Australian Government

The Treasury

Regulation Impact Statement

Tobacco Excise and Excise Equivalent Customs Duty Staged increases and reduction in the duty-free threshold

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POLICY OBJECTIVE

Context

1.1 The Government announced two tobacco excise measures as part of the 2016-17 Budget. These measures are:

- increasing excise and excise equivalent customs duty on tobacco and tobacco related products under a staged process, with a 12.5 per cent increase on 1 September 2017 and further 12.5 per cent increases on 1 September 2018, 1 September 2019 and 1 September 2020.
- lowering the duty free tobacco allowance to 25 cigarettes or equivalent from the current allowance of 50 cigarettes.

1.2 An interim regulation impact statement was prepared during the 2016-17 Budget process.

EXCISE TAXATION

1.3 Excise duty imposed under the *Excise Tariff Act 1921* is a tax on tobacco as well as alcohol, fuel and petroleum products (including gaseous fuels) produced or manufactured in Australia. Collectively, these products are referred to as excisable goods.

1.4 Imported goods, comparable to those subject to excise, attract customs duty at the same rate as the excise rate. Such duty is referred to as 'excise equivalent customs duty' and its application means that imports and locally-produced goods are taxed in an equivalent fashion.

1.5 A per stick duty applies to all cigarettes with a tobacco content not exceeding 0.8 grams per cigarette. All other tobacco products (including cigarettes containing more than 0.8 grams of tobacco, loose tobacco and cigars) are taxed at a per kilogram rate equivalent to the rate effectively imposed on the tobacco content of cigarettes containing 0.8 grams of tobacco.

PREVIOUS RATE INCREASES

1.6 The last series of increases in tobacco excise commenced in 2013 when excise and equivalent customs duties on tobacco and tobacco related products were increased via four annual 12.5 per cent increases. These took place on 1 December 2013, 1 September 2014, 1 September 2015 and 1 September 2016.

1.7 The excise rate for tobacco was also increased by 25 per cent on 29 April 2010.

PREVIOUS CHANGES TO THE DUTY FREE LIMIT

1.8 The duty-free allowance for tobacco products was reduced from 250 cigarettes or 250g of cigars or tobacco products to 50 cigarettes or 50g of cigars or tobacco products per person, from 1 September 2012.

GOVERNMENT COMMITMENTS TO REDUCE SMOKING RATES

1.9 In 2008, the Council of Australian Governments (COAG), committed to reducing the adult daily smoking rate to 10 per cent of the population, and to halving the daily rate of smoking among Aboriginal and Torres Strait Islander people by 2018.[1]

1.10 The National Tobacco Strategy (NTS) 2012-2018 is an overarching tobacco strategy that draws together a number of tobacco-related initiatives and policies with the goal to reduce the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes. It sets out nine priority areas for action on tobacco control in Australia, including priority area 6.3 to: 'Continue to reduce the affordability of tobacco products', under which priority action 6.3.2 is to 'Continue to implement regular staged increases in tobacco excise as appropriate, to reduce demand for tobacco'.[2]

1.11 The NTS takes into account the public consultation on the draft of the NTS 2012-2018, the review of the National Tobacco Strategy 2004-2009, key policy contexts for tobacco control, such as the COAG National Healthcare Agreement, the COAG National Partnership Agreement on Preventive Health, the Australian Government's response to the National Preventative Health Taskforce Report, the National Drug Strategy 2010-2015 state and territory tobacco strategies and policy frameworks, and recent Australian Government tobacco reform initiatives.

AUSTRALIA'S FUTURE TAX SYSTEM REVIEW

1.12 The December 2009 Report to the Treasurer on *Australia's Future Tax System* (AFTS) recommended that 'the existing regime for tobacco taxation in Australia should be retained, with the rates of tax substantially increased, depending on further evidence on the costs of harm from tobacco smoking' (Recommendation 73).[3]

1.13 The AFTS review noted the following about tobacco taxation:

> *While consumer sovereignty is an important principle in tax policy design, government intervention in the tobacco market is justified by the strongly addictive qualities of tobacco, its serious health impacts, its uptake by minors and the costs that smoking imposes on non-smokers.*
>
> *Tobacco taxes raise prices and reduce both smoking rates and smoking intensity. Australian retail prices for cigarettes are moderate by international standards and taxes constitute a relatively small share of the retail price.*
>
> *As Australia's tobacco taxes are low by international standards, it is feasible to increase them substantially.*

1 Council of Australian Governments. National Healthcare Agreement. 2012, Council of Australian Governments Canberra.

2 Intergovernmental Committee on Drugs. 2012. National Tobacco Strategy 2012-2018. Commonwealth Of Australia: Canberra.

3 The final report of the Australia's Future Tax System Review (AFTS), 2011 Commonwealth of Australia 2011. Available from http://taxreview.treasury.gov.au/content/Content.aspx?doc+html/home.htm.

WHO Framework Convention on Tobacco Control

1.14 In 2003, Australia became a party to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), which supports the use of price and tax measures to reduce the demand for tobacco products. An increase in tobacco excise is consistent with Australia's obligations under this Convention, and represents a move towards international best practice in the pricing of tobacco products.

- Article 4(4) of the FCTC states that comprehensive multi-sectoral measures and responses to reduce consumption of all tobacco products are essential.
- Article 6 of the FCTC describes price and tax measures as 'an effective and important means' to reduce tobacco consumption by various segments of the population, in particular young persons'.

International best practice

1.15 The WHO recommends that tobacco excise taxes account for at least 70 per cent of retail prices for tobacco products.[4] As at 1 September 2015 excise on cigarettes in Australia accounted for around 54 per cent of the final consumer price[5].

Problem

1.16 The scope of the problem of tobacco use in Australia can be defined by:

- rates of smoking;
- market failure which includes externalities of tobacco use (that is, health, social and economic costs);
- information failure which lead to higher rates of smoking; and
- the regulatory framework which requires consideration of the effectiveness of existing government regulation to combat tobacco use.

Smoking Rates in Australia

1.17 Table 1.1 shows the daily rate of smoking of adults, 18 years or older.

Table 1.1: Daily rate of smoking of adults

	1995	2001	2004-5	2007-8	2011-12	2014-15
Total %*	23.8	22.4	21.3	18.9	16.1	14.5

Source: Australian Bureau of Statistics 2016. Australian Health Survey: First Results, 2014-15 cat no. 4364.0.55.001

4 World Health Organisation Technical Manual on Tobacco Tax Administration 2010 Reprinted 2011, p. 104.
5 Treasury analysis, 2015

HEALTH IMPACTS

1.18 There are no safe levels of consumption of tobacco products. The harms from smoking are well documented.

1.19 The 2014 report by the US Surgeon General *The Health Consequences of Smoking — 50 Years of Progress* states:

> *Since the 1964 Surgeon General's report, cigarette smoking has been causally linked to diseases of nearly all organs of the body, to diminished health status, and to harm to the fetus.'*[6]

1.20 The report goes on to state:

> *A half century after the release of the first report, we continue to add to the long list of diseases caused by tobacco use and exposure to tobacco smoke. This report finds that active smoking is now causally associated with age-related macular degeneration, diabetes, colorectal cancer, liver cancer, adverse health outcomes in cancer patients and survivors, tuberculosis, erectile dysfunction, orofacial clefts in infants, ectopic pregnancy, rheumatoid arthritis, inflammation, and impaired immune function. In addition, exposure to secondhand smoke has now been causally associated with an increased risk for stroke.* [7]

1.21 A British study found that about half of long-term smokers died prematurely from cigarette smoking, and that the average number of years of life lost by long-term smokers was 10 years.[8] More recently (11 October 2013), the Sax Institute reported on findings from the 45 and Up Study that 'the first ever analysis of long-term Australian smoking data has found that up to two-thirds of deaths in current smokers can be directly attributed to smoking — much higher than international estimates of 50 per cent'.[9]

1.22 Smoking cessation is associated with the following health benefits[10]:

- lowers the risk for lung and other types of cancer;
- reduces the risk for coronary heart disease, stroke, and peripheral vascular disease. Coronary heart disease risk is substantially reduced within 1 to 2 years of quitting;
- reduces respiratory symptoms, such as coughing, wheezing, and shortness of breath. The rate of decline in lung function is slower among people who quit smoking than among those who continue to smoke;

6 The report is available at: http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html, Executive Summary, p.4, para 3.

7 Ibid. Preface.

8 Doll R, Peto R, Boreham J and Sutherland I. 'Mortality in relation to smoking: 50 years' observations on male British doctors'. British Medical Journal, 2004. 328: 1519–33.

9 Banks et.al, 'Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence' BMC Medicine, 2015 Vol.13 No. 1

10 U.S. Department of Health and Human Services (2010). How Tobacco Smoke Causes Disease: The Biology and Behavioural Basis for Smoking Attributable Disease. Fact Sheet. National Centre for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health. Atlanta. Available from: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm#benefits.

- reduces the risk of developing chronic obstructive pulmonary disease (COPD), one of the leading causes of death in the United States; and
- reduces the risk of infertility of women during their reproductive years. Women who stop smoking during pregnancy also reduce their risk of having a low birth weight baby.

1.23 Compared with non-smokers (never smoked or ex-smokers), smokers are more likely to rate their health as being fair to poor, more likely to have asthma and more likely to suffer from mental illness. In Australia, tobacco smoking is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer and various other diseases and conditions.[11] In the most recent analysis of the burden of disease in Australia in 2011, tobacco use was the risk factor responsible for the greatest disease burden, accounting for 9 per cent of the total burden of disease.[12]

1.24 Smoking remains a significant cause of poor health among newborn babies, and smoking is a major contributor to the poorer health outcomes for Indigenous babies.[13]

1.25 Secondhand (or passive) smoking also poses health risks to Australians, including children. Exposure to second hand smoke causes lung cancer, with long term exposure elevating the risk of lung cancer in a non-smoker by up to 30 per cent. Exposure to second-hand tobacco smoke may also increase the risk of brain tumours, lymphomas, and acute lymphocytic leukaemia in children. [14]

SOCIAL AND ECONOMIC COSTS

1.26 In the most recent survey of the burden of disease in Australia, tobacco was the risk factor responsible for the greatest disease burden.[15] Annually, over 750,000 hospital bed days are attributable to tobacco-related disease.[16]

1.27 The 2008 study by Collins and Lapsley, *The costs of tobacco, alcohol and illicit drug abuse to Australian Society in 2004/05*, is the most recent major study which seeks to quantify the social and economic costs of tobacco use in Australia.[17] The study estimates that the tangible and intangible social costs of tobacco use amounted to $31.5 billion in 2004-05,[18] which includes $5.7 billion attributed to absenteeism and a reduction in the workforce.[19]

11 Australian Institute of Health and Welfare 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
12 Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra: AIHW.
13 Wills R and Coory M. Effect of smoking among Indigenous and non-Indigenous mothers on preterm birth and full-term low birth weight. Medical Journal of Australia. 2008;189(9): pages. 490-494.
14 Cancer Council Australia 2016, Link between smoking and cancer Available from: http://wiki.cancer.org.au/policy/Tobacco_control/Link_between_smoking_and_cancer#_ga=1.240462277.734311134.1455579995
15 Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra: AIHW.
16 Collins D and Lapsley H. 2008. The costs of tobacco, alcohol and illicit drug abuse to Australian Society in 2004/05. Commonwealth of Australia: Canberra. p. 40, Table 13.
17 ibid.
18 ibid. p. 65.
19 ibid. p. 59.

1.28 Table 1.2 sets out the key components of the tangible and intangible social costs of smoking, (noting that tangible costs refers to the extra resources which would have been available if there had been no past or present abuse with intangible costs being costs that cannot be shifted, for example, in the case of loss of life, there is no mechanism by which this cost can be passed on to others).

TABLE 1.2: KEY COMPONENTS OF SOCIAL COSTS OF SMOKING

COMPONENT	$M
Net healthcare costs (gross costs minus savings from premature deaths	318.4
Total net labour costs (including lost production in the workplace and in the household)	8,009.1
Resources used in tobacco consumption	3,635.6
Value of loss of life from tobacco consumption[20]	19,459.7

From Tables 33 and 34 of the study

1.29 Of the tangible costs shown in Table 1.2, the government sector bore 8 per cent, while households and businesses bore 50 per cent and 42 per cent, respectively.[21] The study also includes the cost of secondhand (passive) smoking. It assumes that all smoking attributable symptoms suffered by people aged less than fifteen years reflect involuntary smoking.[22]

1.30 The Collins and Lapsley study is the latest and most comprehensive research that the Australian Department of Health uses as the estimate of the social and economic (including healthcare) costs of tobacco use.

1.31 Experts note that Collins and Lapsley take a conservative approach to the estimation of costs.[23]

Collins and Lapsley's estimates of the social costs of tobacco abuse are extremely conservative; the actual costs are likely to be much higher. Lack of data prevented Collins and Lapsley assigning values to many of the social costs known to be attributable to smoking. For example, the following are not included: the purchase of over-the-counter medicines, domiciliary care and allied health services.[24]

1.32 Furthermore, the study did not cost reduced on-the-job productivity. A study published in 2006 estimated that between eight to 30 minutes per day are lost due to smoking. If five minutes are spent daily on smoking outside of normal break times, the employee is one per cent less productive.[25]

1.33 As noted above, Collins and Lapsley acknowledge that some of their cost estimates were almost certainly too low. For example, the cost of pharmaceutical products is based only on the highest volume drug categories on the PBS. The hospital cost estimates are based on

20 For explanation of valuation of life see page 15 of the study.
21 ibid. p. 67.
22 ibid. p. 14.
23 ibid. p. xi.
24 Hurley, S. Chapter 17: The economics of tobacco control, in Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. 4th ed. Melbourne: Cancer Council Victoria; 2012. Last updated November 2011. Available from: http://www.tobaccoinaustralia.org.au/downloads/chapters/Ch17_Economics.pdf.
25 Javitz HS, Zbikowski SM, Swan GE and Jack LM. Financial burden of tobacco use: an employer's perspective. Clinics in Occupational and Environmental Medicine. 2006;5(1):9–29, vii.

average treatment costs for each condition and do not reflect the fact that health care costs for smokers are likely to be higher than for non-smokers.[26] For example, smoking up to the time of any surgery increases cardiac and pulmonary complications, impairs tissue healing and is associated with more infections, therefore increasing the average length of stay, staff workload and requirements for medicines.[27] [28] Costs associated with the management of birth complications for women in the United States who smoke during pregnancy exceed those of non-smokers by 66 per cent.[29] Costs for smokers having orthopaedic surgery can be up to 38 per cent higher than those of non-smokers due to infections resulting in prolonged hospital stay and double the re-admission rate.[30]

1.34 Tobacco-related health expenditure includes more than primary healthcare and hospital costs. It also includes expenditure on the prevention of tobacco use through strategies such as social marketing campaigns and Quitline.

INFORMATION FAILURE

1.35 It is recognised internationally that many people are not fully informed about the health effects of smoking. Australia is a party to the WHO FCTC. FCTC Guidelines for Article 11, Packaging and labelling of tobacco products, states 'Globally, many people are not fully aware of, misunderstand or underestimate the risks for morbidity and premature mortality due to tobacco use and exposure to tobacco smoke.'[31]

1.36 International studies report that while most smokers agree that smoking poses a health risk many have important gaps in their knowledge, are unable to recall specific health effects and tend to underestimate the magnitude of the risks.[32]

1.37 It is possible that even if some consumers had full information about the harms and costs of smoking (and excluding the influence of addiction on rational decision making), they might still choose to smoke. However, there are gaps in smokers' knowledge of the mechanisms the tobacco industry uses to influence the experience of smoking. For example, additives can be used to improve the flavour and aroma of cigarettes, and decrease the harshness of tobacco.[33,34] The combined effects of increased filtration and increased ventilation make

26 Bertakis KD and Azari R. The influence of obesity, alcohol abuse, and smoking on utilization of health care services. Family Medicine. 2006;38(6):427-34. Available from: http://www.stfm.org/fmhub/fm2006/June/Klea427.pdf.

27 Peters MJ. Should smokers be refused surgery? British Medical Journal. 2007;334(7583):20. Available from: http://www.bmj.com/cgi/content/full/334/7583/20.

28 Theadom A and Cropley M. Effects of preoperative smoking cessation on the incidence and risk of intraoperative and postoperative complications in adult smokers: a systematic review. Tobacco Control. 2006;15(5):352–8. Available from: http://tc.bmjjournals.com/cgi/content/abstract/15/5/352.

29 Medical care expenditures attributable to cigarette smoking during pregnancy — United States, 1995. Morbidity and Mortality Weekly Report. 1997;46(44):1048-50. Available from: http://www.cdc.gov/mmwr/PDF/wk/mm4644.pdf.

30 Whitehouse JD, Friedman ND, Kirkland KB, Richardson WJ and Sexton DJ. The impact of surgical-site infections following orthopedic surgery at a community hospital and a university hospital: adverse quality of life, excess length of stay, and extra cost. Infection Control and Hospital Epidemiology. 2002;23(4):183-9. Available from: http://www.journals.uchicago.edu/ICHE/journal/issues/v23n4/4183/4183.text.html?erFrom=-2198106237673852801 Guest.

31 WHO 2008. 'WHO Guidelines for the implementation of Article 11 of the WHO FCTC Packaging and labelling of tobacco products'

32 Hammond, Fong, McNeill, Borland, Cummings. 2006 Effectiveness of cigarette warning labels in informing smokers about the risks of smoking: findings from the International Tobacco Control (ITC) Four Country Survey Tobacco Control 115 19-25. Available at http://tobaccocontrol.bmj.com/content/15/suppl_3/iii19.full.

33 Rabinoff M, Caskey N, Rissling A, Park C. Pharmacological and chemical effects of cigarette additives. Am J Public Health Nov 2007;97(11):1981–1991.

the smoke more dilute so it tastes weaker or 'milder' and produces less harshness (the immediate burning/scratching sensations in the mouth and throat) and irritation (the lingering tingling sensations in the throat and chest).[35] This 'lighter' or 'milder' taste can support the smoker's perception that these cigarettes deliver less tar and nicotine, and by tasting less harsh, stimulate beliefs about diminished dangers to health.[36]

1.38 Findings from the International Tobacco Control Four Country Survey, which included Australian smokers, has reported significant knowledge gaps among adult smokers (age 18 years or older), regarding the health effects and the magnitude of risk associated with smoking .[37] For example, among the Australian smokers in the survey, 10 per cent did not believe smoking caused heart disease, 20 per cent did not believe smoking caused stroke and 30 per cent did not believe smoking caused lung cancer in non-smokers.

1.39 Studies also indicate that many smokers fail to personalise the risks, believing that their own risk is less than the risks faced by other smokers.[38] Studies have also shown that smokers know relatively little about the nature of illnesses caused by smoking or what it might be like to experience these illnesses.[39] For example, one study found that smokers underestimate lung cancer death rates, overestimate survival from lung cancer, and only a minority realise that emphysema is incurable.[40] Research has also found that some smokers believe myths about reducing their risk including that exercising or taking vitamins can reverse most of the effects of smoking.[41]

1.40 Studies have also documented that adults, and young smokers in particular, misunderstand addiction, fail to recognise the signs of addiction in themselves or others and believe that their personal risk of addiction is less than others.[42, 43] Young smokers also tend to believe they are unlikely to become addicted and that the health risks are only associated with long term use and are therefore irrelevant.[44]

34 Tobacco Products Scientific Advisory Committee Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations. A report to the US FDA, 2011.

35 King B, Borland R. The 'low tar' strategy and the changing construction of Australian cigarettes. Nicotine & Tobacco Research 2004;6(1):85–94.

36 Kozlowski & O'Connor. Cigarette Filter Ventilation is a Defective Design Because of Misleading Taste, Bigger Puffs and Blocked Vents. Tobacco Control 2002:11(Suppl I):i 40-i50.

37 ibid.

38 Weinstein, Marcus and Moser. 2005. Smoker's unrealistic optimism about their risk. Tobacco Control Vol 14, pp 55-59.

39 Weinstein, Slovic, Waters et al. 2004 Public understanding of the illnesses caused by cigarette smoking. Nicotine & Tobacco Research. 6(2) p349-355. AND Weinstein, Marcus and Moser. 2005. Smoker's unrealistic optimism about their risk. Tobacco Control Vol 14 pp 55-59.

40 Weinstein, Slovic, Waters et al. 2004 Public understanding of the illnesses caused by cigarette smoking. Nicotine & Tobacco Research. 6(2) pp 349-355.

41 Weinstein, Marcus and Moser. 2005. Smoker's unrealistic optimism about their risk. Tobacco Control Vol 14 p55-59.

42 Weinstein, Slovic & Gibson, 2003. Accuracy and optimism in smokers' beliefs about quitting. Nicotine & Tobacco Research. 6(Suppl 3) pp 375-380.

43 Eureka Strategic Research, 2005. Youth Tobacco Prevention Project. Australian Government Department of Health and Ageing.

44 Eureka Strategic Research, 2005. Youth Tobacco Prevention Project. Australian Government Department of Health and Ageing.

1.41 Almost no one starts smoking after age 25. Nearly nine out of 10 smokers started smoking by age 18, and 99 per cent started by age 26 and progression from occasional to daily smoking almost always occurs by age 26.[45]

1.42 The evidence around the health effects of tobacco use also continues to grow each year. The National Preventative Health Taskforce acknowledged in 2009 that there was extensive new evidence about the health effects of smoking that Australian consumers had not yet been warned about.[46]

1.43 Given the multitude of anti-smoking campaigns to raise awareness of the health risks of tobacco, the perceived information deficiency may be explained by the addictive nature of smoking, rather than a lack of public awareness.

1.44 Most smokers regret starting smoking and have the desire to quit. A major international study of smokers, including Australian smokers, reports an 'overwhelming' high level of regret among adult smokers about starting to smoke, with nearly nine out of 10 agreeing with the statement 'If you had to do it over again, you would not have started smoking'.[47]

1.45 A survey, conducted annually from 2002 to 2009, reports that each year an average 72.8 per cent of Australian smokers are interested in quitting and plan to make a quit attempt either within the next month, within 6 months or at some point in the future.[48] Additionally, around 39 per cent of Australian smokers report making an actual quit attempt in the previous 12 months.[49]

EFFECTIVENESS OF CURRENT REGULATORY REGIME

1.46 Australia has a long history of tobacco control measures, and currently has a comprehensive set of tobacco control strategies in place at the national level and in every state and territory.

1.47 Multi-pronged approaches that are population wide in reach have proved to be the most successful public health responses to the prevalence of preventable risk factors (for example, tobacco use) for chronic diseases. Based on historical experience, smoking rates do not decline without major and comprehensive policy intervention to successfully change community-wide behaviour to 'non-smoking'. These tobacco control strategies include addressing tobacco use and withdrawal, secondhand (passive) smoking, tobacco

45 U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 2012.

46 National Preventative Health Taskforce. 2009. Australia: the healthiest country by 2020, National Preventative Health Strategy — the roadmap for action 30 June 2009. Commonwealth of Australia: Canberra.

47 Fong, Hammond, Laux et al, 2004 The near universal experience of regret among smokers in four countries: Findings from the International Tobacco Control Policy Evaluation Survey. Nicotine & Tobacco Research. Vol 6 (Suppl 3) p341-351. Available at http://ntr.oxfordjournals.org/content/6/Suppl_3/S341.abstract.

48 Cooper, Borland & Yong. 2011 Australian smokers increasingly use help to quit, but number of attempts remains stable: Findings from the International Tobacco Control Study 2002-2009. Australian & NZ Journal of Public Health. Vol 35 no 4 p 368-376 available at http://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.2011.00733.x/pdf.

49 Cooper, Borland & Yong. 2011 Australian smokers increasingly use help to quit, but number of attempts remains stable: Findings from the International Tobacco Control Study 2002-2009. Australian & NZ Journal of Public Health. Vol 35 no 4, pp368-376 available at http://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.2011.00733.x/pdf.

advertising, taxation and pricing, sales restrictions, public education, and smoke-free premises and environments (for example, enclosed and public places).[50]

1.48 As outlined above, the last series of increases in the excise rate for tobacco began in 2013 when excise equivalent customs duties on tobacco and tobacco related products were increased via four annual 12.5 per cent increases. These took place on 1 December 2013, 1 September 2014, 1 September 2015 and 1 September 2016.

1.49 Prior to this increase, the previous increase occurred on 29 April 2010, when the former Government increased the excise and excise equivalent customs duty applying to tobacco products by 25 per cent.

1.50 In addition to taxation measures, at the national level, other tobacco control initiatives include the following:

- measures to protect public health policy, including tobacco control policies, from tobacco industry interference;
- investment in anti-smoking social marketing campaigns;
- listing of nicotine replacement therapies on the PBS, which subsidises access for lower-income Australians and people with a prescription from their GP, and extended listings for the smoking cessation support drugs bupropion (available in two brands) and varenicline (Champix®);
- investment in support for Aboriginal and Torres Strait Islander communities to reduce smoking rates, including:
  - the $14.5 million Indigenous Tobacco Control Initiative, which funded 18 innovative tobacco control projects in a mix of urban, rural and remote Indigenous communities; and
  - $100.6 million Tackling Smoking and $35.6 million Healthy Lifestyle measures under the COAG Closing the Gap in Indigenous Health Outcomes National Partnership Agreement to support Regional Tackling Smoking and Healthy Lifestyle Teams in 57 regions;
- legislation to restrict Australian internet advertising of tobacco products, from 6 September 2012, bringing restrictions on tobacco advertising on the internet into line with other points of sale;
- legislation to mandate the plain packaging of tobacco products – from 1 December 2012 all tobacco products sold in Australia are required to appear in a drab, dark brown colour with a matt finish. Tobacco industry logos, brand imagery, colours and promotional text other than brand and product names must be in a standard colour, position, font style and size;
- regulations to update and expand the graphic health warnings appearing on tobacco products, in line with tobacco plain packaging requirements; and

50 Gruszin, S, Hetzel D and Glover J. Advocacy and action in public health: lessons from Australia over the 20th century. Canberra: Australian National Preventive Health Agency, pp 118-120.

- introduction of a maximum penalty of ten years' imprisonment for tobacco smuggling offences, from 6 November 2012.

1.51 These measures are in addition to a number of long-standing tobacco control initiatives including:

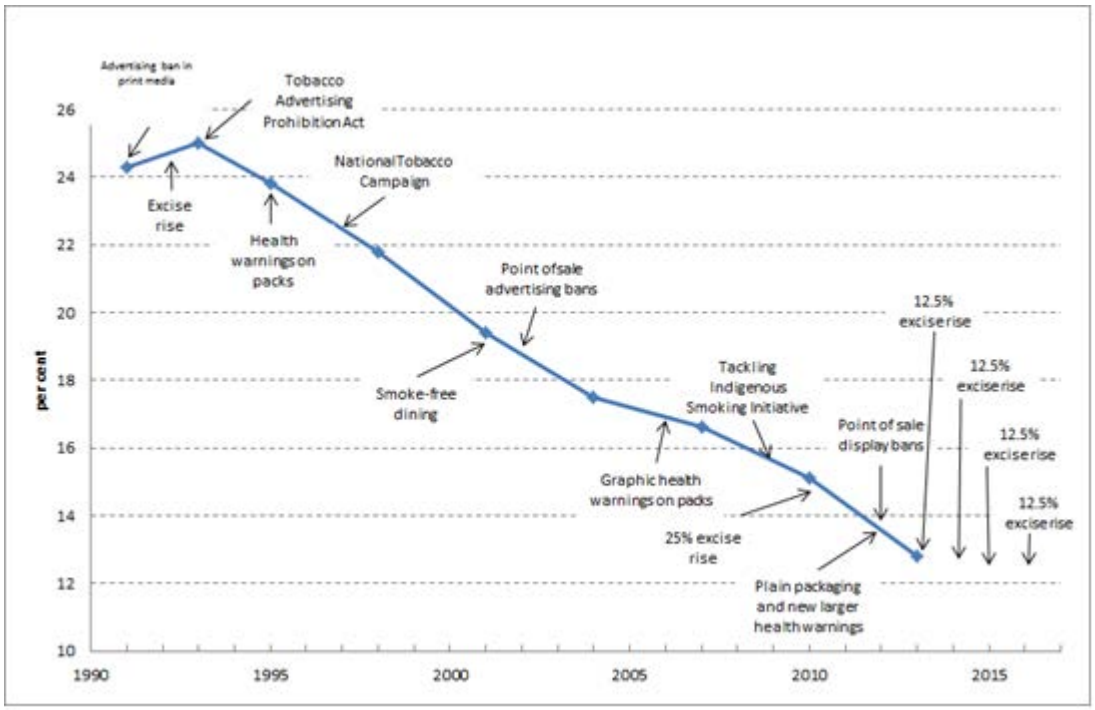
- minimum age restrictions on the purchase of tobacco products;
- comprehensive advertising bans under the Tobacco Advertising Prohibition Act 1992;
- retail display bans;
- bans on smoking in offices, bars, restaurants and other indoor public spaces, and increasingly outdoor places where children may be exposed to second-hand tobacco smoke;
- extensive and continuing public education campaigns on the dangers of smoking;
- PBS subsidies for smoking cessation supports; and
- Quitlines and other smoking cessation support services in each state and territory to help people quit.

1.52 As shown in Table 1.1 above, Australia has made significant gains in reducing smoking prevalence over many years. However, Australian smoking rates are still too high. As noted earlier, COAG committed to the following performance benchmark: 'By 2018, reduce the national smoking rate to 10 per cent of the population, and halve the Indigenous smoking rate, over the 2009 baseline'. Progress against this benchmark is measured by reference to the adult daily smoking rate.

1.53 Despite Australia's comprehensive efforts on tobacco control, the COAG Reform Council's most recent report states that while good progress has been made in reducing smoking rates over the last decade Australia's smoking rate may need to fall more quickly than it has since 2004-05 (when it was 21.3 per cent) to meet the target of 10 per cent by 2018.

1.54 Figure 1.1 below shows daily smoking rates among Australians 14 years and older and examples of some of the key policy interventions, 1990 to 2013.

FIGURE 1.1: DAILY SMOKING RATES AND POLICY INTERVENTIONS



Source: National Drug Strategy Household Survey reports: 1991, 1993, 1995, 1998 to 2013.

1.55 As outlined above, it is well recognised that price and tax measures are one of the most effective instruments to reduce tobacco consumption.[51] Tobacco control measures interact synergistically as a suite of measures, to help bring down smoking rates and keep them down over a sustained period of time.

1.56 It is difficult to separately quantify the dollar value of individual measures within the comprehensive package of measures.[52] A study prepared by the consultancy firm Applied Economics for the then Department of Health and Ageing estimated that over a 30 year period (from 1970), government investment of $176 million in public health programs to reduce tobacco consumption returned a net benefit of about $8.4 billion, and averted 17,400 premature deaths. Benefits attributed to tobacco control public health programs (including national mass media campaigns, health warnings on cigarette packets, regulations restricting the promotion of cigarettes as well as the conditions under which the cigarette products might be consumed, and changes in taxes, which contributed to a 154 per cent increase in the price of tobacco products) were estimated at a total of $12.3 billion, comprising longevity gains (approximately $9.6 billion), improved health status gains ($2.2 billion) and lower health care costs ($0.5 billion).[53]

51 Australian Government. Preventative Health Taskforce. 2009. Australia: the healthiest country by 2020. Technical Report No. 2. Tobacco control in Australia: making smoking history. Canberra: Commonwealth of Australia.

52 Department of Health and Ageing. 2003. Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing by Applied Economics, p. 22. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/8E28958A40B64604CA257BF0001A4CCF/$File/roi_eea.pdf).

53 As cited in Gruszin, S, Hetzel D and Glover J. Advocacy and action in public health: lessons from Australia over the 20th century. Canberra: Australian National Preventive Health Agency, pp127-128.

1.57 The Post-implementation Review for the 25 per cent tobacco excise increase that took effect from 29 April 2010, found that the increase exceeded the objective of cutting licit tobacco consumption by around 6 per cent as indicated by the decline in tobacco volumes.

Objective

1.58 The objective of these measures, and of tobacco control more generally, is to minimise the prevalence of smoking in order to limit the associated health effects discussed above.

1.59 In the medium term it will assist Australia to meet theCouncil of Australian Governments (COAG) target to reduce the adult daily smoking rate to 10 per cent of the population, and to halving the daily rate of smoking among Aboriginal and Torres Strait Islander people by 2018.[54] This target was implemented as a means of measuring progress on tobacco control with the overall goal of minimising smoking rates.

1.60 Excise taxation is at the centre of Australia's tobacco control policy. Compared to other taxes, excise can be applied selectively to pursue non-revenue objectives like the health, social and economic related impact of smoking outlined above.

Policy options

1.61 Option 1: The Government has committed to increasing excise and excise equivalent customs duty on tobacco and tobacco-related products through four annual increases of 12.5 per cent per year from 2017 until 2020. The increases will take place on 1 September each year and will be in addition to existing indexation to average weekly ordinary time earnings. The Government has also committed to reduce the duty free tobacco allowance from 50 cigarettes or equivalent to 25 cigarettes or equivalent, beginning 1 July 2017.

NO ALTERNATIVE POLICY OPTIONS WERE CONSIDERED. THE DECISION TO NOT EXAMINE ALTERNATIVE OPTIONS WAS TAKEN BECAUSE THE PREVIOUS 12.5 PER CENT INCREASES HAD PROVEN TO BE AN EFFECTIVE, BIPARTISAN POLICY THAT WAS UNDERSTOOD AND SUPPORTED BY THE COMMUNITY. ANALYSIS OF COSTS/BENEFITS

COSTS

1.62 The costs of the two measures, which will result in an increase in tobacco prices for consumers are:

- a reduction in real incomes for those continuing to smoke at the same rate or take up smoking (see Impact Group Identification);
- a loss of any benefits to consumers from smoking;

54 Council of Australian Governments. National Healthcare Agreement. 2012, Council of Australian Governments Canberra.

- possible small increases in compliance costs for various stakeholders in the tobacco industry including licenced tobacco distributors and retailers (see Impact Group Identification);
- Increased compliance costs related to the duty free limit change for the aviation industry, airports, duty free shops and the tourism industry which will need to update their videos and information for travellers
- increased administrative costs for the ATO and the Department of Immigration and Border Protection (DIBP) (see Impact Group Identification); and
- a possible shift to illicit tobacco and other unregulated products.

LOSS OF BENEFITS FROM SMOKING

1.63 Smokers may gain enjoyment from smoking. Smokers that are addicted are able to temporarily satiate their cravings.

1.64 There are also possible benefits from smoking but these benefits are extremely small. Consumption of tobacco appears to provide some protective effect from Parkinson's disease in males and females and endometrial cancer in females.[55] Any protective effect of smoking associated with a specific disease will not necessarily stop a given smoker from developing another disease caused by smoking.

1.65 If, as a result of the price rises, smokers quit or reduce their smoking or not take up smoking, these benefits may be lost.

SUBSTITUTION TO ILLICIT TOBACCO AND OTHER UNREGULATED PRODUCTS

1.66 There is a risk of a substitution effect, where smokers shift their consumption towards illicit and unregulated products including illicit tobacco and electronic nicotine delivery systems (ENDS) also known as e-cigarettes [56].

1.67 ENDS products containing nicotine are prohibited from retail sale in Australia through state and territory legislation. The health effects of ENDS products are still uncertain.

1.68 The Department of Immigration and Border Protection (DIBP), including its operational arm, the Australian Border Force (ABF), is responsible for detecting, deterring and disrupting the illicit trade of tobacco at the border. DIBP also manages the flow of legitimate trade across the Australian border and collects customs duty and taxes on imported tobacco products. Imported tobacco is considered to be illicit if the applicable duty is not paid.

1.69 Australia has a strong legislative and regulatory framework to control illicit trade in tobacco products. The maximum penalty for tobacco smuggling, including conveying or possessing smuggled tobacco products, is 10 years imprisonment in addition to pecuniary penalties of up to five times the amount of duty evaded.

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55 Collins and Lapsley, op. cit, p. 4

56 Electronic cigarettes are devices for making mists for inhalation that usually simulate the act of cigarette smoking and are sometimes marketed as a tobacco replacement. Australian health authorities are concerned about the use of electronic cigarettes in Australia because of a lack of evidence on their safety and efficacy. The impact of wide scale use of these devices on tobacco use is not known, and the outcome in the community could be harmful.

1.70 It is difficult to accurately measure the size of the illicit tobacco markets or the amount of excise or excise equivalent customs duty forgone through the sale of illicit tobacco consumed in Australia. Relevant enforcement agencies including DIBP and the Australian Taxation Office instead focus on a risk-based intelligence-led approach to focus on high risk areas of non-compliance.

1.71 Historically, most imported illicit tobacco has been imported into Australia in the sea cargo environment. A shift in smuggling methodology to smaller shipments through the international mail, air cargo and traveller streams has been observed. Strategies are in place and continually assessed to address the shifting smuggling methodologies.

1.72 The proposed increase in excise rates for tobacco may increase the risk of tobacco smuggling into Australia. Increases in excise rates increase the profitability of tobacco smuggling, which, all else being equal, attracts opportunists and organised crime to enter the illicit market.

1.73 The Government announced as part of the 2016-17 Budget that it would strengthen its regulatory and enforcement response to illicit tobacco. Strengthening the Government's regulatory and enforcement response to tackling illicit tobacco will help to counterbalance the excise increase by reducing the appeal of Australia as a low risk, high profit market for illicit tobacco.

BENEFITS

BENEFITS FOR INDIVIDUALS AND SOCIETY

1.74 There are significant health, social and economic benefits for individuals, their families and society from lower rates of tobacco consumption. Tobacco excise is an important component of Australia's broader tobacco control strategy to lower smoking rates and deliver these benefits to the Australian community.

1.75 It is a widely held view that increasing excise on tobacco leads to higher prices which reduces tobacco consumption. Lower consumption, in turn, reduces the health and social costs (outlined above) which are associated with tobacco consumption.[57]

1.76 An increase in the price of cigarettes will reduce smoking both through current smokers quitting and a lower take-up rate over the longer term. Treasury estimates that the increase in excise will reduce consumption by about 17 per cent by 2020.

1.77 This will further the goal of Australia's tobacco control policy: to minimise the rate of smoking.

1.78 In the medium term it will assist Australia to achieve its COAG target of reducing the adult daily smoking rate to 10 per cent of the population, and to halving the daily rate of smoking among Aboriginal and Torres Strait Islander people by 2018. The exact contribution the excise increase will have towards meeting these targets is not clear as Treasury estimates refer to a reduction in consumption while the COAG targets are based on the daily smoking rate.

57 WHO Framework Convention on Tobacco Control Price and tax polices (in relation to Article 6 of the Convention) (Technical Report by WHO's Tobacco Free Initiative, 2010 FCTC/COP/4/11 15 August 2010, paragraphs 4–6.

1.79 It will also move Australia towards meeting the WHO's recommendation that countries adopt excise levels that account for 70 per cent of the retail price for tobacco products.

1.80 The four annual increases will take Australia's excise on a cigarette to almost 69 per cent of the average price of a cigarette (assuming no other changes to cigarette prices over this period), close to the World Health Organisation recommendation.

1.81 Higher excise helps to combat information failure by sending a signal to the public about the harms of smoking.

1.82 Recent experience suggests that excise increases are an effective part of Australia's tobacco control strategy. A Post-implementation Review of the impact of the April 2010 25 per cent excise increase compared consumption immediately prior to the increase with consumption two years later. It showed a decrease in consumption of licit tobacco by 11 per cent, according to estimates of expenditure on tobacco products.[58]

1.83 A survey conducted in November 2010 (Victorian Smoking and Health Survey) to assess smokers' reported changes in smoking habits following the 25 per cent increase in tobacco excise in April 2010 indicates a range of behaviour change. It reported as follows:

> *Of all smokers surveyed…45 per cent reported that they had changed their smoking behaviour in response to the price increase, either by trying to quit (28 per cent) or by smoking fewer cigarettes (34 per cent)….Only 18 per cent of smokers changed their purchasing behaviour without attempting to change their smoking behavior (sic) ….* [59]

1.84 The survey data shows that about two-thirds of the smokers (62 per cent) surveyed said they had changed their smoking behaviour, with younger respondents (37 per cent) and low socioeconomic status smokers (about half) more likely to have done so. Less than one in five (18 per cent) of the smokers surveyed only changed the types of tobacco products purchased without also trying to quit or cut down.

REVENUE

1.85 In 2014-15 the Government received $8,848 million in tobacco excise revenue.

1.86 The increases to tobacco excise and the reduction in the tobacco duty-free threshold is estimated to increase revenue by $4,685 million over the forward estimates period. An additional $445 million in goods and services tax is estimated to be collected and paid to the States and Territories over the forward estimates period.

1.87 Revenue will increase because the increase in revenue from the excise rate increase outweighs the decline in revenue from lower consumption.

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58 Post-implementation Review 25 per cent tobacco Excise Increase The Treasury February 2013 p. 16 Available on the website of the Office of Best Practice Regulation. http://ris.finance.gov.au/category/post-implementation-reviews p. 25.

59 Scollo, M. Chapter 13, The pricing and taxation of tobacco products in Australia, in Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from: http://www.tobaccoinaustralia.org.au/chapter-13-taxation.

DIFFERENT SOCIO-ECONOMIC GROUPS

1.88 Smoking rates among the most disadvantaged groups are higher than for the general population. In 2014-15, people (18 years or older) living in areas with the lowest socioeconomic status were 2.5 times more likely to smoke daily than people with the highest socioeconomic status, 21.4 per cent compared with 8 per cent[60].

1.89 The proportion of Aboriginal and Torres Strait Islander people aged 15 years and over who were daily smokers was 38.9 per cent in 2013, down from 44.6 per cent in 2008, but still far higher than the smoking rate for the general population[61].

1.90 There is a link between tobacco consumption and poverty. Lower income households are particularly vulnerable as expenditure on tobacco products may replace food and other essential goods and services for the family. The health impact of tobacco consumption also puts pressure on family budgets and reduces the income-generating potential of family members.[62]

1.91 The available evidence suggests that the impact of the 2010 tobacco excise increase did not appear to negatively affect the ability of continuing smokers to pay for essentials such as food.[63][64]

1.92 Opposition to tobacco excise increases has often focussed on the argument that tobacco taxation is 'regressive' i.e. it has a disproportionately greater impact on the economically disadvantaged. However, there is evidence to suggest it may have the opposite effect. Chaloupka et al make the following observations:

> *The regressivity of existing taxes, however, does not necessarily imply that tax increases are regressive as well. In many countries, tobacco use among the lowest income/socioeconomic status populations is most responsive to price, while use among the highest income/socioeconomic status populations is least responsive. Thus, a tax increase that raises tobacco product prices will lead to the largest declines in smoking among the lowest income persons, and the burden of tax increase will fall more heavily on higher income consumers whose smoking behaviour changes little in response to the tax increase.*[65]

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[60] Australian Bureau of Statistics 2015, *National Health Survey, 2014-15*, 'Table 9: Smoking – Australia', cat. no. 4364.0.55.001. Available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument

[61] Australian Bureau of Statistics, 2015 *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*. Cat.no 4714 Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0/

[62] International Agency for Research on Cancer, Chapter 7. Tax, price and tobacco use among the poor, in Effectiveness of tax and price policies for tobacco control 2011, IARC: Lyon, France.

[63] Hayes L. Smokers' Responses to the 2010 Increase to Tobacco Excise: Findings from the 2009 and 2010 Victorian Smoking and Health Surveys. CBRC Topline Research Report. Prepared for Quit Victoria. November 2011, Centre for Behavioural Research in Cancer, The Cancer Council Victoria: Melbourne.

64 Scollo M, Zacher M, Warne C, Hayes L, Durkin S and Wakefield M. Impact in Victoria of the April 2010 25% Increase in Excise on Tobacco Products in Australia: Short-term Effects on Prevalence, Reported Quitting and Reported Consumption, Real Cost, and Price-minimising Strategies in Victoria. April 2012, Centre for Behavioural Research in Cancer, The Cancer Council Victoria: Melbourne.

65 Chaloupka, F.J., A. Yurekli and Fong (2012). Tobacco taxes as a tobacco control strategy. Tobacco Control; 21:172-180.

1.93 According to the Cancer Council Victoria, for those low income people who do not give up smoking and do not cut down, it is true that the price of purchasing their regular pack of cigarettes would be greater following an excise increase. However, the effects of an excise increase would be offset by consumers cutting down on the number of cigarettes smoked. A recent cohort study of Victorian smokers showed that while consumption among light smokers did not decline, heavy smokers reduced consumption substantially after the April 2010 price rise. Further, the numbers of smokers experiencing financial stress did not change significantly following the tax increase.[66]

1.94 As the Cancer Council of Victoria has noted, failing to increase taxes on tobacco products does not ensure that smokers will pay less for cigarettes. As occurs in many countries,[67] tobacco companies in Australia have consistently 'over-shifted' tax increases to consumers, that is, charged consumers higher prices than required by tax increases, thereby benefiting from the increase of revenue while consumers blame the government's tax increase for the price rise.

1.95 Increasing tobacco taxes, in combination with investment in other tobacco control measures, can be expected to contribute to reducing smoking rates among low-income people.

1.96 Staged introduction of excise increases will give smokers several chances to quit prior to the transition to higher prices at each stage.

1.97 In addition to the incentive of price increases, a range of initiatives are available to help people quit smoking including Quitline and smoking cessation support services in each State and Territory. Subsidised smoking cessation aids including nicotine replacement therapy (for example, nicotine patches and medicines to assist with quitting smoking) have been available on the subsidised PBS since February 2011.

LICENCED TOBACCO COMPANIES

THE AUSTRALIAN TOBACCO MARKET

1.98 The tobacco wholesale market is estimated to generate around $2.5 billion of revenue in 2015-16.[68]

1.99 There are three major tobacco companies operating in Australia; British American Tobacco, Philip Morris and Imperial Tobacco.

1.100 The structure of the tobacco industry has changed significantly in recent years following the cessation of local cigarette manufacturing. Phillip Morris and British Tobacco both ceased manufacturing in 2014-15 and instead entered the tobacco wholesaling industry as major players.

66 Scollo, M., et al., Impact in Victoria of the April 2010 25 per cent increase in excise on tobacco products in Australia. Short-term effects on prevalence, reported quitting and, reported consumption, real cost, and price-minimising strategies, 2012, Centre for Behavioural Research in Cancer, Cancer Council Victoria: Melbourne, Australia.

67 International Agency for Research on Cancer, Chapter 3. Tobacco industry pricing, price-related marketing and lobbying, in Effectiveness of tax and price policies for tobacco control2011, IARC: Lyon, France.

68 IBISWorld Industry Report F3606b Tobacco Product Wholesaling in Australia, August 2015 op cit p.4

1.101 British American Tobacco has the largest share of the Australian wholesale market with 48.4 per cent. Phillip Morris has 23.5 per cent, Imperial Tobacco has 12.8 per cent while the remaining 15.3 per cent is split among a number of smaller players.[69]

1.102 IBISWorld notes that tobacco companies have been affected by falling demand over the past five years because of increasing health concerns, anti-smoking campaigns, increasing regulations and higher excise taxation. However industry revenue is still forecast to increase at an annualised rate of 2.2 per cent over the five years through 2020-21, to reach $2.8 billion.[70]

IMPACT ON COMPLIANCE COSTS – EXCISE INCREASE

1.103 The main compliance cost of excise increases is adjusting prices, which has previously been reported as taking two to three days.[71] However, these price changes occur at the same time as bi-annual indexation of tobacco excise and excise equivalent customs duty, meaning the staged excise increase will not impose additional compliance costs.

1.104 Tobacco companies reported difficulties resulting from the 25 per cent increase in tobacco excise in April 2010. This was because of the short notice given and the flow-on impact on companies. The long lead time provided ahead of the excise increases beginning in 2017 means that there should be no difficulty in terms of excise payments.

IMPACT ON COMPLIANCE COSTS – DUTY FREE REDUCTION

1.105 The duty free reduction is expected to have minimal impact on travellers. The change is minor in comparison with the most recent reduction, from 250 cigarettes or equivalent to 50 cigarettes or equivalent in 2012.

1.106 It is anticipated the changed duty free concession will have an initial minimal compliance cost impact, which will decrease as travellers become aware of the new limit. DIBP will develop a communication plan to inform travellers and industry of the change.

1.107 The industry (the aviation industry, airports, duty free shops and the tourism industry) will need to update their videos and information for travellers, however, industry undertakes these activities as part of its business as usual costs so the impact is likely to be minimal.

IMPACT ON COMPLIANCE COSTS - QUOTAS

1.108 A further cost may arise to businesses because of tobacco quotas. Quotas may be imposed to protect government revenue from anticipatory behaviour and stockpiling of product prior to the new rate taking effect. The quotas have the effect of setting the amount of tobacco products that could be released into home consumption at the excise and excise equivalent customs duty rates prior to the rate rise taking effect. The quota system is administered by the ATO under delegation from the Comptroller-General of Customs.

1.109 Where quotas are imposed, the amounts are determined by reference to the expected levels of product that would be released into the market place if there were no anticipation

69 Ibid op. cit p.21
70 Ibid op. cit p.8
71 Post-implementation Review: 25 per cent tobacco excise increase op. cit. p.25.

of rate increase present. The ATO administers quotas in a manner to provide sufficient amounts for suppliers to continue supplying product at normalised levels at the current rate of duty. The quotas allow an uplift factor to adjust for seasonal variations and known individual circumstances. However, there is also provision for entities that have quotas imposed to have their individual circumstances reviewed and quota amounts adjusted.

1.110 The ATO has imposed quotas for the past three staged excise increases.

1.111 While the quotas are in operation, the allocation of tobacco products to specific retailers is a business decision for tobacco importers and distributors upon which the quotas have been imposed. The imposition of a quota does not prohibit the release of tobacco products for sale to retailers above the quota amounts. Quotas do no more than effectively limit what can be entered into the Australian market at the current rate of duty.

1.112 If an importer or distributor exceeds their quota limit they would in effect have to pay duty at the rate applicable from the date of the staged increase on that excess amount.

1.113 The quota system may impose some additional costs on manufacturers, and distributors as these businesses will have to monitor their sales to ensure that they operate within the quota or otherwise pay a higher rate of duty on the excess over the quota limit. The costs of either of these two options are not expected to be significant.

CHANGING BUSINESS STRATEGIES TO RESPOND TO PRICE RISES

1.114 Tobacco companies in Australia have the potential to 'over-shift' tax increases to consumers by charging consumers higher prices than required by tax increases, thereby benefiting from the increase of revenue. By increasing tobacco prices above that required by the excise increases and bi-annual indexation, tobacco companies have been able to counteract some of the impact of a decline in total tobacco consumption on their revenue and profit.

1.115 As part of consultation on the Post-implementation Review for the 25 per cent tobacco excise increase from 29 April 2010, tobacco companies submitted that the 25 per cent increase encouraged adult smokers to move from their current product to cheaper brands and 'roll-your-own' (RYO).

1.116 One of the companies submitted that the increase in quantity of cheap cigarettes consumed was an unintended effect of the 25 per cent tobacco increase. That is, increases in tobacco excise or excise equivalent duties had unintentionally encouraged smokers to 'down trade' to smoking cheap cigarettes, rather than reducing the total number of cigarettes they consume.

1.117 The same tobacco company submitted the excise increase had the effect of unintentionally altering the relative competitive positions of cigarette suppliers in the markets for not only their products, but also in the markets for their inputs of raw materials and factors of production (that is land, labour and capital). The company argued that this, in turn, reduced the effectiveness of excise and excise equivalent duties as a means of reducing cigarette consumption.

1.118 Tobacco companies submitted that there was no public health benefit in a policy which encourages adult smokers to move from their current product to a cheaper and / or illicit or unregulated product.

1.119 Over the past five years standard cigarettes have declined as a proportion of revenue due to the increasing popularity of RYO. Demand for premium cigarettes is less affected by price than cheaper cigarettes and has remained stable as a proportion of revenue.[72]

1.120 It is expected that further excise increases will create an increase in cheaper brands and RYO. This shift combined with any consequent decline in tobacco consumption may affect business decision-making of the tobacco companies. It may require them to adapt their strategies to try to capture market share of an increasingly competitive market, for example, by increasing their range of products at various price points.[73] Further, as highlighted above by the Victorian Smoking and Health Survey, strategies aimed at encouraging consumers to 'switch' to an alternative product have not been overly successful to date.

A SHIFT TO ILLICIT AND UNREGULATED PRODUCTS

1.121 As part of consultation to the Post-implementation Review for the 25 per cent tobacco excise increase from 29 April 2010, tobacco companies submitted that the excise increase in 2010 also contributed to an increase in the illicit tobacco trade.

1.122 As outlined above, while increases to excise and excise equivalent rates have the potential to increase the illicit trade in tobacco, DIBP detection data does not support the premise that tobacco smuggling increased following previous excise rate increases.

RETAILERS

1.123 Tobacco wholesalers distribute products to retailers such as supermarkets, grocery stores, convenience stores, service stations and tobacco stores.

1.124 Retailers do not pay excise but will incur the cost of changing their displayed prices for tobacco products but as all increases occur at the same time as bi-annual indexation, there will be no incremental compliance cost arising from the staged excise increases.

1.125 Retailers may suffer from declining sales. However, daily smoking rates in Australia have been declining gradually for the last few decades. Any further decrease in tobacco consumption that occurs as a result of the staged increases will occur in this context. The impact of a further decrease in tobacco consumption is difficult to quantify and will vary considerably depending on the size of the retailer, their reliance on income from tobacco products and their product mix. The significant lead time before the commencement of most of the staged increases provides retailers with an opportunity to adapt their business if required.

1.126 There will be no additional compliance costs arising for retailers from the imposition of quotas. However, if their suppliers choose to withhold supplies of tobacco products rather than pay duty on the excess over the quota limit, there is a potential restriction on supply that may deprive them of the opportunity to sell additional tobacco products.

72 IBISWorld Industry Report F3606b, Tobacco Product Wholesaling in Australia August 2015 op. cit. p.12
73 IBISWorld Industry Report C1220 Cigarette and Tobacco Product Manufacturing in Australia July 2013

IMPORTERS

1.127 Importers are required to pay excise equivalent customs duties. The DIBP advises of the changes in rates by way of the publication of an Australian Customs and Border Protection Notice and advice on the DIBP website via the ICS message facility for customs brokers and agents. Importers will need to change their price lists and make adjustments to their computer systems. As above, because the staged excise increases occur at the same time as indexation there will be no incremental cost.

DUTY FREE SHOPS / PROVIDORES

1.128 There are a number of duty free shops / providores in Australia that are required to pay duty on tobacco in certain circumstances, for example when goods are not exported. These businesses are informed of excise increases by the ATO and, apart from being aware of the changes, are not expected to experience additional compliance costs.

1.129 Duty free stores that cater to inbound travellers may experience a decline in demand for their tobacco products.

Compliance Cost Impact

1.130 Table 1.10 below sets out the estimated additional compliance costs for business arising from the four staged excise increases and the reduction in the duty free tobacco allowance.

1.131 Using the regulatory burden measurement framework, it has been estimated that the measure will increase compliance costs by $0.3m. For all reporting periods, the Treasury portfolio has reported net compliance cost reductions and there is no reason why the portfolio will not continue to deliver on its red tape reduction targets this year, in line with the Government's regulatory reform agenda.

TABLE 1.10: REGULATORY BURDEN ESTIMATE

Average annual regulatory costs (from business as usual)				
Change in costs ($ million)	Business	Community organisations	Individuals	Total change in costs
Total, by sector	$ 0.002	$	$0.3	$0.3

1.132 The costs in the table 1.10 have been calculated on the assumption that tobacco companies do not incur transitional costs for extra administration as a result of the four staged excise increases given these occur at the same time as ongoing indexation. The costs assume that the quotas being imposed during this period will create administrative costs. On average four tobacco companies will be subject to quotas each year there is a staged increase.

1.133 In response to consultation on the previous excise increases beginning in 2013, one company indicated positively that the imposition of quotas resulted in increased administrative costs. It is assumed that all companies who are subject to quotas will incur additional administrative costs.

1.134 The costs of administering quotas are based on 20 hours of labour assuming average earnings of $65.45 per hour. The costs are calculated over a 10 year period.

1.135 The regulatory costs are transitional and thus it is assumed that there are no on-going compliance costs. It assumes that quotas will not be applied after the last staged increase on 1 September 2020.

1.136 Reducing the duty free allowance will have the following regulatory impacts:

- Queuing and traveller flow at airports will be interrupted at the duty barrier where other transactions take place (e.g. Quarantine Infringement Notices, Travellers Infringement Notice Scheme and other payments).
- The industry (the aviation industry, airports, duty free shops and the tourism industry) will need to update their videos and information for travellers, however, industry develops videos and information for travel as part of its business as usual costs so the initial upfront cost is likely to be minimal and an insignificant regulatory burden when costed over ten years.
- Travellers will be affected by the change in duty concession for tobacco as they will need to interact with the Australian Border Force to pay for tobacco above the duty free concession.

1.137 It is assumed that for the first nine months after implementation of the new threshold, fourteen per cent of travellers will have tobacco above the new threshold limit. After this period it is expected travellers will be aware of the new threshold.

ADMINISTRATIVE IMPACTS

1.138 There are only minor additional administrative costs for the ATO and DIBP from the staged excise increases given these occur at the same time as the usual indexation. The DIBP will face minor additional costs to administer the lower duty free limit at the border.

1.139 The ATO incurs some additional cost in its administration of quotas. However, these are minimal and arise from monitoring market behaviours, determining whether quotas should be imposed, preparation of quota orders, settling variation requests and recovering additional revenues where applicable.

1.141 ConsultationTreasury did not conduct specific consultation with stakeholders on these changes. Stakeholder positions were well understood given the extensive stakeholder consultation that occurred prior to previous excise changes, the government's recent tax package and in relation to development of the Government's broader tobacco control polices.

1.142 Following the announcement of tobacco excise changes the excise increases received strong support from the health sector. The tobacco industry raised concerns about substitution with illegal tobacco and cheaper legal products, while many smokers, as anticipated, demonstrated resistance to the price increases.

1.143 In response the excise increases British American Tobacco said the policy would increase the size of the illicit tobacco market, highlighting the role of organised crime and the Government revenue lost to the illicit tobacco trade[74].

1.144 The Cancer Council was supportive of the change. Cancer Council CEO Professor Sancha Aranda. said "the increase in tobacco tax alone will translate to tens of thousands of cancer deaths avoided, with trend data showing that the recurrent increases will lead to around 320,000 smokers quitting and 40,000 teenagers deterred from taking smoking up.[75]"

1.145 The Heart Foundation: "applauded the Australian Government for maintaining support of a significant increase in the tobacco tax in its 2016 Budget". They said the "change will provide real health benefits and will be enhanced by the comprehensive set of tobacco control initiatives in place such as tax, education campaigns and plain packaging."[76]

1.146 The Australasian Association of Convenience Stores said the change would result in a loss of business to retailers and increase the size of the illicit tobacco market[77].

1.147 The Newsagents Association of NSW and ACT said that the increase would raise security risks and increase the attraction of the black market[78].

Consultation under the NPHS

1.148 The NPHS was developed by the National Preventative Health Taskforce (Taskforce) and released in September 2009. The Taskforce recommended a sequence of increases in tobacco excise on public health grounds.

1.149 The development of the NPHS took into account extensive consultations from October 2008 to February 2009 with the public, professional and consumer groups, and other

[74] British American Tobacco Australasia Media Release, May 2016, available from: http://www.bata.com.au/group/sites/bat_9rnflh.nsf/vwPagesWebLive/DO9RNMTE/$FILE/medMDA9M8WN.pdf?openelement

[75] Cancer Council Media Release, May 2016

[76] Heart Foundation, 'Tobacco tax helps take the puff out of smoking', May 2016, available from: http://heartfoundation.org.au/news/tobacco-tax-helps-take-the-puff-out-of-smoking

[77] Jeff Rogut, 'Tobacco tax all about money not health', April 2016, available from: https://insidesmallbusiness.com.au/finance/tobacco-tax-all-about-money-not-health

[78] The Canberra Times, 'Retailers unimpressed by potential $40 cigarette pack' March 17 2016, available from: http://www.canberratimes.com.au/act-news/retailers-unimpressed-by-potential-40-cigarette-pack-20160316-gnk571.html

interested stakeholders. Feedback on the proposed excise increases indicated overall support for the increases, particularly if they were complemented by a range of tobacco control initiatives, including programs targeted towards smokers from lower socio-economic backgrounds.

1.150 The Taskforce also received over 400 submissions from interested individuals and organisations following the release of its discussion paper — Australia: the healthiest country by 2020, in October 2008. The range of stakeholders who provided submissions included the tobacco industry, tobacco retailers, smokers, non-smokers, tobacco control advocates, researchers, and health consumer advocates. The submissions received, combined with the consultations conducted, were considered by the Taskforce and informed the development of the NPHS, which was provided to the former Government on 30 June 2009.

Consultation conducted during the development of the NTS 2012-2018

1.151 The draft for consultation of the National Tobacco Strategy (NTS) 2012-2018 was developed by the Intergovernmental Committee on Drugs Standing Committee on Tobacco (Standing Committee). As noted in paragraph 1.13, the draft for consultation included the priority action area, '6.2 Continue to reduce the affordability of tobacco'.

1.152 At the 27 April 2012 meeting of the Standing Council on Health, all Health Ministers approved the public release of the draft for consultation of the NTS 2012-2018.

1.153 Public consultation on the draft for consultation of the NTS 2012-2018 was conducted during June 2012 and included a national call for written submissions, consultations with non-government stakeholders with expertise in tobacco control, and consultations with Aboriginal and Torres Strait Islander stakeholders with an interest in tobacco control.

1.154 Written submissions were received from academics, government organisations, non-government organisations, Aboriginal and Torres Strait Islander organisations, pharmaceutical and insurance organisations, retail and hotel organisations, smokers and non-smokers, and the tobacco industry and associated groups.

1.155 Feedback received on the draft for consultation of NTS 2012-2018, in relation to priority action area 6.2, indicated that:

- the majority of stakeholders were supportive of further proposed tobacco excise increases;
- many stakeholders agreed that further tobacco excise increases are the most reliable way to accelerate declines in national smoking rates, notwithstanding the importance of a range of tobacco initiatives to support specific population subgroups;
- some stakeholders opposed further proposed excise increases. These stakeholders suggested that further tobacco excise increases would increase the demand for cheaper tobacco alternatives and illicit tobacco.

1.156 The Standing Committee considered the views of stakeholders obtained during the public consultation on the draft for consultation prior to revising and finalising NTS 2012-2018.

The final NTS 2012-2018, endorsed by all Health Ministers on 9 November 2012, includes the priority action area, '6.3 Continue to reduce the affordability of tobacco products.'

1.157 The consultation processes for the NPHS and the NTS 2012-2018 provided substantial opportunity for stakeholders to provide input on the issue of tobacco excise increases. Conducting additional consultation on the new tobacco excise increases is unlikely to reveal additional views and would consequently be an inefficient use of public resources.

Re:think discussion paper

1.158 Government invited the Australian community to contribute their thoughts on potential reform to the tax system, including the taxation of tobacco and other excisable goods, through the Re:think discussion paper.

1.159 Responding to the paper the Cancer Council submitted that they recommend the Australian Government 'continue to increase tobacco taxation levels after 2016 with the level of increase determined so that the 'weighted average retail price' of cigarettes continues to increase and the 70 per cent target is met within four years'.[79]

1.160 The Heart Foundation recommended the Government 'continue to increase tobacco taxation levels after 2016 to a position where Australia is a world leader - as it is in a number of other areas of tobacco control policy…'[80]

Consultation with licenced tobacco companies / distributors

1.161 Tobacco companies have historically opposed tobacco control measures including past increases in excise.

CONCLUSION AND RECOMMENDED OPTION

1.162 The current rate of smoking in Australia is too high given the large social and economic costs it imposes on the Australian community.

1.163 Option 1, the 2016-17 Budget measures to increase tobacco excise and lower the duty free limit will:

- reduce the rate of smoking in Australia and therefore the negative social and economic consequences associated with tobacco consumption;
- progress the commitment by Commonwealth and state and territory governments to reduce the adult daily smoking rate to 10 per cent of the population, and halving the rate of smoking among Aboriginal and Torres Strait Islander people by 2018;

79 Cancer Council submission to the Re:think discussion paper, 2015.
80 Heart Foundation submission to the Re:think discussion paper, 2015. Available from http://bettertax.gov.au/files/2015/06/Heart-Foundation.pdf

- priority area 6 of the National Tobacco Strategy 2012-18 to 'continue to implement regular staged increases in tobacco excise as appropriate, to reduce demand for tobacco';
- move Australia towards the World Health Organisation's recommendation that excise should account for at least 70 per cent of the retail price of tobacco products; and
- do so in a way that has bipartisan and broad community support.

1.164 Option 1 will result in minor transitional compliance costs for major tobacco companies which result from administering quotas that result from the four staged increases.

IMPLEMENTATION AND EVALUATION

1.165 Changes to the rates of excise and excise equivalent customs duty and indexation method for the rates of duty can be achieved through amendments to the *Excise Tariff Act 1921* and the *Customs Tariff Act 1995.*

1.166 The effectiveness of this option, and the Government's broader tobacco control policy, will be measured against COAG targets to reduce the smoking rate. There are a number of sources the Government relies on to monitor smoking rates, including data from national surveys conducted by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.