UNIVERSITY OF OXFORD

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When there is not enough evidence, and when evidence is not enough:
An analysis of policy-making to reduce the prevalence of Australian Indigenous smoking

Thesis submitted in partial fulfilment of the requirements for the Degree of Doctor of Philosophy.

by

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Abstract

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Background: Evidence-based policy making (EBPM) has become an article of faith. While critiques have begun to emerge, they are predominately based on theory or opinion. This thesis uses the 2008 case study of tobacco control policy making for Indigenous Australians to analyse empirically the concept of EBPM.

Research questions: (1) How, if at all, did the Government use evidence in Indigenous tobacco control policy making? (2) What were the facilitators of and barriers to the use of evidence? (3) Does the case study augment or challenge the apparent inviolability of EBPM?

Methods: Data were collected through: (1) a review of primary documents largely obtained under the *Freedom of Information Act 1982*; and (2) interviews with senior politicians, senior bureaucrats, government advisors, Indigenous health advocates and academics.

Results: Historically, Indigenous smoking was not problematised because Indigenous people faced other urgent health/social problems and smoking was considered a coping mechanism. High prevalence data acquired salience in 2007/08 in the context of a campaign to reduce disparities between Indigenous and non-Indigenous health outcomes. Ensuing policy proposals were based on recommendations from literature reviews, but evidence contained in those reviews was weak; notwithstanding this, the proposals were adopted. Historical experiences led policy makers to give special weight to proposals supported by Indigenous stakeholders. Moreover, the perceived urgency of the problem was cited to justify a trial-and-evaluate approach.

Conclusion: While the policies were not based on quality evidence, their formulation/adoption was neither irrational nor reckless. Rather, the process was a justifiable response to a pressing problem affecting a population for which barriers existed to data collection, and historical experiences meant that evidence was not the only determinant of policy success. The thesis proposes a more nuanced approach to conceptualising EBPM wherein evidence is neither a *necessary* nor a *sufficient* condition for policy. The approach recognises that rigorous evidence is always desirable but that, where circumstances affect the ability of such research being conducted, consideration must be given to acting on the basis of other knowledge (e.g. expert opinion, small-scale studies). Such an approach is justifiable where: (1) inaction is likely to lead to new/continued harm; and (2) there is little/no prospect of the intervention causing additional harm. Under this approach, non-evidentiary considerations (e.g. community acceptability) must be taken into account.

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Empirical research is nothing without data. Were it not for the generous participation of the respondents in this project, there would be few pages following on from this one.

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Abbreviations

ABS	Australian Bureau of Statistics
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AU$	Australian Dollars
CEITC	Centre for Excellence in Indigenous Tobacco Control
CO	Carbon monoxide
CI	Confidence Interval
DALY	Disability Adjusted Life Year
DoHA	Department of Health and Ageing
EBM	Evidence-based medicine
EBPM	Evidence-based policy making
FoI	Freedom of Information
IBSS	International Bibliography of the Social Sciences
IHW	Indigenous Health Worker
ITCI	Indigenous Tobacco Control Initiative
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NGO	Non-government organisation
NRT	Nicotine Replacement Therapy
NTER	Northern Territory Emergency Response
QL	Quitline
RR	Rate ratio
TARP	Target Audience Rating Points
TISM	Tackling Indigenous Smoking Measure
TVC	Television commercial

1. Introduction

"Science ... dies of dogma" (Susser 1995).

'Evidence-based policy' has become a synonym for 'good policy', prompting Marston and Watts (2003) to remark that "[i]t is difficult to imagine anyone arguing that policy should be based on anything but the best available evidence." Similarly, a former Secretary of Australia's Department of Prime Minister and Cabinet described the present era as one in which "all sides of politics genuflect before the altar of 'evidence-based' policy" (Shergold 2011). In the popular imagination, to be 'evidence-based' is to be objective, legitimate and reasonable. Conversely, to act without or against the evidence is perceived to be irrational and reckless. Used as both a shield and a sword in political debates, evidence-based policy is now "a slogan whose rhetorical effect is to discredit opposition" (Hammersley 2001). Presenting the evidence is a way of deflecting criticism and defending one's choices; exposing the absence of evidence is a way of undermining credibility and attacking policies.

The power of the concept of evidence-based policy making (EBPM) is certainly manifest in the area of health, where resources are often scarce and policy decisions bear upon matters of life and death. The consequences of a 'bad' health policy have the potential to be grave, and there are numerous examples in which ill-conceived interventions have caused physical harm, or have resulted in wasted resources and high opportunity costs. Upon hearing a crematorium worker remark that "what fascinated him was the way in which so much went in and so little came out", Professor Archie Cochrane famously remarked that the man ought to "get a job in the NHS" (Cochrane 1972). Cochrane considered that the only way to redress the yawning gap between

inputs into the public health service (e.g. human, financial and technological resources) and outputs (e.g. improvements in morbidity and mortality) was to increase the use of evidence in making decisions.

This chapter comprises four parts. First, it charts the rise of the concept of evidence-based policy making, noting in particular the groundwork that was laid by the evidence-based medicine movement of the 1990s. Second, it makes the case for a nuanced empirical investigation of the role of evidence in the policy process using Indigenous tobacco control policy making in Australia as a case study. Third, key concepts will be defined. Fourth, the structure of the thesis is outlined and the focus of each of the ensuing chapters is summarised.

1.1. A BRIEF HISTORY OF THE RISE OF EVIDENCE-BASED POLICY

1.1.1. Evidence-based medicine

The 1990s yielded a new "Zeitgeist in medicine" (Hooker 1997). In a 1992 editorial in *The Lancet* it was observed that, "[s]peciality by specialty, authoritarianism based on mere seniority is giving way to authoritativeness based on randomised trials" (Anonymous 1992). The speed with which the concept of evidence-based medicine (EBM) became intellectually fashionable is captured by a basic bibliometric analysis of publications on Embase (Hooker 1997). Hooker (1997) found that there were no Embase records published in 1990 which contained the terms "evidence-based" or "evidence-based medicine" in their title or abstract; in 1997, over 400 were published.

Certainly, the concept bears an intuitive appeal. In a short report, Isaacs and Fitzgerald (1999) summarised the alternatives to EBM in a style that was at once facetious and based on (admittedly caricatured) truths:

> *Eminence based medicine* – The more senior the colleague, the less importance he or she placed on the need for anything as mundane as evidence. Experience, it seems, is worth any amount of evidence ...
>
> *Vehemence based medicine* – The substitution of volume for evidence is an effective technique for brow beating your more timorous colleagues ...
>
> *Eloquence based medicine* – The year round suntan, carnation in the button hole, silk tie, Armani suit, and tongue should all be equally smooth. Sartorial elegance and verbal eloquence are powerful substitutes for evidence.
>
> *Providence based medicine* – If the caring practitioner has no idea of what to do next, the decision may be best left in the hands of the Almighty. Too many clinicians unfortunately are able to resist giving God a hand with the decision making.
>
> *Diffidence based medicine* – Some doctors see a problem and look for an answer. Others merely see a problem. The diffident doctor may do nothing from a sense of despair ...
>
> *Nervousness based medicine* – Fear of litigation is a powerful stimulus to overinvestigation and overtreatment ...
>
> *Confidence based medicine* – This is restricted to surgeons ... (Isaacs & Fitzgerald 1999).

Of course, it would be misleading to describe EBM as a new idea (Williams & Garner 2002). In his *Thoughts on Hospitals*, the eighteenth century surgeon, John Aikin (1771), criticised the "itinerant quack, whose whole practice is nothing but random guesses, and presumptuous rashness" and, instead, lauded the value of medical knowledge derived from the results of experimental practice. Even earlier examples of these sentiments abound.[1]

However, the British epidemiologist, Archie Cochrane, is widely acknowledged to have been a key figure in resuscitating the idea of EBM for a modern audience. In *Effectiveness and efficiency: random reflections on health services*, Cochrane (1972) presented numerous examples of commonly used medical interventions for which there

[1] See James Lind Library (2014).

was a lack of evidence of effectiveness (e.g. specific hypotensive treatment for hypertension in women and some asymptomatic men; treatment of ischaemic heart disease in coronary care units instead of at home; oral drug therapy and insulin for mature diabetes; tonsillectomy in children in cases in which there is no obstruction). For Cochrane, the principal priority of researchers should include, "prevent[ing] the introduction of new drugs and therapeutic procedures unless they are more effective (or equally effective and cheaper) than existing therapies", and "evaluat[ing] all existing therapies ... slowly excluding those shown to be ineffective or too dangerous" (Cochrane 1989). The objectives of 'no waste' and 'no harm' thus underlie the enthusiasm for evidence.

While modern EBM has been interpreted in a number of ways (and, presumably, will continue to evolve), the essence of the concept has been distilled to five core practices. In order to guide decisions on diagnosis, prognosis, therapy and other relevant clinical issues, evidence-based practitioners are required to:

i. convert these information needs into answerable questions
ii. track down, with maximum efficiency, the best evidence with which to answer them (whether from the clinical examination, the diagnostic laboratory, the published literature, or other sources)
iii. critically appraise that evidence performance for its validity (closeness to truth) and usefulness (clinical applicability)
iv. apply the results of this appraisal to our clinical practice
v. evaluate our performance (Sackett & Rosenberg 1995).

When it comes to "track[ing] down ... the best evidence" to determine whether certain therapies/interventions are likely to be effective, various hierarchies have emerged in which systematic reviews and randomised controlled trials are placed at the top. For instance, Greenhalgh (1997) has suggested the following order of priority:

1. Systematic reviews and meta-analyses
2. Randomised controlled trials with definitive results (confidence intervals that do not overlap the threshold of clinically significant effect)

3. Randomised controlled trials with non-definitive results (a point estimate that suggests a clinically significant effect but with confidence intervals overlapping the threshold for this effect)
4. Cohort studies
5. Case-control studies
6. Cross sectional surveys
7. Case reports.

It is clear that high quality studies are a *necessary* component of EBM; however, proponents of the concept have suggested that evidence is not, of itself, a *sufficient* basis for medical decision making. Sackett and colleagues (1996) define EBM as the integration of "the best available clinical evidence from systematic research" with "individual clinical experience" which, they go on to explain, includes "thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences". However, the nuances of EBM have often been overlooked as the concept has become popularised; the voices of the 'founders' are frequently drowned out by the fervour of the crowds.

1.1.2. Towards evidence-based everything

Modern EBM evangelism was quick to spread. It was not long before the concept captured the imagination of other professions and service providers, as demonstrated by the neologism "evidence-based everything" (Oakley 2002). An example of the migration of EBM logic into other areas is found in the 1996 address to the Royal Statistical Society in which the mathematician, Adrian Smith (1996), considered that

> [m]ost of us with rationalist pretensions presumably aspire to live in a society in which decisions on matters of substance ... are taken on the basis of the best available evidence, rather than on the basis of irrelevant evidence or no evidence at all.

He then went on to note that "the growth of a movement in recent years calling itself 'evidence based medicine' ... perhaps has valuable lessons to offer" (Smith 1996).

Again, the notion that evidence should be at the heart of decisions (this time, with respect to matters of public importance) was not novel (Davies, Nutley & Smith 2000; Davoudi 2006). The seventeenth century English philosopher, Sir Francis Bacon, described a utopia in which "policy is informed by knowledge, truth, reason and facts" (Bacon 1660). This aspect of Bacon's 'New Atlantis', became central to another Englishman's utopian imaginings – namely, Tony Blair's 'New Labour' manifesto in 1997 which promised:

> We will be a radical government. New Labour is a party of ideas and ideals but not of outdated ideology. What counts is what works. The objectives are radical. The means will be modern. Britain will be better with new Labour (Blair 1997).

The 1999 *Modernising Government* White Paper reiterated this commitment, noting that "policy decisions should be based on sound evidence" (Cabinet Office 1999).[2] The neologism used to describe this newly packaged concept was 'evidence-based policy making' (EBPM).[3]

Far from being 'radical', references to EBPM are now a common feature in the political landscape. In 2013, the British Government launched a network of What Works research centres to provide evidence-based guidance on a range of social policy issues, including crime, ageing, education and economic growth (Cabinet Office 2013). In a memorandum to the Heads of Executive Departments and Agencies, the United States Office of Management and Budget (2012) noted that "the President [Obama] has emphasised the need to use evidence and rigorous evaluation in budget, management, and policy decisions to make government work effectively", and stated that "[a]gencies

[2] Other facilitators of the (re)birth of EBPM are considered to be (1) the information technology revolution which enabled data to be more readily shared and accessed (Cloete 2009), and (2) the rise of New Public Management which emphasised procedural competence in the administration of public affairs (Grundy & Smith 2007; Marston & Watts 2003; Head 2008).

[3] Unlimited searches for the phrase 'evidence[-]based policy' anywhere in the record of documents contained in one search database (International Bibliography of the Social Sciences) yielded zero entries for documents published between 1990 and 1998, and 277 entries for documents published between 1999 and the end of 2013 suggesting that the term is a relatively recent construction.

should demonstrate the use of evidence throughout their ... budget submissions." Similarly, in 2008, senior Australian public servants were informed by the then Prime Minister, Kevin Rudd, that "[p]olicy innovation and evidence-based policy-making is at the heart of being a reformist government ... We are interested in facts not fads" (Rudd 2008).

1.2. INDIGENOUS TOBACCO CONTROL CASE STUDY

Under the leadership of Kevin Rudd, the Australian Labor Party's evidence-based rhetoric was particularly prominent in discussions around Indigenous issues (Sanders 2009; Partridge 2013). On the whole, Indigenous Australians[4] were (and remain) disadvantaged across a number of outcomes when compared to the general population. In 2007, when the Rudd Government came to power, Indigenous Australians:

- were expected to have lives that were 17 years shorter than non-Indigenous Australians;
- were less than half as likely to complete secondary school than non-Indigenous Australians;
- were three times more likely than non-Indigenous Australians to be unemployed; and
- after adjusting for age differences, were thirteen times more likely to be imprisoned than non-Indigenous Australians (Steering Committee for the Review of Government Service Provision 2007).

[4] The term 'Indigenous Australians' will be used to describe Australia's Aboriginal and Torres Strait Islander population. Consistent with the University of Sydney Style Guide (as recommended by the Koori Centre), "Indigenous [will] always be spelt with a capital 'I' when referring to Indigenous Australians; when being used generically (for example to discuss the indigenous people of the world) a lower case 'i' is used" (University of Sydney 2009).

According to the then Secretary of the Federal Treasury, Ken Henry, the persistence of such glaring disparities "has not been for want of policy action. Yet it has to be admitted that decades of policy action have failed" (Henry 2006).

Rudd's Labor Party presented evidence as the antidote. This was best captured in a speech by the Honourable Chris Evans MP:

> Both major parties have pursued their ideological convictions in Indigenous policy to the detriment of Indigenous Australians ...
>
> Labor in government pursued an agenda that focused on rights, reconciliation and self-determination ... The core of the [conservative] Coalition's approach is a belief that Indigenous people should be subsumed into the broader mainstream. Their ideology requires a fierce denial of past injustice ...
>
> Labor remains committed to the recognition of past injustices and the need for reconciliation and Indigenous self-determination. They are crucial contributors to removing disadvantage. But from here on our guiding principle will be the evidence of what works and what does not work in reducing disadvantage. Not ideology – evidence (Evans 2006(a)).

The *Indigenous Tobacco Control Initiative* and the *Tackling Indigenous Smoking Measure* were both announced in the Rudd Labor Government's first year in office when the rhetoric of 'evidence over ideology' was strong. Together, the policies committed over AU$120 million in government funds to Indigenous tobacco control and served as a turning point, marking the beginning of a period "that has seen more action on indigenous smoking than any other time in our history" (Calma & Daube 2011). Yet, perhaps surprisingly in light of the foregoing context, it was said of some aspects of the policies that "the government hasn't produced evidence to back up its campaign" (McQuire 2012).

These Indigenous tobacco control policies offer a compelling case study for exploring the practical application of the EBPM rhetoric. This thesis will answer the following questions:

1. How, if at all, did the Rudd Government use evidence in Indigenous tobacco control policy making?
2. What were the facilitators of and barriers to the use of evidence in Indigenous tobacco control policy making?
3. Does the Indigenous tobacco control policy case study augment or challenge the apparent inviolability of the notion of EBPM?

As will be made apparent in the following chapter, there are few studies which seek to critically engage with the concept of EBPM through empirical methods. Moreover, the thesis will contribute to a small but emerging body of literature concerning the feasibility and appropriateness of applying the EBPM ideal to address the problems of populations who may be unable to contribute to the mainstream research agenda, or who may have different ideas and priorities with respect to what constitutes 'good' policy making.

1.3. DEFINITIONS

In a public health context, EBPM is understood as:

> the conscientious, explicit and judicious use of current best evidence in making [policy] decisions about the care of communities and populations in the domain of health protection, disease prevention, health maintenance and improvement (Jenicek 1997).

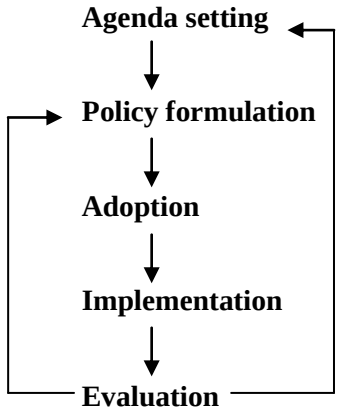
This thesis will define evidence as any information relied upon to support or justify the validity of a statement or belief.[5] The question of what constitutes 'evidence' is necessarily distinct from the question of what constitutes '*best* evidence'. In the policy-making context, the term 'evidence' has been used to describe a diversity of sources of information. For the United Kingdom Cabinet Office (1999), evidence included "expert knowledge; existing domestic and international research; existing statistics;

[5] Adapted from Dobrow, Goel, Lemieux-Charles et al. (2006); Kelly (2006).

stakeholder consultation; evaluation of previous policies." Meanwhile, Leigh (2009) identified the following sources of evidence for policy making: systematic reviews (meta-analyses) of multiple randomised trials; high quality randomised trials; systematic reviews (meta-analyses) of natural experiments and before-after studies; natural experiments (quasi-experiments) using techniques such as differences-in-differences, regression discontinuity, matching or multiple-regression; before-after (pre-post) studies; expert opinion and theoretical conjecture. The decision to adopt an inclusive definition of evidence for the purpose of this thesis ought not to be interpreted as an acceptance that all evidence is inherently equal; rather, it is a recognition of the fact that in order to explore how evidence (or, more precisely, the concept of evidence) is used or misused in the policy process one must begin the search with limited preconceptions and a sufficiently generous 'net'.

With respect to 'policy making', this thesis adopts the model set out in Figure 1 below. The model conceptualises policy making as a series of sub-processes, each of which may be affected by a distinct interplay of forces and decision making mechanisms (Anderson 1984). This recognises the fact that evidence may be used at one stage (e.g. agenda-setting) but not in another (e.g. policy formulation). While critics argue that the stages model reads too much rationality into a system that can, at times, best be characterised as "muddling through" (Lindblom 1959), the model retains its utility in policy research "as long as the heuristic purpose of the framework is considered and … receptivity for other and new approaches in the wider political science literature is taken into account" (Jann & Wegrich 2007).

Figure 1: The stages model of policy making



Source: Palmer & Short (1989)

With the exception of 'implementation', the role of evidence at each stage of the Indigenous tobacco control policy process will be examined in this thesis. The rationale for excluding implementation is both ethical and pragmatic. Unlike the other policy stages which occur predominately within government spaces or (in the case of evaluation) through expert consultants, implementation takes place in the community. Since it is often argued that Indigenous communities have been "researched to death" (Cochran, Marshall, Garcia-Downing et al. 2008), a decision was made to avoid compounding this possible research fatigue. Furthermore, the policies were implemented by over 300 Tobacco Action Workers and approximately 1000 existing health workers; it was anticipated that there would be barriers to identifying these individuals and obtaining responses from a representative sample (Calma 2011). By contrast, the group responsible for making and evaluating the policies was much more well-defined and could thus be researched in greater depth.

Although the 'stages' model is used to organise the findings, this thesis does not subscribe to a technocratic understanding of how policies are made. Instead, the findings lend support to Kingdon's (1984) 'streams model' which posits that issues rise in political prominence when three streams converge – namely, the problem stream

(which comprises information or events that bring attention to an issue), the policy stream which comprises solutions to the problem offered by experts and bureaucrats with the proviso that these need to be politically and technically feasible) and the political stream (which relates to the willingness of politicians to pursue the solutions that have been suggested and is defined to include changes in public mood and turnover of key personnel through events such as elections). As will be shown by this thesis, individuals (often working collectively) make use of 'windows of opportunity' to effect policy change.

1.4. CHAPTER SUMMARY

Chapter Two comprises a literature review of existing studies which examine either the idea or the practice of EBPM within heath and other disciplines. In so doing, the literature review goes further than other reviews which limit their focus to understanding the types of research used by policy makers, or the barriers to and facilitators of EBPM. The chapter seeks to understand how EBPM has been researched and written about more broadly – what aspects of the concepts have been studied, what assumptions are made, what critiques have been levelled, and what data have been used to support the claims. It concludes with a discussion of the shortcomings of the existing literature and describes how this thesis seeks to fill a research gap with respect to the subject of EBPM.

Chapter Three describes the study design that has been used to answer the research questions set out above (page 9), and explains the rationale for using key informant interviews and archival research to investigate the policy making process around Indigenous tobacco control. The chapter then details the sampling methods, interview

techniques, archival search strategy and analytical approach adopted to investigate the role of evidence in Indigenous tobacco control policy making.

Chapter Four offers some background. A broad overview of the history of government policy making with respect to Indigenous Australians is presented, with a particular focus on past policies that continue to loom large in contemporary discussions around Indigenous issues; these include the forced child removal policies and the various 'protection Acts' which historically curtailed Indigenous civic rights. The chapter then examines the current socio-political context of Indigenous affairs in Australia, drawing upon the controversy surrounding the Northern Territory National Emergency Response (2007) to demonstrate the way in which historical experiences inform present responses to Indigenous policies. The chapter concludes by noting the way EBPM was held out by both the Rudd Labor Government and some Indigenous commentators as a constructive alternative to policies made on the basis of ideology, assumptions and racist beliefs.

Chapter Five uses archival and interview data to construct an account of the way Indigenous tobacco control gained political salience under the Rudd Government in 2008. The chapter scrutinises the role played by evidence in increasing the political importance of the issue, and examines the interplay between evidence and other factors in the agenda-setting process, including advocacy, political leadership and competing/complementary priorities. The chapter also scrutinises the notion that evidence 'speaks for itself', by describing the way in which similar data can be ascribed different meaning over time.

Chapter Six lays a foundation for investigating whether evidence played a role in informing the design of the *Indigenous Tobacco Control Initiative* and *Tackling*

Indigenous Smoking Measure. It draws upon two literature reviews commissioned by the Department of Health and Ageing and obtained under the *Freedom of Information Act 1982*. The chapter examines the extent to which the recommendations of the literature reviews matched the content of the ensuing policies, and critically appraises the quality of the evidence cited in those reviews. The relative dearth of research into 'what works' in an Indigenous tobacco control context is highlighted.

In Chapter Seven, interview and archival data are used to understand how those responsible for adopting the policies used the evidence contained in the literature reviews. Policy makers' views on the limitations of relying on the evidence are explored. A key focus of the chapter is the description of policy makers' perceptions of the importance of rigorous evidence of 'what works', relative to other factors such as the urgent need to act, the role of history, and the value placed on 'expert opinion' and Indigenous participation.

Chapter Eight uses documents obtained under the *Freedom of Information Act 1982* to investigate critically the way in which the Indigenous tobacco control policies have been evaluated. The methods of collecting and analysing the data are assessed, and associated barriers are discussed.

Chapter Nine situates the findings within the broader literature, drawing specifically on constructivist critiques of the EBPM movement. In particular, the chapter examines the difficulties associated with relying primarily on evidence when making policies for marginalised populations. The chapter explains the barriers to collecting high-quality evidence in certain contexts, explores the potential consequences of failing to act in the absence of such evidence, and describes the potential tension between effectiveness and acceptability. The chapter concludes by proposing a new, more nuanced approach to

EBPM in which evidence remains central, but is not the only consideration when barriers to high-quality evidence exist and contextual circumstances point to the need for intervention.

Chapter Ten summarises the overall argument, highlights the strengths and weaknesses of the case study and articulates its novel contributions to the literature concerning EBPM, Indigenous policy and health policy studies more generally.

2. Literature review

This chapter has the broad aim of seeking to understand how EBPM has been investigated and written about in the existing body of the literature. Certainly other reviews exist but they are more limited in scope. For instance, Innvaer, Vist, Trommald et al. (2002) reviewed findings from interview studies conducted with health policy-makers to understand the facilitators of, and barriers to, the use of research evidence. Orton, Lloyd-Williams, Taylor-Robinson et al. (2011) included a broader selection of studies in their review (e.g. studies which examined the extent to which research evidence is used by policy makers and the types of research used); however their focus was also on empirical studies. As a consequence, potentially important theoretical and philosophical insights into EBPM are rendered silent in the 'accumulated wisdom' around EBPM. This literature review represents an attempt to understand both what has been written about EBPM as a *practice* and EBPM as an *idea*; in so doing, it identifies gaps in the way EBPM is researched and demonstrates the importance of the approach adopted in this thesis.

2.1. METHODS

The International Bibliography of the Social Sciences (IBSS) was used to search for literature. IBSS was chosen on the basis that it covers a broad range of disciplines, including politics, policy studies and health. The search database contains core journals which one would expect to be target publications for academics writing about the policy process and EBPM, including health policy making.[6]

[6] Examples include: *Political Science Quarterly*; *Political Studies; Politics & Society*; *Australian Journal of Political Science; Public Administration; Journal of Public Policy*; *American Journal of Political Science; British Journal of Political Science; Policy & Politics; Social Policy; International Journal of Health Services; Health Policy & Planning; Science and Public Policy; Journal of Health Politics, Policy & Law; Health Policy; Health Economics, Policy & Law; Evidence & Policy.*

As was demonstrated in the previous chapter, the term 'evidence-based policy' is now prevalent and is used as a convenient and generally accepted short-hand to describe the application of evidence to various stages of the policy decision making process.[7] It was assumed that the majority of publications which examined the concept would make use of the term somewhere in the record (i.e. document title, abstract, subject heading). Consequently, the IBSS search strategy was designed to identify any English-language publications that contained the phrase "evidence based polic?" or "evidence-based polic?" anywhere in the record.

The search yielded 213 results, the titles and abstracts of which were then screened using the inclusion and exclusion criteria set out in Box 1 below. Where it was not clear from the abstract whether an entry should be included or excluded, the full text of that entry was screened. Through this process, 84 articles were identified for inclusion.

Box 1: Inclusion and exclusion criteria for literature review

Include:

- ✓ Entries that discuss whether or how evidence is used in the policy process.
- ✓ Entries that discuss the barriers to and facilitators of EBPM.
- ✓ Entries that analyse EBPM as a concept, including critiques of EBPM.

Exclude:

- × Duplicates.
- × Non-peer reviewed literature (i.e. books, conference proceedings).
- × Entries that merely mention EBPM in passing (i.e. EBPM is not considered a major focus of the publication).
- × Entries that discuss the evidence about a particular social problem and make recommendations about the policy implications of the findings.

A random sub-sample of publications was read and major themes and methods were noted. The recurring themes and methods informed the list of codes for data extraction contained in Box 2 below. All included items were then read in full and coded.

[7] See footnote 3 above.

Box 2: Codes applied to included studies

1. Content:
   a) gap between EBPM rhetoric and reality
   b) barriers to and facilitators of EBPM
      i) open coding for types of facilitators or barriers
   c) critique of EBPM, or aspects of EBPM
      i) nature or meaning of evidence
      ii) sometimes evidence is hard to produce or is not necessary
      iii) only acting on the basis of what is 'known' may stifle innovation
      iv) the significance of other non-evidentiary considerations

2. Main form of data relied upon to inform content
   a) Opinion or personal experience
   b) Primary data other than opinion or personal experience
   c) Secondary data derived from other studies

It is not claimed that this literature review is exhaustive. Instead, the objective is to present a snapshot of some key characteristics of the existing literature concerning EBPM through the analysis of a cross-section of publications selected in an explicitly defined manner. While attempts have been made to minimise selection bias, this review (like all reviews)[8] is not immune to biases that arise from: (1) assumptions about which database is likely to contain the most literature on the topic being investigated; (2) assumptions about which search terms are likely to capture the broadest and most relevant range of publications; (3) subjective interpretations about whether or not the criteria for inclusion have been met; and (4) subjective interpretations about what information ought to be extracted from the included publications, and how the information ought to be coded.

2.2. FINDINGS

2.2.1. The gap between rhetoric and reality

Twelve studies examined the gap between politicians' rhetorical commitment to EBPM, and the extent to which policies were actually supported by evidence (Goldson 2010;

[8] See Sorrell (2007).

Farrell & Morris 2009; Hope 2004; Mackenzie, Blamey & Hanlon 2006; Naughton 2005; Mair 2005; Whitty 2006; Partridge 2013; Baggott 2010; McKay 2010; Pennington, Gray, Donaldson et al. 2012; Shaoul, Stafford & Stapleton 2007). The majority of these articles highlighted the lack of evidence to support key policies enacted by Tony Blair's New Labour Government – namely, performance-related pay for school teachers (Farrell & Morris 2009), the Academies programme (Whitty 2006), reforms to the justice system (Naughton 2005; Goldson 2010), electronic monitoring of offenders (Mair 2005), alcohol licensing reforms (Baggott 2010), and the Reducing Burglary Initiative (Hope 2004). Of the remaining studies: Mackenzie, Blamey and Hanlon (2006) examined the Scottish Government's commitment to using findings from evaluations of the Health Demonstration Projects; McKay (2010) investigated the evidence-base behind Northern Irish planning laws; and Partridge (2013) critiqued the Australian Labor Government's rhetorical commitment to EBPM in relation to the policies and programs emanating from the Northern Territory National Emergency Response in Indigenous communities, showing that evidence was often ignored or used selectively.[9]

While all of these studies critiqued the *extent* to which governments are truly committed to EBPM, only three (Mair 2005; Whitty 2006; Partridge 2013) questioned the degree to which the concept *merits* commitment.[10] The remainder seemed to accept the appropriateness of EBPM as a given.

[9] Whereas most studies looked at the use of evidence in policy formulation, two studies criticised commitments to (and the rigour of) policy *evaluations* (Pennington, Gray, Donaldson et al. 2012; Shaoul, Stafford & Stapleton 2007).

[10] See 2.3.3 below for a description of their critiques of EBPM.

2.2.2. Barriers to and facilitators of EBPM

Building on the foregoing theme that policies are often not evidence-based, 41 of the studies identified in this literature review explored the barriers to and facilitators of EBPM (Legrand 2012; Khodr & Hasbani 2013; Marais & Matebesi 2013; Hickey 2012; Oliver, Everett, Verma et al. 2012; Monaghan, Pawson & Wicker 2012; Bartlett 2013; Axford, Jonas, Green et al. 2010; Ritter 2011; Hyder, Corluka, Winch et al. 2011; Cherney & Head 2011; Uneke, Ezeoha, Oyibo et al. 2011; Guđmundsson, Jóndsdóttir & Júlíusdóttir 2010; Burton 2006; Huston 2008; Sin 2008; Oreszcyn & Carr 2008; Burnett & Duncan 2008; Bekker, van Egmond, Wehrens et al. 2010; Barton & Harpham 2010; Duncan & Harrop 2006; Nowotny 2007; Freiberg & Carson 2010; Sessa & Ricci 2010; Stanhope & Dunn 2011; Spangaro 2007; Sin 2008(b); Nutley & Homel 2006; Wimbush, Harper & Wight 2005; Lawrence 2006; Evans 2006(b); Whitty 2006; Schwartz & Rosen 2004; Torrance 2008; Nilsson, Jordan, Turnpenny et al. 2008; Squires & Renn 2011; Ogden, Ulvestad Karki & Stegenborg Teigen 2010; O'Brien 2011; Baggott 2010; Wilkinson 2011; McKay 2010).

Barriers identified in these studies include:

- ideological beliefs, emotions and popular assumptions/understandings (Hickey 2012; Monaghan, Pawson & Wicker 2012; Huston 2008; Freiberg & Carson 2010; Schwartz & Rosen 2004; O'Brien 2011);
- features of the political system, including a lack of accountability and transparency, frequent changes in administration, administrative corruption, government mandate and legislative processes (Khodr & Hasbani 2013; Hyder, Corluka, Winch et al. 2011);
- lobbying by stakeholders (Monaghan, Pawson & Wicker 2012; Schwartz & Rosen 2004; Baggott 2010);

- popular opinion (Monaghan, Pawson & Wicker 2012; Hyder, Corluka, Winch et al. 2011);
- conflict with existing organisational direction/commitments/election mandate (Axford, Jonas, Green et al. 2010; Cherney & Head 2011; Burnett & Duncan 2008; Duncan & Harrop 2006; McKay 2010);
- lack of capacity to conduct, access or understand research, due to limited skills or resources (Khodr & Hasbani 2013; Marais & Matebesi 2013; Bartlett 2013; Hyder, Corluka, Winch et al. 2011; Uneke, Ezeoha, Oyibo et al. 2011; Duncan & Harrop 2006; Nutley & Homel 2006; Nilsson, Jordan, Turnpenny et al. 2008; Squires & Renn 2011; O'Brien 2011);
- a perception that research findings are not applicable to a particular context (Khodr & Hasbani 2013; Marais & Matebesi 2013; Spangaro 2007; Nutley & Homel 2006);
- a perception that research findings are unable to be implemented because findings are too heavily qualified or do not point to a clear solution, or because the solution is not feasible (Marais & Matebesi 2013; Monaghan, Pawson & Wicker 2012; Guðmundsson, Jóndsdóttir & Júlíusdóttir 2010; Spangaro 2007; Evans 2006(b));
- cost/profit considerations (Monaghan, Pawson & Wicker 2012; Spangaro 2007; Nutley & Homel 2006; Schwartz & Rosen 2004);
- the nature of the research evidence, including issues surrounding legitimacy and reliability, and lack of practical policy recommendations (Khodr & Hasbani 2013; Huston 2008; Oreszcyn & Carr 2008; Barton & Harpham 2010; Ogden, Ulvestad Karki & Stegenborg Teigen 2010; O'Brien 2011);

- poor communication and weak links between research and policy communities (Khodr & Hasbani 2013; Marais & Matebesi 2013; Oliver, Everett, Verma et al. 2012; Hyder, Corluka, Winch et al. 2011; Wilkinson 2011);
- timing mismatch between the needs of researchers and policy makers (Huston 2008; Burnett & Duncan 2008; Spangaro 2007; Sin 2008(b); Nutley & Homel 2006; Squires & Renn 2011; Wilkinson 2011); and
- the absence of evidence (Spangaro 2007).

Identified facilitators include:

- the need for a decision of a highly technical nature (Schwartz & Rosen 2004; Wilkinson 2011);
- the existence of high quality evidence, especially where it is replicated and consistent (Legrand 2012; Huston 2008; Baggott 2010);
- exposing policy makers to evidence through novel means (e.g. study tours, workshops with researchers) (Axford, Jonas, Green et al. 2010; Oreszyn & Carr 2008);
- the existence of evidence 'champions' who have knowledge of the policy sphere, or 'knowledge brokers' (Cherney & Head 2011; Sin 2008(b); Stanhope & Dunn 2011; Wimbush, Harper & Wight 2005);
- accessibility of research (e.g. through 'Google', research fora and clearinghouses) (Ritter 2011; Hyder, Corluka, Winch et al. 2011; Cherney & Head 2011; Sin 2008(b));
- presenting research results in more user-friendly ways, both in terms of format and ability to present 'clean solutions' (Hyder, Corluka, Winch et al. 2011; Burton 2006; Duncan & Harrop 2006; Nowotny 2007; Stanhope & Dunn 2011; Nilsson, Jordan, Turnpenny et al. 2008);

- strong community support/positive public opinion (Ritter 2011)
- strategies for communicating/disseminating research findings (Cherney & Head 2011; Lawrence 2006);
- increasing the skills of policy makers to use and understand research (Cherney & Head 2011; Burton 2006; Sin 2008(a));
- creating conditions to promote interaction and close collaboration between researchers and policy makers (Bekker, van Egmond, Wehrens et al. 2010; Duncan & Harrop 2006; Guðmundsson, Jóndsdóttir & Júlíusdóttir 2010; Ritter 2011; Sessa & Ricci 2010; Wimbush, Harper & Wight 2005; Lawrence 2006; Torrance 2008; Squires & Renn 2011);
- aligning research to existing socio-political agendas (Stanhope & Dunn 2011); and
- media uptake of research (Ritter 2011; Stanhope & Dunn 2011).

Interestingly, only sixteen of the studies that examined why evidence is or is not used in policy making collected and analysed (primarily) original data, and even then with varying degrees of rigour (Khodr & Hasbani 2013; Marais & Matebesi 2013; Oliver, Everett, Verma et al. 2012; Axford, Jonas, Berry et al. 2010; Hyder, Corluka, Winch et al. 2011; Uneke, Exeohoa, Ndukew et al. 2011; Oreszczyn & Carr 2008; Burnett & Duncan 2008; Barton & Harpham 2010; Nilsson, Jordan, Turnpenny et al. 2008; Squires & Renn 2011; Ogden, Ulvestad Karki & Stegenborg Teigen 2010; O'Brien 2011; Baggott 2010; Wilkinson 2011; McKay 2010). The vast majority either constructed arguments from secondary literature, theory, opinion or the authors' personal reflections.[11]

[11] The reflections based on personal experiences could arguably be categorised as 'ethnographical' research, although they are not described in that way (see Spangaro 2007; Duncan & Harrop 2006).

Additionally, as was the case with the studies examining the gap between EBPM rhetoric and reality (section 2.2.1 above), only a handful of the studies that examined facilitators/barriers contained any reflection on the appropriateness of the EBPM framework as a social or institutional aspiration (see Marais & Matebesi 2013; Bartlett 2013; Nowotny 2007; Spangaro 2007; Nutley & Homel 2006; Whitty 2006).

2.2.3. Critiques

The critiques of EBPM that emerged from this literature review can be divided into four broad (and, at times, overlapping) categories: (1) those that problematise the *nature* of evidence in orthodox conceptualisations of EBPM; (2) those that argue that evidence in some areas is inherently difficult to produce; (3) those that contend that a rigid adherence to EBPM can stifle innovation; and (4) those that advocate for the importance of incorporating factors other than (or in addition to) evidence into public policy deliberations. As was the case above, the vast majority of these critiques constructed arguments from secondary literature, theory, opinion or the authors' personal reflections.[12]

2.2.3.1. The nature of evidence

The majority of critiques identified in this literature review advanced arguments to problematise the popular understanding that, through EBPM, policies based on assumptions and ideologies are replaced with policies based on objective knowledge of what works. The tenor of these articles is that assumptions, constructs and biases are *inherent* in the collection, interpretation and utilisation of evidence, including those forms of evidence that are ranked highly in orthodox hierarchies (Lingard, Creagh & Vass 2012; Seckinelgin 2010; Sorrell 2007; Pearson 2010; Kisby 2011; Buckingham

[12] Exceptions are: Beresford (2007) (interviews); Buckingham (2009) (document review and interviews); Dobrow, Goel, Lemieux-Charles et al. 2006 (interviews); Behague, Tawiah, Rosato et al. (2009) (ethnographic case study); Laforest & Orsini (2005) (interviews); Valentine (2009) (interviews).

2009; Head 2009; Juntti, Russel & Turnpenny 2009; Grundy & Smith 2007; Maddison 2012; Beresford 2007; Murray 2011; Botterill & Hindmoor 2012; Osgood 2009). For instance, Sorrell (2007) argued that systematic reviews (often regarded as the apex of the evidence hierarchy) are susceptible to bias through the selection of question, the selection and appraisal of evidence and the synthesis of results. Similarly, Seckinelgin (2010) used a high-profile systematic review of data examining the prevalence of HIV infection in conflict-affected and displaced populations as a case study to demonstrate how seemingly rigorous studies are products of subjective choices with respect to data collection and analysis. Meanwhile, Grundy and Smith (2007) cited the first questions designed to identify lesbian, gay, bisexual and transgender citizens in North American censuses, noting that the questions related to *same-sex couples* thus both excluding those who did not identify with a single sex/gender, and those who did not belong in 'respectable' couple-type relationships.

Several articles in this category argued that evidence is fundamentally contextual; that is to say, what is considered 'good evidence' necessarily reflects the values, experiences and needs of the maker or user (Pearson 2010; Kisby 2011; Head 2008; Juntti, Russel & Turnpenny 2009; Murray 2011; Grundy & Smith 2007; Maddison 2012).[13] Head (2008) made this point by examining EBPM through a series of 'lenses'. Head (2008) argued that: through the 'political lens' one might see that policy makers do not recognise some evidence because it is inconsistent with the official 'framing' of the

[13] These articles do not necessarily advocate a post-modern view that 'all evidence is equal'. Kisby (2011) presented the following nuanced account of the role of interpretation in evidence: "Facts are discovered; they are not constructed. Nor is the truth or falsity of a factual claim simply dependent on the number of people holding that claim to be true or false. However, which facts, which pieces of corroborated information, are deemed relevant in the development of explanatory theories is dependent on a range of factors, most fundamentally the worldview adopted by the policy analyst or paradigm within which they operate. Facts are framed and advanced as evidence to support or contradict a particular theoretical claim or hypothesis. *Meaning is inscribed through but also from the use of evidence, which may be open to a wide range of plausible interpretations but which also limits the number of reasonable interpretations and in an important respect transcends defective interpretations of it*" (emphasis added).

problem; through the 'scientific lens' one might observe disagreements between researchers, particularly those from different disciplines, about appropriate methods and ways of understanding the nature of problems; and through the 'field experience lens', one might glean 'practical wisdom' about how programs to address the problem can be effectively delivered.

According to Room (2013), the current reverence for systematic reviews and randomised controlled trials risks overlooking local particularities and the complexities of human systems (which might be detected through the 'field experience lens'). Room (2013)[14] argued that variations in the way interventions are implemented tend to be dismissed in randomised controlled trials which assume "that an intervention can be delivered in a standard population according to a standard design"; however, for Room (2013) such an assumption ignores the following realities:

- A medical intervention may be viewed as an active agent that 'impacts' upon a human subject. In contrast, a social policy intervention does not so much *impact upon as engage with* active stakeholders, offering them resources and seeking to secure their compliance. These stakeholders include the intended end-users or beneficiaries, but also the policy managers and professionals who deliver the intervention.
- The 'impacts' of these interventions therefore depend in part on how these stakeholders respond and what projects of their own they pursue. Stakeholders pull the interventions in different directions, in pursuit of these projects, but also as a result of the practical learning and knowledge exchange that accompanies any intervention. Social policy interventions therefore change and diversify, even as their impacts are being assessed.
- Interventions vary also because typically they are embedded in multiple social systems and they unfold within institutionally complex environments. This means that stakeholders have varying scope for blocking, redirecting or reinforcing the 'impact' of the intervention. Rarely, therefore is the 'same' programme delivered across all contexts ...
- [I]nterventions not only produce 'impacts', they also 're-sculpt' the conditions or context into which they were launched and on whose continuation the expectation of impact was predicated. In other words, social interventions are typically 'open' not closed systems, transforming their world in ways that are time and path dependent (Room 2013, original emphasis).

[14] Room (2013) draws and builds on Pawson (2006).

Geyer (2012) similarly contended that EBPM is currently too wedded to "a traditional orderly scientific world view" which pays too little attention to complexity, and Overeem and Tholen (2011) argued that the social sciences cannot produce "law-like generalizations ... [that] would enable them to predict and control the social environment" because human affairs are beset with uncertainty. The analogy used by Rouw and Verhagen (2009) is that "[w]hereas the effect of an aspirin tablet can be established concretely ... this is not the case for social interventions ... because the problem that the intervention originally had to solve may have taken on a different character."

The tendency for EBPM to overlook local knowledge and conditions is also emphasised elsewhere in the literature (Dobrow, Goel, Lemieux-Charles et al. 2006; Maddison 2012; Beresford 2007; Murray 2011; Grundy & Smith 2007; Laforest & Orsini 2005; Behague, Tawiah, Rosato et al. 2009). Most of these articles caution that a rigid conceptualisation of 'good evidence' has the potential to overlook 'experiential' forms of knowledge possessed by minority groups such as Indigenous Australians (Maddison 2012), disabled residents in a care home (Beresford 2007), young people (Murray 2011), lesbian, gay, bisexual and transgender communities (Grundy & Smith 2007), and some voluntary sector groups (Laforest & Orsini 2005).[15] For instance, Maddison (2012) noted that Indigenous Australians have historically had little involvement in guiding and informing the type of research that is valued by proponents of EBPM (i.e.

[15] It is important to note that these articles also concede that EBPM has the capacity to empower. For instance, Maddison (2012) observed that "the considered, just and systematic use of evidence in Indigenous policy making may be welcomed as offering the potential to counter the unsuccessful and ideologically-driven approaches to Indigenous policy making [in Australia]". Meanwhile, Grundy and Smith (2007) noted that, "in some ways, evidence-based knowledge production has displaced the traditional public servant who no longer holds a monopoly on knowledge of the social", and Laforest and Orsini (2005) argued that the EBPM movement has turned many voluntary sector organisations into "experts" and has given them a place at the policy table.

quantitative, predominately statistical studies), while "the more qualitative sources of data to which they have contributed ... are often ignored or diminished." One proffered explanation for this is that the underlying power relations in a society determine what constitutes legitimate knowledge, both in terms of the information that is deemed worthy of 'knowing' and how that information is collected (Juntti, Russel & Turnpenny 2009; Maddison 2012; Grundy & Smith 2007).

2.2.3.2. Sometimes evidence is hard to produce

A further point made in relation to EBPM is that there are a number of areas in which it is difficult to produce 'high quality' evidence for policy makers (Towse 2013; Putland 2008; Faulkner, Kent, Geesink et al. 2006). Towse (2013) described a number of barriers to producing strong evidence to support copyright laws, including the fact that "there is no registration system for copyright ... [and], given the ubiquity of copyright ... there are almost no situations where copyright does not apply that can be compared with ones in which it does". Meanwhile, Faulkner and colleagues (2006) noted that evaluating emerging human tissue-engineered technologies for the purpose of regulation will require novel methods, and Putland (2008) described the barriers to demonstrating the link between community art and population health outcomes:

> Typically the aims of initiatives are framed in positive terms such as 'engage' (hard to reach communities), 'build' (self-esteem, social networks), 'involve' (local communities in defining own health and well-being needs), 'enable' (socially excluded communities to address the effects of their situation). Nevertheless the preoccupation with 'fixing' problems at a policy level results in the imperative to demonstrate impacts on risk factors: physical (hypertension, release of stress hormones), behavioural (smoking, poor nutrition, substance abuse), individual (low self-esteem, high self-blame) and social (isolation, lack of social support)
>
> Moreover, the connection *between* individual and social level effects is controversial. Many participants in community arts activities report 'micro' level effects such as increased social engagement, levels of self-esteem and development of skills; attributing these to specific interventions is difficult

> enough, but linking them to changes at a community level compounds the uncertainty...
>
> The question of which research methods are appropriate is a further complication in this discussion. That these approaches are not amenable to conventional biomedical techniques that presume the ability to control for variables and to predict outcomes is clear (internal citations omitted).

2.2.3.3. Only acting on the basis of what is 'known' may stifle innovation

Sanderson (2009), Little (2012) and Rouw and Verhagen (2009) argued that EBPM has the capacity to curtail the ability to gain relevant knowledge through policy error and experimentation. Rather than postponing policy action until the effectiveness of a given intervention is known, Sanderson (2009) suggested that policies should be viewed as hypotheses to be tested through pilots or trials and/or rigorous monitoring and evaluation, and must be flexible enough to be altered in response to observed consequences.[16] Similarly, Rouw and Verhagen (2009) argued that complex interventions should "offer space to fiddle around and experiment", and Little (2012) considered that the lack of comprehensive knowledge to inform policies should "encourage us to take risks, to investigate innovative ways of grappling with old problems, and to do so in the knowledge that what we do is likely to fail in one way or another."

2.2.3.4. The significance of other non-evidentiary considerations

The final criticism of EBPM to arise from this literature review is that the emphasis on obtaining tangible evidence of 'what works' can eclipse due consideration of other policy objectives. For Sanderson (2003; 2004), the question of 'what works' needs to

[16] Stoker and John (2008) do not critique EBPM, but argue that the outcomes of policy interventions could be closely monitored through more iterative design experiments: "[I]nstead of the once-and-for-all hypothesis test (in the form of a statistical verification common in randomised control trials, which may confirm or reject the hypothesis) there is a quick turnover of research questions linked to the main hypothesis, followed by rapid redesigns of the intervention". Similarly, Csete & Grob (2012) argue for greater focus on evidence at the 'back end' of the policy process, as demonstrated in their case study of Switzerland's experience of piloting heroin-assisted therapy for people with longstanding opiate dependence.

be complemented with an understanding of 'what is appropriate'. In her discussion of the Northern Territory Emergency Response in Indigenous communities, Partridge (2013) argued that there is a need for more discussion of values and the extent to which Indigenous people are involved in the policy process. Similarly, Valentine (2009) observed that the 'rational' answers offered by science "may be impractical or at odds with what 'the people' want" (as has been shown in drug policy making and discussions around biomedical technologies such as stem cell research),[17] and Freiberg and Carson (2010) warned against dismissing "emotion-led evidence" as "illogical". Rather than conceptualising the policy process as being governed by a "single, unique and universal rationality", Kay (2010) considered there is a need to recognise the existence and validity of multiple rationalities that are based on "different assumptions, values and criteria."

A variant of this theme is that, while proponents of EBPM seek proof of the utility of social endeavours (e.g. through post-test reductions in mortality rates or disease prevalence), others argue that some endeavours possess an intrinsic worth that defies the need for empirical justification. Putland (2008) described how the push to demonstrate how community-based arts initiatives improved the health of the community was resisted on the basis that it conceptualised art "solely as a tool to achieve other ends" rather than a central pillar of society in its own right. Morell (2012) advanced a similar point, quoting Higgins' (2010) complaint that the expansion of EBPM rhetoric into UK higher education policy rejects an appreciation that "the humanities in general ... have a value within civilised society ... There is a dark new philistinism abroad."

[17] French (2012) argued that, in a democracy, "politicians reflect as they represent the citizens from which they issue and among whom they return", and that it is therefore unrealistic to "purge politics of passion, power, ideology and interest" by making evidence the guiding force in policy making.

2.3. DISCUSSION

The foregoing literature review stands apart from existing reviews of the relationship between evidence and policy making. In contrast to the other reviews, this chapter is not limited to examining studies that seek to understand how evidence is used in the policy process. Rather, this chapter goes further in that it catalogues the breadth of ways in which EBPM has been previously studied and, in so doing, identifies gaps that may need to be addressed.

The findings yield three major insights into the existing state of EBPM literature. First, a large proportion of articles which examine EBPM accept the validity of the concept as a given. The consequence is this: by limiting their focus to examining whether and/or why evidence has or has not been used to make a policy, these studies bolster the inviolability of the idea that policies *should* be evidence-based. Yet, none of the studies identified in this literature review offer evidence (other than opinion) to support the notion that EBPM is preferable to alternative means of making policies.[18] In simply *assuming* without proving that recourse to an evidence-base is a 'better' way to make decisions, much of the pro-EBPM literature rests on a weak, logical foundation (that is to say, the absence of evidence to support EBPM undermines the proponents' ability straight-facedly to argue that the worth of an idea should be measured wholly or largely by the evidence to support it).[19] In order for the current ascendancy of EBPM to be sustainable, proponents must either demonstrate empirically the concept's merit, or concede that some forms of evidence are difficult to obtain but that the absence of evidence ought not to be fatal necessarily. For instance, in response to a similar critique levelled against EBM, Straus and McAlister (2000) highlighted the barriers to proving

[18] While Grundy and Smith (2007) and Laforest and Orsini (2005) used case studies to demonstrate instances in which EBPM has given activists greater power and involvement in policy making, their accounts do not conclude that EBPM is the most desirable or effective approach to policy making.
[19] See Miles, Bentley, Polychronis & Grey (1997) for a comparable early critique of EBM.

that clinicians who have access to evidence make 'better' decisions than those who do not:

> No such evidence is available from randomized trials because no investigative team has yet overcome the problems of sample size, contamination and blinding that such a trial raises. Moreover, it is questionable whether withholding access to evidence from a control arm in such a trial would be ethical. However, outcomes researchers consistently document that patients who receive proven efficacious therapies have better outcomes than those who do not.
>
> Given this evidence, the focus has shifted from whether to teach evidence-based medicine to how to do so, and recent randomized trials have compared alternative strategies for enhancing evidence-based practice.

The second major insight of this chapter builds on the first. While a large proportion of the articles identified in the literature review accepted EBPM as the norm and described the barriers to and facilitators of the use of evidence in policy-making, just over one-third (n=15) of these relied on original empirical data to support these descriptions; the remainder were largely based on opinion, the authors' experiences or secondary literature. If it is to be argued that evidence is a powerful antidote to the potential risks of acting on assumptions or personal views, then it follows that the literature should attempt to collect data to test assumptions about how policies are actually made and thus better understand how EBPM can be realised.

The third major insight offered by this chapter is, at first blush, a paradoxical one. The literature review showed that the critiques of EBPM were also predominately opinion-based. Both Chapter One and the findings in this chapter demonstrate the power and appeal of evidence in public discourse. This reverential regard for 'evidence', when coupled with the aforementioned observation that very little evidence has actually been cited to support EBPM, potentially creates a unique window of opportunity for EBPM critics. In a world where 'evidence trumps', the arguments against an un-nuanced adherence to the EBPM concept have the potential to gain more traction if real world

examples and case studies are used to support them. It is possible that critics of EBPM have been reluctant to appeal to evidence for fear of being rebuked for hypocrisy.[20] If this is indeed the case, the EBPM critics are inflicting unnecessary harm to their cause. It would be rare to find a critic of EBPM who would be prepared to argue that empirical evidence is useless. As Morrell (2012) observed, "'[h]eretics' are not heretical against evidence, but they do doubt the claims of 'believers' who promote an orthodoxy that is presented as superior to all other modes of knowledge production, and suitable to all social problems." Instead, the critics argue that evidence needs to be used both *reflectively* (that is, with an appreciation of how it is produced, interpreted and valued), and *non-exclusively* (because evidence is not everything). Thus, critics ought not to shy away from using empirical evidence to breathe life into their arguments, so long as they are clear about how it is being used.

2.4. CONCLUSION

The findings of this chapter have been used to expose two shortcomings in the existing EBPM literature. The first is that the body of literature which supports or accepts the concept of EBPM generally does not present (what most EBPM adherents would consider to be) 'rigorous evidence' to justify said support or acceptance. The second shortcoming is that the body of literature which criticises the concept of EBPM generally also does not present evidence to support the criticisms, but *ought to*. A foundational premise of this thesis is that it is possible to both recognise the importance of evidence while simultaneously subjecting the concept of EBPM to critical scrutiny.

The thesis addresses the shortcomings identified in the literature by using an empirical case study to investigate both (1) how evidence was (or was not) used in Indigenous

[20] There is precedent for this in the critique of the postmodernists' reliance on "the great narrative of the end of great narratives" (Lyotard 2001; see criticism by Callinicos 1991).

tobacco control policy making and (2) whether the Indigenous tobacco control policy case study augments or challenges the apparent inviolability of the notion of EBPM.

3. Methods

In the previous chapter it was noted that a minority of the reviewed studies used empirical methods to understand how evidence is (or is not) and should (or should not) be used in policy making. Yet the empirical study of how policies are made (policy process analysis) is a well-established field of inquiry. This chapter uses the results of a literature review of empirical studies of health policy making processes to present future researchers with a 'tool box' of possible ways of understanding the role of evidence and other factors in the policy process. The findings are also used to inform the design of the present study of the use of evidence in Indigenous tobacco control policy making.

3.1. METHODS FOR HEALTH POLICY PROCESS ANALYSES

The search strategy and coding strategy for a review of empirical health policy process analyses is set out in Appendix One. The search identified 175 publications for inclusion. The studies adopted a range of methods for researching the health policy making process, as demonstrated in Table 1 below.

Table 1: Included studies, by study design[21]

Data collection method / study design used	Number of included studies
Interviews	78
Primary document review	61
Quantitative survey	23
Observation	15
Focus group	9
Ecological study	12
Open-ended survey	5[22]
Systematic review	6[23]
Case control	1

[21] The sum of the right column exceeds 175 because some studies used multiple methods.

[22] These studies are not discussed below in detail and so are cited here: Welte, Trotter, Edmunds et al. (2005); Bryson, Duclos & Jolly (2010); Burns, Mitrovich, Jauregui et al. (2010); Poulos, Donaldson & Finch (2010); Iglesias, Drummond & Rovira (2005).

[23] These studies were: Miller (2005); Welte, Trotter, Edmunds et al. (2005); Bryson, Duclos, Jolly et al. (2010); Krasovsky (2010); Knight & Chapman (2004); Iglesias, Drummond & Rovira (2005).

3.1.1. Qualitative techniques

Interviews were the most commonly used method of data collection (78 studies),[24] either alone or in combination with another method. Individuals within government were the most frequently interviewed group. The non-government actors interviewed included representatives from public-interest non-government organisations and advocates, academics/experts, health professionals, private sector representatives, patients and journalists. Of the interview-based studies which included government actors, the majority employed either a purposive sampling technique (33 studies) or a combination of purposive and snowball techniques (10 studies).

The 61 studies based on reviews of primary documents drew upon a range of sources listed in Box 3 (below).[25] Of these, policy documents and news media sources were the most frequently used (23 studies and 18 studies respectively).

[24] These studies were: Beyer (1998); Bravo Vergel & Ferguson (2006); Breton, Richard, Gagnon et al. (2006); De Vries & Klazinga (2006); Dearlove & Glantz (2002); Declercq (1999); Drope & Glantz (2003); Duncan & Reutter (2006); Durrheim, Williams, Barnes et al. (2003); Elshaug, Hiller & Moss (2008); Goldman & Glantz (1999); Hooker & Chapman (2006); Mitton, Patten, Donaldson et al. (2005); Varone & Schiffino (2004); Milio (1981); Lavis, Farrant & Stoddart (2001); Rock (2003); Sato & Frantz (2005); Teng, Mitton & MacKenzie (2007); Tenbensel, Cumming, Ashton et al. (2008); Schauffler & Wilkerson (1997); Strayer (1991); Waddell, Lavis Abelson et al. (2005); Whittaker (2002); Wilkins, Nsubuga, Mendlein et al. (2008); Wirtz, Cribb & Barber (2005); Albuja & Daynard (2009); Bate, Donaldson & Murtagh (2007); Campbell, Redman, Jorm et al. (2009); Garfield (2009); Buyana (2009); Gladwin, Church & Plotnikoff (2008); Greener, Douglas & Teijlingen (2010); Guldbrandsson & Fossum (2009); Haq, Sood, Yansen et al. (2010); Harpham & Tuan (2006); Hasman, McIntosh & Hope (2008); Jahan (2003); Kapiriri, Norheim & Heggenhougen (2003); Lewis (2009); Mamudu & Glantz (2009); Owusu-Dabo, McNeill, Lewis et al. (2010); Nakkash & Lee (2009); Petticrew, Platt, McCollam et al. (2008); Poulos, Donaldson & Finch (2010); Piovesan & Labra (2007); Ponte (2008); Richards, Murdoch, Reeder et al. (2010); Ritter (2009); Sargeant, Ramsingh, Wilkins et al. (2007); Stockwell, Whiteford, Townsend et al. (2005); Smyth (1998); Tapp & Thomson (2009); Taylor-Robinson, Milton, Lloyd-Williams, et al. (2008); Tsui, La Montagne, Levine et al. (2009); Yothasamut, Putchong, Sirisamutr et al. (2010); Tantivess & Walt (2008); Atun, Menabde, Saluvere et al. (2006); Austin-Lane, Girasek & Barbour (2004); Burgin (2003); Hyslop & Thomson (2009); Marando & Melchior (1995); Vogel, Burt & Church (2010); Backstrom & Robins (1998); Bagley, Lin, Sainsbury et al. (2007); Bedsworth (2009); Coster, Mays, Scott et al. (2009); Gaglia & Davis (2006); Teerawattananon & Russell (2008); Williams, Bryan & McIver (2007); Tkatchenko-Schmidt, Renton, Gevorgyan et al. (2008); Tay & Thomson (2008); Schneider, Gilson & Ogden (2006); Patten, Mitton & Donaldson (2005); Philpott, Maher & Grosskurth (2002); Bryan, Williams & McIver (2007); Hoeijmakers, de Leeuw, Kenis et al. (2007); Weissert & Weissert (2000).

[25] These studies were: Bravo Vergel & Ferguson (2006); De Vries & Klazinga (2006); Duncan & Reutter (2006); Potter, Avard & Wilson (2008); Hoeijmakers, de Leeuw, Kenis et al. (2007); Thuraisingam, Riddell, Cook et al. (2009); Breton, Richard, Gagnon et al. (2006); Dearlove & Glantz (2002); Declercq (1999); Drope & Glantz (2003); Durrheim, Williams, Barnes et al. (2003); Goldman & Glantz (1999);

Box 3: Types of source documents used in included studies

- Policy documents
- Government reports
- News media sources
- Minutes of meetings
- Parliamentary records
- Speeches
- Internal tobacco industry documents
- Data/technical documents
- Programme reviews/evaluations
- Public submissions
- Memoranda
- Letters of correspondence
- Transcripts of meetings
- Written recollections

Other qualitative research methods were also employed, but with less frequency. Observation (used in 15 studies) took three forms.[26] First, some researchers drew on their experience of having been actively involved in health policy making as advisors, advocates and employees. Second, some researchers attended meetings in which policy decisions were made, or observed other activities in order to understand the dynamics of health policy processes. Third, some researchers spent time 'in the field' (e.g. attended meetings and symposia) in order to gain a general understanding of the context within which health policies were made.

Hooker & Chapman (2006); Rock (2003); Milio (1981); Schauffler & Wilkerson (1997); Varone & Schiffino (2004); Whittaker (2002); Albuja & Daynard (2009); Amin, Zurovac, Kangwana et al. (2007); Sato & Frantz (2005); Gladwin, Church & Plotnikoff (2008); Guldbrandsson & Fossum (2009); Jahan (2003); Kapiriri, Norheim & Heggenhougen (2003); Mamudu & Glantz (2009); Nakkash & Lee (2009); Petticrew, Platt, McCollam et al. (2008); Piovesan & Labra (2007); Ponte (2008); Sipilanyambe, Simon, Chanda et al. (2008); Tapp & Thomson (2009); Tsui, La Montagne, Levine et al. (2009); Yothasamut, Putchong, Sirisamutr et al. (2010); Tantivess & Walt (2008); Atun, Menabde, Saluvere et al. (2006); Hyslop & Thomson (2009); Vogel, Burt & Church (2010); Coster, Mays, Scott et al. (2009); Williams, Bryan & McIver (2007); Schneider, Gilson & Ogden (2006); Marando & Melchior (1995); Bellew, Schoeppe, Bull et al. (2008); Bennett & Holloway (2010); Esmail, Phillips, Kuek et al. (2010); Harwood, Witson, Fan et al. (2005); Hastie & Kothari (2009); Muggli, Lockhart, Ebbert et al. (2010); Murray & Powell (2009); Parry (2010); Rodriguez-Ocana & Menendez-Navarro (2009); Sato (2003); Simonen, Vtanen, Konu et al. (2009); Cueto (2007); Pick, Rispel & Naidoo (2008); Sloan, Allsbrook, Madre et al. (2005); Williams, Durrheim & Shretta (2004); Arvey & Malone (2008); Bero, Montini, Bryan-Jones et al. (2001); Siegel, Carol, Jordan et al. (1997); Wismar & Busse (2002).

[26] These studies were: Duncan & Reutter (2006); Rock (2003); Wilkins, Nsubuga, Mendlein et al. (2008); Amin, Zurovac, Kangwana et al. (2007); Jahan (2003); Sipilanyambe, Simon, Chanda et al. (2008); Yothasamut, Putchong, Sirisamutr et al. (2010); Tantivess & Walt (2008); Williams, Bryan & McIver (2007); Schneider, Gilson & Ogden (2006); Patten, Mitton & Donaldson (2005); Svendsen & Koch (2006); Bryan, Williams & McIver (2007); Courtney (1987); Hoeijmakers, de Leeuw, Kenis et al. (2007).

Focus groups (used in 9 studies)[27] were most commonly used to ask members of the policy community to generate lists of factors considered relevant to the process of policy change. Other uses included developing timelines of key events relating to policy change, sharing experiences of the policy process, and exploring the relevance of particular factors to the policy process (e.g. the role of evidence).

3.1.2. Quantitative techniques

The most frequently used quantitative technique was numerical surveying of decision makers (23 studies).[28] Surveys were used to a variety of ends including to: (1) identify and/or rank factors that influenced the policy making process (i.e. Andreae, Lamarand, Abraham et al. 2009; Austin-Lane, Girasek & Barbour 2004; Baltussen, Asbroek, Koolman et al. 2007; Ottersen, Mbilinyi, Mæstad et al. 2008; Varone & Schiffino 2004); (2) identify key features of policy making processes, including the actors involved and types of information used (i.e. Burns, Mitrovich, Jaurequi et al. 2010); (3) identify barriers to decision making (i.e. Bedsworth 2009); and (4) quantify variables so that regression analyses could be performed to explore the link between policy decisions and the personal characteristics of decision makers and/or contextual factors (i.e. Brownson, Ballew, Dieffenderfer et al. 2007; Gottleib, Goldstein, Flynn et al. 2003; Price & Oden 1999).

[27] These studies were: Durrheim, Williams, Barnes et al. (2003); Mitton, Patten, Donaldson et al. (2005); Buyana (2009); Pearson, Zwi & Buckley (2010); Petticrew, Whitehead, Macintyre et al. (2004); Poulos, Donaldson & Finch (2010); Sargeant, Ramsingh, Wilkins et al. (2007); Ottersen, Mbilinyi, Maestad et al. (2008); Patten, Mitton & Donaldson (2005).

[28] These studies were: Dobbins, Cockerill & Barnsley (2001); Dobbins, Thomas, O'Brien et al. (2004); Dobbins, Cockerill, Barnsley et al. (2001); Gottlieb, Goldstein, Flynn et al. (2003); Lavis, Farrant & Stoddart (2001); Price & Oden (1999); Tenbensel, Cummin, Ashton et al (2008); Varone & Schiffino (2004); Andreae, Lamarand, Abraham et al. (2009); Baltussen, Asbroek, Koolman et al. (2007); Bryson, Duclos & Jolly (2010); Burns, Mitrovich, Jauregui et al. (2010); Ruiz Matus & Andrus (2010); Stopka, Garfein, Ross et al. (2006); Thompson, Boardley, Kerr et al. (2009); Austin-Lane, Girasek & Barbour (2004); Marando & Melchior (1995); Backstrom & Robins (1998); Bedsworth (2009); Brownson, Ballew, Dieffenderfer et al. (2007); Maibach (2003); Otterson, Mbilinyi, Maestad et al. (2008); Tsurumoto, Fukushima, Ando et al. (2009).

Twelve studies explored whether certain policy outcomes were statistically associated with the social, political, demographic and economic characteristics of populations.[29] For instance, Ahrens, Uebelher and Remington (2005) analysed the features of 15 Wisconsin cities in which smoke-free restaurant ordinance campaigns were conducted and found that successful campaigns were more likely to have politically experienced leaders, high levels of newspaper coverage and strong editorial support than unsuccessful campaigns. Boehmer and colleagues' (2008) regression analyses of child obesity prevention bills in 50 United States legislatures found that bills were more likely to be enacted if there was bipartisan sponsorship, if the bills related to safe routes to school or walking/biking trails, and if there was Democratic control of both chambers (among other factors).

Only one example of a case-control study emerged from the review of the existing literature (Cook, Tyler, Goetz et al. 1983). The researchers were informed when an investigative report about fraud and abuse in home health care would be aired on a major national television station. One week before the report was aired a purposive sample of policy makers was asked whether they viewed fraud and abuse in home health care as a serious policy issue. The same question was asked a week after the report was aired and the researchers found that the policy makers who saw or heard about the report were significantly more likely to change their views about the seriousness of the problem than those who did not know about the report.

[29] These studies were: Jones & Keiser (1986); Boehmer, Luke, Haire-Joshu et al. (2008); Clark (2009); Hersey, Lynch, Williams-Piehota et al. (2010); Miller & Wang (2009(a)); Miller & Wang (2009(b)); Niederdeppe, Farrelly & Wenter (2007); Ahrens, Uebelher & Remington (2005); Nykiforuk, Campbell, Cameron et al. (2007); Peres, Fernandes & Peres (2004); Tsurumoto, Fukushima, Ando et al. (2009); Weissert & Weissert (2000).

3.2. STUDY DESIGN

The foregoing section revealed the dominance of qualitative methods of data collection in health policy process analyses. According to Pope and Mays (1995), qualitative methods "help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meaning, experiences, and views of all the participants." A qualitative study design is thus appropriate for this thesis given the nature of its goals: (1) to understand *how* evidence was used (if at all) in a natural setting; and (2) to identify and critically reflect on the advantages and disadvantages of EBPM in an Indigenous Australian context.

Of the available qualitative techniques, this thesis did not use open-ended surveys, focus groups or observation because:

- it is difficult to probe responses given to open-ended surveys and check understanding, both of which are necessary exercises when trying to provide an accurate and detailed account of a complex phenomenon;
- it would be impractical to bring together a busy group of policy makers and advocates from different locations around Australia to participate in focus groups; and
- observation is only suitable when studying a phenomenon in 'real time', and has limited usefulness when understanding a historical policy process.

Instead, data were collected through a combination of document reviews and interviews. These methods were used by the majority of qualitative studies identified in section 3.1 above.

While approximately one quarter of the included studies described in section 3.1 relied *solely* on either interviews or documents reviews to collect their data, it is considered

prudent to combine the two methods in an attempt to overcome their respective limitations (Tansey 2007; Buse, Mays & Walt 2005). These limitations include the fact that:

- some important events in policy processes are often not recorded or the documents may be withheld from public access;
- documents can possess official and perhaps incomplete versions of events and may give a misleading perception of consensus;
- respondents may under- or over-represent their role in a policy process; and
- the passage of time might impede a respondent's ability to recall events accurately or with sufficient detail (Tansey 2007).

The overarching purpose of data collection with respect to each method is set out in Table 2 below.

Table 2: Summary of goals of data collection, by method

<table>
<tr><td></td><td colspan="2">METHOD</td></tr>
<tr><td rowspan="4">GOALS</td><td>Document review</td><td>Interviews</td></tr>
<tr><td>Identify key policy actors to be included in the interview sample.</td><td></td></tr>
<tr><td>Understand the content of relevant Indigenous tobacco control policies and aspects of how those policies were made in order to inform the interview questions.</td><td></td></tr>
<tr><td colspan="2">Obtain information to piece together an account of how the Indigenous tobacco control policies were made and understand perceived advantages/disadvantages of EBPM.</td></tr>
<tr><td colspan="2">Corroborate and fill in gaps in findings obtained through other methods of data collection.</td></tr>
</table>

3.2.1. Sampling strategy

3.2.1.1. Document review

Box 3 above (page 37) contained a list of the types of source documents consulted in the reviewed health policy process analyses; they include both documents that are

typically publicly available (i.e. policy documents, government reports, speeches, news media sources, public submissions), and those that have been produced for the private use of members of the policy making community (i.e. minutes of meetings, memoranda, internal reports, letters of correspondence). Table 3 below summarises the search strategy that was adopted for the various types of publicly available documents consulted in this thesis.

Table 3: Search strategy for publicly available documents

Type of document	**Strategy**
Policy documents and government reports	• Searched Department of Health and Ageing website ('Publications' and 'Media Release and speech archive') • Searched Australian Indigenous HealthInfoNet ('Policies' and 'Tobacco') • Searched Tobacco Control Supersite ('Australian Tobacco Timeline') • Searched websites of the following potentially relevant Government agencies: - National Aboriginal and Torres Strait Islander Health Equality Council - National Preventative Health Taskforce - Australian National Council on Drugs - Ministerial Council on Drug Strategy - Intergovernmental Committee on Drugs - Quit
Speeches	Searched Department of Health and Ageing website ('Media Release and speech archive' from December 2007)
News media sources	Searched *Factiva* for all articles published between 01/01/2007 and 06/02/2012 in the national newspaper containing the following text "(Aboriginal OR Indigenous) AND (tobacco OR smok*)"
Public submissions to government bodies, position papers etc	• Searched National Preventative Health Taskforce website • Searched websites of the following potentially relevant non-government organisations: - Action on Smoking and Health - Australian Council on Smoking and Health - Australian Drug Foundation - Cancer Council Australia - Centre for Excellence in Indigenous Tobacco Control - National Centre for Education and Training of Addiction - National Drug and Alcohol Research Centre - National Aboriginal Community Controlled Health Organisation - OxyGen

Documents produced for the private use of members of the policy making community were either provided by interview respondents or accessed under the *Freedom of*

Information Act 1982. The *Freedom of Information Act* requests and responses are reproduced in Appendix Two.

Lee (2004) has argued that academics could make much more use of the disclosure regime noting that, in 2002, requests from academics accounted for only 5% of applications under the UK Code of Practice on Access to Government Information. A recent systematic review of healthcare research since 2005 found only 16 articles where use of the UK *Freedom of Information Act 2000* was described (Fowler, Agha, Camm et al. 2013). Although there are no recent Australian data on the subject, Hazell (1989) found a similarly low proportion (3%) of *Freedom of Information Act* requests made by academics/students in 1985-86. In the research conducted as part of Chapter Two, there were no studies that explicitly stated that they had made use of documents obtained in this manner and, in the review of health policy process analyses in section 3.1 above, only one study (Thuraisingam, Riddell, Cook et al. 2009) referred to this method of data collection. The barriers to greater academic use of government disclosure legislation include: lack of knowledge of relevant procedures; cost; time constraints; and methodological concerns about the dangers of relying on information 'filtered' by third-parties (Bourke, Worthy & Hazell 2013; Lee 2004).

A number of these challenges were encountered in obtaining *Freedom of Information Act* documents for the present case study. The fact that public decision making largely occurs in private means that it is difficult to know which specific documents exist and ought to be requested to shed light on the policy making process; however, requests that are too broadly framed run the risk of high processing costs. Appendix Two shows how the first attempt to obtain documents about the *Indigenous Tobacco Control Initiative* resulted in an estimated charge of AU$10,845. Subsequent requests represented an

attempt to ensure that the scope was broad enough to capture documents that were relevant to the research questions but not so broad as to be financially prohibitive. One document was exempted from disclosure under the *Freedom of Information Act* on the basis that it was produced predominately for the purpose of Cabinet deliberations.

Despite these challenges, the use of the *Freedom of Information Act* to successfully collect 24 previously undisclosed documents relevant to the making of Indigenous tobacco control policies represents a particular strength in the design of this case study.

3.2.2. Interviews

In section 3.1 above it was observed that most of the government interview-based studies identified in the review derived their data from a purposively selected sample, as opposed to a mixture of purposive and snowballing sampling strategies. In his review of sampling methods for political process studies, Tansey (2007) observed that purposive sampling is appropriate where the researcher has sufficient knowledge of the identity of the key policy actors (e.g. a study of decision making in a government advisory committee where the members of the committee are known). However, Tansey (2007) suggested that a purposive-and-snowballing strategy is more appropriate when trying to ascertain key actors in a less discrete policy community in which individuals and groups may exercise influence in subtle and indirect ways. Indeed, Farquharson (2005) has noted that using a purposive approach, as opposed to a reputational snowball process, to identify influential actors would have led her to miss independent consultants and some academics in her analysis of Victorian health policy and tobacco control communities.

In this thesis, the documents described in section 3.2.1 above were used to create a list of individuals which included:

- those who were members of Indigenous tobacco control or drug decision making/advisory bodies (e.g. the National Preventative Health Taskforce; National Indigenous Drug and Alcohol Committee);
- senior politicians;
- individuals who occupied senior positions in the Department of Health and Ageing (DoHA) and the Office of the Minister for Health; and
- Indigenous tobacco control researchers.

Purposefully selected respondents were also asked to name other people who influenced the Indigenous tobacco control policy process under the Rudd Labor Government. A criticism of conventional 'snowballing' in policy process analyses is that 'influence' is a contested term and there is a risk that respondents might understand the concept in a way that differs from what the researcher intends (Polsby 1980). In order to overcome this problem, this thesis followed the approach adopted by Headey and Muller (1996), Considine (1998) and Farquharson (2005) and provided respondents with the following standard definition of 'influential people:

> Influential people are those who have a demonstrated capacity (not merely the potential) to do one or more of the following:
> - Shape ideas about government policy;
> - Initiate policy proposals;
> - Substantially change or veto others' proposals ... (Headey & Muller 1996).

Those identified as potential respondents (either through purposive or snowballing sampling strategies) were sent emails and a Participant Information Sheet describing the study and inviting them to participate. In the case of non-response, a maximum of three follow-up attempts were made.

Of the 50 individuals approached for interview, thirty-one participated in the study, representing a response rate of 62%. A source population of 50 policy actors was

considered reasonable given that the focus of the thesis is limited to the making of only two specific policies. A response rate of 62% is realistic for a study based on 'elite interviews'. In a meta-analysis of 175 studies reported in five leading management and behavioural science journals in 1975, 1985 and 1995, Baruch (1999) found that the average response rate for questionnaires sent to members of the public services sector was 58.2% (standard deviation 13.4); across all sectors, the average response rate for managers was 61.8% (standard deviation 21.9) and only 36.1% (standard deviation 18.2) for top managers. Of those that did not respond to or declined the interview invitation, four were politicians, seven were government advisors, one was a senior bureaucrat, four were Indigenous health researchers/experts, and three were Indigenous advocates. The anonymised characteristics of those that did respond are set out in Table 4 below.

Table 4: Characteristics of interview sample

Groups	Identifier/Code	Description	How identified
Political actors	Ministerial advisor 1	Health Ministerial advisor, 2008	Snowballing
	Ministerial advisor 2	Health Ministerial advisor, 2008	Snowballing
	Senior politician 1	Senior politician, 2008	Purposive
	Senior politician 2	Senior politician, 2008	Purposive
Bureaucrats	Senior bureaucrat 1	Senior health bureaucrat, 2008	Snowballing
	Senior bureaucrat 2*	Senior health bureaucrat, 2008	Purposive
	Senior bureaucrat 3	Senior health bureaucrat, 2008	Snowballing
	Senior bureaucrat 4	Senior health bureaucrat, 2008 (off record)	Purposive
Government advisors	NPHT member 1	National Preventative Health Taskforce member	Purposive
	TWG member 1	National Preventative Health Taskforce, Tobacco Working Group member	Purposive
	TWG member 2	National Preventative Health Taskforce, Tobacco Working Group member	Purposive
	TWG member 3	National Preventative Health Taskforce, Tobacco Working Group member	Purposive

Table 4 continued

Groups	Identifier/Code	Description	How identified
Government advisors continued	TWG member 4	National Preventative Health Taskforce, Tobacco Working Group member	Purposive
	TWG member 5	National Preventative Health Taskforce, Tobacco Working Group member	Purposive
	TWG assistant 1	National Preventative Health Taskforce, Tobacco Working Group expert assistant	Snowballing
	TWG expert assistant 2	National Preventative Health Taskforce, Tobacco Working Group assistant	Purposive
	TWG expert assistant 3	National Preventative Health Taskforce, Tobacco Working Group assistant	Purposive
	NIDAC member 1*	National Indigenous Drug and Alcohol Committee member	Purposive
	NIDAC member 2*	National Indigenous Drug and Alcohol Committee member	Snowballing
	DoHA consultant researcher	Department of Health and Ageing consultant researcher	Purposive
Indigenous health advocates	Indigenous tobacco control advocate 1*	Bureaucrat and Indigenous tobacco control advocate	Snowballing
	Indigenous tobacco control advocate 2*	Academic and Indigenous tobacco control advocate	Snowballing
	Indigenous tobacco control advocate 3*	Health NGO member	Snowballing
	Indigenous health advocate 1*	Indigenous health NGO member	Snowballing
	Indigenous health advocate 2*	Indigenous health NGO member	Snowballing
	Indigenous health advocate 3*	Academic and Indigenous leader	Snowballing
	Indigenous health advocate 4*	Academic and Indigenous leader	Snowballing
	Indigenous health advocate 5*	Indigenous health NGO member	Snowballing
Academics	Indigenous tobacco control academic 1	Indigenous tobacco control researcher and occasional government advisor	Purposive
	Indigenous tobacco control academic 3	Indigenous tobacco control researcher	Purposive
	Indigenous health academic 1	Indigenous health researcher and former bureaucrat	Snowballing

Note:
** indicates Indigenous respondent*

While there would be merit in interviewing Indigenous Australians *affected* by the policies to gain their understanding of the advantages and disadvantages around EBPM, this thesis does not do so for both ethical and pragmatic reasons. First, the researcher is an European Australian and is mindful of the perception that "indigenous communities have been 'researched to death'" (Cochran, Marshall, Garcia-Downing 2008) by Western academics whose practices were once "intimately bound up with the history of colonisation" (Humphery 2001). Second, the question of 'who speaks for Indigenous Australians?' has been a subject of debate (especially since the abolition of the national peak Indigenous representative body in 2005). The question is complicated by the fact that 'Indigenous Australian' is itself a Western construct that brings together culturally, linguistically, historically and socio-economically diverse populations who have different views and experiences. The policies being examined in this thesis were aimed at *all* Indigenous Australians (as opposed to those living in specific towns or communities) and, as such, it would be disingenuous to sample purposively a few Indigenous Australians and claim that the findings are generalisable. While 10 of the 31 respondents are Indigenous, they do not claim to speak for the Indigenous community; rather, their perspectives are those of bureaucrats, government advisors, advocates and academics who are also Indigenous.

3.2.3. Interview method

The style of interviewing that a researcher should adopt largely depends on the subject being investigated and the questions being asked (Leech 2002). A structured interview (comprising of a prepared list of questions in a fixed order) is appropriate where the researcher is familiar with the research topic, and therefore knows all of the variables of interest. However, the approach is rarely appropriate for studies in which the dynamics of a complex social phenomenon are being investigated. Such studies benefit from

being able to explore respondents' novel insights, and prompt the respondent to give greater detail where appropriate. Thus, in this thesis, semi-structured interviews were conducted using a combination of open-ended and probing questions (Berry 2002; Lilleker 2003).

Topic guides were prepared before each interview and were tailored to the knowledge and experience of each respondent. Table 5 below contains an outline of the types of items generally included in the topic guides for each group of respondents.

Table 5: Usual structure for topic guides by category of respondent

Type of respondent	**Usual structure for topic guides**
Politician or staff advisor Bureaucrat	• Perception of factors that might explain why Indigenous smoking had not been a historical priority • Perception of factors that might explain policy attention given to Indigenous tobacco control under the Rudd Government • Description of how the Indigenous tobacco control policies were developed • Description of why certain interventions were prioritised over others • Description of available evidence • Perception of the extent to which the policies were evidence-based • Description of facilitators of and barriers to the use of evidence in formulating recommendations/policies
Preventative Health Taskforce / Tobacco Working Group member	• Perception of factors that might explain policy attention given to Indigenous tobacco control under the Rudd Government • Description of how Taskforce/Working Group set about making recommendations for Indigenous tobacco control • Description of available evidence • Perception of extent to which recommendations were supported by evidence • Description of facilitators of and barriers to the use of evidence in formulating recommendations • Perception of how well the recommendations were translated into policy
Advocate	• Insights into history of Indigenous tobacco control in Australia • Perception of factors that might explain why Indigenous smoking had not been a historical priority • Perception of factors that might explain policy attention given to Indigenous tobacco control under the Rudd Government • Overview of whether/how advocates used evidence to influence the policy process • Perception of how well evidence was used to formulate recommendations and policies for Indigenous tobacco control • Perception of facilitators of and barriers to the use of evidence in formulating Indigenous tobacco control policies • Ideas as to how evidence should have been used

Table 5 continued

Type of respondent	Usual structure for topic guides
Academic	• Insights into history of Indigenous tobacco control in Australia • Perception of factors that might explain why Indigenous smoking had not been a historical priority • Perception of factors that might explain policy attention given to Indigenous tobacco control under the Rudd Government • Description of the available evidence • Perception of how well evidence was used to formulate recommendations and policies for Indigenous tobacco control • Perception of facilitators of and barriers to the use of evidence in formulating Indigenous tobacco control policies

All interviews commenced with an introduction to the study as a means of reminding the respondents of the intended parameters of the discussion, and putting the respondents at ease. This was typically followed up with a 'grand tour' question (e.g. "Tell me what you know about the history of Indigenous tobacco control policies in Australia"; or "Can you give me a sense of how Indigenous smoking came onto the political agenda?"); the purpose of this was to allow the respondent to demonstrate their knowledge through a nonthreatening question, and to mention key events and factors that could then be explored through subsequent questions, thus providing a sense of flow to the discussion (Leech 2002).

The interviews generally then advanced through more focussed, open-ended questions moving from the general to the specific; for instance, some respondents were asked, "How did the Taskforce go about making its Indigenous tobacco control recommendations?" followed by "What information, if any, did the Taskforce find helpful in making its Indigenous tobacco control recommendations?" Probing techniques (e.g. "That was very interesting, could you just elaborate on ...") were employed where more detail was required, or where it was necessary to discern whether an unanticipated insight was worth investigating further or merely amounted to a

"distracting digression" (Berry 2002; Lilleker 2003). Care was taken to use the respondents' own language when probing, to avoid contaminating the data by importing the interviewer's own conceptual understandings (Leech 2002).

All interviews were audio recorded to enhance reliability and validity of the data. The interview methods described received ethics approval from the Central University Research Ethics Committee, University of Oxford (Ref: SSD/CUREC1/12-013) and the Human Research Ethics Unit of Deakin University (Ref: 2012-218). Respondents were required to give express, informed consent to participate in the study (and were told of their right to withdraw at any time) and the anonymity of respondents' data was guaranteed to protect their reputations and interests. Respondents were also given an opportunity to review and discuss chapters in which they were quoted.

3.2.4. Data analysis

The Framework Analysis method devised by the National Centre for Social Research was used to analyse the archival and interview data. The method offers a systematic and transparent approach to interpreting qualitative data (Ritchie, Spencer, O'Connor et al. 2003), as outlined in the key steps summarised in Table 6 below. In essence, the process involved:

- becoming familiar with the data by listening to recordings, transcribing and reading the transcripts/documents;
- noting down key recurring themes and sub-themes (as set out in Box 4 below);
- using NVivo to code the data according to the themes and sub-themes;
- transferring the coded data into charts (one for each theme, e.g. barriers to EBPM) which were organised in rows by source (e.g. respondent or document

title) and in columns by sub-theme (e.g. quality of evidence, time pressures); and

- looking down the chart columns to observe recurring patterns and tensions.

Table 6: Summary of Framework Analysis

Step	Description
Familiarisation	Researcher becomes immersed in the data through reviewing audio recordings and reading interview transcripts and documents.
Identifying a thematic framework	Researcher records key issues, concepts and themes expressed by the respondents/documents that are relevant to the research questions.
Indexing	Researcher returns to the data and identifies extracts that correspond to the issues, concepts and themes identified in the previous stage.
Charting	Researcher transfers data extracted in the previous stage into charts arranged according to themes and sub-themes.
Mapping and interpretation	Researcher uses the charts created in the previous stage to observe patterns and tensions, define concepts, identify associations and provide explanations of events and phenomena.

Based on information in Srivastava and Thomson (2009)

The codes used to index the data are summarised in Box 4 below.

Box 4: Codes and sub-codes for data analysis

Political priority

- Why Indigenous smoking historically not prioritised
- Factors explaining rise in prominence in 2008
    - Evidence
    - Other (open coding)

Process – How the policies were made/adopted

- Descriptions at each level
    - National Preventative Health Taskforce Tobacco Working Group level
    - Department of Health level
    - Ministerial level
- Role of evidence
- Role of other factors (open coding)

Evidence

- Amount available
- Quality available
- Appropriateness/applicability to policy question
- Barriers to use (open coding)
- Facilitators to use (open coding)

In interpreting the data, the following set of questions was considered:[30]

- Who is providing the information?
- Was the person providing the information in a position to be authoritative about the subject (i.e. did they have first-hand knowledge)?
- Are there reasons to believe that the person providing the information is unreliable?
- For whom is the information being provided?
- Why/under what circumstances is the information being provided?
- Is the meaning of the information clear and unambiguous?
- Can the information be corroborated through other sources?

Naturally, the answers to these questions were not always apparent and there is a large degree of judgment needed to determine the weight to be placed on the data. As such, in reporting the findings, quotations are reproduced (along with a description of the source) and consensus/disagreement between the data sources is noted to maximise transparency.

3.2.5. Quality considerations and potential limitations

Aside from the risks associated with subjective interpretations of the data, there are a number of other potential limitations to the study design. With respect to the document reviews, it is possible that key sources have been omitted due to the nature of the *Freedom of Information Act* regime – namely, the need to identify specific documents or incur the high costs associated with more generalised searches.

[30] The questions are an amalgam of those recommended by George and Bennet (2005) in their work on case study methodology, Buse, Mays and Walt (2005) in their advice for conducting health policy process analyses, and Davies (2001) in his reflections on the challenges of researching members of the intelligence and security services.

With respect to the interviews, two potential limitations arise. First, it is possible that a non-response bias exists in the sense that the respondents may have differed from those who declined or did not answer requests for an interview. However, this is an inherent risk of all policy process studies and the response rate of 62 percent is above average for elite interview studies. Second, interview responses might have been affected by the memories of the respondents, and other barriers to accuracy and frankness such as the desire to give socially-desirable answers or to protect one's professional reputation or career prospects (Lea 2008; Oxman, Lavis & Fretheim 2007). The fact that interviews were being recorded might have further affected the data in that respondents may not have been comfortable revealing sensitive or potentially embarrassing information (Peabody et al. 1990; Al-Yateem 2012). Attempts have been made to guard against these risks by using probing questions and corroborating key findings with data from other sources. Guaranteeing confidentiality and anonymity might have also increased the respondents' willingness to provide accurate accounts of their experiences and observations.

3.3. CONCLUSION

This chapter drew upon a literature review of methods used in empirical health policy process analyses to investigate ways of filling the gaps in EBPM research identified in Chapter Two. It noted that most existing empirical health policy analyses rely on interviews or archival/primary document research, and that there are strong reasons for combining the two approaches to data collection. The thesis therefore adopts a study design based on both methods. While most existing health policy process analyses that include government respondents adopt a purposive sampling strategy, the chapter notes that such an approach risks overlooking policy actors who may have subtle and indirect (although important) influences on the policy process. As such, this thesis has used

purposive-and-snowballing methods to identify 50 Indigenous tobacco control policy actors, 31 of which participated in the study yielding an above average response rate of 62 percent. The findings drawn from the interviews and review of primary documents are set out in subsequent chapters.

4. The context of Indigenous policy

Indigenous people account for 2.5% of the total Australian population, and 27% of prisoners (ABS 2010), 4% of hospital separations (ABS 2013), 9% of the homeless population (AIHW 2011), and 34% of all children in out-of-home care arrangements (AIFS 2013). It is thus clear that, despite its small size, the Indigenous population features prominently in debates about socio-economic disadvantage in Australia. As Kowal (2013) has noted, "Indigenous disadvantage is considered by many Australians to be the greatest policy challenge our nation faces." Government policies are (often simultaneously) perceived as both the reason for Indigenous disadvantage, and the potential solution to it. On the one hand, past policies are often cited as having placed Indigenous Australians at a relative disadvantage compared to other Australians through officially sanctioned discrimination. On the other hand, current policy makers are frequently criticised for not doing enough to overcome the legacies of the past and create the conditions for Indigenous advancement. The purpose of this chapter is to provide an entry-point for understanding the context within which Indigenous policies are made.[31]

4.1. A BRIEF OVERVIEW OF INDIGENOUS POLICY, 1780s-1960s

4.1.1. Land policies: dispossession

British colonies began to be established in parts of what is now Australia in the late eighteenth century. Unlike New Zealand (where Britain entered into a treaty with the indigenous population) and North America (where policy eventually dictated that colonial settlers and governments should *acquire* land from indigenous inhabitants), the continent of Australia was regarded as *terra nullius* (land belonging to no-one) and

[31] For a more detailed discussion of the history of Indigenous policy making see Chaney (2012).

could thus be acquired through the simple act of occupation or settlement (Banner 2005). A rationale for the application of the concept was that "the indigenous inhabitants of the Australian colonies [were perceived] as people too low in the scale of social organization to be acknowledged as possessing rights and interests in land" (*Mabo v Queensland (No 2)*, per Brennan J). As a consequence, large numbers of Indigenous people were dispossessed from their traditional lands or had their proprietary rights ignored or curtailed.

4.1.2. Health policies: palliation

When combined with nineteenth century social Darwinist theories of society, the belief that the Indigenous people were "low in the scale of social organisation" meant that the population was imagined to be on an unchangeable course of demographic decline owing to a primitive and weak disposition which made it unable to survive contact with the modern European world (McGregor 1997). As such, the formulation of Indigenous health policies was initially viewed as a futile exercise, save in so far as those policies might protect the white population from the threat of contagion (e.g. venereal disease, trachoma and leprosy), or protect the Indigenous people "from overt injustice and brutality – for the short time they had left upon this earth" (McGregor 1997). Thomas' (2004) archival research supports this interpretation, finding "[m]ost people [in the nineteenth century] believed that little could be done to prevent the inevitable demise of the race, so only palliative services would be required for the short time that remained before this final moment, 'smoothing the pillow of a dying race'."

4.1.3. Social policies: segregation and assimilation

As long as the Indigenous population survived, it was widely accepted that there was a need for social policies to regulate how the population would co-exist with Anglo-

Australians. At least until the late 1960s, the majority of these policies existed along a spectrum with 'segregation' at one end and 'assimilation' at the other.

For example, the *Aboriginal Ordinance Act 1918* (which applied to the Northern Territory) contained a number of segregationist provisions, including: (1) the ability to keep Indigenous people in reserves or institutions, and prevent them from leaving (section 16); (2) allowing authorised persons to order Indigenous people out of "any municipality, town, township, public house, or wine and spirit store" (section 18); and (3) prohibiting Indigenous women from marrying non-Indigenous men without permission (section 45).

The same law also contained provisions which deemed the Chief Protector the legal guardian of "every aboriginal and of every half-caste child, notwithstanding that the child has a parent or other relative living" (section 7), and enabled the Chief Protector to "undertake the care, custody and control of any aboriginal or half-caste, if, in his opinion, it is necessary or desirable" (section 6). Such 'child welfare' provisions were replicated in the laws of other Australian jurisdictions and became a mechanism through which forced child removal ('Stolen Generation') policies were carried out.

These assimilationist policies were generally aimed at 'light skinned' children who were deemed to be part of an Indigenous sub-population that was not 'dying' as the 'doomed race' theory suggested. According to the 1997 *Report of the Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*:

> By the late nineteenth century it had become apparent that although the full descent Indigenous population was declining, the mixed descent population was increasing ... In social Darwinist terms they were not regarded as near extinction. The fact that they had some European 'blood' meant that there was a place for them in non-Indigenous society, albeit a very lowly one.
>
> Furthermore, the prospect that this mixed descent population was growing made it imperative to governments that mixed descent people be forced to join the

workforce instead of relying on government rations. In that way the mixed descent population would be both self-supporting and satisfy the needs of the developing Australian economy for cheap labour.

...

Government officials theorised that by forcibly removing Indigenous children from their families and sending them away from their communities to work for non-Indigenous people, this mixed descent population would, over time, `merge' with the non-Indigenous population. As Brisbane's *Telegraph* newspaper reported in May 1937,

> Mr Neville [the Chief Protector of Western Australia] holds the view that within one hundred years the pure black will be extinct. But the half-caste problem was increasing every year. Therefore their idea was to keep the pure blacks segregated and absorb the half-castes into the white population. Sixty years ago, he said, there were over 60,000 full-blooded natives in Western Australia. Today there are only 20,000. In time there would be none. Perhaps it would take one hundred years, perhaps longer, but the race was dying. The pure blooded Aboriginal was not a quick breeder. On the other hand the half-caste was. In Western Australia there were half-caste families of twenty and upwards. That showed the magnitude of the problem (quoted by Buti 1995 on page 35).

In Neville's view, skin colour was the key to absorption. Children with lighter skin colour would automatically be accepted into non-Indigenous society and lose their Aboriginal identity (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families 1997).

The report estimated that "between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970" (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families 1997).

4.2. THE CONTEMPORARY POLICY LANDSCAPE

From the 1970s, public discourse around Indigenous policy making has variously centred on the following main principles:

- **self determination:** providing the Indigenous population with some power over the administration of its own affairs (e.g. the creation in 1990 of the Aboriginal and Torres Strait Islander Commission which gave an elected body of Indigenous representatives control over some programs and services);

- **rights and reconciliation:** attempting to redress past wrongs and acknowledging that the government has distinct obligations to the Indigenous population (e.g. the passage of the *Native Title Act 1993*, the commissioning of an independent inquiry into child removal, the provision of distinct forms of welfare for Indigenous Australians, and the delivery of a national apology to the Stolen Generations); and
- **shared responsibility or partnership:** the idea that both the government and Indigenous communities have responsibilities when it comes to improving Indigenous outcomes (e.g. the emergence of Shared Responsibility Agreements in the 2000s in which payments to communities/individuals were contingent on recipients achieving agreed goals in areas such as school attendance and employment).

It is beyond the scope of this chapter to examine each policy paradigm in detail. Instead, for the purposes of the case study it is sufficient to note that, despite the development of these contemporary paradigms, the historical treatment of Indigenous Australians continues to loom large in policy debates.

Arguably the most controversial Indigenous policy in recent times was the Northern Territory National Emergency Response (hereafter, 'Emergency Response' or NTER) which was announced and implemented in the months preceding the Federal election in which Rudd's Australian Labor Party defeated the incumbent conservative Government of then Prime Minister John Howard. The policy was supported by both major parties and was framed as a response to the *Little Children are Sacred* report documenting the problem of child abuse, including sexual abuse, in some Indigenous communities

(Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007).

The legislation enabling the Emergency Response included measures to: compulsorily acquire some townships from native title holders; outlaw the purchase, transportation or consumption of alcohol in prescribed areas; and impose compulsory income management of welfare payments received by residents in prescribed areas.[32] The health aspects of the Emergency Response originally included "compulsory health checks for all Aboriginal children to identify and treat health problems and any effects of abuse" (Minister for Families, Community Services and Indigenous Affairs 2007). The policy was later modified so that all health checks became voluntary and limited to non-forensic examinations, such as height and weight measurements and pin-prick blood tests (Department of Health and Ageing 2007).

It is estimated that over 70 percent of Aboriginal people living in the Northern Territory resided in the prescribed areas (Northern Territory Emergency Response Review Board 2008). In order to facilitate the implementation of the policy, the *Northern Territory Emergency Response Act 2007* excluded itself from the operation of the *Racial Discrimination Act 1975*. In addition, the Federal Government deployed 600 Australian Defence Force personnel, including 400 soldiers, into the affected communities (Ashby-Cliffe 2008).

While some Indigenous public figures supported the spirit of the initiative (e.g. Langton 2008; Pearson 2007), other voices compared aspects of the Emergency Response to historical injustices committed against the Indigenous population. An advocate for

[32] *Northern Territory Emergency Response Act 2007; Social Security and Other Legislation Amendment (Welfare Payment Reform) Act 2007; Families, Community Services and Indigenous Affairs and Other Legislation Amendment (Northern Territory National Emergency Response and Other Measures) Act 2007.*

Indigenous rights described the Emergency Response as "officially sanctioned racial discrimination" (McMullen 2010). Indigenous leaders, such as Pat Turner, questioned the aspects of the policy that permitted compulsory acquisition: "We believe that this government is using child sexual abuse as the Trojan horse to resume total control of our lands" (Turner cited in Robertson 2007). Other Indigenous people perceived that the Emergency Response represented a backwards step, as articulated in the following quotations gathered through a health impact assessment of the policy measures:

> It felt like the stolen generation was coming back, so I was scared [Indigenous community member].
>
> ... '[I]'s gone back to the old way now'. That's what the old people said it's gone back to the old way ... It's that dictatorship and it's the controlling of Aboriginal people's lives and how do they expect us to control our lives if they're trying to control it in a culturally foreign manner and totally violating human rights [Indigenous doctor].
>
> It's taking away our self-management and autonomy, disempowering us. People are feeling pain in their hearts. There seems to be nowhere to go and all the roads seem to be blocked no matter which way we turn [Indigenous community member] (Australian Indigenous Doctors' Association & Centre for Health Equity Training, Research and Evaluation 2010).

The Government-appointed Northern Territory Emergency Response Review Board (2008) confirmed some of these views and concluded the following from its inquiry:

> In many communities there is a deep belief that the measures introduced by the Australian Government under the NTER were a collective imposition based on race.
>
> There is a strong sense of injustice that Aboriginal people and their culture have been seen as exclusively responsible for problems within their communities that have arisen from decades of cumulative neglect by governments in failing to provide the most basic standards of health, housing, education and ancillary services enjoyed by the wider Australian community.
>
> Support for the positive potential of NTER measures has been dampened and delayed by the manner in which they were imposed.
>
> The Intervention diminished its own effectiveness through its failure to engage constructively with the Aboriginal people it was intended to help.

4.3. EBPM AS AN ALTERNATIVE POLICY PARADIGM

Pat Anderson, an Indigenous leader and co-author of the *Little Children are Sacred* report (which was cited as the justification for the Emergency Response) has expressed anger about the way the policy was made. The following excerpt from a speech by Anderson (2011) summarises her complaints:

> As many of you will know, in 2006 I was asked by the Northern Territory Government to carry out – along with Rex Wild QC – an inquiry into child sexual abuse and neglect in the Territory.
>
> This followed disturbing – though I am sorry to say, not new – revelations about the way children were being maltreated and neglected in Aboriginal communities in the Territory.
>
> In looking at this difficult area, our approach was based on two sources of evidence.
>
> First, we wanted to look at the formal published evidence about what works in these kind[s] of situations – we had experts in this field on our team and we spoke to many more during the course of our investigation.
>
> Second, we wanted the evidence and experience of Aboriginal communities and organisations – what they felt, what they believed, what they thought would work 'on the ground'.
>
> ...
>
> When Rex Wild and I came to write the report, we recorded as faithfully as we could what people told us, and we put forward almost one hundred recommendations to address the issues they raised.
>
> But for me the very first recommendation was the most significant. It said:
>
> > It is critical that both [the Northern Territory and Federal] governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities [to address child sexual abuse and neglect].
>
> This recommendation was strongly informed by the willingness and determination of many in the Aboriginal community to work with the authorities to address the problems they faced.
>
> It was also strongly based on the evidence.
>
> We know that the evidence on the social determinants of health includes confirmation that 'the control factor' – what we might call empowerment – is a critical determinant of health.

> Conversely, disempowerment and social exclusion have powerful negative effects on health.
> ...
>
> Our recommendations were premised on the idea that many of these communities needed substantial assistance and support.
>
> However, in keeping with the evidence (and, I might add, various international conventions to which Australia is a signatory) our report recommended an approach where the support is delivered with and in consultation with communities, rather than imposed upon them
>
> Critically, however, our recommendation about working with Aboriginal communities was ignored.
>
> Where we emphasised the need for resources and for flexible processes of engagement with Aboriginal families and communities, the Intervention emphasised external control and 'blanket' provisions affecting all Aboriginal people.
> ...
>
> These proposals were accompanied by a 'get tough, quick fix' rhetoric that made it abundantly clear where the problem lay: it lay with us, it was Aboriginal people who were to blame for the conditions in which we lived.
>
> What we needed was a good kick up the bum, and then the non-Aboriginal State would just have to come in and fix it all for us, as we were obviously incapable of doing so ourselves (Anderson 2011).

For Anderson (2011), evidence was regarded as less important than other factors such as "calculations about narrow political advantage, unexamined prejudices and assumptions" and, as such, evidence was ignored or used selectively by those who formulated the Emergency Response.

Others have joined Anderson (2011) in arguing that greater use of evidence is the remedy for a culture of policy making that harms and fails Indigenous Australians.[33] For instance, the Indigenous academic, Larissa Behrendt (2008), has argued that there is a need to move "away from failed ideological policies to an evidence-based approach to reducing the disadvantage, violence, substance abuse faced by Aboriginal women and

[33] See Partridge (2013) for a general discussion.

children." Elsewhere, Behrendt (2011) has argued that the only way to investigate why the gap between Indigenous and non-Indigenous socio-economic outcomes endures despite considerable investment over time is "to understand where and why policy success occurs ... through an evidence-based approach." Director of the Onemda VicHealth Koori Health Unit, Professor Ian Anderson, has expressed the need for EBPM along similar lines:

> Debate in Aboriginal health policy is too frequently hijacked by ideology and political philosophy. Well-focused, rigorous research and evaluation underpins an approach to Aboriginal health policy that is evidence based. This provides a significant corrective for uninformed rhetoric and 'policy by anecdote'. A non-politicised approach to Aboriginal health policy, informed by evidence, has the potential for generating the insights fundamental to innovation and the intellectual alliances necessary for sustained commitment to action (Cooperative Research Centre for Aboriginal Health 2008).

4.4. CONCLUSION

This chapter has offered a lens through which to examine the contemporary Indigenous policy context. It noted that, following Britain's colonisation of Australia, the Indigenous population was the target for a range of overtly discriminatory policies, including dispossession from native lands, segregation, the denial of rights enjoyed by non-Indigenous citizens, and the forced removal of children from families. While Indigenous policy paradigms since the 1970s have centred on concepts such as self-determination, rights, reconciliation and partnership, the example of the 2007 Emergency Response showed how historical legacies continue to bear upon contemporary policy discussions. The chapter concluded with the observation that the controversy surrounding the Emergency Response has been used by some Indigenous leaders and academics (and others) to advocate for a greater commitment to evidence in Indigenous policy making, including health policy making.

As was explained in Chapter One, the Rudd Labor Government rose to power in December 2007 with an explicit commitment to EBPM, particularly in the area of Indigenous affairs. As the Labor parliamentarian, Chris Evans (2006(a)), noted, "[b]oth major parties have pursued their ideological convictions in Indigenous policy to the detriment of Indigenous Australians ... But from here on our guiding principle will be the evidence of what works and what does not work in reducing disadvantage. Not ideology – evidence." The chapters that follow will use two major Indigenous health policies as lenses through which to examine: how (if at all) evidence was used by the Rudd Government; the barriers to and facilitators of its use; and whether EBPM is as helpful and desirable as its proponents promise, including Indigenous advocates and academics such as Pat Anderson, Larissa Behrendt and Ian Anderson.

In particular, it will be shown that top-down evidence-based policy making may invoke comparisons with past paternalistic policies, and may not give due consideration to historical legacies of discrimination and the call for greater Indigenous involvement in policy processes. The findings will highlight the potential dangers of championing EBPM as a comprehensive solution to Indigenous disadvantage – particularly where there is a dearth of evidence or where the evidence that does exist conflicts with the values and preferences of Indigenous community members.

5. Indigenous smoking on the agenda

The election of the Rudd Government served as a turning point for Indigenous tobacco control, as demonstrated by the investment of more than AU$120 million into Indigenous anti-smoking measures in 2008. According to Mike Daube (an experienced tobacco control advocate) and Tom Calma (a high-profile Indigenous leader), 2008 marked the beginning of a period "that has seen more action on indigenous smoking than any other time in our history" (Calma & Daube 2011).

Prior to then, there had been no major Australian government policy specifically geared towards reducing Indigenous smoking rates. In 2005, a government report (*National Tobacco Strategy, 2004-2009*) noted that:

> Little progress has been made in institutionalising the treatment of tobacco dependence in [Indigenous] community-controlled health centres or in making smoking cessation a focus of service for Indigenous people using mainstream health services (Commonwealth of Australia 2005).

Another report (*Indigenous-specific Alcohol and Other Drug Interventions: Continuities, Changes and Areas of Greatest Need*) showed that tobacco was specifically targeted in only 2% and 3% of Indigenous-specific alcohol and other drug intervention projects in 1999-2000 and 2006-07 respectively (Gray, Stearne, Wilson et al. 2010).[34]

The first part of this chapter examines the scale of the Indigenous smoking problem, and draws upon existing literature to provide some context for the high smoking prevalence. The second part of this chapter uses data collected from interviews and archival research to understand what role (if any) evidence played in bringing Indigenous smoking onto the agenda in 2008.

[34] While the focus of the report was on both government and non-government projects, 97% of the projects were government funded.

5.1. BACKGROUND TO THE INDIGENOUS SMOKING PROBLEM

5.1.1. Prevalence

Although Indigenous tobacco control did not feature prominently on the political agenda until 2008, there had long been evidence to indicate high Indigenous smoking rates. For instance, a 1994 survey of over 15,700 Indigenous Australians found that 49.7% of respondents over the age of 13 years smoked daily (ABS 1995). Similarly:

- a 2002 survey found that 48.6% of Indigenous Australians aged 15 years and over (n=9,400) were current daily smokers (ABS 2008; ABS 2009);
- a 2004-05 survey found that 50% of Indigenous Australians aged 18 years and over (n=10,439) were current daily smokers (ABS 2006); and
- a 2008-09 survey found that 45.1% of Indigenous Australians aged 15 years and over (n=13,300) smoked according to a regular pattern (including daily and weekly) (ABS 2010; ABS 2013).[35]

At the time the *Indigenous Tobacco Control Initiative* and *Tackling Indigenous Smoking Measure* were introduced, Indigenous Australians were 2.4 times more likely to smoke daily than their non-Indigenous counterparts and were less likely to have never smoked or to have quit smoking, as depicted in Table 7 below.

[35] It is noted that the data are not directly comparable due to differences in age cut-offs and definitions of current smoking (see Thomas 2009; 2012). The significance of this will be discussed more fully in section 7.1 (below).

Table 7: Age-standardised smoking rates among persons aged 18 years and over, by Indigenous status, 2008

	Age standardised rate		Ratio	Rate difference
	Indigenous	Non-Indigenous		
Current smoker	49.8	20.5	2.4	29.3
Daily	47.7	18.6	2.6	29.1
Other	2.2	1.9	1.2	0.3
Ex smoker	21.4	29.9	0.7	-8.5
Never smoked	28.8	49.6	0.6	-20.8
TOTAL	**100**	**100**	...	...

Note: Total includes those whose status is not known.

Source: AIHW (2011)

While overall Indigenous smoking rates were high, there was a great deal of variation within the Indigenous population. For instance, Indigenous smoking rates were generally higher in remote communities (59% for males and 50.4% for females) than in non-remote communities (50.2% for males and 46.3% for females) (Thomas 2012). In some communities (e.g. Milingimbi, Northern Territory), the prevalence was reported to be as high as 70% (Coppa & Tay 2011).

5.1.2. Possible reasons for high Indigenous smoking rates

Several reasons have been posited for the high rates of Indigenous smoking. The reasons broadly fall into three categories – namely, smoking as a means of coping with socio-economic pressures, smoking as a consequence of lack of access to services, and smoking as a social norm.

5.1.2.1. Smoking as a means of coping with socio-economic pressures

There is a well-established association between socio-economic disadvantage and smoking (Jarvis & Wardle 2006). In general, Indigenous Australians are disadvantaged across a range of indicators. For instance, compared to the non-Indigenous population, Indigenous Australians are half as likely to complete ten years of formal schooling, 14.2 times more likely to be imprisoned, and 4.8 times more likely to live in overcrowded

housing (Steering Committee for the Review of Government Service Provision 2011). In 2008, the median Indigenous household weekly income (AU$445) was almost AU$400 lower than the non-Indigenous equivalent (AU$746) (Steering Committee for the Review of Government Service Provision 2011).

A logistic regression analysis of data from the 2002 *National Aboriginal and Torres Strait Islander Social Survey* (NATSISS) found statistically significant associations between non-smoking and socio-economic position, as measured by various measures including income, education level, employment participation and housing ownership, as demonstrated in Table 8 below. Specifically, Indigenous people who were in the highest three income quintiles had 2.5 times the odds of being non-smokers; those who had completed at least the penultimate year of secondary school or non school-qualifications, and those who were employed had 1.6 times and 2.03 times the odds of being non-smokers, respectively.

Table 8: Odds ratio for being an Indigenous smoker versus being a non-smoker, adjusted for age and gender, by socio-economic variables, 2002

	N	% of total smoking population	Odds ratio	(95% CI)
Income[a]	7,954			
Lowest quintile		42.5	1.00	
2nd quintile		28.2	1.49[b]	(1.20-1.85)
3rd, 4th or highest quintile		29.3	2.50[b]	(1.96-3.18)
Education	9,169			
Year 10 or below or never attended		60.5	1.00	
Year 11 or 12 or non-school qualifications		39.5	1.60[b]	(1.36-1.89)
Employment	9,188			
Not in labour force		40.4	1.00	
Employed in public or private sector		33.5	2.03[b]	(1.64-2.52)
Unemployed or CDEP [c]		26.1	0.76[d]	(0.61-0.94)
Principal source of income	9,200			
Government cash pensions (including CDEP)		60.8	1.00	
Not Government pensions		39.2	2.52[b]	(2.09-3.03)
Financial stress				
Could not raise $2000 within a week	8,872	57.0	1.0	
Could raise $2000 within a week		43.0	2.33[b]	(1.94-2.79)

Notes:

a) *Equivalised household gross weekly income using national quintiles from 2002 General Social Survey*
b) *p<0.0001*
c) *CDEP = Community Development Employment Projects*
d) *p<0.05*

Source: Thomas, Briggs, Anderson et al. (2008)

Social disadvantage has the potential to result in greater exposure to life stressors, such as financial vulnerability and ill health. A recurring explanation for high Indigenous smoking rates is that smoking is perceived to be a way of dealing with the stress of high community death rates, the absence of opportunities, and the legacies of dispossession and racism (Fletcher, Fredericks, Adams et al. 2011; Lindorff 2002; Mark, McLeod,

Booker et al. 2005; Di Giacomo 2007; Thomas, Briggs, Anderson et al. 2008).[36] Data from the 2008 NATSISS indicated that 37% of current daily Indigenous smokers had experienced high/very high levels of psychological distress in the month preceding the survey, compared with 23% of non-smokers (ABS 2010). Of course, the possibility of other confounding factors cannot be discounted in this study.

5.1.2.2. Smoking as a consequence of lack of access to services

The 2008 NATSISS also found that, on a national level, 26.4% of Indigenous people aged 15 years and over had problems accessing health services generally, and 14.5% of Indigenous persons living in remote areas had problems accessing doctors, specifically (ABS 2010). The types of problems encountered include cost, transport barriers, and an absence of services in the area, all of which are more commonly reported by the remote Indigenous population (see Table 9 below). Such factors have the potential to also impede Indigenous access to tobacco cessation services, such as quit advice delivered by medical professionals (Winstanley, van der Sterren & Knoche 2012).

Table 9: Types of problems encountered by remoteness, Indigenous people aged 15 years and over, 2008

Reason	Non-remote %	Remote %
Waiting time too long/not available when needed	55.0	33.2
No services in the area	27.3	50.9
Not enough services in the area	34.0	47.1
Transport/distance	24.7	45.8
Cost of service	37.5	16.5
Don't trust services	7.3	5.6
Services not culturally appropriate	5.5	4.7

Source: ABS (2010)

Only a small minority of Indigenous persons (5.5% of the non-remote population and 5.7% of the remote population) reported problems accessing Indigenous Health

[36] Some studies suggest that smoking *causes* rather than alleviates stress: see Parrott (1999).

Workers (IHWs) (ABS 2010). IHWs generally live in the communities in which they serve and are often the first point of contact for Indigenous persons seeking health services; they deliver a range of primary healthcare services including screening, referrals and community education (Mitchell & Hussey 2006; Allied Health Professionals Australia 2013). However, some studies suggest high rates of smoking among IHWs. For instance, a study of the effectiveness of brief intervention training in north Queensland health care settings found that 11 of 24 IHWs (46%) interviewed at baseline were smokers (Harvey, Tsey, Cadet-James et al. 2002). A 1995 survey of IHWs employed in western New South Wales (54% response rate, n=22) found that 64% were current smokers (Andrews, Oates & Naden 1997). An IHW's own smoking status may serve as a barrier to the provision of smoking cessation advice to clients owing to a fear of appearing hypocritical (Thompson, Robertson & Clough 2011). Other barriers to IHWs providing quit advice include competing health issues and community priorities. Harvey and colleagues' (2002) interviews with IHWs included the following responses: "People make fun of you [when you try to give smoking cessation advice] and don't take you seriously" and "There are so many other things happening such as alcohol-related issues and domestic violence, petrol sniffing."

5.1.2.3. Smoking as a social norm

It has been suggested that the high rates of current Indigenous smoking create a social norm that both encourages people to take up smoking and makes it difficult to quit. In relation to uptake, a survey of 324 Indigenous Australian students found that 70% said that they smoked because "most of [their] friends smoke", and 55% said that they smoke because "most of [their] family smoke" (Lowe, Saeck, Brough et al. 2004). Focus group discussions conducted as part of the National Aboriginal and Torres Strait Islander Tobacco Control Project were reported to have "[o]verwhelmingly ... stated

that tobacco was very much accepted in their communities. They thought that people's attitudes were fairly complacent, it was seen as normal, not unusual and that virtually everyone does it" (Lindorff 2002).

In relation to quitting, it has been suggested that smoking serves an important social function in Indigenous communities, and that not smoking can result in alienation. For instance an evaluation of a tobacco control intervention in Indigenous health care settings evoked the following responses: "People who don't smoke become a pariah, they can be ostracised" and "It's hard for me because everyone I know smokes. I don't socialise that much and people say you're a snob" (Harvey, Tsey, Cadet-James et al. 2002). Semi-structured interviews with members of a remote Indigenous community revealed that, against a cultural background in which reciprocal exchange is an expression of kinship ties, "the passing around and sharing of cigarettes is part of the social fabric of the community" (Johnston & Thomas 2008); being a non-smoker therefore affects one's ability to interact with others in this way.

Furthermore, high levels of contact with other smokers may compromise quit attempts. One study found that having other smokers in the household ($p=0.01$) and having a smoking partner ($p<0.001$) were significantly associated with Indigenous female smoking during pregnancy (Gilligan, Sanson-Fisher, D'Este et al. 2009). Qualitative research on the subject offers some potential explanations for the link. According to a participant in one study:

> Family pressure is huge – not only family pressure – peer pressure is huge and I think often people will say to practitioners, 'oh yes, I want to give up' and then they go back out and people are smoking around them and it's just so hard. The environment at home is not often conducive to making it easy for people to give up (Johnston & Thomas 2008).

5.1.3. Consequences of high Indigenous smoking rates

It is well established that smoking is a risk factor for a range of diseases, including cardio-vascular diseases, respiratory diseases, and certain types of cancers (e.g. lung, mouth, throat, and oesophagus) (Doll, Peter, Boreham et al. 2004). These diseases disproportionately affect the Indigenous Australian population.

Between 2007 and 2009, the age-adjusted rate of Indigenous hospitalisations for cardiovascular disease was 1.7 times the rate of non-Indigenous Australians and, cardiovascular disease accounted for 27% of Indigenous deaths between 2003 and 2007 (AIHW 2011). While respiratory diseases accounted for a smaller proportion of Indigenous hospitalisations (6% in 2007-09) and deaths (7.8% in 2004-08), they were managed in 21% of Indigenous encounters with general practitioners in 2005-06 and 2009-10 (AIHW 2011). With respect to cancers, the age-standardised incidents rates were higher for Indigenous Australians when compared with non-Indigenous Australians for cancers of the lung (RR 1.5 for males; RR 1.6 for females), oesophagus (RR 2.0 for males; RR 1.3 for females), mouth and throat (RR 2.2 for males; RR 1.1 for females) (Stumpers & Thomson 2009). Data suggest that Indigenous people are more likely to die from cancer than non-Indigenous Australians with the disease, perhaps as a result of later diagnoses and barriers to treatment (Supramaniam, Grindley & Pulver 2006).

Compared to the non-Indigenous population, Indigenous Australians had 4.1 times the rate of hospitalisation with a principal diagnosis related to tobacco-use for the period 2007-08 to 2008-09 (AIHW 2011). A study of the Indigenous Australian burden of disease in 2003 found that smoking contributed to 20% of total deaths and 12.1% of Disability Adjusted Life Years (DALYs), as set out in Table 10 below. Table 11 below shows that, of 11 risk factors, the largest relative differences for rates of disease burden

between the Indigenous and the total Australian population related to low fruit and vegetable consumption (RR 7.0) and tobacco (RR 6.3).

Table 10: Deaths and DALYs attributable to tobacco by specific cause, Indigenous Australians, 2003

Specific causes	Deaths (% of total)	DALYs	
		Number	% of total
Ischaemic heart disease	7.7	4,246	4.4
Chronic obstructive pulmonary disease	3.5	2,430	2.5
Lung cancer	4.0	1,780	1.9
Stroke	2.0	1,063	1.1
Low birth weight	0.4	632	0.7
Other	2.4	1,482	1.5
Total attributable	**20.0**	**11,633**	**12.1**

Source: Vos, Begg, Barker et al. (2007)

Table 11: DALYs attributable to 11 selected risk factors by proportion of total DALY and rate, Indigenous Australian and total Australian populations, 2003

	Indigenous Australian			Total Australian			
Risk	**DALY**	**% of total**	**Rate per 1,000**	**DALY**	**% of total**	**Rate per 1,000[a]**	**RR[b]**
Tobacco	11,633	12.1	24.5	204,788	7.8	3.9	6.3
High body mass	10,919	11.4	23.0	197,632	7.5	4.2	5.5
Physical inactivity	8,032	8.4	16.9	174,431	6.6	3.1	5.4
High blood cholesterol	5,262	5.5	11.1	163,591	6.2	2.7	4.1
Alcohol							
Harmful effects	5,982	6.2	12.6	87,936	3.3	3.3	3.8
Beneficial effects	-811	-0.8	-1.7	-26,845	-1.0	-0.5	3.7
Net effects	5,171	5.4	10.9	61,091	2.3	2.9	3.8
High blood pressure	4,417	4.6	9.3	199,315	7.6	2.6	
Low fruit/vegetable intake	3,344	3.5	7.0	55,259	2.1	1.0	7.0
Illicit drugs	3,264	3.4	6.9	51,463	2.0	2.4	2.9
Intimate partner violence	2,469	2.6	5.2	29,360	1.1	1.3	4.0
Child sexual abuse	1,390	1.4	2.9	23,513	0.9	1.1	2.7
Unsafe sex	1,174	1.2	2.5	14,897	0.6	0.5	4.7

Notes:
(a) Age standardised to the Indigenous Australian population
(b) Indigenous Australian to total Australian rate ratio

Source: Vos, Begg, Barker et al. (2007)

As Table 12 below indicates, Vos and colleagues (2007) also found that, of 11 risk factors, smoking was the leading contributor to both the overall Indigenous disease burden and the health gap between Indigenous and non-Indigenous Australians, measured in DALYs.

Table 12: Indigenous burden of disease and health gap (DALYs) due to 11 risk factors, 2003

	Disease burden		Health gap	
	DALYs	**% of total**	**DALYs**	**% of total**
Total Indigenous burden of disease	95,976	100	56,455	100
Attributable to:				
Tobacco	11,633	12	9,816	17
High body mass	10,919	11	8,953	16
Physical inactivity	8,032	8	6,554	12
High blood cholesterol	5,262	5	3,994	7
Alcohol	5,171	5	2,362	4
High blood pressure	4,417	5	3,215	6
Low fruit and vegetable intake	3,344	3	2,873	5
Illicit drugs	3,264	3	2,150	4
Intimate partner violence	2,469	3	1,836	3
Child sexual abuse	1,390	1	869	2
Unsafe sex	1,174	1	926	2
11 risk factors combined	34,908	37	27,383	49

Source: Vos, Begg, Barker et al. (2007)

5.2. DATA ON THE POLITICAL SALIENCE OF INDIGENOUS SMOKING

The following section uses interview and archival data to put forward suggestions as to why the issue had historically been ignored, and construct a narrative to explain how and why it emerged on the policy agenda in 2008.

5.2.1. Potential reasons for historical policy inaction

5.2.1.1. Evidence of competing health problems

The interview findings suggest that the problems associated with smoking were historically eclipsed by other social issues facing the Indigenous population. From a community perspective, an Indigenous leader and expert government advisor summarised the perceived relationship between smoking and other social problems thus:

> I've actually experienced feedback from people in community settings that says to me quite clearly, tobacco smoking doesn't cause the violence and the suicide deaths and the child abuse; it's other drugs and other social factors that create the real issues of trauma and diminished quality of life. It's not tobacco (*NIDAC member 1 2012*).

Other respondents also made reference to the problems associated with prioritising tobacco control when Indigenous communities had to grapple with so many other urgent and competing societal issues. For instance, a respondent with clinical experience working in the Indigenous context said:

> [W]hen you've got high needs people with very acute alcohol problems, heroin problems, amphetamines problems, the clients with tobacco control problems are quite a different group of people and they ... don't have as acute needs most of the time. You know, they are not in crisis mode. And I think the priorities of the other clients just took over (*TWG member 3 2012*).

An Indigenous health professional and advocate expressed a similar view:

> [P]eople come in and they've got half a dozen other social issues they're bringing with them, and often health professionals are a bit loathe to start ruining their therapeutic relationship by nagging them about smoking when, you know, their husband's just got out of gaol and bashed the hell out of them (*Indigenous health advocate 2 2012*).

According to an Indigenous health advocate, the way in which tobacco-related morbidities develop (that is to say, gradually over a number of years) meant that there was a tendency for the Indigenous smoking problem to be eclipsed by other problems where the link between 'cause' and 'effect' was more readily discerned:

> You don't see the health effects [of smoking] until years down the track. Someone can have six cigarettes – you can't see a difference in them. They can have six beers – there's a difference straight away (*Indigenous health advocate 1 2012*).

The 'visibility' of other problems, relative to smoking, was also cited by two expert government advisors as a possible explanation for the historical lack of political priority given to Indigenous tobacco control:

> [C]ertainly in [my jurisdiction] a lot of the time and space of the alcohol and other drugs groups ... tended to be consumed much more with alcohol and petrol sniffing ... and then, in recent years, with marijuana ... and the impact of all of these, and in particular alcohol, is very visible at a social level ... (*TWG member 3 2012*).

> [Smoking] usually got lumped with alcohol and, because of the social disruption of alcohol, alcohol always trumped it. Obviously tobacco might kill more people, but it doesn't kill them in a fight (*Indigenous tobacco control academic 1 2012*).

All told, the findings suggest that the evidence of an Indigenous smoking problem existed alongside, and had difficulty gaining traction over, competing problems including the use of illicit substances, problematic alcohol consumption, violence and community trauma. This interpretation is supported by data from other sources. For instance, in an evaluation of Australia's *National Tobacco Campaign* it was posited that drugs such as alcohol "were considered to have greater impact, due to the immediacy and complexity of their effects" and "more obviously destructive associations (for example, family violence)" (Murphy & Mee 1999; see also Ipsos-Eureka & Winangali 2010).

5.2.1.2. Ethical considerations[37]

Social and economic problems such as those described in the foregoing section have the potential to serve as stressors for Indigenous Australians (Holland, Dudgeon & Milroy 2013). Respondents described a historical reluctance to introduce Indigenous tobacco control measures because smoking was seen as a way of coping, and it was thought to be inappropriate to stop Indigenous people from smoking without first addressing the broader systemic and societal issues. According to a former senior bureaucrat: "I think

[37] Here, ethics is defined broadly to include a range of moral considerations about how individuals ought to be treated in society: see Childress, Faden, Gaare et al. (2002).

people probably said, 'leave people their cigarettes ... given the sorts of problems people have in their lives'" (*Senior bureaucrat 3 2012*). An Indigenous leader and expert government advisor expressed the dilemma in this way:

> I'm not going to get that concerned where I'm going to say, 'shit, we've got to reduce tobacco smoking down to 21% like the rest of Australia' because if you actually look at the social settings of Aboriginal Australians, they have every reason to smoke tobacco. They have every reason to want to try to find a drug or a substance that can take them away from the everyday trauma of the oppression that the ongoing colonising of Australia is [causing] ... around us ... [P]olicy developing around a single substance isn't going to work. What I'm saying is that smoking comes about because of a whole multitude of other factors ...
>
> Why do people give up things that they enjoy? Because they find something to replace it with that they equally enjoy and can't then give it up … [U]s Indigenous peoples are different in the fact that we've had lots and lots of other things stolen from us, not just our soul and a little bit of anxiety because of who we are. We've actually had our land, we've had our languages ... all of that stolen from us. Now how do you put all that into a policy context to say 'well to stop people from smoking you've really got to replace what they've lost.' …
>
> What's wrong with having a bit of tobacco ... because all you can see around the corner is a lot of your mob getting really [drunk] on alcohol and then going and popping a few pills and fighting across the park? And all you're doing is smoking a cigarette. And you're looking at them and you're thinking: 'Shit. And they want me to give up smoking cigarettes?' (*NIDAC member 1 2012*).

The view that parts of the Indigenous population were resistant to the idea of addressing issues such as smoking in a socio-political vacuum was confirmed by non-Indigenous expert government advisors. When explaining his view that "smoking ... is not taken on by the Indigenous leadership", an expert government advisor and tobacco control advocate said, "for some, and who am I to argue ... the issues about dispossession ... have been all important" (*TWG member 1 2012*). Another expert government advisor and tobacco control advocate perceived that "there's always arguments by the [Indigenous community controlled] health services against single issue funding; tobacco is one of those" (*Indigenous tobacco control academic 1 2012*).

Thus, evidence of high Indigenous smoking rates competed with ethical considerations regarding the appropriateness of controlling tobacco use given its perceived 'palliative' function for people whose lives were affected by legacies of dispossession and contemporary social dysfunction. The concerns discussed bear an analogy to debates surrounding proposals to control tobacco use in mental health settings in which patients' smoking is seen as a product of disadvantage, stress and anxiety (e.g. Cresswell 2009).

5.2.1.3. Feasibility considerations

Finally, even if it could be accepted that tobacco control was both urgent and appropriate for Indigenous Australians, there was a small amount of interview data to suggest that policy-makers had doubts about the feasibility of addressing the problem. An expert government advisor and tobacco control advocate said that Indigenous smoking was considered "the thing that's too hard to address ... it's so normal – everyone does it" (*Indigenous tobacco control advocate 3 2012*). A senior bureaucrat explained policy makers' attitudes thus:

> Everyone said, 'yeah, it's important but nothing is really ever going to work really with the kind of communities and kinds of environments we're working in.' And I think the general attitude from particularly central agencies was 'we'd just be [wasting] all of the money and it would be sucked into general Aboriginal health administration' which was seen in some quarters as being ... grossly over-staffed with little income and little output and, therefore ... a waste of money and just another population health strategy where you couldn't measure any impact (*Senior bureaucrat 3 2012*).

The prevalence of smoking among Indigenous Health Workers was another perceived barrier to successful implementation mentioned by the senior bureaucrat:

> [H]ealth ministers said it to me all the time, 'but every time I go to a health service, all the health workers are out the front smoking.' And that's actually true ... [W]henever we put a case around a smoking intervention, every minister would say, 'yeah, well who the hell's going to run it because they all smoke anyway?' And to some degree there was truth in it (*Senior bureaucrat 3 2012*).

While it is beyond the scope of this thesis to examine the accuracy of these perceptions, they nevertheless provide some evidence of scepticism among policy-makers about the potential to successfully reduce smoking rates even if Indigenous tobacco control was prioritised.

5.2.2. Explanations for the rise in political prominence in 2008

An analysis of the interview findings suggests that the increased political attention given to Indigenous smoking in 2008 was the product of a confluence of three factors – namely, (1) the publication of evidence showing that tobacco use was the single largest contributor to the 'gap' between Indigenous and non-Indigenous health outcomes, as measured in Disability Adjusted Life Years (DALYs); (2) the success of the *Closing the Gap* advocacy campaign which was led by Indigenous and civil society groups, and supported by the incoming Labor Government; and (3) the appointment of a Health Minister committed to tobacco control, perhaps best evidenced in the Government's decision to make Australia the first country in the world to introduce a law to mandate plain cigarette packaging.

5.2.2.1. The 'Vos' burden of disease study

Six respondents cited a burden of disease study by Vos, Begg, Barker et al. published in 2007 (hereafter, 'the Vos study') as an explanation for why Indigenous smoking became more politically prominent from 2008 (Vos, Begg, Barker et al. 2007). The study found that chronic diseases were responsible for 70% of the health gap (the difference between actual Indigenous DALYs lost and the DALYs that would have been lost if Indigenous Australians had the same rate of disease and injury as the total population). Moreover, of 11 risk factors, tobacco emerged as the biggest single contributor to both the overall Indigenous disease burden measured in DALYs (12%),

and the health gap between Indigenous and non-Indigenous Australians (17%). For instance, a senior bureaucrat said:

> One of the things that I always tell people working in this area is that the [study] was so important ... [W]e were able to show people what were the contributing factors to excess mortality ... [Y]ou know that was really valuable (*Senior bureaucrat 3 2012*).

Other respondents explained the significance of the research in similar terms:

> A piece of work was done out of the University of Queensland quantifying the burden of disease for Aboriginal and Torres Strait Islander people. In that was a statistic that said that 20% of all mortality was attributable to smoking, using that burden of disease methodology ... I think that the catalyst was that we had a figure, a statistic that said smoking causes 20% of all mortality (*Senior bureaucrat 2 2012*).

> [I]t was quite striking to show that tobacco had a greater impact on the burden of disease than any of the other risk factors and the data that it accounted for 20% of deaths ... and I think that that could be used by advocates to talk to the government about the importance of tobacco (*DoHA consultant researcher 2012*).

> This effort that you are seeing ... was prompted by a burden of disease study done by a fellow called Theo Vos (*Indigenous health advocate 3 2012*).

According to an Indigenous leader and health advocate, the study prompted Indigenous research organisations to focus on the issue of smoking:

> So [the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health] did a bit more research ... once they found that out ... They put briefings together and all that and started to tell their story to the Minister ... And then they did this presentation ... in Parliament House. Within a fortnight [the Government] found $14 million (*Indigenous health advocate 3 2012*).

The presentation to which the respondent referred formed part of the Parliamentary Showcase of Aboriginal Health Research which was held in March 2008 and opened by the Health Minister. As part of the program, Viki Briggs of the Centre for Excellence in Indigenous Tobacco Control delivered a presentation entitled "Reduce smoking, reduce the gap: the Centre for Excellence in Indigenous Tobacco Control", in which the findings of the Vos study were highlighted (Cooperative Research Centre for Aboriginal Health 2008). An expert government advisor and academic considered that

"that was probably an absolutely crucial event" (*Indigenous tobacco control academic 1 2012*).

A Ministerial advisor did not agree that the event was crucial, but nevertheless recalled its usefulness:

> I wouldn't say ... we wouldn't have thought about Indigenous tobacco had it not been for this meeting ... I remember it ... helping to crystallise the view that tobacco was a critical factor [that needed to be addressed] (*Ministerial advisor 1 2012*).

5.2.2.2. The 'Closing the Gap' movement and government commitment

A number of respondents considered that the impact of the Vos study must be considered in its socio-political context. The study was published in 2007 at a time when the Closing the Gap campaign for Indigenous and non-Indigenous equality was gaining momentum (Australian Indigenous HealthInfoNet 2013). In the lead up to the 2007 Federal election, the Labor Party made a policy commitment to improve Indigenous social and health outcomes in response to the Closing the Gap campaign. Shortly after winning the election, the Labor Government signed the Close the Gap Statement of Intent, the aim of which was to achieve equality in Indigenous and non-Indigenous health outcomes by 2030 (Aboriginal and Torres Strait Islander Social Justice Commissioner & the Steering Committee for Indigenous Health Equality 2008). According to a senior politician:

> [W]hile the strong research helped galvanise people around [Indigenous tobacco control] I don't think it was the cause or catalyst for action. Once the Close the Gap target was set, smoking intervention became a no-brainer because of the evidence around successful interventions ... [T]he very successful campaign around Close the Gap ... helped create political momentum and interest – the research is vital in this context but could've gone unnoticed without the broader campaign (*Senior politician 1 2012*).

A Ministerial advisor, expert government advisor and senior bureaucrat all agreed:

> I guess the context ... of those [tobacco control] announcements was Labor's commitment ... that if we formed government we would commit to closing the

> gap ... And basically we worked out pretty quickly that we were never going to achieve this if we didn't do something about Indigenous smoking. It's really pretty much that ... at a higher level, pretty much that simple (*Ministerial advisor 1 2012*).
>
> We had the whole Closing the Gap campaign ... and eventually that was picked up through the Government. And so this concept of ... '20% of the gap is due to tobacco' ... was becoming much more prominent. And so with the focus on Closing the Gap ... this sort of message that one of the greatest gains you could get was around tobacco control started to really get some traction (*TWG member 3 2012*).
>
> I think that a catalyst was that we had a figure, a statistic that said 'smoking causes 20% of all mortality'. It came at the same time as Closing the Gap. So, okay, to close the gap, you've got to prevent mortality, you've got to prevent premature mortality. So, I think that's where some of the drive came from (*Senior bureaucrat 2 2012*).

These findings suggest that the importance of the evidence derived from the fact that it was framed and presented in a way that was consistent with emerging political and community priorities. That is to say, evidence demonstrating the large impact of smoking on Indigenous mortality and the 'gap' between Indigenous and non-Indigenous health outcomes was difficult to ignore so long as improving Indigenous life expectancy and 'closing the gap' remained valued goals.

5.2.2.3. Political leadership

While the confluence of evidence and political/community agendas created a positive environment for Indigenous tobacco control to become more politically salient, several respondents emphasised the crucial role of the Health Minister in actually securing policy action. It was noted that the Department of Health and Ageing's (DoHA) interest in Indigenous tobacco control pre-dated the policy developments in 2008 but that, despite this, the issue never gained political attention. According to a senior bureaucrat:

> [I]n all of the work that we would do and think about in terms of the ... burden of disease and the contributing factors to excess mortality ... always smoking you know was such a high issue. But there was always a lot of cynicism (*Senior bureaucrat 3 2012*).

This is confirmed in the reflections of an academic and former bureaucratic advisor:

> I think there were people within the Commonwealth Department of Health and Ageing who were really lobbying hard for it ... I know 10 years ago when I was involved, 12 years ago, they were really keen to fund reviews into what would work [in Indigenous tobacco control] and what was worth spending money on (*Indigenous tobacco control academic 3 2012*).

The interview findings reveal a perception that the developments in 2008 were a product of the importance of the issue being understood and championed at the Ministerial level: "[The] bottom line is [that] Nicola Roxon [the Health Minister] ... got it and put money into [Indigenous tobacco control]" (*TWG member 2 2012*). An Indigenous leader and health advocate held a similar view:

> [T]o be quite honest I think you can put it down to a couple of people in the Minister's office and the Minister herself. She was committed to saying, 'if that's what the evidence is telling us, we need to put a bigger effort into here' (*Indigenous health advocate 3 2012*).

Similarly, another expert government advisor and health advocate said, "Roxon got it. She really gets tobacco control very, very acutely and understands it very well" (*TWG member 2 2012*).

5.3. CONCLUSION

The foregoing account of how the political salience of Indigenous tobacco control increased sits well with Kingdon's (1984) model of agenda-setting. According to Kingdon (1984), issues rise in political prominence when three streams converge – the problem stream, the policy stream and the political stream. The problem stream comprises information or events that bring attention to an issue. In this instance, the publication of research quantifying the burden of smoking-related disease in the Indigenous population helped to overcome the perception that tobacco control was less important or less urgent than other policy interventions. The policy stream, according to Kingdon's (1984) model, comprises solutions to the problem offered by experts and bureaucrats with the proviso that these need to be politically and technically feasible.

The findings suggest that the success of tobacco control policies in the general Australian population gave credibility to the argument that targeted policies could have similar effects on Indigenous smoking rates. Finally, the political stream relates to the willingness of politicians to pursue the solutions that have been suggested. One of the early commitments of the newly elected Rudd Labor Government was to close the gap between Indigenous and non-Indigenous disadvantage; the commitment was the product of a well-organised campaign by non-government organisations such as Oxfam and various health professional groups. The existence of research demonstrating that smoking was the largest contributor to both the Indigenous burden of disease and the gap between Indigenous and non-Indigenous health outcomes meant that the issue of Indigenous tobacco control was consistent with the Government's political interests.

All told, this chapter reveals that evidence is not simply discovered and applied in a technocratic manner. Despite long-standing evidence of high Indigenous smoking prevalence, Indigenous tobacco control had historically not been a policy priority. However, the findings demonstrate that context plays an important role in understanding whether a decision to not act on evidence amounts to 'good' or 'bad' policy making. Evidence of a phenomenon (in this case, high smoking prevalence) does not speak for itself and is silent as to whether or not the issue constitutes a 'problem'; rather, evidence is only capable of revealing a 'problem' through interpretation and the application of value judgments.

The findings suggest that before 2007 Indigenous smoking was not problematised partly because it was seen to serve a positive function (e.g. a mechanism for coping in the context of historical injustice and contemporary disadvantage), and partly because Indigenous people faced a multitude of other urgent and competing health and social problems. Given the negative history of Indigenous policy making described in

Chapter Four, one could argue that it would have been inappropriate and/or ineffective to introduce tobacco control policies without Indigenous demand/support for the policy. Tobacco control policies are always susceptible to charges of 'nanny state' paternalism, but that charge carries added meaning in an Indigenous context.

While the burden of disease study conducted by Vos, Begg, Barker et al. (2007) was important, the information it presented was not new (since it had long been known both that Indigenous Australians had a higher smoking prevalence and that smoking is linked to negative health outcomes). However, the data acquired a new meaning when viewed through the lens of a popular, Indigenous-led (and government supported) campaign to reduce the disparities between Indigenous and non-Indigenous health outcomes within a generation. Within the context of the Closing the Gap campaign, smoking became seen as a problem (in the sense of being a major contributor to the health gap) and, accordingly, the high prevalence data became evidence that warranted a policy response.

6. Policy formulation and evidence

The *Indigenous Tobacco Control Initiative* (ITCI) was announced by then Prime Minister Kevin Rudd at the Indigenous Health Equality Summit on 20 March 2008. Through ITCI, the Government committed AU$14.5 million over four years to the following:

- supporting research into Indigenous tobacco control. In partnership with research organisations such as the Cooperative Research Centre for Aboriginal Health (CRCAH), this initiative will help build the evidence base around what works in helping Indigenous people to quit smoking;
- trialling a range of innovative community interventions, including targeted, culturally appropriate communication activities; and
- offering smoking cessation training to staff working in Indigenous health (Prime Minister of Australia 2008).

It was envisaged that the community intervention trials would take the form of "five or six pilot projects in selected locations" (Anonymous n.d.(a)).

The *Tackling Indigenous Smoking Measure* (TISM) formed part of the Council of Australian Governments' AU$1.58 billion *National Partnership Agreement on Closing the Gap in Indigenous Outcomes* which was signed in December 2008 (Council of Australian Governments 2008(a)). Pursuant to the Agreement, the Rudd Government committed AU$100.61 million to reduce Indigenous smoking rates and the burden of tobacco related disease through a number of measures, the most prominent of which were the following:

- Establish a national network of tobacco action coordinators.
- Develop a national Indigenous tobacco action training program for health workers and community educators.
- Strategies to improve delivery of smoking cessation services, including nicotine replacement therapy.
- Social marketing campaigns to reduce smoking-related harms among Aboriginal and Torres Strait Islander peoples.
- Enhance Quitline to provide culturally sensitive services (Council of Australian Governments 2008a; Council of Australian Governments 2008b).

As was the case with the ITCI policy, there was also a commitment to fund formative research and information-sharing conferences (Council of Australian Governments 2008b).

This chapter begins by drawing upon interview data to understand which actors and agencies had responsibility for formulating the two policies. It then uses archival documents to show what evidence was presented to the relevant policy makers in relation to 'what works' in Indigenous tobacco control; in so doing, it seeks to understand the extent to which the various components of the ITCI and TISM policies were informed by the evidence.

6.1. ACTORS RESPONSIBLE FOR POLICY FORMULATION

6.1.1. Indigenous Tobacco Control Initiative

The interview data suggest that the ITCI policy was designed over a short time period. A Ministerial advisor noted that "there was a sense after the Apology [to the Stolen Generations in February 2008][38] that ... [the] good will created by that needed to be translated into some sort of firm commitments" (*Ministerial advisor 1 2012*). The Indigenous Health Equality Summit was scheduled to take place in Parliament House, Canberra, between 18 and 20 March 2008, and was expected to culminate in the signing of a partnership agreement between government and non-government organisations to achieve health equality between Indigenous and non-Indigenous Australians (Aboriginal and Torres Strait Islander Social Justice Commissioner & the Steering

[38] On 13 February 2008, Prime Minister Kevin Rudd moved a successful motion in the House of Representatives that noted: "The time has come for the nation to turn a new page in Australia's history by righting the wrongs of the past and so move forward with confidence to the future. We apologise for the laws and policies of successive Parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians. We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country ... We today take this first step by acknowledging the past and laying claim to a future that embraces all Australians ... A future where we harness the determination of all Australians, Indigenous and non-Indigenous, to close the gap that lies between us in life expectancy, educational achievement and economic opportunity" (Rudd 2008).

Committee for Indigenous Health Equality 2008). The interview data suggested that the Prime Minister had expressed an intention to attend the event, and that this served as a catalyst for the development of the policy. A Ministerial advisor said:

> I do remember this being an example where we were kind of going, 'Ergh! I think the PM might want to announce something' ... [A]s I say, it was all a little bit chaotic in those early days. So it meant that a lot of the sort of detailed policy development was done at the Departmental level more so than at Ministerial level." (*Ministerial advisor 1 2012*).

Media reports, to which the respondent referred, revealed that the Health Minister had been dissatisfied with unrealistic time pressures imposed by Rudd during his premiership (Anonymous 2012).

According to the Ministerial advisor, "the Department [of Health and Ageing] sort of came up with this bunch of proposals and said 'look ... we'll give you something concrete to announce at this event'" (*Ministerial advisor 1 2012*). The respondents' account of DoHA's role in developing the ITCI policy is consistent with documents obtained under the *Freedom of Information Act* which show DoHA as the author of Ministerial briefing notes on the policy.

6.1.2. Tackling Indigenous Smoking Measure

The interview data also suggested that DoHA played a key role in the development of the TISM policy. According to the Ministerial advisor:

> ... the sort of policy development process followed the same/similar process to that I've just outlined [in relation to the ITCI policy]. I do remember getting the set of proposals from the Department [of Health and Ageing] ... so the Department developed the proposals that we then kind of further refined in cooperation with them I guess (*Ministerial advisor 1 2012*).

Interviews with DoHA staff confirmed the central role of the Department in designing the policy, and also highlighted the informal influence of external advisors. According to a senior bureaucrat:

> In the early stages of [determining] 'well, what do we do?' we talked to the Centre for Excellence [in] Indigenous Tobacco Control ... and we had conversations with them initially about 'well, we've got money to do X and Y and Z, if you could do something else what do you think needs to be done?' (*Senior bureaucrat 1 2012*).

As will become apparent in this chapter, the Centre for Excellence in Indigenous Tobacco Control (CEITC) drafted a Scoping Paper at the request of DoHA, and the paper was completed a few months prior to the TISM announcement.

Additionally, advice on the formulation of the policy was received from the National Preventative Health Taskforce. The Taskforce was established by the Government in April 2008 to assist in the development of strategies to prevent diseases related to tobacco, alcohol and obesity, both with respect to the general population and at-risk sub-populations. The Tobacco Working Group of the Taskforce comprised a number of tobacco control experts, including Viki Briggs from CEITC who was the only Indigenous group member. While the Taskforce did not release its final recommendations until September 2009, a Government report revealed that "[t]he Taskforce provided interim advice to the Government in 2008" (Commonwealth of Australia 2010). Both a Ministerial advisor and a respondent from the Taskforce's Tobacco Working Group confirmed that the Taskforce had a role to play in the formulation of the TISM policy:

> [T]he Taskforce was to report to us by mid-2009 or something ... but there was this big [Council of Australian Governments] meeting at the end of 2008 where there was going to be all this money on the table so we wanted to have their kind of input earlier so that you didn't do a whole bunch of stuff that they might have seen as being in the wrong. Basically we were trying to line everything up even though the timing didn't quite line up really neatly on some things. So my recollection is that we sort of had [the Taskforce] engaged on some of this stuff ... before [TISM] was announced (*Ministerial advisor 1 2012*).

> They involved us in the development of the Tackling Smoking Initiative ... We were doing the same recommendations formally and informally... (*TWG member 1 2012*).

6.2. EVIDENCE AND THE FORMULATION OF THE POLICIES

Through the *Freedom of Information Act* requests made to DoHA, two research reviews were discovered on the subject of Indigenous tobacco control. The first review (dated June 2007) was authored by a DoHA employee for the DoHA Program Management and Evaluation Unit. The second review (dated September 2008) was authored by Anke van der Sterren of CEITC and was also prepared for the DoHA Program Management and Evaluation Unit. In the following sections, the evidence contained in the cited studies is summarised for each aspect of ITCI and TISM.

6.2.1. Indigenous Tobacco Control Initiative

At the time of the announcement of ITCI (March 2008), the DoHA (2007) review was the only government authored/commissioned review in existence. While it is acknowledged that other papers may have informed the Rudd Government's policy deliberations, it is reasonable to assume that an internal literature review conducted by the government agency primarily responsible for the formulation of the policies provides a reliable insight into what evidence policy makers considered influential. The DoHA (2007) review proposed five policy options (see Box 5 below), each of which is discussed below in the context of the three components of the ITCI policy.

Box 5: Policy options presented at conclusion of DoHA (2007) review

1. Target specific communities/regions with programs that provide support and training for local staff to provide brief tobacco cessation interventions and supportive quit programs including NRT.

2. Target specific communities/regions with programs that provide more intensive interventions similar to the approach in North Queensland or by Ivers (2006) described above.

3. Develop or adapt resources to enhance community understanding of the effects of tobacco including environmental tobacco smoke with a priority on young people including primary school aged children, pregnant women and families with young children.

Box 5 continued

4. Media campaigns that involve local identities/locally produced artwork to promote tobacco cessation, and the effects of environmental tobacco smoke.

5. Funding for CEITC to audit recent and future evaluations of identified tobacco control initiatives.

Source: DoHA (2007)

6.2.1.1. Supporting research into Indigenous tobacco control

A major component of ITCI was the funding of formative research to "help build the evidence base around what works in helping Indigenous people to quit smoking" (Prime Minister of Australia 2008). This aligns with the DoHA (2007) proposal to fund CEITC "to audit recent and future evaluations of identified tobacco control initiatives" (recommendation 5 in Box 5 above).

The 2007 DoHA review cited three sources that contained findings supporting the need for further research into Indigenous tobacco control initiatives. The first source was a systematic review by Ivers (2001; 2003[39]). Ivers (2001; 2003) sought to identify studies on Indigenous Australian tobacco control interventions by electronically searching seven databases, hand-searching four key journals, and seeking grey literature from relevant non-government organisations and government departments. The search

> uncovered only four reports of evaluations of tobacco interventions for Indigenous Australians, only two of which had been published in the medical literature. None of the studies assessed evaluated smoking cessation as an outcome. None of the studies entailed a randomised controlled trial (Ivers 2001; 2003).

[39] The original version of the systematic review was published by the Menzies School of Health Research and the Cooperative Research Centre for Aboriginal and Tropical Health. The 2003 version was condensed for publication in a peer-reviewed journal (*Australian & New Zealand Journal of Public Health*).

The second source cited in the DoHA (2007) review was a set of ten unpublished recommendations from a workshop on reducing Indigenous smoking which had been convened by DoHA in 2005 and "involved jurisdictional representation from [three Australian States and one Territory] and other stakeholders (researchers, NGOs etc)" (DoHA 2007). The workshop's relevant recommendations (numbers 8-10) were as follows:

8. Develop and implement an appropriate research program, including market research, which should be fully evaluated.
9. Following the research program, develop a national campaign specifically aimed at encouraging Aboriginal and Torres Strait Islander people to cease smoking...
10. Undertake research on what smoking cessation interventions are appropriate for adolescents... (DoHA 2007).

Finally, a descriptive review of Indigenous tobacco control programs delivered by government and non-government organisations found that "program evaluation was an important component of tobacco control research funding, however, only two of six national organisations funded Indigenous specific research" (Adams & Briggs 2005).

Thus, there seems to be a clear link between the 'evidence of an absence of evidence', and the decision to include funding for formative Indigenous tobacco control research in the ITCI policy proposal.

6.2.1.2. Innovative trials, including culturally appropriate communication

In addition to supporting more formative research to inform future policy design, the ITCI policy also laid the groundwork for an innovate-and-evaluate approach whereby up to six sites would be selected for innovative community intervention pilots. This approach was consistent with a recommendation in the DoHA (2007) literature review: "Target specific communities/regions with programs that provide more intensive

interventions similar to the approach in North Queensland or by Ivers (2006)" (recommendation 2 in Box 5 above).

In the DoHA (2007) review, the "approach in North Queensland" is described in the context of a broader discussion of the Adam and Briggs (2005) report as follows:

> A ... comprehensive approach is being developed in far north Queensland with interventions to include event support programs, school based tobacco education, a smoke-free policy guide for organisations, tobacco brief intervention in health services, quit support groups and monitoring of Queensland tobacco laws in communities. This is being implemented in eight Indigenous communities as a randomised controlled trial over three years.

The Adam and Briggs (2005) report did not contain any findings from the north Queensland trial; nor are the findings contained in any other sources cited in the DoHA (2007) review.

By contrast, the findings of the Ivers, Castro, Parfitt et al. (2006) study were presented. The study compared tobacco consumption in six remote Indigenous communities, three of which had received a government grant to address the problem of Indigenous smoking through multi-component interventions (e.g. introduction of smoke-free public places policies, tobacco education programs, provision of nicotine patches, point-of-sale restrictions, health worker training) and three of which were chosen as matched control communities. Both baseline and follow-up surveys were completed by 32%, 35% and 12% of residents in the intervention communities and found no decreases in smoking prevalence one year post-intervention. When compared to control communities, one intervention community experienced a statistically significant decrease in the amount of tobacco consumed after one year,[40] while others experienced problems with implementation (e.g. poor weather, bureaucratic delays etc). The DoHA (2007)

[40] Tobacco consumption was calculated by dividing the number of cigarettes or loose tobacco cigarette equivalents purchased in community stores by the estimated number of community members over the age of 12 years. Of course, tobacco may have been purchased from places other than community stores.

summary noted that "[t]he impact of the intervention was an increase in knowledge about the effects of tobacco and readiness to quit"; specifically, the percentage of smokers who reported thinking about quitting/taking action to quit significantly increased from 61% to 72% over the intervention year and knowledge about the risks of lung cancer and heart disease respectively increased by 5% ($p<0.01$).

The study's limitations include the fact that the intervention communities were self-selected, and the fact that less than one-quarter of residents across the intervention communities participated in surveys at both baseline and follow up (by contrast, 20% participated at baseline only, 19% participated at follow-up only and 37% did not participate at any stage).

Thus, the absence and limitations of the data in the two studies cited in DoHA (2007) suggests that the recommendation to "[t]arget specific communities/regions with programs that provide more intensive interventions" was not clearly evidence-based. Neither the north Queensland example, nor the Ivers, Castro, Parfitt et al. (2006) study provided a clear indication that intensive community interventions work in reducing Indigenous smoking prevalence. However, given the fact that there was a dearth of existing evidence as to 'what works' in the Indigenous Australian tobacco control context (see section 6.2.1.1 above), the studies offered ideas as to how the efficacy of other community interventions might be tested empirically in a policy pilot scenario.

The ITCI policy specifically introduced trials of innovative culturally appropriate communication strategies. This reflects another recommendation put forward in the DoHA (2007) review – namely: "Media campaigns that involve local identities/locally produced artwork to promote tobacco cessation, and the effects of environmental tobacco smoke" (recommendation 4 in Box 5 above).

Three of the sources in the DoHA (2007) review related to culturally-specific media campaigns. First, the Lindorff (2002) study found:

> Focus groups mentioned features of health promotion resources that were desirable similar to those reported by previous projects including: text in [Indigenous] Language and English; Aboriginal and Torres Strait Islander faces and people; lots of pictures and simple language; the use of video and radio media (eg. BRACS); the use of music; interactive resources such as puppets; the use of real body parts or pictures of real body parts; and television ads featuring Aboriginal and Torres Strait Islander people.

Focus groups comprised a total of 275 participants from health services, legal centres, women's centres, men's groups, drug and alcohol rehabilitation centres, school staff, resource centres, employment programs, elders groups and university student and staff populations. However, a major limitation of the study was that:

> [i]t was quite difficult to assure people that the groups were not going to be a lecture about quitting tobacco and about the negative consequences of tobacco use. As a result a number of potential participants chose not to take part in the groups, many of who were smokers and whose information would have been valuable (Lindorff 2002).

Second, the Adams and Briggs (2005) report summarised an evaluation of a program that incorporated some culturally-specific social marketing strategies – namely, radio advertisements and car/bus signs featuring local Indigenous identities delivering tobacco control messages. The report noted that, of 151 Indigenous people randomly approached in the street, "22 per cent had heard the radio advertisement, with 13 per cent recall. A further 10 per cent had seen the car/bus advertisement, with 5 per cent recall." The effect of the program on tobacco use was not discussed.

Finally, the Ivers (2003) systematic review identified the evaluation of a mainstream (non-Indigenous specific) social marketing campaign ('Every cigarette is doing you damage'). Based on the content of 15 focus group discussions with 43 Indigenous adults, 20 Indigenous teenagers and 23 community and health workers recruited by

workers from local Indigenous organisations across four locations, the evaluators concluded that:

> Overall, the groups gave no indication that awareness of, or exposure to, the campaign was any different amongst the indigenous and non-indigenous populations. Similarly, the results of this research program gave no reason to believe that indigenous people received the campaign messages any differently to the non-indigenous population (Murphy & Mee 1999).

However, the methods by which participants were recruited and data were analysed are not stated.

It is therefore clear that the evidence cited in DoHA (2007) does not lend unequivocal support to a policy for Indigenous-specific communication strategies. While some qualitative evidence suggested that some Indigenous people want Indigenous-specific messages, data from other studies showed good Indigenous recall of 'mainstream' campaigns and fairly low recall of a campaign featuring Indigenous personalities. All three studies had methodological shortcomings.

6.2.1.3. Smoking cessation training for Indigenous health staff

The third aspect of the ITCI policy "offer[ed] smoking cessation training to staff working in Indigenous health" (Prime Minister of Australia 2008). Again, this mirrors another recommendation in the DoHA (2007) review – namely, "[t]arget specific communities/regions with programs that provide support and training for local staff to provide brief tobacco cessation interventions and supportive quit programs" (recommendation 1 in Box 5 above). Four sources cited in the DoHA (2007) review potentially informed this recommendation.[41]

First, in the Ivers (2001; 2003) systematic review, one of the included studies was a qualitative study of a training program for Indigenous health workers. Harvey, Tsey,

[41] A possible fifth source is the unpublished list of workshop recommendations, which included the following: "Develop an appropriate infrastructure to ensure adequate support for people wanting to cease smoking."

Cadet-James et al. (2002) evaluated a one-day workshop which provided 34 employees in three north Queensland Indigenous health care settings with training in motivational interviewing and the stages of change model for addressing addictive behaviours. The evaluation was based on pre- and post-training interviews with doctors, nurses, Indigenous health workers and allied staff, but staff turnover and availability meant that "[p]re-training and follow-up interview participants were not the same" (Harvey, Tsey, Cadet-James et al. 2002). The evaluation produced no evidence that any staff or clients had given up smoking at the six-month follow-up. However, there was some evidence that the training led some Indigenous staff to reassess their own smoking status; moreover, some staff reported that the written resources provided as part of the training were appropriate for initiating tobacco cessation discussions with pregnant women who tended to be most receptive to the message. The findings must be read in light of the small sample.

Second, the Lindorff (2002) report recommended "[c]omprehensive programs with long-term funding involving training for health workers" (DoHA 2007). In relation to training, the report found that 62% of a sample of 67 surveyed health staff wanted more training, although Lindorff (2002) noted that "given this small number, interpretations and generalisations from these findings should be treated with caution." Some participants in focus groups (which included the surveyed health staff) also "emphasised the need for more training if staff were to deal with tobacco on a day-to-day basis ... Staff training was also seen as an opportunity to prompt staff into thinking about their own smoking".

Third, the Adams and Briggs (2005) report recommended that:

- Tobacco training for Aboriginal health workers should be supported through accredited training delivery.

- Professional development training in Indigenous tobacco control should be available.

It is important to note that the Adam and Briggs (2005) study was a descriptive review of the role of non-government and government tobacco control organisations in Indigenous tobacco control. While the study noted that a number of training programs had been developed/delivered by various organisations, it only referred to one evaluation – namely, the Harvey, Tsey, Cadet-James et al. (2002) qualitative study described above.

Fourth, Ivers, Castro, Parfitt et al. (2006) reported the findings from a pre- and post-study of the effects of a multicomponent tobacco control intervention (including training health professionals in the delivery of smoking cessation advice). The findings and limitations of the study are set out in section 6.2.1.2 above (pages 96-97). Additionally, because of the way in which the study was designed, it was not possible to ascertain the effects of the training relative to other components (e.g. introduction of smoke-free public places policies, tobacco education programs, provision of nicotine patches, and point-of-sale restrictions).

All told, the DoHA (2007) review contained no evidence that training health staff in tobacco cessation strategies (e.g. brief intervention) reduced Indigenous smoking prevalence.[42] There were some data that health staff wanted training, and that training may encourage some health staff to reflect upon their own smoking status; however,

[42] This was consistent with mainstream (i.e. non-Indigenous) studies available at the time. While there was good evidence that verbal 'stop smoking' instructions from physicians increase patient quit rates (Stead, Bergson & Lancaster 2008), the effectiveness of training health professionals to deliver smoking cessation interventions (e.g. setting quit dates, offering follow-up consultations and encouraging the use of nicotine gum) was less clear. A Cochrane systematic review found that while such training increased the likelihood that health professionals would perform smoking cessation tasks, six of eight control studies comparing the patient smoking behaviours of trained and untrained health professionals found no difference in quit rates (Lancaster & Fowler 2000).

methodological limitations need to be considered in determining the amount of weight that ought to be placed on the findings.

6.2.2. Tackling Indigenous Smoking Measure

The TISM policy (announced in December 2008) built on the tobacco control measures introduced by ITCI. In September 2008, Anke van der Sterren (a researcher for CEITC) provided DoHA with a 'scoping paper' that was "largely based on a review of the available published literature" (van der Sterren 2008) and grey literature. The paper was prepared at the request of DoHA "to inform the further development of the Indigenous Tobacco Control Initiative" (van der Sterren 2008). Results from the *Freedom of Information Act* request set out in Appendix Two suggested that the van der Sterren (2008) and DoHA (2007) papers were the only literature reviews specifically prepared for DoHA prior to the development of the TISM policy. It is reasonable to surmise that, to the extent that TISM was evidence-based, the supporting evidence can be found in either of the papers.

6.2.2.1. Introduction of a network of tobacco action coordinators

Under the TISM policy, regional tobacco coordinators would work with specific tobacco action workers to address Indigenous tobacco use at the individual, family and community levels. This component of the policy was broadly consistent with the following recommendation in the van der Sterren (2008) paper:

> Resources should be provided to increase the number of Indigenous Tobacco Control workforce in order to better support communities to address tobacco control through ... [p]lacing Indigenous Tobacco Control Workers in each [National Aboriginal Community Controlled Health Organisations] state and territory affiliate to support Indigenous communities to: raise the profile of tobacco control; to create smoke-free environments through organisational and community policy changes; and to develop and deliver prevention and cessation activities.

This passage was replicated almost verbatim in the recommendations of the Tobacco Working Group of the National Preventative Health Taskforce,[43] suggesting that the van der Sterren paper also had a strong influence on the advice they provided to Government in relation to the TISM policy. It is significant that a member of the Working Group was also the Director of CEITC.

The evidential basis of the recommendation appears to be two-fold. First, van der Sterren (2008) pointed to a number of qualitative studies suggesting that Indigenous health workers were reluctant to provide smoking cessation advice. There were a number of explanations for the reluctance including not wanting to "add to the other health and social problems facing their clients and make them feel bad about themselves" and not wanting to appear hypocritical on account of their own smoking status (e.g. Wood, France, Hunt et al. 2008; Zandes, Holloway & Mason 2008; Murphy & Mee 2000; Mark, McLeod, Booker et al. 2005; Karen & Walker 2006). This suggests the potential need for a specialist tobacco control workforce.

Second, van der Sterren cited a report prepared for the Australian Medical Association and Australian Pharmaceutical Manufacturers Associated entitled *The Forgotten Smokers – Aboriginal Smoking: Issues and Responses* (Market Equity 2000). The findings of the report were predominately based on interviews with 15 "key intermediaries involved in Indigenous health related to smoking." The 'intermediaries' were government bureaucrats, representatives of Aboriginal health organisations, and representatives of other non-governmental public health organisations.

[43] "Place Indigenous Tobacco Control Workers in each NACCHO state and territory affiliate to support Indigenous communities, in the context of a coordinated national approach, in order to: raise the profile of tobacco control; create smoke-free environments through changes in organisational and community policies; and develop and deliver prevention and cessation activities" (Tobacco Working Group 2009).

The Market Equity (2000) report used the intermediaries' responses as a basis for recommending the introduction of a specialised Indigenous workforce to address tobacco control:

> Some of the intermediaries who had worked in mainstream health organisations discussed the benefits and drawbacks of this working style. Working as the only Aboriginal person on a team is seen as very hard. ... [A]n Aboriginal working on a non-Aboriginal team can find it hard to make inroads and difficult to fit in. It was suggested that, where possible, teams of Aboriginal people work together.
>
> The lack of Indigenous teams was seen largely as a resource issue. Whilst there is often a team of people in health organisations dedicated to smoking prevention, it was felt that in light of the enormity of the Indigenous smoking problem, there needed to be a complementary team of Indigenous people working on Indigenous smoking prevention programs.
>
> It is essential that people doing the work in the actual communities are Indigenous or have high acceptance by the Indigenous community. Currently there are not enough Indigenous people trained in smoking education and this is a gap that needs to be addressed. It is not a gap that can be filled by non-Indigenous people.
>
> > *"Aboriginal people have been killed off, oppressed and trodden on by white skinned people and their systems, so if a white skinned person came to me today and said smoking is no good for you, then I would tell them to piss off because while I have a cigarette I feel good and look what these people have done to my relatives so why should I trust them"* (Market Equity 2000).

The findings from this report seem to align neatly with van der Sterren's (2008) recommendation for (and the Government's subsequent introduction of) regionally coordinated networks of Indigenous tobacco action workers to deliver multi-component, community-based tobacco cessation interventions.

However, the strength of the findings is undermined by a number of factors including, the small sample size (15 respondents), the fact that the sampling strategy for recruiting the "key intermediaries" was not clear, and the fact that the content/nature of the interviews was not described.

6.2.2.2. Tobacco action training for health and other key workers

Similar to the ITCI policy (see section 6.2.1.3 above), the TISM policy also provided for "a national Indigenous tobacco action training program for health workers and community educators" (Council of Australian Governments 2008(b)). This aspect of the policy mirrored van der Sterren's (2008) recommendation that:

> The success of individual-level primary health care interventions (brief interventions, counselling, and pharmacotherapies) is likely to be improved through improved health worker access to appropriately designed training (that is realistic and empowering) ...

.

Again, the National Preventative Health Taskforce Tobacco Working Group's advice to Government was almost identical to van der Sterren's (2008) recommendation.[44]

However, van der Sterren (2008) does not cite any strong empirical basis for the recommendation. In particular, van der Sterren (2008) cited a Cochrane systematic review by Lancaster and Fowler (2000) which showed "there is no strong evidence that [training health professionals to provide smoking cessation interventions] translates into more people quitting smoking". Furthermore, the van der Sterren (2008) review referred to only one completed evaluation of the success of training Indigenous health workers in brief intervention techniques. The evaluation by Harvey, Tsey, Cadet-James et al. (2002) (described at section 6.2.1.3 above) produced no evidence that Indigenous health workers or clients had quit smoking at the six-month follow-up, and only limited evidence about attitudinal changes.

6.2.2.3. Improved delivery of services, including NRT

Under the TISM policy, the Government also committed to subsiding nicotine replacement therapies for Indigenous people under the Pharmaceutical Benefits

[44] "[F]und appropriately designed training that is realistic and empowering for health workers, and ensure that they are able to provide their patients with pharmacotherapies" (Tobacco Control Working Group 2009).

Scheme. Van der Sterren's review (2008) had recommended "improved access to pharmacotherapies."

In addition to rigorous studies showing the effectiveness of pharmocotherapies in reducing smoking prevalence in a mainstream context (e.g. Stead, Perera, Bullen et al. 2008; Hughes, Stead & Lancaster 2007), van der Sterren (2008) also cited: (1) a randomised controlled trial which demonstrated that buproprion and cessation counselling was more effective than cessation counselling only in a group of 134 Maori smokers (Holt, Timu-Parata, Ryder-Lewis et al. 2005); and (2) a review of United States studies (three randomised controlled trials and three secondary analyses of those randomised controlled trials) which demonstrated the effectiveness of nicotine replacement and bupropion for smoking cessation in African American populations (Robles, Singh-Franco & Ghin 2008).

Van der Sterren (2008) cited four studies relating to the effectiveness of pharmacotherapies in the Indigenous Australian context. Of these, two studies investigated the effectiveness of nicotine replacement therapy (NRT) (used in combination with counselling, behavioural therapy and self-help resources) in mixed Indigenous and non-Indigenous populations; however, the studies did not present disaggregated results for the different sub-populations, perhaps owing to the small sample sizes (Campbell, Duguemin, Swinbourne et al. 2008; Richmond, Butler, Belcher et al. 2006).

The remaining two studies had methodological limitations. Ivers, Farrington, Burns et al. (2003) conducted a study in which pre- and post-test interviews were conducted with 34 Indigenous smokers who self-selected to receive free nicotine patches and a brief intervention, and a further 59 who chose to receive brief intervention only (i.e.

receiving advice, viewing a flip-chart about tobacco and being offered a pamphlet). At the six-month follow-up, 15% of the NRT and brief intervention group reported that they had quit smoking (10% with biochemical validation) compared to 1% (biochemically validated) of the group that elected brief intervention only. While the data suggested that brief interventions delivered in conjunction with pharmacotherapy may be an effective way of reducing Indigenous smoking prevalence, such findings must be read in the context of the studies' methodological limitations – namely, the small sample size and the method of assigning participants to the two groups through self-selection.

In a later study, Karen, Rumbiolo and Charles (2006) reported a 19% quit rate among only 32 Indigenous participants in a multi-component program. Under the program, Indigenous people were provided with the opportunity to sign up for Quitline and receive weekly phone calls from the service (in combination with other strategies such as access to NRT and Zyban, general practitioner consultations, and access to a Quit Facilitator and Quit Educator). An evaluation found that of 32 participants, six people had quit smoking (based on figures collected by the Quit Facilitator who assisted participants in the lead up to their planned Quit day). However, the impact of the NRT/Zyban in influencing tobacco cessation behaviours (relative to the other components of the program) was not clear.

All told, the recommendation (and ultimate Government decision) to improve access to pharmacotherapies was supported by strong evidence from mainstream and non-Australian minority contexts, but weaker evidence pertaining to the Indigenous Australian population.

6.2.2.4. Social marketing campaigns

Social marketing campaigns to reduce Indigenous smoking prevalence were another key feature of the TISM policy. The van der Sterren (2008) paper had recommended (and the National Preventative Health Taskforce's Tobacco Working Group agreed)[45] that:

> A well-researched and focus-tested Indigenous-specific social marketing campaign should be developed and delivered at national and local levels to complement messages in other locally delivered programs.

In her review of the evidence, van der Sterren (2008) pointed to two studies that reported high Indigenous recall of mainstream (non-Indigenous specific) social marketing campaigns,[46] but low levels of tobacco cessation. In addition to Murphy and Mee's (1999) focus group study (described in section 6.2.1.2 above, page 96), van der Sterren (2008) noted a study in which Ivers, d'Abbs, Parfitt et al. (2005) interviewed 351 Indigenous people from six communities as part of an evaluation of multi-component tobacco control interventions. The study found that while 86% of smokers

[45] "[F]und a focus-tested, Indigenous-specific social marketing campaign to be delivered at national and local levels that would complement messages in locally delivered programs" (Tobacco Control Working Group 2009).

[46] These findings are consistent with studies published after the Indigenous tobacco control policies were developed. Boyle and colleagues (2010) found high levels of awareness of a mainstream campaign which used the metaphor of a cigarette burning holes in a piece of plastic bubble-wrap to demonstrate the irreversible effects of emphysema. Based on interviews with 198 Indigenous smokers, the researchers found that, when prompted, 89.9% of participants recalled seeing the television advertisement related to the campaign, but only 34.0% could recall hearing the relevant radio advertisement. The majority of participants who recalled seeing or hearing the advertisements thought that they: were believable (television 87.6% and radio 82.5%); were personally relevant (television 87.6% and radio 77.4%); made them think about reducing their cigarette consumption (59%); and resulted in them speaking to family and friends about quitting (59%). The study did not measure actual quit rates. Limitations of the study include the low participant response rate (46%), the nature of the sampling (opportunity or convenience sampling of staff and clients in medical and community care settings), and the fact the questionnaire did not measure unprompted awareness of the campaign. A study by Stewart et al. (2011) went further in that it compared Indigenous and non-Indigenous responses to mainstream campaigns. The researchers showed 10 anti-smoking advertisements (representing the range of advertisements typically aired in Australia) to 143 Indigenous smokers and 136 non-Indigenous smokers in the State of South Australia. After viewing each advertisement, participants completed a five-point Likert scale questionnaire which assessed a number of concepts. To the extent that there were statistically significant differences in the responses between Indigenous and non-Indigenous participants, those differences were a consequence of Indigenous participants giving *higher* ratings to the advertisements, including mainstream advertisements.

recalled seeing mainstream anti-tobacco advertising, those who recalled seeing the advertisements were not significantly more likely to quit than those who did not.

In light of data indicating high rates of Indigenous recall of mainstream social marketing but potentially low impact on smoking behaviour, the question that arises is whether tailored campaigns are likely to be more effective. Van der Sterren (2008) reported that "[t]here have been very few [Australian] Indigenous-specific media campaigns around tobacco control, and evaluations of these have not been identified."

In the absence of Australian evidence, van der Sterren (2008) looked to indigenous-specific social marketing campaigns in other countries but, again, found that the results of evaluations were not available. However, a New Zealand study was cited, the findings of which cast some doubt on the assumption that indigenous-specific social marketing is likely to yield better tobacco control outcomes for indigenous populations. In New Zealand, the 'It's about whānau' campaign included testimonials from Māori ex-smokers and their whānau (close family/friends); by contrast, the 'Every cigarette is doing you damage' used 'threat appeal' themes to appeal to mainstream audiences. Both campaigns promoted the Quitline telephone counselling number. Wilson, Grigg, Graham et al. (2005) found that the mainstream campaign generated 115 calls per 100 total target audience rating points (TARPs), compared to 91 calls per 100 TARPS for the Māori-specific campaign (see Table 13 below). In the literature review, van der Sterren (2008) correctly observed that, while the 'Every cigarette is doing you damage campaign' did appear to be more effective at generating Quitline calls, it is not known whether this had any actual impact on quit rates. Furthermore, as the Māori-specific

advertisements included broad messages about health, wellbeing and cultural identity, the two campaigns may not be directly comparable.[47]

Table 13: Impact of various campaigns and television commercials (TVCs) for generating calls to the New Zealand national Quitline from Māori callers (for calls within one hour of showing a TVC)

	Total TVC placements	Total calls within 1 hour	Total target audience rating points*	Calls per 100 total target rating point	Rate ratio (95% CI)
Every cigarette is doing you damage	372	383	333	115	1.26 (1.08 to 1.46)
It's about whānau	483	439	480	91	Reference

Notes: Total target audience rating points are a measure of estimated exposure to the target audience.

Source: Wilson, Grigg, Graham et al. (2005)

The van der Sterren (2008) literature review therefore did not provide policy makers with any rigorous evidence of the comparative impact of Indigenous-specific versus mainstream social marketing campaigns on Indigenous smoking behaviour. The recommendation for a "well-researched and focus-tested Indigenous-specific social marketing campaign" seems to have emerged from qualitative studies in which some Indigenous Australians expressed a preference for culturally-relevant advertisements. For example, van der Sterren (2008) noted the following:

[47] Another New Zealand study was not reported but further complicates the question of whether Indigenous-specific campaigns are likely to be more effective. Moewaka Barnes and McPherson (2003) conducted a baseline survey of 254 Māori smokers one month before the 'It's about whānau' campaign was launched, with follow up surveys at four months and 13 months post-intervention (comprising 420 and 404 smokers, respectively). The percentage of Māori smokers at second follow-up who said that the 'It's about whānau' campaign was 'very relevant' (67%) and made them more likely to quit smoking (54%) was higher than the percentage at baseline who said that the mainstream 'Every cigarette is doing you damage campaign' was 'very relevant' (50%) and made them more likely to quit smoking (37%). However, the data do not make it possible to discount the possibility that the mainstream campaign was perceived as less relevant or less effective because it had been launched two years prior to the 'It's about whānau' campaign and was therefore less novel. Between baseline and follow-up there were no statistically significant differences in the average daily number of cigarettes smoked by respondents, or in the proportion of people who had tried quitting in the last three months.

> [P]articipants in [the Murphy & Mee (1999)] evaluation suggested some general principles on which Indigenous-specific strategies should be based...:
>
> - need to be locally based and include local content;
> - should involve Elders and significant community members in their design and delivery; and
> - must have a broad community focus.
>
> In another study, Indigenous people identified the need to use local people, or people that they could identify with in media campaigns; it was felt to be more effective to use 'regular' people to whom they could relate, rather than 'famous' people, whose lifestyles are very different to their own (Market Equity 2000). Some of the campaign messages that they suggested might be effective were: the financial burden of smoking; 'smoking is not part of our culture'; health effects presented simply; the effect of smoking on fitness; and the effects of smoking on children.

However, as was described in section 6.2.1.2 (above, pages 99, 103-104), both of the Murphy and Mee (1999) and the Market Equity (2000) studies had weaknesses in the way in which data were collected and reported.

6.2.2.5. Enhanced Quitline services

While the TISM policy provided for upgrades to Quitline services, the van der Sterren (2008) paper did not contain a specific recommendation for funding to enhance Quitline services. However, van der Sterren (2008) did argue that:

> From [the] evidence it is likely that Quitlines can be both acceptable and effective with Indigenous communities in Australia. Raising the profile of Quitlines to Indigenous communities could be a cost effective way of improving quit rates.

The evidence to which van der Sterren (2008) referred included an Australian study by Karen, Rombiolo and Charles (2006). The details of this study are set out at section 6.2.2.3 above (page 107). As was noted there, the multi-component nature of the study meant that it was not possible to determine the impact of the Quitline in influencing tobacco cessation behaviours (relative to the other components of the program). The study simply stated:

> [A] difficulty has been people expressing apprehension about receiving support through enrolment with Quitline. With encouragement to receive one call and

give it a try all participants have used Quitline with to date no negative complaints voiced about the service (Karen, Rombiolo and Charles 2006).

Two North American studies were also cited by van der Sterren (2008). Maher, Rohde, Dent et al. (2007) attempted to recruit 2,638 English-speaking adult smokers who called a Washington Quitline over a twelve month period. The Washington Quitline trained counsellors in cultural awareness and competency. Forty-eight percent of eligible callers (n=1,271) were contacted and surveyed approximately three months after their first Quitline call. Survey questions sought to obtain information on key demographic variables, smoking behaviour and satisfaction with Quitline services. Table 14 below summarises the relevant findings. Notably, the study found a higher 7-day quit rate (35%) among American Indian/native Alaskan callers to the Washington Quitline three months after their initial call, compared to white callers (30%) (p = 0.42), and high rates of service satisfaction. It is not clear from the study whether there was any difference in response rates between white and American Indian/native Alaskan callers, or the characteristics of the respondents in each group.

Table 14: Percentage quit rates and Quitline (QL) satisfaction at 3-month follow-up survey, by race/ethnicity

	Percentage (%)					
	Latino	**African American**	**Asian / Pacific Islander**	**American Indian / Alaskan native**	**White**	
	n=154	**n=147**	**n=58**	**n=101**	**n=762**	**p value[a]**
7-day quit rate[b]	35	35	33	35	30	0.42
Satisfied with QL overall	93	92	91	93	92	0.99
Would suggest QL to others	98	97	95	98	97	0.78
Satisfied with QL specialist	94	93	95	97	95	0.64

Notes:
a) p value based on Peason x^2 test with Rao and Scott second order correction.
b) Defined as quit for at least 7 days.
No more than 1% of participants were missing data for each of the quit and satisfaction measures listed.

In the second North American study, Hayward, Campbell & Sutherland-Brown (2007) interviewed adult first-time callers to a Canadian Quitline (August 2002 to December 2005) who expressed a willingness to participate in an evaluation (percentage not reported). The names of willing callers were then randomised to either a 30-day or 6-month follow-up telephone interview. While response rates were not reported, 7,082 callers participated in the evaluation, of which 516 (7.3%) self-identified as having indigenous ethnic/cultural ancestry. Table 15 below shows that tobacco cessation rates at six follow-ups were slightly higher for indigenous participants, compared to non-indigenous participants. Additionally, the study found that 88.7% of indigenous participants would recommend the service to a friend at the six-month follow-up, compared to 89.9% of non-indigenous participants (p=0.247). The authors concluded:

> Given that current counselling protocols lead to fairly high quit attempts and prolonged abstinence, our recommendation would be for Canadian quitlines to focus on increasing reach at this time. Other quitlines around the world could also consider this approach ... (Hayward, Campbell & Sutherland-Brown 2007).

It is important to note that Hayward and colleagues (2007) identified the small sample size as a limitation and noted that the findings cannot be assumed to be representative given they are based on responses from only those who provided their ethnic status and agreed to participate in the evaluation.

Table 15: Six month cessation rates for indigenous and non-indigenous smokers in Canada

6 month prolonged abstinence	Number (percentage)		p-value
	Indigenous	Non-indigenous[a]	
Male	n=90 15 (16.7)	n=1,180 111 (9.4)	0.041
Female	n=153 11 (7.2)	n=1,770 147 (8.3)	0.759
Both sexes	n=243 26 (10.7)	n=2,953 259 (8.8)	0.293
(p value within group)	(0.030)	(0.319)	

Notes:

a) Figures are reproduced as reported. It is not clear why the sum of non-indigenous males and females does not correspond with the numbers in the 'both sexes' row.

It thus appears that the decision to prioritise the use of Quitline services as a strategy for reducing Indigenous Australian quit rates was supported by studies from other indigenous populations, although there are questions about the internal validity of the studies (due to possible selection bias) and their external validity (because Quitline services are designed and delivered differently across jurisdictions).

6.3. CONCLUSION

This chapter has shown that the recommendations and policy options presented in government authored/commissioned literature reviews obtained under the *Freedom of Information Act* seem to have heavily influenced the design of the ITCI and TISM policies. One might be inclined to conclude from this that the policies were evidence-based. Certainly, studies were identified by both DoHA (2007) and van der Sterren (2008) to support each recommendation/policy option. That body of studies is notable for its diversity, and includes: unpublished recommendations emanating from a stakeholder workshop; findings from focus groups and qualitative interviews with Indigenous people; pre- and post-test studies, including surveys; and systematic reviews.

However, a critical analysis of the studies reveals that many suffer limitations such as: inadequate reporting of techniques of data collection and analysis; the possibility of selection bias; and small sample sizes. Moreover, very few of the Indigenous Australian studies actually measured the effects of tobacco control interventions on actual smoking behaviour (e.g. quitting, amount smoked or uptake); instead, most Indigenous Australian studies measured subjective preferences for interventions, perceptions of *likely* impact of interventions, or thoughts and attitudes about smoking. In the absence of rigorous evidence from the Australian context, van der Sterren (2008)

cited studies of indigenous populations in North America and New Zealand; yet, it is open to debate whether the results from those contexts are generalisable to Australia.

The findings in this chapter therefore demonstrate that, while each of the policies seem to have resulted from recommendations emanating from literature reviews, the evidence relied upon did not suggest unequivocally that the recommendations would lead to positive tobacco control outcomes.

7. Policy adoption and evidence

The previous chapter demonstrated that there was a high confluence between (a) the policy options proposed in two government authored/commissioned literature reviews and (b) the policies ultimately adopted by the Health Minister, acting on the advice of DoHA and the National Preventative Health Taskforce Tobacco Working Group. In particular, it showed that the advice provided by the Tobacco Working Group to Government was almost identical to the recommendations set out in the van der Sterren (2008) review. This chapter primarily draws upon interview data from key decision makers to understand why the literature review recommendations were adopted as policies, notwithstanding the dearth of Indigenous-specific tobacco control evidence and the uncertainty around the few studies that did exist. In so doing, the role of the evidence in the decision making process and its interaction with other factors and considerations will be analysed.

7.1. THE PERCEIVED FAILURE OF MAINSTREAM POLICIES

Notwithstanding the relative paucity of rigorous evidence of the effectiveness of Indigenous-specific tobacco interventions, some policy makers reported that they accepted the proposals in the DoHA (2007) and van der Sterren (2008) literature reviews because there was a widespread belief that the alternative (i.e. mainstream tobacco control policies) had failed to have an appreciable impact on reducing Indigenous smoking rates.

In 2006, the Australian Bureau of Statistics published the smoking prevalence data in Table 16 below which were derived from the 1995 and 2001 *National Health Surveys*, and the 2004-05 *National Aboriginal and Torres Strait Islander Health Survey* (ABS 2006). The data suggested that between 2001 and 2004-05 there was no statistically

significant change in current daily smoking rates for the total Indigenous adult population, and that the rates for non-remote Australian Indigenous adults (who comprised the majority of the Indigenous population) only decreased by 1% in the ten years between 1995 and 2004-05.[48] By contrast, smoking prevalence in the general population was estimated to have decreased from 26% in 1995 to 23% in 2001 and 22% in 2004 (Winstanley & White 2011). The success in the general population was widely attributed to successful tobacco control efforts, such as bans on cigarette promotion, the introduction of smoke-free areas, the use of mass public education programs, and strategies to make cigarettes less affordable (White, Hill, Siahpush et al 2003).

Table 16: Percentage of current daily smokers among Indigenous Australian people aged 18 and over, by remoteness, 1995, 2001 and 2004-05

	Non-remote	Remote	Total
1995	50	...	...
2001	48	57	51[a]
2004-05	49[b]	52[b]	50[a]

Notes: a) Difference between 2001 and 2004-05 data is not statistically significant.
b) Difference between remote and non-remote 2004-05 data is not statistically significant.

Source: ABS (2006)

When asked why policy makers accepted the need for Indigenous-specific tobacco control policy options, the apparent resilience of Indigenous smoking habits over time was cited as a justification. For instance, a senior bureaucrat recalled:

> Smoking was the one [area] where there was clear evidence of success of the Australian policies and strategies for the non-Indigenous population and a really

[48] After the policies were adopted, new research was published by Thomas (2009; 2012) showing that the results from surveys that had been used to show longitudinally static Indigenous smoking prevalence were not directly comparable. In particular, the surveys differed in: (a) the questions asked and how smokers were classified; and (b) reported age cut-offs. On that basis, Thomas (2012) reanalysed the data (including more recent data from the 2008 NATSISS) and found that daily smoking prevalence for Indigenous males over the age of 18 decreased from 58.5% in 1994 to 52.6% in 2008 with a statistically significant annual decrease of 0.4% per year. There was also a statistically significant annual decrease of 0.5% in daily smoking prevalence for non-remote Indigenous females over the age of 18 between 1994 and 2008. Correspondingly, statistically significant annual increases in the ratio of ex-smokers to 'ever-smokers' (the quit ratio) were reported between 2002 and 2008 for both Indigenous males and females over the age of 18 years, and the prevalence of ex-smokers increased for both Indigenous males and females between 2002 and 2008.

> marked difference in terms of ... a lack of effectiveness in relation to Aboriginal and Torres Strait Islander people (*Senior bureaucrat 1 2012*).

Similarly, one member of the National Preventative Health Taskforce's Tobacco Working Group said:

> [P]revalence of smoking at national and state level hadn't really shifted over two decades ... So certainly a great awareness that while mainstream programs have some effect across the broader population (and certainly there is some evidence they do have an effect on Aboriginal people as well) they certainly weren't having enough effect to see some sort of quite significant changes in prevalence (*TWG member 5 2012*).

Confirmation of this perceived lack of effectiveness of mainstream policies can be found in the archival data. The briefing papers obtained under the *Freedom of Information Act* ('Questions and Answers for ITCI' and the 'Facts and Figures for ITCI') both state: "Half of Indigenous Australians aged 18 years and over reported that they were current smokers, a figure that has not changed since 1995" (Anonymous n.d.(a) & (b)). The 'Facts and Figures' document added:

> While the efforts across governments have raised awareness about the health risks associated with smoking amongst the broad population and have prompted many to seek out smoking cessation programs and services, the messages have not had the same impact on Aboriginal and Torres Strait Islander people (Anonymous n.d.(b)).

7.2. THE NEED TO ACT AND BARRIERS TO ACCUMULATING EVIDENCE

Faced with both a dearth of rigorous Indigenous-specific evidence and an understanding that Indigenous smoking rates were inexorably high despite the presence of mainstream strategies, some policy makers saw the need to take action based on inference. An academic with close links to key policy makers noted that "the problem is we didn't have any evidence from this setting so … people had to make guesses. And they probably weren't bad guesses" (*Indigenous tobacco control academic 1 2012*). A Tobacco Working Group member used similar language, describing the research conducted to develop policy priorities as "predominately guess-based" (*TWG member 5*

2012).

An innovate-and-evaluate approach was accepted as being an appropriate solution in the circumstances. Internal documents obtained under the *Freedom of Information Act* demonstrate the extent to which policy makers considered that it was both necessary and justifiable to act without a strong evidence base, so long as there was a commitment to accumulating knowledge in the process:

> Currently there is little available evidence for what works in Indigenous tobacco control. In partnership with research bodies ... the Government can make an immediate start on building that evidence-base...
>
> In tandem with the research program, it is proposed to run five or six pilot projects in selected locations to trial innovative approaches to smoking prevention and cessation ... Evaluation of these pilots could inform future phases of the initiative ...
>
> *The approach recommended here combines action (the pilot programs) coupled with a strong research focus to ensure that resources are not wasted on misdirected initiatives* (Anonymous 2008, emphasis added).

The alternative approach – that is, waiting for evidence to emerge before taking policy action – was not considered practical. Two policy makers noted that the Indigenous context presented distinct challenges to the conventional understanding of evidence-based policy making, arguing that evidence needed to play more of a back-end role. According to a Tobacco Working Group member:

> [W]e need to look at ways of finding types of interventions that would resonate better with Aboriginal communities and I think a part of what came with that [was] also an acceptance that certainly when it comes to mainstream programs, it is driven by research and best practice and pretty much an evidence-base, but ... when it comes to Aboriginal smoking there's a need to be willing to take a few more risks, and trial different ways of addressing the problem in order to arrive at what works best (*TWG member 5 2012*).

Similarly, a senior bureaucrat suggested that the diversity of the Indigenous population meant that research was not always thought to contain generalisable lessons on which to

develop policies, arguing that localised policy trials with built-in evaluations were preferable:

> [O]ften the evidence of what does work is very hard to interpret in terms of whether it works long term, or whether it worked because of a particular local characteristic (so a particular person who was involved) ... [I]n many cases the success that they've had locally [is] not possible to replicate. It's been driven by a particular group within that community who are particularly passionate and who did things that government could never do. And that's one of the real challenges – is how to do things from a national policy perspective that are adaptable enough locally, and then to overlay that with I guess some performance measurement and some evaluation so that you don't then keep doing things that aren't working? So that you identify those that are having an effect – you can evaluate them in terms of their potential to be rolled out more broadly, to try to understand what factors are driving their success etc (*Senior bureaucrat 3 2012*).

Certainly, researchers with links to policy makers shared the view that the Indigenous research context presented distinct challenges. A researcher offered the following example of the limitations:

> [T]he logistics of doing high level randomised controlled trials in [remote] populations ... it's ridiculous. We did the numbers on doing randomised controlled trials for nicotine replacement therapy ... you'd need thousands of people. There were a whole lot of issues with cross-contamination between communities, [which] perhaps doesn't happen so much in [the] mainstream.
>
> We did the numbers for a randomised control trial in giving quit advice ... lots of evidence from Cochrane, from everyone else around the world that it has an effect; however, the numbers to do a proper randomised control trial in the Northern Territory were going to be 30,000 participants. You couldn't get it ... you know, there's no way ... there's not even that [many eligible participants] ... (*Indigenous tobacco control academic 3 2012*).

An Indigenous advocate with research experience added:

> [T]here's always challenges from the remoteness of going out to do the pre- and post-questionnaires ... and just being able to find the right people, because a lot of these people they move around in their communities. They won't sit in one place. They will travel around and visit family and the neighbouring community. Could be anything ... even the weather. You know wet season, cyclone comes so you can't travel out there. From all those kind of logistic things, to even the language being a barrier (*Indigenous tobacco control advocate 1 2012*).

7.3. CULTURAL CONSIDERATIONS

Not all of the members of the policy community subscribed to the view (described in section 7.1 above) that Indigenous-specific interventions were needed because mainstream approaches to tobacco control were ineffective. For instance, a member of the Tobacco Working Group said the following:

> [T]he thing that's driven smoking down in Australia is not just programs, interventions, media things; it's policies like having smoke-free workplaces, the price of cigarettes. I mean there is absolutely zero evidence that those approaches do not impact Indigenous people in the same sort of way that they affect the rest of us (*TWG member 2 2012*).

Another Working Group member warned against "overdoing the differences" when developing solutions to tobacco control, noting that "Aboriginal people are people. They smoke like other people. They quit like other people. And I think we need to be almost a bit wary of assuming that you need to have something incredibly and dramatically different" (*TWG member 1 2012*).

When asked why the Working Group advised the Government to adopt a number of Indigenous-specific tobacco control strategies, respondents cited cultural and pragmatic factors including the fact that Indigenous-specific measures were seen to be favoured by Indigenous stakeholders. It is noted that the only Indigenous member of the Working Group was the Director of CEITC. CEITC was commissioned to draft the van der Sterren (2008) review. Interview responses indicated that the Indigenous Working Group member played a central role in formulating the Working Group's advice to Government:

> Viki Briggs was the Indigenous representative ... I think I'm pretty right in saying that when we came to that item on the agenda we would have said, 'okay, Viki. You liaise with [the report writer]' ... [T]hey would have worked out what to put in it and it would have come back to the committee (*TWG member 2 2012).*

The apparent mismatch between the advice provided to Government and the view of some members that some Indigenous-specific interventions were not necessary was explained in the following way:

> I know there would have been at least two or three people around the table who would have shared what I just said to you about 'oh god, do we really have go down this ... culturally distinctive route?' But I think in the scheme of things we didn't feel that strongly about it to say, 'listen, let's just can that.' Because I think that that critique needs to come out of the Indigenous community rather than be given like Moses from above by people that have been working in it for a long, long time (*TWG member 2 2012*).

Another member described the seeming incongruity as "probably a bit of playing to the gallery":

> That's not to sound hypocritical but you want to get the support of as many people as possible for this program and a lot of Aboriginal people were really keen on the idea of local workers. Would it be in my core program? Not necessarily. But if it's the price we pay for getting Aboriginal people support the rest of the program – willingly pay it.

A third Working Group member noted:

> [B]ecause of the awful history for Aboriginal people in this country there's a real strong desire amongst representatives of the Aboriginal community that you'll be working with (whether they be working in the community or part of other health agencies) wanting it to be Aboriginal-determined, controlled etc, and that in itself can be a good thing but it also creates some tensions... (*TWG member 5 2012*).

The member referred to there being "sometimes a difficult conversation" between the Indigenous and non-Indigenous representatives of the Working Group but noted, ultimately, that "there was a great deal of courtesy and respect in terms of how this committee functioned" (*TWG member 5 2012*).

The importance of history in the Indigenous policy making process was emphasised by an expert government advisor on substance and drug abuse:

> [S]ome of the policy settings in this country leave a lot to be desired and the way that they're developed and the way that governments react to them is indicative to me that it's a very patronising, paternalistic effort and it says to me that white Australians are still very juvenile. This country ... hasn't grown up to accept that other peoples outside of mainstream Australia have a right and

> should be involved in leading the progression of policy development around those marginalised populations ... It's very difficult for white Australians or mainstream Australians; in fact I would say in many instances it's not possible for them to do the assessments of the trauma that's occurred in Aboriginal Australia and then try to equate policy direction for their governments in relation to what's needed for marginalised populations like Indigenous peoples in Australia. They've been doing that for 200 years with all the best of intent but as you know the road to hell is paved with good intentions ... So I say to you with all good faith that it's time for the policy developers in Australia to now say to Aboriginal Australians, 'you must develop the policies and you must assist us on the pathways out.' I always say to other Australians, 'you've got to allow Aboriginal people to own the pathways out of poverty.' And the only way we're going to own those is to feel as though we're in control of the policy development and that we've got sufficient support and empathy from within the mainstream governments in Australia ... (*NIDAC member 1 2012*).

Another respondent suggested that historical and political sensitivities were particularly acute at the time the Indigenous tobacco control policies were made because of the controversies surrounding the Northern Territory National Emergency Response (described in Chapter Four above):

> [The Minister for Indigenous Health] ... was aware of some of the insensitivities particularly [by the previous Government] in the early days of the [Emergency Response] and obviously the need to consult and be respectful of Aboriginal people was very high in his mind ... (as it is, high in the mind of Aboriginal families and communities around the country always … they've been trampled on by different government policies over the years) (*Indigenous tobacco control academic 1 2012*).

7.4. CONCLUSION

The interview data suggested that policy makers relied on either one of two conflicting justifications for the adoption of the policy proposals described in Chapter Six. On the one hand, some policy makers did not think that there was any evidence to suggest that the policy proposals were necessary; however, the proposals were nevertheless supported because they were perceived to be popular among members of the Indigenous community. In agreeing to the proposals, this group of policy makers placed weight on factors such as the importance of Indigenous involvement in, and approval of, Indigenous policy processes. The weight placed on cultural/community acceptability

seems to have been informed, at least in part, by historical experiences of Indigenous socio-political marginalisation. The importance of culturally tailored solutions seems to have been championed by some Indigenous policy advisors, including Viki Briggs whose colleague authored the van der Sterren report (2008) that featured so prominently in the findings of the previous chapter.

On the other hand, some policy makers regarded the Indigenous-specific policy proposals as having an intuitive appeal, owing partly to a perception that mainstream policies had not succeeded in reducing Indigenous smoking rates over time. However, the policy makers' acceptance of these proposals did not necessarily amount to a repudiation of role of evidence in policy making. While there was a dearth of evidence to suggest that the Indigenous-specific policies would be effective in reducing smoking prevalence, evidence did exist to indicate that Indigenous smoking prevalence had been unresponsive to mainstream strategies (although the quality of the evidence has been more recently called into question). Moreover, some policy makers recognised that there were barriers to accumulating rigorous, generalisable evidence and that, as such, the policy process could combine the 'need for action' with the 'need for research' by introducing innovative strategies and evaluating them. This approach is akin to Sanderson's (2009) position that policies should not stifle innovation but, rather, be viewed as hypotheses to be tested through pilots or trials and/or rigorous monitoring and evaluation (see section 2.2.3.3 above, page 29).

While there is a "conventional assumption that policy making becomes more rational in direct proportion to the influence of evidence on the policy process" (Sanderson 2004), the findings in this chapter challenge this logic. Far from being irrational or reckless, this chapter shows that the policy makers' acceptance of the proposals described in

Chapter Six was based on logical reasoning, notwithstanding the absence of a rigorous evidence base.

8. Policy evaluation and evidence

This chapter critically examines the extent to which lessons about 'what works' in Indigenous tobacco control have been gleaned from the ITCI and TISM policies. As was made clear in previous chapters, the decision to act in absence of a strong evidence base was partly justified through the adoption of an 'innovate-and-evaluate' strategy. This chapter uses sources derived from a *Freedom of Information Act* request to identify relevant government commissioned evaluation reports, and critically appraise the quality of the evidence contained therein. The importance of this chapter is bolstered by the fact that policy evaluation reports are often not in the public domain because they are either produced by government departments internally or, "[w]hen external evaluators are used, it is common for the government to insist that the results not be published" (Cobb-Clark 2013).

8.1. EVALUATION OF INNOVATIVE PILOTS UNDER ITCI

A *Freedom of Information Act* request for "[a]ny documents containing evaluations of the first six multi-component community projects funded as part of the Indigenous Tobacco Control Initiative"[49] yielded three evaluation reports relating to the following programs:

- *Yaki Ngarli* Tobacco Control Program;
- Healthy Start: smoking prevention and early treatment targeting young people and pregnant women; and
- *Bila Muuji* Smoking Cessation Project.

Other documentation obtained under the *Freedom of Information Act* revealed the existence of another evaluation:

[49] At the time the policy was formulated and adopted, the intention was to only fund up to six pilot projects in the first instance (see Chapter Six above, page 86).

> [A] research project funded by the department and finalised in 2011-2012 was the review of the Indigenous Tobacco Control Initiative (ITCI) ... Through the ITCI 18 organisations across Australia trialled and evaluated innovative approaches to smoking prevention and cessation among Aboriginal and Torres Strait Islander communities. The review aimed to identify barriers and success factors to delivering smoking prevention and cessation projects (KPMG 2013).

Information about the review was provided by DoHA to the audit firm KPMG in September 2012; however, findings from the evaluation were not released in response to the *Freedom of Information Request* dated 12 September 2012. The findings that follow must be read in light of the absence of these data.

8.1.1. *Yaka Ngarli* Tobacco Control Program

In 2008, the Miwatj Health Aboriginal Corporation Inc. entered into a funding agreement with DoHA as part of the implementation of the ITCI policy (Hefler 2012). The project commenced in early 2009 and involved the formation of a Tobacco Control Team which:

- coordinated and delivered training in smoking cessation and brief intervention;
- supported the organisation's clinical staff to provide information and education about smoking cessation strategies;
- produced multimedia resources to be used by the organisation's staff in outreach and education sessions; and
- developed a social marketing campaign including t-shirts, signage and stickers with the *Yaka Ngarli* (no smoking) message.

The evaluation of the project was completed in January 2012. A striking limitation of the evaluation was the inability to provide data around community smoking cessation and uptake before and during the intervention. The report noted:

> Due to recent changes in clinical data management systems at Miwatj Health, and because a standardised clinical dataset for this project had not been designed at project commencement, minimal clinical characteristics were able to be

> collected, and there was no opportunity to compare statistics at different points throughout the project (Hefler 2012).

The evaluator interviewed four community members "who had quit as a result of the project, and was told of several others" (Hefler 2012). While data from clinical audits indicated that the number of brief interventions conducted by the organisation increased from 44% in 2008 to 100% in 2010, the yearly figures are based on audits conducted on a single day and are thus based on small samples (n=16 and n=13 respectively). The evaluator conceded that the figures "represent only a very limited snapshot" (Hefler 2012).

As such, the evaluation was predominately based on qualitative data. These data suggested that: the project's *Yaka Ngarli* message was widely disseminated; the social marketing campaign had popular appeal; and that Miwatj Health Aboriginal Corporation Inc. had successfully cultivated a smoke-free culture and identity within its own organisation, as evidenced by the introduction of workplace smoking bans with no breaches observed during the evaluation and "no resistance" reported. However, a number of factors may have limited the quality of the qualitative data also. In particular, the evaluation report noted:

- The timeframe between appointing the evaluator and the evaluation visit to the project was very tight (less than 4 weeks). As a result, it was not possible to develop a detailed evaluation plan ahead of time, and [there was] minimal opportunity to review project documentation such as plans and progress reports prior to the evaluation visit. The evaluator was able to undertake interviews and small focus groups with over 40 people representing a wide range of stakeholders, however there were still a number of key stakeholders who were not able to provide input. Cultural business obligations also impacted on the availability of some key stakeholders ...
- The evaluator is experienced in health program evaluation, tobacco control and community development, however is a non-Indigenous outsider with minimal previous experience in remote areas in the Top End [Northern Territory]. Although community-based Yolngu Miwatj workers accompanied the evaluator on some community visits, requests to interview community members were sometimes refused and it was culturally inappropriate for her to interview some people. This

> limitation was overcome to some extent by interviewing health workers and others who were also able to provide insight into wider community views (Hefler 2012).

Moving forward, the report recommended that project staff should regularly and systematically record and collect qualitative data, in addition to collaborating with clinical staff to develop a data set on: smoking status; counselling offered; interventions provided; quit and relapse outcomes; and exposure to tobacco smoke in the home.

8.1.2. Healthy Start

In 2010, Maari Ma Health Aboriginal Corporation received AU$635,726 from DoHA to build on its existing tobacco control activities and:

1) Implement strategies that reduce the promotion of smoking to Aboriginal young people.
2) Improve community health literacy about the benefits of not smoking.
3) Support Aboriginal young people and pregnant women to quit through enhancement of the existing 12 week smoking cessation program.
4) Improve the rate of successful quit attempts in the existing 12 week smoking cessation program (Hardwick Consulting 2012).

The methods by which these project aims were evaluated are described in the report as "informal". The absence of rigorous evaluation methods was justified on the following grounds:

> The evaluation used both qualitative and quantitative data collection methods. Data was [sic] sourced from client medical records, informal interviews and other existing data collections. General observation was also used to formally monitor retailers' compliance with legislation ...
>
> The informal nature of this evaluation proved to be a positive step. Maari Ma is approached to participate in many research projects and the community soon tires of the ongoing attention. Through informal discussions with staff and clients, information about the effectiveness of this project was able to be ascertained without the participants feeling like they were the subject of a research initiative. Instead, it was marketed as a quality improvement initiative that aimed to improve the care provided to clients (Harwick Consulting 2012).

As a consequence of this 'informal' approach, the findings lack internal validity. For instance, the report noted:

> Informal interviews with health service staff have reported a decrease in the number of people who are smoking within their homes. Staff would often report that houses were full of smoke when they were completing their routine home visits, so much so that they often suggested sitting outside. Nowadays, far fewer families, particularly those with young children, smoke indoors. The staff say that the difference seen in the past three years is considerable (Harwick Consulting 2012).

The accuracy of the finding cannot be reliably ascertained since the sampling strategy was not detailed, and measures to guard against the risk of social desirability bias were not described. Efforts to corroborate the data through other methods (e.g. community surveys, direct observation) were not reported.

Similarly, in the context of a discussion around the development of plain language community brochures and posters, the report found:

> These community brochures were well received by the community. The use of the photographs of local people, often well known in the community, was commented on as making the pamphlets stand out from other generic resources on display in the waiting room.
>
> Staff have reported that clients are more aware of the harmful effects of smoking. This is particularly the case for pregnant women, people with existing chronic disease and people with young children. Whilst we cannot say that the community brochures have been the reason for these increases in health literacy, we believe that they have been a contributor (Harwick Consulting 2012).

Again, the report is silent as to how many community members were asked to comment on the brochures/pamphlets. Moreover, it is not clear why the evaluators did not ask the same community members to demonstrate their awareness of information contained in the resources, rather than rely on the general impressions of an unspecified number of staff recruited through unspecified means.

While the report contained quantitative data from "maternal audits" indicating a high percentage of brief interventions conducted in 2011 (n=50, 79%), it is not clear how the

audits were conducted or whether they offer a representative picture of service delivery. The report also stated that "[t]here has been some improvement in the rate of successful quit attempts during the time of this project" without presenting any supporting data, or details of the methods used to arrive at this claim.

8.1.3. *Bila Muuji* Smoking Cessation Project

The *Bila Muuji* Smoking Cessation Project was funded under the ITCI policy in 2010 to deliver a multi-component project with the following objectives:

- Provide training to smoking cessation advisors (SCA) to enable them to deliver effective education, screening and brief intervention to support indigenous smokers to quit.
- Provide expert clinical training and back up support to SCAs who deliver smoking cessation programs; to increase their capacity to deliver interventions to Indigenous nicotine smokers.
- Engage community members who smoke to tell their stories about how much they smoke, why and the barriers to quitting.
- Educate community members on the harmful effects of smoking.
- Provide expert clinical training and specialist support to clinicians, GPs, primary health care workers, SCA and medical staff to increase the capacity to oversee the interventions and cessation support delivered by health workers.
- Development of promotional activities to raise the awareness of the effects of smoking.
- Suitable trained clinicians to provide training and support to SCA and health workers.
- Provide cost free nicotine replacement therapy and pharmacotherapy.
- Actively engage the community to support the establishment of smoke free areas such as house, workplaces and recreational areas (Stephenson 2012).

While the evaluation report presents quantitative, longitudinal data on relevant outcomes across the participating sites, it does not describe how the data were collected. For instance, Table 17 below shows average carbon monoxide (CO) readings (presumably in exhaled breath). However, the number of participants who had carbon monoxide readings taken is not clear and the report includes the following general caveat: "Data is [sic] incomplete for some participants reflecting the ongoing recruitment of new participants and the difficulty of recording information for people

who leave the program." The report is also silent as to whether the readings were taken at consistent times at each follow-up. Since concentrations of alveolar CO decay exponentially over time (half life estimates range from 214 minutes to 385 minutes),[50] the timing of measurements (e.g. first thing in the morning versus late in the day) may be significant. Additionally, it is not clear whether the percentage of people who quit smoking (Table 18 below) was based on self-reports, or self-reports verified by alveolar CO readings. The definition of 'quitting' (e.g. period of abstinence) is also not set out in the evaluation report.

Table 17: Average CO readings (parts per million) at baseline and follow-up, by community and sex[51]

		Average CO parts per million			
		Months in program			
Community	**Sex**	Start	3 months	6 months	12 months
Balranald	Female	22	13	21	15
	Male	22	25	20	
Bourke	Female	16	8	5	11
	Male	23	7	8	6
Brewarrina	Female	18	16	6	12
	Male	23	13	7	2
Coonamble	Female	25	12	6	12
	Male	21	3	6	12
Dareton	Female	25	16	8	
	Male	21	4	4	
Dubbo	Female	21	10	7	3
	Male	21	9	6	3
Orange	Female	21	16	6	3
	Male	26	7	5	2
Walgett	Female	12	2	2	2
	Male	9	2		
Wellington	Female	20	9	10	3
	Male	23	5	1	6

[50] Jo & Oh (2003).

[51] The absence of sample sizes in this table reflects the difficulty in discerning from the report the number of participants who had CO readings taken.

Table 18: Percentage of Indigenous participants reported to have quit smoking following intervention

Community	%
Balranald (n=27)*	3.7
Bourke (n=44)*	25.0
Brewarrina (n=43)	25.6
Coonamble (n=59)	45.8
Dareton (n=36)	5.6
Dubbo (n=78)	52.3
Orange (n=52)	26.9
Walgett (n=24)	12.5
Wellington (n=80)	11.3

Note:
Entries marked with an asterisk were miscalculated in the evaluation report (Balranald was shown to be 3% and Bourke was shown to be 22%). The figures have been corrected for the purposes of this table.

It is of course possible that details of data collection methods were reported in other documents not obtained under the *Freedom of Information Act* (e.g. an initial evaluation plan, although it is not known whether such a document exists). Notwithstanding this possibility, the evaluation suffers from another weakness. Tables 17 and 18 above suggest that the program was more successful in some communities (e.g. Dubbo) compared to others (e.g. Balranald). However, the report does not include any process evaluation to shed light on the seemingly disparate final outcomes, and no separate process evaluation report was identified in the *Freedom of Information Act* disclosure process.[52] While the evaluation report might provide some evidence of effectiveness, it does not provide details of the circumstances and/or elements required to replicate successful outcomes in other contexts.

[52] The *Freedom of Information Act* request was worded broadly to capture "any evaluations"; there is an expectation that any process evaluations in existence would have been disclosed along with the final evaluation report.

8.2. EVALUATION OF TISM

In February 2013, the then Shadow Minister for Indigenous Affairs (Senator Scullion) questioned the effectiveness of the second Indigenous tobacco control policy, the *Tackling Indigenous Smoking Measure*, by asking: "What results have been achieved in reducing the rate of Indigenous people smoking?" (Senate Community Affairs Committee 2013). DoHA's response to the question on notice was as follows:

> The 2008 COAG National Healthcare Agreement set a target to halve the Indigenous smoking rate by 2018 ...
>
> The next update of Indigenous smoking rates will be provided by the Australian Bureau of Statistics (ABS) Aboriginal and Torres Strait Islander Health Survey, conducted in 2012-13, with results due for release in 2013-14. ...
>
> The Indigenous Chronic Disease Package evaluation framework recognises that the roll out of a national workforce [of tobacco action workers] and the reduction of chronic disease risk factors takes time.
>
> However, *anecdotal evidence* in the form of stories about individuals and organisations, suggests that positive change in attitude and behaviour is occurring (Senate Community Affairs Committee 2013, emphasis added).

Senator Scullion pressed for further evidence in a Budget Estimates hearing, resulting in the following exchange with senior bureaucrats:

> **Senator SCULLION:** ... You said: Anecdotal evidence in the form of stories about individuals and organisations suggest that a positive change in attitude and behaviour is occurring.
>
> That is heartening, but for a $100 million spend you would usually have, in this place anyway, some sort of objective and objective evidence that we would seek from that—often a KPI of some form. Do you have any particular KPI about what sort of target this would seek to meet?
>
> **Mr SMYTH:** ... [T]he target is the COAG target that has been set to halve the rate of adult Indigenous smoking by 2018. That is to bring that figure down to 22 per cent. That is the target. As you know, tobacco is a highly addictive product and it takes time, multiple quit attempts often with people. In the Indigenous context I think the emphasis around role models and particular local solutions are going to take time to develop and be implemented and reach a mature state.

> **Senator SCULLION:** I accept all those things. My questions really goes to how are we able to track that?
>
> **Mr SMYTH:** I think we are able to track that through the [ABS] surveys that are being undertaken and we should, as I said, get some headline figures later this year or earl[y] next year from the Indigenous component of the Australian survey.
>
> **Senator SCULLION:** It has been running for a while now. Do you have any indications in terms of evidence about whether you are on trend between here and the COAG target date, because it is a target and a date - half by 2018?
>
> **Mr SMYTH:** I would have to wait for those statistics to be tabled.
>
> **Ms KILLEN:** If I could add something, for the whole of the package there was a monitoring and evaluation framework developed. As part of that we did a lot of thinking through the time frames in which you expect to see change. When you look through that the types of things that we expected to see in the first four years did not include changes to smoking rates. That was, as Mr Smyth said, in part because it takes time to achieve change. It is a graduated implementation framework. These teams have been implemented over time with the final tranche only being implemented now. So we would not expect to see at a national level much change this early, but we would expect to see it happening in the intermediate term (Community Affairs Legislation Committee 2013).

The ABS data on which DoHA and its representatives sought to rely were eventually released in November 2013. The statistics showed that "[t]here has been a progressive decrease in daily smoking rates for Aboriginal and Torres Strait Islander people, declining from 51% in 2002 to 45% in 2008, and then to 41% in 2012-13" (ABS 2014). However, the results were merely descriptive and did not purport to explain the reasons behind the downward trend. While it has been noted that the "declines in Indigenous smoking [between 2008 and 2012] have occurred at a time of massive increase in government investment and attention in tackling Indigenous smoking" (Thomas quoted in Menzies School of Health Research 2013(a)), it is also true that the trend pre-dated the ITCI and TISM policies and it is therefore not possible to discount the impact of other factors and interventions based on the prevalence data alone.

Documents obtained from DoHA under the *Freedom of Information Act* provide a more complete picture of the suite of evaluation activities that were undertaken specifically in relation to the TISM policy. As is clear from the above exchange, much of the content of existing evaluation reports focuses on implementation processes, and/or outcome measures other than rates of tobacco cessation/uptake. The findings of these evaluations are summarised in the remainder of this chapter.

8.2.1. KPMG evaluation reports

The audit and advisory firm, KPMG, provided a number of monitoring reports to DoHA. The *Freedom of Information Act* request revealed:

- a baseline report for the years 2009-10;
- a first monitoring report for the years 2009-2010; and
- a second monitoring report incorporating the years 2011-2012.

The second monitoring report contained a table which summarised the "likely effects" of TISM. Two things are striking about the approach to evidence in Table 19 below. First, in several cases, the evidence relied upon to demonstrate effectiveness is described as "measure documentation" and "literature review". However, as has been demonstrated in previous chapters, good quality literature on 'what works' in tobacco control is predominately derived from non-Indigenous settings and there are questions around its applicability to the Indigenous context. Indeed, the logic behind introducing the Indigenous-specific policies in the absence of a strong evidence base was that, through evaluation, *new* data on effectiveness could be obtained.

Second, where original data were relied upon, the source was invariably qualitative evidence "gathered from a small group of stakeholders". The report contains no information about actual sample sizes, sampling strategies, or the methods used for

qualitative data collection; as a result, the quality of the data cannot be critically appraised. The repeated reference to "a small group" of informants casts some doubt around the generalisability of the findings.

Table 19: Assessment of likely effects of measures based on implementation progress

Key dependencies	Finding	Evidence
Recruitment, retention and capacity building of the workforce	There was a shortfall in recruitment in 2011-2012, and recruitment challenges were again reported. There was considerable effort to train recruited staff with high levels of participation in training.	Analysis of data provided by the department on workforce, and qualitative evidence gathered from a small group of stakeholders.
Supports are effectively implemented and evidence based	In 2011-12, the department continued to progress various program supports for a smoke-free workplaces policy. The evidence for some of the program supports (resources and National Coordinator) has not been assessed. There is some evidence that brief interventions (training in this as a program support) can be effective in mainstream contexts. There is also recent [mainstream] evidence that smoke-free workplaces can reduce exposure to smoking and improve the health of those impacted.	Analysis of measure documentation and qualitative evidence gathered from a small group of stakeholders.
Individuals and communities are receptive to messages	Continued receptivity to messages was seen amongst some but not all community members consulted. Receptivity is a complex issue impacted by social norms and the diverse reactions of individuals to messages about health risks.	Analysis of measure documentation and literature and qualitative evidence gathered from a small group of stakeholders.
Individuals and communities are motivated to change	There are variable levels of motivation amongst community members to changing lifestyle behaviours. RTSHLTs [Regional Tackling Smoking and Healthy Lifestyle Teams] have focused on building relationships with communities, which may be an enabler to behaviour change. Organisations' receptivity to becoming smoke-free cannot be adequately measured.	Qualitative evidence gathered from a small group of stakeholders.

Table 19 continued

Expected impact	Observed impact	Evidence
Contextual considerations	There are likely to be regional variations in factors that impact on receptiveness to change, and thus could impact on the effectiveness of these measures. The availability of supports for healthier lifestyles and smoking, which RTSHLTs can refer to, varies across jurisdictions and remoteness areas.	Analysis of measure documentation and literature review.
Increase in knowledge and understanding of the risks and dangers associated with smoking or lifestyle related chronic risk factors	The evaluation found a high level of awareness amongst Aboriginal and Torres Strait Islander community members consulted about the risks of smoking and unhealthy lifestyle behaviours. Some community members engaged with RTSHLTs linked the work of the teams to their increased understanding. Recent research shows knowledge of risk factors may not translate to behaviour change amongst Aboriginal and Torres Strait Islander people.	Qualitative evidence gathered from a small group of stakeholders and literature review.
Changes in attitudes towards taking up smoking and quitting smoking/to making healthy lifestyle choices	There is emerging qualitative evidence that some of the Aboriginal and Torres Strait Islander people consulted want to make changes to their lifestyle / behaviours to become healthier (e.g., quit smoking, eat a better diet).	Qualitative evidence gathered from a small group of stakeholders and literature review.
Reduced smoking rates through a reduction in new smokers and an increase in people quitting smoking/improved uptake of healthy lifestyle choices	Data is not available in the Second Monitoring Report.	Not applicable
Reduces chronic disease risk factors	Data is not available in the Second Monitoring Report.	Not applicable
Contextual considerations	Organisational capacity and orientation to preventative health, and commitment to support RTSHLTs can impact on the traction teams can gain.	Qualitative evidence gathered from a small group of stakeholders.

Source: KPMG (2013)

8.2.2. Menzies School of Health Research evaluation reports

Through the *Freedom of Information Act* request, five sentinel sites' evaluation reports were also discovered (dated December 2010, June 2011, December 2011, June 2012 and February 2013). The reports described the following methods of data collection, although further details of the methods were not provided:

- Interviews were conducted with a range of key informants who would be expected to have some knowledge of the Tackling Smoking measure in ... case study sites;
- Interviewers also sought information about attitudes and perceptions related to reducing smoking rates amongst Aboriginal and Torres Strait Islander communities from a range of other relevant stakeholders;
- Community focus groups were asked about their perceptions of the health risks associated with smoking, their perceptions and awareness of the local smoking cessation services and programs, and their perceptions of change since the previous reporting period;
- Workforce and program delivery data provided by DoHA (Menzies School of Health Research 2010; 2011(a); 2011(b); 2012; 2013(b)).

According to the most recent report, 83% of Regional Tobacco Coordinator positions had been filled (Menzies School of Health Research 2013(b)). By contrast 50% of Tobacco Action Workers' positions were vacant (although approximately half of the vacant positions were newly created positions). Qualitative data indicated a number of recruitment barriers; these included delays in the provision of funding to employing organisations, a lack of suitably skilled applicants and a lack of individuals with interest and skills in the delivery of tobacco control interventions.

Placing recruitment challenges to one side, there was a sense among stakeholder respondents that the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams was hampered by "[t]he relatively small number of positions, large distances and large service populations" (Menzies School of Health Research 2013(b)). Conversely, the effectiveness of the teams was perceived to be enhanced by

organisational and management factors (e.g. organisational stability, adequate supervision and good team functioning).

In terms of use of specific supports, there was a sense that, despite service improvements, the Quitline was underutilised in remote areas "due to language barriers and low telephone ownership." By contrast, there were positive findings around the uptake of nicotine replacement therapy (NRT). Pharmaceutical Benefits Scheme data suggested that the rate of prescriptions for NRT increased approximately three-fold among Indigenous people aged 15 years and over between September to November 2010 and March to May 2011; moreover, the number of NRT prescriptions per 1000 people was higher in the non-remote sentinel sites compared with Indigenous populations elsewhere. This was consistent with focus group data suggesting high awareness of NRT availability. However, data did not consider whether NRT was being used appropriately.[53]

While the report claimed a general increasing trend in clinicians' perceptions of clients seeking support to quit smoking, the data were derived from small sample sizes as shown in Table 20 below. The small sample sizes (particularly in remote and regional areas) are perhaps a corollary of the limited presence of clinicians in some sites.

[53] The study of free nicotine patches conducted by Ivers, Farrington, Burns et al. (2003) found that no Indigenous participants had completed the full course of patches, and that a large number experienced bad dreams which could have negative cultural connotations and deter treatment. The mean number of patches used was 10% of the recommended course.

Table 20: Percentage of clinicians in sentinel sites who responded 'strongly agree' or 'partly agree' to the statement 'Over the past six months there has been an increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking', by rurality and evaluation cycle

Rurality	Evaluation cycle 1	Evaluation cycle 2	Evaluation cycle 3	Evaluation cycle 4	Evaluation cycle 5
Overall	57 (n=16)	52 (n=33)	56 (n=25)	40 (n=20)	80 (n=20)
Remote	71 (n=7)	20 (n=5)	50 (n=8)	33 (n=3)	80 (n=5)
Regional	50 (n=4)	59 (n=17)	33 (n=6)	40 (n=10)	50 (n=2)
Urban	40 (n=5)	55 (n=11)	73 (n=11)	43 (n=7)	85 (n=13)

Notes:
n = number of people who responded to statement.
Included in the denominator are the respondents who indicated 'don't know/can't say'.

While change in smoking status was not a focus of evaluation in the first four years of TISM, the report noted that:

> At Health Service level, there was a notable lack of recording of smoking status in clinical information systems. Documentation of smoking status is an important step in the implementation of brief interventions and smoking cessation measures in Health Services. The lack of documentation has implications for identifying 'target' groups and monitoring effectiveness of tobacco control activities (Menzies School of Health Research 2013(b)).

Table 21 below sets out the data showing that, on average, 49% of Aboriginal Health Services clients and 29% of General Practice clients did not have their smoking status recorded.

Table 21: Percentage of all Indigenous patients who had their smoking status recorded in the past 12 months, by health services in sentinel sites, 2011-12

Services	Mean	Min	Max
Aboriginal Health Services (n=10)	51.3	15.0	91.1
General Practices (n=16)	71.8	33.8	96.1

8.2.3. Talking about the Smokes (TATS) project

The KPMG Second Monitoring Report (discussed in section 8.2.1 above, pages 136-138) noted the following:

> At the end of 2010-11, [DoHA] funded Menzies School of Health Research to undertake an Aboriginal and Torres Strait Islander tobacco smoking research project called *Talking About the Smokes* (TATS). The TATS project aims to improve understanding about pathways to quitting, the impact of tobacco control initiatives such as policies and programs, and the differences in attitudes and behaviours between smokers and non-smokers, and Aboriginal and Torres Strait Islander and non-Indigenous populations. Data will be collected via surveys of both smokers and non-smokers in two 'waves' of data collection across 2010-11 to 2012-14. Results from the first wave of the project will be available from late 2013 (KPMG 2013).

While the first wave data measure indicators such as quit attempts and attitudes and beliefs about smoking, the publicly available analyses do not attempt to draw an explicit link between these indicators and the ITCI or TISM policies (e.g. Menzies School of Health Research 2013(c)). For instance, it is not clear whether the TATS participants were directly exposed to any of the components of these policies; moreover, the publicly available data does not compare indicators over time.

8.3. CONCLUSION

In the previous chapters it was explained that, despite the relative dearth of research on effective Indigenous tobacco control measures, the ITCI and TISM policies were introduced because the nature of the problem necessitated a policy response. Acting in the absence of strong evidence was partly justified on the basis that the policies would be monitored and evaluated with the aim of ascertaining their effectiveness, thereby both minimising the risk of waste and harm and strengthening the evidence-base. However, the findings in this chapter suggest that, to a large extent, the evaluations of the ITCI and TISM policies did not achieve their stated aim because of the way the evaluations were planned and carried out.

Significantly, both the evaluation of the *Yaka Ngarli* project and the Menzies' evaluation of TISM noted that information on patient smoking status over time had not been uniformly collected in clinical data systems. The corollary of this is that it is difficult to ascertain the impact of the interventions on individual actual smoking behaviour. While the *Bila Muuji* evaluation obtained data on quit rates, the evaluation report omitted information about how quitting was defined and measured, and why some communities had high rates of success while others did not. The extent to which future TATS findings will redress the lack of longitudinal data on smoking status in ITCI and TISM target communities remains unclear.

It is accepted that changes in smoking behaviour may take time to materialise. While there is value in accumulating data that can perhaps be more readily discerned (e.g. information on attitudes, knowledge, cultural acceptability etc), the data presented in the evaluation reports generally lacked rigour. In particular, the data were generally based on small sample sizes and poorly defined collection methods. In that respect, the data did not represent a significant improvement on the data available at the time the ITCI and TISM policies were formulated and adopted. The evaluations thus represent a missed opportunity to obtain evidence of what works and why in Indigenous tobacco control.

The chapter also highlights another challenge to the intuitive appeal of EBPM. Complex questions (for which there is no immediately clear answer) are revealed when the concept is scrutinised empirically. For instance, can evidence produced in one context be the basis for policy action in another context? The findings in Chapter Six demonstrated that evidence of the effectiveness of Quitline services in native North American populations was relied upon to justify culturally appropriate Quitline enhancements in the Australian context. However, the evaluation data presented in this

chapter show that, in Australia, the effectiveness of the Quitlines may have been undermined by local factors including a shortage of telephones and/or poor English language proficiency to facilitate calls to the Quitline. Far from being a 'magic bullet' that policy makers can simply aim at a problem, evidence is thus often loaded with complicated questions about its ability to be applied neatly to specific policy contexts.

9. Discussion

This chapter brings together the empirical findings of the foregoing chapters and makes a case for scrutinising and unpacking the EBPM concept. In particular, it reflects on: the variety of ways in which evidence can be used; the difficulties inherent in collecting rigorous evidence; the context in which evidence is interpreted; and the salience of other factors that may impede a neat translation of evidence into policy. The chapter then uses the example of the ITCI and TISM policy processes as a blue print for the development of an original, more nuanced approach to EBPM. The approach recognises the importance of evidence, while making allowances for situations in which evidence is not available or where application of the evidence would not be appropriate due to contextual factors. It is argued that while an innovate-and-evaluate approach was justifiable in the Indigenous tobacco control context, the way the policies were ultimately evaluated was sub-optimal.

9.1. MAIN MESSAGES

9.1.1. Evidence can be used at different policy stages

It is perhaps because EBPM grew as an extension of the evidence-based medicine movement that the concept is often assumed to mean the application of evidence in formulating solutions to policy problems ('treatments' in medical parlance). However, this case study highlighted the way in which evidence can be used (or can be claimed to be used) at different stages of the policy process. Chapter Five demonstrated how both data on Indigenous smoking prevalence and the impact of smoking on Indigenous health outcomes played a role in bringing Indigenous tobacco control onto the policy agenda. Chapter Six showed that, while there was acknowledged to be a dearth of high quality evidence, many of the initiatives contained in the ITCI and TISM policies were

based on research conducted in Indigenous Australian, international indigenous, and mainstream contexts. In Chapter Seven, some policy makers revealed that they adopted the Indigenous-specific policy proposals because of a perception, based on data, that mainstream tobacco control policies had been ineffective at reducing Indigenous smoking prevalence over time. Meanwhile, Chapter Eight revealed how data were collected to monitor the effectiveness of the ITCI and TISM policies.

These findings suggests the need to more closely scrutinise claims that policies are 'evidence-based'. The term EBPM glosses over the extent to which policy making is, in fact, a *process* typically comprising of multiple decisions. Section 2.2.1 above (pages 18-19) described eight empirical studies which sought to examine the extent to which various policies described as being 'evidence-based' actually drew upon the evidence. All of those studies focused on only a few stages of the policy process. For instance, Goldson (2010) considered the role of evidence in getting the issue of youth crime onto the UK policy agenda and formulating policy solutions. By contrast, Partridge (2013) only examined the role of evidence in evaluation.

There is, thus, a need for greater clarity in both policy-making and academic circles about what is meant by EBPM and, in particular, whether a policy that uses evidence at one stage of the process but not others can be properly described as being 'evidence-based'. The absence of a definitive answer to these questions in the literature creates a risk that users of the term are speaking at cross-purposes, thus eroding the conceptual strength and utility of EBPM.

Unpacking the role of evidence at various stages of the policy process is also important because, "[i]t may well be that success in influencing an agenda [through evidence], for example, often requires a different kind of approach than that needed for influencing the

implementation of policy" (Sutcliffe & Court 2005). Indeed, the findings of this case study suggest that different forms of evidence were invoked at different stages of the policy process. Generally, prevalence data were central at the agenda setting stage, experimental studies were valued at the policy formulation stage, and qualitative data were a major component of evaluation. This is consistent with a three-tiered typology of evidence in which:

> Type 1 evidence defines the causes of disease and the magnitude, severity and preventability of risk factors and diseases. It suggests that "Something should be done" about a particular disease or risk factor. Type 2 evidence describes the relative impact of specific interventions that do or do not improve health, adding "Specifically this should be done." Type 3 evidence ... shows how and under which contextual conditions interventions were implemented and how they were received, thus informing "how something should be done" (Brownson, Baker, Left et al. 2010).

9.1.2. Evidence does not speak for itself

As was described in Chapter One, the appeal of the use of 'evidence' in policy making lies in the perception of objectivity – evidence 'speaks for itself', and is therefore above politics and other factors that may cloud rational judgment. However, the findings in this case study lend empirical support to Kleeberg's (2005) theory-based observation that "[s]cience might be able to deliver empirical knowledge ... but this knowledge has to be interpreted and warranted in order to be understood".

As was made plain in Chapter Five, it had long been known that smoking rates in the Australian Indigenous population were high. On its own, the empirical knowledge that approximately half of all adult Indigenous Australians smoke does not have any meaning beyond being a neutral statement of prevalence. It is only when interpreted in light of additional information that the statement can begin to forfeit its 'neutral' quality. For instance, in a society in which good health and longevity are valued, the

knowledge that smoking heightens the risk of morbidity and premature mortality provides a reason for believing that a high prevalence of smoking is undesirable.

The complicating factor is that contexts (which are a prerequisite for meaningful interpretation of empirical knowledge) are fluid, multiple and sometimes contested. The consequence is that a single piece of empirical knowledge can be ascribed different meanings. In Chapter Five, some respondents expressed the view that tackling the high rates of Indigenous smoking had not been a priority before 2008 because smoking was seen as a way of helping people to 'cope' with the myriad other Indigenous health and social problems; this perceived 'positive' aspect to smoking seems to have served as a counterpoint to the 'negative' aspect that was derived from knowledge of the adverse health outcomes. However, the respondents suggested that the high prevalence began to be interpreted more negatively with the advent of a concerted campaign to reduce the gap between Indigenous and non-Indigenous health outcomes, combined with the additional empirical knowledge that smoking contributed to 17% of that gap. Consistent with Kingdon's (1984) model of agenda setting, the election of a reformist Labor Government sympathetic to the 'Closing the Gap' movement created a window of opportunity for the evidence to help spur policy change.

The message from these findings is that empirical knowledge derives meaning from the context in which it is interpreted and, as a consequence, the same data can be read in different ways and be the impetus for different courses of action.[54] This is, by no means, to say that evidence is useless; rather, the point is that it is inaccurate to celebrate EBPM as a form of decision making in which values, beliefs and other contextual factors are entirely ignored.

[54] This is consistent with the view of Nutley, Walter and Davies (2007) that the uses of research occupy a fluid continuum "ranging from simply raising awareness of research findings, through enhanced knowledge and understanding and shifts in attitudes and ideas, to direct changes in policy and practice."

This point is further demonstrated in Chapters Six and Seven. Some policy makers and researchers argued that evidence from non-Indigenous and international studies could be used to solve the Indigenous tobacco control problem. An example of this was the claim that Indigenous-specific evidence was unnecessary because there was very good mainstream evidence of 'what works' to reduce smoking prevalence (e.g. taxation, social marketing campaigns etc). Yet, while evidence plays a key role in this line of logic, the evidence is not 'speaking for itself'. Instead, unspoken assumptions (perhaps grounded in theory or experience) are being used to generalise the findings from one context to another. For instance, the view that evidence of the effectiveness of tobacco pricing policies or a social marketing campaign in one population can be applied to other populations might be based on a theory that human beings behave in predictable ways in response to market forces or certain forms of messaging.[55] It would thus be inaccurate to use the 'evidence-based' appellation as shorthand for a style of decision making that is devoid of interpretation and speculation.

Additionally, the view that 'evidence-based' decision making is inherently objective ignores the fact that our values and judgments play a central role in determining what counts as 'good evidence'. For instance, the evaluation report of the *Maari Ma* pilot project described in Chapter Eight described the adoption of "informal" data collection methods as "positive" because it enhanced stakeholder willingness to participate in the study (Harwick Consulting 2012). However, the application of contemporary, Western scientific research standards would suggest that the evaluation findings are unlikely to

[55] Concerns have been expressed that relying on the results of 'non-group-specific' randomised controlled trials could have unexpected consequences for the health of sub-populations because inaccurate assumptions are made about human homogeneity (Williams 2011). For instance, Kotaska (2004) has argued that: "Randomisation improves the internal validity of trials by homogenising study and control populations thereby avoiding the bias from differences between the two. Clinically important factors that are variable within populations are, however, homogenised as well. Their importance to the outcome is lost, and the trial loses external validity for individuals within subsets of the population. Results represent the mean outcome for all participants and are not [necessarily] applicable to subgroups".

be considered either internally or externally valid. Far from being superfluous to EBPM, values are therefore essential in defining what counts as good evidence. Drawing on the work of Code (1991; 1993), Goldenberg (2006) has argued:

> the experience with which empiricism works is an abstraction in which cognitive specificities are homogenised under one dominant conception of what counts as knowledge and who counts as the knower. In practice, those conceptions mirror and replicate the experiences that their (usually white, male, prosperous, and educated) creators are positioned to regard as exemplary ... '[O]bjectivity' is 'a generalisation from the *subjectivity* of quite a small group.'

9.1.3. Evidence of 'effectiveness' must be weighed against 'acceptability'

Just as contextual factors (including values) inform decisions about what counts as evidence and how the evidence is interpreted, the findings in Chapter Seven demonstrate that contextual factors also have an influence over how much weight is ascribed to evidence in the policy process. Even though some members of the Tobacco Working Group were convinced of the applicability of mainstream evidence to the Indigenous population, they were not inclined to push it as an alternative to Indigenous-specific tobacco control measures. The reasons cited for this seeming incongruity related to issues of cultural sensitivity, and pragmatic considerations about the need for policies to be acceptable to members of the Indigenous population (some of whom were vocal in expressing the need for tailored solutions).

While critics might consider it reckless to not act on good evidence,[56] the policy makers' approach was consistent with the concept of evidence-based medicine favoured by Sackett and colleagues (1996) – that is to say, evidence must sit alongside "thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences". For instance, in a study of the use of evidence by Accident

[56] Here, we leave aside the question of whether the policy makers' belief that mainstream approaches would work to reduce Indigenous smoking prevalence was supported by the evidence-base (see discussion in section 9.1.2 above about the transferability of research findings from one context to another).

Alliances, Green (2000) reported resistance to the evidence-based decision to encourage the use of soft-hip protectors among the elderly; accident prevention officers considered that the intervention was not acceptable because asking elderly people to wear 'padded knickers' undermined their right to respect and dignity. Similarly, Glasby (2011) has noted:

> There may ... be clear *empirical evidence* about the impact of [a] vaccine on infection rates and the spread of disease. However, if policy makers ignore experiential evidence (how members of the public or the parents of children might view the vaccine if they thought it had been rushed and/or were frightened by past media-driven vaccination 'scandal' stories), a national vaccination program might not 'work' in practice.

The view that "an efficacious treatment cannot produce public health benefits if it is not adopted widely by its intended recipients" (Gonzales, Ringeisen & Chambers 2002) is particularly salient in the Indigenous Australian policy context. In Chapter Four, the controversy surrounding the Northern Territory National Emergency Response was discussed. In particular, the government-commissioned evaluation of that policy initiative noted that "[i]n many communities there is a deep belief that the measures introduced by the Australian Government under the NTER were a collective imposition based on race", and "[t]he Intervention diminished its own effectiveness through its failure to engage constructively with the Aboriginal people it was intended to help" (Northern Territory Emergency Response Review Board 2008). The debates around the acceptability of the Emergency Response were prominent at the time the Indigenous tobacco control policies were being formulated.

9.1.4. Waiting for evidence may not be acceptable or feasible

Ideally, solutions that are 'acceptable' to the target population will also be supported by evidence of their likely effectiveness. However, the Indigenous tobacco control case

study demonstrates that there are situations in which it may be justifiable to introduce policies in the absence of high quality evidence.

Chapter Six demonstrated that at the time the ITCI and TISM policies were designed, there was a dearth of high quality evidence on 'what works' in reducing Indigenous smoking rates. An examination of the broader literature suggests that the absence of high quality evidence in this area was not surprising. It has been noted that barriers to research in Indigenous contexts include:

- the fact that the Indigenous Australian source population is small (670,000), meaning that sample populations in Indigenous-specific studies are also likely to be small and only very large program impacts are likely to be statistically significant (Cobb-Clark 2013);[57]
- Indigenous distrust of research on the basis that it was historically associated with "the politics of colonial control" and, in the present day, can be perceived to be exploitative, stigmatising or unresponsive to Indigenous needs and concerns (Cochran, Marshall, Garcia-Downing et al. 2008; Tuhiwai Smith 1999; Humphrey 2001); and
- the fact that, in order to be culturally sensitive, there is often a call for research in Indigenous communities to be participatory which can result in a conflict between "the values of the academic setting and those of the community"

[57] See the introductory caveat in the *Northern Territory Emergency Response Evaluation Report* which summarises the problems of Indigenous-specific public health research: "While the report does have a strong focus on data, it is important to understand that there are only around 45,000 Indigenous Australians resident in the NTER communities. It can be difficult at times to observe trends in some outcome data for what is a relatively small population over a four-year period. It is also important to understand that the NTER is a very complex policy response that has many elements. It is not always possible to identify the additional impact of individual measures because so many changes, both NTER and other measures, were introduced at a similar time" (Northern Territory Emergency Response Review Board 2008).

(Cochran, Marshall, Garcia-Downing et al.. 2008; see also Black 1996; Green & Tones 1999; Allison & Rootman 1996).

As Rychetnik, Frommer, Hawes et al. (2002) point out, the consequence is that "'best' evidence is often gathered on simple interventions and from groups that are easy to reach in a population", and evidence from those that are harder to reach tends to be regarded as inferior.

Of course, this research bias is not unique to the Indigenous Australian context. Minas and Jorm (2010) have noted that low-income countries often have limited resources to invest in research, and cultural minorities within high-income countries are often excluded from research protocols because of the logistical and financial costs, such as those related to translation. With respect to tobacco control research, a systematic review of studies examining the effectiveness of NHS stop smoking services in the United Kingdom found there is currently a lack of high-quality research into the potential differential impact of interventions in other sub-populations, such as black and minority ethnic groups, despite qualitative and anecdotal evidence suggesting different beliefs and attitudes to smoking and smoking cessation (Bauld, Bell, McCullough et al. 2010).

Birch (1997) presents the potential resulting paradox thus:

> If there is no evidence of effectiveness among the most deprived group ... [e]fficient use of scarce resources ... would imply the intervention not be given to these individuals with the anticipated increase in social inequalities in health. The resources of a health care system would become increasingly concentrated on less deprived populations. This results not necessarily because the problems of the more deprived groups are insoluble, but because the mechanisms we choose to evaluate for dealing with the observed problems are particularly suited to less deprived groups, i.e. it is a feature of the 'service focus'.

Applied to the Indigenous tobacco control context, a rigid adherence to the belief that there should be 'no policy without evidence' could feasibly have resulted in a widening

gap in the smoking prevalence (and associated health outcomes) between Indigenous and non-Indigenous Australians simply because there was more research to demonstrate the effectiveness of interventions in the latter population.[58]

9.1.5. Innovate-and-evaluate is an alternative to evidence-before-action

When the potential corollaries of the 'no policy without evidence' approach are laid bare, the policy makers' decision to adopt the ITCI and TISM policies in the absence of strong Indigenous-specific evidence seems justifiable. It is clear from Chapter Six that the policies were not made with reckless disregard for what would work; instead, evidence from other settings and the opinions of experts working in the Indigenous tobacco control field were used to generate novel yet conceptually plausible responses to the policy problem. Moreover, the policy proposals were accompanied by a commitment to evaluate their effectiveness. This approach is consistent with that proposed by Sanderson (2009) and others in Chapter Two – namely, policies should be viewed as hypotheses to be tested through pilots or trials and/or rigorous monitoring and evaluation.

However, the findings in Chapter Eight suggest that more could have been done in laying the groundwork for evaluating the programs. In particular, some evaluations were conducted over short time periods or using unscientific (or "informal") methods. There also appears to have been an absence of planning to ensure that appropriate infrastructure and processes were in place to enable key data to be recorded in a systematic way over time (e.g. clinical data systems to record smoking status and other

[58] Other ironies of the EBPM logic have been noted elsewhere. For instance, the Community Restorative Centre (CRC) approached the Bureau of Crime Statistics and Research to conduct an evaluation of a post-prison release program that they ran in order to demonstrate its apparent effectiveness but was told "they would need at least 600 people to study, and a control group of the same size, to get a meaningful result" (Arnold 2014). A researcher at the Bureau of Crime Statistics and Research explained, "You get caught in a viscious cycle. You can't show the program is successful so you can't attract additional funds [from Government]. But if you don't attract additional funds you can't scale the program up so that it can be evaluated" (Weatherburn quoted in Arnold 2014).

relevant variables). Finally, at least two evaluation reports noted that scientific rigour may have been compromised by issues associated with using non-Indigenous 'outsiders' to research policy outcomes in Indigenous communities. As Pennington, Gray, Donaldson et al. (2012) note, "[t]he societal costs of basing policy on weak evaluations can be considerable." All told, while it was logical for policy makers to focus on the accumulation of evidence at the 'back end' of the policy process, the way in which the strategy was executed may have compromised the ability to derive rigorous insights into 'what works'.

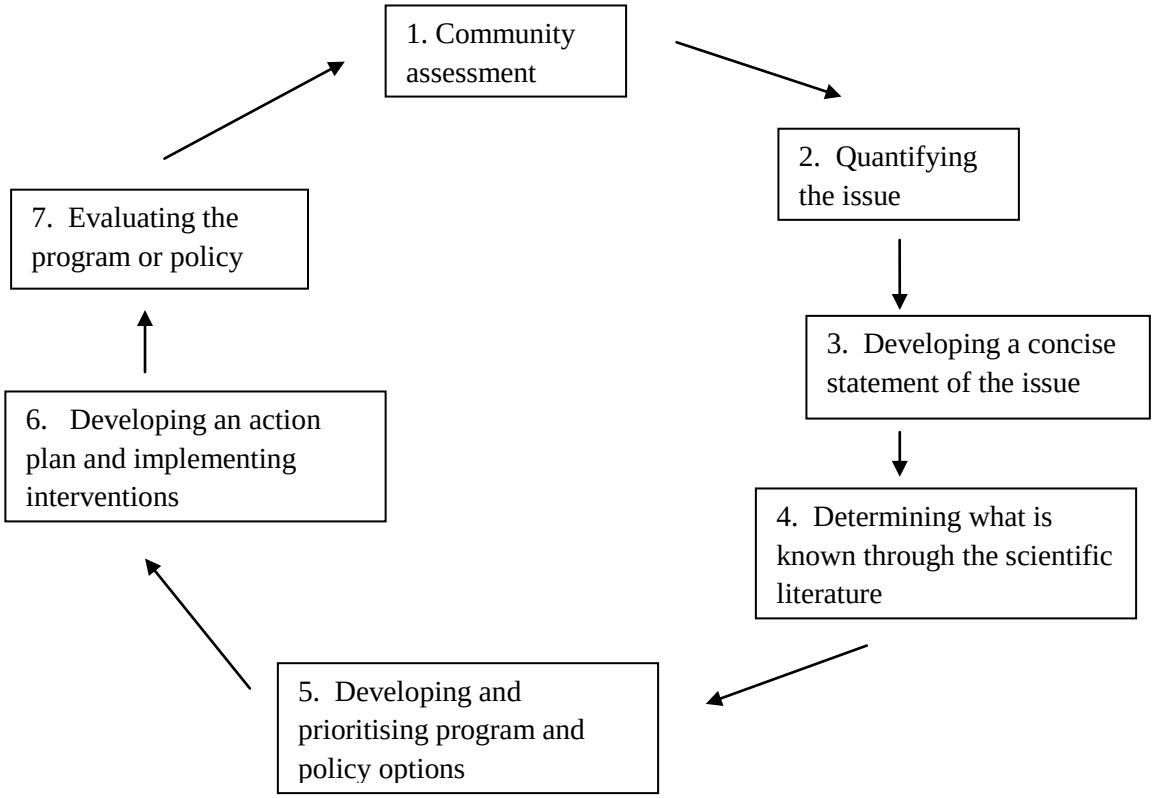
The failure to properly evaluate the Indigenous tobacco control policies ought not to be interpreted as an indication that the innovate-and-evaluate approach is unworkable or unachievable. Indeed, there are examples in which the innovate-and-evaluate approach has been more faithfully executed. For instance, in 1999, the New South Wales Government established a Drug Court pilot program to determine whether a model which diverted drug-dependent offenders away from prison and into treatment programs would lower recidivism for drug and property crimes (Lind, Weatherburn, Chen et al. 2002). Existing research on the model mainly related to the United States justice system and had quality limitations; there also was a dearth of cost-effectiveness analyses (Lind, Weatherburn, Chen et al. 2002). The New South Wales pilot randomly allocated eligible offenders to either a treatment arm involving drug rehabilitation, social support and frequent drug testing (n=309), or a control arm where normal sanctions were applied (n=191). Outcome measures included time spent out of custody and frequency of re-offending. The evaluation showed that those in the treatment arm had significantly lower rates of offending for drug offences than the control group; it also demonstrated that the model was more cost-effective at reducing the rate of offending than the application of traditional sanctions (Lind, Weatherburn, Chen et al.

2002). The program was continued beyond the pilot period and remains a feature of the New South Wales justice system. A re-evaluation of the program in 2008 found that Drug Court study participants (n=645) were "17 per cent less likely [than the comparison group, n=329] to be reconvicted for any offence, 30 per cent less likely to be reconvicted for a violent offence and 38 per cent less likely to be reconvicted for a drug offence at any point during the follow-up period" (Weatherburn, Jones, Snowball et al. 2008).

9.2. WHITHER EBPM?

Figure 2 below has been described as "the most commonly applied framework in evidence-based public health" (Satterfield, Spring, Brownson et al. 2009). While it recognises the role that evidence can play at different stages of the policy process (e.g. quantifying the issue for agenda setting, determining what is known for policy formulation and, finally, acquiring data to evaluate the policy), it glosses over other complexities of the policy process that have been highlighted by the Indigenous tobacco control case study. For instance, the framework assumes that rigorous scientific literature is available to inform the development of policy options; the case study demonstrated that there may be barriers to accumulating such evidence. Additionally, the framework does not highlight the potential tension between 'what is known' to be an effective solution and 'what is acceptable' to the target population; instead, the role of the community is limited to the first stage of the process (namely, defining the issue requiring a policy response). The framework thus feeds into the popular conception that EBPM is intuitive and commonsensical.

Figure 2: The seven-stage EBPM framework



Adapted from Satterfield, Spring, Brownson et al. (2009)

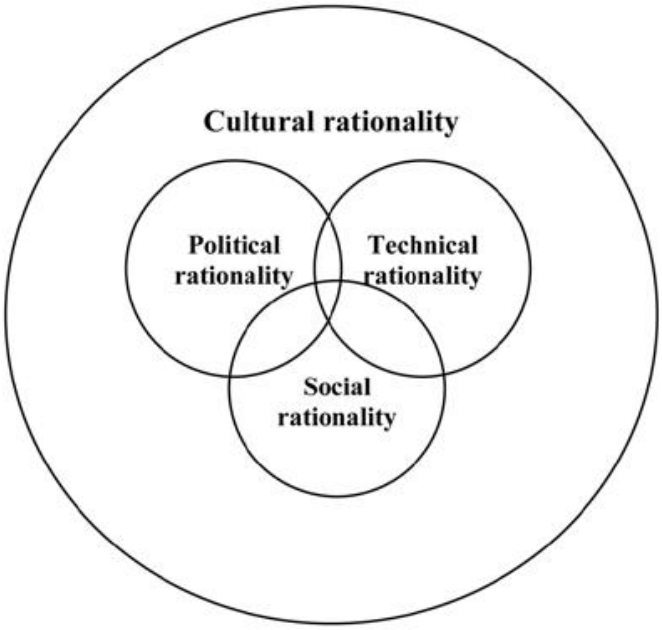
Other frameworks go further but not far enough. Various versions of the framework presented in Figure 3 below appear in the literature, including the version in Figure 4 (also below) which has been specifically developed to explain Indigenous health policy-making (Larkin 2006). In Larkin's (2006) framework, policy is a product of the interaction between 'technical rationality' (evidence), 'political rationality' (factors that weigh upon the minds of policy makers including resources and time pressures) and 'social rationality' (values, ethics and social opinions). The entire decision making process is embedded in a fourth sphere (cultural rationality) which reflects the points advanced in section 9.1.2 above (pages 19-150) – namely that "[r]esearchers and policy makers engage in 'world making' or 'reality making' practices that are influenced by

their cultural norms, assumptions and ideas" about what constitutes 'valid knowledge' (Larkin 2006). However, the weakness of these frameworks is that they do not offer a 'blue-print' for action; they merely present the factors that play a role in the process. In particular, it is not clear how evidence should be considered in relation to these other factors.

Figure 3: Model for evidence based practice

Source: Satterfield, Spring, Brownson et al. (2009)

Figure 4: Framework for analysing Indigenous health policy



Source: Larkin (2006)

This thesis has critiqued an un-nuanced, overly literal commitment to EBPM. However, it does not contest the premise that evidence should be, as a general rule, the first consideration in any policy process. As was stated in Chapter One, the critical role of evidence in the area of health decision making is related to: (1) the scarcity of resources, which means that effort should be made to reduce the likelihood of waste; and (2) the potential impact of ill-informed decisions on the health and well-being of the target population. In Figure 5 below, this thesis proposes a new sequential decision tree to guide policy makers. The decision tree recognises the importance of evidence but incorporates lessons learnt through the empirical investigation of Indigenous tobacco control policy making.

While evidence is the *first* consideration in the decision tree, it is neither a *necessary* nor a *sufficient* condition for the creation of policy. Based on the findings of the case study, the decision tree recognises that rigorous empirical evidence is always desirable but that, where such evidence is not available, consideration must be given to acting on the basis of other forms of knowledge (e.g. expert opinion, preliminary studies based on small samples, theory).[59] Such an approach is *justifiable* where: (a) inaction is likely to lead to (new or continued) harm; and (b) there is no or little prospect of the intervention causing additional harm.[60,61]

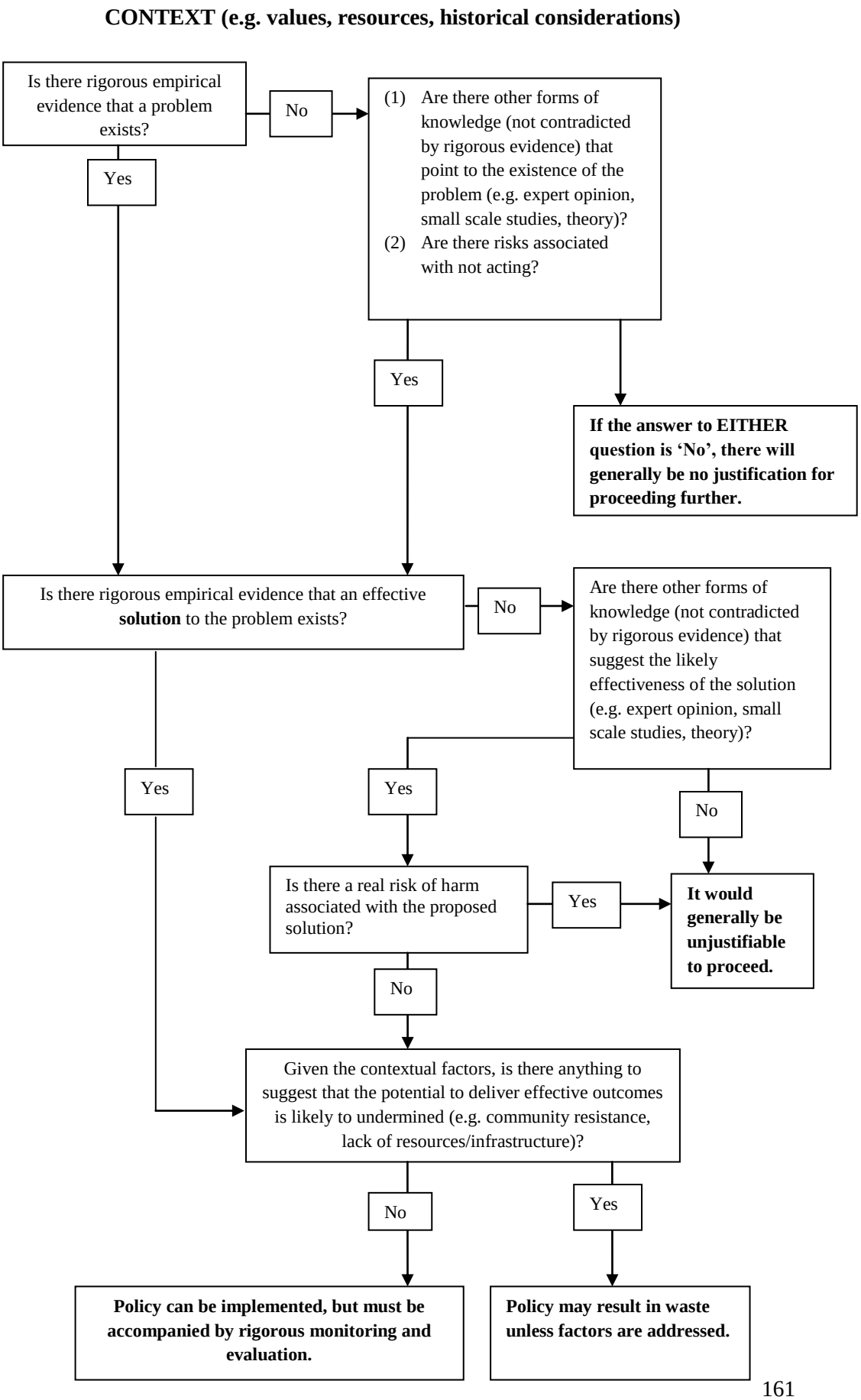
The decision tree then makes the important distinction that *justifiable* actions are not necessarily *appropriate* actions (in a normative or practical sense), and that questions

[59] This mirrors Glasby's (2011) description of the typologies of evidence – namely, theoretical evidence, empirical evidence and experiential evidence.
[60] It follows that it would not be justifiable under this decision tree to approve a new drug with potentially serious side effects as a new treatment for cancer on the basis of qualitative evidence of effectiveness.
[61] Since a central argument of this thesis is the significance of context, the framework does not offer proscriptive definitions of 'rigorous research' and 'harm'. These concepts are inherently subjective and their meaning will need to be interpreted and debated in the policy contexts to which they are being applied.

such as feasibility and acceptability need to be considered as an adjunct step in the decision making process before an action can be responsibly pursued. That is to say, policy proposals (whether based on rigorous evidence or other forms of knowledge) should not be implemented if contextual circumstances (e.g. community resistance, lack of resources/supporting infrastructure) suggest that their potential to deliver effective outcomes is likely to be undermined.

The approach is faithful to the underlying EBPM objectives of 'no waste' and 'no harm'. Even where rigorous research or other forms of knowledge suggest that the policy is likely to be safe, effective and acceptable to the target population, the framework requires the policy to be accompanied by rigorous monitoring and evaluation of the effects of the intervention.

Figure 5: Nuanced decision tree for EBPM



The decision tree offers a unique mechanism for addressing policy problems which:

1. values the role of evidence in reducing harmful and wasteful interventions;
2. is responsive to the real life complexities associated with amassing rigorous evidence in some policy contexts; and
3. recognises that failing to act for want of evidence is not always a safe or desirable option.

9.3 CONCLUSION

All told, this thesis concludes that, while the Indigenous tobacco control policies were not based on rigorous evidence, the decision to adopt an innovate-and-evaluate strategy was justifiable given: (a) the potential for the gap between Indigenous and non-Indigenous health outcomes to worsen in the absence of an imminent policy response; (b) the contextual barriers to developing a rigorous evidence base; (c) the need for policy solutions to reflect community preferences, given socio-historical sensitivities. While, under the circumstances, it was acceptable for policy makers to rely on expert opinion and the results of small scale studies to develop hypotheses as to what might work to reduce smoking prevalence, the legitimacy of the approach was undermined by weak evaluation planning (e.g. the failure to collect relevant baseline data) and execution (e.g. reliance on 'informal' discussions with stakeholders to ascertain effectiveness). Despite this, the case study offers a useful blue print for developing a more nuanced approach to EBPM 'where there is no evidence or where evidence is not enough'.

10. Conclusion

Chapter One opened with Marston and Watts' (2003) observation that "[i]t is difficult to imagine anyone arguing that policy should be based on anything but the best available evidence." In the chapters that followed, this thesis challenged the growing tendency to unthinkingly "genuflect before the altar of 'evidence-based' policy" (Shergold 2011) and, in so doing, achieved what Marston and Watts (2003) considered 'unimaginable'. The purpose of this concluding chapter is to: (1) summarise the thesis narrative; (2) identify the limitations; (3) highlight the unique contributions; and (4) suggest avenues for further research and inquiry.

10.1 THESIS SUMMARY

While the literature review in Chapter Two identified a number of existing critiques of EBPM, few of those critiques were grounded in empirical findings. The reluctance to utilise evidence to question the inviolability of EBPM might have been borne of a fear of being rebuked for hypocrisy. However, the chapter noted that challenges to EBPM are not generally based on a repudiation of evidence; rather, sceptics tend to argue that evidence ought to be used both *reflectively* (i.e. with an appreciation of how it is produced, interpreted and valued), and *non-exclusively* (because evidence is not everything). There is therefore no reason that empirical research should not be used to critically analyse the logic and desirability of EBPM; indeed, in a socio-political context in which evidence is revered, arguments based on empirical research are more likely to gain traction.

Chapter Three described a number of ways in which the policy process can be researched empirically, and noted the strengths of drawing upon archival/documentary resources and interviews with members of the policy community. These techniques

were applied to investigate the role of evidence in Indigenous tobacco control policy making. Members of the Indigenous tobacco control policy community were identified through purposive-and-snowball sampling and the response rate was above-average for studies of this nature. Additionally, a number of key archival resources were obtained under the *Freedom of Information Act* process, thus providing a detailed account of an otherwise 'closed' process.

Chapter Four highlighted how the Indigenous policy context serves as a useful case study for examining EBPM critically. On the one hand, evidence was championed by politicians and Indigenous commentators as an antidote to failed policies based on ideologies and assumptions. On the other hand, past experiences suggested dangers associated with introducing policies without looking beyond the evidence to other factors such as history. These tensions were demonstrated empirically by the findings in the ensuing chapters.

Chapter Five showed that evidence of high Indigenous smoking prevalence was originally not sufficient to put the issue onto the policy agenda; this was in part because the Indigenous population was simultaneously dealing with other problems (e.g. substance abuse, socio-economic disadvantage), and there was a perception that smoking offered a means of coping with legacies of dispossession and discrimination. The evidence was given new salience in the context of an Indigenous-led and Government supported campaign to 'close the gap' between Indigenous and non-Indigenous health outcomes within a generation (and the emergence of evidence that explicitly demonstrated the impact of smoking on that gap).

Chapters Six and Seven showed that, while the ITCI and TISM policies seem to have been developed with reference to two literature reviews produced/commissioned by

DoHA, most of the studies cited in those reviews had methodological weaknesses. Rather than wait for high quality evidence to emerge, policy makers designed policies based on the existing studies and undertook to evaluate policy outcomes with a view to strengthening the evidence-base (although the findings in Chapter Eight showed that the evaluations had their own shortcomings, both in terms of their planning and execution). Despite having reservations about the absence of evidence to support the policy proposals, some policy makers reported that they did not challenge the proposals because they were perceived to be popular with Indigenous stakeholders. There was a desire to avoid replicating historical examples of Indigenous exclusion from (and resistance to) the policy process.

The central message of this thesis is that, while the ITCI and TISM policies were not based on rigorous evidence, their formulation and adoption was neither irrational nor reckless. Rather, the policy making process was a response to a pressing health problem affecting a population in which some barriers existed to the collection of rigorous evidence, and historical experiences meant that the existence of rigorous evidence was not the only determinant of policy success. Chapter Nine used the case study to construct a more nuanced approach to EBPM in the form of a decision tree that reflects real world challenges. Under this approach, all policy decisions should generally be informed by rigorous evidence. The exception to this is where the following conditions are met:

1. there are barriers to the collection of rigorous evidence, but
2. there exist other forms of knowledge to guide intervention, such as theory or preliminary research, and
3. there is a risk of harm associated with not intervening, and
4. the risk of harm *resulting* from the intervention is minimal.

Whether the policy scenario falls under the general rule or the exception, the decision tree recognises that other factors (e.g. community resistance, lack of infrastructure) may offer a legitimate reason for not proceeding. All policies introduced under the decision tree must be monitored and evaluated to reduce the risk of harm or waste.

10.2 LIMITATIONS

The limitations of this dissertation principally relate to the methodological challenges of conducting health policy process analyses. Interviews with members of the policy community formed the major data source in this case study. While a response rate of 62% is considered strong when compared to other interview-based studies of the policy sphere (Baruch 1999), there is the potential that relevant insights have been omitted from the policy process analysis advanced in the foregoing chapters. In particular, three Indigenous people whose names repeatedly emerged in the 'snowballing' exercise either declined or did not respond to interview requests. The problem is a corollary of researching this source population (i.e. people whose professional obligations impose high demands on their time, and who may be sceptical of external inquiries), coupled with the ethical obligation to avoid exerting undue pressure on individuals by repeatedly following up interview requests. Adams (2002) has also noted that:

> [I]t is a common experience for Aboriginal people in positions of responsibility to be swamped by all manner of requests and demands. I was yet another unknown person seeking to intrude upon their busy schedules to discuss the highly contentious issue of research.

As a non-Indigenous researcher conducting research from a non-Australian institution, my ability to recruit some Indigenous participants may have been curtailed. It is possible that future research of this nature may need to be conducted from within, or in close partnership with, Indigenous communities to enhance response rates and thereby ensure that important voices are included in the resulting data.

The difficulties of interview-based research do not end with recruitment. There is always a risk that respondents may: misremember or forget key events; overstate or downplay their involvement; withhold sensitive information; and provide responses that they perceive to be socially desirable (Beamer 2002; Lea 2008; Oxman, Lavis, Fretheim 2007; Peabody, Hammond, Torcom et al. 1990; Al-Yateem 2012). It is significant that the subject of the case study was a source of political debate. The conservative Liberal Party who, at the time of the interviews, looked likely to win the next election had been critical of the Indigenous tobacco control policies in Parliament (Senate Estimates Committee 2012). Moreover, a Cabinet document obtained by a national news station under the *Freedom of Information Act* in 2011 stated that Government Indigenous spending yielded "dismally poor returns" (Department of Finance and Deregulation 2009), and media reports referred to the Indigenous tobacco control campaign in the context of this report, with one using the headline "Indigenous anti-smoking campaign burns $100m" (Seven News 2011). Respondents would have been aware of this contextual background, and it is therefore possible that their answers were influenced by their view as to whether the policies ought to be continued by the next Federal Government; for instance, those who supported the principle of the policies may have been unwilling to articulate negative aspects of policy design.

As was noted in Chapter Three, strategies for enhancing the reliability of the interview data in light of these risks included: the guarantee of anonymity to facilitate frankness; the practice of allowing respondents to review drafts containing their responses to gain trust; the use of probing questions to challenge inconsistencies and obtain greater detail; and corroboration of responses through other interview data, and documents produced under *Freedom of Information Act* requests.

10.3 UNIQUE CONTRIBUTIONS

A major contribution of this thesis is the depth of insight into the policy process gleaned from the *Freedom of Information Act* disclosures. In Chapter Three it was noted that *Freedom of Information Act* requests are under-utilised in scholarly research. However, as the findings reveal, obtaining internal government documents can enhance a researcher's ability to both understand closed decision-making processes, and check policy makers' *post facto* accounts against contemporaneous sources. Moreover, the critical appraisal of evaluation reports obtained under the *Freedom of Information Act* regime directly answers Cobb-Clark's (2013) call for policy evaluations to be made public so as to: (a) increase scrutiny and, thereby, provide a catalyst for improved methodological quality; and (b) ensure that lessons from interventions are widely disseminated to inform and improve future research and practice. Policy researchers thus ought to make greater use of *Freedom of Information Act* requests, and there is a need for more methodological scholarship around this form of data collection, especially regarding appropriate wording/scoping of requests.

A second strength of this thesis is its contribution to another under-developed body of literature – namely, studies that question the logic of EBPM through empirical means. In so doing, it has been possible to demonstrate that a dogmatic adherence to EBPM has the potential to create problems when translated to real-world policy scenarios. Criticisms of EBPM have thus been taken out of the realm of the hypothetical and made tangible. While the results of one case study cannot settle the debate, they provide an impetus for more nuanced investigations of the concept of EBPM in other contexts.

The third major strength of this thesis is that, in questioning EBPM, the baby has not been thrown out with the bath water. A foundational premise of the foregoing piece of work is that evidence remains an important and desirable commodity, but that its

existence is neither a necessary nor a sufficient condition for policy action. The decision tree that is advanced offers a practical guide for reconciling these two truths. While evidence serves as the starting point, the decision tree goes on to provide policy makers with guidance to help them discern situations in which it may be acceptable to make policy decisions based on other considerations and forms of knowledge. It also emphasises the importance of obtaining evidence at the 'back end' of the policy process, through the development of clear evaluation plans that require key indicators to be measured using appropriate methods both at baseline and follow-up. Having been designed as a practical, decision making tool, this approach stands apart from other, more abstract representations of the role of evidence in the policy process.

10.4 FUTURE CONTRIBUTIONS

All told, the thesis demonstrates the importance of examining empirically the role of evidence in policy making processes. Future research ought to investigate the complexities of EBPM in other real world contexts. For instance, the debates concerning the introduction of compulsory bicycle helmet laws raise important questions about what level of evidence is required to justify state intervention, and how decisions should be made when evidence is invoked to support opposing sides of an argument. While advocates of the mandatory helmet laws point to case-control studies suggesting that helmets help to reduce the incidence of head injuries, opponents point to difficulties adjusting for confounders and cite other evidence suggesting that helmet laws may reduce health outcomes by deterring people from engaging in cycling as a form of physical activity (Goldacre & Spiegelhalter 2013).

The current controversy around e-cigarette regulation exposes similar problems. On the one hand, some suggest that the product should be regulated on the basis of evidence

showing harms associated with nicotine intake, chemical vapour inhalation and its potential use by teenagers as a gateway to conventional cigarettes; on the other hand, others argue that the use of the product should not be discouraged because it reduces consumption of conventional cigarettes and associated harms (Polosa & Caponnetto 2013). The question for researchers ought to be how policy makers actually use evidence in such complex situations, and whether there is a need for us to return to first principles and clarify precisely what we mean when we demand EBPM.

Additionally, more research should be conducted in other minority populations in order to determine whether the EBPM dilemma alluded to by Birch (1997) rings true – namely, that there is a dearth of rigorous research with respect to some minority groups, and that refusing to act in the absence of such evidence may disadvantage those groups relative to mainstream populations. If so, greater attention will need to be given to sensitively overcoming the barriers to conducting research in these populations. For instance, in the Australian context, the need to train more Indigenous researchers has been identified as a potential means of overcoming the exploitative connotations of traditional Western research (Laycock 2009). Similarly, Larkin (2005) has argued that "the answer to culturally sensitive development and use of evidence lies in technical skill within a decision making process based on collaboration between Aboriginal people and [policy and research] organisations."

Finally, there needs to be more empirical investigation into how policy makers reconcile values and evidence. For example, the debate around the re-classification of drugs such as ecstasy (which, according to some studies, is less harmful than other less regulated substances) would provide a useful case study for examining the way in which policy makers interpret evidence in the context of societal ideas of 'appropriateness'. By identifying and investigating actual situations in which evidence

and values have conflicted, we can lay the groundwork for more informed public debates around how such conflicts ought to be resolved as a matter of best practice.

Far from being a "nihilistic 'demolition job'" (Sanderson 2004) to undermine the importance of evidence in policy making, this thesis has set the stage for a more constructive and realistic dialogue around the facilitators of and barriers to the use of evidence in complex policy contexts. In being one of only a few studies to examine the strengths and limitations of EBPM through empirical means (including the novel use of *Freedom of Information Act* requests), this research has acquired data to inform the creation of an original decision tree to guide policy makers. The decision tree redresses the conceptual weaknesses of current understandings of EBPM in so far as it explicitly accounts for situations in which evidence is absent, conflicting or at odds with what is considered 'acceptable'. In so doing, this thesis refines and strengthens the concept of EBPM in a way that makes it more resilient in and relevant to real world policy environments.

Appendix One: Methods review

The search strategy began with a search which combined the terms "health policy" and "policy analysis" in three OvidSP databases (Medline, Embase and Global Health). The abstracts of the search results were then scanned with a view to ascertaining the types of keywords and Medical Subject Heading (**MeSH**) terms that were used in publications identified as health policy process analyses. The extracted keywords and MeSH terms were then entered into the OvidSP databases (Medline, Embase and Global Health) and mapped to MeSH and non-MeSH terms therein.[62]

The subject headings and keywords in each of the three categories were combined with headings and keywords in the same category using the Boolean operator "OR". The combined searches for each category were then aggregated using the "AND" operator so as to reduce the pool to only those publications which were tagged with at least one public health term, one (health) policy term and one policy process term (see Tables A1-A3 below). The strategy yielded almost 286,148 results in Embase, 266,204 in Medline and 13,954 in Global Health.

In conducting literature reviews, a balance must be struck between comprehensiveness and relevance (Lefebvre, Mannheimer & Glanville 2008). A review of the search results demonstrated that a large number of publications were unrelated to the research questions in that they focussed on clinical health as opposed to public health. An advisory group consisting of an outreach librarian with knowledge of OvidSP databases and a senior academic with extensive experience in the conduct of systematic reviews assisted with the process of refining the search strategy. The record of the final search

[62] 'Mapping' is a process by which databases search for related terms and concepts.

strategies applied in each database is set out in Tables A1-A3 below. The refined search strategy identified 48,683 publications for potential inclusion in the review.

Table A1: Search strategy, Ovid MEDLINE(R) <1950 to October Week 4 2010> (updates since 2010-11-02)

#	Search History	Results
1	exp Public Health/ec, ed, ep, hi, lj, sd [Economics, Education, Epidemiology, History, Legislation & Jurisprudence, Supply & Distribution]	74526
2	public health.ti,ab.	90673
3	exp State Medicine/	40512
4	exp Preventive Health Services/ec, ed, hi, lj, mt, og, sd [Economics, Education, History, Legislation & Jurisprudence, Methods, Organization & Administration, Supply & Distribution]	94683
5	exp ! Preventive Medicine/ec, ed, hi, lj, mt, og [Economics, Education, History, Legislation & Jurisprudence, Methods, Organization & Administration]	5402
6	exp Health Promotion/ec, ed, hi, lj, mt, og, sd [Economics, Education, History, Legislation & Jurisprudence, Methods, Organization & Administration, Supply & Distribution]	16420
7	health education/ or exp consumer health information/ or exp health education, dental/ or exp health fairs/ or exp sex education/	60290
8	exp Communicable Disease Control/ec, ed, hi, lj, mt, og, pc [Economics, Education, History, Legislation & Jurisprudence, Methods, Organization & Administration, Prevention & Control]	66170
9	health services/ or exp adolescent health servic! es/ or exp child care/ or exp community health services/ or exp dental health services/ or exp dietary services/ or exp health services for the aged/ or exp health services, indigenous/ or exp mental health services/ or exp preventive health services/ or exp reproductive health services/ or exp rural health services/ or exp student health services/ or exp suburban health services/ or exp urban health services/ or exp women's health services/	636430
10	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9	843895
11	exp Public Policy/	90784
12	exp Health Policy/	66078
13	(program$ and national).ti,ab.	39477
14	(program$ and government).ti,ab.	9149
15	exp Health Planning/ec, ed, hi, lj, mt, og, sd [Economics, Education, History, Legislation & Jurisprudence, Methods, Organization & Administration, Supply & Distribution]	63963
16	health policy.ti,ab.	8620
17	health program$.ti,ab.	8191
18	policy.ti,ab.	79668
19	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18	235416

20	exp Policy Making/mt [Methods]	1
21	policy maki$.ti,ab.	1685
22	priorit$.ti,ab.	41659
23	policy agenda.t! i,ab.	316
24	agenda setting.ti,ab	135
25	policy formulation.ti,ab.	417
26	policy development.ti,ab.	1466
27	policy analysis.ti,ab.	529
28	implement$.ti,ab.	151563
29	policy adoption.ti,ab.	43
30	walt.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]	127
31	advocacy.ti,ab.	6168
32	decision mak$.ti,ab.	47644
33	20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32	239550
34	10 and 19 and 33	17059
35	limit 34 to updaterange="mesz(20101102100538-20101102100538]"	0

Table A2: Search strategy, EMBASE <1980 to 2010 Week 44> (updates since 2010-11-05)

#	Search History	Results
1	exp public health/	86147
2	public health.ti,ab.	105762
3	exp preventive health service/	17119
4	exp preventive medicine/	18377
5	prevention.ti,ab.	319752
6	exp health promotion/	53643
7	health education/ or exp breast feeding education/ or exp childbirth edu! cation/ or exp death education/ or exp dental health education/ or exp diabetes education/ or exp hiv education/ or exp nutrition education/ or exp parenting education/ or exp psychoeducation/ or exp school health education/	73827
8	exp disease control/	99143
9	health service/ or exp public health service/	145540
10	exp mass screening/	113365
11	(immuni?ation and government).ti,ab.	443
12	(immuni?ation and national).ti,ab.	2908
13	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	867076
14	exp policy/	53094

15	exp HEALTH CARE POLICY/	109780
16	planning/ or exp health care planning/ or exp program development/ or exp strategic planning/	84876
17	health policy.ti,ab.	10169
18	exp health program/	66645
19	health program$.ti,ab.	8380
20	policy.ti,ab.	92624
21	(program$ and national).ti,ab.	45030
22	(program$ and government).ti,ab.	8589
23	14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22	374712
24	policy mak$.ti,ab.	9494
25	priorit$.ti,ab.	49684
26	policy agenda.ti,ab.	369
27	agenda setting.ti,ab.	151
28	policy formulation.ti,ab.	449
29	policy development.ti,ab.	1718
30	policy analysis.ti,ab.	666
31	implement$.ti,ab.	185014
32	policy adoption.ti,ab.	40
33	advocacy.ti,ab.	6901
34	decision m ak$.ti,ab.	56700
35	walt.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer]	174
36	24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35	294559
37	13 and 23 and 36	24114
38	limit 37 to updaterange="emez(20101105111846-20101105111846]"	0

Table A3: Search strategy, Global Health <1973 to October 2010> (updates since 2010-11-01)

#	Search History	Results
1	exp public health/	32994
2	public health.ti,ab.	37383
3	exp preventive medicine/	501
4	prevention.ti,ab.	60614
5	exp health promotion/	7716
6	exp health education/	7302
7	exp disease control/	25063
8	health services/ or exp public health services	18848

9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	151087
10	exp policy/	16358
11	policy.ti,ab.	21551
12	exp health policy/	7130
13	health policy.ti,ab.	2237
14	exp planning/	1545
15	exp health programs/	5222
16	(program$ and national).ti,ab.	12320
17	(program$ and government).ti,ab.	3451
18	policy mak$ .ti,ab.	2886
19	priorit$.ti,ab.	9857
20	policy agenda.ti,ab.	98
21	agenda setting.ti,ab.	34
22	policy formulation.ti,ab.	151
23	policy development.ti,ab.	475
24	policy analysis.ti,ab.	167
25	implement$.ti,ab.	30142
26	policy adoption.ti,ab.	13
27	walt.mp. [mp=abstract, title, original title, broad terms, heading words]	65
28	advocacy.ti,ab.	1061
29	decision mak$.ti,ab.	4902
30	exp program development/	57
31	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17	46164
32	18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30	45879
33	9 and 31 and 32	7458
34	limit 33 to updaterange="cagf(20101101145010-20101101145010]"	0

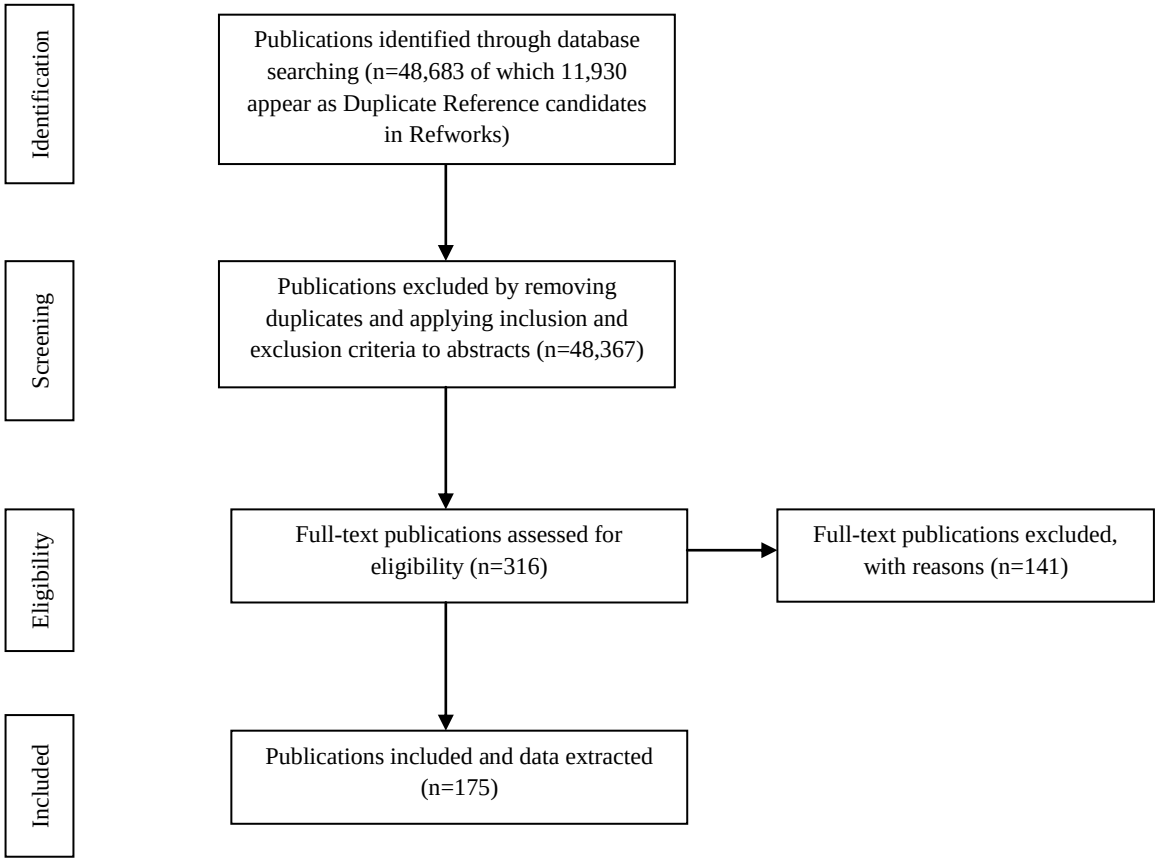
The titles and abstracts of the 48,683 publications were screened against the inclusion criteria set out in Box A1 below.

Box A1: Criteria for inclusion

- The publication focuses on how or why a policy is or is not made (i.e. any aspect of the policy process prior to implementation).
- The publication focuses on a public policy taken by or on behalf of a national, state/provincial or local government.
- The publication focuses on a public policy directly concerned with public health.
- The title or abstract of the publication includes reference to at least one of the following study designs: numerical survey; RCT; case-control; ecological study; systematic review; observation; interviews; historical research; survey; focus groups; role play or simulation.
- The policy making process is more than merely an ancillary or tangential focus of the publication.
- The publication is written in English.

Figure A1 below summarises the screening process and the number of results at each stage.

Figure A1: Modified PRISMA diagram



Appendix Two: *FoI Act* response

Australian Government

Department of Health

Mr Daniel Vujcich
12 Taxal Close
CARINE WA 6020

via email: daniel.vujcich@univ.ox.ac.uk

Dear Mr Vujcich

Your Freedom of Information Request No: 006-1314

I refer to your request to the Department of Health and Ageing (the Department) of 9 July 2013 seeking access under the *Freedom of Information Act 1982* (the FOI Act) to:

- *Minutes of meetings held between December 2007 and December 2008 in which the tobacco control elements of the National partnership Agreement on Closing the Gap in Indigenous Health Outcomes was discussed;*
- *Any research commissioned before December 2008 to inform the Tackling Indigenous Smoking Measure specifically;*
- *Memoranda, advice or briefing papers drafted before December 2008 in which the Tackling Indigenous Smoking Measure is mentioned;*
- *Any evaluations of the Tackling Indigenous Smoking Measure;*
- *In the case of multiple versions of the same document, only the first and final versions are required.*

I am authorised to make decisions on behalf of the Department under section 23 of the FOI Act. This letter sets out my decision on your request for access.

Decision

I have identified twenty (20) documents relevant to your request. I have decided to release seventeen (17) in full and to release two (2) in part. I have decided that one (1) document is wholly exempt from disclosure. My reasons for this decision are set out at Attachment A to this letter. At Attachment B is a schedule setting out each document and detailing my decision in relation to each document.

Documents subject to third party appeal rights

Although I have decided to release all of documents 11, 15 and 16 and part of document 13 to you, a third party has objected to the disclosure of those documents. As such, I am unable to provide access to those documents until the third party has had an opportunity to exercise their appeal rights and the outcome of any such appeal is known. The Department will keep you informed in relation to any third party appeal on those documents. A third party has 30 days to appeal.

FOI Unit Legal Services Branch MDP 350 GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 1666 Fax: (02) 6289 5604 ABN 83 605 426 759

Review rights

You are entitled to seek review of this decision. Your rights are set out at Attachment C.

Relevant provisions

I have enclosed copies of the provisions of the FOI Act relevant to your request at Attachment D.

Publication

Section 11C of the FOI Act requires the Department to publish information that has been released in response to each freedom of information access request subject to certain exceptions. This publication is known as a 'disclosure log'. The disclosure log requirement does not apply to personal information or to information about the business, commercial, financial or professional affairs of any person if publication of that information would be unreasonable. The Department is not required to consult you on any decision to publish information that is released to you and the decision to publish information is not subject to internal review by the Department or the Australian Information Commissioner. Any person can however, make a complaint to the Australian Information Commissioner about how an agency handles an FOI request.

Contacts

If you require clarification of any of the matters discussed in this letter you should contact Michelle Mount on +61 2 6289 8715.

Yours sincerely

Alison Killen
Assistant Secretary
Program Management and Evaluation

27 September 2013

ATTACHMENT A – SCHEDULE OF RELEVANT DOCUMENTS

1. Copy of the media release for the announcement of the Indigenous Tobacco Control Initiative at the Indigenous Health Equality Summit, 20 March 2008.

2. Questions and Answers prepared during the development of the Indigenous Tobacco Control Initiative.

3. Facts and figures for the Indigenous Tobacco Control Initiative.

4. Facts and figures for the announcement of the Indigenous Tobacco Control Initiative at the Indigenous Health Equality Summit.

5. Project Evaluation prepared by the Miwatj Health Aboriginal Corporation.

6. Project evaluation prepared by the Maari Ma Health Aboriginal Corporation.

7. Project evaluation prepared by the Wellington Aboriginal Corporation Health Service.

Australian Government

Department of Health and Ageing

Mr Daniel Vujcich
12 Taxal Close
CARINE WA 6020

Dear Mr Vujcich

Your Freedom of Information Request No. 067-1213

I refer to your request of 14 September 2012 seeking access under the *Freedom of Information Act 1982* (the FOI Act) to:

- *Minutes of meetings held between December 2007 and 20 March 2008 in which the Indigenous Tobacco Control Initiative was discussed.*
- *Memoranda or advice prepared between December 2007 and 20 March 2008 in which the Indigenous Tobacco Control Initiative is mentioned.*
- *Minutes of any meetings relevant to the selection of the first six multi-component projects funded as part of the Indigenous Tobacco Control Initiative in 2008-09.*
- *Any documents containing evaluations of the first six multi-component community projects funded as part of the Indigenous Tobacco Control Initiative in 2008-09.*

This letter sets out my decision on your request for access. I am an authorised decision-maker under section 23 of the FOI Act.

Decision

I have identified seven documents relevant to your request. I have decided to release these documents to you in full. A schedule of the relevant documents identified for this request is provided at Attachment A.

Charges

I notified you of your liability to pay charges on 11 October 2012. I have calculated the actual time taken to process your request and advise that your final charges liability is $377.47.

As you have paid a deposit of $121.55, the outstanding balance of your charges is $255.87. Your payment for the outstanding balance of charges should be received within 30 days by way of cheque and made payable to the Department of Health and Ageing and sent to:

FOI Coordinator (MDP 350)
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

I will provide you with access to the documents released to you under this decision when we receive the balance of the outstanding charges.

Review rights

You are entitled to seek review of this decision. Your rights are set out at Attachment B to this letter.

Since my decision is to release all documents to you in full, an application for review would be limited to a situation where you consider that I have not identified all the documents in the Department's possession that are relevant to your request.

Publication

I take this opportunity to remind you that the Department must publish information that has been released in response to each freedom of information access request subject to certain exceptions. This publication is known as a 'disclosure log'. The disclosure log requirement does not apply to personal information about any person if it would be unreasonable to publish the information or to information about the business, commercial, financial or professional affairs of any person if publication of that information would be unreasonable. The Department is not required to consult you on any decision to publish information that is released to you and the decision to publish information is not subject to internal review by the Department or the Australian Information Commissioner. Any person can however, make a complaint to the Australian Information Commissioner about how an agency handles an FOI request.

Contacts

If you require clarification of any of the matters discussed in this letter you should contact the FOI unit on (02) 6289 1666.

Yours sincerely

Colleen Krestensen
Assistant Secretary
Drug Strategy Branch
Population Health Division
17 December 2012

Australian Government

Department of Health and Ageing

Mr Daniel Vujcich
25 Staverton Rd
Oxford
OX2 6XL
United Kingdom

Dear Mr Vujcich

Your Freedom of Information Request No: 309/1112

I refer to your request of 1 May 2012 seeking access under the *Freedom of Information Act 1982* (the FOI Act) to written reports / letters of advice and internal reports or memoranda used by the Government to inform the design of the Indigenous Tobacco Control Initiative.

The Freedom of Information (Fees and Charges) Regulations (the Regulations) prescribes that charges can be levied in respect of a request for access to documents. These charges are set out by the Regulations and are for search and retrieval of documents, decision making and provision of access (for example, copying and postage).

I have decided that you are liable to pay a charge in respect of the processing of your request. I am an authorised decision-maker under section 23 of the FOI Act.

A search and retrieval of documents relevant to your request has been undertaken and a preliminary estimate of charges has been calculated in accordance with the Regulations and is set out in the table below.

search and retrieval time (including time spent locating relevant files and collating relevant documents contained on those files)	35 hours @ $15.00 per hour	$525.00
decision making time (including time spent examining the documents, considering exemptions, undertaking consultation, writing the decision and preparing any documents for release)	5 hours @ $0.00 per hour 501 hours @ $20.00 per hour	$ 0.00 $10,020.00
photocopies of documents		$300.00
TOTAL		$10,845.00

The Regulations allow for the first five hours of decision making time to be made available free of charge. The estimate provided has accounted for that time.

The Regulations prescribe that where a charge is imposed and exceeds $25.00 but is less than $100.00, a deposit of $20.00 may be sought and where the charge exceeds $100.00, a deposit of up to 25% of the estimated charges may be sought. Based on the preliminary estimate of charges for your request which is $10,845.00, I have decided you are required to pay a deposit of $2,711.25.

Section 29 of the FOI Act provides that you must notify this Department, in writing, within 30 days of receipt of this notice that you either:

- Agree to pay the charge (in which case you should also forward the deposit);

or

- Contend that the charge has been wrongly assessed, or should be reduced or not imposed (including where such charges would cause you financial hardship or where you believe access to documents is in the general public interest). You should provide full reasons for so contending;

or

- Withdraw your request.

If within 30 days of receipt of this notice you have not notified the Department in the manner mentioned above, the FOI Act deems that you have withdrawn your request.

The time limit for processing your request is suspended, in accordance with section 31 of the FOI Act, from the date you received this written notice about your charges liability and resumes on either the day you pay the charges or deposit or the day on which the Department makes a decision not to impose a charge.

If you agree to the charges, you will then accept liability for settlement of the debt with the Department upon completion of processing the FOI request as prescribed by section 29 of the FOI Act. Once the agency has processed your FOI request it will determine the actual charges for which you are liable. In the event that the actual charges are less than this estimate, you will only be liable for the lesser amount. If the actual charges are more than this estimate, then you will only be liable for the lesser amount notified in this estimate, unless the Department releases every document to you in full, in which case it may impose the higher actual charges.

It may be possible to reduce the charges by refining your request - for example, by limiting the date range of documents sought, by excluding draft versions of documents or duplicates of documents, or by refining the scope of the request more generally. We would be happy to discuss options for refining your request with you and I understand you have spoken with Penny Dakin from this Department about some initial ideas for how you might best do this. If you wish to discussion this in more detail please feel free to contact Ms Dakin on (02) 6289 7978.

Once your FOI request has been processed the outstanding charge amount is a debt created in favour of the Commonwealth and therefore the Department is obliged to pursue recovery of the debt in accordance with the *Financial Management and Accountability Act 1997.*

Should you accept liability for your estimated charge your cheque for the deposit should be made payable to the Department of Health and Ageing and sent to:

FOI Coordinator (MDP 350)
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Third Party Consultation
As your request relates to documents which concern [as relevant: a person or organisation's business or professional affairs / an individual's personal information / material originating or received from a State or Territory government], the Department is required to consult with the relevant third parties before making a decision on the release of those documents. Also, the decision-maker may decide to consult a foreign government, authority of foreign government or an international organisation. Subsections 15(6) and 15(7) of the FOI Act provides for an extension of 30 days to the statutory time limit for processing requests in these situations. The time period for processing your request will be extended accordingly.

If you require clarification of any of the matters discussed in this letter you should contact Ms Penny Dakin on (02) 6289 7978.

Yours sincerely

Monique Machutta
A/g Assistant Secretary
Chronic Disease Branch
22 May 2012

ATTACHMENT A

REASONS FOR DECISION

Where the schedule of documents indicates an exemption claim has been applied to a document or part of document, my findings of fact and reasons for deciding that the exemption provision applies to that document or part of document are set out below.

Subsection 34(1) – Cabinet documents generally

Section 34(1)(a) exempts a document that has been submitted to Cabinet for its consideration, or is proposed by a Minister to be submitted to Cabinet, if the document was brought into existence for the dominant purpose of submission for consideration by the Cabinet. The part of document 20 relevant to your request, Attachment 1, was submitted to cabinet for consideration and was brought into existence for the dominant purpose of submission to cabinet.

Accordingly, I am satisfied that the document is exempt under section 34(1).

Section 47(B) – Commonwealth-State relations

Paragraph 47B(a)
Paragraph 47B(a) provides that a document is conditionally exempt if its disclosure under this Act would, or could reasonably be expected to, cause damage to relations between the Commonwealth and a state.

Part of Table 8 in document 13 is exempt from release under paragraph 47B(a) as it relates to project components and funding of state government entities for Indigenous smoking initiatives. In particular it includes operational information about the individual entities.

Two of the entities are statutory corporations set up under State legislation. While they are separate entities from the States, they report to the State parliaments and keep the parliaments regularly informed of their activities. The information in table 8 of document 13 is not publicly available. Given that the project is still under way the release of the information could reasonably be expected to undermine relations with the States by making it less likely that the States will co-operate with the Department.

Release would damage relations with the States by causing the Commonwealth to be regarded as less reliable and co-operative in relation to undertakings which depend on continuing mutual reliance and trust.

Public interest

There is greater public interest in maintaining Commonwealth-State relations than the public interest in the information being released given the above considerations. Disclosure of the information would not contribute towards public participation in Government activities, nor would it inform debate on the publicly important matter of Indigenous smoking. Disclosure would, however, be contrary to the public interest because it would risk damage to the co-operative relationship between the Commonwealth and the States.

I have therefore decided that it would, on balance, be contrary to the public interest to release part of table 8 in document 13. It is therefore exempt under paragraph 47B(a).

Section 47F - Personal privacy

Section 47F conditionally exempts a document if its disclosure would involve the unreasonable disclosure of personal information about any person (including a deceased person).

Personal information

Personal information is defined in section 4 of the FOI Act as:

- Information or an opinion (including information forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

For those documents where the conditional exemption in section 47F is claimed, I have found that the information is personal information. The case studies in document 5 contain quotes from individuals from indigenous communities and information where from the context persons in the communities would be able to identify the persons who provided input.

Disclosure unreasonable

If information is personal information, it will be exempt if disclosure would be 'unreasonable'.

I find that disclosure of the case studies in document 5 conditionally exempted under section 47F would involve unreasonable disclosure of personal information. Release of the personal information would be unreasonable because of identification of specific individuals who may not have fully understood that what they said may be published in a publically available report. Such association may adversely affect their standing and relationships within their community.

Public interest

There is a greater public interest in Indigenous persons participating in case studies from which policy is developed and in protecting their personal information than the public interest in this information being released given the above considerations. Release of this identifying information would also undermine the ability of the Department to gain the co-operation of Indigenous persons in the future and therefore the ability of the Department to develop targeted programs. I have therefore decided that it is not in the public interest to release the case studies in document 5.

Accordingly, those parts of document 5 which contain the case studies are exempt under section 47F.

Paragraph 47G(1)(b) - information that could prejudice the future supply of information to the Commonwealth

Paragraph 47G(1)(b) conditionally exempts a document if it would disclose information concerning the business affairs or professional affairs of a person or the business, commercial or financial affairs of an organisation and disclosure could reasonably be expected to prejudice the future supply of information to the Commonwealth.

Business affairs information
The case studies in document 5 exempted under paragraph 47G(1)(b) contain information provided by Indigenous organisations about their programs and therefore is their business information.

Prejudice to future supply of information
I find that the disclosure of that information could reasonably be expected to prejudice the future supply of information to the Commonwealth by those organisations. Indigenous organisations that have provided information to inform policy development would be less likely to participate in the development of policy in the future if it is known this type of information is to be released to the public. The Indigenous organisations co-operate with the Department on various initiatives on the understanding that the information will only be available to the Department and not to the public at large. Release would damage the trust Indigenous organisations have in the Department and therefore undermines their willingness to provide information in the future.

Public interest

There is a greater public interest in Indigenous organisations providing input into policy development than the public interest in this information being released given the above considerations. All indigenous health initiatives rely to a substantial extent on the co-operation of indigenous health organisations in developing policy. Without the ability to collect this type of information, it would substantially impact on the Department's ability to develop effective targeted programs.

Accordingly, I am satisfied that the case studies in document 5 are exempt under paragraph 47G(1)(b).

Material taken into account

In making my decision, I had regard to the following:
- The terms of your request;
- The content of the documents to which you sought access;
- Consultation responses from third parties consulted in accordance with the FOI Act;
- Advice from Departmental officers with responsibility for matters relating to the documents to which you sought access;
- Advice from other Commonwealth Departments (particularly the Department of the Prime Minister & Cabinet);
- The relevant provisions of the FOI Act;
- The Department's guidance material on the FOI Act, and
- Guidelines issued by the Australian Information Commissioner under s93A.

ATTACHMENT B – SCHEDULE OF RELEVANT DOCUMENTS

FOI Doc No	File No.	Folio No.	Date	Author	Addressee	Description of Document	Decision[1]	Portion exempted
1.			Dec 2010	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Draft Chapter 6 National Action to reduce Indigenous smoking rates	R	
2.			Dec 2010	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Final Chapter 6 National Action to reduce Indigenous smoking rates	R	
3.			June 2011	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Draft Chapter 6 National Action to reduce Indigenous smoking rates	R	
4.			June 2011	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Final Chapter 7 National Action to reduce Indigenous smoking rates	R	
5.			Dec 2011	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Draft Chapter 9 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease Chapter 23 Case Studies	RD s47F(1) s47G(1)(b)	Chapter 23 Part of Case Studies
6.			Dec 2011	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Final (published) Chapter 9 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease	R	

[1] R=Release, RD=Release with Deletions, E=Exempt in full

7.			June 2012	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Draft Chapter 5 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease Chapter 21 Case studies	R	
8.			June 2012	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Final Chapter 5 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease Chapter 21 Case studies	R	
9.			Feb 2013	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Draft Chapter 3 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease	R	
10.			Feb 2013	Menzies School of Health Research	Program Policy & Evaluation	Sentinel Sites Evaluation Report Final Chapter 3 National Action to Reduce Indigenous Smoking Rates & Helping Indigenous People Reduce Their Risk of Chronic Disease	R	
11.			Nov 2011	KPMG	DoHA Program Policy & Evaluation	Baseline report Draft Chapter 4 National Action to Reduce Indigenous Smoking Rates Chapter 5 Measure specific baseline data Appendix E – Individual Measure information	R	Release pending third party appeal rights
12.			Jan 2013	KPMG	DoHA Program Policy & Evaluation	Baseline report Final KPMG disclaimer Chapter 5 National Action to Reduce Indigenous Smoking Rates	R	

13.			May 2012	KPMG	DoHA Program Policy & Evaluation	First Monitoring Report Draft Chapter 4 National Action to Reduce Indigenous Smoking Rates and Helping Indigenous Australians to Reduce their Risk of Chronic Disease	RD s47B(a)	Part of Table 8 Release pending third party appeal rights
14.			Aug 2013	KPMG	DoHA Program Policy & Evaluation	First Monitoring Report Final KPMG disclaimer Chapter 4 National Action to Reduce Indigenous Smoking Rates and Helping Indigenous Australians to Reduce their Risk of Chronic Disease	R	
15.			Feb 2013	KPMG	DoHA Program Policy & Evaluation	Second Monitoring Report Draft Chapter 3 National Action to Reduce Indigenous Smoking Rates and Helping Indigenous Australians to Reduce their Risk of Chronic Disease Appendix E	R	Release pending third party appeal rights
16.			June 2013	KPMG	DoHA Program Policy & Evaluation	Final Report Draft Chapter 1 Regional Tackling Smoking Health Lifestyle Teams, and other national level support for smoking cessation Appendix D National Action to Reduce Indigenous Smoking Rates and Helping Indigenous Australians to Reduce their Risk of Chronic Disease Chapter 3 Case study – Integration and organisational support	R	Release pending third party appeal rights
17.	Background Papers		Nov 2008	DoHA	Program Management & Evaluation	Closing the Gap – Tackling Chronic Disease Risk Factors	R	

18.	2007/041327		June 2007	DoHA	DoHA Program Management & Evaluation	Collation of recent reviews of Indigenous tobacco control	R	
19.	2008/057500		September 2008	Anke van der Sterren CEITC	DoHA Program Management & Evaluation	Scoping Paper – Review of evidence for the Indigenous Tobacco Control Initiative	R	
20.	KR08/0301 08/109		26/5/2008	Health Minister Nicola Roxon	Cabinet	Cabinet Submission Indigenous Reform: Achieving the Government's "Closing the Gap" targets	E s22(1)(ii) s34(1)(a)	All

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