where there were adult non-smokers and where children were present. In 1997, only 6% of smokers in smoker-only homes without children always smoked outside. This compared to 43% in homes with both other non-smoking adults and children.[9]

Additional surveys were conducted in 1998 and 1999. Changes in the surveying methodology mean some caution is needed in interpreting the results. A precise estimate of the effect of the method change on reported rates has not been computed, although it will be small. In 1999, over 40% of respondents from smoker homes reported that the smokers always smoked outside. If those saying they 'usually smoke outside' are included, this shows majority behaviour. Discouraging visitors from smoking inside has similarly increased.

Photo courtesy of *The Age.*

Exposure to passive smoking used to be an accepted annoyance, part of the price of socialising with smokers or going into public places. This standard has changed and non-smokers (and, indeed, many smokers) now expect smoke-free environments. This both motivates and makes it easier to create smoke-free homes. People have moved from being grateful if there isn't smoking, to being annoyed if the environment they spend time in is not smoke-free. Today there is increasing public demand for smoke-free environments. The Government has responded, in part, with recent legislation banning smoking in restaurants (sorry, it doesn't become effective until July 2001), but there is increasing public support for taking this even further and mandating that all workplaces and public places become smoke-free. It may not be necessary to extend the legislation to the home. Most people take the responsible approach and are discovering it not only protects their health but also enhances their personal environment.

How has this change come about? It is likely to be because of concerted action to raise awareness and keep the issue on the public agenda. This has been led by strong mass media campaigns. In the mass media, the strategy of keeping the issue topical in news and current affairs has been important, as has the use of dedicated advertising campaigns. There is evidence that a Quit Victoria advertising campaign targeting smoking around children led to increased action to restrict smoking in the home by families with children as compared to those without.[10] The benefits experienced through the introduction of smoke-free workplaces and bans in other places (such as on public transport) have also been instrumental in bringing about this change.

The information came top-down but, armed with that information, there has been activity generated from all levels of the community—governments, businesses, community groups and individuals. We as a community can work to shape the world we live in. When a problem is tangible and real, and the solutions are acceptable, communities have a remarkable capacity to change.

[1]US Department of Health and Human Services. *The Health Consequences of Involuntary Smoking: A Report of the Surgeon General*, Public Health Services, Centers for Disease Control, Rockville, Maryland, 1986. (DHHS Publication No (CDC) 87-8387.)

[2]National Health and Medical Research Council. *Effects of passive smoking on health*. Australian Government Publishing Service, Canberra, 1986.

[3]National Health and Medical Research Council, *The Health Effects of Passive Smoking: A Scientific Information Paper*. NHMRC, Canberra, 1997.

[4]R Mullins & M Morand, 'Environmental Tobacco Smoke: Public opinion and behaviour'. *Quit Evaluation Studies No 8*, Victorian Smoking and Health Program, Anti-Cancer Council of Victoria, Melbourne, 1996.

[5]R Borland, N Owen, D Hill & S Chapman, 'Changes in acceptance of workplace smoking bans following their implementation: A prospective study', *Preventive Medicine*, vol. 19, pp. 314-322, 1990.

[6]L Trotter & J Boulter, 'Patrons' opinions of environmental tobacco smoke at racecourse, football and live music venues', in L Trotter L & T Letcher (eds), *Quit Evaluation Studies No.10*, Victorian Smoking and Health Program, Melbourne (in press).

[7]R Borland, R Mullins, L Trotter & V White, 'Trends in environmental tobacco smoke restrictions in the home in Victoria, Australia', *Tobacco Control*, vol. 8, pp. 266-271, 1999.

[8]ibid.

[9]ibid.

[10]ibid.

Manufacturers of cigarettes for sale in Canada will be required to print one of 16 new health warnings on each pack of cigarettes by the end of 2000.

Tobacco manufacturers in Australia are not required to tell anyone from the Health Minister down about what they put in their cigarettes or to provide any product safety information about any of the thousands of ingredients known from chemical analysis to be found in different brands.

Splinters in the Titanic's Handrails

Associate Professor Simon Chapman,
Department of Public Health and Community Medicine,
University of Sydney

When companies learn their products might harm users, most act swiftly to withdraw them from supermarket shelves. They worry about their customers, their reputation and that they might get sued and consumer safety laws force them to do it anyway.

SmithKline Beecham and Herron Pharmaceutical's withdrawal of paracetamol from the entire Australian market because it might be adulterated with strychnine poison has caused the companies to lose millions. Two incidents apparently arising from a purchase in a Brisbane shop were all that were needed to spark entire national recalls.

In 1996, Kraft, owned by tobacco giant Philip Morris, withdrew its peanut butter after salmonella bacteria was found in the product in four states.

Recently in the USA, Kraft announced it was recalling cheese that might be contaminated with a bacteria that could cause illness. Like the Sydney water scare, no one was found to be ill, but the product was recalled as a precaution.

Down the corridor from Philip Morris' food division is its tobacco division. There, they have been concerned about harming customers' health since at least 1954 when an official stated '…if any one of us believed that the product we were making and selling was in any way harmful to our customers' health—we would voluntarily go out of business'.

More recently, Philip Morris has posted on its website that 'There is an overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases in smokers. Smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers. There is no 'safe' cigarette'.

So how is it that Philip Morris cigarette products are still filling the shelves? What exactly is the moral difference between a remote chance of dying from salmonella poisoning and a very good chance of dying from lung cancer or heart disease? And why didn't the cigarette boys walk up the corridor and tell their peanut butter pals to tough it out and just put up a web site simply explaining that 'eating Kraft peanut butter might cause a serious dose of the squirts or even kill you'? Perhaps all this means that while Philip Morris agrees that 'smoking' can cause all these horrid diseases it somehow thinks this does not apply to its own brands.

On 28 September 1994, the managing director of WD & HO Wills sent a memo to his British American Tobacco company bosses in London. He reported on on-going investigations into the contamination of Stradbroke cigarettes with an unnamed foreign body capable of being detected by x-ray equipment, suggesting some form of fine metal particle. It seemed that an employee was sabotaging the production line by tossing some unplanned extras into the chemical cocktail mixed in what Wills breezily calls its 'flavour stations'. A psychiatrist was called in to evaluate 700 people who may have had access to the factory area. The person responsible was not found and an internal memo concluded 'Water towers, flavour stations etc. are locked or sealed but these measures do not exclude the possibility of further problems'.

The idea of a tobacco company being worried about contamination in its cigarettes is rather like the owners of the White Star Line worrying about splinters in the handrails of the Titanic. But the memo—discovered in a search through 26 million pages of internal tobacco industry documents published by US court order on the world wide web—raises important questions about tobacco company attitudes toward their customers. With the deep concern within Wills about the contamination, why was no public warning issued? How did they find out about it? Did a customer complain? Did a customer become ill quickly? Why was there no product recall?

The collective corporate mental contortions that would produce company panic about contamination, but decades of determination to deny that half of their customers will die from routine smoking-caused diseases, must have intrigued the prominent psychiatrist who was summoned to their assistance.

The incident and the pushme-pullyou logic of the Philip Morris product recalls raises a more fundamental question of why the tobacco industry remains protected from any form of product regulation. Any food, beverage or pharmaceutical manufacturer wanting to launch a new product is required to spend thousands of dollars to ensure safety and purity. Yet, with tobacco, the old joke that Camel cigarettes are the only brand with a picture of the factory on the packet could in theory be true.

Tobacco manufacturers in Australia are not required to tell anyone from the Health Minister down about what they put in their cigarettes or to provide any product safety information about any of the thousands of ingredients known from chemical analysis to be found in different brands.

When they can even raise themselves to comment on the matter, the tobacco companies have used the Coca-Cola or KFC secret formula defence to justify their contempt for their customers' right to product information. This defence is now in tatters in British Columbia where, since 1998, the government has posted a full chemical analysis of all local tobacco products on the world wide web (www.cctc.ca/bcreports/).

The Wills memo can be found at: http://outside.cdc.gov:8080/BASIS/ncctld/web/mnimages/EDW?W=DETAILSID=2644

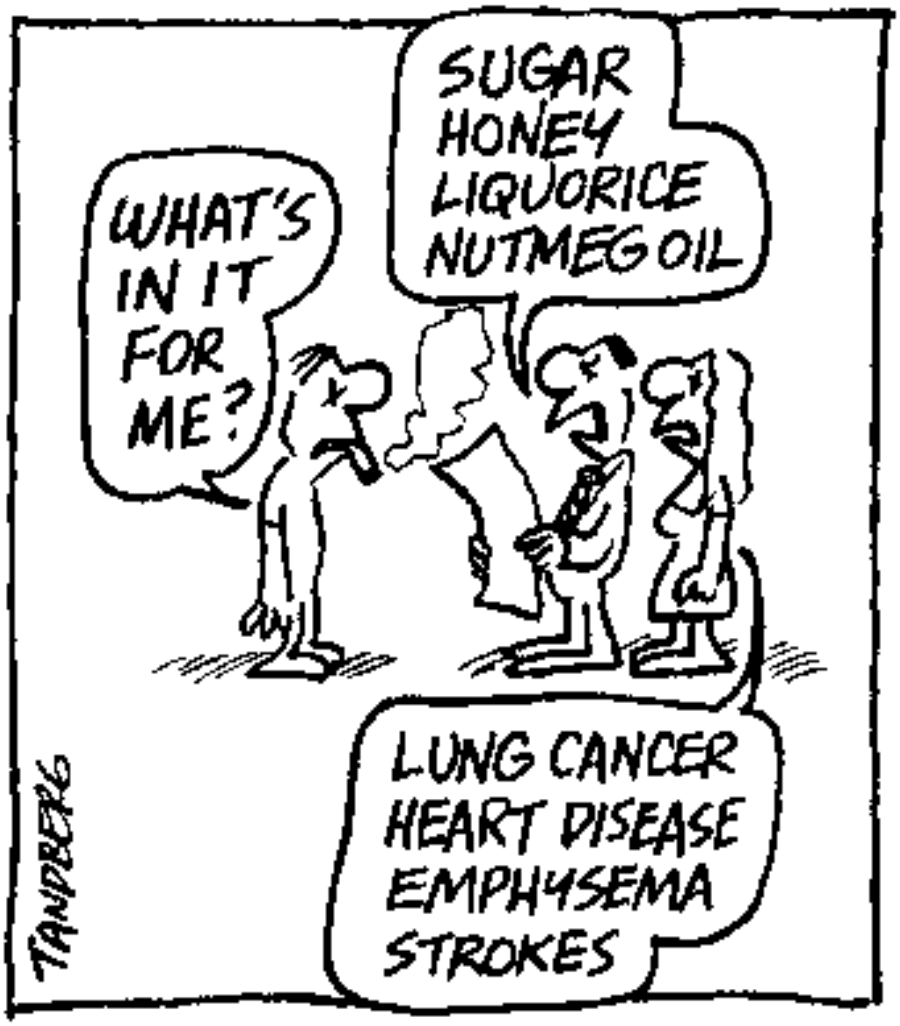


Photo courtesy of *The Age*.

Why the Tobacco Farce is Such a Tragedy

Jonathan Liberman, Legal Consultant, VicHealth Centre for Tobacco Control
Dr Rob Moodie, CEO, VicHealth

For just one year, for every dollar Philip Morris spends on hospitality, sponsorship and advertising, it should spend another dollar organising tours of cancer and cardiac wards for politicians and policy makers.

There is a disquieting unreality at the heart of the drug policy debate in which we, as a community, are now engaged. It is an unreality which plagues this entire debate, gnawing away at its credibility.

It was brought sharply into focus in April when the Australian arm of the world's biggest tobacco company, Philip Morris, hosted a trade lunch at the Liberal Party's National Convention. The trade lunch was, unfortunately, just one of a long line of recent episodes which have highlighted the hypocrisies and contradictions that can make our treatment of drug policy issues seem farcical.

Over the last few months, we've discovered that Philip Morris has received hundreds of thousands of dollars in tax concessions to help it develop high tar cigarettes for Third World countries. We've seen the great orgy of tobacco promotion around the Formula One Grand Prix, with our local newsagents and milk bars reborn as tobacco advertising booths. We've seen Australian Electoral Commission records disclosing tobacco company donations to both major political parties and revelations of tobacco companies offering hospitality to our political leaders.

Each of these episodes has generated comment and controversy. Each is a symptom of a profound confusion in our treatment of drug issues. Each forces us to ask ourselves whether, despite the quality of our rhetoric, we are serious about reducing the enormous human, social and economic consequences of drug use in this country.

Tobacco kills about 18,000 Australians a year; about 50 a day. The overwhelming majority of smokers started when they were children and continue to smoke primarily because they are addicted to nicotine. Yet you can buy tobacco in any old milk bar, petrol station, newsagent or supermarket. In most states, including Victoria, you don't even need a licence to sell it. Tobacco companies are allowed to promote and advertise and offer hospitality, and to enjoy taxpayer funded R&D concessions. And to make extraordinary profits.

Photo courtesy of *The Age.*

When politicians or tobacco company spokespeople are confronted with these uneasy contradictions, they reach for the same 'defence'. They say, 'Tobacco is a legal product'. Of course, this 'defence' is a load of nonsense—it's a tobacco company spin of the highest order. In truth, products are neither legal nor illegal. It's only the conduct of individuals or corporate entities who do things with or in relation to products that can be legal or illegal.

It might be that use of the term 'legal product' is supposed to suggest that tobacco companies act, and have always acted, in accordance with the law. But who is qualified to make such an assertion? Isn't this something that, under our system, courts are supposed to decide?

In the US, four separate juries have heard mountains of evidence and found that US tobacco companies have acted unlawfully. At the moment, there's a case before the Federal Court in Sydney that alleges a wide range of unlawful conduct by the Australian tobacco companies. And the Commonwealth, State and Territory Attorneys-General are investigating the possibility of suing tobacco companies to recover taxpayer health care expenditure on tobacco-related disease caused by these companies' unlawful conduct.

So why must a blind eye be turned to all of this? Why can people say 'legal product' and just make all of this go away?

Philip Morris' corporate affairs director, Eric L.Windholz, was quoted recently bleating about 'draconian' tobacco legislation. When you put side by side the toll wrought by tobacco and a comparison of the way tobacco companies and other drug pushers are treated, it's hard to know whether to find this outrageously offensive or to conclude that Mr Windholz is a comic genius with an exquisite sense of the absurd.

Of course, none of this confusion will disappear overnight. But here's a small suggestion to start with. For just one year, for every dollar Philip Morris spends on hospitality, sponsorship and advertising, it should spend another dollar organising tours of cancer and cardiac wards for politicians and policy makers. Instead of grotesquely portraying his multibillion dollar multinational as some poor victim, Mr Windholz could introduce his tour participants to Philip Morris' lifetime customers seeing out their final days inside these wards. He and his guests could listen to stories about how it feels to have been led by addiction to die 10 or 20 years before your time. And then, hopefully, his guests could take the stories they hear and use them to inform their policy approaches.

Until we are prepared to treat tobacco addiction and the enormous losses to which it leads as seriously as we treat other drug addictions, we shouldn't pretend that our drug policy debate is a genuine one.

This an edited version of a piece that appeared in The Age *on 18 April 2000.*

Examples of point-of-sale advertising during the Australian Formula One Grand Prix, Melbourne 2000.

What may be the shape of future initiatives? There are more substantive issues that need urgent attention. Experience suggests the tobacco industry may be adept at identifying ways of undermining such public health initiatives.

Are We There Yet?

Todd Harper, Executive Director, Quit Campaign Victoria

Tobacco control is firmly back on the agenda in Victoria.

Unanimous support for our recent tobacco reforms by State Parliament has given Victoria's number one health issue a much-needed boost.

Public health advocates and our political representatives deserve a pat on the back. And to be told to 'get back to work!'.

Restrictions on tobacco marketing at point-of-sale and on passive smoking, and enforcement of long-standing laws to prevent sales of cigarettes to children, are welcome.

But what may be the shape of future initiatives? There are more substantive issues that need urgent attention. Experience suggests the tobacco industry may be adept at identifying ways of undermining such public health initiatives.

As a recent example, Imperial Tobacco, a minnow in the Australian tobacco market, recently announced it had changed agencies for its $10 million advertising account.[1] This is despite extensive advertising bans on tobacco companies in Australia. Apparently, their activities will include 'below the line' marketing activity—including point-of-sale material, packaging, events management, relationship marketing, strategic planning and e-commerce. Hardly the actions of an industry on the back foot. Their expenditure compares to a total amount spent on all anti-smoking initiatives in Australia in 1997 of just $14 million.

Adequate funding of anti-smoking campaigns remains our biggest hurdle. As Associate Professor Simon Chapman[2] recently highlighted, campaigns against the leading cause of preventable death in Australia receive less money per death ($112) than many other health initiatives, including illicit drugs ($118,571), black spot road safety ($19,619) and falls prevention ($1,438).

The value of investing in tobacco control, and specifically smoking cessation programs, is clear. The first six months of the National Tobacco Campaign is estimated to have paid back its $9 million investment twice over, preventing 920 premature deaths and resulting in 190,000 smokers quitting.[3]

In Victoria, the value of investment in anti-smoking initiatives has been clearly identified by Collins and Lapsley, who estimated that the net benefits of the Quit campaign over a thirty-year period were almost $1 billion, while the ratio of the benefits to the costs of the program was 15:8.[4] This report also identified the staggering costs of tobacco to the State as being in excess of $3.2 billion per annum. While tobacco funding in US states ranges from US$2.50 to $10 per head of population[5], in Australia states are more likely to be spending less than A$1 per capita.

And having established that more investment in tobacco control is warranted, additional funding must also be directed into cessation programs. In particular, substantial investment in resourcing of tailored programs to disadvantaged groups in the community is required.

Ensuring all enclosed working environments are smoke-free must be a public health policy goal. Such changes will impact primarily on the hospitality industry and, to a lesser extent, smaller retailers. All employees deserve the right to work in safe, smoke-free work environments. Having accepted the arguments against smoking environments on health and occupational health and safety grounds, it is impossible to argue that all employees should not be afforded the same consideration. Ensuring all enclosed public places are smoke-free is the only way to protect employees and the public from passive smoking illnesses and to provide a level playing field for industry, protecting them from the threat of litigation.

Litigation against the tobacco companies in Australia offers the potential to change the way tobacco and its manufacturers are regulated. It is hard to believe this product, responsible for around 18,000 deaths a year,[6] contains no details of ingredients, offers no warranty from its producers, provides little detail of the deadly effects when used, and provides no indication about its carcinogenic compounds. Indeed, any legislative reforms to require such disclosure have been vociferously opposed by the industry. Litigation offers an opportunity to force a reasonable level of regulation on this industry. In the recent landmark Engle case in Florida, the jury found that cigarettes are addictive. It found that tobacco companies had placed cigarettes on the market that were defective and unreasonably dangerous. It also found the industry had engaged in fraud and misrepresentation, engaged in fraud by concealment, conspired to misrepresent information relating to the health effects of smoking or the addictive nature of smoking, and conspired to conceal or omit information regarding the health effects of smoking or the addictive nature of smoking cigarettes. The verdicts are likely to be appealed.

In this globalised industry, is it realistic to believe the conduct of the tobacco companies in Australia is any different?

By exposing their past and present conduct and obtaining documents on the public record, there can be a focus on how this deadly industry can be properly regulated, and on regulating tobacco as the addictive drug that it is.

The result of such regulation may be that tobacco would be available to those addicted to nicotine, but there would be no tobacco industry. Does any company deserve to profit from a substance that hopelessly addicts and kills half of its long-term users?

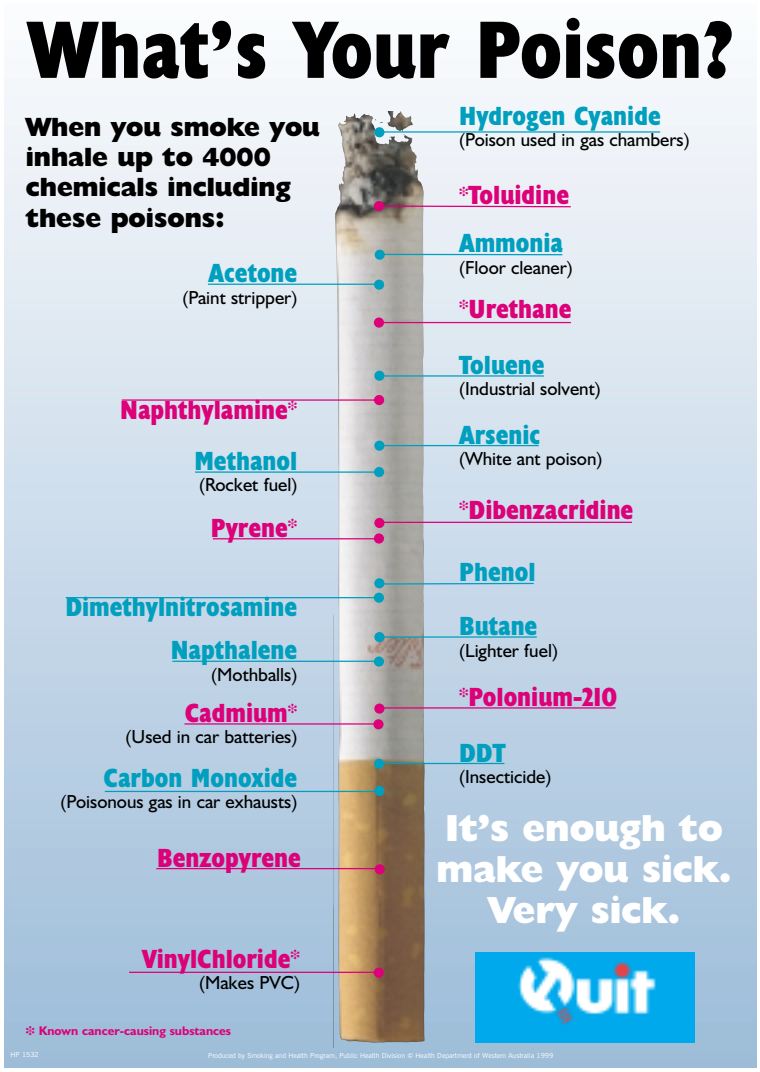
The new *mandatory health warnings at point-of-sale*, to be introduced in Victoria from 1 July 2001, provide an opportunity to counter the pervasive marketing influences of the tobacco companies. Worthy of consideration is a proposal that would integrate the images and messages of the highly successful National Tobacco Campaign's *Every Cigarette is Doing You Damage* advertisements. Such an integrated approach would add value to the successful national campaign and allow smokers to be exposed to these effective messages and quitting information at the point-of-sale.

Similarly, these warnings and images could be extended to cigarette packs themselves as part of *a revamp of the existing, tired cigarette packet warnings*. The existing pack warnings need to be updated and consideration should be given to the new pictorial warnings recently adopted in Canada. Such a proposal in Australia would allow the successful images and messages from the National Tobacco Campaign to be included on packs. Packs should also include the Quitline number. Seventy-nine per cent of smokers[7] have made an attempt to quit. Providing quitting information on the pack means smokers could be exposed to the Quitline message every time they need to be: when they light up!

How could we make room for this additional information? Simple: remove all tobacco brands and advertising on the pack. If the tobacco companies are, as they claim, only targeting existing smokers with their marketing, providing plain information on the product is reasonable and fair to all companies.

Banning the use of misleading terms such as 'mild' and 'ultra light' of which the tobacco companies are so fond is also necessary. It took until 1999 for one tobacco company, Philip Morris, to feebly admit on its web site that 'smokers should not assume, that 'light' or 'ultra light' brands are 'safe', or are 'safer' than full-flavor brands'.[8]

But that's just for starters…



Manufacturers of cigarettes for sale in Canada will be required to print one of 16 new health warnings on each pack of cigarettes by the end of 2000.

[1]*B and T Weekly*, 9 June, p. 2.

[2]*MJA 2000*; vol. 172, pp. 612-614.

[3]Australia's National Tobacco Campaign, Evaluation Report Volume 2, p. 203.

[4]DJ Collins & HM Lapsley, *The Social Costs of Tobacco in Victoria and the Social Benefits of Quit Victoria*, Victorian Smoking and Health Program, 1999.

[5]US Department of Health and Human Services, *Best Practices for Comprehensive Tobacco Control Programs—August 1999*, US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Atlanta GA, August 1999, p. 8.

[6]DR English, SDJ Holman et al., *The Quantification of Drug-caused Morbidity and Mortality in Australia, 1995 edition*, Commonwealth Department of Human Services and Health, Canberra, 1995.

[7]Centre for Behavioural Research in Cancer, *1996-97 Quit Evaluation Studies, Volume 9*, CBRC, Melbourne, 1998.

[8]http://www.philipmorris.com/tobacco_bus/tobacco_issues/tar_noctine.html

The jury's decision, and its damages award, have been hailed as a great victory for public health. After decades of unlawful conduct, and an extraordinary trail of death and disease, the US tobacco companies have finally been brought to legal account.

Record Punitive Damages Award Against US Tobacco Companies

Jonathon Liberman, Legal Consultant, VicHealth Centre for Tobacco Control, Cancer Control Research Institute

On 14 July 2000, a Florida jury handed down the highest punitive damages award in history. After listening to two years of evidence, including the testimony of 157 witnesses, and seeing thousands of tobacco industry documents, the jury ordered the major US tobacco companies to pay almost $US145 billion to sick Florida smokers.

The verdict was explained by jury foreman, Leighton Finegan:

'We want this message loud and clear: We will not tolerate fraud and misrepresentation … They belittled or denied causation of the health effects of smoking and addiction, and had the gall to challenge public health authorities.
…

We had a sense of mission … And we did not want to ignore the tremendous devastation that the product has caused. The number had to match that. It had to be significant.'

In July 1999, the jury had already found:

- smoking causes 20 different diseases or conditions, including lung cancer, heart disease, emphysema, bladder cancer, throat cancer, kidney cancer, tongue cancer, pregnancy complications, pancreatic cancer and stomach cancer;
- cigarettes are addictive;
- the defendant tobacco companies:
  - placed defective and unreasonably dangerous cigarettes on the market;
  - engaged in fraud and misrepresentation;
  - engaged in fraud by concealment;
  - conspired to misrepresent, and to conceal or omit, information relating to the health effects of smoking or the addictive nature of smoking;
  - breached implied and express warranties;
  - acted negligently; and
  - engaged in intentional infliction of emotional distress.

The jury's decision, and its damages award, have been hailed as a great victory for public health. After decades of unlawful conduct, and an extraordinary trail of death and disease, the US tobacco companies have finally been brought to legal account.

The defendant tobacco companies have criticised the verdict, saying that if it is upheld on appeal it will send them into bankruptcy. While the outcome of the appeals process—expected to take up to two years—remains to be seen, the verdict might signal the beginning of the end of the tobacco industry as we know it (at least in the US).

With the tobacco industry now finally on the back foot, it is time to seriously question the right of companies and individuals to continue to make obscene profits from the sale of an addictive, lethal product. It is time to examine regulatory options that are genuinely aimed at the reduction of the death and disease caused by tobacco, and that treat tobacco as the dangerous drug it is.

This debate needs to take place in Australia and internationally. While no case has yet made it to trial in this country, the death toll of 18,000 a year makes the issues equally pressing.

There are no easy solutions to the high levels of smoking in Indigenous communities and all the associated health problems. Specific, well-staffed, well-funded, Indigenous community controlled programs are the key.

Taking Smoking out of Koori Culture

Viki Briggs, Aboriginal Project Coordinator, Quit Campaign Victoria

Ask a Koori person why they smoke and you'll get a mix of answers—I smoke because I'm stressed, I smoke because I'm hooked, I smoke because I like it. Whatever the reason, the fact is that with around 57% of Kooris smoking in Victoria, tobacco is contributing significantly to ill-health and death in the community. The fact also remains that it's hard to encourage people to quit in a community where smoking is so socially acceptable and perhaps even part of our modern culture.

There are no official early records of smoking prevalence in Koori communities. I can, however, estimate from talking to Elders that smoking rates were low in the early 1900s. Unfortunately, by the 1950s smoking rates had soared. This seems to have happened for a couple of reasons. Tobacco was included in rations given out on missions and, ironically, smoking was seen as something that Kooris could do every bit as well as the wider community, so being a smoker was something to aspire to. Now we are left in a situation where most potential Koori role models are smokers.

As part of the National Tobacco Campaign evaluation in 1998, focus groups on perceptions and attitudes to smoking were run in Victorian Koori communities. Role modelling of smoking behaviour by parents, grandparents and community Elders was regarded as an influence on the uptake of smoking by young people. For example, young people commonly talked about being supplied with cigarettes by their parents. It appeared that parents who were smokers almost expected their children to take up smoking. Further, parents who smoked generally felt that they could not prevent their children from taking up smoking because it was something they did themselves.

The role of Elders was seen to be especially important in terms of influence, therefore whether such a role model is a smoker or not can be very significant in terms of influencing the behaviour of young people. This is especially so when combined with such high community smoking rates.

Smokers themselves commonly regarded quitting as too hard. Nicotine replacement therapy was often seen as their only hope of quitting. Peer influence was a major barrier to successful quit attempts. The reasons given for this were the high incidence of smoking among workmates and peers, along with easy availability and the social role of cigarettes and smoking.

On 19 July 2000, the Australian Medical Association released a report on Aboriginal smoking in Australia. That report found:

- 61% of Indigenous people aged 25 to 44 smoke;
- 60% of Aboriginal and Torres Strait Islanders reported smoking at some time during their pregnancy, compared with 20% of all mothers; and
- Aboriginal smoking rates of up to 86% have been recorded in some areas.

In addressing the problem, there are often difficulties specific to certain areas. In some areas distance is a problem and workers often have to travel in some states and territories. In Western Australia, for example, it wouldn't be unusual for a project worker to travel 12 or 14 hours to run information sessions for health workers in a remote community. The financial burden of being a smoker and living in remote communities also causes specific problems. A colleague of mine from Cairns recently told of a trip to Palm Island where, she said, around 80% of the community smoke. If you combine that with the fact that a packet of cigarettes costs considerably more up there, a lot of that community's finances are literally going up in smoke.

There are no easy solutions to the high levels of smoking in Indigenous communities and all the associated health problems. Specific, well-staffed, well-funded, Indigenous community controlled programs are the key. At the risk of repeating what has been said over and over in the areas of Aboriginal health, education, employment and housing, unless more time and money are committed from both the State Government and the Federal Government the problem will continue to get worse.

Smoke Gets in Your Eyes

Zoe Furman, Media Communications Manager, Quit Campaign Victoria

The message is very clear—smoke-free music is receiving the support of punters and performers, and venue owners who are prepared to give it a go are being rewarded.

Joe Cammilleri was hot, the crowd was pulsing and the Yarraville Hotel was packed—a typical live music gig. The only thing missing at this World No Tobacco Day performance was the smoky haze traditionally part and parcel of the live music scene.

Throughout May 2000, Melburnians were able to enjoy live music without the smokescreen thanks to Breathing Easy, a campaign coordinated by Diana Wolfenden to promote smoke-free live music. In this, its second year, Breathing Easy saw nine venues and 30 gigs sign the smoke-free banner for World No Tobacco Day.

For some people, the combination of 'smoke-free' and 'live music' is almost inconceivable. Pubs are a common venue for many gigs and are seen by some as the smoker's last bastion. However, while there is no doubt music venues are a hard nut to crack when it comes to the idea of smoke-free gigs, there is clearly support from punters.

A 1999 survey conducted by Melbourne's Centre for Behavioural Research in Cancer found 75% of punters surveyed at four live music spots supported venues having smoke-free nights. Surprisingly, 50% of smokers surveyed supported smoke-free nights. Similarly, a survey conducted at four live music venues in Sydney this year by the New South Wales Cancer Council found 79% of patrons preferred either entire or partial smoking restrictions.

A growing number of venues are responding to this trend and providing either smoke-free nights or totally smoke-free venues. The pressure is not just from punters—a number of prominent musicians and entertainers are also taking a stance on the issue. Jazz crooner Vince Jones is one, as is stand-up comedian Tracey Bartram.

As a vocalist herself, Diana Wolfenden understands musicians' concerns about performing in smoky venues.

'I'm very conscious of the effects of a gig in a smoky venue. In a smoke-free environment, I can breathe more deeply, sing more clearly and strongly, and there are no damaging after-effects on my voice,' she says.

Diana points out it is also an occupational health and safety issue, as a venue is a musician's workplace.

'Musicians have the right to perform in a smoke-free environment if they choose to do so, but unless they're a big name they're often concerned that insisting on smoke-free gigs may mean less work.'

Diana says the main barrier to smoke-free gigs is the fear of losing customers and revenue. But the experience of a number of people in the industry demonstrates these fears are unfounded.

Jazz musician Carlos Ferreira is the driving force behind Ozcat at the Parkview, Melbourne's first permanent smoke-free jazz club. Carlos says the response has been enthusiastic.

The enthusiastic crowd of over 150 at Joe Cammilleri's gig also proves that smoke-free gigs are a hit.

Chris Keeble, Entertainment Manager of Australia's largest nightclub and live music venue Panthers World of Entertainment in New South Wales, says adopting smoke-free policies has meant increased profits and lower costs.

Chris says the introduction of a smoke-free nightclub and live music venue in 1997 has been good for business, with bar and tickets sales up, and costs on air conditioning and refurbishing down.

So the message is very clear—smoke-free music is receiving the support of punters and performers, and venue owners who are prepared to give it a go are being rewarded.

Diana says the main objective for Breathing Easy now is to build on the project's success and encourage more venues to offer regular smoke-free nights. She is currently promoting resources for venues, such as a guide that covers areas like staff training and patron education.

Diana says it's important for punters to be more vocal about the issue too: 'One of the most powerful ways for this message to get through to venues is from their punters.'

Where to find out about smokefree live music:

- Check out the OZCAT website at http://www.ozemail.com.au/~melsamba/ozcat.htm

  You can join the e-list and be updated about forthcoming smoke-free jazz events.
- The Age CitySearch website now lists smoke-free gigs. Check out www.citysearch.com.au
- In Melbourne, OZCAT at the Parkview, Dizzys, Bennetts Lane, The Boite and Chapel Off Chapel are all smoke-free. Find out what's on by checking papers.

The whole effect of passive smoking on cardiovascular health is an enormous issue. Quite simply, there are a lot of smokers and lot of people with heart disease. When put together, the seriousness of the situation from a public health perspective is quite significant.

Passive Smoking

Close to the Heart

Not surprisingly, Victoria's Heart Foundation threw its full support behind the recent passing of Victorian legislation banning smoking in restaurants and cafes. The move marked a significant step in achieving one of their major policy objectives—to see all enclosed public spaces free of cigarette smoke.

Passive smoking is known to be a cause of heart disease, increasing a person's risk by 25% through regular exposure. Non-smokers with high blood pressure and high cholesterol who are exposed to passive smoking are likely to be at even greater risk. People who already have heart disease, such as angina, may experience exacerbated symptoms and disturbances of the heart's electrical rhythms, with potentially serious consequences.

The Heart Foundation's Executive Director, Robyn Charlwood, says the Foundation has taken the lead on developing a passive smoking policy. Prior to introduction of this legislation into Parliament, the Foundation was closely involved in discussions with relevant MPs, encouraging them to look at the research and seriously examine the issue from a public health perspective.

As Robyn explains, the key point in the policy is that everyone should be able to go about their daily lives without involuntary exposure to other people's tobacco smoke. Therefore, all workplaces, homes, cars, enclosed indoor public places and outdoor restricted public places, such as sport stadiums, should be smoke-free.

The Foundation's approach to the policy has been two-fold. In one aspect, the policy works to protect people from developing future heart disease by eliminating exposure to passive smoke, particularly those with high risk factors such as high blood pressure and high blood cholesterol. On the other hand, it aims to reduce the risk of complications in individuals already experiencing health problems associated with heart disease.

'The important thing to understand with environmental tobacco smoke is that passive smoke is an environmental toxin. We know what compounds it contains and we know how hazardous to health they can be,' said Robyn.

'But while there is legislation in place to protect against the polluting effects of many different toxins in our air and waterways, there is still a long way to go with cigarette smoke. In workplaces such as bars and casinos, workers are continually being exposed to what we know are toxic compounds from second-hand smoke.'

'As our policy states, comprehensive smoke-free policies are needed for all public places and workplaces and are preferred because they have the advantage of simplicity, clarity and promoting health for everyone.'

As Robyn says, the whole effect of passive smoking on cardiovascular health is an enormous issue. Quite simply, there are a lot of smokers and lot of people with heart disease. When put together, the seriousness of the situation from a public health perspective is quite significant. Cardiovascular disease is still the major cause of ill-health and disability in Australia and is responsible for 41% of deaths in Australia each year.

For information about the Heart Foundation's position and policy on passive smoking, contact the Heart Foundation's Heartline on 1-300 36 27 87.

Smoking Cessation in Victorian Prisons

The project outcomes were very positive. Participants responded well to the course content and attendance levels were more sustained compared to earlier cessation courses.

Suzanne Stillman, Executive Manager, Quit Campaign Victoria

Photo courtesy of *The Age.*

Approximately 25% of adult Australians smoke, but in some population groups such as prison inmates, these rates are substantially higher. Surveys show that upwards of 80% of prison inmates smoke, extremely higher than mainstream rates.

Prison environments present unique and often difficult challenges for introducing smoking cessation programs. Attempts to introduce programs such as Quit's *Fresh Start* into prisons have at best been only marginally effective. Certainly previous attempts have highlighted issues that need addressing to improve outcomes of prison-based smoking cessation programs. Often prisoners reported repeated failure in their attempts to stop smoking and there was a high attrition rate in course attendance. Little information exists about smoking cessation programs in prison settings. Reports from the United States show prisons have increasingly adopted restrictions on cigarette smoking but there are few details about programs and support provided to prisoners.

The project *Working Towards a Smoking Cessation Program in Victorian Prisons* involved adapting Quit's *Fresh Start* course, following a needs assessment within three prisons. The project helped raise awareness of the problem. Based on the survey results, course materials were developed to help meet the unique needs of inmates.

Survey results indicated that prisoners' smoking behaviour was often influenced by stress, boredom, chemical addiction, confinement, peer pressure, attitudes of staff, money and health. The prisoners indicated that a desire to be healthier, availability of nicotine replacement patches, alternative methods of replacing cigarettes (exercise program, hobbies), peer education and support and stress management skills would encourage them to change their smoking habits. Other factors and incentives including certificates of achievement, other acknowledgments (for example by the Adult Parole Board), low cost patches, making it a privilege to participate and providing relapse prevention helped reinforce prisoner's willingness to participate. It was also important that stopping smoking was seen as a high priority within the system.

The project outcomes were very positive. Participants responded well to the course content and attendance levels were more sustained compared to earlier cessation courses. Posters were developed by prisoners, which became a fixture throughout the institutions. Most participants made a determined effort to change their smoking behaviour, although at three months only one participant was still not smoking. However nearly all others had reduced their cigarette consumption. Some had halved the number of cigarettes smoked and many were smoking lower tar cigarettes. As well, some had made additional attempts to quit following relapse and there were requests for further Quit programs. All reported the prison situation as being a major factor in making it difficult to quit.

As Quit's Prisons Course is disseminated, the findings and recommendations from the project will inform other prisons considering tobacco control programs. Facilitator and participant workbooks provide clear guidelines for Quit-trained facilitators who wish to run similar courses. Written materials were sensitive to literacy levels and care was taken that themes and images were relevant to participants.

This cessation project was a partnership between Community Health Bendigo (Health Promotion Unit), CORE - The Public Correctional Enterprise in particular Bendigo Prison, Loddon Prison and Tarrengower Prison, Quit Victoria and the Centre for Behavioural Research in Cancer (Anti-Cancer Council of Victoria).

For more information please contact Quit on (03) 9663 7777.

Reversing the Brain Drain

Interview with Dr Melanie Wakefield

VicHealth Senior Research Fellowships are primarily designed to repatriate outstanding Australian public health and clinical researchers currently working overseas to Victoria. The program aims to build a critical mass of these researchers in the State.

Soon to take up a Fellowship is Dr Melanie Wakefield, who is currently working at the Health Research and Policy Centers, University of Illinois at Chicago, as a visiting research scientist. She is also senior editor of *Tobacco Control*: an *International Journal*.

Dr Wakefield will commence her work for VicHealth at the Centre for Behavioural Research in early 2001. Her research project aims to better describe and understand the influence of the media on tobacco smoking in Australia. She will examine the impact of changes in anti-smoking advertising and portrayal in news, film, television and music media on smoking in adults and school children.

Here she answers some questions about her work.

Recognising the high profile institution and large research budget you are working with in the US, what is the drawcard for returning to Australia?

Australia has an excellent track record in tobacco control research, and in health behaviour research in general, so it is no second cousin to the research being undertaken in the USA. Sometimes I think we fail to recognise that. The research funding available in the USA is much larger, but it is possible to tap into that from Australia through international collaborations and by applying for US-based funding, some of which is accessible to Australian researchers. It's terrific to have the opportunity to work at the Centre for Behavioural Research in Cancer at the Anti-Cancer Council of Victoria, since the team consistently produces first-class research and there are some great people to collaborate with. And, life is not all about work. There are many things about the USA that I have found difficult to deal with, predominantly the social and economic inequities between different groups in society. I really like the Australian way of life—we have much to be grateful for!

What have you gained from working in the US that you feel you can bring back home to Australia?

I have been exposed to many new ideas, which has been challenging and stimulating. In addition, I have had the opportunity to work with some excellent researchers and to build new collaborations. The project I have been working on in the USA is an enormous multi-site project, and I've learned some valuable lessons about managing something like that. All of these things will be coming home with me.

What are your thoughts about working with David Hill in particular, and other Australian scientists in general?

I am very excited about the opportunity to work with David. I greatly admire his creativity and productivity. I also enjoy his enthusiasm for his work and I think I can learn a lot from him. Australia has some very talented behavioural scientists, some of whom I am honoured to call friends, and I'm very much looking forward to working with them again.

Can you explain your upcoming work for VicHealth?

My research will involve trying to develop better measures of population exposure to anti-smoking advertising and news media messages about tobacco control, so we can eventually determine the extent to which these types of influences might change teenage and adult smoking. There's good evidence that anti-smoking advertising does have a positive influence, but it's getting more difficult to make sure this continues to be the case when there are many other factors that could be responsible. Also, news reporting about tobacco issues is a vastly under-researched area—clearly what people see and hear through the news shapes their thinking about tobacco, so the way in which issues are framed by the media is important to monitor and understand.

What do you hope for your future career?

I think the combination of managing some big research projects and playing a role supervising and bringing on younger researchers is just where I want to be right now and in the near future. I'm very committed to seeing smoking prevalence decline in Australia and I want to do research that helps to make that happen.

Racing

to the Smoke-free Finish Line

The survey results clearly indicated that people would enjoy race meetings even with smoking restrictions. In fact, the research showed that the majority of patrons would find a day at the races more pleasurable if indoor areas were smoke-free.

Racing clubs are no exception when it comes to growing community concern over the health effects of passive smoking and now are taking their place in the smoke-free winner's circle. Within the betting ring the odds are good that more Victorian racing clubs will join other sporting clubs to go 100% smoke-free.

On 1 April 2000, the Victorian Amateur Turf Club (VATC) joined the Moonee Valley Racecourse and other members of the smoke-free sporting movement by introducing indoor smoke-free policies. These racing clubs were the first in metropolitan Victoria to do so. All indoor areas at both Caulfield and Sandown Racecourses were officially declared 100% smoke-free.

In 1999, VicHealth commissioned the Anti-Cancer Council of Victoria's Centre for Behavioural Research in Cancer to conduct a study of Victorian racecourse patrons, thereby laying the groundwork for the VATC's smoke-free move. The study of eight Victorian racecourses looked at how many punters would support smoking restrictions and measured whether these restrictions would affect future race attendance. The study also explored patrons' experience of being exposed to environmental tobacco smoke at the racecourse.

Results of the study, which included both smoking and non-smoking punters, indicated that 77% of the patrons surveyed supported banning smoking in enclosed areas. Even the majority of smokers indicated their support for smoking bans in enclosed areas. Importantly, those surveyed also indicated the restrictions would not keep them from attending race meetings. The study concluded that there is strong support for smoking bans in enclosed areas at racing venues. The survey results clearly indicated that people would enjoy race meetings even with smoking restrictions. In fact, the research showed that the majority of patrons would find a day at the races *more* pleasurable if indoor areas were smoke-free.

The VATC is keen to protect the rights of both patrons and staff to breathe smoke-free air, and its new policy is not about whether patrons *can* smoke but instead *where* they smoke. Patrons are free to smoke outdoors, and the Club is currently arranging covered shelters on the outside balcony of the Rupert Clarke Stand at Caulfield Racecourse for the protection and comfort of smokers.

Caulfield, Sandown and Moonee Valley are setting a smoke-free standard for Victoria's racing community. It is encouraging to see these sporting venues taking positive steps by declaring themselves smoke-free.

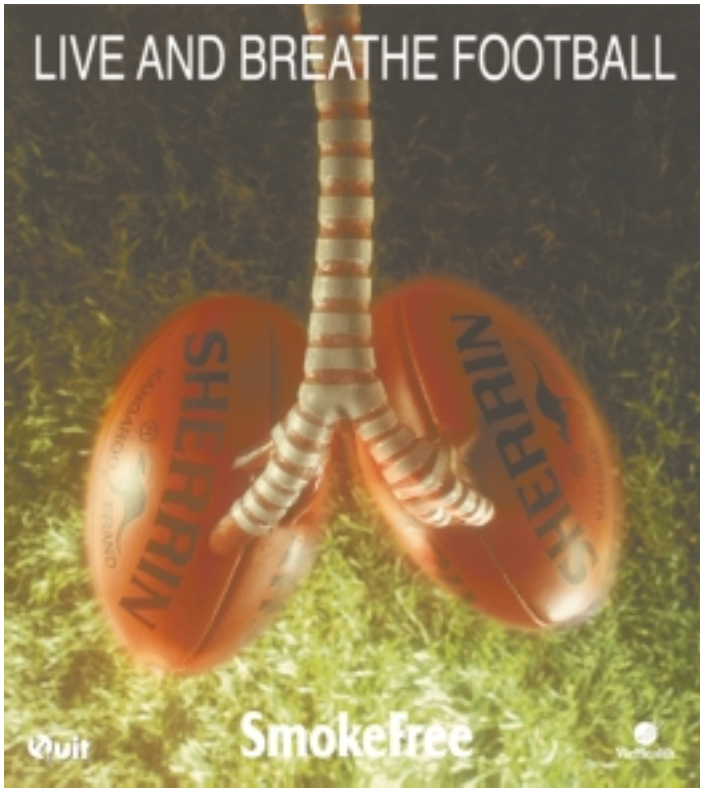
'I would say the 100 per cent indoor smoke-free policy introduced at Caulfield and Sandown on April 1st this year has been extremely well-received by our patrons,' says Denis Cox of the VATC.

'The Club has continued to receive positive feedback from racegoers on the changes, with many patrons, including smokers, saying they prefer the smoke-free environment.'

‘Players are mindful that playing football is a healthy pursuit. You don’t want to destroy the health benefits of it by ripping into too many lagers or smoking your lung capacity away.’

Kicking Smoking

out of the Club



Brett Connell recalls a time last year when VicHealth and Quit joked about nominating the Victorian Amateur Football Association (VAFA) for a bravery award. The task would be to introduce a smoke-free policy to the VAFA. Brett serves as general manager of football operations for the 74 VAFA clubs and major general in charge of storming the last bastion of the smoking frontier.

It’s no secret that post-match celebrations are as much a part of Australian Rules Football as the game itself. And traditionally these celebrations have included a few beers and smokes—making the club’s function room serious competition for the local pub.

However, in just under two years, Brett has seen the number of clubs adopting a smoke-free policy leap from 6% to 85%. According to Brett, the response is not surprising considering the changing attitude towards smoking in general and the leadership shown by premier venues such as the MCG.

‘At first a lot of the clubs felt the move was going to hurt them financially because the bar is where the majority of money comes into the club,’ he says, pointing out that no VAFA club charges a gate fee. ‘The concern was that the move would frighten people away by not allowing them to smoke in the facility.’

‘But our response to those clubs was that a lot more people would feel comfortable to use the shared facilities, like wives with children and older people. This has turned out to be true.’

In 1998, the Fitzroy Reds Amateur Football Club was one of the first VAFA clubs to commit to becoming smoke-free. The club’s president, Mark Frisby, says that after the initial step was taken to become a smoke-free club, very little effort was required to implement the changes.

As well as providing signage to reinforce the smoke-free message, the club also promoted reading of health promotion literature provided by VicHealth. Membership cards and the club newsletter were altered to display the SmokeFree logo alongside the club sponsors. The smoke-free message is promoted during the club’s trivia nights, when Quit statistics and information are incorporated in the questions.

As Brett explains, the introduction of the Quit-guided policy in 1998 was not so much about making people address their smoking behaviour as a matter of habit, but making structural changes within each of the clubs’ operations. It has been about telling people when and where they can smoke, rather than telling them not to smoke.

Initial moves in the first year included phasing out the sale of cigarettes and having smoke-free areas. Last year the majority of clubs adopting the policy saw all indoor facilities, including change rooms and function rooms, become completely non-smoking.

The job has been made easier by the fact that many of the clubs hire the grounds and facilities through their local councils which have a smoke-free policy in place. The current level of awareness about the health risks associated with smoking has helped too, says Brett.

‘After all, players are mindful that playing football is a healthy pursuit. You don’t want to destroy the health benefits of it by ripping into too many lagers or smoking your lung capacity away.’

The move to make the VAFA smoke-free is part of a broader program which aims to see all levels of competition adopt the policy. Jointly coordinated by Quit and VicHealth, the push also involves the Victoria Country Football League and the North Melbourne Football Club.

For more information about the program, contact Matt Finnis at Quit on (03) 9635 5000.

‘Smoking poses a health threat to everyone, whether by directly engaging in it or through exposure to passive smoke.’

David Clarkson, South Melbourne Soccer Club.

Soccer

Joins the Smoke-free Club

In 1999, Victoria’s largest soccer club and current national champion—South Melbourne—followed the lead of the MCG and the Victorian Amateur Turf Club (VATC) in making the Bob Jane Stadium at the club’s home ground smoke-free.

In conjunction with VicHealth, the International Diabetes Institute has been working with the soccer club to introduce the smoke-free message to an environment traditionally marked by plumes of smoke.

South Melbourne Soccer Club General Manager, Damien Phillips, says that when the club agreed to introduce the no-smoking policy he anticipated some opposition from some of the older members of the club.

However, since the gradual introduction of smoke-free areas over the last year, he says the response has been excellent, with few problems relating to people complying with the new policy. In fact, during a function earlier this year, patrons were observed heading outdoors to smoke, even when the area was not yet declared smoke-free.

This, he says, is a sign of the times—part of the growing understanding and acceptance that smoking is not only unhealthy but can be offensive to non-smokers, especially in eating areas. Most people who have been found smoking in the new smoke-free areas have simply been unaware of the changes in policy.

‘The transition has been relatively trouble free, with the exception of a few of the older members,’ says Damien. ‘For a very high percentage of our supporters smoking is something that is very much a part of their lives, particularly the older generations.’

‘When the habit is ingrained in cultural behaviour, it is harder to get the message across. It’s just a matter of reinforcing the idea and reminding people that areas within the grounds have been made smoke-free.’

Signage plays a key role in alerting people to the new policy, as does the promotion of the SmokeFree logo on players’ clothing. As Damien points out, although people may not be aware they are in a smoke-free area, seeing the familiar signage eventually drives the message home.

The original plan was to increase the smoke-free areas in the stadium gradually over the next three years. Now in the second year, the program is operating ahead of schedule, with the members’ grandstand, corporate hospitality facilities and restaurant area to become 100% smoke-free. The general admission area will follow suit in the third year, making the entire stadium smoke-free.

Noelle Wengier, health promotion coordinator at the International Diabetes Institute, has been working with the soccer club to help introduce the new policy. With extensive experience in introducing the concept of no smoking to environments with a long history of allowing smoking, she says that getting the idea across is a matter of continually reinforcing the underlying health messages.

‘We are coming from everybody’s health perspective, not just people with diabetes who are at increased risk of complications if they smoke,’ she said. ‘Smoking poses a health threat to everyone, whether by directly engaging in it or through exposure to passive smoke.’

With an average weekly crowd of 7,000 to 8,000 fans, South Melbourne is Victoria’s most well-supported soccer team with a loyal entourage of fans of all ages filling the grandstands each week.

For more information about South’s story, please contact Noelle Wengier, Health Promotion Coordinator, at the International Diabetes Institute on (03) 9258 5025.

The extent students had close and confiding relationships with others—the feeling that there was someone they could confide in and trust if they needed someone to talk to—was also deemed a key factor that affected emotional wellbeing.

School Connectedness

Making a Difference for Young People

As researchers from the Centre for Adolescent Health in Melbourne have found, if you look at the big picture, sometimes small miracles, such as a reduction in teenage smoking, can happen.

An extensive examination of 26 secondary schools co-funded by VicHealth has shown that enhancing students' sense of 'connectedness' to school can have a positive influence on smoking and drinking rates.

As project coordinator Sara Glover explains, the main aim of the study was to identify the key risk factors in the school environment that influence emotional wellbeing in young people.

Twelve of the 26 schools were randomly selected and the results from these schools were compared with the other 14 schools.

The initial findings identified that peer influence, which provides a sense of security in relation to bullying, teasing, peer victimisation, rumour spreading and being excluded, formed a primary area of concern. The extent students had close and confiding relationships with others—the feeling that there was someone they could confide in and trust if they needed someone to talk to—was also deemed a key factor that affected emotional wellbeing.

At a broader level, the group also examined the extent to which young people felt valued in the school community. In particular, it was important to investigate the contributions young people felt they could make to activities and learning, and the extent to which they felt their contributions were worthwhile.

From their findings, the team was able to provide participating schools with a profile of how students perceived the school environment. Twelve schools then established an 'intervention' team to tackle problems at the individual, school and community-related levels. Teams varied but included the school's principal/vice-principal, a student welfare coordinator, teachers, community agencies and, in some cases, parents and students.

The project was designed to sit within current welfare, pastoral care and curriculum frameworks and to allow an improved interface between schools and community agencies.

After two years of implementation, a follow-up study was made of year 8 students from each of the schools. The students at the intervention schools were found to view school as a more positive part of their lives and feel more connected with schooling than those at the comparison schools.

Even more promising was the finding that significantly fewer year 8 students in the intervention schools reported a history of smoking and fewer students described themselves as a drinker.

'Overall it is about that sense of wellbeing—promoting that positive feeling of being engaged in what you do—which is less likely to result in the adoption of harmful behaviour. This is about cultural and structural change, it relates not only to doing particular programs, but to a whole system of change.'

Early findings from the study indicate that the model produced is feasible and affordable in the everyday context of schools and has broad utility within the Australian secondary school system.

For more information about the study, contact Sara Glover on (03) 9345 6249.

VicHealth News

Ron Casey 1927–2000

VicHealth pays tribute to Ron Casey, valued and respected VicHealth Board member, North Melbourne Football Club chairman and legendary broadcaster. Casey was a champion in the sporting area, but he will also be remembered as a visionary leader. As a member of VicHealth's Board of Directors since its beginnings in 1987, Ron has been a key player in the Foundation's evolution. He was involved in the development and introduction of the Tobacco Act in Victoria, and a leading force behind the move to get tobacco sponsorship off the sports fields. Casey was instrumental in using sporting personalities as positive role models for promoting key health messages, and played a key role in working with the Kangaroos to promote the SmokeFree health message. Ron's presence and drive will be sadly missed at VicHealth and in the wider community.

Injecting facility, Eastside Crisis Centre, Frankfurt.

International Drug Fact-finding Mission Brings Back Ideas

A week-long investigation of international drug policy models in the US, Germany, Sweden and Switzerland has crystallised the need for a comprehensive mix of solutions and the importance of community collaboration.

Whether we like it or not, Victoria has a visible heroin problem. Until we come together to discuss a variety of solutions in a rational and realistic manner, we will neither get it off our streets, nor be able to provide adequate prevention, treatment and care for users.

Despite the wide range of philosophies for dealing with drug policy issues, our international colleagues reinforced the need for a comprehensive and collaborative approach. They highlighted the importance of getting services and sectors working together as paramount to the success of any drug reform program.

In Sweden, Germany and Switzerland, particular emphasis was placed on active cooperation between the social services sector and police. Social services and law enforcement workers have an excellent level of cooperation and have adopted a common strategy. The success of LA's Drug Court also depends on the cooperation of judges, prosecutors, probation authorities, law enforcement personnel, local service providers and the greater community.

Any solution needs long-term commitments rather than simply short-term fixes. In 1991, the Swiss Government made a commitment to become serious about it's drug problem and developed a strategy based on prevention and health promotion, harm reduction, law enforcement and therapy. They now show dramatic decreases in deaths from overdoses, reduction in rates of hepatitis B, C and HIV, double the number of users under treatment and a decrease in the number of young injecting drug users.

The importance of social programs for users was emphasised as vital to rehabilitation, treatment, and reintegration into society. The common theme of establishing a 'package' of approaches was clear during each visit. A singular short-term approach will not rectify Victoria's drug problem. We must build our capacity to deal with a large range of social, health and law enforcement problems over 5 to 10 years.

In Frankfurt, crisis centres provide food, shelter, medical treatment, one-for-one needle and syringe exchanges, street outreach, work projects, methadone substitution programs as well as supervised injecting facilities. Centres were offering primary health care, medical treatment, and counselling, before injecting facilities were introduced. According to a senior police official, it was only after services were in place to provide an alternative space for users to go, were the police successful in closing down the city's open drug scene.

What is useful to take away from these international visits is the notion that programs operate as an integral part of the community's overall comprehensive drug strategy. These have become standard approaches in Switzerland, Sweden and Germany.

In Germany and Switzerland, injecting facilities are an integral element in addressing the heroin problem. It is clear however that they are only one small part of the overall solution and should not be mutually exclusive of other programs. Unfortunately in Victoria the debate has been polarised on the issue of injecting facilities versus policing and we are not moving forward with our efforts to deal with the big issues.

There is a great deal we can learn from our visits to LA, Frankfurt, Stockholm, Bern and Zurich. There is a range of options that we can adapt locally. Any approach we take must have bipartisan and strong community support. If not, it will be more difficult to make any long-lasting inroads and progress.

VicHealth CEO Dr Rob Moodie, together with Shadow Health Minister Robert Doyle and Parliamentary Secretary to the Premier Bruce Mildenhall examined new measures in primary and secondary prevention, treatment and rehabilitation, policing and law enforcement and managing the open drug scene in Los Angeles, Frankfurt, Stockholm, Bern and Zurich in July 2000.

Redevelopment of VicHealth's Sport and Recreation Program

VicHealth has been involved in funding initiatives in sport to promote health for the last 13 years. As part of VicHealth's ongoing commitment to improving the health of Victorians, and in recognition of current and emerging issues, the sport and recreation program is undergoing a review and redevelopment of its funding guidelines. Changes will be in alignment with VicHealth's *Strategic Directions 1999–2002*.

As specified in the Tobacco Act, VicHealth will continue to invest 30% of its appropriation to promote health through sport. However, the 2000–2001 financial year is considered a transitional year, and three grant schemes offered through the sport and recreation program will still be available during this time. Details about these grant schemes and their proposed timelines are available on the website under *Funding Programs*.

VicHealth is keen to continue working with sport to enhance opportunities for health promotion. Initiatives to promote healthy environments, to increase awareness of health-related behaviours, and to provide opportunities for greater participation in sport and recreational pursuits, particularly for specific target groups, will be discussed during the redevelopment process. Sporting bodies will be invited to participate in the consultation process that VicHealth will undertake to guide the redevelopment. It is proposed the redevelopment will be complete, and a new framework for health promotion investment in the sport setting available, by January 2001 for projects to commence post-July 2001.

For more information please contact VicHealth on (03) 9345 3200 or visit the website at www.vichealth.vic.gov.au.

Arts for Health

VicHealth's arts program, which has injected nearly $20 million into the Victorian arts sector over the past 13 years, is set to take on a different focus. On 19 July 2000, the Hon. Mary Delahunty, Minister for Education and the Arts, officially launched VicHealth's new Arts for Health program and funding guidelines.

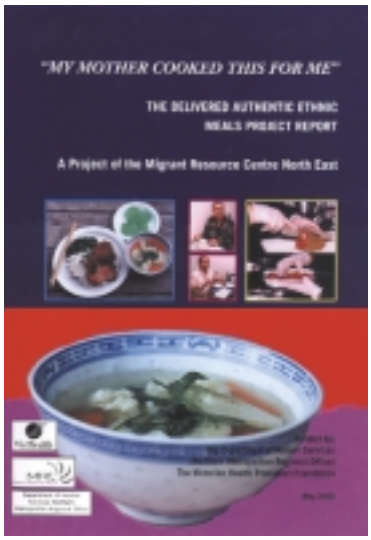
Recognising how important arts activities are in promoting health and wellbeing, it is vital we work to address access issues so that all Victorians have an equal opportunity to reap the positive benefits of involvement. Participation in arts and cultural activities also has a role in breaking down social isolation, improving people's feelings of connection and belonging, celebrating diversity and improving physical and mental health.

The new $1.7 million funding program will focus on providing access to the arts for those who are socially and economically disadvantaged, encouraging projects that work to build communities and helping to bolster arts activities in rural and regional Victoria. There are three funding schemes under the new program: the Major Partnerships Scheme, the Community Arts Participation Scheme and the Community Festivals Scheme. VicHealth invites funding applications from agencies and/or individuals interested in these funding schemes.

Funding Guidelines for this program are available by calling VicHealth on (03) 9345 3200 or by visiting the VicHealth website at www.vichealth.vic.gov.au.

Healthy, Wealthy and Wise Women

On 16 June 2000, Nicola Roxon, Member for Gellibrand, officially launched the report *Healthy, Wealthy and Wise Women*. The VicHealth funded project was conducted over a two-year period by Women's Health West in conjunction with the University of Melbourne and Deakin University.



My Mother Cooked This for Me

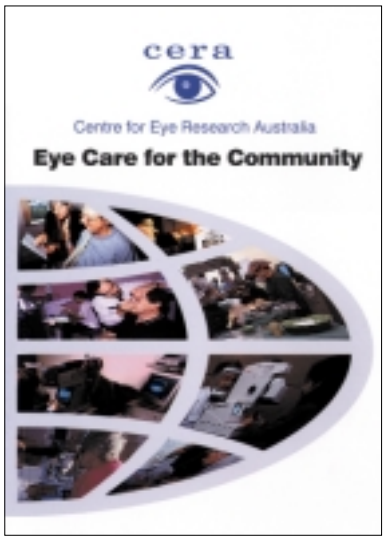
On 18 May 2000, the Hon. Bronwyn Pike, Victorian Minister for Housing and Aged Care, officially launched the report *My Mother Cooked This for Me*. The Delivered Authentic Ethnic Meals Project was undertaken by the Migrant Resource Centre North East in collaboration with the local councils of Yarra, Darebin, Whittlesea, Banyule and Hume during 1998 and 1999. The project was funded by VicHealth and the Department of Human Services Northern Metropolitan Region.

For more information please contact Stephanie Lagos or Fiona Tinney on (03) 9484 7944.

Eye Care for the Community

On 21 July 2000, the Hon. John Thwaites, Victorian Minister for Health, officially launched the report *Eye Care for the Community*, produced by the Centre for Eye Research Australia.

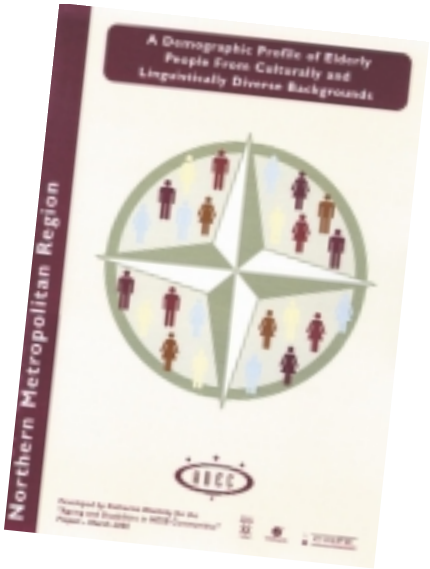
For more information, please contact Professor Hugh Taylor, Managing Director, Centre for Eye Research Australia, 1st Floor, Royal Victorian Eye & Ear Hospital on (03) 9929 8368 or fax (03) 9662 3859 or email htaylor@cera.unimelb.edu.au.



Demographic Profile of Elderly People from Culturally and Linguistically Diverse Backgrounds

This series of five regional reports (Eastern, Western, Northern Metropolitan, Southern Metropolitan and Barwon South Western Regions) was launched by Julian Gardner, Public Advocate, on 5 June 2000.

For more information please contact Nuran Ozdemir on (03) 9383 5566.



Rumbalara Football Netball Club Book Launch

On 6 July 2000, Syd Jackson, a former Carlton football player, officially launched a book documenting the history of the Rumbalara Football Netball Club, from the beginnings on the Cumeragunga Mission to the present success as Premiers in the Goulburn Valley Football League.

COMING UP

Intersectoral Mental Health Promotion Forum

An Intersectoral Mental Health Promotion Forum is scheduled to take place in October 2000. The forum will cover international, national and state activity in relation to mental health promotion and include presentations from Dr Benedetto Saraceno, Director Department of Mental Health, WHO; Dermot Casey, Director, National Mental Health Branch; and Dr Rob Moodie, VicHealth CEO. Following the forum, projects in receipt of first phase funding under VicHealth's Mental Health Promotion Plan will be launched.

For more information, please contact Irene Verins on (03) 9345 3255 or email iverins@vichealth.vic.gov.au.

VicHealth Awards 2000

Each year VicHealth recognises outstanding achievements and innovative contributions to health promotion through the annual presentation of awards to funded projects.

We invite you to send in nominations for the VicHealth Awards 2000. Nominations can be on behalf of organisations receiving funding and/or those working in partnership with health agencies on VicHealth initiatives.

There are four award categories, each with a winner and a runner up. The criteria for each category reflect the size of the projects and the objectives and outcomes in relation to funding guidelines.

All nominated projects must have been funded by VicHealth or VicHealth in partnership with another organisation. The project must have been in progress for a minimum of 12 months or have been completed within the year to 30 June 2000.

Nominations must be received by VicHealth no later than 5.00pm on 29 September 2000.

This year's awards will be presented at the VicHealth Awards Presentation Dinner to be held on 21 December 2000 at the Melbourne Town Hall. VicHealth's Annual General Meeting will be held prior to the dinner.

For more information and nomination forms please contact VicHealth on (03) 9345 3200 or email sosman@vichealth.vic.gov.au. *You can also visit our website to download awards information at* www.vichealth.vic.gov.au.

Frontiers: World Music & Dance Refugee Event

A fantastic world music and dance event featuring:

African Dance Band - Soukous Ba Congo
The Ethiopian Circus
E Bario

This is a hot evening featuring the best of the dance and music scene in Melbourne.

Date: Saturday 7 October 2000
Venue: Swanston Room at Melbourne Town Hall
Tickets: $15.50 full and $10.50 concession

For more information contact: martsvic@vicnet.net.au

VicHealth News

Twelfth National Health Promotion Conference

Health Inequalities – Reflecting Back, Stepping Forward

29 October–1 November 2000
Hotel Sofitel, Collins St, Melbourne

One of the most pressing challenges facing health promotion at both the local and global level is the rapidly growing inequality in health. Despite many successful outcomes and more than 20 years of robust health promotion policy and practice, the gaps between those who have benefited from these activities and those who have not are widening. The 12th National Health Promotion Conference will tackle these issues and the program committee has secured a group of outstanding leaders in this field including Sir Donald Acheson, Professor Richard Wilkinson and Dr Pamela Hartigan.

The conference is a partnership between the Australian Health Promotion Association, VicHealth, the Department of Human Services, Deakin University and VACCHO.

The conference program will be available early September on the conference website at www.icms.com.au/health. The deadline for early registrations is 31 August 2000.

For more information on the conference please contact the conference secretariat, ICMS Pty Ltd, 84 Queensbridge St, Southbank 3006 on (03) 9682 0244 or email health@icms.com.au.

Herald Sun Tour October 5–15

VicHealth is pleased to be a sponsor of the Herald Sun Tour 2000 for the twelfth consecutive year. The Foundation's twelve-year sponsorship of the Tour has helped Victorians understand the importance of participating in regular moderate exercise.

The Tour's course through many Victorian towns also provides the opportunity to conduct a series of local community promotions to further encourage Victorians to be *Active for Life*. The 2000 Tour will kick off in Melbourne's CBD on 5 October, culminating in the *Active for Life* free family festival at the Geelong waterfront on 15 October.

For more information please contact VicHealth on (03) 9345 3200 or email sosman@vichealth.vic.gov.au.

Second Annual National Congress, Council on the Ageing: Forging Our Future

On 12–14 November 2000 a gathering of policy makers and older people will endeavour to reset agendas for the creation of social and economic environments to improve health and wellbeing.

The Keynote Speaker will be Professor Richard Wilkinson, a research fellow at the Trafford Centre for Medical Research at the University of Sussex. The venue is Union House, University of Melbourne.

Registration: Full $380. Non-profit organisations $305. Individual COTA members $75.

Early Bird Registration: Friday 8 September. Full $325. Non-profit $275.

For further information contact the congress organiser on phone (03) 9655 2108, fax (03) 9654 4456, email congress@cotavic.org.au or visit www.cotavic.org.au.

Community Arts for Health's Sake

Network Meeting

VicHealth's Community Arts Participation Scheme, part of the new Arts for Health Program, aims to support community arts projects that facilitate community development and achieve participation in creative activity for those who have restricted access as a result of geographic, social or economic factors. A network meeting will be held on 31 August to outline the funding guidelines for the scheme and explore some of the ways community arts make a difference in people lives.

Date: Thursday 31 August 2000

Time: 2.30pm-4.00pm followed by drinks

Venue: Gasworks Art Park
21 Graham Street, Albert Park 3206

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