Reducing tobacco-related health inequities

An evidence summary

FAIR FOUNDATIONS HEALTH EQUITY SERIES

VicHealth

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Contents

Introduction

Background

There has been considerable progress in reducing tobacco smoking and related harm in Victoria and across Australia over the past four decades. However, smoking rates remain significantly higher among disadvantaged Australians, including low socioeconomic groups, Aboriginal Australians, people living with mental illness, and people who are unemployed, imprisoned or experiencing homelessness. Disparities also exist in relation to foetal exposure to tobacco smoke during pregnancy, exposure to second-hand smoke in the home, early smoking uptake and longer periods of smoking prior to quitting.

Over time, smoking in Victoria has declined across all socioeconomic groups in the population, but inequities in use have persisted because smoking has declined faster among more advantaged groups. There is now evidence that the equity gap for tobacco use in Victoria is beginning to narrow and that, for the first time – between 2005 and 2011 – the prevalence of regular smoking declined most rapidly among the most disadvantaged groups, reversing a trend apparent in previous years.

Tobacco use compounds existing social inequalities and poverty. High prevalence of smoking within families, peer groups and local communities acts to reinforce smoking as a 'normal' behaviour, while the high levels of stress associated with poverty and multiple life challenges can make it more difficult to quit smoking. The health consequences of tobacco use and exposure can be particularly devastating for people facing multiple disadvantages who may also have reduced access to health care and/or poor health literacy.

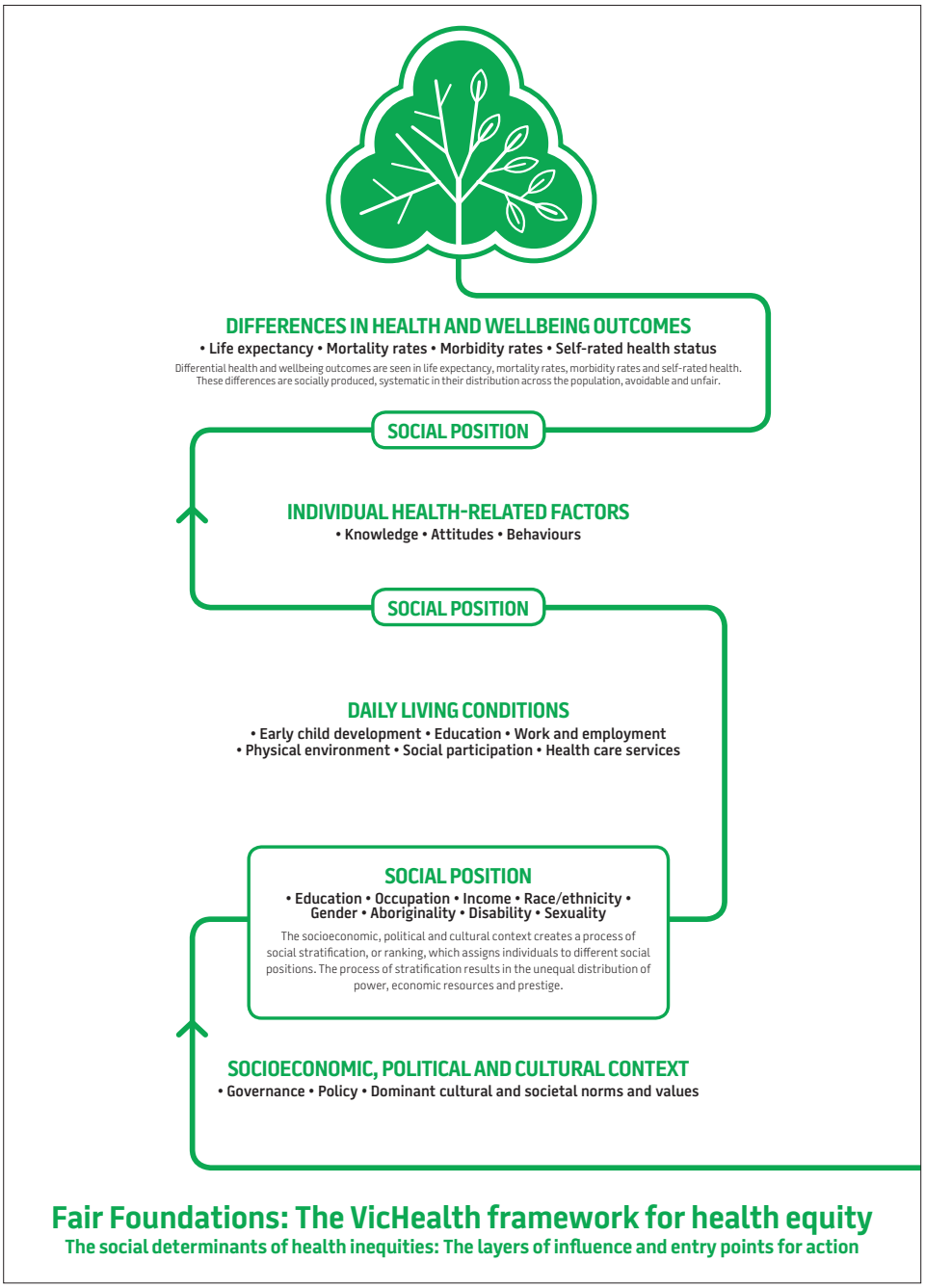
There is strong evidence about what works in reducing smoking rates in the population. Several population-based measures, including price increases, mass media campaigns and legislation for smoke-free places, also appear to have contributed to the recent reduction in tobacco-related inequities. Overall, however, evaluation evidence on the equity impacts of tobacco control measures is still limited in comparison to the evidence base for other areas of tobacco control.

There is an urgent need to accelerate recent gains made in narrowing the equity gap in Victoria by complementing proven population-wide interventions with enhanced targeted approaches to assist and support disadvantaged smokers to quit and to denormalise smoking in disadvantaged groups. There is also a need for the wider social determinants of tobacco-related health inequities to be taken into account within the broader macroeconomic and social policy context.

Health equity is the notion that all people should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential if it can be avoided.

Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair.

The social determinants of health inequities are the social determinants of health – or the health-influencing social conditions in which people are born, grow, live, work, play and age – and the social processes that distribute these conditions unequally in society.



www.vichealth.vic.gov.au/fairfoundations

Using this document

This evidence summary is intended to provide policy makers and practitioners in Victoria and across Australia with practical, evidence-based guidance on reducing inequities in health caused by tobacco use. It is designed to be used alongside 'Fair Foundations: The VicHealth framework for health equity' www.vichealth.vic.gov.au/fairfoundations – a planning tool developed and published by VicHealth in 2013 to stimulate and guide action on the social determinants of health inequities.

Common underlying drivers and determinants of health inequities are outlined in the Fair Foundations framework. This evidence summary is one of eight that use the framework to examine a specific health issue and its determinants (mental wellbeing, healthy eating, physical activity, alcohol, and tobacco use), or specific opportunities for action (through social innovation, settings-based approaches, or a focus on early childhood intervention as an upstream solution to health inequities over the life course). In many cases, the key social determinants of health inequities (such as education or employment) are also discussed as settings for action (e.g. schools, workplaces) within each summary.

This summary focuses on tobacco control approaches that have successfully impacted on, or that have significant potential to address, health inequities if designed and targeted appropriately. It highlights best practice and priorities for action across all three layers of the Fair Foundations framework – Socioeconomic, political and cultural context; Daily living conditions; and Individual health-related factors – in order to support coordinated, multisectoral approaches.

What can be done to reduce tobacco-related health inequities?

Socioeconomic, political and cultural context

Governance

National and state governance systems determine the framework for policies, legislation, services and interventions in relation to tobacco use, the level of funding available for tobacco control and the extent to which various social groups in society are able to participate in decision-making processes. Strong governance frameworks underpin government efforts to limit the harm associated with tobacco use and to control tobacco-company activities. They also underpin efforts to implement international treaties such as the World Health Organization Framework Convention on Tobacco Control.

Australia's comprehensive and multifaceted approach to tobacco control is widely recognised to have led to significant reductions in tobacco use in the population. There has also been growing recognition among policy makers about the importance of reducing inequities associated with smoking across Australia, as reflected in the National Tobacco Strategy (2012–2018). However, explicit equity objectives need to be incorporated as a central goal of all relevant health promotion and tobacco control programs and policies.

Policy

A whole-of-government approach has been successfully developed over many decades to reduce tobacco use across Australia. This response involves a wide range of portfolios at the state and federal levels, including health, social services, treasury, finance, attorneys general, trade, consumer protection, industrial relations and education.

Key policies implemented in Australia include comprehensive regulation prohibiting the advertising, promotion and marketing of tobacco, smoke-free legislation, increasing the price of tobacco, mandatory health warnings on cigarette packaging and the world's first legislation to require plain packaging of cigarettes. Complementing these policy efforts have been sustained mass media campaigns and provision of a range of cessation-support services and research and evaluation.

Coherent cross-government policy action is also needed to tackle the key social determinants of health more generally, including poverty, insecure or poor-standard housing, education, child health, unemployment, low social capital and low-control work environments, in order to support efforts to reduce tobacco-related inequities.

Pricing policies

Increasing the price of tobacco is the most effective measure to reduce both tobacco use in the general population and socioeconomic disparities in smoking. There is strong evidence that increases in tobacco price have a beneficial effect on socioeconomic disparities in smoking, and are particularly effective at reducing tobacco use among young people and low-income smokers.

The Australian Government has committed to regular increases in the price of tobacco to reducing smoking prevalence. This measure is likely to have a significant impact in reducing smoking prevalence among people experiencing disadvantage. A tobacco tax increase of 25% in April 2010 substantially increased the price of tobacco – the first real-terms tobacco tax increase in Australia in a decade. Four tobacco excise increases (of 12.5% each year) are being implemented over 4 years, commencing 1 December 2013. This staged approach is likely to maximise quit attempts by price-sensitive smokers over time, while providing time for smokers to adjust their consumption and their household expenditure on tobacco and non-tobacco items.

It is true that for individual smokers who do not quit or cut down as a result of price rises, the economic burden of smoking increases. However, the evidence clearly shows that decreasing the affordability of tobacco is an effective intervention to reduce inequities in tobacco use. Because low-income smokers are more responsive to price increases than more advantaged smokers, their consumption of cigarettes will generally fall more sharply, and their relative financial burdens from smoking are more likely to be reduced.

There is a need to monitor carefully the impact of increases in tobacco prices on disadvantaged groups, in terms of both smoking behaviour and levels of financial stress, in order to identify and minimise any unintended consequences associated with this policy.

Smoke-free laws

There is evidence that smoke-free legislation can reduce consumption and increase quit attempts across all socioeconomic groups. The evidence of the impact of this legislation on smoking prevalence is less clear.

Implementation of smoke-free laws in Australia is widespread, covering indoor workplaces and public spaces and many outdoor public spaces. There is limited scope or rationale for extending these approaches further. However, smoke-free policies have been slow to be implemented in some settings – such as prisons, as well as drug and alcohol and mental health facilities. These settings should constitute the focus of future efforts.

There is mixed evidence about whether workplace-smoking bans have increased inequities by socioeconomic status or occupational class. This may reflect slower uptake of smoke-free policies among low socioeconomic or blue-collar workplaces, rather than a lack of effectiveness. There is need for further evaluation of the effectiveness of smoking bans in workplaces across the social gradient.

The introduction of smoke-free legislation in all Victorian prisons by July 2015 is expected to reduce inequities in smoking and exposure to second-hand smoke (SHS) relating to imprisonment. Prisoners and corrections staff will be able to access nicotine-replacement therapy (NRT) and other cessation-support services as part of the implementation. The experience of New Zealand in this regard is likely to be a promising model to inform Australia's approaches. Evaluation of the equity impacts of this legislation will provide valuable evidence.

Plain packaging and labelling

The introduction of plain packaging in Australia is expected to reduce the appeal of tobacco for young people, increase the effectiveness of health warnings about tobacco and challenge erroneous beliefs about the relative harms, or quality, of different brands. A comprehensive evaluation of the effectiveness of plain packaging is currently being completed. It will be essential that the evaluation include detailed analysis of the impact of this intervention across the social gradient. The impact of the larger health warnings implemented at the same time as plain packaging will provide additional data and should include analysis across all socioeconomic and educational groups.

Sale of tobacco to children

Sale of tobacco to children can be restricted through a combination of retailer and community education, legislation and its enforcement. Enforcement appears to be the critical factor influencing the effectiveness of the approach, at least among adolescents. There is insufficient evidence to determine the equity impact of this approach. More research in this area is needed.

Advertising and promotion restrictions

There is also insufficient evidence to determine the equity impact of legislation prohibiting the advertising, promotion and marketing of tobacco, although Australia's comprehensive ban on tobacco advertising is widely recognised to have made a significant contribution to reducing tobacco use across the population.

Electronic nicotine delivery systems

Rates of use of electronic nicotine delivery systems, or e-cigarettes, in Australia remain low at this time compared to those of some other countries. However, more research is urgently needed to establish the overall benefits and harms of e-cigarettes at both individual and population levels within a comprehensive tobacco control framework. There is also a need to identify their potential equity impacts.

Regulating the content and disclosure of ingredients of cigarettes

Regulation of the content and disclosure of cigarette ingredients, including the range of tobacco additives used to improve the flavour and aroma of cigarettes and mask the harshness of tobacco, is an emerging area of international tobacco control. More countries are regulating the use of these additives in order to reduce the attractiveness of cigarettes, particularly to young people. There is insufficient evidence to determine the equity impact of these approaches at this time.

Social and cultural norms and values

Social and cultural norms and values influence whether smoking is seen as socially acceptable, desirable or appropriate within various social and cultural groups. In Australia, the gradual erosion of social norms favouring smoking has resulted from the implementation of comprehensive tobacco control policies that have delivered reductions in smoking rates. Tobacco advertising and marketing is now almost eradicated, while restrictions on smoking in public places are widespread, and apply even in many outdoor settings. Smoking and the tobacco industry are commonly portrayed in the media in negative ways, and community attitudes to the tobacco industry have also become more negative.

Cultural influences about the depiction of smoking and the way in which smoking is addressed in news and entertainment media, in everyday conversation and on the internet are also likely to have acted synergistically with Australia's comprehensive tobacco control programs to reduce people's motivation to smoke and to have created an environment that supports non-smoking. The recent trends of low smoking prevalence among young people will be a key driver of reduced smoking prevalence among adults in the future, and will further contribute to the denormalisation of smoking.

However, targeted strategies are needed to shift entrenched social and cultural norms favouring smoking among specific population groups in which smoking rates remain persistently high, including Aboriginal communities, prison populations and clients of mental health facilities. These efforts need to be implemented within a framework that takes into account the social context of smoking, as well as barriers and challenges to quitting, and does not stigmatise smokers or increase existing inequities. Approaches that include a focus on families and social networks, that promote smoke-free role models, that encourage implementation of smoke-free homes and building, and that foster the capacity of Aboriginal leaders and communities in tobacco control are also likely to be most effective.

Daily living conditions

Early childhood

Early childhood is a critical period in human development, setting the foundation for future educational and employment opportunities, as well as long-term health outcomes. Child development and education also affect risk of mental health problems and criminality later in life, both of which are associated with higher risk of smoking.

Young children are at particular risk of exposure to SHS because of their immature respiratory, immune and nervous systems, as well as their lack of control over their exposure in various settings, such as the home and the car. Children exposed to SHS are more likely to experience illness that can degrade their learning opportunities at school and that, in the long term, may diminish their employment prospects. They are also more likely to become smokers later in life.

Tobacco-related risks begin during the prenatal period, with smoking in pregnancy a risk factor for many serious medical conditions for both the mother and child, including low birthweight, pre-term birth, placental complications and perinatal mortality. Smoking in pregnancy is also associated with an increased risk of a range of physical and behavioural problems in children that may continue into adulthood.

There is strong evidence demonstrating the effectiveness of smoking-cessation interventions in early pregnancy. These are best integrated with existing health services and as a routine component of antenatal care. Broader social and health programs, such as supporting breastfeeding and nutrition, supporting mothers and partners during pregnancy and during early childhood, and maternity-leave benefits can also have indirect effects on tobacco use.

Relapse prevention following childbirth is crucial, although there is little evidence available about effective interventions to reduce relapse rates. Identifying women at high risk of relapse, focusing on the health effects of SHS on the family, empowering the mother, partner and family members to quit and remain abstinent, and promoting smoke-free homes are promising interventions to prevent relapse.

There is very little evidence on effective interventions to reduce Aboriginal maternal smoking. Establishing this evidence base should be a priority. Interventions with Aboriginal and Torres Strait Islander women should consider the smoking behaviour of pregnant women, and of partners and social networks. This type of broader intervention could offer benefits during pregnancy, as well as begin to challenge existing social norms and community attitudes, and influence smoking rates in the broader community.

There is evidence that effective early childhood interventions can reduce inequities resulting from poverty, poor nutrition, and limited educational and development opportunities. The most disadvantaged and vulnerable children benefit most from these interventions because there is an opportunity to modify or reduce the multiple risk factors influencing their future life chances. While there is a lack of evidence for the effectiveness of interventions to tackle the social determinants of health inequities beginning in early childhood on future tobacco use and exposure, there is evidence that demonstrates their role in reducing overall inequity and disadvantage.

Education

Educational attainment itself is a well-established social determinant of health, affecting health through many mechanisms that influence neural development, health literacy and health behaviours, the sense of personal control and empowerment, and future employment opportunities and financial security. The prevalence of regular smoking (daily or weekly) is significantly higher among those with lower levels of education (who have completed up to year 12 or less) than among those with a tertiary education.

Various factors can improve educational outcomes, offer benefits in terms of future employment and help to reduce inequities. Such factors include the provision of high-quality primary and secondary education accessible to all children; the identification and removal of barriers to enrolment in school; the adoption of small class sizes, the employment of well-trained teachers and the administration of policies that seek to prevent children leaving school early.

There is limited evidence for the effectiveness of school-based tobacco control programs in reducing uptake of smoking. Strategies to improve effectiveness include making programs interactive, utilising a focus on social influences and networks, and sustaining the intervention over time. There is also evidence that comprehensive school-based programs focused on improving young people's emotional and behavioural wellbeing, as well as changing the school environment, can enhance educational outcomes and indirectly reduce health-risk behaviours such as smoking.

Employment and working conditions

Employment conditions have a direct impact on the financial security of workers and their families. Poor working conditions, such as inflexibility, lack of job security, shift work, and working overtime or multiple jobs, can result in increased stress, fatigue, conflict, poor job satisfaction and financial hardship, all of which can influence smoking rates and intensity of smoking, and act as barriers to quitting.

Unemployment is also associated with high levels of stress and high prevalence of smoking as a coping mechanism. Smoking is frequently viewed as a coping mechanism to help deal with life stressors such as financial pressures, boredom and living in unsafe environments. Long-term unemployment can compound the deficits of such stressors, resulting in social exclusion, low self-esteem and mental health problems. Moreover, long-term unemployment is associated with high prevalence of smoking.

The workplace is a setting where many adults spend a large proportion of their time. Workplace-smoking bans and health promotion programs therefore have the potential to reach a large number of people and provide opportunities for support and positive peer pressure to improve health. These measures can complement and reinforce community-based programs and health-system initiatives.

However, workplace health promotion programs have the potential to increase inequities because participation in these programs is generally higher among those who are younger, female, well-educated, non-smokers and those with a professional occupation. They are less likely to reach low earners and those who are intermittently employed. Overall, workplace programs that focus on a range of health behaviours and on working conditions – instead of focusing exclusively on smoking – are more effective at protecting and improving employee health and wellbeing than single-issue workplace interventions.

Physical environment

Physical environments can play an important role in encouraging or discouraging smoking, reinforcing high smoking prevalence, and undermining or supporting quit attempts. The design of urban environments, including the distribution and density of retail outlets selling tobacco, can have a particularly important influence on smoking behaviours. There is evidence to suggest that tobacco retail outlets are more concentrated in disadvantaged areas of Australia, and that this creates an environment favourable to price discounting.

At present, there are few controls on the number of outlets that can sell tobacco across Australia, and there is a lack of evidence about the likely effectiveness of control measures. Policy approaches to license tobacco retailers, to limit the number of tobacco retail licences granted and to reduce the geographic density of outlets in more disadvantaged suburbs and towns may offer promising means of reducing inequities in tobacco use. The impact of these policies across different social groups should be comprehensively evaluated.

Social participation

There is a lack of evidence on how interventions to promote social participation (including involvement in community activities, civic engagement, and participation in decision-making and implementation processes) impact on tobacco-related inequities. However, inclusive societies in which all groups feel valued and able to participate in social and economic life are vitally important to health equity.

Involving disadvantaged communities in the planning, delivery and evaluation of interventions is likely to enhance participation and ownership of tobacco control approaches. Tobacco control programs in Aboriginal communities, in particular, are likely to be most effective when they include a strong focus on community and elder participation. Effective approaches to promoting Indigenous health and connection to family, community and culture have included acknowledgement of community ownership and capacity building; deployment of well-trained and committed staff; fostering of effective partnerships; utilisation of existing community strengths and capacities; integration with traditional cultural approaches; support for young people and empowerment of women to undertake leadership roles.

Health care services

Cessation services delivered through health care and other settings complement other tobacco control efforts such as price increases, mass media campaigns and smoke-free legislation, and can greatly increase successful quitting. Telephone-support services such as Quitlines are an efficient means of delivering acceptable, accessible and evidence-based treatment to large numbers of smokers. They can reduce barriers to accessing services, including lack of transportation and of affordable or accessible childcare, geographical remoteness and financial disadvantage. Pharmacotherapies, such as NRT, are also effective in increasing quit rates, particularly when combined with support and brief interventions.

However, there is consistent evidence that mainstream smoking-cessation services – including Quitline, as well as online services, brief interventions from health professionals, and specialised services – produce higher quit rates among higher socioeconomic smokers, and are therefore likely to increase inequities in smoking. Smokers from low socioeconomic groups tend to have higher levels of dependency on nicotine, and smoke for longer before trying to quit. Disadvantaged smokers are less likely to use cessation services or pharmacotherapies to quit, and are also less likely to be able to quit without assistance. Therefore, additional cessation support may be particularly important for disadvantaged smokers and may play an important role in preventing relapse.

The strongest equity-focused evidence relates to cessation approaches for people with mental illness. Cessation interventions that are effective in the general population appear to be equally effective for people with severe mental illness. There is a comparative lack of evidence about the effectiveness of cessation interventions for other disadvantaged groups, including Aboriginal people, people who are homeless, and prisoners.

It is important to ensure that disadvantaged smokers can access affordable quitting medication and cessation services that meet their needs. Smoke-free policies and integration of cessation support into routine care in some health care services, such as mental health facilities and drug and alcohol services, are less advanced compared to other health care areas. This has been influenced by a range of factors, including high smoking rates among clients as well as staff and concerns that tackling smoking may have a negative impact on attendance, treatment or behaviour. Erroneous beliefs that people from disadvantaged groups are not interested in quitting or cannot quit have also been widespread and have often been promoted within these settings until quite recently. As a result, people with mental illness or substance-use problems are less likely to be asked whether they smoke and offered brief interventions and quitting support as part of routine care.

Strategies to increase uptake of pharmacotherapies and cessation-support services could include mass media advertising by pharmaceutical companies, encouraging smokers to use pharmacotherapies as part of brief cessation advice, and increasing referrals to Quitline and other cessation services. The provision of subsidised or free quitting medications is another important strategy to improve access to cessation support by disadvantaged groups. There may also be a need to promote the availability of subsidised NRT more widely to encourage greater uptake and correct use of NRT, streamline access arrangements and overcome barriers to accessing subsidised NRT.

Also likely to be beneficial are additional strategies designed to provide further encouragement and assistance to low-income and vulnerable populations to access support to quit smoking. These may include greater promotion of, and access to, subsidised NRT, additional quitting support (e.g. through Quitline, health services or social- and community-service organisations) and strategies to improve self-efficacy and confidence in quitting.

Interventions such as face-to-face counselling or quit support combined with NRT are likely to increase quit rates among Indigenous people. Training Aboriginal health workers to provide brief interventions, and include a broad community and family focus, are also likely to contribute to increased quit rates.

Another promising approach lies in the development of partnerships between health organisations and the social and community sector to build the capacity of social and community organisations to provide brief advice and cessation support to their clients. The non-government social- and community-service sector already provides a range of services to highly disadvantaged populations who have a high prevalence of smoking. Service providers in this sector are viewed by clients as a trusted source of advice. There is evidence that brief advice and cessation support from staff in these organisations to their clients can reduce smoking and that such services are acceptable to both the clients and the organisations.

Individual health-related factors

People receive information and advice about smoking from multiple sources, including government, the media, family, health professionals and friends. Access to sustained, credible and informed tobacco and health messages, and understanding of these messages, is critical to reducing smoking prevalence.

Mass media campaigns

'Mass media' refers to a range of media channels able to reach large numbers of people within a population. Such channels include television, radio, newspapers, magazines, outdoor advertising, point-of-sale advertising and digital media. Mass media campaigns are a central element of a comprehensive approach to tobacco control. They are very cost-effective because they can disseminate messages to large numbers of people at frequent intervals in an incidental manner, and at a low cost per head.

Numerous studies have demonstrated the effectiveness of mass media campaigns. They can reach and influence large numbers of smokers at all stages of the quitting process – from those who are not considering quitting, to those who are contemplating quitting or engaged in a quit attempt, to recent quitters and ex-smokers who are at high risk of relapse. There is also evidence that returns on investment exceed the costs of the campaigns.

Recent evidence, much of it from Australia, identifies approaches to increase the effectiveness of mass media campaigns with smokers from lower socioeconomic groups and, in turn, to reduce inequities in smoking. The effectiveness of mass media campaigns at reducing inequities in tobacco use appears to be dependent on whether a number of criteria are met – namely, sufficient population exposure, adequate intensity, format and emotional tone, adequate funding, appropriate campaign messaging and repetition.

In terms of population exposure, there is evidence of a threshold effect for effectiveness. Exposure to an average of at least 1200 Target Audience Ratings Points (TARPs)[1] per quarter is needed to result in measurable declines in smoking prevalence in youth and adults. Additional exposure to campaign messages in the range of 1800–2100 TARPs per quarter delivers even greater behavioural impact. Exposure to mass media campaigns at a TARP level lower than 1200 will increase recall of the message but will be unlikely to influence behaviour.

1 TARPs are also referred to as 'Gross Rating Points' (GRPs). TARPS are standard advertising industry measures of campaign reach and frequency. For example, 100 TARPS per quarter equates to, on average, 100% of those within a region exposed to one ad, or 50% exposed to two ads. 1000 TARPs per quarter equates to, on average, 100% of those in a region exposed to 10 ads, or 50% exposed to 20 ads and so on.

Campaign-message format and emotional tone also influence effectiveness. Highly emotive, negative health effects messages, using testimonials or graphic depictions, are the most effective at generating increased knowledge, beliefs and quitting attempts among low socioeconomic status (SES) smokers.

Among media channels, television remains the most effective at reaching smokers. While social media is increasingly being used as part of an overall campaign approach, some evidence suggests that it may increase inequities between lower and higher SES population groups, because lower SES groups do not engage with health messages to the same extent as higher SES groups.

Although significant evidence demonstrates the capacity of mass media campaigns to attract the general population and low SES groups, a mass-reach approach is not efficient for capturing other smaller vulnerable population groups such as the homeless, those with mental illness or those with substance-use problems. For these groups, it is likely that advice provided by health professionals or social- and community-service organisations may be more effective, in combination with exposure to mainstream campaign messages.

More evidence is needed to identify the effectiveness of mass media campaigns for Aboriginal smokers and the most appropriate balance between mainstream and targeted campaigns, as well as the mix of mass media and community-based interventions. Evidence suggests that exposure to mainstream campaign messages that contain strong graphic and emotive images and personal narratives about the health effects of smoking are likely to be effective and to motivate quit attempts among Aboriginal smokers. However, some qualitative research suggests that Aboriginal people prefer more culturally targeted messages with local community involvement.

Family and peer influences

The smoking status of parents and peers is a particularly important influence on the smoking behaviour of children and adolescents. Family and peer groups also have an important influence on supporting quit attempts by smokers. Recent declines in both youth and adult smoking, particularly among low socioeconomic smokers, are likely to have had beneficial effects in changing smoking norms, reducing uptake by young people and encouraging quit attempts.

Adolescence is a particularly critical period during which children are more vulnerable to influences that may encourage them to smoke or experiment with tobacco. The behaviour of their peer group is especially influential as young people are more likely to use tobacco if their peers also smoke. Young people who are socially isolated, have low self-confidence and lower levels of education are more likely than their more advantaged peers to become smokers and engage in other health risky behaviours. On the other hand, young people who report feeling a sense of control over their lives, are socially connected and have higher levels of education are less likely to become smokers.

Therefore, broad interventions to improve educational outcomes, promote resilience and enhance the emotional wellbeing of adolescents, and programs that encourage school connectedness, are likely to reduce inequities in smoking.

Actions across the life course

Interventions to reduce tobacco-related inequities must be implemented across the life span to be effective.

In the early years, priorities include interventions to support and encourage pregnant women and their partners to quit, and to prevent relapse for women who have quit smoking during pregnancy. Given the disparity in exposure to SHS across socioeconomic groups, interventions to increase smoke-free homes and cars among disadvantaged groups, including Aboriginal children, are also important. Action to promote equity in early childhood development more generally will also support tobacco control-specific approaches.

Regular tobacco price increases, mass media campaigns and enforcement of smoke-free laws are very effective in reducing both adolescent and adult smoking across all socioeconomic groups. One of the most influential factors on youth smoking is whether their parents smoke; therefore, efforts to encourage parents and other adults from disadvantaged groups to quit are also important in reducing smoking prevalence among young people.

Finally, increased access to quitting support and medication for disadvantaged groups, and enhanced efforts to denormalise smoking in disadvantaged communities, are also priorities for an equity approach.

Priority actions

Priorities for all actions seeking to address health inequities:

- Coordinate a blend of measures across all three layers of the Fair Foundations framework.
- Seek to address both inequities in health outcomes and the wider social determinants of these inequities.
- Incorporate explicit equity goals and objectives.
- Apply principles of proportionate universalism: interventions should be universal, but the level of support should be proportionate to need.
- Ensure that targeted supports do not stigmatise particular groups.
- Promote active and meaningful engagement of a wide range of stakeholders, and increase the diversity of representation and level of involvement at all stages of development and implementation.
- Conduct a thorough assessment of the needs, assets, preferences and priorities of target communities.
- Allocate adequate, dedicated capacity and resources to ensure sufficient intensity and sustainability.
- Monitor and evaluate differential impacts across a range of social indicators to ensure that they achieve their objectives without doing any harm, as well as to strengthen the evidence base for future interventions.
- Invest in equity-focused training and capacity building in both health and non-health sectors, from front-line staff to policy and program decision-makers.

Priorities for action within each layer of the Fair Foundations framework:

Socioeconomic, political and cultural context

- Continue comprehensive, population-level tobacco control approaches and implement additional targeted measures to ensure that policies work in all population groups.
- Encourage better integration and coherence between policy efforts to influence the broader social determinants of health inequities.
- Continue to implement regular tobacco price increases.
- Accompany tobacco price increases with strategies to ensure that NRT and smoking-cessation support are affordable and accessible to low-income groups.
- Implement comprehensive smoke-free policies in prisons, mental health and drug and alcohol services that also include access to free/subsidised NRT and cessation support both within the setting and when transitioning to the community.

Daily living conditions

- Implement targeted approaches to reach and support disadvantaged pregnant women and mothers to quit smoking and implement smoke-free homes and cars. Include a focus on involving and supporting partners and families.
- Address barriers to accessing high-quality cessation services for disadvantaged groups.
- Ensure that smoke-free policies are enforced in low-income workplaces and implement comprehensive smoke-free policies in settings such as prisons, drug and alcohol and mental health facilities.
- Strengthen investment in, and build capacity of, social- and community-service sector and Aboriginal organisations to implement tobacco control programs
- Implement school programs to promote resilience and encourage school connectedness and improve the emotional and behavioural wellbeing of young people, and reduce the risk of substance use.

Individual health-related factors

- Implement mass media campaigns at sufficient intensity and frequency to reach low socioeconomic groups (i.e. achieving at least **1200 Target Audience Ratings Points (TARPs) per quarter**). Use television as the main media channel and air highly emotional negative health effects messages to reach and motivate low SES smokers.
- Build community support and ownership among Aboriginal and disadvantaged communities to encourage smoke-free policies (e.g. at sporting and community events) and promote importance of smoke-free homes and involve communities in developing and implementing tobacco control strategies.
- Implement interventions to improve educational outcomes, build self-efficacy and confidence skills of disadvantaged adolescents, along with programs that encourage school connectedness and build resilience in adolescents.

Priority evidence gaps

- Disaggregated data on smoking prevalence and trends for disadvantaged population groups not adequately captured by existing survey methods and trend data.
- Monitoring the implementation of tobacco control policies to identify any negative, unintended impact for disadvantaged groups and identifying strategies to minimise these.
- Continued research on those who continue to smoke – why they continue to smoke and how best to support them to quit smoking.
- The most effective interventions to encourage and support Aboriginal women and their partners to quit smoking.
- The most effective interventions to prevent relapse among women and their partners who quit during pregnancy.
- Continued development of the evidence base around reaching Aboriginal and low SES smokers through mass media campaigns, and appropriate mix of mass media and community-based programs.
- More research is also needed on the impact and effectiveness of partnerships between health organisations and the social- and community-service sector to build the capacity of social and community organisations to provide brief advice and cessation support to their clients.

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