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Jennifer Buckley
Secretary to the Legislative Assembly of the Northern Territory Economic Policy Scrutiny Committee
GPO Box 3721
Darwin NT 0801

Emailed to: EPSC@nt.gov.au

19 September 2018

Dear Ms Buckley,

RE: Submission to the Economic Policy Scrutiny Committee Inquiry into the Tobacco Control Legislation Amendment Bill 2018.

AMSANT welcomes the invitation to provide a submission to the committee for the inquiry into the *Tobacco Control Amendment Bill 2018.*

AMSANT is the peak body for the Aboriginal community controlled health sector (ACCHS) in the Northern Territory and advocates for equity in health, focusing on supporting the provision of high quality comprehensive primary health care services for Aboriginal communities.

The NT has the highest smoking prevalence in Australia, and rates of Indigenous smoking in some parts of the NT exceed 60%. Smoking is a major contributor to morbidity and mortality, however of all the social determinants of health smoking is potentially one of the most modifiable risk factors.

AMSANT works closely with its member services and key stakeholders to advocate for tobacco cessation strategies, recently providing a submission to the National Tobacco Strategy (attached).

AMSANT supports the amendments to the Bill as a measure to further restrict the supply of tobacco and e-cigarettes and expand smoke-free zones in public spaces. Nationally, only 14% of adults are regular daily smokers, therefore measures to expand smoke-free public spaces assists to de-normalise smoking and to decrease the non-smoking majority of the population, and especially children's, exposure to second hand smoke.

The main amendments to the Bill for consideration by the committee are:

- Regulate e-cigarettes and vaping devices in the same manner as other tobacco products

- Implement a 10 metre smoke-free zone at entrances and boundaries of community events and community facilities
- Prohibit employees under 18 from selling tobacco products
- Prohibit cigarette vending machines from venues that allow under 18 year olds on premises

The Committee seeks input and is required to report on the following matters. AMSANT shall respond to each matter separately.

1. **whether the Assembly should pass the Bill**

AMSANT supports the Committee to report to the Assembly the recommendation to pass the Bill.

AMSANT welcomes future research findings to more accurately note the level of harm posed by e-cigarettes and related products, and in the meantime endorses the approach to regulate these products in the same manner as cigarettes. Expansion of smoke free areas is good public health policy and confers greater protection to non-smokers from second hand smoke. AMSANT supports the restriction on sale of tobacco by employees aged under 18, and with this, the provision to limit vending machines to adult-only premises, restricting the supply of tobacco products in a similar manner to alcohol.

2. **whether the Assembly should amend the Bill**

AMSANT encourages the Assembly to consider a further amendment that removes the ability for staff of educational facilities to have dedicated smoking areas. Other NT government employees such as Department of Health staff are prohibited from smoking anywhere on department premises, grounds or in vehicles. The present exemption that allows for schools to nominate a staff smoking area on campus is inconsistent with the overall aims of the legislation. AMSANT understands only a minority of NT schools apply for an exemption to maintain a smoking area on campus, and given the legislation's intent to prohibit smoking at educational facilities, AMSANT encourages the present exemption be removed, thus rendering all educational facilities completely smoke-free.

Additional consideration should also be given to enforcement of the legislation, especially regarding smoke-free areas in remote communities. Presently there is the real potential for smoke-free areas to be breached without effective enforcement, thus undermining the intent of the legislation and putting the public at risk of the harms of second hand smoke. Resources to support culturally appropriate and effective enforcement strategies need to be considered to fully realise the gain potential of amendments to this Bill.

3. **whether the Bill has sufficient regard to the rights and liberties of individuals**

AMSANT contends that the public health rights of non-smokers, especially children come before any perceived intrinsic right of an individual to smoke freely. Protection of

community facilities and public spaces from pollution by tobacco smoking is essential to de-normalise smoking, prevent ready access to discarded butts for smoking, and to protect non-smoking users of these facilities from second hand smoke.

4. **whether the Bill has sufficient regard to the institution of Parliament.**

AMSANT has no comment to make on this matter.

AMSANT supports these legislative changes and other measures to reduce smoking, and to assist smokers to quit. Culturally effective quit strategies as well as enhanced enforcement are two key aspects in reducing smoking prevalence in the NT.

Thank you for the opportunity to provide this submission.

Yours sincerely

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Chief Executive

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AMSANT Submission to the National Tobacco Strategy

August 2018

AMSANT is the peak body for the Aboriginal community-controlled health service (ACCHS) sector in the Northern Territory, home to an Aboriginal population of approximately 58,000 persons or 9% of the total Aboriginal population of Australia (ABS, 2017). AMSANT member services provide comprehensive Primary Health Care (PHC) from larger townships (Darwin, Katherine, Tennant Creek and Alice Springs) to the most remote parts of the NT. These PHC services include small single site ACCHSs and large town-based and regional ACCHSs. In the NT, the Aboriginal PHC sector is comprised of both ACCHS and government PHC clinics. The ACCHS sector provides over half of the care in the Aboriginal PHC sector with the remainder provided by the government PHC clinics. Outside of Darwin, most Aboriginal people receive PHC through the Aboriginal PHC sector.

AMSANT advocates for equity in health and recognises the strong relationship between good health and the social determinants of health. It is from this perspective that AMSANT is pleased to provide the following submission with the goal of reducing smoking among Aboriginal people of the NT.

Smoking rates are decreasing over time, but the gap is widening between population groups.

Smoking rates are declining nationally since the introduction of key tobacco control measures in 1990 from rates of 28% in that year to 15% in 2014/15 (ABS, 2015). Mid-point indicators of the current National Tobacco Strategy include favourable measures around reduction of uptake, reduction in amount of cigarettes smoked daily, and reduction in second hand smoke exposure, however evidence of increased and sustained cessation was less clear (AIHW, 2016). Although nationally smoking rates are declining, there are some population groups where smoking rates are not falling at the same rate, or at all. Across Australia, smoking rates of Aboriginal and Torres Strait Islanders who live in remote areas have not dropped in the past 20 years (AIHW, 2018). Daily adult smoking prevalence has declined in the NT since the 1990's with 18.5% of all adults smoking in 2016, although the rate of decline is not statistically significant (AIHW, 2018). The mid –point progress report of the current National Tobacco Strategy reveals population groups more likely to smoke are;

- Those **living outside of major cities**, with smoking rates increasing with increasing levels of remoteness;
- **Aboriginal and Torres Strait Islanders**, with the national prevalence of smoking among this group at 45% compared to 16% of non-Indigenous Australians.
- Those at the **lower end of the socioeconomic index** are more likely to smoke than those at the higher end, and less likely to have sustained a quit attempt.

These three factors compound in the NT with Aboriginal people reporting current smoking rates of over 50% and as high as 68% in some areas (AIHW, 2016; NT AHPKI, 2017). The inequity of gains among population groups is effectively widening the gap in health status, and eventual smoking related morbidity and mortality between Aboriginal and non-Aboriginal people Australia wide, but most especially in remote NT.

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"Tobacco use accounted for 12% of the burden of disease for Indigenous Australians and 23% of the health gap between Indigenous and non-Indigenous Australians" (AIHW, 2018). Addressing this disparity is vital to improve Aboriginal health and close the gap in disadvantage.

> **Recommendation:** That reducing smoking rates among Aboriginal and Torres Strait Islander people remain a priority in the next National Tobacco Strategy with program activity and funding targeted particularly at remote and low SES communities

Social determinants of smoking

Smoking initiation is influenced by a range of demographic factors such as SES status, remoteness, and Aboriginal status, and once established, smoking is acknowledged as an addiction, cessation of which requires overcoming both the behavioural and chemical desire to smoke. Population wide tobacco control measures are contributing to the reduction in smoking rates Australia wide, however as noted earlier, Aboriginal people still have higher rates than other population groups, with remote Aboriginal people recording the highest rates of all Australians. To reduce smoking among this population, it is essential to address the social determinants of smoking to adequately provide deterrents from uptake as well as support sustained quit attempts.

Aboriginal people of the NT disproportionately experience poor social determinants of health including access to appropriate and affordable housing, high unemployment rates, low health literacy, high rates of infectious and chronic diseases, high rates of trauma and grief, poverty, racism and high rates of incarceration. The psychological impacts of poor social determinants can lead to substance misuse as a coping strategy to alleviate stress (Atkinson, 2002). Multiple and compounding life stressors experienced by many Aboriginal people are a barrier to successfully quitting (Van der Sterren, Greenhalgh et al, 2016). A 2013 Lowitja study in the NT found smoking initiation among teens was higher where immediate family influences normalised and modelled smoking behaviours. With half of the adult Aboriginal population of the NT smoking, smoking is commonly normalised in the family setting and smoking uptake remains higher among this population than other Australian population groups (AIHW, 2016). Strategies to encourage smoking cessation and dissuade young people from initiating smoking that fail to take into account the social determinants of health will do little in the long term to curb smoking rates among particularly vulnerable groups (Garrett et al, 2014).

> **Recommendation:** That the significant impact of poor social determinants of health on smoking rates be recognised in the National Tobacco Strategy with specific measures identified to address the social determinants. This should link to other national strategies including the latest iteration of the *Implementation Plan for the National Aboriginal Torres Strait Islander Health Plan*, which focuses on the social and cultural determinants of heath.

Addiction is harder to overcome for poorer people, while at the same time the cost of the addiction can contribute to poverty (Bonevski, Boreland et al, 2017). Those in the lowest income brackets spend proportionately more of their income on tobacco (Greenhalgh, Scollo et al, 2016) and the cost of tobacco increases with increasing remoteness. Annual tobacco tax increases introduced in 2012 do not appear to curb smoking rates in remote Indigenous communities in the same manner as they dissuade other Australians from smoking. This is evidenced by data from the NT Aboriginal Health Key Performance Indicator Report 2016-17, which shows that the proportion of Aboriginal ex-smokers in the NT has remained relatively unchanged over this time period (NT AHPKI, 2017although further evidence is needed to fully explore this area (Thomas, Ferguson et al, 2012). Annual tobacco tax increases may presently result in a greater amount of weekly income spent on tobacco which is

particularly burdensome for those on low incomes and in remote areas. Unfortunately, rather than acting as a catalyst for quitting, the increased prices entrench poverty and contribute to poorer social determinants.

AMSANT supports tobacco excise increases as a strategy to reduce smoking rates although highlights the additional investment and support required for Aboriginal people to successfully quit. A similar need was identified in action 6.3.3 of the National Tobacco Strategy, however the mid-term review found that there has not been enough resourcing in this area. AMSANT also suggests more work is needed to complete action 6.3.1 of the National Tobacco Strategy to extend the evidence base regarding the impact on the lowest socioeconomic groups and young people of tobacco price increases.

> **Recommendation:** That the National Tobacco Strategy support investment in research to better understand the impact of tobacco price increases among people in low socioeconomic groups, including its potential impacts in exacerbating poverty and disadvantage.

Priority populations

As already stated, Aboriginal and Torres Strait Islander Australians are a priority population for increased investment and effort to reduce smoking rates. Within this population there are further priority groups including youth and pregnant women.

Aboriginal Youth

Aboriginal youth initiate smoking at a younger age and their non-Aboriginal counterparts (van der Sterren, Greenhalgh et al, 2016). Youth are significantly influenced in their attitudes and smoking behaviour by their immediate families, peer groups and community social norms. (Johnston, Thomas et al, 2013). The social determinants that increase the likelihood of smoking initiation among adults are the same for young people, therefore initiatives to address poor social determinants will have positive impacts on all sections of the population. Young people are sourcing cigarettes most usually from family or friends, with anecdotal reports from ACCHS that discarded butts are a further source for young people. AMSANT supports increased measures to educate young people about tobacco as well as strategies to reduce the uptake of smoking among young people. These include whole of population approaches that aim to reduce adult smoking as a reduction in smoking prevalence and a normalisation of non-smoking is likely to have a positive effect on reducing young peoples' uptake of smoking. Strategies that reduce smoking among youth will likely have a beneficial effect on smoking rates during pregnancy for young Aboriginal mothers.

Pregnant women

Aboriginal women are younger at first pregnancy than non-Aboriginal women, with a median age of first time Aboriginal mothers of 25 years (AIHW, 2017). Of all pregnant women aged under 25, Aboriginal women are more likely to smoke at the time of becoming pregnant and more likely than non-Aboriginal women to continue smoking throughout the pregnancy (AIHW, 2015). The adverse health outcomes for the baby are well established (Banderali et al, 2015).

As recommended by the mid-term review of the current National Tobacco Strategy, strategies to reduce smoking among pregnant women must be evidence based, financially supported by both Commonwealth and State/Territory governments via three year minimum funding cycles, tailored to be culturally appropriate, community designed and implemented, and supported by national and local mass media campaigns. AMSANT also recommends that strategies recognise the social influences that

contribute to young women smoking and address these determinants also. The Australian Nurse Family Partnership Program is an evidenced based intensive home visiting program to support mothers and babies from pregnancy to two years old. This program operates from 3 large ACCHS in the NT and demonstrates smoking reduction among participating mothers. It also has multiple other benefits including reducing child neglect and injury (Department of Health and Ageing, 2012).

Prisoners

NT prisons are smoke free, however two thirds of prison entrants are regular smokers (AIHW, 2016). Aboriginal people are significantly over-represented in the NT prison population and are released into community environments where smoking is prevalent and normalised. Despite ceasing smoking for the period of incarceration, resumption of smoking in the immediate post-release period is the norm (Butler and Yap, 2015). Some smoking cessation support is available in NT prisons however AMSANT advocates for intensive and culturally appropriate smoking cessation support be provided to inmates to assist with permanent smoking cessation. Prison health services should also ensure released prisoners are referred to their local PHC for follow up to assist maintenance of smoking abstinence. This will be strengthened by expansion of smoke-free zones within communities as released prisoners return to communities with increasingly less places to smoke.

E cigarettes

E-cigarettes are an emerging area in Australia with scant, and often conflicting evidence about their use as a quitting tool, harms and benefits. State and Territory data on the use of e-cigarettes is not yet available. A recent study showed that use of e-cigarettes was less among Aboriginal smokers than non-Aboriginal smokers, and further showed that use of e-cigarettes was associated with a desire to quit (Thomas, Lusis et al, 2018). Access to and use of e-cigarettes is likely to grow and is potentially a product that will assist with people's quitting attempts. AMSANT supports ongoing research in this area and recommends that future restrictions and strategies regarding e-cigarettes are evidence-based.

> **Recommendation:** That further research on the harms and benefits of e-cigarettes, including as a quitting tool, be supported in the National Tobacco Strategy.

Strengthening Aboriginal Community Controlled Health Services

The majority of Aboriginal smokers want to quit, with almost half having made some attempt to quit within the past year (Nicolson, Borland et al, 2012). Aboriginal PHCs are well positioned to assist initiating and maintaining quit attempts by being providers of comprehensive primary health care including social and emotional wellbeing supports. Most smokers will not be seen by AOD professionals simply because they smoke which means the primary support for quit attempts will come from other PHC staff. This workforce needs to be equipped with the knowledge and support to provide brief interventions. AMSANT agrees with recommendation 6 of the National Tobacco Strategy mid-term review which calls for greater funding support for health agencies in remote areas to undertake tobacco control (AIHW, 2016), as ACCHS in particular are optimally positioned to be the best mechanism to provide culturally appropriate, locally based smoking cessation support.

> **Recommendation:** That the National Tobacco Strategy increase support and training to ACCHSs primary health care workforce, recognising both the vital role that comprehensive primary health care plays in the providing holistic support for smoking cessation, and the status of community controlled organisations as preferred providers of services to Aboriginal people.

Tackling Indigenous Smoking Program

AMSANT welcomes the 4 year funding commitment for Tackling Indigenous Smoking Program and advocates for evidence based, culturally and locally appropriate strategies under this program. Presently there is an inequitable distribution of Tackling Indigenous Smoking (TIS) workers across Australia and the NT, and many priority population groups are missing out. Increased Territory and State government investment is also required to address the high rates of smoking among priority populations including Aboriginal and Torres Strait Islander people. There will continue to be rises in GST revenue through until 2020 due to the annual 12.5% excise on tobacco products totalling $11 billion per year (AMA, 2018). This should be reinvested in tobacco control.

TIS grant funding recipient organisations have been challenged by changes to the program over time, including the move from tobacco cessation support as part of a healthy lifestyle program, to tobacco cessation support workers now having a single health issues focus. With respect to the complex interactions of social and behavioural determinants of health, as well as the comprehensive primary health care approach of ACCHSs, the current single issue focus of TIS workers is incongruous. Evidence of effectiveness of dedicated tobacco control staff is limited (Nicholson et al, 2015), however ACCHSs report that the value of TIS workers in remote communities lies in the ability to form strong interpersonal relationships and support individuals in their quit attempts. With changes to the TIS program that requires TIS workers to focus on public health initiatives rather than one on one cessation support, the impact TIS workers are having on smoking rates is further in doubt.

Data from the Talking About the Smokes Study found that the presence of dedicated tobacco control staff or resources at the local health service had little impact on people's desire to quit. Instead, being advised to quit smoking by a health professional and targeted anti-tobacco advertising were predictive of wanting to quit, regardless of relevant attitudes and beliefs about smoking (Nicholson et al 2015). AMSANT advocates for an approach that assesses the effectiveness of TIS workers as well as funding further upskilling of the PHC workforce in line with recommendation 6 and 19 of the National Tobacco Strategy mid-term review (Health Policy Analysis, 2016).

> **Recommendation:** That the National Tobacco Strategy consider if the effectiveness of the Tackling Indigenous Smoking workforce could be increased by expanding the role beyond the current single health issue focus in line with a holistic, social determinants approach to smoking cessation support.

Quitline

Quitline is not frequently utilised by Aboriginal people of the NT with one ACCHS reporting to AMSANT only two (2) Indigenous clients of their total PHC client population of approximately 12,000 called Quitline in the previous 6 months. Even nationally, use of Quitline by current smokers in their attempts to quit was low with the *National Drug Strategy Household Surveys* of 2010 and 2013 showing only 3.8% and 2.9% of smokers using this service (Health Policy Analysis, 2016). Low PHC referral and self-referral is widely reported among ACCHSs, with AMSANT member services noting the biggest barrier to usage is poor English proficiency among Aboriginal clients. For this reason, telephone services are less preferred than face to face support. Additionally, practitioners report Aboriginal clients have barriers with access to phones and cost of phone calls (Martine, Dono et al, 2017).

AMSANT acknowledge the enhancements to the Quitline service to include a greater number of call-backs for Aboriginal clients, as well as Aboriginal counsellors, however Quitline should be considered simply one smoking cessation support option with further options based upon local, culturally

appropriate and language appropriate initiatives that provide one on one support to clients (Health Policy Analysis, 2016).

Presently the evidence that Quitline is an effective tool to support smoking cessation among Aboriginal people of the NT is lacking. TIS worker reporting that requires numbers of referrals to Quitline to be reported is a challenge for ACCHSs who recognise the limitations of this service for their clients. At best, this indicator may see a rise in the number of referrals, however this is unlikely to result in improved outcomes.

> **Recommendation:** That continued investment in Quitline be measured against its efficacy, and it's limitations for culturally and linguistically diverse populations be noted, and alternative supports and investments directed to these groups.

Mass Media to promote quitting

The Australia-wide *Talking About the Smokes* project found that mass media campaigns did have an effect on Aboriginal people's motivation to quit but also that targeted Aboriginal messages had an additional and more potent effect due to greater cultural relevance, or because of community involvement and leadership in its development (Nicholson et al. 2015). However, Aboriginal people who spoke a language other than English at home were less likely to make a quit attempt – which may be due to mainstream resources being much less effective for that group (Ibid).

It is critical that campaigns targeting Aboriginal people are informed by Aboriginal people's views with appropriate market testing. Given the linguistic diversity of the Aboriginal population in the NT, localised media campaigns in language are likely to be particularly important. There should be resourcing of NT-wide campaigns with a strong focus on Aboriginal people as the target audience and resourcing of local community or regional media campaigns e.g. through Aboriginal radio stations translated into local languages. AMSANT supports the view of the AMA and the Australian Council on Smoking and Health (ACOSH) for increased government investment in evidence-based nationwide tobacco media campaigns and notes that this investment has disappeared in recent years with no national tobacco media campaign since 2012 (AMA, 2018). The mid-point review of the current National Tobacco Strategy recommends national media campaigns targeted to Aboriginal and Torres Strait islander people, especially pregnant women, which have a broader applicability to a wider mainstream audience, rather than investing in mainstream campaigns with a hope that they will be of some relevance to Aboriginal audiences. This kind of targeted national campaign should be in addition to local, community-specific media campaigns (Health Policy Analysis, 2016).

Social media is an emerging area where campaigns can be targeted to particular communities and language groups. There also needs to be work targeting youth with the aim of changing their perception of smoking so as to reduce uptake. Targeted culturally sensitive social media campaigns and community designed educational activities can influence individual attitudes and social norms including in young people (Upton et al. 2016).

> **Recommendation:** That the National Tobacco Strategy support investment in both national campaigns and local, community-specific media campaigns that target Aboriginal people, with particular consideration for at risk groups such as pregnant women and youth. The role of social media campaigns should particularly be considered at the local level and to influence young people.

Reducing tobacco supply - licensing and price

Nationally, licensing fees for tobacco retailers could be increased significantly, along with caps on the number of tobacco retailers to reduce density of tobacco outlets as retailer density is positively associated with smoking rates, especially in low SES areas (Ackerman, Etow, et al, 2016). Outside of the major townships of the NT, tobacco retailer density is not high, however measures to further reduce access to tobacco could be introduced by way of limiting the hours or days when tobacco is able to be sold. This licensing strategy has been successfully used to reduce access to alcohol across the NT, and has now also been shown to work for tobacco (Ribisil, 2017).

Additionally, a floor price could be instituted on tobacco products so that companies do not aim to mitigate the effect of price rises by reducing pack sizes for instance. Discounting tobacco products could also be prohibited particularly in low SES areas. As noted previously however more evidence is needed to understand the extent to which price is an effective mechanism in reducing smoking rates in Aboriginal communities. Reducing supply of tobacco should remain a central aspect of tobacco policy, however the potential impacts that increased price may have in exacerbating poverty must be carefully considered and weighed against investment in improving the social determinants.

> **Recommendation:** That the National Tobacco Strategy consider reduction of tobacco outlet density, limiting hours in which tobacco can be sold and implementing a floor price on tobacco products as key supply reduction mechanisms to reduce the harmful impacts of smoking.

Smoke free zones

Smoke free zones contribute to the de-normalisation of smoking, offer less opportunities for to smoke as well as reduce exposure of non-smokers to second-hand smoke (Greenhalgh and Scollo 2018). Additionally, designated smoking areas with receptacle bins for butts, help remove butts from wider distribution in public areas, thus reducing the opportunity for people (especially youth) to source tobacco from discarded butts. Existing smoke-free zones should be extended to include greater smoking exclusion zones around doorways of public buildings and complete bans implemented in public areas such as hospital grounds, school grounds and outdoor areas of licensed premises.

AMSANT endorses the proposed NT government amendments to the Tobacco Control Legislation to extend smoke-free zones around entranceways and community events, prohibit the sale of tobacco products by employees aged under 18, and prohibit tobacco vending machines from premises accessible to under 18's. Currently, a range of smoke-free zones are legislated, including a complete ban at all outdoor community and sporting events. However, throughout the NT the responsibility for ensuring compliance with this legislation lies with authorised officers which include police. There are a number of shortcomings ensuring compliance of tobacco legislation within the NT, in particular;

- Police are not primarily concerned with enforcement of smoke-free zones as other matters of law enforcement and community safety are prioritised,
- In many remote communities, police are not present, so no enforcement of the legislation is possible,
- Enforcement by way of fines is neither desirable nor effective in low socio-economic populations as is the case of many Aboriginal people in the NT who lack the financial means to pay a fine.

AMSANT supports measures to strengthen smoke-free areas. Across all localities in the NT, but most especially in remote communities these measures will require community consultation and support for effective and appropriate enforcement strategies.

Recommendation: That the Strategy continue to support the strengthening of smoke-free areas across jurisdictions including through increased monitoring and appropriate compliance mechanisms

Monitoring and evaluation

Monitoring and evaluation of smoking cessation strategies is essential to ensure those strategies with evidence of effectiveness are funded and sustained, and those that require modifying or ceasing are adapted or discontinued based upon robust, locally specific evidence.

AMSANT agrees with the National Tobacco Strategy mid-term review that all States and Territories should have a jurisdictional tobacco control plan that is current and compliments the objectives of the National Tobacco Strategy (Health Policy Analysis, 2016), and is pleased to be working with a range of government and non-government stakeholders to update the current NT Tobacco Action Plan. A further improvement to this synergy between plans, and to enhance monitoring and evaluation would be align the TIS program team indicators to tobacco strategy outcomes to gain a better national picture.

Recommendation: That the National Tobacco Strategy align its objectives and indicators with that of States and Territory tobacco strategies, and the Tackling Indigenous Smoking program indicators.

Presently data on national smoking rates is collected from the *National Drug Strategy Household survey* and ABS surveys. Results are estimates only with high levels of sampling errors. There are limitations of the data collection and representativeness of the sample relating to Aboriginal and Torres Strait Islander and other minority populations, especially those with low levels of English literacy. To gain an Australia-wide picture of all adults smoking habits with the greatest accuracy possible a question regarding smoking should be added to the census as recommended in 2009 by the National Preventative Health Taskforce (Thomas and Scollo, 2018).

Recommendation: That a question regarding smoking status be added to the census, as recommended by the National Preventative Health Taskforce

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