2015

Equity Focused Health Impact Assessment of the Quit Victoria Review 2012-2015

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Introduction

This Equity Focused Health Impact Assessment (EFHIA) will inform the 2015 Quit Review and will be considered by the Review Task Force. The Task Force will convene in late April, 2015 to conduct the review. Although health inequities in tobacco are addressed in explicit activities in the proposal for future funding, there is a need to clarify both the potential impacts of the equity activities, and also the unanticipated impacts of other activities laid out in the proposal.

As a funder of Quit Victoria, VicHealth contracted a team of equity experts and researchers from the Centre for Primary Health Care and Equity at UNSW Australia to conduct the EFHIA.

Screening and Scoping

The EHFIA is a rapid desk-based assessment, meaning that the scope of work only considered existing literature and did not involve engagement with stakeholders. This is due to the extremely tight timeline (less than 4 weeks) that the authors had to complete the review in time for the Task Force meeting.

Priority Activities to Review

The EFHIA considered the equity impacts of activities falling under the four main categories for future funding:

1. Population level social marketing
2. Policy and advocacy
3. Smoking cessation support services
4. Reducing tobacco related health inequities.

Although the proposal contains specific activities to address health inequities, it is likely that there are further considerations and unanticipated impacts on equity associated with the other activities. As well, there may be potential to enhance the activities specified to address equity.

Priority Populations

The EFHIA considered the potential impacts to vulnerable populations as identified by existing public health literature:

- People with low socioeconomic status
- Aboriginal and Torres Strait Islander peoples
- People with mental illness
- Prisoners
- People with drug and alcohol dependence

Data Sources

The EFHIA relied on existing literature, such as literature reviews prepared by VicHealth and Quit Victoria, to inform the assessment. The assessment was conducted by a panel of health equity experts at UNSW Australia to determine the potential impacts.

Research Questions for Assessment

The assessment sought to answer the following research questions:

- *What is the proposal trying to achieve?*
- *Is it likely to be successful? Is there evidence that it works?*
- *Is there any evidence of inequity?*
- *Who are likely to be the major beneficiaries of the proposal? Who are likely not to benefit from the proposal?*
- *Are there likely to be any unintended consequences?*
- *How could the proposal be improved to address equity?*

Definitions

The following definitions will be used in the EFHIA.

Health Impact Assessment (HIA)

HIA is a structured, step-wise process to identify and address the ways in which a proposal can promote and enhance health through assessing plans, projects, programs or policies before they are implemented and predicting the health impacts of these proposals. During an HIA, the severity and likelihood of health impacts are assessed as is the distribution of these impacts on population groups. The HIA process engages decision-makers to consider health impacts and develops recommendations to maximise positive health impacts and minimise negative health impacts.

Equity Focused Health Impact Assessment (EFHIA)

EFHIA is related to HIA and was developed in response to concerns that consideration of health equity is often limited within HIAs. The term was first used in the WHO *Jakarta Declaration on Leading Health Promotion* and subsequently in the WHO Bangkok Charter [1] but was operationalised with the development of the Equity Focused Health Impact Assessment Framework in 2004 [2, 3]. EFHIA focuses on improving the consideration of equity and differential impacts at each step of the HIA process.

Health Equity

The EFHIA uses Margaret Whitehead's widely accepted definition of health equity as a measure of having brought health differentials to the lowest level possible through the provision of:

- Equal access to available care for equal need,
- Equal utilisation for equal need
- Equal quality of care for all

In addition, the principle of equitable distribution of health outcomes – or reducing the differences in population health status and mortality rates will be used. Inequities are characterised as being systematic differences in access to services and resources for health that are seen as avoidable and unfair [4].

Brief Literature Review

Although rates of smoking have steadily declined in Victoria across the general population, falling as low as 14.4% in 2011, there are still marginalised groups within the population that have extremely high rates of smoking – as high as 84% [5]. This disparity reflects the fact that although sustained and innovative tobacco control programs have been effective at decreasing rates of smoking as a whole, there is a need for targeted approaches to address the requirements of vulnerable, high-risk populations. Table 1 shows the rates of tobacco use in some high-risk groups compared to the Australian general population.

Table 1: Estimates of smoking rates in different population groups in Australia

Group	% who smoke	Source
Australian general population	15.1 Males 16.4 Females 13.9	[6]
People in low socioeconomic groups	24.6	[6]
Unemployed people	27.6	[6]
People with a mental illness	32.4	17
Sole parents	36.9	[6]
Aboriginal and Torres Strait Islanders	47.7	[7]
People living with psychosis	66	[8]
Prisoners	84	[9]
People experiencing homelessness	77	[10]
Young people in custody	79	[11]
People with other substance use disorders	85	[12]

Note: the data derives from a range of different studies from different years. Different research methods have been used; therefore, meaningful comparisons cannot be made between the different groups.

Source: Australian National Preventive Health Agency (ANPHA), *Evidence Brief: Smoking and Disadvantage 2013 [13]*.

The summary below describes the prevalence of smoking and associated health and social effects in selected vulnerable populations. Many researchers and organisations, including Quit Victoria, have conducted extensive literature reviews to examine the impacts of various tobacco control policies, cessation support services, and targeted interventions for these populations. While some evidence does exist, there are still significant gaps in the evidence to determine the best approaches for each of these high-risk groups.

Low Socioeconomic Status (SES) Populations

There is a clear gradient in smoking rates according to SES in Victoria. In 2011 rates of smoking were lowest for high SES Victorians (11.1%), with general increases in mid-SES (15.6%), and highest in low SES groups (17.5%) [5]. Socioeconomic status and smoking are closely linked with experiencing disadvantage and increasing the risk of being a smoker [13, 14]. Smoking also leads to further disadvantage with increased morbidity, declining quality of life, and cutting short employment from

chronic disease and subsequent loss of income [14-17]. As smoking becomes less common in general populations it's also possible for there to be increased marginalisation and stigmatisation of smokers [13].

Smoking not only impacts low SES individuals but can also have subsequent effects on their families. Low SES smokers spend a higher percentage of their income on tobacco, leading to increased financial burden and decreased ability to pay for household items like food, clothing and accommodation [8, 14, 16, 18]. Children exposed to second-hand smoke in the home are also more likely to experience illness and to become smokers later in life [19].

Multiple disadvantage is also associated with a higher risk of smoking. People with less education, low income, or living in low SES areas are more likely to be smokers and are more likely to be exposed to second hand smoke [6, 13, 20]. One study found that every additional indicator of disadvantage (sole parent, living in high disadvantage area, unemployed, etc.) increased smoking by 5% for up to four indicators; by 10% for people with up to five indicators; and by an additional 15% for people with five to six indicators of disadvantage [8, 21]. People who live in disadvantaged areas are also more likely to be in environments where smoking is normal and to have limited access to quit support [22].

People with Mental Illness and People with Drug and Alcohol Dependence

Although there is evidence for separate associations between tobacco use and people with mental illness and people with drug and alcohol dependence, it is common that individuals will simultaneously fall into both these categories.

Rates of smoking for people with mental illness vary with studies showing high smoking rates in people living with psychosis (66%) [8], depression (57%), and bipolar disorder (66%) [23]. It was estimated in 2008 that 32% of 3.6 million people who identified as a smoker also had a 12-month mental disorder [24]. Tobacco use amongst people with substance use disorders vary from 68% to 90% [25, 26]. Research has found that people with schizophrenia [27] and people with severe drug and alcohol dependence [28] are more likely to die of tobacco related disease than the general population.

Smokers with mental illness and/or drug and alcohol dependence often face many barriers to quitting. Smoking is often used as a means of coping [29, 30] or self-medication [31, 32], and service centres are often environments where smoking is reinforced [15, 33].

Service providers often overlook smoking as a significant health issue in these populations. Smoking is often seen as the least of a client's concerns [17, 34] and it is often believed that people from these disadvantaged groups do not have a desire to quit [35]. There are also higher rates of smoking among staff, many of whom believe that asking clients to quit smoking will have a negative impact on attendance, treatment or behaviour [13, 20], despite evidence that it does not negatively affect the client [36]. People with mental illness or substance use disorders are less likely to be asked if they would like to quit or to be offered quitting support [13].

People experiencing Homelessness

Rates of smoking can be as high as 77% amongst homeless populations [10]. Similarly to people facing multiple disadvantages, smoking can serve as a coping mechanism to deal with stressful circumstances, financial pressure, living in unsafe environments, and as a means of enjoyment, recreation and to alleviate boredom [29, 37, 38]. While many homeless people do express a desire to quit, they face several significant barriers including the cost of nicotine replacement therapy (NRT), lack of organised counselling programs, low self-efficacy, unpredictability of their environment and routine, and the perception that smoking is socially acceptable by their peers and service providers [39, 40].

Aboriginal and Torres Strait Islander Populations

Despite falling rates of tobacco use in Aboriginal and Torres Strait Islander populations in recent years, smoking rates in these communities are more than double those in the rest of the population [41-43]. Nearly half of the Aboriginal and Torres Strait Islander population (47%) smokes daily [7]. Smoking is responsible for 20% of deaths in Aboriginal and Torres Strait Islander Australians [43-45] and over 50% of Aboriginal and Torres Strait Islander women smoked while pregnant [46].

Effective marketing campaigns, installed over years, have successfully begun to shift the social acceptability of smoking in mainstream culture. However, in many marginal communities, such as Aboriginal and Torres Strait Islander communities, smoking is still socially acceptable as it is linked to community interaction, and tied to social and family relationships [47, 48]. In communities where smoking is more socially acceptable and tobacco is widely used, it can be challenging for smokers to quit and remain abstinent [49].

Prisoners

As much as 84% of the prison population smokes [9]. Prisoners face many compounding tobacco-related indicators of disadvantage, such as also having a mental illness and/or drug and alcohol dependency, and are often Aboriginal, unemployed, and have low levels of education [9]. In one study over a third of all prisoners who smoked had not completed year 10 or above at school and 67% were unemployed at the time of entering prison [9]. In November 2013, the Victorian government announced that all Victorian prisons will be smoke free by July 2015 [50]. As part of this implementation, all prisoners and corrections staff will be able to access NRT and other cessation support services [50].

People in Rural and Remote Areas

People living in remote and very remote areas are twice as likely to have smoked daily in the previous 12 months as those in major cities (22% compared with 11%) [6]. Also, while smoking rates have steadily declined in metropolitan areas over the past fifteen years, there has not been a significant decline in smoking among people living in rural and regional areas. In fact, in rural and remote Australia, the average *number* of cigarettes smoked per smoker has actually increased [6].

Culturally and Linguistically Diverse Communities (CALD)

Rates of smoking among people who speak a language other than English at home are lower than the general population [6]. However, this is not consistent across all CALD communities and there are considerable differences in populations according to gender [51, 52]. Migration induces added stress that may hinder quitting and in some cases migrating to Australia has been associated with an uptake of smoking [20].

Health Equity Assessment

Tobacco use is more than just a health issue; it is a social issue. Disparities in the populations with high prevalence of smoking reflect not just differences in access to cessation services and support, they reflect the confluence of history, discrimination and disadvantage that have made them marginalised to begin with. While it is important to ensure that various populations have equal access to existing tobacco control policies and support services, it is even more important to understand that what is required to effect change in these populations is not always the same as what has worked for the majority of the population. To enact equity does not always mean approaches need to be equal.

The prevalence of smoking continues to be high in vulnerable populations because they have been marginalised from the avenues through which information about the health effects of smoking and quitting is disseminated, and from contributing to and receiving information that is cognitively salient to their group [53]. Likewise these groups are excluded from social settings in which smoking is no longer the norm. In fact for many of these vulnerable populations smoking is still a pervasive and culturally appropriate behaviour.

Many of the strategies to address tobacco-related disparities by Quit Victoria reflect a commitment to offering greater access to and reach of existing services to vulnerable populations. While this effort should be applauded, it is important to recognise that reach alone may not be sufficient to enact change. Existing interventions are not always appropriate for various high-risk groups, but to understand what is appropriate requires examination of each group's unique characteristics, values and norms. To effectively close the gap in smoking prevalence Quit Victoria may need to enact different, new and innovative strategies from what has been used to effect change for the majority population.

In order to determine which strategies are needed for each vulnerable population, Quit should examine the existing evidence base, and conduct new research to conceptualise which approaches are most effective. Funding to address tobacco related disparities will be most useful if approaches are based on evidence that is developed in partnership with high-risk communities and the health and community providers that service them.

A universal tobacco control strategy is absolutely critical to support any targeted interventions and should be continued as part of the Quit Victoria strategy. However, effective strategies to target vulnerable groups do not need to only occur as separate interventions from the universal approach. By working in partnership with vulnerable groups, it is possible to determine which strategies are effective for minority groups as well as the majority; which strategies can be adapted to better suit the needs of high-risk groups; and which new approaches are needed for vulnerable populations.

Implementation of such strategies is not easy. For policy makers, funders, and practitioners there are always tensions between the implementation of proven, effective and efficient population-wide public health initiatives and the need for focused interventions for smaller, high-risk groups based on much less certain evidence, needing longer time frames, and relatively higher levels of funding[1]. The

[1] REAIM is one strategy that can be used to determine equity considerations in project implementation.

persistence of inequities in the prevalence of smoking among low socioeconomic groups, Aboriginal communities, and vulnerable groups suggests that when resources are limited, priority is almost always given to actions to influence the majority of people in a population. This prioritisation of needs of the majority has helped to perpetuate the increasing gap in tobacco use between majority and vulnerable populations. In order to begin to address this disparity, program developers will need to shift funding strategies to continue universal platforms while increasing support for the needs of disadvantage groups.

Creating change in tobacco use in high-risk populations will require similar levels of time and funding as has taken to effect change in the majority. Current approaches that use short-term interventions targeted at select groups may create change, but it will only be at the same marginal rate that has been seen previously. It is only through sustained engagement, high levels of funding, and using innovative and population-appropriate strategies that high decreases in smoking prevalence can be expected.

The following section examines the anticipated equity impacts of the four proposed funding activities by Quit Victoria:

- population level social marketing;
- policy and advocacy;
- smoking cessation support services; and
- reducing tobacco related health inequities.

Each section offers recommendations to augment existing strategies to better address equity. The authors assume that all four components of the proposal will proceed. It is important to note that the recommendations only reflect what is being proposed by Quit Victoria, and that there may be additional approaches needed to address equity that have not been brought forward in the proposal.

54. Glasgow, R.E., T.M. Vogt, and S.M. Boles, *Evaluating the public health impact of health promotion interventions: the RE-AIM framework.* American journal of public health, 1999. **89**(9): p. 1322-1327.

Population level social marketing

	People who are homeless	People with a mental illness	People with alcohol or drug dependency	People from low socioeconomic groups	Aboriginal and Torres Strait Islander Peoples	People who don't have access to internet and digital technology
Vulnerable populations who will be **MOST** positively impacted by this initiative				✓		
Vulnerable populations who will be **LEAST** positively impacted by this initiative	✓					✓

What is the initiative trying to do?

To enable mass media campaigns to be continued as one of the core components of the four-part proposal presented by Quit Victoria in order to expose Victorian smokers and recent quitters to mass (and targeted) media campaigns of sufficient reach, intensity, duration and relevant message type to achieve optimal effect.

With the recommended level of investment the initiative will drive calls to Quitline and traffic to quit.org.au and ensure that these platforms continue to serve as a source of comprehensive content for quitters. With optimum funding the initiative will aim to increase calls and traffic to Quit Victoria platforms particularly from low SES groups.

Is there evidence that the initiative is likely to work?

Quit, in its proposal, has provided strong evidence of the effectiveness of social marketing campaigns when they are delivered with sufficient reach, intensity, duration, and deliver messages that have been developed explicitly with and for diverse target groups [55]. Quit has also identified the optimal levels of campaign intensity required to achieve positive outcomes among the majority of adult and adolescent smokers, and among low SES groups, and has demonstrated its capacity to reach each of these groups with information that has resulted in reduced uptake, reduced prevalence, and greater maintenance of former-smoker status [55].

The effectiveness of the mass media campaigns is determined by the cognitive salience of the messages to their intended audiences, and to the level of exposure – reach, intensity, and duration –

of campaigns. It would be expected that the majority of Victorian smokers will be exposed to evidence-based, multi-channel social marketing campaigns if the recommended level of funding is invested, and will be exposed to more diverse and longer-running campaigns with optimum investment.

Is there evidence of inequity?

Inequity in the uptake, prevalence, and maintenance of quitting will persist if the level of funding invested in social marketing campaigns is limited to the recommended level only. It is probable that the more limited reach, intensity and duration will have a negligible impact on the high prevalence population groups. Existing successes in achieving greater reductions in smoking among people of low SES are likely to be halted, and it is possible that the prevalence in smoking will increase disproportionately among people of low SES if optimum funding is not provided [41, 55].

There is limited evidence of the effectiveness of social marketing campaigns (as they have been designed and delivered to date) as a strategy to contribute to reducing the prevalence of smoking among social groups that comprise relatively small proportions of the population, that are not usually represented visually in mass media campaigns, and in which smoking continues to be a strong social norm [56]. Quit and its research partners have recognised the need to identify steps that will reverse this situation through research, tailored cessation measures, and working in partnership with organisations that are working directly with the marginalised groups. However, it may be that more is needed to address the specific needs of these groups beyond what has been done in the past or what is currently being implemented.

Specific attention will be needed to ensure that the evidence base and perspectives of high-risk groups, and the health providers and community organisations that service them, are incorporated into the design and delivery of social marketing campaigns that are geared towards these populations [56].

Who are likely to benefit most?

The population level mass media campaigns (MMCs) will benefit the majority of Victorian smokers and recent quitters if the optimum level of TARP is achieved for maximum (or at least recommended minimum) duration, and if the support activities (digital presence, public relations, etc.) are sustained.

Smokers who have access to and are familiar with using the internet and computers will be expected to benefit more than groups that are less familiar with the internet and whose access to personal computers is more limited. This gap may close as the role of Smart phones as a delivery device for information sharing and for shaping social norms within smaller social networks is explored and expanded.

Who are likely not to be reached or benefit?

Members of the vulnerable social groups that have been marginalised from exposure to the sources of information about smoking and its health effects, that have not been included in developing the cognitively salient messages for their group or in the delivery of the messages, and that have not

been supported to take actions to change social norms around smoking within their own social groups will benefit the least from MMCs.

There is little evidence of the role and effectiveness of multichannel anti-smoking social marketing campaigns in contributing to the reduction in smoking prevalence in Aboriginal communities, and even less evidence of its effectiveness in other vulnerable groups. It is possible that changes in media use and the potential of Smart phones as a means by which to inform and engage with vulnerable groups will change the effectiveness of MMCs in these populations.

Likewise, it is possible that as Quit shifts its marketing strategies from TV and radio to internet-based applications, that some members of low SES groups will be missed. There is evidence to suggest that television campaigns are most likely to reach low SES populations [57]. As well, populations with limited access to internet, including rural and remote communities in addition to low SES groups, will continue to rely on TV and radio even as Quit shifts the marketing focus to online forums. Without sustained TV and radio marketing in addition emerging content forms it is possible that low SES, rural and remote populations will not be sufficiently reached.

Recommendations

1. Quit should ensure that the funding for the evidence-based multichannel antismoking social marketing campaigns be at the optimum investment level in order to sustain and expand upon the results achieved already in reaching and supporting people with low socioeconomic status to quit and maintain their former-smoker status.

2. Quit should investigate the values and characteristics of Aboriginal and vulnerable communities and assess whether there are opportunities for more overt inclusion within current, population-wide multichannel campaigns (or whether separate, targeted campaigns delivered via other channels are necessary).

3. Quit should give priority in this next funding round to investigating the factors that have prevented marginalised social groups from quitting at rates similar to the population as a whole in order to understand the reasons why these groups haven't benefited equally from social marketing and mass media campaigns in the past.

4. With the potential for social marketing to reach a wide audience, including marginalised populations, it is important that Quit consider enacting campaigns that target vulnerable populations, both in terms of imagery and relevant social norms. It is unclear whether the goal of the proposed social marketing campaign is to drive smokers to cessation programs such as Quitline and quit.org.au, to change the social norms about smoking, or a combination of both. It is important for Quit to consider that the social marketing goals that may be necessary and appropriate for the population as a whole may not equally suit the needs of vulnerable populations.

Policy and Advocacy

	People who are homeless	People with a mental illness	People with alcohol or drug dependency	People from low socioeconomic groups	Aboriginal and Torres Strait Islander Peoples	Low SES smokers who spend more of their household income on tobacco
Vulnerable populations who will be MOST positively impacted by this initiative	✓	✓	✓	✓	✓	
Vulnerable populations who will be LEAST positively impacted by this initiative						✓

What is the initiative trying to achieve?

To continue policy research, development and advocacy as one of the core components of the four-part proposal presented by Quit Victoria in order to explore, develop and advocate for regulatory interventions relating to tobacco control and disseminate this information to relevant stakeholders and Government.

With the recommended level of investment Quit will drive legislative reform to further reduce smoking prevalence in Victoria and the health disparities caused by smoking. With optimum funding the initiative will also generate data on a variety of supply-side issues such as an understanding of price manipulation in low SES areas.

Is there evidence that the initiative is likely to work?

There is strong evidence to indicate that population-wide policies such as tax increases and smokefree environments are effective at reducing smoking prevalence. These policies have helped to decrease the social acceptability of smoking [58], create supportive environments for those trying to Quit, and reduce the uptake and experimentation of smoking among adolescents across socio-economic groups [59]. Likewise, international standards, such as the WHO Framework Convention on Tobacco Control (FCTC) call for public policies such as regulation of tobacco pricing and availability, oversight of tobacco marketing and protection from exposure to tobacco smoke [60].

Is there evidence of inequity?

Public policies that regulate the price, availability, marketing and exposure to tobacco products are effective in decreasing population-wide smoking prevalence, as has been seen in Australia throughout the past decade [61]. Some population-wide policies have been shown to have a greater effect in reducing smoking in low socioeconomic groups such as price increases, smokefree policies, and mass media campaigns [62-65].

Policies that increase the cost of tobacco are likely to affect low SES groups the most [66]. While it is important to generate policies that are effective at targeting this group due to the higher rates of smoking, it is also important to consider the potential financial impacts of price increases to low SES families. Low SES smokers spend significantly more money on tobacco than in other SES quintiles [67]. While price increases do stimulate reduced tobacco consumption in low SES groups, it is possible that smokers will prioritise smoking over other family needs [16]. While this alone should not discourage these types of policies, it is important to simultaneously provide and promote free cessation services, NRT, and other support for these populations in order to offset the increased financial burden.

Who are likely to benefit most?

While all populations are likely to benefit from tobacco control policies and advocacy, there is evidence that some policies will benefit low SES groups the most. Due to the limitations in survey sampling for other vulnerable populations, it is unclear to what extent tobacco control policies also benefit these groups.

Who are likely not to be reached or benefit?

As all populations are likely to be reached through tobacco control policies, it is unlikely that any one group will be differentially reached. However, it is possible that policies have differential effects on various groups, such as price increases on low SES populations. Without close monitoring of smoking prevalence and evaluation of public policies it is not currently possible to determine to what extent these policies impact on vulnerable populations.

Recommendations

1. In addition to developing and advocating for policies that alter the environment in which tobacco products are accessed, marketed, and used, Quit should also support the development of public policies that reduce poverty, provide access to education, support families, and maintain opportunities to employment as these reduce the social conditions that are associated with higher rates of tobacco use and dependence. Particularly as Quit develops end game strategies, it will be important to examine policies and interventions that support vulnerable populations.
2. In order to determine the impacts of tobacco control policies on marginalised populations, there is a need for better monitoring of smoking prevalence in these populations, and also evaluation of smoking policies and interventions. Current survey sampling does not enable monitoring of data for priority populations. Quit should explore the use of different survey methods or implementation of new surveys specifically targeted at vulnerable groups.

3. Quit should conduct an analysis of existing policies and evidence review for future policies to determine which will be most effective at addressing the needs of vulnerable populations and narrowing the equity gap.

Smoking Cessation Support Services

	People who are homeless	People with a mental illness	People with alcohol or drug dependency	People from low socioeconomic groups	Aboriginal and Torres Strait Islander Peoples	People with limited access to internet and phone
Populations who will be **MOST** positively impacted by this initiative	✓	✓	✓	✓	✓	
Populations who will be **LEAST** positively impacted by this initiative						✓

What is the initiative trying to achieve?

To enable smoking cessation support services as one of the core components of the four-part proposal presented by Quit Victoria in order to deliver effective, population-wide cessation supports through Quitline.

With the recommended level of investment the initiative will ensure cessation support tools are readily available to all Victorians by telephone and online from desktops and laptops but not mobile devices. With optimum investment cessation tools will be made available on all platforms and adaptable to the needs of priority populations.

Is there evidence that the initiative is likely to work?

Previous evaluations of Quitline have found the program to be effective in supporting smokers to quit. In evaluations from 2011 and 2014 approximately 40% of Quitline users were not smoking at six months [68]. Clients from low SES and priority groups represented 23% of all callers in 2014 compared to 20.5% in 2011, indicating a proportional increase in callers from vulnerable populations. There was no reporting of differential quit results for these priority groups in the evaluation.

The overall number of users of Quitline has fallen as have calls from low socio-economic groups and people with mental illness [69]. According to Quit this is thought to be related to the disinvestment by government in mass media campaigns and highlights the importance of maximum levels of social marketing required to bring about and sustain change. However, there has not been a formal evaluation to determine the precise cause for the decline in calls.

Is there evidence of inequity?

Quit has invested in broad social marketing and tailored interventions to ensure that its cessation programs can be reached by both broad and disadvantaged populations. There is evidence of a strong correlation between social marketing campaigns and smoking prevalence in low SES groups [70] particularly from TV advertising [71]. However, it is possible that as Quit shifts its marketing strategies to focus on internet-based advertising, low SES and other vulnerable populations will not be reached, potentially decreasing the use of Quitline for these groups. Likewise, internet-based marketing and cessation support has the potential to exclude populations with limited internet access, such as people experiencing homelessness and people who live in rural and remote areas, as well as people who don't speak English.

Who are likely to benefit most?

People who are most likely to benefit are those who have easy access to technology, such as phones and internet, and who are comfortable with technology use. Vulnerable populations with targeted cessation programs will also benefit more than others.

Who are likely not to be reached or benefit?

Populations with limited phone and internet access will potentially have less benefit from cessation programs such as Quitline. As well it is possible that the recent decline in calls to Quitline from low SES groups and people with mental illness is due to more than just a decline in social marketing. For example, the current Quitline program only includes tailored elements for people with mental health conditions and Aboriginal smokers [72]. Without evidence as to the best cessation support strategies for each vulnerable population it is possible that not all groups will benefit equally from Quitline.

Recommendations

1. Quit should continue to provide strong universal platforms such as the Quitline supplemented by targeted programs for priority groups. Additionally Quit should consider the integration of proportionate services for vulnerable populations (i.e. more follow up calls for high-risk groups).
2. Quit should review the relevance of Quitline for vulnerable populations with the potential to create modified support services for individual high-risk groups. This should occur in tandem with current and future programs that are designed to create access to cessation programs for vulnerable groups. For example, in addition to developing shorter calls for people who have limited phone time, such as prisoners, Quit should explore the development of tailored cessation counselling that is relevant to the prison context.
3. Quit should evaluate the use and effectiveness of Quitline and other cessation programs by vulnerable groups with the intention of understanding barriers to cessation in these populations.
4. Quit should adjust investment in social marketing to ensure that sufficient TV and radio advertising is created to reach low SES, rural and remote populations.
5. Quit should explore use of other cessation support strategies that are evidence-informed but are more adapted to fit the needs of priority groups.

Reducing Tobacco Related Health Inequities

	People who are homeless	People with a mental illness	People with alcohol or drug dependency	People from low socioeconomic groups	Aboriginal and Torres Strait Islander Peoples	Other vulnerable populations*
Vulnerable populations who will be **MOST** positively impacted by this initiative	✓	✓	✓	✓	✓	✓
Vulnerable populations who will be **LEAST** positively impacted by this initiative						

*Other disadvantaged populations where smoking prevalence is high (for example prisoners, single mothers, etc.).

What is the initiative trying to achieve?

To continue to advocate for sectoral change in order to reduce tobacco related health inequities as one of the core components of the four-part proposal presented by Quit Victoria.

With the recommended level of funding Quit seeks to reduce disparities in the Aboriginal and one other vulnerable population through organisation-led improvements in one or two sectors. With optimum investment, Quit aims to more rapidly reduce disparities in Aboriginal and other vulnerable populations through a systems approach that supports these communities through engagement with community, social and health services.

Is there evidence that the initiative is likely to work?

There is evidence that systems-based approaches to promote health are effective when provided with high levels of funding over long periods of time [73]. However, there is limited evidence to the efficacy of systems approaches at addressing equity.

Is there evidence of inequity?

Prior work conducted by the authors has found that systems approaches without specific measurement and inclusion of relevant data to identify inequalities; without explicit governance methods and processes to decide on when these are inequitable and which are priorities for action;

without explicit preparation by and capacity in the prevention system; without explicit implementation methods and resources; and without appropriate evaluation and reporting, have the potential to reproduce the conditions that have resulted in inequities in health [74].

Likewise, if only the recommended investment level is provided for this initiative, it is likely that minimal tobacco reduction will only be achieved in the Aboriginal and one other vulnerable community. Without targeted approaches to address inequities in all marginalised groups, it is likely that tobacco related disparities will be perpetuated in these populations.

Who are likely to benefit most?

If only recommended investment is provided then the Aboriginal and one selected priority population will benefit more than other marginal populations who are not targeted in the approach.

Who are likely not to be reached or benefit?

Even with optimum funding there is the potential that only one vulnerable population will be targeted. If systems approaches are only targeted at Aboriginal communities and selected populations then it is possible that other marginalised populations will not benefit as greatly. Additionally, systems-based approaches require high levels of funding over long periods of time. In order to ensure that the systems approach is effective at addressing inequities in the selected populations Quit will need to secure sustained funding even in the absence of high decreases in smoking prevalence, particularly at the start of the initiative.

Recommendations

1. At least optimum investment should be committed to this initiative to stimulate innovative approaches to address tobacco related health inequities for all vulnerable populations. The limited activities associated with the recommended investment level are likely to only drive change in the Aboriginal and one selected vulnerable population. Likewise, replication and continuation of existing approaches to address health inequities are likely to only produce similarly marginal decreases in smoking rates in vulnerable populations as have been seen in past years.
2. Quit should integrate equity into logic models, building blocks and evaluation frameworks for the systems-based approach to address smoking related health inequities. Systems-based approaches have the potential to impact the social determinants of smoking and create wide-reaching sectoral support and organisational change. However, if equity is not appropriately integrated into the design and implementation of the approach, then it is possible, as is evidenced by the HTV EFHIA [74], that health disparities can be perpetuated.
3. Even with optimum funding it is not clear to what extent Quit plans to achieve systems change for more than the Aboriginal and one selected vulnerable population. It is recommended that Quit incrementally develop a multi-stage systems-based approach to eventually address health inequities in *all* vulnerable populations.

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