

# Smoking Prevention Strategy

2017 to 2020

Queensland is increasingly becoming smoke-free. The adult daily smoking rate has halved since 1998 and youth smoking is at its lowest recorded level.<sup>1</sup>

More than 4 million Queenslanders are non-smokers. Three-quarters of adults actively avoid places where they could be exposed to other people's smoke. Encouragingly, most current smokers are trying to quit or intend to do so.<sup>1</sup>

While there has been a substantial reduction in smoking rates over recent years, significant challenges remain. The number of people who smoke is still too high—in 2016 there were 450,000 adult daily smokers. Furthermore, some groups continue to have much higher smoking rates than for the whole population.<sup>1</sup>

For the improved health and wellbeing of all Queenslanders, the smoke-free cultural change needs to be strengthened and sustained.

## Smoking burden

Tobacco smoking is a leading cause of chronic diseases such as cardiovascular disease, chronic lung disease and many cancers. Two-thirds of deaths in current smokers can be directly attributed to smoking.<sup>1</sup> One-third of smokers die in middle age losing at least 20 years of life.<sup>1</sup> Exposure to second-hand smoke also causes diseases and premature death in children and adults who do not smoke.<sup>2</sup>

Smoking contributes to health inequality because it has such a profound effect on health and increases the risk of early death.<sup>1</sup>

Beyond the personal toll of smoking-related illness and premature death, smoking imposes a heavy financial burden on the Queensland community, estimated at \$6.3 billion per annum.<sup>1</sup> These costs include healthcare, lost production in the workplace due to absenteeism and premature death, and impact on household finances.<sup>1</sup>

## Opportunity

There are indisputable health, social and economic reasons to encourage young people not to start smoking, reduce exposure to second-hand smoke, and to help smokers to quit.<sup>2</sup>

Quitting smoking leads to a large and rapid fall in the risk of heart disease, stroke and vascular disease.<sup>3</sup> Quitting by the age of 30 years leads to a gain of almost 10 years in lost life expectancy.<sup>4</sup>

Two decades of comprehensive state and national action to reduce smoking rates has identified approaches that work (Figure 1).<sup>1</sup> These include, for example, legislation to restrict tobacco sales, smoking in public places and advertising; education and public media campaigns; cessation interventions and services; price increases; health warnings; and plain packaging.

Universal strategies to reach all smokers and potential smokers, and targeted strategies to help those who find it hardest to quit, work in tandem and provide for sustainable population-wide behaviour changes (Figure 1).

The Smoking Prevention Strategy is part of the [Health and Wellbeing Strategic Framework 2017 to 2026](#) which sets a prevention-focused pathway for:

- creating healthier places where people live, work, learn and play
- empowering people with the knowledge, positive attitudes, motivation and skills to live healthy lives.

## Smoking is not the same for everyone

The Queensland adult daily smoking rate was 12% in 2016 but significant disparities remain:

- smoking rates among people living in disadvantaged areas are about 3 times those of people living in advantaged areas in 2016: 17% (or 119,000 people) compared with 6% (or 47,000 people)
- male smoking rate is 13%, compared with 10% for females
- among Indigenous Queenslanders, smoking rates are 2.5 times higher than non-Indigenous
- workers in blue collar occupations (technicians and trade workers; community and personal service workers; machinery operators and drivers; and labourers) have smoking rates almost double those of white collar workers<sup>1</sup>
- 2 in 3 women who smoked during pregnancy were from disadvantaged areas
- smoking rates are higher for people experiencing unemployment (28%), sole parents (37%), and homelessness (77%)<sup>1</sup>
- smoking rates in regional and remote areas are higher, varying from about 30–40% higher than in major cities.

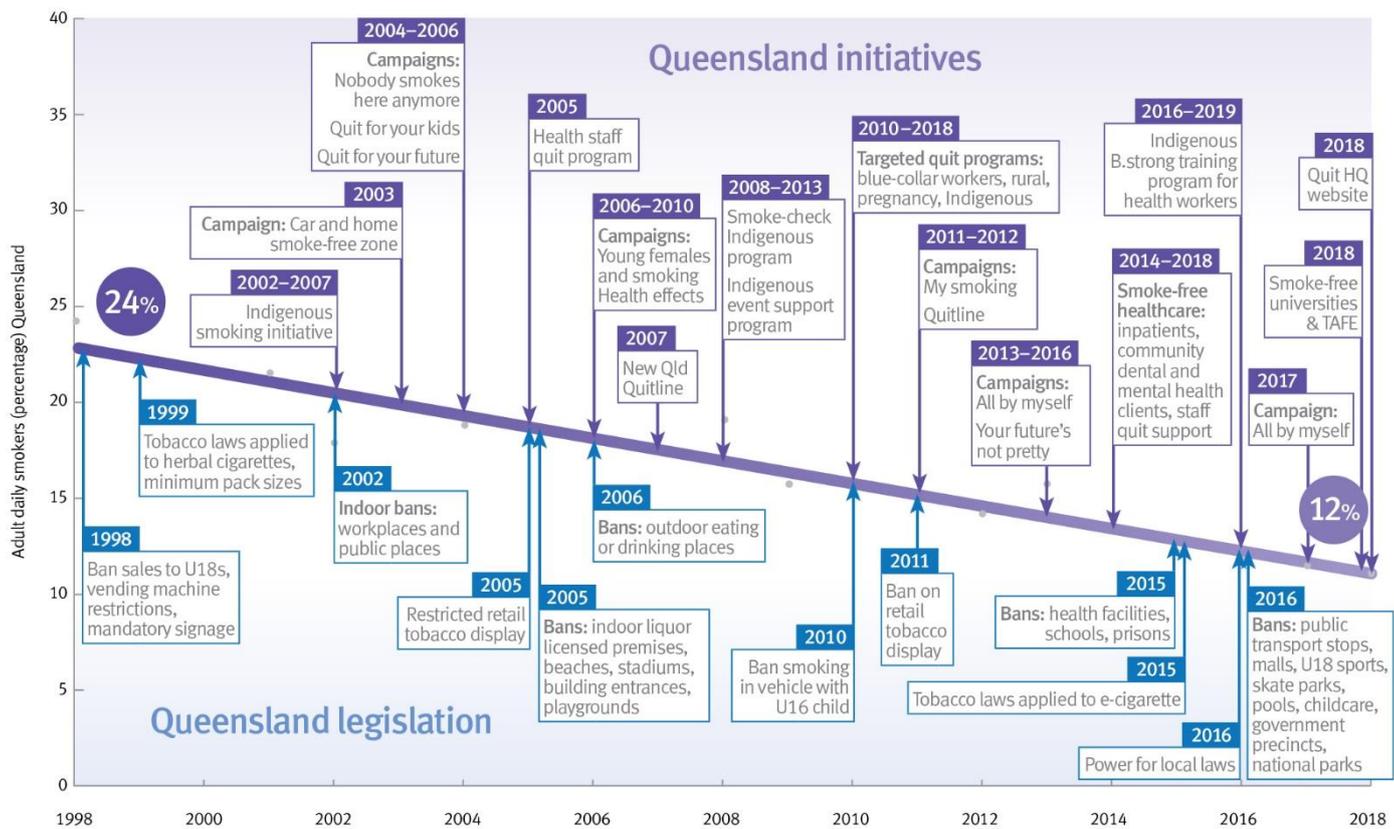
## Trend data

Latest trend data (Figure 1 and page 4) show that in Queensland the rate of adult daily smoking has decreased by 3.9% per annum since 2009. The strongest decline was for young adults aged 18–29 years.

Among secondary school students, those who reported that they smoked in the previous week has reduced from 24% in 1999 to 6% in 2014. This is a significant achievement towards preventing new generations of smokers.

The rate of smoking decline in disadvantaged areas is substantially less than advantaged areas, indicating the possible emergence of a socioeconomic gap. Over the past 12 years there has been no decrease in smoking rates for males in disadvantaged areas and only modest improvements for females in disadvantaged areas.<sup>1</sup>

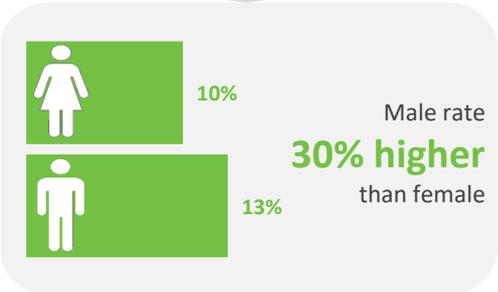
**Figure 1: Adult smoking prevalence in Queensland 1998 to 2018: legislation and initiatives**



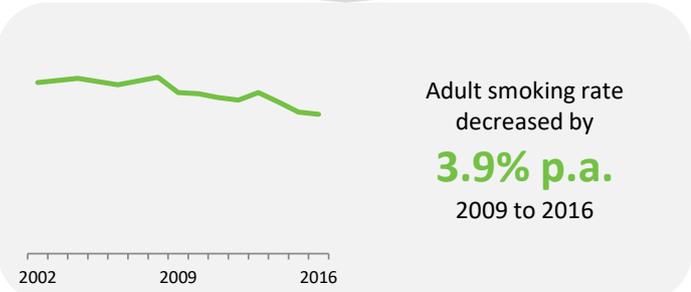
# Smokers in Queensland

**12%** of adults smoked daily in 2016 = **450,000 smokers**  
 250,000  200,000 

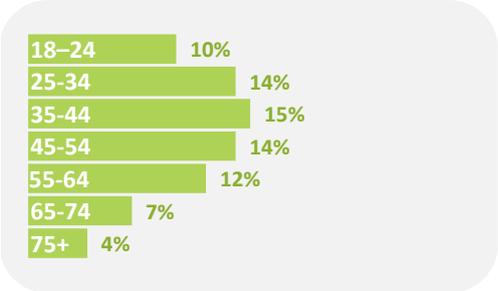
**prevalence 2016**



**trend**



**age**

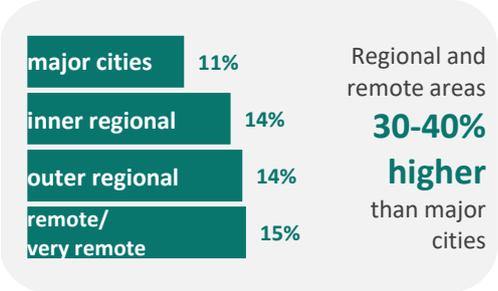


**Strongest decline was for young adults aged 18-29 yrs**

Smoking in the previous week **down** from 24% to **6%** among **secondary students** (1999 to 2014)

Age of **1st cigarette** up from 14 years to **16 years** over the past decade

**region**

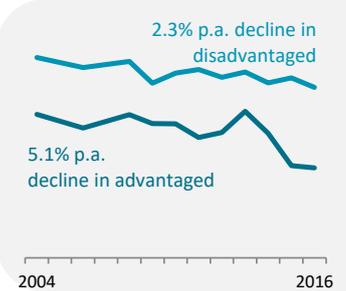
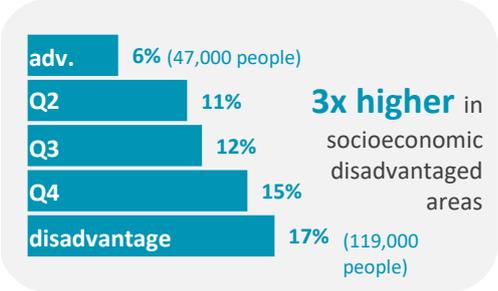


Compared to Queensland, the smoking rate was:

- 78% ↑** in South West
- 76% ↑** in Torres & Cape
- 61% ↑** in North West
- 36% ↑** in Central Queensland, Central West, Wide Bay
- 27% ↑** in Cairns & Hinterland, Townsville

Children in remote areas **30% more likely** to live with a smoker than their city counterparts

**socioeconomic status**



Smoking rate in **disadvantaged areas is declining more slowly** than advantaged areas—evidence of a widening SES gap

**Indigenous Queenslanders**

**2.5x** the smoking rate of non-Indigenous Queenslanders (49,000 people)  
**4x** the smoking rate during pregnancy as non-Indigenous women

**pregnant mothers**



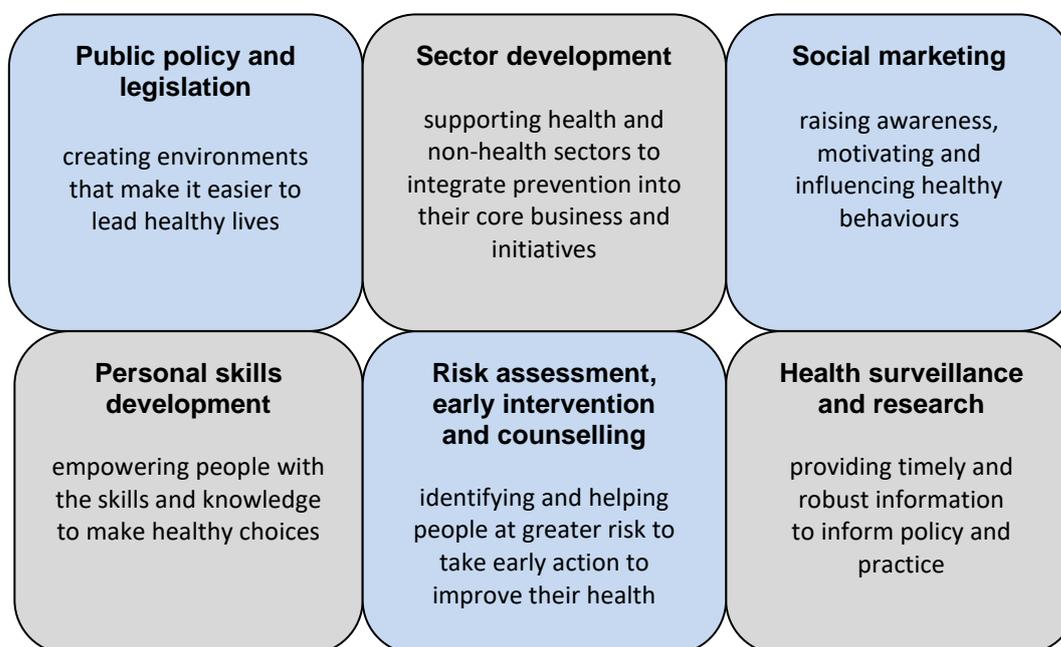
**13%** smoked at some time during pregnancy

**2 in 3** women who smoked during pregnancy were from disadvantaged areas

Teenagers were more than **2x** as likely to smoke during pregnancy compared to older women

## Our approach

A multi-strategy approach can significantly contribute to the achievement of smoking reduction objectives and targets. The six integrated strategies below are informed by evidence-based recommendations for influencing broad and sustainable health improvements.



## Shared commitment and partnerships

Actions to be implemented by Preventive Health Branch, Prevention Division, under this Strategy are part of a growing movement led by the health sector and increasing in the non-health sector to improve health and wellbeing. Examples of other agencies and sectors involved in smoking prevention include:

- Queensland Government departments and agencies, particularly Department of National Parks, Sport and Racing; Department of Transport and Main Roads; Department of Education and Training; Workplace Health and Safety Queensland; Department of Housing and Public Works; Department of Aboriginal and Torres Strait Islander Partnerships; and Public Service Commission
- Australian Government departments and agencies, particularly the Department of Health
- Local Government and the Local Government Association of Queensland
- Hospital and Health Services (HHSs)
- Aboriginal community-controlled health services
- Primary Health Networks
- health research networks
- non-government organisations
- academia, education and training sectors
- industry and businesses.

## Monitoring performance

A [Performance Measurement Strategy](#) has been developed to monitor and report on the outputs, impacts and outcomes of the *Health and Wellbeing Strategic Framework 2017 to 2026* and the Smoking Prevention Strategy.

A specific target to be achieved by 2020 has been set for smoking prevalence. This target of 157,000 fewer adult daily smokers is ambitious but essential for achieving improved health and wellbeing in Queensland.

The [Performance Report for 2016-17](#) assessed progress to date towards the 2020 targets, and shows the current trend is on track to achieve this target.

2020 Target		Numbers to reach 2020 Target*
Reduced daily smoking	10% adult smoking daily (2014:14%)	157,000 fewer adults smoking daily

*\* Than there would have been if no behaviour change had occurred since 2014 baseline.*

## Action Plan

Our actions are influenced by current evidence, best-practice, innovations and engagement, and are guided by the strategic priorities of [Our Future State: Advancing Queensland's Priorities](#).

A plan outlining universal and targeted actions for smoking reduction to be delivered under the multi-strategy approach have been developed for the period 1 July 2018 to 30 June 2020 (see over).

Preventive Health Branch, Prevention Division, is accountable for implementing the actions in these plans. This may be undertaken directly by the Branch, in partnership with others (including financial support), or procured from non-government organisations. The action plan will be updated every two years.

Strategic Communication Branch, Corporate Services Division, is accountable for developing and delivering social marketing activities which contribute to the multi-strategy approach and achievement of smoking reduction targets.

Continued effective delivery of initiatives, combined with ongoing investment and effort to create healthier environments and systems responsive to prevention will contribute to empowering Queenslanders to live healthier lives through improved lifestyles.

Sources:

1. Queensland Health. The health of Queenslanders 2016: report of the Chief Health Officer Queensland. Queensland Government: Brisbane; 2016.
2. Intergovernmental Committee on Drugs. *National Tobacco Strategy 2012-2018*, Australian Government: Canberra; 2012.
3. US Department of Health and Human Services. The health benefits of smoking cessation a report of the Surgeon General. DHHS publication no. (CDC) 90-8416. US DHHS: Rockville, Maryland; 1990.
4. World Health Organization. Tobacco free initiative (TFI): quitting tobacco. Available: <http://www.who.int/tobacco/quitting/en/>.

## SMOKING PREVENTION Action Plan 2018-19 and 2019-20

	Public policy and legislation	Sector development	Social marketing	Personal skills development	Risk assessment, early intervention and counselling	Health surveillance and research
<b>Universal actions that can reach people living in cities, and regional and remote areas</b>	<ol style="list-style-type: none"> <li>1. Develop a suite of legislative reform options informed by smoking reduction modelling and other evidence to: <ul style="list-style-type: none"> <li>- further reduce the acceptability and appeal of smoking products</li> <li>- increase smoke-free places</li> <li>- decrease accessibility of smoking products.</li> </ul> </li> <li>2. Implement the outcomes of the tobacco retail and wholesale licensing scheme for Queensland review including potential legislative options.</li> <li>3. Take policy and legislative action in response to emerging changes in smoking markets.</li> <li>4. Contribute to the development of national policy approaches for tobacco control, including the renewed National Tobacco Strategy.</li> </ol>	<ol style="list-style-type: none"> <li>6. Collaborate with the health sector to embed delivery of quit smoking interventions.</li> <li>7. Strengthen partnerships with HHSs, local governments and other relevant agencies to increase compliance activity, encourage local management and investment, and build capacity for tobacco legislation.</li> <li>8. Form a coalition with community and property industry sectors to develop novel solutions to empower community action on smoke-free living, including smoke-drift in multi-unit dwellings.</li> </ol>	<ol style="list-style-type: none"> <li>14. Collaborate with Strategic Communications Branch to support the development and delivery of marketing activities that provide clear and consistent messaging to promote quit smoking.</li> <li>15. Provide expert smoking reduction advice to Strategic Communications Branch to expand the impact of media and communication activities.</li> </ol>	<ol style="list-style-type: none"> <li>17. Collaborate with Strategic Communications Branch to build the knowledge and skills of Queenslanders to quit smoking and understand tobacco laws by encouraging engagement with the QuitHQ website.</li> </ol>	<ol style="list-style-type: none"> <li>19. Collaborate with and resource the Quitline service to provide statewide single-session quit smoking information and support.</li> </ol>	<ol style="list-style-type: none"> <li>21. Monitor prevalence, trends and impacts of smoking using: <ul style="list-style-type: none"> <li>- Queensland preventive health survey</li> <li>- hospitalisations</li> <li>- deaths</li> <li>- burden of disease.</li> </ul> </li> <li>22. Assess changes in prevalence of smoking by sociodemographic groups (sex, age, socioeconomic status, remoteness, and HHS) for adults and children.</li> <li>23. Identify and apply insights through monitoring and sharing updates on public health approaches, research and media related to smoking reduction.</li> <li>24. Assess the outputs and impacts of the Smoke-free Healthcare and use findings to inform future activity.</li> </ol>
<b>Targeted actions for groups with higher smoking rates and/or at high risk of harm</b>	<ol style="list-style-type: none"> <li>5. Maintain partnerships with Queensland-based Tackling Indigenous Smoking providers to: <ul style="list-style-type: none"> <li>- promote compliance of tobacco laws</li> <li>- support the development of local smoke-free policies</li> <li>- reduce secondhand smoke exposure at local community events</li> <li>- promote referral to Quitline.</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>9. Support HHSs to increase proportion of pregnant Aboriginal and Torres Strait Islander women to quit smoking.</li> <li>10. Engage midwives and shared care providers to encourage and support pregnant women and their partners to quit smoking.</li> <li>11. Incentivise HHSs to use clinical pathways for increased delivery of quit smoking support, commencing with patients booked for elective surgery.</li> <li>12. Strengthen partnerships with Department of Housing and Public Works, Corrective Services, and social service organisations to increase smoke-free places and promote quit smoking support for clients.</li> <li>13. Strengthen the capacity of local governments with a high proportion of Aboriginal and Torres Strait Islander peoples to increase smoke-free homes and places.</li> </ol>	<ol style="list-style-type: none"> <li>16. Collaborate with Strategic Communications Branch to target marketing and communication activities in groups with high smoking rates specifically pregnant women and partners.</li> </ol>	<ol style="list-style-type: none"> <li>18. Build the knowledge and skills of school students to make healthier lifestyle choices through supporting teaching and learning.</li> </ol>	<ol style="list-style-type: none"> <li>20. Collaborate with and resource the Quitline service to provide and promote statewide intensive quit support programs with a focus on: <ul style="list-style-type: none"> <li>- pregnant women and partners</li> <li>- Aboriginal and Torres Strait Islander peoples</li> <li>- people experiencing disadvantage</li> <li>- people living in regional, rural and remote areas</li> <li>- blue collar workers.</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>25. Explore options to engage adults of child bearing age to support quit smoking and adoption of healthy lifestyle behaviours for pre-conception and beyond.</li> <li>26. Explore and assess options for boosting access and retention rates of existing intensive quit support programs, including partnering with relevant organisations.</li> <li>27. Scope options for engaging and supporting hard-to-reach and unique population groups to quit smoking.</li> <li>28. Scope options for integrating current actions to boost the impact of smoking prevention.</li> </ol>