NATIONAL PREVENTIVE HEALTH RESEARCH STRATEGY 2013–2018

BUILDING KNOWLEDGE FOR A HEALTHY AUSTRALIA

promoting a healthy australia

INCLUDING PRIORITY-DRIVEN RESEARCH AGENDAS FOR:

TOBACCO CONTROL IN AUSTRALIA

OBESITY PREVENTION

PREVENTION OF ALCOHOL RELATED HARM IN AUSTRALIA

Australian Government
Australian National Preventive Health Agency

promoting
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Effective preventive health action is undertaken in a collaborative, integrated model involving researchers and decision makers.

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANPHA	Australian National Preventive Health Agency (the Agency)
ARC	Australian Research Council
CAPHIA	Council of Academic Public Health Institutions Australia
CEIPS	Centre of Excellence in Intervention and Prevention Science
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HILDA	The Household, Income and Labour Dynamics in Australia survey
LSAC	Longitudinal Study of Australian Children
LSIC	Longitudinal Study of Indigenous Children
NGO	non-government organisation
NHMRC	National Health and Medical Research Council
NPAPH	National Partnership Agreement on Preventive Health
PHAA	Public Health Association of Australia

FOREWORD

The Australian National Preventive Health Agency (the Agency) has developed the *National Preventive Health Research Strategy 2013-2018* (the Strategy) using an extensive consultation process, not only to guide the use of the National Preventive Health Research Fund, but more importantly to be the national guide for the preventive health research, policy and practice community generally.

Vision

The vision for this Strategy is that all research needed for effective preventive health action is undertaken in a collaborative integrated model involving researchers and decision makers in creating knowledge. This Strategy aims to be transformative. It advocates a research system that seeks solutions to problems. The envisioned result is necessary for our preventive health infrastructure that supports a healthy Australia where the promotion of health is embraced by every sector, valued by every individual and includes everybody.

Purpose

The Strategy's primary purpose is to foster approaches to research and evaluation which better enable all sectors, whether they are workplaces, schools or other institutions, to implement the most effective preventive health programs and enable individual choices to be evidence-informed. It will build on the already strong research and evaluation capacity in preventive health in Australia and extend this to better support and build policy and program capacity.

It recognises that the change that is sought will evolve over some years and this Strategy constitutes the first step in the national effort. This Strategy's duration is 2013 to 2018 with review and evaluation from 2014.

This Strategy aims to:

- influence the approach to research and knowledge production for supporting the implementation of policies and programs
- build on current research and policy capacity and provide impetus for collaborative production of knowledge to address difficult problems with more insight and understanding
- foster and support working with stakeholders so that the results are applicable in practice and provide feedback for further research.

Audience

This Strategy is for a wide range of stakeholders within and outside the health sector. It is intended to be inclusive of participants and potential participants in knowledge creation for effective preventive health in Australia. Participants may have different roles within the research system, but all roles are necessary for completeness, be they from research institutions, governments, non-government organisations, consumer and community groups, professional organisations, industry or the media.

Priority research questions

This overarching Strategy provides a new model for any solutions-driven preventive health research. Specific Priority-driven Research Agendas for tobacco control, obesity and harmful consumption of alcohol have been developed as Annexes to this Strategy. Each Research Agenda has been developed through engagement of researchers, those from policy and practice and other stakeholders. The process involved ranking policy-relevant questions to promulgate the priority research ideas for all to use as their guide.

INTRODUCTION

The National Partnership Agreement on Preventive Health 2009–2018 (NPAPH) was established to build on previous national programs to address the rising prevalence of lifestyle related chronic diseases by:

(a) laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles

(b) supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

Amongst other commitments, the parties to the NPAPH committed to invest in the evidence base necessary for effective prevention by instituting national programs in chronic disease risk factor surveillance, translational research and evaluation. The Agency was also established under the NPAPH with several national functions, including informing best practice in policy design for preventive health.

The Government response to the Preventative Health Taskforce's report committed the $13.1 million for the National Preventive Health Research Fund to facilitate research translating evidence into policy and programs in each of the preventive efforts tackling obesity, tobacco and harmful alcohol consumption.[1] The Agency commenced implementation of this fund in 2011 through funding research projects and fellowships with an emphasis on co-producing research with practitioners and policy makers.

The Agency has also partnered with the National Health and Medical Research Council (NHMRC) and other funding partners to establish The Australian Prevention Partnership Centre being led by the Sax Institute. This Centre incorporates partnerships of both investigator teams and health policy/practice teams.

Strategy background

This Strategy is the culmination of several consultations and deliberations with stakeholders from June 2011 to March 2013 managed by the Agency. See Appendix A for a summary of submissions.

The Agency established the Expert Committee on Research in 2011 to give advice about the scope and goals for an innovative national preventive health research strategy. This committee has overseen the consultation strategy, the vision and the framing of the recommended actions. The Strategy incorporates advice from the Expert Committee on Research as well as the Agency's Advisory Council, the Agency's other expert committees on alcohol, tobacco and obesity and the state and territory health areas managing their programs under the NPAPH.

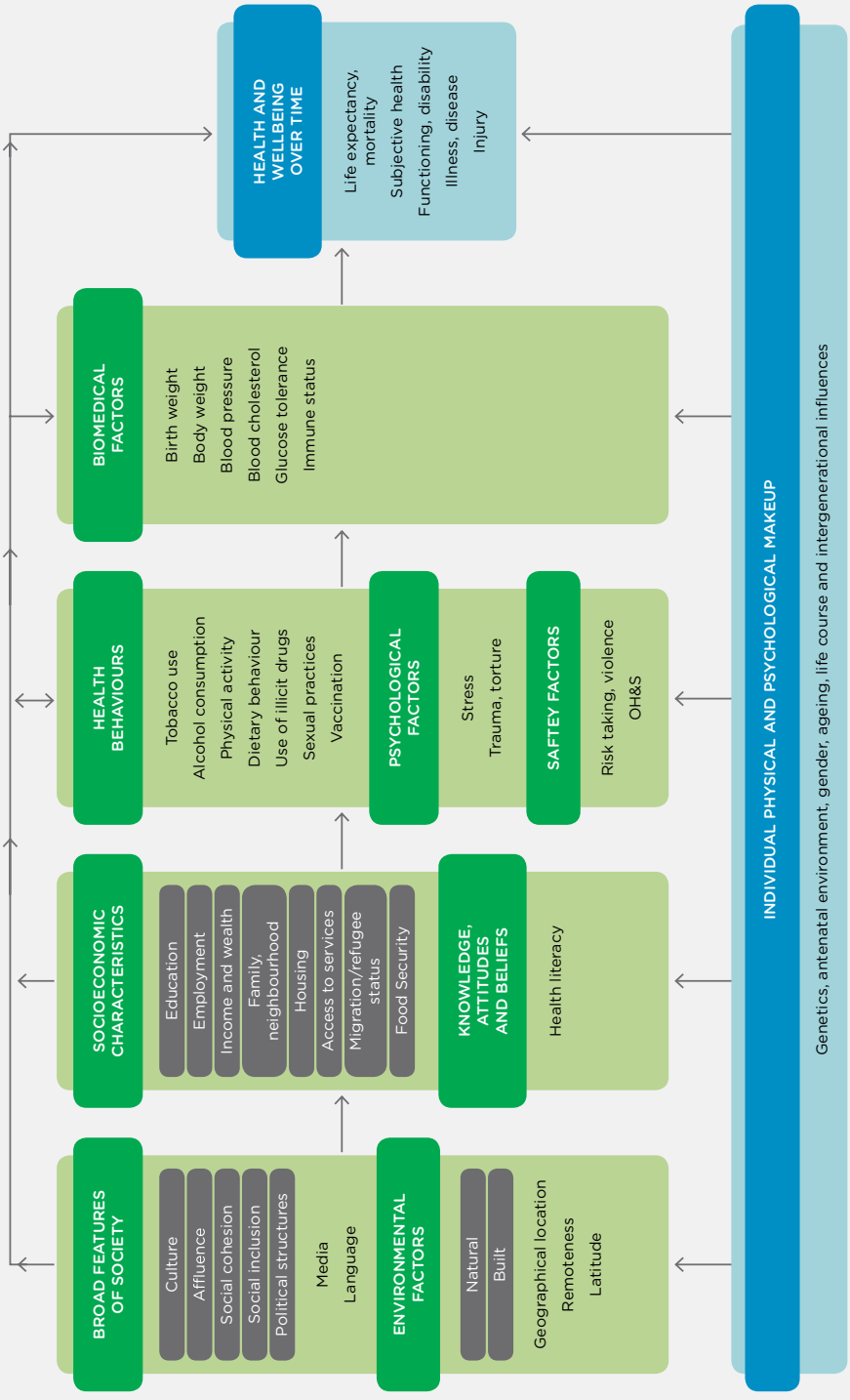
The policy documents referenced and others relevant are listed in Appendix B.

Health and wellbeing

A person's health and wellbeing result from a complex interplay of many factors (Figure 1). The World Health Organization (WHO) defines health as a 'state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. This Strategy uses this understanding of health with a focus on building and maintaining health and wellbeing.

1 Australian Government 2010, *Taking preventative action; a response to 'Australia; the healthiest county by 2020', the report of the National Preventativa Health Taskforce*, Commonwealth of Australia, Canberra.

FIGURE 1: A FRAMEWORK FOR THE DETERMINANTS OF HEALTH



Note: Grey shading highlights selected social determinants of health
Source: Adapted from the Australian Institute of Health and Welfare's *Australia's health 2012* page 12

Promoting good health

Promoting health and preventing disease can benefit individuals, society and the health system by reducing the amount of illness in the community and improving general wellbeing.

According to the Ottawa Charter for Health Promotion:

> *Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to wellbeing.*[2]

In Australia, many existing health promotion programs:

- enable individuals to make healthy living their everyday experience
- enable communities, workplaces, schools and other institutions to make decisions and implement programs that enhance healthy living (e.g. local government planning choices, school canteen policies, children's resilience programs)
- engage with systems beyond the health sector to support healthy living
- use evidence to deploy the tools of government such as taxation, providing information, regulatory interventions in markets, funding of workplace, school, or community programs
- use program evaluations and partnerships with researchers to build to a solid base for further decision-making.

2 Health Organization The Ottawa Charter for Health Promotion. Adopted on 21 November 1986. http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.htmlovember 1986

THE CASE FOR THE STRATEGY: A NEW MODEL TO MEET THE GAPS AND CHALLENGES FOR RESEARCH

Although Australia is generally regarded as a healthy nation and most Australians expect to live a healthy life, there is a rising prevalence of chronic disease, with socially disadvantaged groups experiencing a disproportionate burden. There are multiple factors influencing chronic disease prevalence and outcomes. Causes of these problems are complex, interrelated and difficult to address. While there is a wealth of evidence around what builds and affects health, more evidence on how to build effective policies for change is needed.

The task of promoting a healthier society is complex and long term. No one government or single area within government can achieve that objective alone. While many areas of government have common health and wellbeing objectives, their approaches to delivering the programs are not necessarily coordinated. Government policies and strategies in particular, need to be guided by knowledge and understanding about what works with target groups. All areas of government from social, education, employment and economic policy to justice and environmental protection, would benefit from sound information that would have the most collective impact. Local government, through its planning responsibilities, also has a role to play, together with the non-government, private research funders and commercial sectors, be they in food, transport, health care provision, social support or leisure and entertainment.

The research sector can make a key contribution by working with stakeholders to develop the foundation of knowledge needed for effective policy and system approaches that will help achieve the goal of a healthier society.

Key challenges to be addressed through this Strategy include the need to:

- produce and apply knowledge to develop policies and programs that promote wellness and reduce the levels of disparity in health across the nation
- raise capability to assess programs and publicly report evaluations
- improve national data collection that can also meet regional needs
- develop better research funding and incentives that support creation of solutions
- engage policy experts, service providers, industry and the public
- use more effective formats to publicly communicate answers from such research
- understand better the economic and social benefits of investing in building a healthy society and the inequities, inefficiencies and costs of not doing so.

Existing research and decision-maker perspectives are largely products of historical practice and systems built around professional and agency silos. They have separate objectives, drivers, accountabilities and work practices. The established model about research, and how evidence is used in policy through “transfer” to a different culture, or “translation” to a different language, largely reinforces separation of sectors and professions and affects how policy and research are approached. This is further reinforced by funding and career incentives and also by what is published. Culture also affects beliefs about what constitutes research quality and the ways in which the impact of research is measured and valued.

In recent consultations across Australia it was agreed that new approaches are needed to solve difficult problems, especially new approaches and methods to support knowledge co-production and different ways of thinking about systematic enquiry.

The term 'knowledge' is used in this Strategy to represent the results or outcomes of such research including findings from putting ideas into practice in real world contexts. This knowledge creation will result from collaborations and partnerships among the community, researchers and those in policy and practice so that all create knowledge that can be integrated into policy and practice.

A model to meet the challenges into the future, for policy and practice to be evidence informed, has to be based on an integrated process of framing the problem, sourcing the evidence, generating the evidence, navigating through sharing of contexts and meaning and applying the evidence.[3] "Knowledge translation" has been used in recent years to include dissemination, utilisation, evidence into practice and knowledge transfer. Strategies for knowledge translation are evolving such that the emphasis now is on partnerships and collaborations, including with lay people, to contribute from the early stages of priority setting for more applicable research and better decision making.[4] The knowledge cycle is completed when these players can feed back into further research activities.

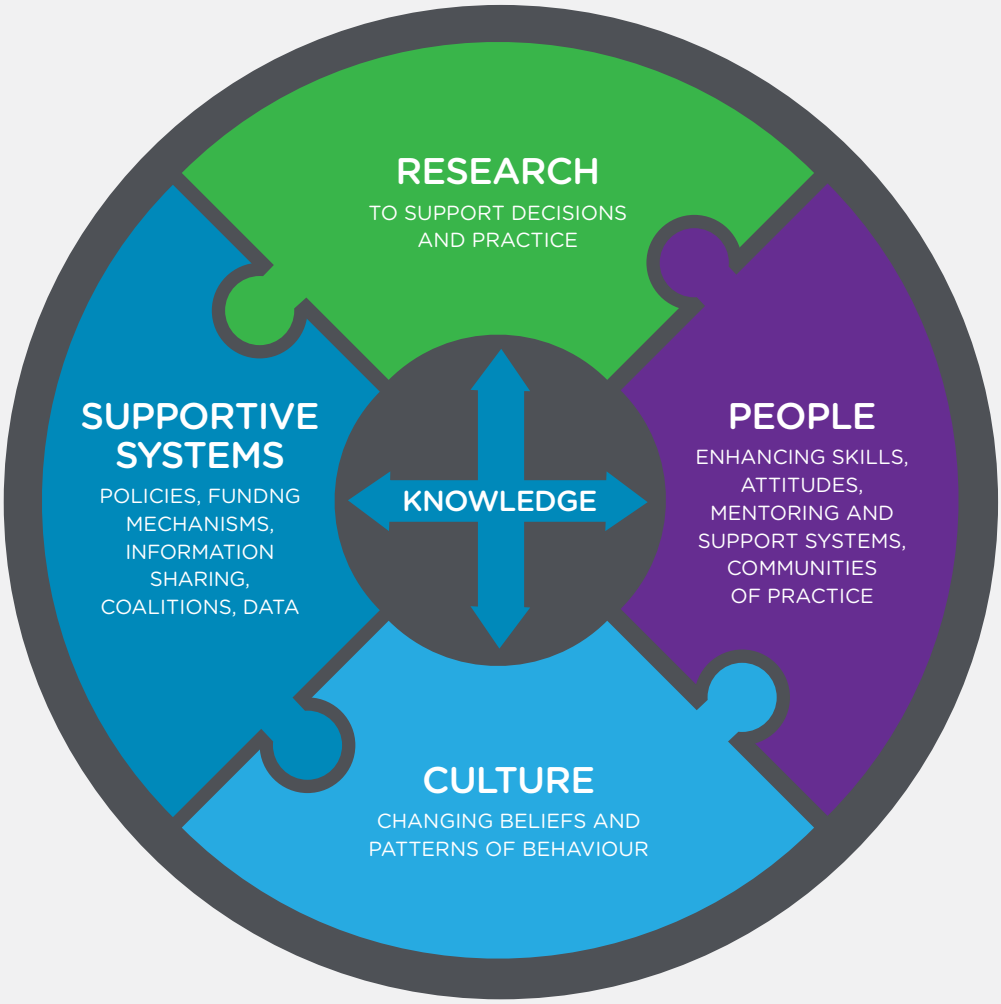
The model on which this Strategy is based aims for better integration of sectors and professions. It allows those placed in various administrations to maintain their roles but come together in a research system which allows research to influence policy and research to accommodate policy needs. The operation of this model is a social and political exercise with many players who work through the research process from problem recognition to interpretation of results. For research to influence policy it has to be transformed into knowledge-for-policy by a personal interaction between players to add interpretation and context within the policy process (being invested with meaning and power).[5] For the complex socialisation process required, the strength of the relationships is the key to success.

3 Bowen S and Zwi AB 2005, *Pathways to 'evidence-informed' policy and practice: a framework for action* PLoS Med 2(7):e166.
4 Armstrong R, Waters E, Roberts H et al. 2006, *The role and theoretical evolution of knowledge translation and exchange in public health* J Public Health 28(4): 384-389.
5 Gibson B 2003, *From Transfer to Transformation: Rethinking the Relationship between Research and Policy* https://digitalcollections.anu.edu.au/bitstream/1885/47083/6/02whole.pdf

STRATEGIC ACTION

This Strategy focuses effort on four building blocks (Figure 2) that lay the foundation for further work in this area over the following decade. The building blocks create the collaborative, integrative preventive health research model for this Strategy. The building blocks together will enable the research sector to maximise its contribution by working as partners with governments and others to provide information that will help develop effective policies and healthy outcomes. The actions arising from the building blocks in this document need to work synergistically in supporting change.

FIGURE 2: A MODEL FOR PREVENTIVE HEALTH RESEARCH: BUILDING BLOCKS FOR COLLABORATION AND INTEGRATION



Building Block 1

RESEARCH: GENERATING KNOWLEDGE NEEDED FOR POLICY AND PRACTICE

This building block comprises actions that aim to:

- create evidence to support policy and decision-making by governments, non-government organisations and the community more broadly
- influence decision-making so that strategies to build health and prevent illness are more effective
- raise public awareness and interest in having systems and policies that are based on good evidence
- show the public the value of investing in research to build health by publicising practical outcomes from that research.

An effective national effort to build health and prevent illness must be based on sound evidence of what needs to be addressed and what approaches are likely to be effective.

The research 'base' for promoting wellness and preventing illness should be as broad as possible. It should include not only health and social sciences, but also areas such as economics and finance, law, environmental sciences, transport and urban design. This will support healthy public policy, features of which include whole-of-government approaches to coordinate social policy (e.g. employment, housing), urban policy (e.g. transport, urban design and improvement) and regulatory and economic policy (e.g. restrictions on accessing products associated with poor health outcomes, and incentives for 'healthier' products).

Public policy and research need to support problem-based approaches as a strategic priority. Research needs to focus on implementing, and tracking the effects of, interventions, particularly where scaling up is required.

Further, rigorous and appropriate evaluation of programs and their results is essential for healthy public policy. Researchers need specific incentives to become involved in evaluation. Theories and methods of systematic enquiry can then be incorporated into producing intervention knowledge.

Topics for methodological research include:

- economic analyses to assess the benefits of 'healthy policies' and a healthy society, and to find the costs (financial and social) of not investing in achieving these outcomes
- the collective impact of multiple policies and strategies, and how to better integrate data sources to support more effective planning by all levels of government and settings-based research
- communication of health messages and evidence informing policies.

Building block 1 Actions*

**Actions are listed for each building block for the many players to select participation appropriate to each role. The actions that the Agency is taking the lead on, or contributing to, are so noted.*

1. Convene regular national forums of policy stakeholders and research leaders to identify issues of common interest and strategies for progressing knowledge co-creation to better inform healthy public policies.
2. Identify non-health partners on issues and topics and work collaboratively with them to produce knowledge.
3. Identify partners across different disciplines and promote methodological research, for example in economic evaluation.
4. Establish partnerships between policy agencies and the research sector to enable continuing sharing of evidence related to policy and program implementation. Build coalitions to advance agenda for building health and preventing illness. The Agency is operating its research fund under this principle.

Building Block 2

SYSTEMS: IMPROVE SUPPORT FOR CO-DISCOVERY THROUGH POLICY AND PRACTICE INTERACTION

This building block comprises actions that aim to:

- maximise the value of investment in promoting good health through joint research by governments, research institutions and non-government bodies
- develop and validate co-discovery approaches to research and evaluation which better support policy development and program implementation
- use appropriate funding and reward systems to attract more research into promoting wellness and expanding the range of disciplines that are engaged.

Ensuring research is able to be practically applied requires researchers to incorporate partnership strategies from an early stage in a research project commencing with a shared understanding of the problem at hand. This can be facilitated by researchers having a relationship with those in policy and practice from the outset. Research approaches and protocols need to evolve to embrace knowledge co-production so that the contributions of all parties throughout the research process are valued.

Involving researchers in policy and practice is a significant change in the emphasis of research to date. It also expands significantly on what is currently valued in the research funding system, where known and respected methodologies attempt to identify determinants and risk factors. Incentives which affect researchers' choices of research area include: whether it is likely to attract funding, interest in and need for the field of study, and the practicality of the research within the current reward structures. The increased value of research within the new model will increase the likelihood of publication and support from universities and research institutions.

In 2006 the Canadian Institutes of Health Research established specific funding to allow a rapid evaluation response for unfolding programs and policies that have the potential to impact health and health equity at the population level. These are considered 'natural experiment' opportunities and are different from the types of interventions that might be designed and implemented by the researchers (and supported through more traditional funding competitions). The granting cycles allow for rapid peer review and funding decisions so that research infrastructure can quickly accompany policy and program rollout.

Data policies and infrastructure

Researchers need access to population health and risk factor data, not all of which is readily and freely available. More research could be done using the existing data sets. Much public interest and social good can come from shared and linked data, while at the same time respecting the importance of individual privacy. Commercial-in-confidence issues can also affect access to data. The Agency published a guide to understanding governance and coordination of preventive health surveillance in Australia. It outlines what data are available and provides information on the current mechanisms for gaining access in 2013.

The examination of complex health, social, economic data in a specific location would be useful. Relevant health policy and implementation research would ideally incorporate data from formal and administrative collections spanning current cross-disciplinary boundaries. Being able to access, analyse and draw connections between data across fields is important for policy responses to be effective.

The infrastructure needed to support research includes improved and better-coordinated databases, appropriate access for researchers to those databases, and public reporting of health improvement indicators. A research workforce priority should include expanding the skills of researchers to better link and analyse data.

Building Block 2 Actions*

**Actions are listed for each building block for the many players to select participation appropriate to each role. The actions that the Agency is taking the lead on, or contributing to, are so noted.*

1. Foster the development of new methods and models for:
    - knowledge co-creation
    - economic evaluation
    - synthesis of current information from research and evaluations on priority issues.
2. Develop partnership and governance structures to foster partnerships between researchers, government agencies and the NGO and private sectors, including philanthropic, to ensure better exchange of information that will help build effective healthy public policies and for communicating to public and stakeholders.
3. Develop communication strategies that support the relationship between policy interests and researchers, foster collaborative thinking and involvement of those involved in a range of public policy work across all levels of government and relevant interested sectors including industry. The Agency is contributing to this action.
4. Develop funding arrangements that reward researchers for researching in 'applied' areas such as effective program design and evaluation.
5. Enhance approaches to research grant assessment to better take into account broad collaborative research programs that demand rigour but tolerate new and emerging methods, and equip reviewers to understand and apply new thinking. The Agency will consult stakeholders for this action.
6. Encourage scholarly journals to support innovation in research which addresses policy and implementation issues, and recognises that research rigor is not necessarily reduced through partnerships between researchers and those involved in policy development and implementation.
7. Share knowledge and develop understanding of research for decision-making through a range of opportunities to bring researchers and policymakers together, for example, through symposia, round tables, training programs and speakers. The Agency is contributing to this action.
8. Continue current approaches to improving access to routinely collected data, with appropriate privacy protections. They also need to be enhanced to encourage data to be integrated from various sectors such as health, social wellbeing, housing and employment to understand better the interactions between various policies and to target support programs to areas of highest need.

Building Block 3

PEOPLE: BUILDING CAPABILITY FOR INTEGRATED KNOWLEDGE CREATION AND APPLICATION

This building block comprises actions that aim to:

- develop skills for all research system participants for relationship building
- promote leadership and increased standing for preventive health research
- boost program evaluation capacity and capability
- make better use of data to support research.

Research that is used for policy and decision-making requires additional research knowledge, skills and perspectives, as well as ways of operating which bridge different contexts. The knowledge and skills include the ability to work in policy and program implementation to design research that takes into account a variety of dynamic contextual issues and perspectives. It can require different and responsive approaches in settings such as policy related work as well as implementation within the community. It often requires multiple designs and sequential work to contribute effectively to policy and its implementation.

All stakeholders need support to develop the capacity to work collaboratively across the cultural and practice norms arising from different contexts. Arrangements for mentoring as well as formal programs and professional development experience should also be considered.

Workforce Development

Preventive health needs a suitably skilled workforce of researchers, evaluators and those applying knowledge. There is also a need to build leadership in the field for knowledge creators across the spectrum. Leaders could play an important part in demonstrating how the vision could be put into practice. Workforce plans should be shaped to support strategic objectives and priorities through supporting careers in prevention research and in developing and implementing policy.

Education and training would embrace both formal qualifications and professional development of those wanting to participate in this field to accelerate capability development. This is important for professional recognition in the field and to help applications for funding. In many cases existing programs and curricula could be built on.

Ideally, a broad spectrum of stakeholders would be encouraged to invest in workforce development in the expectation that it would have broad benefits.

Policy practitioner fellowships should be more widely available. These would develop the skills of people who could bridge the policy/practice and research divide. These could be modelled on the NHMRC Translating Research into Practice (TRIP) fellowships and would be a means of enabling policy and service providers to become more engaged in the research system as part of their career development.

Building block 3 Actions*

**Actions are listed for each building block for the many players to select participation appropriate to each role. The actions that the Agency is taking the lead on, or contributing to, are so noted.*

1. Attract highly skilled researchers to a career in research that will be oriented to solving complex social problems that inhibit the development of a healthy society.
2. Develop the workforce of researchers and those involved in policy, program implementation and service delivery. The Agency is contributing to this action through funding the 'Mapping the preventive health workforce' project at the Workplace Research Centre, University of Sydney.
3. Build research capacity for research for knowledge-for-policy to support decision-making through:
   - project grants focussed on these approaches
   - fellowships for both researchers and policy/practitioners.

   The Agency is contributing through its research fund.
4. Review undergraduate and graduate courses in terms of establishing programs to build the skills of researchers and other participants to collaborate in the design and conduct and/or implementation of research and evaluation and to develop skills in a range of systematic inquiry approaches and methods for such research and evaluation in different settings.
5. Involve reviewers and panels in developing methods to appropriately assess research that is policy and practice oriented.
6. Support the development of coalitions of effort to harness resources and build research capacity. The NHMRC Partnership Centre for Better Health: The Australian Prevention Partnership Centre.
7. Develop opportunities for skills and knowledge through formal undergraduate and postgraduate education programs.

Building Block 4

CULTURE: FACILITATING RESEARCH AND POLICY RELATIONSHIPS TO EFFECT CHANGE

This building block comprises actions to facilitate:

- change management
- relationship building
- research becoming knowledge for policy.

If preventive health research is to better influence policies and programs, then research and policy roles need to evolve to appreciate and value a broad range of perspectives and accommodate them in practice. Collaborative thinking and work requires all parties to change their mindset and practices. Ongoing professional relationships will only flourish where there are constant opportunities to develop an understanding of, and to value, a range of perspectives and skills.

Governments have commenced this change by sponsoring practical integrated research through the NHMRC Partnership Centre for Better Health: The Australian Prevention Partnership Centre, and through research projects and fellowships for translation of research into programs. Such experiences, which provide researchers and policymakers with valuable experience in research co-production, are important to underpin change as they stimulate an understanding of what is possible. Implementing this strategy successfully depends on simultaneous action to change incentive structures. It also illustrates the seriousness of intent. Creation of opportunities for research and policy to engage in dialogue is also occurring.

Securing momentum in this area will require a purposeful approach by government and stakeholders. New incentive structures, opportunities for combined learning, problem solving and debate need to mesh together to stimulate and consolidate a change in mindset and practice in research.

Cultural change depends on the alignment of principles and practice, a clear understanding of success and the building of shared narrative. Strong leadership and aligned approaches by stakeholders will also be needed to mobilise and maintain change.

Building block 4 Actions*

**Actions are listed for each building block for the many players to select participation appropriate to each role. The actions that the Agency is taking the lead on, or contributing to, are so noted.*

1. Influence the broader academic and policy fields as well as a general audience by communicating the intent of the collaborative, integrative model advocated in this Strategy, promoting interest and participation. The Agency will disseminate and promote the use of this Strategy.
2. Develop guidelines for implementing the model. The Agency will consult stakeholders.
3. Build decision-making capacity for those in policy and practice to incorporate evidence from different sources, not just from research, broadening the view of knowledge.
4. Develop the relationship-building skills of researchers and those engaged in policy development and program delivery.
5. Developed methods to measure the success of research and evaluation efforts in supporting effective policies in the relevant priority topic areas.

THE ROLES OF DIFFERENT STAKEHOLDERS

Pursuing the objectives of this Strategy necessarily involve a wide range of players, seeking engagement across sectors and disciplines. This strategy is pertinent to all agencies involved in developing and implementing healthy public policy and implementing programs and services including those involved in addressing the environmental, economic and social determinants of health and to all those involved in supporting research through funding, providing infrastructure and training and exploring new methodologies for improving the research-policy-practice nexus. Participation in this Strategy is open to all who have an interest and who can contribute in some way.

GOVERNMENT

The Australian, state and territory governments through their roles in the national program rollout and other interventions have a key role in production, sponsorship and communicating information through research, investment in research infrastructure and data and as information purveyors. Research infrastructure agencies such as the NHMRC, Australian Research Council, data collection and analysis agencies such as the Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW) make vital contributions to researchers nationally. The National Health Performance Authority undertakes data collection and reporting.

Funding relevant research to understand what can be done to improve health, and equity in health outcomes, is a priority as is making the best use of that research as part of government objectives under the NPAPH.

Governments also produce a lot of information through commissioned and internal research and analysis. Altogether such information and data form an essential contribution to the knowledge needed for health building.

Important partners include a wide range of government agencies that have a strong influence on health through healthy public policy. Such agencies are engaged in similar research and evaluation activity in their respective fields. For example, several longitudinal studies [including The Household, Income and Labour Dynamics in Australia survey, the Longitudinal Study of Indigenous Children (LSIC) and The Longitudinal Study of Australian Children (LSAC)] important for improving research into building health are sponsored by agencies such as the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). This Department has policy and funding responsibilities in areas such as housing, welfare and Indigenous affairs that are key to many of the social determinants of health. Educational achievement is an important social determinant and schools in particular play an important role in healthy child development, especially as they may need wrap around health and community services.

LOCAL GOVERNMENT

Local governments plan, control local amenities and environments, and partner with local community organisations. They are represented by the Australian Local Government Association and state peak bodies.

Although their work is guided by national and state policies, they translate this into local action. Settings-based research and evaluation is important so that their planning, policies and local services are relevant economically, socially and environmentally. Their contribution to research through settings will provide local perspectives to for national, state and local government policies and their implementation.

AUSTRALIAN NATIONAL PREVENTIVE HEALTH AGENCY

The Agency is a leader and catalyst in supporting the development of a research field that has the people, culture and systems that will build health and prevent illness. This ongoing role requires facilitating community and decision-makers to work together to determine research priorities and approaches.

The Agency also plays a role in funding research and supporting research infrastructure. It partners with other funding agencies to support suitable funding and assessment processes to ensure high quality, relevant research.

HEALTH CARE

Health care service agencies can be a partner in population-focused programs in their communities, and act as knowledge purveyors. Those that are involved in primary health care (such as Medicare Locals and Aboriginal community-controlled health services), as well as secondary providers, have important opportunities to initiate and support actions with individual patients, which build health and prevent illness.

COMMUNITY SERVICE

A range of national, regional and local service agencies including employment, housing, and community support have similar opportunities as the health care services above. They have important opportunities to initiate and support actions with individual patients that build health and prevent illness.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL (NHMRC) AND AUSTRALIA RESEARCH COUNCIL (ARC)

Under the national research priorities, both of these bodies are responsible for supporting research that will build and maintain a 'healthy Australia'. Their processes of allocating research funding influence approaches to grant assessment and peer review. The NHMRC in particular has a formal role in funding research in public health and in research that has practical applications. The ARC supports research in social, environmental, economic and public policy sciences that is relevant to promoting good health.

The work of NHMRC and ARC is fundamental to the success of this Strategy. Their role is to work as partners and advisers in research funding. They could work collaboratively and separately with stakeholders to build on current approaches to meet identified needs. As respected research funding bodies they could support changes in the research system.

RESEARCH BODIES

Research associated bodies, both Australian and international, are sources of evidence, expertise and innovation. They include academia, respected expert national and international entities, and research and development corporations.

Representatives of universities and research centres potentially have a strong role in this Strategy. Australian, state and territory governments, and other sources, fund them to conduct research in priority areas. The Council of Academic Public Health Institutions Australia (CAPHIA) has a network of 24 universities and a tradition in public health education and research that relates directly to the Strategy. The CAPHIA members can contribute to research in priority areas which build good health, support the development of new methods and approaches to research which can be practically applied, and participate in the development and conduct of education and training for researchers and users alike. CAPHIA centres also cover the Agency's priority areas of alcohol, nutrition and obesity, and tobacco, with many focusing on particular areas.

Centres like the Sax Institute in NSW and the Centre of Excellence in Intervention and Prevention Science (CEIPS) in Victoria are funded by state governments and focus on evidence reviews and areas of specific interest to this Strategy.

INDUSTRY

Industry, incorporating a diverse range of entities within and beyond the health sector, is a key stakeholder in building a healthy nation. Industry shares a number of direct interests and concerns for example, health insurers need evidence of effectiveness to support their funding policies and programs. Most employers are concerned with workplace health and safety and minimising the cost of illness and disability.

WORKPLACES

Workplaces can define issues and, can also participate in research to generate setting based-evidence and relevant solutions. Workplaces, workforce development groups and employers across the spectrum of large corporate organisations to small business, and office-based and remote (such as mines transport, tourism and road safety) are also important as governments embrace a settings approach to partnerships that support illness prevention and health promotion.

PUBLIC HEALTH BODIES

These include health promotion foundations, public health advocacy bodies and peak health organisations and alliances, including state-based foundations and public health bodies e.g. Public Health Association of Australia (PHAA).These are experienced partners whose existing programs and influence will provide opportunities to extend and promote efforts across Australia. Many are involved in research and communication and are prospective partners in this effort. Some already collaborate with other sectors and partners.

NON-GOVERNMENT ORGANISATIONS (NGOs)

These non-government and community-based organisations include entities not specifically focused on health, such as sporting clubs, schools, unions, special interest groups, organisations considering gender-based health issues, assisting people with a disability or those living in remote or regional Australia, Aboriginal and Torres Strait Islander groups and other groups that have the potential to reach large numbers of people in their daily lives. Other entities, including cultural and faith-based organisations, can educate and implement associated programs and build an operational culture that supports healthy living and choices.

Professional associations, peak bodies, charities, statutory bodies and interest groups form connections between governments, service providers and consumers on issues of preventing illness and promoting health. The advocacy role of organisations such as Cancer Council Australia and the Heart Foundation means that they already have strong relationships with many sectors. Each represents areas of priority for the Strategy and has functions important to the Strategy. These include research, stakeholder information, the need for suitable evidence, and a desire to foster change. Many of these organisations already support a number of collaborations in research and evaluation and they could form supportive advisory, implementation and dissemination functions for the Strategy.

OTHER ORGANISATIONS, INTEREST GROUPS AND INDIVIDUALS

Organisations listed such as Healthy Soils Australia and the Climate Alliance bring additional perspectives to the Strategy. They are able to highlight implications of their field on health and how health strategies could incorporate this thinking.

MEDIA

The media has a powerful role influencing culture and opinion and is a key partner in strategic communications. It has a formal role in educating and creating interest and readiness for change through strategic communications. The media is also able to draw attention to issues from the consumer's perspective.

CONSUMERS

Consumers are the reason for undertaking, and are the participants in, research exercises. Consumers also play a demand role by identifying and using approaches and services that build health. This group includes consumers and consumer advocacy and representative bodies such as the many groups and organisations working in, or with an interest in, promoting good health. All Australians, regardless of age, health status, physical ability and region of residence or work, are the ultimate consumers and the beneficiaries of this Strategy.

Next steps

The Agency will maintain contact with these stakeholders to promote the use and dissemination of this Strategy and to seek their participation in an evaluation of the Strategy from 2014.

APPENDIX A

SUMMARY OF CONSULTATIONS AND SUBMISSIONS

Respondents strongly supported the need for a national preventive health research strategy and the approach proposed by the Agency in its 2011 Interim Strategy. The premises most widely supported were that:

- The research strategy should be a national strategy involving all stakeholders and not just a strategy for the Agency, although the role of the Agency within the broader strategy should be clearly identified.
- The purpose of the strategy should clearly set out the overall contribution of research to improved health for Australians; the roles of the various stakeholders including governments, the community, funders of research, research institutions and researchers; and the particular sub-strategies in relation to research priorities, infrastructure and capacity building and linking research with population and policy needs. The strategy should focus on evidence to promote health building rather than disease cure. It needs to be inclusive, involving sectors outside health, and promote understanding of the need for and the role of a health prevention system.
- The strategy should support strategic priority policy or problem-based approaches.
- Emphasis must be placed on communicating research findings to the general public and to stakeholders.

RESEARCH

There were several key points of agreement on key research priorities and strategies. These included:

- Conducting high priority implementable research to support policy and program development. Developing ongoing working relationships between users (decision-makers at all levels) and researchers to build understanding among all partners of the nature of user needs and how research can inform decision-making in specific contexts.
- Building on existing information. Many submissions urged analysis of what evidence exists, as a first step in exploring what to do next. However there will remain a need to fill evidence gaps.
- Broaden the scope from the priority areas of alcohol, tobacco and obesity to produce new information across a spectrum of topics such as mental health; all drugs; healthy ageing including productive mid-life; and large studies to support legislative and policy such as research into constituents of processed food and its contribution to obesity.
- Foster more comprehensive or different research approaches, such as whole-of-life approaches, research-based in community settings and involving community actors such as consumers and service providers. Developing the methods and approaches to support whole-of-system design, whole-of-government action and strategy implementation research and evaluation.

SYSTEMS AND INFRASTRUCTURE

Respondents identified a need for improved approaches to information collection and analysis to support a comprehensive and effective preventive health research approach. Key aspects included the need for improved access to routinely collected data; and capacity for data linkage and nationally consistent approaches to data collected for surveillance and other specific purposes. Funding for longitudinal and cohort data collections and for bio-repositories was also a priority.

Evaluation of policies and programs was seen as a high priority for research infrastructure development. Many respondents advocated national standards for rigorous evaluation and commitments from governments to have programs independently evaluated according to those standards. It was also argued that there should be more research into evaluation.

Funding and peer assessment mechanisms need to be developed that recognise the value of research that is co-produced between researchers, stakeholders and the community.

CAPABILITY

There was a commonly shared view about the need for and the means of achieving a suitably skilled research workforce to enable strategic objectives and research priorities to be met. Development programs that support careers in translational research and team performance as well as individual performance need to be developed. Dedicated funding for Australian researchers to collaborate with international researchers was seen as a high priority for building Australia's research workforce in preventive health. Specific programs to increase capacity in such areas as data linkage and analysis were also identified as a preventive health research workforce priority.

There is support for a specific preventive health research workforce development program including components such as traineeships; programs to encourage researchers and users to collaborate in the design and conduct of research; and translation of findings into policies and programs.

CULTURE

Implicit in many responses was the need to change research and policy cultures if preventive health research is to better inform policies and programs.

The current cultures in both research and policy arenas are largely products of historical organisational and institutional silos that persist and are reinforced by funding and other practices.

ROLE OF THE AGENCY

For most respondents, the Australian National Preventive Health Agency was seen as a leader and catalyst in supporting the development of the preventive health research field. This ongoing role requires facilitating the community and decision-makers in working together on determining research priorities and approaches.

The Agency would also play an important role in advocating for preventive health research including for funding and infrastructure support. Partnering with funding agencies in supporting suitable funding and assessment processes to ensure quality and relevant research would be a key approach.

Several respondents favoured the Agency having an information brokerage role – a central source for information and advice for researchers and decision makers. The Agency would provide a link between the two for sharing information and understanding the relative contributions of each sector and ensuring that the community and other sectors' perspectives are taken into account.

The Agency is also perceived as a key facilitator in the development of community health literacy in preventive health to ensure that relevant research evidence is communicated effectively across the community to inform debate and aid decision-making.

APPENDIX B

POLICY CONTEXT

The policy context in which the National Preventive Health Research Strategy has been developed includes a number of Australian Government and Council of Australian Governments (COAG) priorities and commissioned reports and state and territory documents including:

HEALTH REFORM

National Health and Hospitals Reform Commission 2009, *A Healthier Future for all Australians Final Report June 2009* Commonwealth of Australia, Canberra.

Australian Government 2010, *A National Health and Hospitals Network for Australia's Future Delivering the Reforms* Commonwealth of Australia, Canberra.

Rudd K, & Department of Families, Community Services and Indigenous Affairs 2009. *Closing the gap on Indigenous disadvantage: the challenge for Australia*. Commonwealth of Australia, Canberra.

Department of the Prime Minister and Cabinet, Social Inclusion Unit 2010, *A stronger, fairer Australia [National Statement on Social Inclusion],* Department of the Prime Minister and Cabinet, Canberra.

Department of Health and Ageing 2010, *Building a 21st century primary health care system: Australia's first national primary health care strategy*, Department of Health and Ageing, Canberra.

Council of Australian Governments 2009, *National Healthcare Agreement*, Ministerial Council for Federal Financial Relations, Canberra.

PREVENTIVE HEALTH

National Preventative Health Taskforce 2009, *Australia: the healthiest country by 2020*, National Preventative Health Strategy – the roadmap for action, Australian Government, Preventative Health Taskforce, Canberra.

National Preventative Health Taskforce, Obesity Working Group 2009, *Australia: the healthiest country by 2020: technical report 1: obesity in Australia: a need for urgent action, including addendum for October 2008 to June 2009*. Australian Government, Preventative Health Taskforce, Canberra.

National Preventative Health Taskforce, Tobacco Working Group 2009, *Australia: the healthiest country by 2020: technical report 2: tobacco control in Australia: making smoking history* Australian Government, Preventative Health Taskforce, Canberra.

National Preventative Health Taskforce, Alcohol Working Group 2009, *Australia: the healthiest country by 2020: technical report 3: preventing alcohol-related harm in Australia* Australian Government, Preventative Health Taskforce, Canberra.

Council of Australian Governments 2008, *National Partnership Agreement on Preventive Health*, COAG, Canberra.

Australian Government 2010, *Taking preventative action: a response to 'Australia: the healthiest country by 2020', the report of the National Preventative Health Taskforce*, Commonwealth of Australia, Canberra.

Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing 2009, *Weighing it up: obesity in Australia* House of Representatives Standing Committee on Health and Ageing, Printing and Publishing Office, House of Representatives. Canberra.

RESEARCH POLICY AND STRATEGIES

Public Health Research Advisory Committee and NHMRC 2008 *The Report of the Review of Public Health Research Funding in Australia* [the Nutbeam report] Commonwealth of Australia, Canberra.

National Health and Medical Research Council 2009 NHMRC response to The Report of the Review of Public Health Research Funding in Australia, Nutbeam Committee Report Commonwealth of Australia, Canberra.

Victorian Health Promotion Foundation (VicHealth) 2009 *The VicHealth Knowledge Policy: Discussion paper* VicHealth, Carlton, Victoria.

NSW Department of Health 2010 *Promoting the generation and effective use of population health research in NSW: a strategy for NSW Health 2011–2015* NSW Government.

Department of Industry, Innovation, Climate Change, Research and Tertiary Education 2012 *2012 National Research Investment Plan* Commonwealth of Australia, Canberra.

National Health and Medical Research Council (2012) NHMRC Strategic Plan 2013-2015 *Working to build a healthier Australia* Commonwealth of Australia, Canberra.

Department of Health and Ageing 2013 *Strategic Review of Health and Medical Research: Better health through research* February 2013 [McKeon Review] Commonwealth of Australia, Canberra.

RISK FACTOR AND CHRONIC DISEASE STRATEGIES

Intergovernmental Committee on Drugs (Australia) *2012 National Tobacco Strategy 2012–2018* Australian Government, Canberra.

Council of Australian Governments 2011, *National Disability Strategy: an initiative of the Council of Australian Governments 2010-2020*, Department of Families, Housing, Community Services and Indigenous Affairs, Canberra.

National Health Priority Action Council 2005, *National Chronic Disease Strategy* Department of Health and Ageing, Canberra.

Department of Health and Ageing 2009, *4th National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014*, Department of Health and Ageing, Canberra.

Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010-2015: a framework for action on alcohol, tobacco and other drugs.* Department of Health and Ageing, Canberra.

Ministerial Council on Drug Strategy (Australia) & Intergovernmental Committee on Drugs (Australia) 2006, *National Alcohol Strategy 2006-2011*. Ministerial Council on Drug Strategy, Canberra.

Department of Health and Ageing 2010, *National Male Health Policy: building on the strengths of Australian males, D*epartment of Health and Ageing, Canberra.

Department of Health and Ageing 2010, *National Women's Health Policy 2010,* Department of Health and Ageing, Canberra.

Council of Australian Governments 2009, *Investing in the early years – a national early childhood development strategy: an initiative of the Council of Australian Governments,* COAG, Canberra.

Australian National Preventive Health Agency 2011 *Strategic Plan 2011-2015* Commonwealth of Australia, Canberra.

NATIONAL PREVENTIVE HEALTH RESEARCH STRATEGY 2013-2018

ANNEX A

A PRIORITY-DRIVEN RESEARCH AGENDA FOR

TOBACCO CONTROL IN AUSTRALIA

April 2014

promoting a healthy australia

Australian Government
Australian National Preventive Health Agency

promoting a healthy australia.

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CONTENTS

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- Kate Purcell, of Purcell Consulting, who was commissioned by the Agency to support the development of the research agenda
- Ella Curnow, Assistant Director, Tobacco Control who managed the project for the Agency

FOREWORD

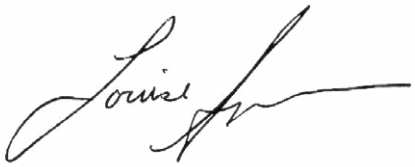
The *Priority-driven Research Agenda for Tobacco Control* is an initiative of the Australian National Preventive Health Agency (the Agency) – an Australian Government agency committed to supporting the development and implementation of evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol consumption and tobacco.

Australia's approaches to tobacco control have formed an excellent track record in reducing smoking prevalence and tobacco-related disease throughout its population. However, smoking still remains one of Australia's single most preventable causes of ill health and latest figures show that approximately 2.8 million Australians over the age of 18 continue to smoke daily. We also know that approximately 48 per cent of Aboriginal and Torres Strait Islander peoples smoke and some of our most disadvantaged groups have smoking rates up to five times higher than the population average.

Research that contributes directly to policy reform and sustained support for tobacco control policies in Australia is essential if we are to meet the Council of Australian Governments' target of reducing Australia's national smoking rate to 10 per cent of the population and halving the Indigenous smoking rate by 2018. Most important is the need to direct research efforts towards specific high-smoking prevalence population groups for whom tobacco control efforts to date have had limited success.

The development of this consensus-based research agenda was undertaken in response to a need identified by members of the Agency's Expert Committee on Tobacco, for a focused and timely priority-driven research agenda that reflects Australia's emerging tobacco research requirements over the coming decade. The report is an annex to the Agency's *National Preventive Health Research Strategy 2013-2018* which aims to foster Australia's capacity to carry out applied research to enable evidence-informed activities by governments, health care systems, individuals, and by civil society and private organisations in the area of preventive health.

I would like to acknowledge the collaborative and consultative approach that was undertaken to develop this agenda and the valuable contribution of so many working in tobacco control – both internationally and within Australia. It is hoped that the research questions prioritised in this document will be used by the broader tobacco control community to inform many future evidence-based tobacco control initiatives.



Louise Sylvan
Chief Executive Officer
Australian National Preventive Health Agency

BACKGROUND

Tobacco smoking remains the single most preventable cause of ill health and death in Australia today.[1] Tobacco is a highly addictive and lethal product that kills around half of its long-term users.[2] Despite reductions in smoking prevalence, around 3.3 million Australians still smoke at least daily or weekly[3] and the most recent estimate available suggests that around 15,000 people die each year of smoking related disease.[4]

Following the development of the Framework Convention on Tobacco Control (FCTC)[5] by the World Health Organization (WHO), tobacco control is now a global health priority. Globally, tobacco kills nearly 6 million people each year. That toll is rising rapidly, especially in countries in our region.[6] The WHO estimates that approximately one person dies every six seconds due to tobacco, accounting for one in 10 adult deaths.

Australia has a long and successful record in tobacco control. Over the past four decades Australia has implemented comprehensive tobacco control strategies that have included mass media campaigns, pricing and tax strategies, cessation support, regulation of tobacco advertising, sponsorship and marketing, sale of tobacco to minors and smoke free public places.

Underpinning these approaches has been a commitment to a population focus and to evidence based practice informed by an extensive knowledge base and effective public health research and evaluation programs. The history of tobacco control in Australia–as elsewhere–features many examples where research was instrumental, and sometimes pivotal to policy reform or sustaining support for tobacco control policies.[7] The evidence generated by Australian preventive health research efforts is critical to informing tobacco control policies both here and internationally. For example, as Australia implements the world's first tobacco plain packaging legislation there is a need to comprehensively evaluate the impact of this important policy and build a knowledge base that can be used by other countries.

Almost 25 years ago, the National Health and Medical Research Council (NHMRC) called for a greater emphasis on priority-driven research. The NHMRC defined priority-driven research as strategic development and evaluation research that contributes directly, in the short to medium term, to population health and the effectiveness, efficiency and equity of the health system.[8]

In response to this important issue, the Australian Cancer Society and the National Heart Foundation initiated a consensus process in 1999 to develop Australia's first priority-driven research agenda for tobacco control. The resultant report included research ideas judged by tobacco control experts to be both practical and necessary in order to advance strategic tobacco control goals in Australia.

"Rather than continuing to be dominated by investigator-driven research, tobacco policy research in Australia could be tied to a set of priorities agreed to by those working in the fields of tobacco research, policy and control. This would concentrate the research effort, addressing more policy-relevant questions than is currently the case." Tobacco Control in Australia: A Priority-Driven Research Agenda 1999.

Analysis of the 1999 document confirms that research has been undertaken to answer the majority of the questions identified in the report. The process was particularly successful at identifying the most useful research questions for informing future tobacco control policies in Australia.

The purpose of this report

This report builds on the successful consensus process undertaken in 1999, and identifies an updated priority-driven research agenda for tobacco control in Australia for the coming decade.

The priority-driven research agenda has been developed to:

- Inform future tobacco control policies and programs
- Enhance the national research capacity to respond in a focused and timely fashion to emerging tobacco research needs
- Enhance the shared understanding between policy makers, advocates and researchers about research priorities in tobacco control and encourage links between these groups.

Policy context for tobacco control in Australia

The *National Tobacco Strategy 2012-18* (NTS) articulates Australia's national policy framework to reduce tobacco-related harm. The goal of the strategy is "to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes".[9]

The Strategy also details objectives and targets for tobacco control until 2018 and sets out nine priority areas for action. These priority areas take account of the extensive evidence base for tobacco control and reflect best practice approaches to reducing tobacco-related harm. The nine priority areas are as follows:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference.
2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking.
3. Continue to reduce the affordability of tobacco products.
4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander peoples.
5. Strengthen efforts to reduce smoking among people in populations with a high prevalence of smoking.
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products.
7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems.
8. Reduce exceptions to smoke-free workplaces, public places and other settings.
9. Provide greater access to a range of evidence-based cessation services and supports to help smokers to quit.

Several states and territories have also developed strategies to guide tobacco control policies in their jurisdictions.

Other policy frameworks are also relevant to tobacco control such as the National Healthcare Agreement[10] and the associated National Partnership Agreement on Preventive Health[11] which set the target of reducing the national adult daily smoking rate to 10 per cent of the population and halving the Indigenous smoking rate, by 2018.

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is also highly relevant because smoking is the leading risk factor for chronic disease in Aboriginal and Torres Strait Islander peoples, making efforts to reduce smoking in this population a priority.

Australia is a signatory to the World Health Organization's Framework Convention on Tobacco Control (FCTC). The FCTC and its Guidelines commit nations to implement policies on tobacco price and tax increases, prohibiting or restricting tobacco advertising, promotion and sponsorship, introducing labelling with more prominent health warnings, reducing exposure to second-hand smoke, smoking cessation interventions and combating illicit trade. The Australian Government reports every two years to the Conference of the Parties on progress in implementing the FCTC.[8]

Links between the National Tobacco Strategy and this project

The NTS provides a framework for national policy and tobacco control in Australia. At the time this project was undertaken the NTS had not been finalised or formally approved by governments. The FCTC was therefore used as the framework for the priority-driven research agenda with two additional themes focussing on smoking rates among high smoking prevalence groups: low socio-economic and disadvantaged groups, and Aboriginal and Torres Strait Islander peoples.

It should be noted that there is high degree of consistency between the NTS and the FCTC Articles and that the FCTC provided an internationally recognised framework for tobacco control that enhanced the ability of expert researchers from Australia and internationally to collaborate and identify priority research questions relevant to the Australian context.

Methodology

FCTC Articles relevant to future tobacco control in Australia were used to identify and organise research questions that will help inform future policies and programs in Australia, and evaluate existing ones. Two themes targeting smoking rates among high smoking prevalence groups: low socio-economic and disadvantaged groups, and Aboriginal and Torres Strait Islander peoples, were added.

The **first stage** of the process required the identification of Australian and international researchers and tobacco control experts with suitable expertise and research track records who would be prepared to generate research questions. Suitable experts were identified under each FCTC article according to their identified area(s) of research expertise. These experts were then invited to participate in the project by identifying up to 4 potential research questions with supporting rationales – under their respective FCTC article(s) – that they believed are the most important priorities for Australia, based on their experience and the information provided to them. Each international expert was provided with a briefing paper summarising Australia's progress to date in meeting its obligations under the relevant FCTC Article, and addressing smoking among disadvantaged groups and Aboriginal and Torres Strait Islander peoples. To assist in the ranking process, experts were asked to ensure that research questions were very specific, rather than too general or broad brush. Fourty-four of the participating researchers/experts generated questions for the research agenda. A list of these researchers is provided in Appendix 1.

The generation of research questions was completed in October 2012. Once submitted, the questions were reviewed by a working group comprising Agency staff and some members of its Expert Committee on Tobacco (ECT). A number of questions were merged or deleted to reduce duplication and others were amended to ensure greater clarity or relevance to the Australian context. The shortlist of questions and their accompanying rationales were reviewed and gaps identified by the Agency's ECT. Some additional questions were generated in relation to these issues.

The **second stage** involved developing a comprehensive list of Australian tobacco control experts from the government and non-government sectors. These experts were assigned to the various FCTC articles and additional themes according to their identified area of expertise, and asked to rank the research questions. Of the 53 Australian tobacco control experts approached to participate, 44 participated in the final ranking exercise (Appendix 2). Each participant was asked to read the proposed research questions and supporting rationales provided by the research experts during the first stage, and rank the questions in terms of their **relevance** and **importance** to the development of Australian tobacco control policies for the next 5 to 10 years. They then ranked the questions on a scale of 1-5 (1 being the highest priority and 5 being the lowest priority). A full list of the research questions provided to experts for ranking is in Appendix 3.

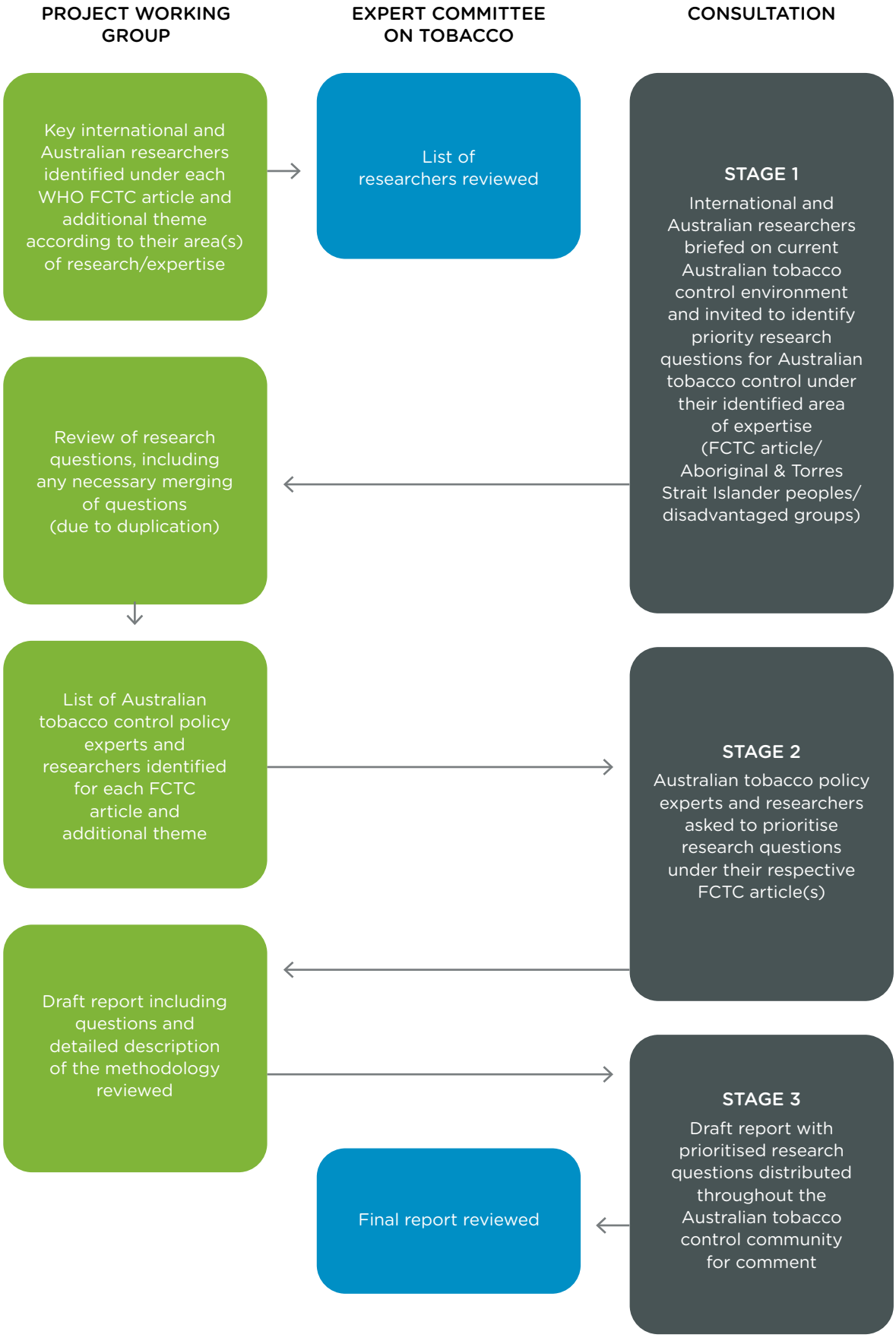
The method used to rank questions in relation to disadvantaged groups and Aboriginal and Torres Strait Islander peoples was slightly different from that used for the FCTC Articles. While relevant experts were approached in the first stage to generate up to four research questions for these groups, there was an additional step in the process. Questions from the other FCTC Articles that related to disadvantaged groups and Aboriginal and Torres Strait Islander peoples were also included in the list of research questions for ranking. As this process resulted in a large number of research questions for ranking, experts were asked to rank the questions from 1-10 with 1 being the highest priority and 10 the lowest priority.

A score was assigned based on each ranking: a ranking of 1 received a score of 5, while a ranking of 2 received a score of 4 and so on down to a ranking of 5 which received a score of 1. In relation to disadvantaged groups and Aboriginal and Torres Strait Islander peoples where the ranking was 1-10, a ranking of 1 received a score of 10 points and so on down to a ranking of 10 which received a score of 1 point. The 5 questions that received the highest scores for each Article and the 10 questions for the disadvantaged groups and Aboriginal and Torres Strait Islander peoples were the questions judged by tobacco control experts as being the most important and relevant to informing future tobacco control policies.

The release of the draft report for consultation was the **third and final stage** of the project. This stage involved consultation with tobacco control representatives from Australian and state and territory governments and non-government organisations such as Cancer Councils, the National Heart Foundation, Action on Smoking and Health Australia, the Australian Medical Association, peak Indigenous organisations and social and community service organisations relevant to tobacco control. The report was also distributed to members of the Intergovernmental Committee on Drugs - Standing Committee on Tobacco, as well as the Smoking and Disadvantage Network for comments and feedback.

A submission form was developed to assist stakeholders in responding to this report.
A copy is provided in Appendix 4.

METHODOLOGY



RESULTS

Overview

This report identifies those research questions judged through a collaborative, consultative process to be most important and relevant to inform tobacco control policies over the next decade in relation to each of the relevant FCTC Articles as well as disadvantaged groups and Aboriginal and Torres Strait Islander peoples. In doing so it is consistent with the comprehensive approach to tobacco control implemented in Australia over many years.

A broad range of important tobacco control policies and programs is covered including tobacco advertising, marketing and sponsorship, protection from exposure to environmental tobacco smoke, tobacco company interference in public health, price and tax policies, packaging and labelling, illicit trade, cessation services, and mass media campaigns. There is also a focus on emerging issues such as the regulation of tobacco products, the regulation of tobacco product disclosures and liability. Importantly, this process has placed a strong emphasis on identifying priority research needs in relation to Aboriginal and Torres Strait Islander peoples and other groups with high smoking rates. The need for a stronger evidence base in relation to these population groups is highlighted in the *National Tobacco Strategy 2012-18*.

This report focuses on identifying the most important and relevant research questions as judged by tobacco control experts who participated in this process for each of these important areas. For each of the relevant FCTC Articles, the top 5 research questions from the ranking process are presented. In relation to Aboriginal and Torres Strait Islander peoples and disadvantaged groups the top 10 research questions are presented.

It is hoped that linking future tobacco control research efforts to the set of priorities developed through this consensus process will concentrate future research efforts, and focus attention on the most policy-relevant questions.

Article 5.3: Tobacco Company Interference

FCTC OBLIGATION

In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

The Guidelines for Article 5.3 recommend the following activities to limit tobacco industry interference in public health policies:

(1) Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies

(2) Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur

(3) Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry

(4) Avoid conflicts of interest for government officials and employees

(5) Require that information provided by the tobacco industry be transparent and accurate

(6) Denormalize and, to the extent possible, regulate activities described as "socially responsible" by the tobacco industry, including but not limited to activities described as "corporate social responsibility"

(7) Do not give preferential treatment to the tobacco industry

(8) Treat State-owned tobacco industry in the same way as any other tobacco industry.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What are the extent, nature, and consequences of "third party" strategic engagement by Australian tobacco companies post 2012? Which Australian organisations are directly or indirectly associated with tobacco companies and thus supporting their activities? What is the nature and extent of their association?
2. What is the extent and nature of tobacco industry engagement with government agencies other than health (e.g. Department of Foreign Affairs and Trade, and The Treasury)? What is the nature and extent of the discussions, association and support between these agencies and the tobacco industry? How can these arrangements be made more transparent? What do government employees in other agencies outside the Department of Health know about the FCTC and the provisions of Article 5.3?
3. How do tobacco industry "corporate social responsibility activities" (CSR) affect recipients' views and activities related to tobacco control policy and their support for stronger regulation? Does this vary by type of CSR or type of recipient/beneficiary of CSR?
4. What is the extent of tobacco industry marketing, promotional and support activities remaining in Australia – including public relations and lobbying by tobacco companies and associated groups and legal activities? How much is the tobacco industry continuing to invest in these activities?
5. To what extent are tobacco companies able to exert influence through commercial or other associations? What is the nature and extent of this influence?
6. How much do the tobacco industry and industry-affiliated groups contribute to political parties annually, and are there differences between the parties in amounts received and organisations donating?

Note: Six questions are presented for this Article. The last two received the same score in the ranking process.

Article 6: Price and tax measures to reduce the demand for tobacco

FCTC OBLIGATION

Each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include:

(a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption

(b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. How has the tobacco market changed in Australia since the 25 percent increase in tobacco excise and customs duty in April 2010, in relation to: overall volume of sales; market share smoking tobacco vs. cigarettes vs. cigars; number and nature of brands on the market; market share by pack size (sales revenue and volume); brand share (sales revenue and volume) both for individual brands and by market segment; and estimated prevalence of use of illicit tobacco products?
2. What influence has tax reform, and associated industry pricing strategies, had on smokers' purchasing habits – in particular down trading (i.e. moving to a cheaper brand) versus premiumisation (smoking premium brands) and choice of pack size? What has been the effect on disadvantaged smokers in particular?
3. Would the effect of an increase in the taxation of tobacco products (i.e. the effect of the increase, not the effect of the tax itself) most likely be regressive, proportional, or progressive? Would the relative burden on the low-income population decline as a result?
4. How does the price elasticity of demand for cigarettes change as taxes and prices increase further and further?
5. What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among smokers from low-socioeconomic groups and other disadvantaged populations?*

**Note: This question was also identified as a priority under Disadvantaged groups*

Article 8: Protection from exposure to tobacco smoke

FCTC OBLIGATION

Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What combination of individual/household level interventions and population-based policies (mass media, smoke free policies in other settings, community based interventions etc.) are most effective at reducing smoking in homes, particularly among disadvantaged populations?
2. What are the levels of tobacco smoke exposure in prisons for non-smoking prisoners and non-smoking prison officers – measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners' and staff's experiences of and views on smoking in prison?
3. What is the impact of smoke free home policies on the health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc.), especially among disadvantaged populations?
4. What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home) and/or children's salivary cotinine? Who are the main sources of this exposure?
5. What are the levels of tobacco smoke exposure in outdoor areas where smoking is permitted, as measured by e.g. PM2.5 (airborne smoke particles in general, workers with monitors), and/or cotinine in non-smoking workers and clients?

Note: While some tobacco control experts ranking this Article felt it was an important priority for future research, other experts commented that they viewed this issue as a lower priority compared to other issues given the progress already made in Australia.

Article 9: Regulation of the contents of tobacco

FCTC OBLIGATION

Each Party shall, where approved by competent national authorities shall propose guidelines for testing and measuring the contents and emissions of tobacco products, and for the regulation of these contents and emissions.

Each Party shall, where approved by competent national authorities, adopt and implement effective legislative, executive and administrative or other measures for such testing and measuring, and for such regulation.

GUIDELINES FOR ARTICLES 9 & 10

In 2010, the Conference of Parties (COP) agreed on partial guidelines to assist parties in the implementation of Articles 9 and 10 of the FCTC.

The guidelines recommend that member countries take action to:

- require manufacturers and importers to disclose information on ingredients used at each stage of the manufacturing process and notify when changes are made
- require manufacturers and importers to disclose information about design features
- prohibit or restrict ingredients that may be used to increase palatability, have colouring properties, create the impression that they have a health benefit or are associated with energy and vitality (such as stimulant compounds)
- require manufacturers and importers to report on sales to assist with effective product regulation.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What health, behavioural and social impacts would a nation-wide policy of reducing nicotine content in cigarettes have on addicted tobacco users and on non-addicted tobacco users, both positive and negative? What would be the impact on youth and adult prevalence and consumption, as well as morbidity and mortality? What would be the impact of cigarettes with very low nicotine content and unchanged tar (reduction in filler nicotine, not tar delivery) on quitting success? How could the impact of a nationwide policy of reducing nicotine content be evaluated? What information should be collected prior to, during, and after, such a policy?

2. What would be the impact of banning additives and flavours (including menthol) in cigarettes on the uptake of smoking, transition to dependence, smoking behaviour and smoking cessation in children and adult smokers?

3. What is the impact of e-cigarettes on the perception of the product, tobacco use behaviours and potential for initiation and use of other tobacco products? Are there differences between adults and children and vulnerable groups with high smoking prevalence? Do cigarette smokers who try to quit using e-cigarettes switch completely or do they continue to smoke cigarettes? What is the extent of reduction in cigarette smoking? What has been the impact on smoking prevalence in countries where Electronic Nicotine Delivery Systems (e.g. e-cigarettes) are widely available (e.g. the USA)?

4. What impact would a ban on tobacco additives have on the brand variants in the market and brand selection/brand switching by smokers? What would be the impact on smokers as some products disappear, change recipe or alter cigarette engineering features as a result of a ban? What would be the impact of a ban on additives on the composition of cigarettes and smoke deliveries of tobacco products following such a ban? What would be the impact on puffing patterns in both the short term and long term as smokers adapt to the changes?

5. How do components and design features of new and emerging tobacco products like e-cigarettes affect the bioavailability of nicotine, other addictive substances, and harmful tobacco constituents? What are the tobacco use behaviours of individuals using new and emerging tobacco products, including the multiple tobacco use behaviours?

6. What additives enhance the palatability, attractiveness and addictiveness of tobacco products? What is their role and how do they act? Are particular brands of Australian cigarettes designed through the use of variable additive levels to appeal to specific groups of smokers? What influence do tobacco additives have on quitting behaviour?

7. What is the impact of tip ventilation (i.e. filter vents) on cigarette experimentation? Are inexperienced smokers more likely to start with a highly ventilated product or one with little ventilation? Note: Filter vents are perforations in the tipping paper of cigarettes. Filter vents dilute the smoke with fresh air when the smoker takes a puff thereby by creating a lighter and milder taste and making the smoke easier to inhale.

8. What would be the potential implications (risks and benefits) of requiring higher pH levels in tobacco smoke to attempt to make inhalation less likely or less deep? What is the capacity for smokers to inhibit the tendency to inhale cigarette smoke into the lung?

Note: There was a large degree of variance in the ranking of these research questions, perhaps reflecting less agreement on future priorities among tobacco control experts in relation to this issue. Two factors were identified as likely to have had a significant influence on these rankings.

The first is that regulation of the contents of tobacco and disclosure arrangements are relatively new tobacco policy areas in Australia and policy and regulatory responses are still in a developmental stage. Unlike some other countries, Australia has relatively little regulation governing the contents of tobacco and a Voluntary Agreement is in place to guide the disclosure of ingredients.

The second significant factor that may have influenced the rankings and the comments received is that at the time of consultation, the Australian government was undertaking work on the development of a Regulation Impact Statement for further implementation of Articles 9 (tobacco product regulation) and 10 (tobacco product disclosure) of the WHO FCTC.

The consultation process highlighted the need for ongoing discussion to continue to refine the research priorities for Articles 9 and 10 as the preferred policy options for Australia become clearer. This will ensure "strategic fit" between the research priorities in this area and the policy initiatives under consideration by the Australian government.

In light of these issues and comments received during the consultation, 8 questions are presented for this Article. The last three questions all received the same score in the ranking process.

Article 10: Regulation of tobacco product disclosures

FCTC OBLIGATION

Each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products. Each Party shall further adopt and implement effective measures for public disclosure of information about the toxic constituents of the tobacco products and the emissions that they may produce.

GUIDELINES FOR ARTICLES 9 & 10

In 2010, the Conference of Parties (COP) agreed on partial guidelines to assist parties in the implementation of Articles 9 and 10 of the FCTC.

The guidelines recommend that member countries take action to:

1. require manufacturers and importers to disclose information on ingredients used at each stage of the manufacturing process
2. require manufacturers and importers to disclose information about design features
3. prohibit or restrict ingredients that may be used to increase palatability, have colouring properties, create the impression that they have a health benefit or are associated with energy and vitality (such as stimulant compounds)
4. require manufacturers and importers to report on sales to assist with effective product regulation.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

How best might the information released under disclosure (now or in the future) be effectively used to inform the public? What are the risks, unintended consequences and benefits of potential approaches? How can we ensure that these efforts do not contribute to an increase in false beliefs among the population and vulnerable groups about reduced harmfulness of some tobacco products?

How can disclosure be an effective tool to guide/drive/boost other interventions (in particular product regulation)? How can policy makers use the information provided under disclosure arrangements to develop more effective regulatory models? What are the top priorities for using the information obtained via disclosure?

What is the impact of different formats for listing tobacco constituents on the public's understanding of harmful and potentially harmful constituents? Does the format influence understanding among individuals from vulnerable groups with high smoking prevalence (e.g. Aboriginal and Torres Strait Islander people)?

Aside from studies of comprehension, how do different formats for communicating tobacco constituents ultimately influence downstream processes such as tobacco-related beliefs, intentions, product/brand selections and smoking behaviours?

What is the best approach to ensuring ingredients and engineering features of e-cigarettes are disclosed to governments and/or the general public? How should a disclosure regime check that the information disclosed by companies on e-cigarettes is accurate?

Article 11: Packaging and lebelling of tobacoo products

FCTC OBLIGATION

Within a period of three years, adopt and implement effective measures to ensure that:

(a) tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions

(b) each unit packet and package of tobacco products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable groups with high smoking prevalence in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (including perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?
2. What tobacco marketing, pricing, brand variant and product variation strategies are used by tobacco companies to attempt to reduce the impact of plain packaging and larger pictorial health warnings? What marketing strategies are used by the tobacco companies to reduce the impact of plain packaging – for example creative naming of brands or brand variants, price discounting, use of social media and public relations activities?
3. How do smokers respond to plain packaging and new health warnings? Do they use strategies to minimize the impact of plain packaging and the new health warnings? What strategies do they use e.g. attempt to hide cigarette packs or use covers?
4. Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?
5. What is the effect of plain packaging on new entrants in the tobacco market?

Note: There was very strong agreement on the top two priorities for this Article with the other rankings very spread out. Questions 4 and 5 received the same score in the ranking process.

Article 12: Education, communication, training and public awareness

FCTC OBLIGATION

Each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote:

(a) broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke

(b) public awareness about the health risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles

(c) public access, in accordance with national law, to a wide range of information on the tobacco industry as relevant to the objective of this Convention

(d) effective and appropriate training or sensitization and awareness programmes on tobacco control addressed to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons

(e) awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the tobacco industry in developing and implementing inter-sectoral programmes and strategies for tobacco control

(f) public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. How can we optimise the reach and effect of mass reach health communications in an increasingly cluttered, complex and evolving media environment? What are the implications for future campaigning on smoking and health, and media planning in particular?

2. What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and smokers from low socio-economic groups? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level?
*(*This question was also identified as a priority under Disadvantaged groups.)*

3. When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum Target Audience Rating Points (TARPs) over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?

4. How can digital media (such as online advertising, social media, SMS, interactive games, Smartphone applications and expert systems) best engage audiences with tobacco control messages, as well as complement or interact with broadcast media campaigns?

5. What are the immediate and long term impacts of reduced anti tobacco campaign spending (and the associated reduction in exposure to campaign messages) on the overall population and vulnerable groups?

Note: Questions 3 and 4 received the same score in the ranking process.

Article 13: Tobacco advertising, promotion and sponsorship

FCTC OBLIGATION

Each Party shall, in accordance with its constitution or constitutional principles, undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship.

The Guidelines for Article 13 include the following:

- Bans on advertising should be comprehensive and should apply to cross-border advertising, promotion and sponsorship.
- Retail displays of cigarettes should be banned
- Tobacco advertising has promotional effects, and parties should consider adopting plain packaging requirements.
- Internet sales should be banned.
- Brand stretching activities should be banned.
- Tobacco company donations under the guise of "corporate social responsibility" should be banned.
- The promotion of tobacco products through films and other entertainment media should be addressed.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. In what ways does the tobacco industry continue to promote itself and its products (advertising/ promotion/sponsorship) in Australia? What activities does it undertake, what is the total expenditure, and what legal/ regulatory measures might be needed to obtain this information? What is the impact of these types of tobacco promotion on tobacco consumption? Are there any differences between states and territories who have taken action to restrict these remaining forms of promotion (e.g. price boards, digital media and social networking, internet sales, reward schemes)?
2. How do young people's perceptions of smoking, smokers and 'youth' tobacco brands develop as plain packaging is introduced? What is the relationship between these perceptions and smoking susceptibility? How do young people perceive the tobacco industry (e.g. measures of credibility, sympathy to key messages and arguments)?
3. In the absence of little branding on cigarette packaging, how important are other factors such as price and taste on brand selection?
4. Where have young adults seen or heard about tobacco brands? What brands are young people smoking and how are the identities of these brands being maintained in a 'dark market' like Australia?
5. What incentive schemes are provided to retailers to encourage them to sell tobacco products or to sell particular tobacco products? What legal/regulatory measures might be needed to obtain this information?
6. What is the nature and extent of young people's exposure to cross-border tobacco marketing in Australia (as well as to tobacco portrayals and brand communication that may be independent of the tobacco industry), including on the internet and through social media? What is the impact on smoking attitudes and behaviours of such exposure?

Note: Six questions are presented. The last two questions received the same score in the ranking process.

Article 14: Demand reduction measures concerning tobacco dependence and cessation

FCTC OBLIGATION

Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.

The Guidelines for Article 14 stress the importance of the following:

- Tobacco dependence treatment measures must be implemented within a comprehensive integrated tobacco control framework.
- Cessation strategies should be based on the best available evidence of effectiveness.
- Cessation services should be accessible, affordable and inclusive.
- Monitoring and evaluation are essential.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. Are smokers who use nicotine replacement therapy, bupropion, varenicline and other pharmacotherapies more likely to remain abstinent than those who quit without medications in the 'real world', when used outside of the clinical trial situation?
2. Have Australia's smokers "hardened" i.e. are today's smokers smoking more cigarettes on average than in the past; do a greater proportion of smokers smoke within 30 minutes of waking than in the past; has the ratio of daily to less than daily smokers changed?
3. What are the most effective approaches to encourage and support smokers from vulnerable high prevalence groups to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can these be minimized? *(*This question was also identified as a priority under Disadvantaged groups.)*
4. Has smoking cessation really "stalled" in Australia, or does the apparent levelling off in the proportion of adults who are former smokers reflect the combined impact of (1) a growing cohort of never-smokers (who could never quit to become former smokers); and (2) deaths among smokers?
5. Does the experience of quitting match the anticipated experience of quitting i.e. do smokers who quit find the experience easier, harder or about as expected?

Note: questions 4 and 5 received the same score in the ranking process.

Article 15: Illicit trade

FCTC OBLIGATION

Each Party shall adopt and implement effective legislative, executive, administrative or other measures to ensure that all unit packets and packages of tobacco products and any outside packaging of such products are marked to assist Parties in determining the origin of tobacco products, and in accordance with national law and relevant bilateral or multilateral agreements, assist Parties in determining the point of diversion and monitor, document and control the movement of tobacco products and their legal status.

The Parties shall, as appropriate and in accordance with national law, promote co-operation between national agencies, as well as relevant regional and international intergovernmental organizations as it relates to investigations, prosecutions and proceedings, with a view to eliminating illicit trade in tobacco products.

Each Party shall endeavour to adopt and implement further measures including licensing, where appropriate, to control or regulate the production and distribution of tobacco products in order to prevent illicit trade.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What are the best methods and models for estimating the magnitude, forms and causes of illicit trade activities related to tobacco products?
2. Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?
3. What, if any, laws, policies and/or programmes would need to be introduced/changed in order for Australia to implement the FCTC protocol on illicit trade?

Note: Some experts only provided limited rankings for this Article (e.g. identifying only 2 or 3 priorities). For this reason only 3 research questions are presented. There was general agreement regarding the top priority for this Article (question 1) and lesser agreement regarding the other research questions.

Article 18: Protection of the environment and the health of persons

FCTC OBLIGATION

In carrying out their obligations under this Convention, the Parties agree to have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture within their respective territories.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What are the best methods and models for developing a comprehensive approach for butt waste mitigation in Australia?
2. Could a case be made to remove the cellulose acetate filter from commercial cigarettes in order to reduce the quantity of tobacco product waste in the environment?
3. What level of support might stakeholders (smokers, non smokers, industry, government) show for policies on cigarette filters (i.e. regulating or removing filters), assuming the predicted impacts are significant?
4. What are the environmental and human health consequences of butt waste deposition?
5. What might be the impact of a 'deposit' or 'abatement fee' for cigarette butts levied on manufacturers to defray costs of cleanup and environmental impact? How can the environmental impact of plastic wrapping and packages be minimised?

Note: There were differing views on the importance of this Article. There was general agreement regarding the top two priorities for this Article and less agreement regarding other research questions.

Article 19: Liability

FCTC OBLIGATION

1. For the purpose of tobacco control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate.
2. Parties shall cooperate with each other in exchanging information including information on the health effects of the consumption of tobacco products and exposure to tobacco smoke; and information on legislation and regulations in force as well as pertinent jurisprudence.
3. The Parties shall, as appropriate and mutually agreed, within the limits of national legislation, policies, legal practices and applicable existing treaty arrangements, afford one another assistance in legal proceedings relating to civil and criminal liability consistent with this Convention.
4. The Convention shall in no way affect or limit any rights of access of the Parties to each other's courts where such rights exist.
5. The Conference of the Parties may consider, if possible, at an early stage, taking account of the work being done in relevant international fora, issues related to liability including appropriate international approaches to these issues and appropriate means to support, upon request, the Parties in their legislative and other activities in accordance with this Article.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What resources and infrastructure would be most effective to support and/or co-ordinate Australian and international efforts in tobacco litigation by governments and individuals? How could such an infrastructure be provided and funded?
2. Is it feasible to create an effective, and constitutionally valid, tobacco specific liability regime in Australia at State and/or Federal level that:
    - Recognises the right of governments and private health insurers to sue tobacco manufacturers to recover tobacco related health care costs and sets out rules for the calculation of such losses
    - Modifies the cost rules (especially the loser pays rule) to prevent the tobacco industry from using the threat of adverse cost orders to deter litigation or force claimants to drop their claims
    - Makes it easier for individual victims of smoking related disease to bring their claims to court, and obtain compensation
3. Would it be legally feasible to bring 'cost recovery' litigation against the tobacco industry in Australia? If so, who would be the appropriate applicant/s and how could it be funded? Would cost recovery litigation require the enactment of any legislation, regulations or rules, and, if so, of what kind and by whom? What criteria might be applied to determine whether cost recovery litigation would be a worthwhile undertaking in Australia? What are the possible benefits and risks of undertaking cost recovery litigation in Australia, and what is a realistic timeframe for its conduct?
4. Is the use of certain descriptors and brand variants by the Australian tobacco industry e.g. 'smooth' and 'gold' misleading and deceptive or likely to mislead or deceive within the meaning of section 18 of the Australian Consumer Law?

Note: There was less agreement on this issue compared to some others. In particular, the relative priority that should be given to this approach compared with other tobacco control strategies within the Australian context.

Aboriginal and Torres Strait Islander people

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What message strategies are persuasive among Aboriginal and Torres Strait Islander populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Aboriginal and Torres Strait Islander-specific campaigns, such as the recent "Break the Chain" campaign? What is the impact in terms of quit intentions, quit attempts and successful cessation? *(*Also nominated as a priority research question under Article 12: Education, communication, training and public awareness)*
2. Why is it that some Indigenous people never take up smoking or are able to quit successfully despite often living in circumstances where the vast majority of their family and peers smoke? What is it about these individuals and their environment that support being a non-smoker or never-smoker? Are there attributes of the individuals' coping mechanisms that could be learned by others? How might their experiences inform new approaches to communicating with Aboriginal people about smoking?
3. What is the impact of smoke free laws and rules (public places, health services, Indigenous organisations, cars, events) on exposure to second hand smoke, smokers' quit intentions, quit attempts, tobacco consumption and successful cessation among Aboriginal and Torres Strait Islander people? What has been the impact on children?
4. What works in targeting smoking and chewing of tobacco by Aboriginal and Torres Strait Islander youth?
5. What is the reach and effectiveness (short and long term) of social media strategies (i.e. smart phone apps, Twitter and Facebook) to communicate health messages to Aboriginal and Torres Strait Islander people? Are there any unintended barriers or consequences (for example high download costs for people living in rural and remote areas), and if so, how can these be overcome?
6. What are the most effective approaches to reduce tobacco use and exposure to second hand smoke among Aboriginal and Torres Strait Islander peoples in the justice system? What is the most effective way to support these individuals to remain quit once they leave prison?
7. What are the most effective ways that Indigenous leaders and tribal authorities can be supported by health organisations to progress towards smoke free remote communities (e.g. workable bans on tobacco sales; feasible bans on tobacco products in certain remote towns and rural areas)?
8. What is the impact of raising the price of cigarettes and tobacco (through tax increases) on Aboriginal and Torres Strait Islander smoking prevalence, consumption, cessation and initiation?
9. What are the exposure levels of Aboriginal and Torres Strait Islander children (by age) in the home - measured by e.g. PM2.5 (airborne smoke particles in the home) and children's salivary cotinine? Who are the main sources of this exposure? *(*A similar question was nominated as a priority under Article 8: Protection from exposure to tobacco smoke).*
10. Which health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a "set" of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population and Aboriginal and Torres Strait Islander peoples in relation to these issues? *(*A similar question is nominated as a priority under Article 11: Packaging and labelling).*

Note: The questions with an asterisk next to them also appear in other Articles in this report.
One tobacco control expert noted that the research questions nominated are primarily from a public health/tobacco control perspective and that the importance of broader cross cultural issues should also be acknowledged.

Disadvantaged groups

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What is the most effective approach to changing the behaviour of health professionals and other staff and the culture of social service organisations and other settings such as mental health facilities and prisons to ensure they can appropriately address smoking among socially disadvantaged groups?

2. What is the impact of financial incentive programs on smoking behaviour, including quit attempts and cessation, among the most disadvantaged population groups? To what extent would the provision of financial incentives through the social security system be an effective means of encouraging quit attempts among very disadvantaged smokers?

3. What is the optimal way to develop a national smoking prevalence monitoring or surveillance system among groups with multiple forms of disadvantage?

4. What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among smokers from low socio-economic groups and other disadvantaged populations? *(*This question was also identified as a priority under Article 6: Price and tax measures.)*

5. What is the impact of a rise in tobacco excise on the smoking behaviour and financial stress of population groups experiencing multiple disadvantage e.g. clients of social and community service organisations? How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?

6. What are the most effective approaches to encourage and support smokers from vulnerable high prevalence groups to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can these issues be minimized? *(*This question was also nominated as a priority under Article 14: Demand reduction measures concerning tobacco dependence and cessation.)*

7. What are the social network factors that most impact on smoking uptake and quitting smoking among disadvantaged groups? How can social networks among these disadvantaged groups be employed to de-normalise smoking, discourage uptake and encourage quitting?

8. What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and smokers from disadvantaged groups? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level? *(*This question was also identified as a priority under Article 12: Education, communication, training and awareness)*

9. What are the reasons underlying Quitline underutilisation among disadvantaged groups? How can these barriers be addressed?

10. What is the effect on 'quit attempts' and 'amounts smoked' when staff from community service organisations ask their clients the following questions:

    - How many cigarettes do you smoke each day?
    - Have you tried to quit in the last three months?
    - Are you interested in getting some help quitting? providing them with a brochure about quitting (and in a sub-sample of the group organising a call from Quitline)?

Note: The questions with an asterisk next to them also appear in other Articles in this report.

Additional research questions identified during the process

During stage 2, in addition to ranking the lists of research questions, Australian tobacco control experts were also invited to respond to the following two questions:

- *Do you have any additional comments that you wish to make about this process?*
- *Do you wish to nominate research questions within the Article that you think are important that were not on the list?*

The additional research questions provided below were not ranked but are presented for completeness. These questions could be considered in future priority setting exercises.

ARTICLE 5.3: TOBACCO INDUSTRY INTERFERENCE

- What tactics have been/are used by the tobacco industry to influence or obstruct public health policy in Australia? What specific strategies can policy makers use or develop to combat those tactics?

ARTICLE 8: PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

- What measures can be implemented for ensuring smoke-drift complaints and smoke-free areas in multi-unit housing are adequately addressed?
- How many and (in particular) how much are people bothered by smoking in areas such as outdoor dining spaces, the family areas of beaches, near play structures in parks etc.?
- What strategies are most effective when developing and implementing smoke-free policies in custodial settings?

ARTICLE 9: REGULATION OF TOBACCO

- Can we effectively get rid of cigarettes rapidly using some combination of reducing nicotine in cigarettes and other sources of nicotine? What regulatory framework do we need to move forward to ensure any residual nicotine and tobacco problem is managed as effectively as possible?
- What are the actual impacts of policy changes to regulate tobacco after they are implemented?
- What data is necessary to establish a baseline data set relevant to the regulation of tobacco i.e. what is the level from which we should reduce?
- Do filters reduce the harmfulness of cigarettes and do they falsely reassure smokers?

ARTICLE 11: PACKAGING AND LABELLING

- Would major changes to the style and design of the health warnings be a more effective way of refreshing health warnings rather than changing the content?

ARTICLE 12: EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

- What is the likely impact of media fragmentation and changes in the way that audiences are consuming media on anti-tobacco mass media campaigns? What would be the likely impacts and risks and benefits of diversifying from “traditional paid advertising” to placing greater emphasis on embedded marketing or working in content e.g. brand placement?
- Have the local community campaigns to support Aboriginal and Torres Strait Islander peoples and their families changed community behaviour?

ARTICLE 14: DEMAND REDUCTION MEASURES CONCERNING TOBACCO DEPENDENCE AND CESSATION

- What proportions of smokers have a history of repeated failures in quit attempts and what characterizes them? Is there evidence that pharmaceutical advertising messages have a role in failed quit attempts? (Is there any evidence that plain packaging reduces the probability of relapse among recent quitters and does it differ by age? For recent quitters who have relapsed, what factors are associated with purchasing their first pack after a quit attempt? What is their exposure to marketing and price promotions and what are the predictors of relapse?

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

- What are the key lessons from successful community engagement with Aboriginal and Torres Strait Islander peoples and how can the relevant approaches best be applied to tobacco control?
- What is the relationship/association between alcohol and social smoking'?
- Do Aboriginal and Torres Strait Islander peoples quit the same way as a non Aboriginal person?
- Have the local community campaigns to support Aboriginal and Torres Strait Islander peoples and their families changed community behaviour?

DISADVANTAGED GROUPS

- What will the cost be to governments for healthcare of prison populations due to smoking caused illnesses? What are the flow on effects for the community post-release (transfer of costs, etc.)? What interest is there in quitting amongst the prison populations? How might prisoners respond to different scenarios (e.g. increased costs of cigarettes, gradual toughening up of restrictions on smoking, improvements in support for quitting)? What impact would changes in investment and range of recreational/ occupational activities for prisoners have on their smoking behaviours?
- How effective are current strategies to reduce second-hand smoke in different settings such as prisons. How can these strategies be improved?
- Is there a difference in quit rates for disadvantaged groups between intensive support to quit versus taking NRT without support to quit?

LICENSING AND AVAILABILITY OF TOBACCO PRODUCTS

- What are the potential benefits, feasibility and best practice regulatory approaches of placing controls on the number and type of tobacco outlets in the community?
- What is the relationship between tobacco retail density (number of tobacco outlets) and smoking behaviour (uptake, quit attempts, relapse)?
- What is the relationship between tobacco retail structure (types of tobacco outlets) and smoking behaviour (uptake, quit attempts, relapse)?
- What is the attitude of young people towards legislation that increases the legal age for purchasing tobacco (e.g. increasing it to 21 or 25 years of age)? Are there any differences between current smokers vs. non-smokers?

OTHER ISSUES

- What is the potential contribution of genomics to tobacco control?
- What are the effects of different tobacco policies on women?
- Does stigmatisation of smokers affect their access to preventive health care?
- What are the benefits and disadvantages of harm minimisation approaches to tobacco control?

CONSULTATION

Consultation took place between December 2012 and March 2013, during which time the draft report was widely distributed to tobacco control stakeholders across Australia. Feedback was received by respondents on the process undertaken to develop the research agenda, as well as the research questions' comprehensiveness in scope and their importance and relevance to tobacco control in Australia over the coming decade.

While the majority of respondents agreed with the overall methodology used to develop the research agenda, the following comments were received for consideration:

- The process may have been improved with an additional step involving greater discussion or workshopping of the research questions between experts prior to the ranking of questions
- When ranking the research questions, more explicit criteria for judging relevance and importance may have assisted the process
- A different methodology for identifying, refining and ranking research questions may have resulted in better defined questions and a different ranking of questions
- Some of the larger research questions may be refined with further discussion
- The NTS may have provided a more relevant and comprehensive framework than the FCTC
- A five-year review of the research questions may assess progress and determine relevance and importance

When asked to consider the research questions' comprehensiveness in scope, respondents identified a number of gaps. Licensing of tobacco retailers and approaches to restricting the availability and supply of tobacco were identified as having not been adequately addressed. Some questions relevant to these issues are now included in the list of additional research questions.

The issue of smoking and mental health among disadvantaged groups was also raised as an area in need of stronger focus. However, several research questions identified under Articles 6, 14 and Disadvantaged Groups relate to this issue. The omission of FCTC Articles 20 *(Research, surveillance and exchange of information)* and 22 *(Cooperation in the scientific, technical, and legal fields and provision of related expertise)* was also raised. While this report focuses on identifying those research questions most relevant to Australian tobacco control, it is acknowledged that there is a need to ensure relevant research findings are widely distributed to our international partners.

There were also diverse views about the importance of Articles 8 *(Protection from exposure to environmental tobacco smoke)* and 18 *(Protection of the environment and the health of persons)*. Some respondents argued that the questions identified under Article 8 were of lesser importance than others. However one respondent differed, suggesting that the involuntary exposure of disadvantaged groups (especially children) through smoke drift in multi-unit dwellings (particularly in public housing) is not receiving sufficient attention in Australia. Article 18 was considered by some respondents as relating more to the environmental agenda rather than health. One respondent also noted that all five questions pertaining to this Article dealt with cigarette butts and that plastic wrapping and packaging are also of concern. Question 5 was modified accordingly.

The significance of some of the additional research questions identified in this report was also highlighted. For example, one respondent suggested that the additional research questions under Article 9 *(Regulation of the contents of tobacco)* may help inform future policies in this area.

A range of views was received in relation to Article 9 and 10 *(Regulation of tobacco disclosure)*. Both Articles were viewed as critically important to tobacco control efforts; however, respondents acknowledged that these are relatively new tobacco policy areas in Australia, and that policy and regulatory responses are still in the developmental stage. Unlike other countries, Australia has relatively little regulation of the contents of tobacco. A Voluntary Agreement is in place to guide the disclosure of ingredients. At the time of consultation, the Australian Government was developing a Regulation Impact Statement for further implementation of Articles 9 and 10. Respondents identified a need for ongoing discussion to continue refining the research priorities for these two Articles as policy options for Australia become clearer.

Finally, there was strong support for a research focus on disadvantaged groups and Aboriginal and Torres Strait Islander peoples. The need to strengthen the capacity of Indigenous Australians to undertake health research was highlighted as well as the importance of ensuring that the priority-driven research agenda is widely disseminated and "fed back" to relevant community groups and organisations.

CONCLUSION

In 2008, all Australian governments made a committment to reducing the adult daily smoking rate to 10 per cent or less, and halving the rate of smoking among Aboriginal and Torres Strait Islander peoples by 2018.[9] In order to achieve these targets tobacco control must remain a priority for governments and non government organisations alike. The *National Tobacco Strategy 2012-18* sets out the policies and programs needed to achieve these targets including a focus on the continued implementation of proven tobacco control programs such as mass media campaigns, regulation and pricing policies. It also includes new tobacco control policies such as the world's first implementation of plain packaging and development of policies in relation to the regulation of tobacco products and tobacco product disclosure. The NTS also places a priority on strategies to reduce smoking among disadvantaged groups in our community who have high smoking rates. Central to these approaches is the generation of new evidence to address knowledge gaps and robust evaluation of tobacco control programs. This report identifies those research questions judged by Australian tobacco control experts who participated in the process to be most important and relevant to inform tobacco control policies over the next decade.

Research should not only generate more knowledge but also help to translate knowledge into action through innovative approaches.[12] It is hoped that this report will serve as a useful guide to those implementing and funding research in relation to preventive health and tobacco control in Australia; enhance the national research capacity to respond in a focused and timely fashion to emerging tobacco research needs over the coming decade; and further develop the shared understanding between policy makers, advocates and researchers about research priorities in tobacco control.

LIST OF AUSTRALIAN AND INTERNATIONAL TOBACCO CONTROL EXPERTS WHO GENERATED RESEARCH QUESTIONS

ARTICLE 5.3: TOBACCO INDUSTRY INTERFERENCE

Professor Mike Daube, Curtin University, Australia.
Professor Simon Chapman, University of Sydney, Australia.
Professor Ruth Malone, University of California, San Francisco, USA.

ARTICLE 6: PRICE AND TAX MEASURES TO REDUCE THE DEMAND FOR TOBACCO

Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.
Professor Frank Chaloupka, University of Illinois, Chicago, USA.
Professor Ken Warner, University of Michigan, Michigan USA.
Dr Evan Blecher, American Cancer Society, Atlanta Georgia USA.

ARTICLE 8: PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

Dr Mark Travers, Roswell Park Cancer Institute, Buffalo, New York.
Professor Sally Haw, University of Stirling, Scotland UK.
Professor Richard Edwards, University of Otago, New Zealand.
Professor Amanda Amos, University of Edinburgh, Scotland UK.

ARTICLE 9: REGULATION OF THE CONTENTS OF TOBACCO

Dr David Ashley, Office of Science, Center for Tobacco Products, US Food and Drug Administration, USA.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria Australia.
Professor Dorothy Hatsukami, University of Minnesota, Minnesota USA.
Professor Thomas Eissenberg, Commonwealth University, Richmond, Virginia USA.
Mr Denis Choiniere, Health Canada, Canada.
Ms Ana Claudia Andrade, National Health Surveillance Agency, Brazil.
Mr Andre Luiz Oliveira da Silva, Office of Tobacco Product Control, National Agency of Health Surveillance, Brazil.

ARTICLE 10: REGULATION OF TOBACCO PRODUCT DISCLOSURES

Mr Matthew Allen, Allen & Clarke, Policy & Regulatory Specialists, New Zealand.
Dr Lois Biener, Center for Survey Research, University of Massachusetts, Boston USA.
Ms Ana Claudia Andrade, National Health Surveillance Agency, Brazil.
Mr Andre Luiz Oliveira da Silva, Office of Tobacco Product Control, National Agency of Health Surveillance, Brazil.
Dr Ellen Peters, Ohio State University (Chair Risk Communication Advisory Committee, FDA) USA.
Mr Denis Choiniere, Health Canada, Canada.

ARTICLE 11: PACKAGING AND LABELLING OF TOBACCO PRODUCTS

A/Professor David Hammond, School Of Public Health and Health Systems, University of Waterloo, Ontario, Canada.
Dr Crawford Moodie, University of Stirling, Scotland UK.
Professor Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Australia.
Dr Caroline Miller, South Australian Health & Medical Research Institute, South Australia.
Professor Andrew Mitchell, Melbourne Law School, University of Melbourne.

ARTICLE 12: EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

Professor Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Australia.
Dr Jeff Niederdeppe, College of Agriculture and Life Sciences, Department of Communication,
Cornell University, New York, USA.
Ms Karen Guteriez, Social Marketing Consultant.
Ms Trish Cotter, Victorian Comprehensive Cancer Centre, Victoria, Australia.
Ms Denise Sullivan, Chronic Disease Prevention, WA Department of Health, Australia.

ARTICLE 13: TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP

Professor Gerard Hastings, University of Stirling, Scotland UK.
A/Professor Tim Dewhirst, University of Guelph, Ontario, Canada.
Professor Janet Hoek, Otago University, New Zealand.
Dr Becky Freeman, University of Sydney, Australia.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.

ARTICLE 14: DEMAND REDUCTION MEASURES CONCERNING TOBACCO DEPENDENCE AND CESSATION

Professor John Pierce, University of California, San Diego, California USA.
Professor Gary Giovino, Dept. of Community Health and Health Behaviour, School of Public Health, University at Buffalo, New York USA.
Dr Lois Biener, Center for Survey Research, University of Massachusetts, Boston USA.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria, Australia.
A/Professor Christine Paul, University of Newcastle, Australia.
Professor Simon Chapman, University of Sydney, Australia.

ARTICLE 15: ILLICIT TRADE IN TOBACCO PRODUCTS

Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.

ARTICLE 16: SALES TO AND BY MINORS

Not required, since all states have appropriate legislation.

ARTICLE 17: PROVISION OF SUPPORT FOR ECONOMICALLY VIABLE ALTERNATE ACTIVITIES

Not required, since no tobacco grown in Australia.

ARTICLE 18: PROTECTION OF THE ENVIRONMENT AND THE HEALTH OF PERSONS.

Professor Thomas Novotny, San Diego State University, California USA .
Dr Richard O'Connor, Roswell Park Cancer Institute, Buffalo, New York USA.

ARTICLE 19: LIABILITY

Dr Andrew Higgins, Oxford Law Faculty, Oxford University, UK.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.

DISADVANTAGED GROUPS

Ms Anita Tang/Mr Scott Walsberger, Cancer Council NSW, Australia.
Dr Billie Bonevski, School of Medicine and Public Health, University of Newcastle, Australia.
A/Professor Nick Wilson, Otago University, New Zealand.
Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Dr Tom Calma, National Coordinator, Tackling Indigenous Smoking, Dept. of Health and Ageing, Canberra, Australia.
A/Professor David Thomas, Menzies Research Institute, Alice Springs Northern Territory, Australia.
Ms Denise Sullivan, Chronic Disease Prevention, WA Department of Health, Australia.

LIST OF TOBACCO CONTROL EXPERTS WHO RANKED THE RESEARCH QUESTIONS

Professor Mike Daube, Director, Public Health Advocacy Institute of WA.
Professor Simon Chapman, University of Sydney.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria.
Ms Anne Jones, Chief Executive, Action on Smoking and Health.
Mr Maurice Swanson, Chief Executive Officer, National Heart Foundation (WA Division).
Dr Caroline Miller, Executive Officer, SA Health & Medical Research Institute.
Ms Michelle Scollo, Senior Consultant Tobacco Control Unit, Cancer Council Victoria.
Ms Denise Sullivan, Director, Chronic Disease Prevention, Department of Health WA.
Professor Melanie Wakefield, Director, Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Dr Becky Freeman, Research Fellow, University of Sydney.
Mr Scott Walsberger, Manager, Tobacco Control Program, Cancer Council New South Wales.
Ms Kylie Lindorff, Policy Manager, Quit Victoria, Cancer Council Victoria.
Professor David Hill, Honorary Professorial Fellow, School of Population Health, University of Melbourne.
Dr Billie Bonevski, Senior Research Academic, Centre for Health Research and Psycho-oncology, University of Newcastle.
Mr Todd Harper, Chief Executive Officer, Cancer Council Victoria.
Dr Vicki White, Deputy Director, Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Mr Jonathan Liberman, Director, McCabe Centre for Law and Cancer.
Ms Trish Cotter, Public Health and Social Marketing Consultant, Victorian Comprehensive Cancer Centre.
Dr Ross MacKenzie, Lecturer, Health Studies, Macquarie University.
Dr Coral Gartner, NHMRC Postdoctoral Research Fellow, University of Queensland.
Dr David Thomas, Tobacco Control Research Program, Menzies School of Health Research.
Ms Fiona Sharkie, Executive Director, Quit Victoria, Cancer Council Victoria.
Dr Sarah Durkin, Senior Research Fellow (Tobacco), Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Ms Kathryn Barnsley, Menzies Research Institute, Tasmania.
Associate Professor Christine Paul, Senior Research Academic Priority Research Centre for Health Behaviour.
Professor Wayne Hall, UQ Centre for Clinical Research, University of Queensland.
Mr Bill King, Senior Research Officer, Vic Health Centre for Tobacco Control.
Dr Lyn Roberts, Chief Executive Officer, National Heart Foundation.
Dr Clair Scrine, Senior Research Officer, Kulunga Research Network.
Professor Mark Davison, Faculty of Law, Monash University.
Mr Mark West, Director, Tobacco and Alcohol Branch, Preventive Health Directorate.
Dr Roscoe Taylor, Director, Public Health, Department of Health and Human Services.
Ms Anita Dessaix, Manager, Cancer Prevention, Cancer Institute NSW,
Ms Della Rowley, Tobacco Control Unit, Drug &Alcohol Services, SA Health Department.
Dr Bruce Bolam, Executive Manager, Knowledge& Environments for Health, Vic Health.
Professor Andrew Mitchell, Melbourne Law School, University of Melbourne.
Ms Sharon Appleyard, Assistant Secretary, Tobacco Control Taskforce, Commonwealth Department of Health and Ageing.
Professor Nigel Gray, Cancer Council Victoria.
Ms Louise Galloway, Manager Screening and Cancer Prevention, Department of Health Victoria.
Professor Ian Olver, CEO, Cancer Council Australia.
Dr Rohan Greenland, National Director Government Relations National Heart Foundation.
Mr Warwick Kneebone, Coordinator, Tobacco Enforcement & Education, Department of Health NT.
Mr Paul Grogan, Director, Advocacy, Cancer Council Australia.

**Two experts on this list utilised an alternative system of ranking the research priorities. The ranking results of these experts were therefore unable to be used for this project.*

COMPLETE LIST OF QUESTIONS SUBMITTED FOR THE RANKING PROCESS

ARTICLE 5.3: TOBACCO INDUSTRY INTERFERENCE

- What are the extent, nature, and consequences of "third party" strategic engagement by Australian tobacco companies post 2012?
- What incentive schemes operate in Australia today between tobacco manufacturers and retailers?
- What is the extent of tobacco industry marketing, promotional and support activities remaining in Australia – including public relations and lobbying by tobacco companies and groups with which they are associated and legal activities and costs? How much is the tobacco industry continuing to invest in these activities?
- Which Australian organisations are directly or indirectly associated with tobacco companies and thus supporting their activities? What is the nature and extent of their association?
- To what extent are tobacco companies able to exert influence through commercial or other associations? What is the nature and extent of this influence?
- What is the extent and nature of tobacco industry engagement with government agencies other than health (e.g. Department of Foreign Affairs and Trade, Department of Commerce, and The Treasury)? What is the nature and extent of the discussions, association and support between these agencies and the tobacco industry? How can these arrangements be made more transparent? What do government employees in other agencies outside the Department of Health know about the FCTC and Article 5.3's provisions?
- How much do the tobacco industry and industry-affiliated groups contribute to political parties annually, and are there differences between the parties in amounts received and organizations donating?
- How does industry "corporate social responsibility activities" (CSR) affect recipients' views and activities related to tobacco control policy and their support for stronger regulation? Does this vary by type of CSR or type of recipient/beneficiary of CSR?

ARTICLE 6: PRICE AND TAX MEASURES TO REDUCE THE DEMAND FOR TOBACCO

- How have industry pricing strategies changed and/or will they change in response to the increasingly high taxes and stronger tobacco control environment in Australia?
- How does the price elasticity of demand for cigarettes change as taxes and prices are raised further and further?
- What strategies are most effective in mitigating illicit trade in tobacco products?
- How has over shifting of excise tax increases influenced cigarette price trends?
  Note: Over shifting is when the consumer price rises by more than the tax increase.
- What influence has tax reform had on smokers purchasing habits – in particular down trading (i.e. moving to a cheaper brand) versus premiumisation (smoking premium brands)?
- What are the best measures to use in establishing a baseline for illicit trade in cigarettes and assessing change over time?
- How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?
- Is a cigarette tax increase (not the total tax) regressive, proportional, or progressive? That is, do enough more low-income smokers quit or reduce their daily consumption than do high-income smokers that the relative burden on the low-income population declines?
- What are the cross-elasticities of demand for roll-your-own cigarettes and other non-manufactured cigarette products (cigars, etc.) and how are these reflected in changes in consumption of these other products when the cigarette tax is increased? Does RYO consumption increase, for example?

- How are youth smoking rates associated with cigarette price increases? Does smoking prevalence in the 18-24 year-old age group strongly reflect price when this group was 4-5 years younger?
- How has the tobacco market changed in Australia since the 25% increase in tobacco excise and customs duty in April 2010, in terms of overall volume of sales, market share smoking tobacco vs. cigarettes vs. cigars; number and nature of brands on the market; market share by pack size (sales revenue and volume); brand share (sales revenue and volume) both for individual brands and by market segment; and estimated prevalence of use of illicit tobacco products?
- What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among low-SES smokers?

ARTICLE 8: PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

- What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home) children's salivary cotinine? Who are the main sources of this exposure?
- What are the levels of tobacco smoke exposure in outdoor areas where smoking is permitted, as measured by e.g. PM2.5 (airborne smoke particles in general, workers with monitors), and/or cotinine in non-smoking workers and clients?
- What are the levels of tobacco smoke exposure in prisons, non-smoking prisoners and non-smoking prison officers – measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners' and prison staff's experiences of and views on smoking in prison?
- What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and second hand smoke exposure among children and adults, particularly from more disadvantaged populations?
- What combination of individual/household level interventions and population-based policies (mass media, other smoke free policies in other settings, community based interventions etc.) are most effective at reducing smoking in homes, particularly among disadvantaged populations?
- What is the broader impact of smoke free policies (e.g. parks, beaches, streets etc.) on social norms about smoking among smokers, non-smokers and children, particularly in disadvantaged populations?
- What is the impact of smoke free home policies on health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc.), especially in disadvantaged populations?
- What is the most successful approach to ensure all common areas in strata title developments (such as apartment complexes) are smoke free? What are the barriers and how can they be overcome? What personal, social and environmental factors and policy development approaches lead to positive progress on this issue?

ARTICLE 9: REGULATION OF THE CONTENTS OF TOBACCO

- What health, behavioural and social impacts would a nation-wide policy of reducing nicotine content in cigarettes have on addicted tobacco users and on non-addicted tobacco users, both positive and negative? What would be the impact on youth and adult prevalence and consumption, as well as morbidity and mortality? What would be the impact of cigarettes with very low nicotine content and unchanged tar (reduction in filler nicotine, not tar delivery) on quitting success?
- How could the impact of a nationwide policy of reducing nicotine content be evaluated? What information should be collected prior to, during, and after, such a policy?

- What is the impact of tip ventilation (i.e. filter vents) on cigarette experimentation? Are inexperienced smokers more likely to start with a highly ventilated product or one with little ventilation?
  Note: Filter vents are perforations in the tipping paper of cigarettes. Filter vents dilute the smoke with fresh air when the smoker takes a puff thereby by creating a lighter and milder taste and making the smoke easier to inhale.
- What would be the potential implications (risks and benefits) of requiring higher pH levels in tobacco smoke to attempt make inhalation less likely or less deep? What is the capacity for smokers to inhibit the tendency to inhale cigarette smoke into the lung?
- What is the impact of e-cigarettes on the perception of the product, tobacco use behaviours and potential for initiation and use of other tobacco products? Are there differences between adults and children and vulnerable groups with high smoking prevalence? Do cigarette smokers who try to quit using e-cigarettes switch completely or do they continue to smoke cigarettes? What is the extent of reduction in cigarette smoking?
- What would be the impact of banning flavoured cigarettes and the potential banning of menthol cigarettes on the uptake of smoking, transition to dependence, and smoking cessation in adult smokers? What influence does the availability of flavoured cigarettes have on smoking behaviour in children and teenagers?
- What influence do cigarette product design features in Australian brands have on smoking behaviour? What is the relationship between smoking topography (i.e. volume inhaled, puff number, puff duration, etc.) among Australians and cigarette product design features (e.g. example additives, paper porosity, filter type, cigarette length and diameter, filter vents)?
- What impact would a ban on tobacco additives have on the brand variants in the market and brand selection/brand switching by smokers? What would be the impact on smokers as some products disappear, change recipe or alter cigarette engineering features as a result of a ban? What would be the impact of a ban on additives on the composition of cigarettes and smoke deliveries of tobacco products following such a ban? What would be the impact on puffing patterns in both the short term and long term as smokers adapt to the changes?
- What approach to tobacco addictiveness reduction would provide the most benefit to public health? What might such an approach involve e.g. steps/processes/main points to be investigated?
- Considering the existence of addictiveness models for some drugs, is it necessary to develop a model specific for tobacco control regulation?
- What additives enhance the palatability, attractiveness and addictiveness of tobacco products? What is their role and how do they act? Are particular brands of Australian cigarettes designed through the use of variable additive levels to appeal to specific groups of smokers? What influence do tobacco additives have on quitting behaviour?
- Are there alkaloids other than nicotine for which a maximum content should be established? What are their current levels in Australian cigarettes? Are there substances, other than alkaloids, that play a role in developing or sustaining tobacco addiction? How could governmental authorities monitor these substances and, if necessary regulate them?
- To minimize, or eliminate, tobacco addictiveness, what criteria should be used to establish the maximum nicotine content that would be permissible in the various types of tobacco products marketed in Australia? For example, set the level according to the lowest nicotine level technologically feasible or set the level just below the level where tobacco dependence cannot develop? What other criteria could be used?
- How can we ensure that tobacco product emissions used for determining toxicant yields are produced in a way that ensures they reflect actual human tobacco use behaviour?
- How do components and design features of new and emerging tobacco products like e-cigarettes affect the bioavailability of nicotine, other addictive substances, and harmful tobacco constituents? What are the tobacco use behaviours of individuals using new and emerging tobacco products, including the multiple tobacco use behaviours?

- What level of reduction in harmful and potentially harmful constituents results in decreased disease risk?
- What is known about the evidence of short-term and long term intakes of toxicants comparing smokers of filtered and unfiltered cigarettes (using cellulose acetate filters)? What is known about smoker perceptions of the impact of filters on cigarette harmfulness?

ARTICLE 10: REGULATION OF TOBACCO PRODUCT DISCLOSURES

- How best might the information released under disclosure (now or in the future) be effectively used to inform the public? What are the risks, unintended consequences and benefits of potential approaches?
- How can disclosure be an effective tool to guide/drive/boost other interventions (in particular product regulation)? How can policy makers use the information provided under disclosure arrangements to develop more effective regulatory models? What are the top priorities for using the information obtained via disclosure?
- What is the impact of different formats for listing tobacco constituents on the public's understanding of harmful and potentially harmful constituents? This research priority requires first understanding what Australia's goals for communication are (what do you want the public to understand)? Does the format influence understanding among individuals from vulnerable subpopulations (e.g. Aboriginal and Torres Strait Islander people; less numerate or less health literate populations)?
- Aside from studies of comprehension, how do different formats for communicating tobacco constituents ultimately influence downstream processes such as tobacco-related beliefs, intentions, product/brand selections and smoking behaviours?
- What is the purpose of individual tobacco ingredients? What system and processes should be put in place and followed to see if there is a secondary purpose or hidden primary purpose to tobacco ingredients (e.g. a 'processing aid' that in reality is a flavouring agent). How should a disclosure regime check that the information disclosed by tobacco companies is accurate?
- What is the best way to communicate with the public about cigarette ingredients and emissions, while ensuring that these efforts do not contribute to an increase in false beliefs among the population and vulnerable groups about reduced harmfulness of some tobacco products? For example, what is the best way to communicate with the public about regulatory or policy approaches that seek to influence the attractiveness, addictiveness and toxicity of cigarettes, while at the same time not discounting the risks of smoking tobacco itself?
- What is the best approach to ensure ingredients and engineering features of e-cigarettes are disclosed to governments and/or the general public? How should a disclosure regime check that the information disclosed by companies on e-cigarettes is accurate?
- To what extent, and/or under what circumstances, does branding information (such as the use of descriptive brand variant names) influence the comprehension and use of different formats for listing potentially harmful tobacco product constituents?

ARTICLE 11: PACKAGING AND LABELLING

- What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable high prevalence population subgroups in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (incl. perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?
- What tobacco marketing, pricing, brand variant and product variation strategies are used by tobacco companies to attempt to reduce the impact of plain packaging and larger pictorial health warnings? What marketing strategies are used by the tobacco companies to reduce the impact of plain packaging – for example creative naming of brands or brand variants, price discounting, use of social media and public relations activities?

- Under the policy of plain packaging, what is the impact on Australian smokers and young people of potentially misleading descriptive brand variant names, different pack sizes and stick lengths, as well as potentially more unattractive stick colours?
- What other innovative packaging measures, beyond plain packaging, can be used to communicate risk/cessation messages to consumers, e.g. pack inserts, the use of on-pack Quick Response (QR) barcodes directing the user to available help, on-cigarette health warnings.
- What are the impacts, if any, of plain packaging for other tobacco products?
- How do smokers respond to plain packaging and large graphic health warnings? Do they use strategies to minimize the impact of plain packaging and the large graphic health warnings e.g. attempt to hide cigarette packs or use covers?
- Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a "set" of multiple warnings; what is the optimum rotation period; what are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; what is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?
- Does the impact of plain packaging vary by brand (i.e. major brands versus generics)?
- How effective are various pack modifications in reducing the beneficial impact of plain packaging? Relative to responses to a particular brand in a plain package with no inserts or changes to cigarette papers or descriptive text (i.e. the control stimulus), how do a variety of modifications effect perceptions of harmfulness, expectations regarding product strength and palatability, and appeal of brand?
- What is the effect of plain packaging on new entrants in the tobacco market?
- How long might plain packaging take to have an impact on smoking rates, particularly of young people, and how could this be discerned from the effects of multiple other tobacco control strategies.

ARTICLE 12: EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

- How can digital media (such as online advertising, social media, SMS, interactive games, smartphone applications and expert systems) best engage audiences with tobacco control messages, as well as complement or interact with broadcast media campaigns?
- What is the impact of news media coverage of tobacco issues (volume of coverage, framing of coverage) on population tobacco-related beliefs and behaviours?
- Are mass media campaigns important in terms of relapse prevention? If so, what types of messages are most effective at preventing relapse among quitters (recent or otherwise)? Can advertising reduce the time from first quit attempt to final quit attempt? What are the predictors of reduced relapse in the population?
- What types of messages are most effective at promoting support for (subsequent) tobacco control policies?
- What message strategies are persuasive among indigenous populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Indigenous-specific campaigns, such as the recent "Break the Chain" campaign?
- Which attitudes and beliefs are the best predictors of support for tobacco control policy advancement? What are the community attitudes and perceptions toward (a) the denormalisation of smoking in Australia and (b) denormalisation of the tobacco industry?
- What is the optimal mix of ads focussing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and low-SES smokers? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level?

- When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum Target Audience Rating Points over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?
- What are the immediate and long term impacts of reduced anti-tobacco campaign spending, on the overall population and vulnerable high prevalence population subgroups?
- Do the effects of different types of ads decay at different rates?
- What are the effects of broadcast mass media campaigns when run with and without implementation of key tobacco control policies such as price increases, package health warnings, product regulation, and tobacco marketing bans?
- What are the health risks of new and emerging alternatives to combustible tobacco and how do we communicate these to smokers, the public and regulators, and in an environment where the evidence and regulatory controls are contested by pro- and anti-tobacco interests?
- How can we optimise the reach and effect of mass reach health communications in an increasingly cluttered, complex and evolving media environment? What are the implications for future campaigning on smoking and health, and media planning in particular?
- Australia is one of the few countries in the world contemplating an end to smoking. What does an end to smoking mean for the lay public and broader public health community? What might the transition to a largely non-smoking Australian population look like? How do we build understanding, support and create a greater sense of urgency and shared responsibility about what might be possible?

ARTICLE 13: TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP

- In what ways does the tobacco industry continue to promote itself and its products (advertising/promotion/sponsorship) in Australia? What activities does it undertake, what is the total expenditure, and what legal/regulatory measures might be needed to obtain this information?
- What incentive schemes are provided to retailers to encourage them to sell tobacco products or to sell particular tobacco products? What legal/regulatory measures might be needed to obtain this information?
- In the absence of little branding on cigarette packaging, how important is price on brand selection?
- What impact does trade-based advertising and promotions have on consumer tobacco brand choices?
- Where have young adults seen or heard about tobacco brands? What brands are young people smoking and how are the identities of these brands being maintained in a ‘dark market’ like Australia?
- What impact is the marketing of alternative nicotine delivery systems (ANDs) (including e-cigarettes) having on the consumption of conventional tobacco products? How does the marketing of ANDs (including e-cigarettes) interact with the marketing of conventional tobacco products?
- What is the nature and extent of young people’s exposure to cross-border tobacco marketing in Australia (as well as to tobacco portrayals and brand communication that may be independent of the tobacco industry), including on the internet and through social media? What is the impact on smoking attitudes and behaviours of such exposure?
- How do young people’s perceptions of smoking, smokers and ‘youth’ tobacco brands develop as plain packaging is introduced? What is the relationship between these perceptions and smoking susceptibility? How do young people perceive the tobacco industry (e.g. measures of credibility, sympathy to key messages and arguments)?
- What types of tobacco promotion persist in Australia (e.g. price boards, promotion through digital media and social networking, internet sales, reward schemes) and what is the impact on consumption? Are there any differences between states and territories who have taken action to restrict these remaining forms of promotion?

ARTICLE 14: DEMAND REDUCTION MEASURES CONCERNING TOBACCO DEPENDENCE AND CESSATION

- Has smoking cessation really "stalled" in Australia, or does the apparent levelling off in the proportion of adults who are former smokers reflect the combined impact of (1) a growing cohort of never-smokers who could never quit to become former smokers; and (2) deaths among smokers?
- Have Australia's smokers "hardened" i.e. are today's smokers smoking more cigarettes than on average in the past; do a greater proportion of smokers smoke within 30 minutes of waking than in the past; has the ratio of daily to less than daily smokers changed?
- Does the experience of quitting match the anticipated experience of quitting i.e. do smokers who quit find the experience easier, harder or about as expected?
- Are smokers who use nicotine replacement therapy, bupropion, varenicline and other pharmacotherapies more likely to remain abstinent than those who quit without medications in the 'real world', when used outside of the clinical trial situation?
- Are smokers properly informed about the effects of and proper use of medications? Would correcting misperceptions facilitate quitting? Do smokers equate stop-smoking medications with other medications, which often solve the problem simply by taking the pill?
- What progress is being made in quit proportions over time in Australia? Does this differ by state and territory? To what extent do tobacco control policies explain any differences?
  **the proportion of people who have quit out of all those who have ever smoked.*
- What are the most effective approaches to encourage and support vulnerable high prevalence sub-populations to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can they be minimized?
- What is the potential of various alternative forms of nicotine (in particular e-cigarettes) to act as long term substitutes for the much more harmful cigarette smoking, rather than being used as short term cessation aids among people who have had a long history of unsuccessful quitting?
- What are the most appropriate methods for rapidly assessing the potential of evidence-based smoking cessation interventions for priority high-prevalence sub-populations?
- What are the critical factors that influence relapse and do they vary by length of time quit? Are there any differences in outcomes between spontaneous quitting attempts and planned quitting attempts?
- Are there any additional benefits associated with cessation approaches that tailor cessation assistance to the needs of the individual, rather than taking a one-size-fits-all approach?
- What is the relationship between financial stress and depression and smoking cessation? Do these factors influence successful quitting behaviours and what interventions are likely to be effective?

ARTICLE 15: ILLICIT TRADE IN TOBACCO PRODUCTS

- What are the best methods and models for estimating the magnitude, forms and causes of illicit trade activities related to tobacco products?
- Is it possible to articulate an 'optimal level' of illicit trade in Australia?
- What, if any, laws, policies and/or programmes would need to be introduced/changed in order for Australia to implement the draft FCTC protocol on illicit trade?
- How best (if at all) can we determine the extent of use in Australia of branded cigarettes which carry health warnings and otherwise appear to be genuine, but on which neither excise nor customs duty has been paid?

- What is the source of cigarettes used in illicit trade (i.e. cigarettes where duty has not been paid rather than counterfeit cigarettes)? Where were they manufactured and by which tobacco companies? Are there links to organized crime?
- Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?
- What does the British experience and experience from other consumer fields tell us about feasible and potentially effective deterrents against retailers selling illicit tobacco products?

ARTICLE 18: PROTECTION OF THE ENVIRONMENT AND THE HEALTH OF PERSONS

- What are the best methods and models for developing a comprehensive approach for butt waste mitigation in Australia?
- What are the environmental and human health consequences of butt waste deposition?
- Could a case be made to remove the cellulose acetate filter from commercial cigarettes in order to reduce the quantity of tobacco product waste in the environment?
- What would be the potential public health and environmental impact of a biodegradability standard for cigarette filters?
- What might be the impact of a 'deposit' or 'abatement fee' for cigarette butts levied on manufacturers to defray costs of cleanup and environmental impact?
- What level of support might stakeholders (smokers, non-smokers, industry, government) show for such filter policies, assuming the predicted impacts are significant?
- What has been the impact of the reduced cigarette ignition propensity standard on smoking materials fire incidence?

ARTICLE 19: LIABILITY

- Would it be legally feasible to bring 'cost recovery' litigation against the tobacco industry in Australia? If so, who would be the appropriate applicant/s? Would cost recovery litigation require the enactment of any legislation, regulations or rules, and, if so, of what kind and by whom? What criteria might be applied to determine whether cost recovery litigation would be a worthwhile undertaking in Australia?
- In what ways could cost recovery litigation be conducted in Australia – how could it be funded and who might be best placed to undertake it? What are the possible benefits and risks of undertaking cost recovery litigation in Australia, and what is a realistic timeframe for its conduct?
- Is the use of certain descriptors and brand variants by the Australian tobacco industry e.g. 'smooth' and 'gold' misleading and deceptive or likely to mislead or deceive within the meaning of section 18 of the Australian Consumer Law?
- Is it feasible to create an effective, and constitutionally valid, tobacco specific liability regime in Australia at State and/or Federal level that:
  - Recognises the right of governments and private health insurers to sue tobacco manufacturers to recover tobacco related health care costs and sets out rules for the calculation of such losses.
  - Modifies the cost rules (especially the loser pays rule) to prevent the tobacco industry from using the threat of adverse cost orders to deter litigation or force claimants to drop their claims.
  - Makes it easier for individual victims of smoking related disease to bring their claims to court, and obtain compensation.
- What resources and infrastructure would be most effective to support and/or co-ordinate Australian and international efforts in tobacco litigation by governments and individuals? How could such an infrastructure be provided and funded?

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

- What is the impact of national mainstream, national Indigenous-specific and local Indigenous specific social marketing campaigns on Indigenous smokers' quit intentions, quit attempts and successful cessation?
- What is the impact of smoke free laws and rules (public places, health services, Aboriginal organisations, cars, events) on Indigenous exposure to second-hand smoke and Indigenous smokers' quit intentions, quit attempts, tobacco consumption and successful cessation?
- What is the impact of raising the price of cigarettes and tobacco (through tax increases) on Indigenous smoking prevalence, consumption, cessation and initiation?
- What is the incidence and what are the health implications of tobacco chewing in Australia, particularly among Aboriginal and Torres Strait Islander populations? What additives, such as bark ash, are used and what are the health and addiction implications of both tobacco chewing and the additives?
- Why is it that some Aboriginal and Torres Strait Islander people never take up smoking or are able to quit successfully despite often living in circumstances where the vast majority of their family and peers smoke? What is it about these individuals and their environment that support being a non-smoker or never-smoker? Are there attributes of the individuals' coping mechanisms that could be learned by others? How might their experiences inform new approaches to communicating with Aboriginal and Torres Strait Islander people about smoking?
- What are the most effective ways that Aboriginal leaders and tribal authorities can be supported by health organisations to progress towards smoke free remote communities (e.g. workable bans on tobacco sales; feasible bans on having any tobacco products in certain remote towns and rural areas)?
- Are the interventions to address smoking addiction applicable for chewers of commercial tobacco and/ traditional tobaccos?
- What is the reach and effectiveness (short and long term) of social media strategies (i.e. smart phone apps, Twitter and Facebook) to communicate health messages to Aboriginal and Torres Strait Islander people? Are there any unintended barriers or consequences (for example high download costs for people living in rural and remote areas), and if so, how can these be overcome?
- What works in targeting smoking and chewing of tobacco by Aboriginal and Torres Strait Islander youth?
- What are the most effective approaches to reduce tobacco use and exposure to second hand smoke among Aboriginal and Torres Strait Islander peoples in the justice system? What is the most effective way to support these individuals to remain quit once they leave prison?
- What message strategies are persuasive among Indigenous populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Indigenous-specific campaigns, such as the recent "Break the Chain" campaign?
- Are Aboriginal and Torres Strait Islander smokers more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policies?
- Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a "set" of multiple warnings; what is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; what is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population and Aboriginal and Torres Strait Islander peoples in relation to these issues?
- What is the impact of plain packaging on Aboriginal and Torres Strait Islander smokers in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (including perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

- What are the exposure levels of Aboriginal and Torres Strait Islander children (by age) in the home – measured by e.g. PM2.5 (airborne smoke particles in the home) and children's salivary cotinine? Who are the main sources of this exposure?
- What tobacco industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among Aboriginal and Torres Strait Islander smokers?
- In the Australian setting, what are the specific health benefits of raising tobacco tax for Aboriginal and Torres Strait Islander smokers (in terms of lower uptake of smoking and increased quitting), relative to any increased economic hardship (for those who neither quit nor reduce their tobacco consumption)?
- Are there any unintended consequences of anti-tobacco mass media campaigns on Aboriginal and Torres Strait Islander peoples (especially smokers)?
- What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and second hand smoke exposure among Aboriginal and Torres Strait Islander children and adults compared to the general population?

DISADVANTAGED GROUPS

- In the Australian setting, what are the specific health benefits of raising tobacco tax for disadvantaged populations (in terms of lower uptake of smoking and increased quitting), relative to any increased economic hardship (for those who neither quit nor reduce their tobacco consumption)?
- What is the scope for making smoke free area laws more effective, especially in deprived communities?
- What are the levels of tobacco smoke exposure in prisons? What are the barriers and facilitators to creating smoke-free prisons, including prisoners' and prison staff's experiences of and views on smoking in prison?
- What is the relative cost effectiveness of local advertising (billboards, bus shelters etc.) versus direct marketing (electronic vs. paper-based mail vs. personal detailing) to doctors to increase referral to Quitline and prescription of NRT specifically to people living in very low SES (lowest decile of index of social disadvantage) neighbourhoods?
- Could financial incentives delivered via community bank savings accounts be a cost-effective strategy for increasing school retention and reducing smoking uptake in highly disadvantaged communities in non-metropolitan areas?
- What is the effect on 'quit attempts' and 'amounts smoked' of welfare workers (simply) asking about smoking status ('how many cigarettes do you smoke each day?) whether the person has tried to quit in the last three months, and interest in getting help quitting ('are you interested in getting a bit of help with quitting?') and providing a brochure (and in a sub-sample organising a call from Quitline)?
- What proportion of prisoners quit and to what extent do remaining smokers cut down following the introduction of smoke-free prisons in the NT (perhaps using a WA or Qld control group)?
- What proportion of people living with psychotic illness have been prescribed NRT patches since PBS listing in January 2011 (could question be inserted in triennial Australian national survey)? Does use of NRT patches increase the odds of quitting among those with mental illness in a real-life setting? Does the provision of NRT gum increase the odds of quitting among those with a mental illness who call the Quitline or participate in quit groups, both among those also using patches and those not?
- What is the impact of a rise in tobacco excise on the smoking behaviour and financial stress of population groups experiencing multiple disadvantage e.g. clients of social and community service organisations?
- How can we best obtain reliable smoking prevalence data over time for the groups experiencing multiple disadvantage?

- What is the impact of financial incentive programs on smoking behaviour, including quit attempts and cessation, among the most disadvantaged population groups? To what extent would the provision of financial incentives through the social security system be an effective means of encouraging quit attempts among very disadvantaged smokers?
- What are the social network factors that most impact on smoking uptake and quitting smoking among disadvantaged populations? How can social networks among disadvantaged groups be employed to de-normalise smoking, discourage uptake and encourage quitting?
- What is the optimal way to develop a national smoking prevalence monitoring or surveillance system among groups with multiple forms of disadvantage i.e. highly socially disadvantaged.
- What are the reasons underlying Quitline underutilisation amongst socially disadvantaged groups?
- Are there any unintended consequences of anti-tobacco mass media campaigns on some disadvantaged groups (e.g. people with psychosis and people with other substance abuse problems, those with low health literacy)?
- What is the most effective approach to changing the behaviour of health professionals and social service organisations to ensure they can appropriately address smoking amongst socially disadvantaged groups?
- How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?
- Is a cigarette tax increase (not the total tax) regressive, proportional, or progressive? That is, do enough more low-income smokers quit or reduce their daily consumption than do high-income smokers that the relative burden on the low-income population declines?
- What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among low-SES smokers?
- What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home), children's salivary cotinine? Who are the main sources of this exposure?
- What are the levels of tobacco smoke exposure in prisons, non-smoking prisoners and non-smoking prison officers - measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners' and prison staff's experiences of and views on smoking in prison?
- What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and second hand smoke exposure among children and adults, particularly from more disadvantaged populations?
- What combination of individual/household level interventions and population-based policies (mass media, other smoke free policies in other settings, community based interventions etc.) are most effective at reducing smoking in homes, particularly among disadvantaged populations?
- What is the impact of smoke free home policies on health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc.) especially in disadvantaged populations?
- What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable high prevalence population subgroups in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (incl. perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

- Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a "set" of multiple warnings; what is the optimum rotation period; what are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; what is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?
- What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and low-SES smokers? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level?
- When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum TARPs over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?
- What are the immediate and long term impacts of reduced anti-tobacco campaign spending, on the overall population and vulnerable population subgroups?
- What are the most effective approaches to encourage and support vulnerable high prevalence sub-populations to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can they be minimized?
- What are the most appropriate methods for rapidly assessing the potential of evidence-based smoking cessation interventions for priority high-prevalence sub-populations?
- Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?

SUBMISSION FORM

Name: _____

Organisation: _____

Mailing Address: _____

Phone: _____

Email: _____

DO YOU THINK THE RESEARCH QUESTIONS IDENTIFIED IN THIS REPORT ARE IMPORTANT AND RELEVANT FOR TOBACCO CONTROL IN AUSTRALIA OVER THE COMING DECADE?

Yes No Somewhat (please circle one)

Why? / Why not?

DO YOU THINK THE RESEARCH QUESTIONS IDENTIFIED IN THIS REPORT ARE COMPREHENSIVE IN SCOPE?

Yes No Somewhat (please circle one)

Why? / Why not?

WOULD YOU LIKE TO COMMENT ON THE RESEARCH QUESTIONS RELATING TO ANY SPECIFIC ISSUE?

- ☐ Article 5.3 Tobacco industry interference
- ☐ Article 6 Price and tax measures
- ☐ Article 8 Protection from exposure to tobacco smoke
- ☐ Article 9 Regulation of tobacco
- ☐ Article 10 Regulation of tobacco product disclosures
- ☐ Article 11 Packaging and labelling
- ☐ Article 12 Education, communication, training and public awareness
- ☐ Article 13 Tobacco advertising, promotion and sponsorship
- ☐ Article 14 Demand reduction measures concerning tobacco dependence and cessation
- ☐ Article 15 Illicit trade in tobacco products
- ☐ Article 18 Protection of the environment and the health of persons
- ☐ Article 19 Liability
- ☐ Aboriginal and Torres Strait Islander peoples
- ☐ Disadvantaged groups

WOULD YOU LIKE TO COMMENT ON THE PROCESS AND HOW IT COULD BE IMPROVED?

promoting a healthy australia

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NATIONAL PREVENTIVE HEALTH
RESEARCH STRATEGY 2013-2018

ANNEX B

A PRIORITY-DRIVEN RESEARCH AGENDA FOR OBESITY PREVENTION

April 2014

promoting a healthy australia

Australian Government
Australian National Preventive Health Agency

Government of Western Australia
Department of Health

promoting a healthy australia.

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CONTENTS

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- Ms Jane Martin Executive Manager, Obesity Policy Coalition who was a member of the project working group
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- Members of the Agency's Expert Committee on Obesity
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- Ms Kate Purcell, of Purcell Consulting, who was commissioned to develop the research agenda on behalf of the Agency
- Ms Sharon Allen and Ms Meriel Schultz who provided analysis, support and review throughout the project
- Ms Tess Winslade, Assistant Director, Obesity Policy for the Agency who managed the project

FOREWORD

The *Priority-driven Research Agenda for Obesity Prevention* is an initiative of the Australian National Preventive Health Agency (the Agency) and the Government of Western Australia (WA), Department of Health.

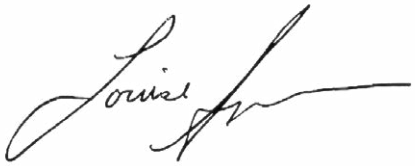
One of the greatest public health challenges confronting Australia and many other industrialised countries is the obesity epidemic. Australia is one of the most overweight developed nations, with 63 per cent of adults and one in four children overweight or obese.

The physical environment, economic factors, laws, policies and social and cultural attitudes all influence how much exercise we get and the types and quantities of foods we eat. The complexity and multitude of these influences means there is no single or simple solution to the obesity problem.

This strategic policy research agenda for obesity prevention, encompassing obesity, physical activity and nutrition priorities, has been developed through a consensus-based process. The report is also an annex to the Agency's *National Preventive Health Research Strategy 2013-2018* which aims to foster Australia's capacity to carry out applied research to enable evidence-informed activities by governments, health care systems, individuals, and by civil society and private organisations in the area of preventive health.

Australian and international obesity prevention experts participated with us to identify research questions that are relevant and important to inform future obesity prevention policies, address Australia's knowledge gaps, and develop a shared national agenda.

We would like to acknowledge the collaborative and consultative approach that was undertaken to develop this agenda and the valuable contribution of many researchers working in obesity prevention. This document will be a useful resource to guide future strategic obesity prevention-related research activity.



Louise Sylvan
Chief Executive Officer
Australian National Preventive Health Agency

Prof. Tarun Weeramanthri
Executive Director, Public Health and Clinical Services
Department of Health, Government of Western Australia

BACKGROUND

One of the greatest public health challenges confronting Australia and many other industrialised countries is the obesity epidemic. Australia is one of the most overweight developed nations, with almost two thirds (63%) of adults and a quarter (25%) of children who are overweight or obese.[1, 2]

Rates of adult overweight and obesity have increased in Australia over the past three decades and show no signs of abating.[3] The prevalence of obesity is higher among lower socioeconomic and disadvantaged groups,[4] Aboriginal and Torres Straight Islander peoples,[5] people with disabilities,[6,7,8] people living in rural or remote areas[4] and some overseas-born populations.[9,10]

There is overwhelming evidence that health problems associated with overweight and obesity are a significant cause of preventable ill health in Australia today. High body mass increases the risk of a number of serious health conditions, particularly high blood pressure, coronary heart disease, stroke, type 2 diabetes, joint problems, sleep apnoea, psychosocial problems and some cancers.[11]

Among children, obesity is associated with a higher likelihood of becoming an obese adult as well as an increased risk of premature death and disability. In addition to increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects.[12,13]

The physical environment, economic factors, regulations, policies, and social and cultural attitudes all influence the level of exercise and the types and quantities of food consumed.[14] Given the complexity and multitude of these influences, this means there is no single or simple solution to the obesity problem.

Modern societies are frequently described as obesogenic environments that increasingly promote a high energy intake through food and also reinforce sedentary behaviours.[14,15] Physical activity and dietary behaviours are influenced by factors across multiple domains, including the individual, social, physical and policy realms. As a result, comprehensive, multi-level approaches are required to address obesity.[15]

Turning the tide of obesity will depend on a willingness to try innovative approaches and to set a priority-driven agenda for research that has the potential to inform and develop the evidence base and accelerate necessary policy changes and investment in interventions.[3]

The purpose of this report

This report sets out a priority-driven research agenda for obesity prevention policies in Australia. This project has been undertaken by the Agency and the Department of Health WA as part of their roles in supporting effective obesity prevention in Australia.

The obesity prevention research agenda is potentially very wide in scope, encompassing many important issues; however this project focuses on research that is most relevant to obesity prevention policies for the coming decade.

Around 25 years ago, the National Health and Medical Research Council (NHMRC) called for a greater emphasis on priority-driven research in the health sector. The NHMRC defined priority-driven research as: strategic development and evaluation research that contributes directly, in the short to medium term, to population health and the effectiveness, efficiency and equity of the health system.[17]

In 1999 the Australian Cancer Society and the Heart Foundation initiated a consensus process to develop Australia's first priority-driven research agenda for tobacco control. In 2012, the Agency co-ordinated the development of an updated priority-driven research agenda for tobacco control.

Following the release of the tobacco research agenda, the Agency partnered with the Department of Health WA to develop a policy research agenda for obesity prevention summarised in this report. The Department of Health WA had previously commissioned Curtin University to undertake some preliminary scoping of the obesity prevention policy research agenda and identify frameworks for a similar project. The Agency has also developed a priority-driven research agenda for the prevention of alcohol related harm.

It is hoped that this document will be a useful resource to guide future strategic obesity prevention-related research activity and funding opportunities.

The aim of developing this priority-driven research agenda was to:

- Define a strategic research agenda that will inform future evidence-based policies for obesity prevention
- Enhance the national research capacity to respond in a focused and timely fashion to emerging obesity prevention policy research needs
- Foster a shared understanding between policy makers, advocates and researchers about policy research priorities in obesity prevention and encourage linkages between these groups.[18]

Policy context for obesity prevention

Obesity prevention has been identified as a national priority by the Council of Australian Governments (COAG). Commonwealth, state and territory, and local governments are implementing a range of strategies to encourage and motivate Australians to adopt healthy behaviours.

The National Partnership Agreement on Preventive Health (NPAPH) was announced by COAG on 29 November 2008. On 28 June 2012, the NPAPH was extended by three years from 2015 to June 2018. The NPAPH aims to address the rising prevalence of lifestyle related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians and includes a focus on settings such as communities, early childhood education and care, schools and workplaces. The NPAPH includes a range of important Commonwealth and state and territory initiatives focused on obesity prevention.

State and territory governments have also developed a range of obesity prevention policy responses in addition to those initiatives that make up the NPAPH. These include mass media campaigns, telephone advice and support programs, healthy school canteens, community programs to promote physical activity and healthy eating, healthy food and drink policies for various settings including workplaces and sporting clubs, kilojoule menu labelling in quick service outlets, urban planning initiatives and active transport programs.

A range of non-government organisations, research institutions and public health groups are also involved in the development and delivery of programs and approaches to reduce overweight and obesity as well as monitoring obesity related trends and undertaking research. Other organisations are involved in awareness raising, community based activities, education and advocacy activities to raise the profile of the issue and advocate for a range of obesity prevention programs and policies to be implemented in Australia.

Methodology

Following agreement between the Agency and the Department of Health WA to establish the project, a working group was formed to guide the development of the project. The working group comprised representatives of the Agency, Department of Health WA, Heart Foundation WA and the Obesity Policy Coalition.

The **first stage** of this project required the development of a framework to guide the generation and organisation of research questions. The framework needed to be relevant to the Australian policy context and appropriate to identify gaps and key research issues for obesity prevention policies. The resulting framework comprised the following domains:

1. Economic interventions
2. Supply, access and availability of food
3. Advertising, promotion and sponsorship
4. Public education, awareness and engagement
5. Packaging and labelling of food
6. Reshaping physical environments
7. Settings and community-based approaches
8. Maternal and child health
9. High risk population groups
10. Emerging issues and cross cutting themes.

The **second stage** of the process required the identification of Australian and international obesity prevention researchers and experts with suitable expertise and research track records who would be prepared to generate research questions. Suitable experts were identified by members of the project working group in consultation with the Agency. These experts were then invited to participate in the project by identifying up to four potential research questions in their particular area of expertise that they believed were the most important priorities for Australia. A briefing paper was prepared to explain the framework and provide an overview of the relevant issues as well as clarify the scope of the issues to be covered under each domain. To assist in the ranking process, experts were asked to ensure that research questions were very specific, rather than too general or broad brush. Fourty-six of the 67 researchers/experts generated questions for the research agenda. A list of these researchers is provided at Attachment 1.

The generation of research questions was undertaken in July-August 2013. Once the experts submitted their research questions for each of the relevant domains, the questions were reviewed by the consultants and the project working group. Some questions were merged or deleted to reduce duplication and others were amended to ensure greater clarity, or relevance to the Australian context. Authors of the research questions were also consulted about proposed changes to their questions. Gaps were identified by the project working group and some additional questions were generated by researchers and the consultant in relation to these issues. The shortlist of questions and their accompanying rationales were reviewed and approved for distribution by the project working group and some members of the Agency's Expert Committee on Obesity.

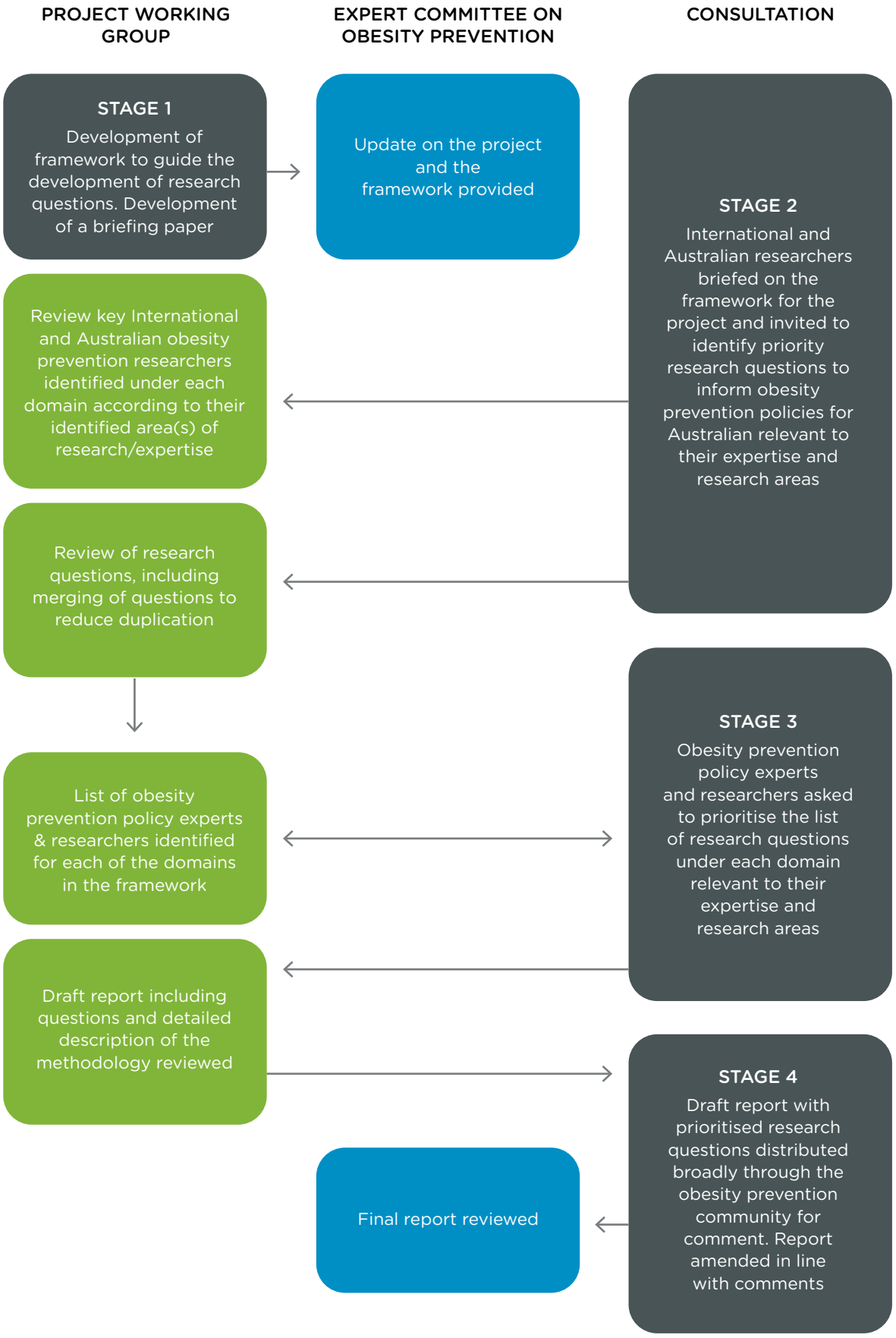
The **third stage** involved developing a list of Australian and international experts in obesity prevention to rank the research questions. The obesity prevention experts from research institutions, government and non-government organisations were approached and asked to rank research questions relating to the various domains according to their identified area of expertise. Of the 83 Australian and international obesity prevention experts approached to participate, 58 participated in the final ranking exercise (Attachment 2). Each participant was asked to read a short document that listed the proposed research questions for their relevant domain(s) and a brief rationale provided by the research experts during the second phase. They were then asked to rank their top five questions in terms of their relevance and importance to the development of Australian obesity prevention policies for the next 10 years. They were asked to rank the research questions for the relevant domain on a scale of 1-5, with 1 being the highest priority of the top five questions and 5 being the lowest priority of the top five questions.

Once the questions were ranked by the experts, a score was assigned based on each ranking. A ranking of 1 received a score of 5, while a ranking of 2 received a score of 4 and so on down to a ranking of 5 which received a score of 1. It was originally planned to present only the top five questions overall, however discussion and feedback with some participants in the process and the project working group suggested that there may be value in presenting the top questions for each domain. The Results area of this report provides a summary of the research questions judged to be most important and relevant to inform obesity prevention policies.

The release of the draft report for consultation represented the **fourth stage** of the project. This stage involved consultation with representatives of a broad range of obesity prevention representatives from the Commonwealth, and state and territory governments and non-government organisations such as Cancer Councils, the Heart Foundation, the Obesity Policy Coalition, the Australian Medical Association, peak Aboriginal and Torres Straight Islander organisations, national working groups and committees, and other peak bodies with a public health interest and role in obesity prevention.

The feedback provided on the draft report was generally very positive. However several respondents raised concerns about the overlap and duplication of some research questions that remained and a few gaps were identified. Following this feedback, the report was restructured to present a more integrated list of the research questions for each domain where questions have now been organised under key themes. These appear in the Results area of this report.

METHODOLOGY



RESULTS

Overview

This section of the report provides an integrated summary of the research questions judged to be most important and relevant to inform obesity prevention policies.

This report covers a broad range of important obesity prevention policies and programs including economic interventions; supply, access and availability of food; advertising, marketing and sponsorship; packaging and labelling; reshaping physical environments; settings and community-based approaches; maternal and child health; and high risk population groups. It also identifies a number of cross cutting themes relevant to several of these domains as well as emerging issues.

This report does not make judgements regarding the priority or importance of one domain or policy/program area versus another. Rather, it focuses on identifying the most important and relevant research questions for each domain as judged by obesity prevention experts who participated in this process. For each of the domains a list of research questions is presented and is organised under research themes in each of the policy domains. Following the consultation process, a number of research questions were merged or moved to other domains to provide a more cohesive summary of policy relevant research questions for obesity prevention in Australia.

It is recognised that the scope of some of the questions reflect work that is already underway or planned; however their addition reaffirms the importance of the research and the need to continue to grow the evidence base that ultimately informs public policy on obesity prevention.

Domain 1: Economic Interventions

Key issues:

- Economic policies and modelling
- Food pricing, taxes and levies
- Economic subsidies on healthy foods, physical activity and public transport

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Economic policies and modelling

- What would an obesity prevention economic benefits model look like for Australia?
- What data would need to be included in the model to assess the benefits of preventing weight gain in the population across various diseases taking into account avoided mortality and morbidity, cost savings over time and impact on adults, children and adolescents in the short, medium and long term?
- What is the cost effectiveness and the potential consequences (positive and negative, intended and unintended) of implementing economic measures to promote healthy eating and physical activity?
- What might be the cost benefits and disbenefits of taxes on unhealthy food and drinks for the overall population and for priority subgroups? What other benefits should be taken into account when an economic policy is considered as an obesity prevention measure?
- What is the likely impact, in terms of substitutes and compensatory behaviour, when fiscal policies designed to promote healthy eating are assessed within a complete food demand system, using reliable, locally applicable cross-price elasticity data?
- How could a health filter be applied to the existing Consumer Price Index (CPI) as a method of monitoring food costs?

Food pricing taxes and levies

- What is the impact of taxes on 'unhealthy' foods on population level consumption patterns? How do the impacts vary by socio-economic group and other vulnerable population groups?
- What is the most appropriate mechanism (e.g. excise tax, changes to GST) to implement a tax on 'unhealthy' foods?
- How can taxes on 'unhealthy' foods be implemented to minimise negative distributional effects on low income groups while maximising impact on consumption of unhealthy foods?
- How does price affect food purchasing behaviour? How important is price relative to other determinants such as taste, promotions, convenience or environmental concerns? Which is more important, the price per packet, the price per serving/portion, the price per 100 g, the price per 100 kJ, etc.?
- What are the price differentials between 'healthy' and 'less healthy' foods and diets throughout Australia? How does this price differential affect 'real world' purchases at household level for various groups in Australia?

Economic subsidies

- What would be the impact of subsidies (e.g. 'food stamps') for healthy foods on vulnerable population groups and food consumption patterns for these population groups? What other impacts would this sort of policy have?

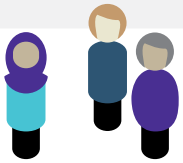
Multi-component approaches

- What is the effect of taxation and subsidy in conjunction with other interventions, as part of a multi-sectoral strategy to improve diets and health?

Domain 2: Supply, Access and Availability of Food

Key issues:

- Access to and availability of healthy food
- Food composition and reformulation



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Food supply

- What is the nutrient/food composition of our current food supply? How is our food system changing over time?
- What incentives and policy levers can influence the various aspects of Australia's food supply in terms of choices made by industry about the production, composition, pricing and sale of food products?
- What are the implications for the Australian food supply of adhering to a dietary pattern consistent with the dietary recommendations in Australia?
- What are the vulnerabilities of the Australian food supply over the next decade with respect to providing, distributing, retailing and consuming food consistent with the dietary recommendations in Australia?

Access to and availability of healthy food

- What are Australians eating? How has this changed over time?
- What is the cost, quality and availability of foods consistent with dietary recommendations in Australia?
- To what extent does the cost and availability of food determine food choice in Australia?
- How does food access and availability interact with intrapersonal characteristics to influence eating behaviours?
- What are the barriers to accessing healthy foods in disadvantaged areas or among disadvantaged groups?
- How can these barriers be overcome?

Food Composition and reformulation

- How effective has the Food and Health Dialogue (and/or other joint government-industry) initiatives been at improving the healthiness of the food supply? Is the Food and Health Dialogue a valuable and effective model for achieving reformulation of food?
- Are there other potentially more effective approaches that should be considered as part of such an approach?
- What are the optimum targets for reformulation of energy, saturated fat and sodium in Australian fast foods that would be achievable within 3 years?

Additional questions suggested to address gaps in this domain (not ranked)

- What is the economic impact on food prices of the freight costs, levies and charges and subsidises associated with food production and distribution, including fresh produce and processed food? Does the price structure of food differ across major cities, regional, and remote areas and is there a link between food price and health outcomes?

Domain 3: Advertising, Promotion and Sponsorship

Key issues:

- Sponsorship, promotion and marketing strategies used by the food industry
- Exposure of children to television advertising for unhealthy foods

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Policy and Regulatory Approaches

- What impact would different policy instruments (e.g. regulations, co-regulation, limit of tax deductions for unhealthy food promotion, buy-back of sponsorship) have on the level of exposure of children to 'unhealthy' food promotions? Which model that would be most effective in reducing children's exposure?
- What are the criteria that should be applied consistently across food industry marketing activities to reduce children's exposure to unhealthy food marketing? How can policy provisions best be structured to achieve consistency between industry groups?
- What are the standard metrics needed for monitoring the effectiveness of policies to reduce marketing and how can these be integrated into research studies?
- What is the cost-effectiveness of policy interventions to reduce food and beverage marketing to children through multiple forms of media (with impact assessments incorporating the loss of quality of life associated with an unhealthy diet and overweight/obesity)?

Exposure to food sponsorship, promotion and marketing

- To what extent are children exposed to food marketing over the course of a day? Which mediums and types of promotion techniques are children exposed to most? Does this vary by age?
- What is the ongoing pattern of Australian children's exposure to food marketing across multiple media?
- What is the impact of this exposure in terms of children's perceptions, attitudes and beliefs toward advertised food and drinks and food consumption patterns?
- To what extent has this changed as a result of industry self-regulatory actions?
- What is the share of marketing spend and volume of promotion of unhealthy food (including marketing to children) across media platforms and by product, including through sponsorship of sports that children and adolescents play and those that they support?
- What is the nature and scale of digital (on-line) food promotion in Australia? What is the exposure of children, young people and the general population to digital food promotion? What impact does this exposure have on attitudes, beliefs and consumption of food among children, young people and the general population?

Additional questions suggested to address gaps in this domain (not ranked)

- To what extent are adults, parents and vulnerable populations exposed to food marketing (both long and short term)? What types of media and promotion techniques are used? What is the impact in terms of perceptions, attitudes and beliefs toward advertised food and drinks and what is the impact on consumption of these products?

Domain 4: Public Education, Awareness and Engagement

Key issues:

- Comprehensive mass media campaigns to support and motivate lifestyle changes and complement environmental/ policy changes
- Telephone advice and support services
- Health literacy
- Education about nutrition and physical activity guidelines
- Community engagement
- Advocacy

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Mass media campaigns and public education

- Based on our knowledge of the basic science of weight loss, what are the most promising campaign messages/angles available to promote weight loss and maintenance of healthy weight?
- How important is the concept of habit in obesity prevention? What are the positive and negative reinforcers of these habits and can they be influenced by policies and media campaigns?
- What are the most effective ways of framing campaign messages for parents and children?
- How can we optimise the reach and effect of population health communications in an increasingly cluttered, complex and evolving communications environment?
- What are the implications for future campaigning on obesity prevention, and media planning in particular? Are there issues specific to obesity prevention communications and how might these be dealt with?
- Are there any unintended consequences of obesity prevention mass media campaigns/public education? If they are occurring, how can these be minimised?
- Can mass media campaigns/public education about what constitutes overweight challenge social norms and reduce self-exemption from messages about diet and physical activity, thereby facilitating behaviour change?
- What intensity of broadcast media investment (i.e. minimum and maximum Target Audience Rating Points over what duration) is needed for effective obesity prevention campaigns?
- Do different types of advertising executions demand different approaches to media planning for greatest return on investment?
- What is the optimal media weight, placement (media channel and media spot/ schedule) and duration of exposure for a highly emotive television advertisement versus other types of executions?
- Can well funded, professionally implemented and sustained public education programs ‘prepare the ground’ and increase support for obesity prevention policy measures such as tax increases, curbs on industry promotion and marketing?

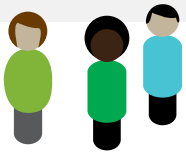
Health literacy

- Would promoting nutrition literacy in relation to packaged foods/evaluating commercial food marketing improve people’s ability to make healthier food choices?
- How is the media contributing to health literacy and misconceptions about obesity? How is it shaping public opinion on obesity, its causes and measures for addressing it?

Domain 5: Packaging and Labelling of Food

Key issues:

- Food labelling systems
- Point of sale signage and/or labelling
- Nutrition and health claims



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Food labelling systems

- What is the impact of the introduction of Health Star Rating labelling on consumer purchasing behaviour and consumption patterns? How useful is the Health Star Rating labelling compared to other front-of-pack systems, such as traffic lights and % Daily Intake (DI)? Which system is most effective in helping consumers to identify healthier options?
- How does the Health Star Rating labelling compete with other aspects of food labelling such as preconceived ideas about brands, price etc., when it comes to making healthier choices?
- What are the most effective public education strategies/campaign messages to increase awareness and use of the new front of pack labelling system by consumers most at risk of diet-related disease?

Food labelling, health claims and reformulation

- What are the reformulation outcomes of food labelling?
- What is the influence of health claims and nutrient content claims and health star rating labels on reformulation?
- What is the time period over which changes occur?
- What influence do health claims and nutrition content claims have on food purchases at point of sale e.g. in the supermarket?
- How do health claims and front-of-pack food labels (FoPL) interact to influence food choices?

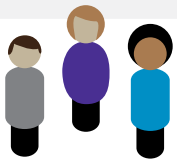
Point of sale signage and/or labelling

- What are the most effective consumer messages when developing and conducting a public education campaign on dietary energy?
- What types of point of sale signage and messages are most effective?
- How should standard serve sizes for different foods be defined and how can these be developed for use on food labels?
- What is the impact of kilojoule menu labelling in fast food outlets on consumers' consumption? Would full labelling of other risk nutrients (e.g. saturated fat or sodium) in fast food outlets have a greater benefit than kilojoule only labelling? What is the impact of fast food menu labelling on product reformulation?

Domain 6: Reshaping Physical Environments towards Healthy Options

Key issues:

- Urban planning, land use and building design
- Sedentary behaviour
- Facilities for physical activity
- Transport policies and infrastructure
- Food outlet location and density



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Transport policies and infrastructure

- What is the cost-effectiveness and broader effects of promising planning and transport policies on health outcomes?
- What contribution does investment in public transport make to physical activity levels and reducing weight?
- What are the benefits and costs of different mixes of transport investment?

Food outlet location and density

- What types, locations/proximity and density of food outlets are correlated with healthy eating practices (supermarkets, greengrocers, growers markets) and conversely what types and locations/density of food outlet are associated with unhealthy eating? (e.g. corner stores, fast food outlets)

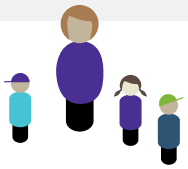
Urban planning, land use and building design

- What is best practice for Australian planners, developers, and other decision makers to orient their thinking toward planning for built environments that support physical activity and healthy eating?
- What methods (including economic) are best suited to explore the health impact of 'natural experiments' and policy change; e.g. evaluating the health and co-benefits of transport infrastructure changes e.g. rapid transit, extended rapid bus routes, the health benefits (or not) of building new suburbs, different planning regulation etc.?
- What aspects are most effective in 'retrofitting' existing suburbs to increase recreational and transport-related physical activity?
- What are the barriers and facilitators within government and the private sector, that prevent the uptake of evidence to create higher density walkable mixed use urban environments?
- Based on established guidance such as that in Healthy Spaces and Places, what is the relative contribution of selected design features in increasing population levels of physical activity (e.g. walkability, public open space, density, mixed use, co-location etc.), and what are the associated co-benefits, e.g. reduced vehicle kilometres travelled, reduced traffic congestion, economic benefit, increased social capital?
- How and for whom do environmental features/conditions/modifications promote physical activity and healthy eating? How do features of the physical environment interact with intrapersonal characteristics to influence physical activity and eating behaviours?
- What impact does living in high density housing have on the physical activity levels of children, and how could the design of higher density housing be enhanced to improve the physical activity levels of children?

Domain 7: Settings and Community Based Approaches

Key issues:

- Child care settings
- Schools and out of hours school care
- Workplaces
- Communities
- The home



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Communities

- How is existing evidence and experience in preventing obesity at the community level best translated to the large scale of a state or nation?
- What are the impacts of a large-scale (state/territory) approaches to obesity prevention?
- What are the successful implementation elements of community based healthy eating and/or physical activity programs? What are the aspects of scalability of community based healthy eating and/or physical activity programs that ensure they are effective and sustainable?
- How are existing systems operating at the community and settings level best oriented to increase the promotion of healthy eating and physical activity?

Multiple settings

- How can the spread of expertise, ideas, knowledge, enthusiasm etc. be spread better from areas of good progress on obesity prevention to areas of little progress?
- Can simultaneous interventions across several settings generate sufficient demand for healthier food to increase profitability of producing and selling healthy food for the relevant private sector stakeholders?
- If so, do these profits translate into market mediated incentives to sustain the programs?
- How can successful models for interventions in homes and workplaces be integrated into child care or school interventions for maximum effects on obesity prevention in children and adults, including ensuring that effects of programs during academic years are not eroded during the holiday when school is not in session (summer months)?
- What dietary changes have resulted from successful implementation of healthy food supply strategies in government owned premises (schools, workplaces and health settings) in Australia? What is the cost-effectiveness of these approaches?
- How can learnings from these interventions be extended to other settings, including sporting clubs, mining camps etc.?

Childcare

- How can we intervene in childcare settings (crèches and other preschool care settings) to support healthy eating and physical activity during infancy and early childhood?

Workplaces

- What environmental interventions in workplaces, would be most effective in reducing time spent sitting?
- What are the long-term health and productivity impacts of reshaping both the physical workplace environment and organisational cultures/social norms to be more 'movement and standing permissive'?

Home

- What is the most effective approach for engaging with parents and extended family to promote children's physical activity and healthy eating in the home setting?

Schools

- What are the short and long-term health and academic performance impacts in children arising from the reshaping of both the school classroom physical environment and modernising teaching practices/social norms to be more 'movement and standing permissive'?

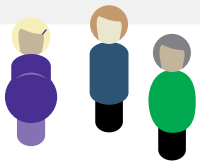
Additional questions suggested to address gaps in this domain (not ranked)

- How effective are systems approaches to changing health behaviours at the population level?
- How effective are systems approaches at improving population health?
- What is the most effective method of operationalising systems approaches?

Domain 8: Maternal and Child Health

Key issues:

- Pregnancy
- Breastfeeding
- Nutrition and early childhood



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Pre-conception and Pregnancy

- What are the most effective ways to improve engagement, awareness, planning and uptake of important evidence based health promotion activities for women and their families from pre-conception through to motherhood?
- How can these best practice approaches be widely implemented?
- What are the most effective approaches for high risk vulnerable populations (including low SES, rural dwelling, refugee and Aboriginal and Torres Straight Islander women)?
- How can we intervene using traditional media, social media or other digital media approaches such as mobile technologies at different life stages to promote healthy eating and physical activity in young women, mothers and children and how effective is this approach?
- How can these approaches be linked to existing health care and/or other family support systems?
- What is the most effective way to implement evidence based lifestyle programs into routine pregnancy care?

Breastfeeding

- How can best practice in increasing breast-feeding and appropriate complementary feeding be widely implemented? What practices in other countries can improve Australia's breast-feeding record?

Early childhood

- Can parents of young children be trained and supported in child-rearing habits that lead to healthy weight in their children?
- What are the 'typical' childhood trajectories of BMI and body composition, and their predictors?
- What role can general practitioners and other primary health care providers play in preventing obesity in children?

Additional questions suggested to address gaps in this domain (not ranked)

- What is the impact of the promotion and monitoring of Baby Friendly hospitals and maternity care – are they working? What gaps, loopholes and barriers do they face? How do mothers perceive them?
- What factors influence a women's decision to breastfeed or bottle-feed? How is this influenced by SES, and by economic and social conditions (such as maternity leave, work-place nursing facilities, public nursing facilities)?
- Is continued breastfeeding undermined by messages from companies promoting formula and weaning/ complementary foods?
- What is the impact and influence of the commercial market for complementary feeding products?
- Do these products support or undermine continued breastfeeding up to 24 months?
- Do food products make recommended serving sizes too large, thereby undermining appetite for breastmilk?
- To what extent do commercial weaning foods aid in the transition to healthy family foods rather than in the transition to highly processed foods (e.g. how is the changing market towards the promotion of baby 'snacks', 'cookies' etc, and the use of dessert flavourings like chocolate, vanilla, or sweetening agents in savoury dishes, affecting children's food preferences)? How aware are parents of these challenges?
- How can the food supply and eating environment of modern society be modified to encourage healthier eating (e.g. more fruit and vegetables and fewer energy dense foods)?

Domain 9: High Risk Population Groups

Key issues

- Low socio-economic populations
- Culturally and Linguistically Diverse Populations
- Aboriginal and Torres Strait Islander peoples
- Young adults
- Remote communities

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Disadvantaged populations

- What are the most effective approaches for preventing obesity in the long-term among socioeconomically disadvantaged groups and why?
- What approaches work to create sustained weight loss among disadvantaged groups and why?
- What is the extent and nature of food and nutrition insecurity in Australia and what are effective interventions and policy responses to reduce food insecurity?
- What are the long-term links between diet, disease, and obesity particularly among disadvantaged groups, as the protective effects and disease development may be over a long period of time?
- What are the social policy options that can improve access to a wide variety of safe, nutritious foods, particularly for disadvantaged groups?
- Which education or other programs are effective in improving healthy living skills in people or their families with low health literacy?
- Which interventions to improve the nutritional quality of the food supply to those in more disadvantaged and culturally and linguistically diverse groups are most effective, feasible, sustainable and able to be scaled up?
- What are the social disparity indicators (including financial stress indicators) for people experiencing overweight and obesity in terms of food, nutrition, physical activity and access to services? What are the food literacy skills and opportunity for skills development for groups vulnerable to obesity?

Remote communities

- Which interventions to improve the nutritional quality of the food supply to those remote and rural areas are most effective, feasible, sustainable and able to be scaled up?

Aboriginal and Torres Strait Islander peoples

- How can the learnings from successful Aboriginal and Torres Strait Islander community-based nutrition intervention projects be extended more broadly to other communities?
- What are the barriers and enablers affecting translation of evidence in Aboriginal and Torres Strait communities and how can these be addressed?

Monitoring systems

- What are the minimum requirements for an ongoing food and nutrition monitoring system to protect the population against obesity and potential chronic disease risk, particularly the most vulnerable?

Additional questions suggested to address gaps in this domain (not ranked)

- Are targeted obesity prevention interventions required for all high risk groups? And where warranted, what is needed that is distinct from what is already on offer?
- What are the specific consumption trends/activity practices/factors that are associated with increases in obesity/unhealthy weight in disadvantaged/priority groups and how are these different from overall population issues (if at all)?
- What are the principles that can most effectively inform culturally appropriate social marketing directed towards Aboriginal and Torres Strait Islander peoples? How should social marketing be presented?
- What are the barriers preventing Aboriginal and Torres Strait Islander peoples from accessing sport and other physical activity programs (e.g. affordability, cultural acceptability, racism etc.)? How can these barriers be overcome? What are the most effective obesity prevention initiatives for late middle-aged and older people?
- What are the potential benefits of obesity prevention initiatives for this group in terms of reduced risk of chronic disease and short and long term economic benefits?
- Retirement is recognised as a major life transition stage linked to overweight and obesity. What are the most effective interventions to promote healthy eating, increase physical activity and reduce sedentary behaviour for retirees?
- Which messages/programs are most likely to be effective during the transition from the workforce to retirement?

Domain 10: Emerging Issues and Cross Cutting Themes

In this domain, researchers and policy experts were invited to contribute specific research questions in relation to emerging issues for obesity prevention, or on those issues that they believe are important and relevant but may not have been covered by the other domains in this framework

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE OBESITY PREVENTION POLICIES

Influence of the food industry on public health policies

- How is the food industry influencing public policy-making?
- What is the extent and nature of food industry engagement with government agencies?
- How can the governance structures be strengthened to ensure that commercial interests are not influencing public policy-making where there are conflicts of interest between commercial and public health outcomes?
- What is the impact (positive and negative) of the actions of the food industry on the healthiness of food environments (composition, price, placement, promotion etc.)?
- What is the extent of food industry marketing, promotional and support activities in Australia – including public relations and lobbying by food companies and associated groups, and legal activities?
- How much is the food industry investing in these activities?
- How does the food industry respond to policy changes including food taxation and subsidies?

Implementation of policies

- What has been (or is being) implemented at the federal and state/territory level from previous and current sets of recommendations (below) and why were (or are) some things implemented and not others (for example NHMRC 'Acting on Australia's Weight', National Obesity Taskforce reports for children and adults, Parliamentary Inquiry on Obesity, Preventative Health Taskforce, Blewett Report, Food and Health Dialogue, National Partnership Agreement on Preventive Health)?
- How is the healthiness of Australia's food environments changing over time and in response to changes in public policies including investment policies and trade agreements?
- What global obesity policy actions are effective and why, and what obesity policy actions are not/have not been effective and why not? What are the implications for Australia?

Trends in dietary intake and physical activity patterns

- What are the current dietary intake and physical activity patterns of Australians (and sub-groups of Australians); how do these compare with current recommendations; and how do these compare with past and (regularly collected) future data? If we can't answer these questions, what systems do we need to put into place to ensure that these questions can be answered in the near future?

Additional questions suggested to address gaps in this domain (not ranked)

- What is the spatial distribution of the prevalence of obesity in Australia?
- What is the spatial variation in the provision of obesity prevention interventions and variations in health outcomes between geographical areas; and
- what are the implications of these issues?

CONCLUSION

Given the multifaceted causes of the obesity problem in modern society, a comprehensive and sustained effort at the population level is required to reduce the prevalence of obesity.

The value and importance of a collaborative consultative approach to research priority settings is well-recognised. The development of a priority-driven research agenda for obesity prevention has the potential to improve the effectiveness, efficiency and equity of obesity prevention policies and programs, and ultimately contribute to improved population health.

This report identifies those research questions judged by obesity prevention experts who participated in the process to be most important and relevant to inform obesity prevention policies over the next decade.

Research should not only generate more knowledge but also help to translate knowledge into action through innovative approaches. It is anticipated that the priority research questions described in this report will be of interest to all those in obesity prevention research, policy and practice. It is hoped that linking future obesity prevention research efforts to the set of priorities developed through this consensus process will concentrate future research efforts, and focus attention on the most policy-relevant questions as well as generating new and important evidence for obesity prevention in Australia and internationally.

LIST OF OBESITY PREVENTION EXPERTS WHO GENERATED THE RESEARCH QUESTIONS

Domain 1: Economic Interventions

Professor Amanda Lee	1
Ms Jane Martin	2
Dr Gary Sacks	3
A/Professor Marj Moodie	4
Professor Boyd Swinburn	5
Dr Anne Marie Thow	6
Dr Mike Rayner	7
A/Professor Tim Gill	8

Domain 2: Supply, Access and Availability

Dr Bridget Kelly	9
Ms Clare Hughes	10
Dr Gary Sacks	10
Ms Jane Martin	10
Ms Kathy Chapman	10
Ms Julie Woods	11
A/Professor Tim Gill	11
Dr Rosemary Stanton	12
Dr Christina Pollard	13
Professor Bruce Neal	14
Dr Corinna Hawkes	15
Ms Angela McDougall	16
Professor Boyd Swinburn	16

Domain 3: Advertising Promotion and Sponsorship

Dr Bridget Kelly	16
Ms Clare Hughes	16
Dr Gary Sacks	16
Ms Jane Martin	16
Ms Kathy Chapman	16
Professor Sandra Jones	17
A/Professor Lesley King	18
Dr Corinna Hawkes	18
Dr Tim Lobstein	19
Dr Mike Rayner	20
Professor Simone Pettigrew	21
Professor Boyd Swinburn	21
Professor Mike Daube	22
Ms Julie Woods	23

Domain 4: Public Education, Awareness and Engagement

Ms Kathy Chapman	23
Ms Clare Hughes	23
Professor David Hill	24
Dr Helen Dixon	25
Mr Maurice Swanson	26
Ms Denise Sullivan	27
Belinda Morely	28
Professor Boyd Swinburn	28

Domain 5: Packaging and Labelling of food

Professor Simone Pettigrew	28
Ms Kathy Chapman	28
Ms Angela McDougall	28
Dr Bridget Kelly	28
Ms Jane Martin	28
Ms Clare Hughes	28

Domain 6: Reshaping the Physical Environment

Dr Christina Pollard	28
Professor David Crawford	29
Professor David Dunstan	30
Professor Billie Giles Corti	31
Professor Rachel Davey	32
Mr Trevor Shilton	33

Domain 7: Settings and Community Based Approaches

Professor Boyd Swinburn	33
Professor David Dunstan	33
A/Professor Lesley King	33
Professor Amanda Lee	33
Professor Jo Salmon	34
Professor Steve Allender	35
Professor Ian Caterson	36
Professor Tony Okely	37
Dr Tahna Pettman	38
Ms Shelley Bowen	39
Dr Siriki Kumanyika	40

Domain 8: Maternal and Child Health

Professor Melissa Wake	41
Professor Colin Binns	42
Dr Helena Teede	43
Professor David Crawford	43

Domain 9: High Risk Populations

Professor Amanda Lee	43
Dr Anna Peeters	44
Professor Kerin O'Dea	45
Dr Christina Pollard	45
Professor Mark Harris	46

Domain 10: Emerging Issues and Cross Cutting Themes

Professor Boyd Swinburn	46
Ms Jane Martin	46
Professor Amanda Lee	46
Professor Ian Caterson	46
Professor David Crawford	46
Ms Denise Sullivan	46
Mr Maurice Swanson	46

LIST OF OBESITY PREVENTION EXPERTS WHO PARTICIPATED IN THE RANKING PROCESS

Professor Steve Allender
Professor Louise Baur
Professor Colin Binns
Ms Patricia Carter
Professor Ian Caterson
Ms Kathy Chapman
Dr Stephen Christley
Ms Megan Cobcroft
Professor David Crawford
Professor Rachel Davey
Professor David Dunstan
Dr Helen Dixon
Mr Jim Dodds
Professor Billie Giles-Corti
A/Professor Tim Gill
Professor Mark Harris
Dr Corinna Hawkes
Professor David Hill
Ms Clare Hughes
Dr Bridget Kelly
Dr Paul Kelly
Professor Lesley King
Dr Rosie King
Ms Sandra King
Dr Siriki Kumanyika
A/Professor Mark Lawrence
Professor Amanda Lee
Ms Sue Leivers
Dr Tim Lobstein
Mr Richard Marson
Ms Jane Martin
Mr Peter McCue
Ms Amanda Mitchell
A/Professor Marj Moodie
Ms Belinda Morley
Professor Bruce Neal
Professor Tony Okely
Professor Tim Olds
Dr Anna Peeters
Professor Simone Pettigrew
Dr Tahna Pettman
Dr Christina Pollard
Dr Mike Rayner
Dr Lyn Roberts
Dr Gary Sacks
Professor Jo Salmon
Mr Trevor Shilton
Dr Rosemary Stanton
Ms Denise Sullivan
Mr Maurice Swanson
Professor Boyd Swinburn
Dr Helena Teede
Dr Anne Marie Thow
Ms Sam Torres
Dr Mark Veitch
Professor Melanie Wakefield
Mr Trevor Webb
Ms Julie Woods

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NATIONAL PREVENTIVE HEALTH RESEARCH STRATEGY 2013-2018

ANNEX C

A PRIORITY-DRIVEN RESEARCH AGENDA FOR

PREVENTION OF ALCOHOL RELATED HARM IN AUSTRALIA

April 2014

promoting a healthy australia

Australian Government
Australian National Preventive Health Agency

promoting
a healthy
australia.

A Priority-driven Research Agenda for Prevention of Alcohol Related Harm in Australia
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CONTENTS

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- Professor Margaret Hamilton, Chair of the Agency's Expert Committee on Alcohol who was a member of the project steering group
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- Members of the Agency's Expert Committee on Alcohol
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- Ms Kate Purcell, of Purcell Consulting, who was commissioned to develop the research agenda on behalf of the Agency
- Ms Sharon Allen and Ms Meriel Schultz who provided analysis, support and review throughout the project
- Ms Kate Murray, Assistant Director, Alcohol Policy and Programs who managed the project for the Agency

FOREWORD

This *Priority-driven Research Agenda for Alcohol* is an initiative of the Australian National Preventive Health Agency (the Agency) – an Australian Government agency committed to supporting the development and implementation of evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol consumption and tobacco.

The *2010 National Drug Strategy Household Survey* reported that about 1 in 5 people drank at levels that put them at risk of harm over their lifetime (more than 2 standard drinks a day on average), and this proportion has remained unchanged since 2007. Daily drinking declined between 2007 (8.1 per cent) and 2010 (7.2 per cent). The proportion of people (28.4 per cent) drinking at least once a month at levels that put them at risk of accident or injury (more than 4 standard drinks in a session) was unchanged between 2007-2010.

The excessive consumption of alcohol is a major cause of health and social harms. For example, heavy alcohol consumption is a major cause of road accidents, domestic and public violence, and crime. Excessive alcohol use may also be linked to drowning, falls and other injuries. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and can contribute to a range of social problems. Alcohol use during pregnancy can cause birth defects and disability, and there is increasing evidence that early onset of drinking during the teenage years leads to a range of both short term and long term risks.

This strategic policy research agenda for the prevention of alcohol related harm was developed through a consensus-based process. The report is an annex to the Agency's *National Preventive Health Research Strategy 2013-2018* which aims to foster Australia's capacity to carry out applied research to enable evidence-informed activities by governments, health care systems, individuals, and by civil society and private organisations in the area of preventive health.

Australian alcohol researchers and alcohol prevention experts participated to identify research questions that were relevant and important to inform priorities for Australia and address Australia's knowledge gaps to develop a shared national agenda.

We would like to acknowledge the collaborative and consultative approach that was undertaken to develop this agenda and the valuable contribution of so many experts in the alcohol prevention field. This document will be a useful resource to guide future strategic alcohol prevention-related research activity and funding opportunities.

Louise Sylvan

Chief Executive Officer
Australian National Preventive Health Agency

BACKGROUND

Consumption of alcohol is widespread throughout Australia and linked with many social and cultural activities. In 2004-05 the cost to the Australian community of alcohol-related social problems was estimated at $15.3 billion; the majority (71 per cent) was attributed to tangible costs such as lost productivity, health, road accidents and crime.[1] Alcohol is a proven causal factor in approximately 60 types of diseases and injuries and contributes to approximately 200 others. Alcohol is also associated with social issues including violence, depression, risky sexual behaviour, adverse behavioural patterns and absenteeism in the workplace.[2]

In 2010, research showed most Australians aged 14 and over consumed alcohol; 47 per cent drank alcohol at least once a week and 34 per cent drank less often than weekly.[3] Daily drinking was most common among males, and males were more likely than females to consume alcohol at risky levels.[3]

Between 1993 and 2007, the daily drinking patterns of people in Australia aged 14 years or older remained largely unchanged, at around 8 per cent. However, between 2007 and 2010, there was a decrease in the proportion of people drinking daily (from 8.1 per cent to 7.2 per cent).

In 2010, 28.5 per cent of the population aged 14 years and over reported they had been victims of an alcohol–related incident in the previous 12 months. Almost a quarter of the population (24.5 per cent) reported they had been victims of verbal abuse, 8.1 per cent reported suffering physical abuse and 14.3 per cent reported being 'put in fear' in the previous 12 months.[3] Despite efforts to curb drink-driving offences, about 13 per cent of recent drinkers admitted to driving under the influence of alcohol.

The *National Alcohol Strategy 2006-2011* aimed to reduce alcohol related harms by focusing on intoxication, public safety and amenity, the health impacts of drinking and the cultural place and availability of alcohol in Australia.[4] A new Alcohol Action Plan is currently in preparation, building on the findings from implementation of the earlier Strategy.

Key strategies during the life of the *National Alcohol Strategy 2006-2011* followed the *National Drug Strategy* three-pronged approach, considering demand for alcohol, supply of alcohol and alcohol-related harm. Responses developed as part of the *National Alcohol Strategy* included reducing the secondary supply of alcohol to minors, consideration of health warning labels on alcohol products, measuring the harms associated with alcohol use (including trends in drink driving deaths and injuries), measuring community perceptions of safety and measuring alcohol related emergency admissions and hospital separations.[5]

In addition, the National Health and Medical Research Council (NHMRC) *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* communicate evidence concerning the health risks that arise from drinking alcohol.[6]

At the international level, the World Health Organization has developed a Global Strategy to reduce harmful use of alcohol,[7] and has produced a draft Global Action Plan for the Prevention and Control of Non-communicable diseases 2013-2020.[8] The Australian policy framework to reduce harmful use of alcohol is consistent with the recommendations of this Strategy.

The purpose of this report

This report sets out strategic research priorities for the prevention of alcohol related harm in Australia. This project has been undertaken by the Agency as part of their role in supporting the prevention of alcohol related harm in Australia.

Around 25 years ago, NHMRC called for a greater emphasis on priority-driven research within the health sector. The NHMRC defined priority driven research as: strategic development and evaluation research that contributes directly, in the short to medium term, to population health and the effectiveness, efficiency and equity of the health system.[11]

The aims of developing this priority-driven research agenda are to:

- Define a strategic research agenda that will continue to inform future evidence-based policies for the prevention of alcohol related harm
- Enhance the national research capacity to respond in a focused and timely fashion to emerging alcohol prevention policy research needs
- Enhance the shared understanding between policy makers, advocates and researchers about research priorities for the prevention of alcohol related harm and encourage linkages between these groups.

Methodology

The **first stage** of this project required the development of a framework to guide the generation and organisation of research questions. The framework needed to be relevant to the Australian policy context and appropriate to identify gaps and key research issues for the prevention of alcohol related harm. The Agency's Expert Committee on Alcohol provided support to develop the framework for identifying research priorities, focused on the prevention of harmful use of alcohol. Consistent with the framing of the current *National Drug Strategy* this framework included seven areas variously related to demand, supply and harm reduction.

These domains include:

1. Economic interventions
2. Advertising, promotion and sponsorship
3. Supply and availability of alcohol
4. Alcohol-related harm in the community
5. Public education, awareness and engagement
6. High-risk population groups
7. Emerging and cross cutting issues.

The **second stage** of the process required the identification of Australian researchers and alcohol prevention experts with suitable expertise and research track records who would be willing to generate research questions. Suitable experts were identified by members of the project steering group in consultation with the Agency. These experts were then invited to participate in the project by identifying up to 4 potential research questions in the domains relevant to their particular area of expertise that they believed are the most important priorities for Australia.

A briefing paper was prepared to explain the framework and provide an overview of the relevant issues as well as clarify the scope of the issues to be covered under each domain. To assist in the ranking process, experts were asked to ensure that research questions were very specific, rather than too general. Of the 53 alcohol researchers and other experts invited to participate, 32 generated research questions for the project. A list of these researchers is provided at Attachment 1.

The generation of research questions was completed in August 2013. Once the experts submitted their research questions for each of the relevant domains the questions were reviewed by the consultants, the project steering group and the Agency. A number of questions were merged or deleted to reduce duplication and others were amended to ensure greater clarity or relevance to the Australian context. Permission was sought from the authors of the questions for these changes. The shortlist of questions and their accompanying rationales were reviewed and approved for distribution by the Agency. Gaps were identified by the project steering group and some additional questions were generated in relation to these issues.

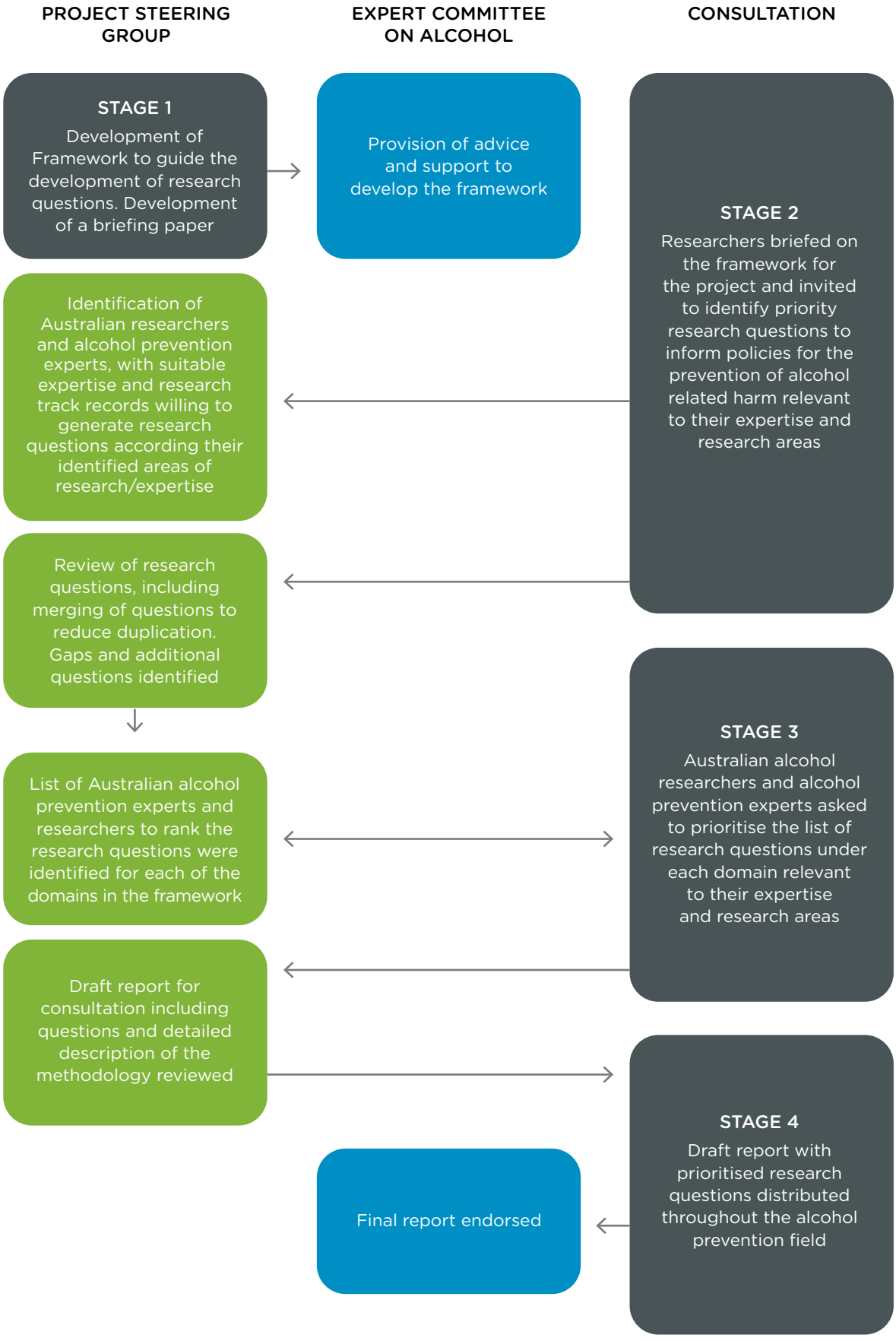
The **third stage** involved developing a list of Australian alcohol prevention experts to rank the research questions. These experts from research institutions, government and non-government organisations were approached and asked to rank research questions relating to the various domains according to their identified area of expertise. All researchers who had submitted research questions in the second stage were included in this list. Of the 36 approached to participate, 24 participated in the final ranking exercise (Attachment 2). Each participant was asked to read a short document that listed the proposed research questions and a brief rationale provided by the research experts during the first phase. They were then asked to rank the questions in terms of their relevance and importance to the development of Australian policies to prevent alcohol related harm for the next 10 years. They were asked to rank the research questions for the relevant domain on a scale of 1-5, with 1 being the highest priority and 5 being the lowest priority.

Once the questions were ranked by the experts, a score was assigned based on each ranking. A ranking of 1 received a score of 5, while a ranking of 2 received a score of 4 and so on down to a ranking of 5 which received a score of 1. It was originally planned to present only the top 5 questions; however discussion and feedback with some participants in the process and the project steering group suggested there may be value in presenting the top questions for each domain. Accordingly, the questions that received the highest scores for each domain are reported in the Results area of this report and were the questions judged by experts in the prevention of alcohol related harm as being the most relevant to informing future policies.

The release of a draft report for consultation was the **fourth stage** of the project. This stage involved consultation with representatives from Australian and state and territory governments and non-government organisations, peak Indigenous organisations and other relevant organisations. The report was also distributed to members of the Agency's Expert Committee on Alcohol and the Intergovernmental Committee on Drugs Alcohol Working Group for comments and feedback.

Following the consultation process, a number of research questions were merged or moved to other domains to provide a more cohesive summary of policy relevant research questions for the prevention of alcohol related harm in Australia.

METHODOLOGY



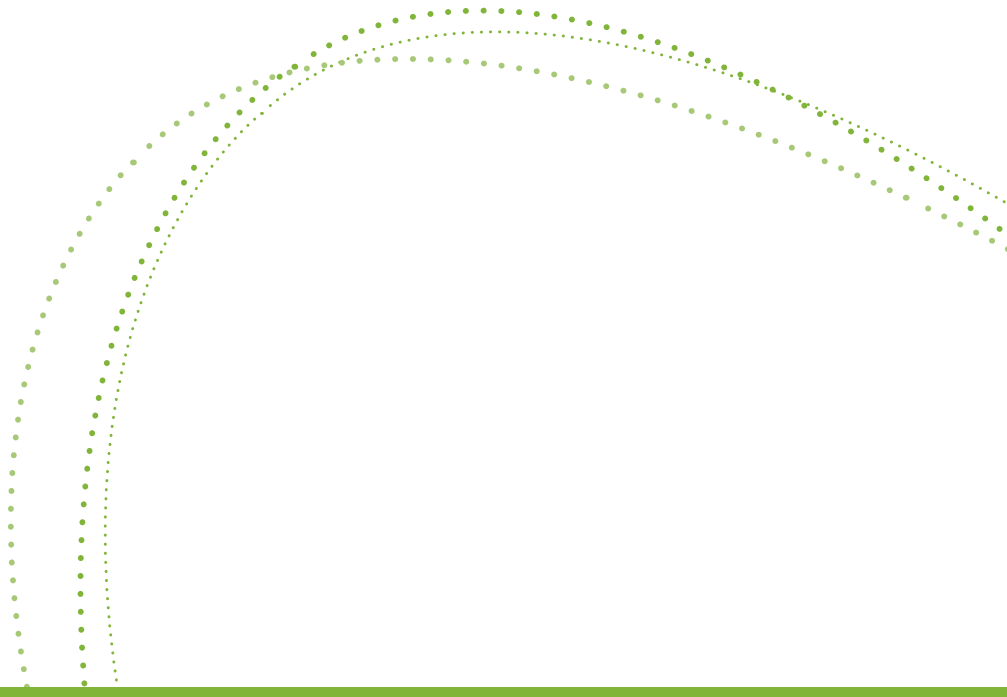
RESULTS

Overview

This section of the report provides a streamlined and integrated summary of the research questions judged to be most important and relevant to inform policies for the prevention of alcohol related harm.

This report covers a range of policy and program areas including economic interventions, systems and policy research; advertising, promotion and sponsorship; supply and availability of alcohol; alcohol related harm in the community; public education, awareness and engagement and high risk population groups. It also identifies a number of cross cutting themes as well as emerging issues.

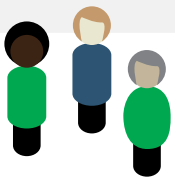
This report does not make judgements regarding the priority or importance of one domain or policy/program area versus another. Rather, it focuses on identifying the most important and relevant research questions for each domain as judged by experts in the prevention of alcohol related harm who participated in this process.



Domain 1: Economic Interventions

Key issues:

- Taxation and price
- Minimum (floor) price
- Cost effectiveness studies



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

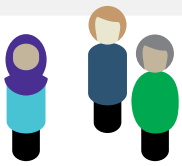
Economic policies and modelling

1. What options for reform of the taxation system are available for reducing alcohol-related harm, and what is the likely impact of each available option on:
   - Overall national levels of alcohol-related harm in Australia;
   - Harms experienced by specific population sub-groups deemed to be at high risk? What are the most effective options for Australia?
2. What impact would price changes in alcohol have on consumption patterns among Australian drinkers?
   - What are the own- and cross- price elasticities of demand for the various alcohol products, differentiated by whether they're sold on- or off-trade?
   - How do the elasticities vary between sub-populations of Australians?
3. For any one specific alcohol policy reform (such as minimum floor price, taxation reform, or restricted trading hours), to what extent will that reform impact on: 1. Abstainers; 2. Light social drinkers; 3. Heavy binge drinkers; 4. Dependent drinkers?
4. What is the cost effectiveness/cost benefit of regulatory restrictions on the supply and availability of alcohol, from a broad community perspective including policing, health and other agency costs, relative to economic benefits? What would be the potential saving in mortality, morbidity and cost if Australia were to adopt a higher legal minimum drinking age across all jurisdictions?
5. What is the role for minimum pricing?
   - What are the impacts of minimum pricing on alcohol consumption and related harms at local levels (i.e. beyond national), including communities that are considered high risk?
   - Would small scale experimentation in selected sites with minimum pricing help make the case for larger policy trials?

Domain 2: Advertising, Promotion and Sponsorship

Key issues:

- Advertising, promotion and sponsorship
- Restrictions on alcohol advertising
- Direct marketing strategies
- Point of sale advertising
- Below-the-line media
- Content and placement of advertisements



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

Exposure to alcohol advertising, promotion and sponsorship

1. To what extent does exposure to alcohol promotions (of various types) influence initiation of alcohol use among young people and later drinking patterns and alcohol related harm?
2. How is the current exposure to alcohol advertising, sponsorship and other promotion, particularly through sport sponsorship, branding and broadcast, influencing young people's perceptions of the role of alcohol and drinking in contemporary social culture?
    - Does this regular exposure diminish perceptions of the extent and seriousness of alcohol-related harm in the society?
    - To what degree does this process of normalising alcohol's constant social presence create a competitive communication environment for alcohol prevention communication and consideration of alcohol public policy measures?
3. What is the nature and extent of young people's exposure to marketing through digital strategies such as the internet and social media and how might it be counteracted or controlled?
    - How is below-the-line marketing organised, co-ordinated and promoted?
    - Which organisations and intermediaries the industry engage to promote these messages (including cultural and online organisations and intermediaries)?
    - What strategies are the alcohol industry or partner organisations using to attract, interact and engage with young people in the social media space about alcohol messages?
    - How much money is being spent above and below the line (including breakdown by promotion and product types and geographic region)?
    - How are these messages and promotions identified, understood and communicated through a population of young people and peer networks?
    - How effective are these media approaches in influencing attitudes and behaviour?
    - How do these media activities inter-relate with drinking culture and practices within peer groups?

Continued next page...

Alcohol advertising, promotion and sponsorship

4. In what ways does the alcohol industry continue to promote itself and its products in Australia?
    - What activities does it undertake including advertising, promotion and sponsorship, public relations, lobbying etc. and what is the total expenditure?
    - To what extent are alcohol companies able to exert influence or conduct marketing activities through commercial or other associations? What is the extent and nature of this influence and which organisations are involved?
    - What legal/regulatory measures might be needed to obtain this information?
    - What is the impact of these types of alcohol promotion on preference/ purchase/ consumption of alcohol?
    - What is the public's understanding of and attitudes to these promotional activities?
    - Are there any differences between states and territories who have taken action to restrict any forms of promotion?

Policy and regulatory approaches

5. Do changes in regulation of the volume or placement of advertising or other promotion affect attitudes or behaviour in relation to drinking (including consumption levels and patterns) or about consumption of specific beverages? What is the impact of policies that restrict the content of advertising and the forms of advertising?
6. What are the potential costs and benefits of policy options for eliminating alcohol sponsorship of major sports, arts and other community events? What are the most effective policy options?
7. What is the impact of point of sale promotions for packaged alcohol on consumption levels (short-term and long-term)?
8. What would be the impact of a ban on all advertising, promotion and sponsorship of alcohol?
9. What are community views on alcohol advertising (in terms of placement and content) and how aware is the general public of complaints mechanisms?

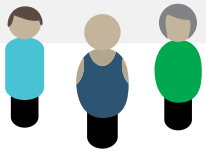
Additional question suggested to address gap in this domain (not ranked)

- What is the impact of exposure to alcohol promotion on the general population and vulnerable sub-populations?

Domain 3: Supply and Availability of Alcohol

Key issues:

- Liquor licensing
- Restrictions of trading days and hours of sale
- Restrictions of high-risk alcoholic beverages
- Responsible service of alcohol
- Liquor Accords
- Outlet density
- Minimum age of purchase



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

Outlet Density

1. How do specific types of alcohol outlets and specific provisions in the design and operation of outlets, influence drinking behaviour and alcohol-related harms?
    - What are the differences between harm from alcohol consumption on-premises compared to off-premises?
2. How does location, size of outlet, clustering and density of bottle shops (off licences) across Australia impact on the:
    - physical and economic availability of alcohol to the surrounding community?
    - purchasing behaviour of consumers from high risk sub-populations?
    - health, crime and amenity of communities?
3. What opportunities are there to influence the planning regulations related to alcohol outlet density in neighbourhoods?
    - What are the regulatory and political barriers to restricting the density, clustering and placement of alcohol outlets in the jurisdictions, and how might these barriers be influenced?
4. What data on alcohol sales at the local level are required to effectively monitor trends in alcohol use and to better understand the interaction between supply and price of alcohol and alcohol related harm?

Liquor Licensing and Responsible Service of Alcohol

5. How effective is licensing law enforcement?
    - How much time and effort is devoted by police and licensing inspectors to enforcement (in particular on enforcement of provisions with direct public health and safety implications) and can the extent of time and effort devoted show differences in occurrence of alcohol related problems?
    - What are the most effective licensing strategies to reduce risk of alcohol related harm?
6. What interventions are effective in enforcing responsible service of alcohol bans on serving intoxicated and underage people in licensed premises?
7. How effective are secondary supply laws in preventing youth access to alcohol and reducing underage drinking?
    - What understanding do adults, adolescents and the community have of secondary supply laws?
    - What factors influence an adult's decision to supply alcohol to adolescents despite these laws?
    - How do parents negotiate secondary supply issues to others including parents/guardians of other adolescents?
    - How are these laws enforced in different states?
8. What would effective regulation of the night-time economy look like?

Continued next page...

Raising the minimum drinking age

9. What is the likely impact on adolescent drinking behaviours if the legal age for purchasing alcohol were raised to 19 years, 20 years or 21 years?
    - What would be the impact on parents' supply of alcohol to their adolescent children?
    - What would be the potential saving in mortality, morbidity and cost?

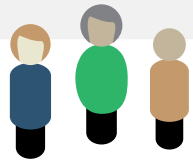
Additional questions suggested to address gaps in this domain (not ranked)

- What difference in rates of harm do changes in closing hours for off-premise sales make? What differences for changes in closing hours for on-premise sales?
- What difference in rates of alcohol problems would it take to set closing hours for alcohol sales half an hour before the last regular public transport ceases?

Domain 4: Alcohol Related Harm in the Community

Key issues:

- Health related harms
- Harm to others
- Drink-driving counter measures
- Sobering up shelters and night patrols
- Workplaces
- Supply to children
- Potential health benefits



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

Alcohol related harm

1. What are the causes of the general increases in rates of alcohol related harm (identified in a range of settings) in light of the ongoing stability of per-capita alcohol consumption in Australia?
2. Can more be done to facilitate harm reduction in relation to drinking?
    - What are the barriers and enablers to positively influencing Australian's perceptions of personal risk of harm due to alcohol?
    - What are the harm reduction measures acceptable to individuals who continue drinking at levels that place them at risk of long term harm?
    - How do the harms from drinking differ with context and setting and what are the implications for harm reduction strategies?
    - What are the harm reduction measures acceptable to individuals when binge drinking?
3. Which specific interactions [or intersections] of substance, bodies, emotions, cultural practices, drinking settings and regulatory frameworks tend to produce alcohol-related harm?
4. What will be the impacts of alcohol consumption and related harms into the future as Australia's population continues to age?
5. Do interventions such as prohibition orders, barring notices and lockouts reduce re-offending amongst violent offenders?
    - Do they reduce the overall level of violence on licensed premises?

Workplaces

6. What workplace policies and programs (or combination of policies and programs) are the most effective in reducing risky levels of alcohol consumption and related harm?
    - What are the best strategies and approaches to encourage employers to develop and implement workplace policies and programs that adopt a 'whole of workplace' and workplace/workforce health and wellbeing approach?
    - What resources and infrastructure would be most effective to support Australian small businesses to develop, implement and evaluate workplace policies and programs designed to reduce risky levels of alcohol consumption and related harm, and how could this infrastructure be provided and funded?

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Health and Child Protection settings

7. How are alcohol issues handled in the Australian child protection (CP) system and with what effect?
    - How are CP workers trained concerning carers' drinking as a risk factor for harm (or inability to protect from harm)?
    - In what circumstances are alcohol factors recorded and acted on?
    - What kinds of responses, including referrals are utilised and how effective are they?
    - What are the differences between families with heavy drinking parents who are not in the CP system and families with heavy drinking parents who are in the CP system)?
8. How do we improve the effectiveness of the health and welfare systems in addressing alcohol-related harm?
    - How do we substantially improve the implementation and adoption of brief interventions for alcohol problems within primary care or other areas of health where alcohol presentations are common?

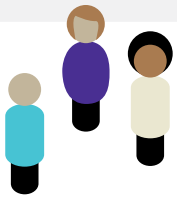
Additional questions suggested to address gaps in this domain (not ranked)

- What are the barriers to governments implementing evidence based alcohol prevention policy and how can we improve the introduction of evidence based policy?

Domain 5: Public Education, Awareness and Engagement

Key issues:

- Education
- Community engagement
- Social marketing
- Labelling and public information



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

1. Which alcohol health warning messages work best and why?
    - What kinds of messages are the most effective in discouraging excessive consumption or encouraging abstinence?
    - Are there differences between sub-population groups?
    - Would messages relating to heart disease, cancer, general health, accidents, etc. be most effective?
    - Would on-product messages or point of sale messages (or a combination of both) be more effective with heavy drinkers?
2. What methods of alcohol harm reduction education are effective with young people (as part of a comprehensive approach in reducing harm)?
    - How are young drinkers being targeted by the alcohol industry and at what point are harm reduction, health promotion messages likely to be most effective?
3. Are parents aware of the health effects of alcohol on children and adolescents? How best do we raise awareness and influence behaviour of parents and children to reduce experiences of risky drinking and harm? What are effective strategies for parents to use when addressing adolescent drinking?
4. What type, execution and level of mass media campaign messages are most effective in creating awareness among young people and in changing behaviours of young people in relation to alcohol? What types of interactive social media strategies are most effective?
5. How can campaigns most effectively operate as integral components of a comprehensive alcohol harm prevention strategy?
6. Why do people choose to abstain from drinking (either permanently or for temporary periods)?
    - What is the appeal and the short and long term effects of charitable fundraising or personal awareness raising events like ‘Dry in July’, FebFast, Sober October, Hello Sunday Morning - all of which have a strong social media presence. Who sees them, who responds, are there any long term benefits?
    - Which psycho-social factors assist people to remain abstinent and which act to sabotage the intention?

Additional questions suggested to address gaps in this domain (these were not ranked)

- How effective are participatory communication approaches in challenging social norms and changing drinking practices within peer groups?
- How can participatory communication approaches be used most effectively to influence identity and cultural practices within peer groups?

Domain 6: High Risk Population Groups

Key issues:

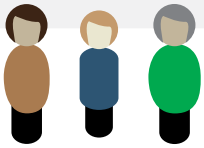
- Young people
- Women
- Indigenous populations
- Low socio-economic populations
- People with mental health and substance misuses issues
- Other population groups

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

1. What are the most effective approaches to encourage and support women and their partners who drink to high or moderate risk levels to reduce their alcohol consumption before and during pregnancy?
2. What are the most effective approaches to reduce high risk drinking and associated harms (especially violence) among young men? How can we influence social acceptance of high risk drinking among young men?
3. What are the likely consumption and/or harm responses by Aboriginal and Torres Strait Islander people and other vulnerable population subgroups to various policy initiatives e.g. limits on price, availability, and advertising?
4. What are the most effective community development approaches to improve lifestyle risk factors (diet, smoking, cannabis and alcohol misuse) in disadvantaged communities?
5. What range of strategies/settings/methods are required to reduce the high risk drinking levels, social acceptance of high risk drinking and associated alcohol-related harm in young women who regularly drink to high risk levels?
6. What range of strategies/settings/methods is required to influence perpetrators of harm to young women who drink to high risk levels?
7. What is the effect on child development from maternal alcohol-use disorder during pregnancy and during childhood at a population level, in Australia? What is the effect of maternal alcohol-use disorder during pregnancy and during childhood on educational achievement at a population level, in Australia?
8. To what extent is contingency management an effective intervention for alcohol abuse among people from socio-economic disadvantaged backgrounds?

Domain 7: Emerging and Cross Cutting Issues

In this domain we invited researchers to identify specific research questions relevant to emerging issues that they believe are and important.



RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE POLICIES FOR THE PREVENTION OF ALCOHOL RELATED HARM:

1. What contributes to the normalisation of harmful drinking in Australian society?
    - How do we change cultural attitudes to intoxication and promote a culture of reduced harms?
    - What are the most effective approaches/interventions?
    - What can we learn from other health areas or other countries?
    - What timeframe is required for change?
2. Would it be legally feasible to bring 'cost recovery' litigation against the alcohol industry in Australia? If so, who would be the appropriate applicant/s and how could it be funded? Would cost recovery litigation require the enactment of any legislation, regulations or rules, and, if so, of what kind and by whom? What criteria might be applied to determine whether cost recovery litigation would be a worthwhile undertaking in Australia? What are the possible benefits and risks of undertaking cost recovery litigation in Australia, and what is a realistic timeframe for its conduct?
3. In what ways do gender and alcohol influence each other?
    - How does drinking help to constitute gender, and how does gender help to constitute drinking?
    - To what extent are particular forms of masculinity reliant on, and enacted through, specific forms of drinking?
    - Does violence emerge from the interaction between drinking, specific forms of masculinity and particular drinking settings rather than through alcohol consumption alone?
    - In violent incidents in which alcohol is involved, are there differences in the way men and women are implicated and why?
    - In what ways does class intersect with gender and drinking?
4. What is driving recent reductions in underage drinking in Australia, especially in the secondary school population?
    - How accurate is the picture of young people's drinking behaviour over time as provided through Australian Secondary Students' Alcohol and Drug (ASSAD) survey data?
    - What are the current and future benefits of underage people drinking less?
    - Is the trend matched in comparable countries?
    - Is the trend likely to continue?
    - What policy options exist to support and maintain the trend?

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5. What is the likely impact on adolescent drinking behaviours if the legal age for purchasing alcohol were raised to 19 years, 20 years or 21 years?
    - What would be the impact on parents' supply of alcohol to their adolescent children?
6. What is the extent and nature of alcohol industry engagement with government agencies?
    - What is the nature and extent of the discussions, association and support between these agencies and the alcohol industry?
    - How can these arrangements be made more transparent?
    - How much do the alcohol industry and industry affiliated groups contribute to political parties annually, and are there differences between the parties in amounts received and organisations donating?
7. What new methods can be employed to detect and define intoxication?
8. What forms of public health advocacy are most effective to support alcohol control policies in Australia? How can research better inform advocacy efforts in Australia?
9. What role do cultural practices and identities play in facilitating and promoting alcohol consumption in Australia? How can qualitative research most effectively inform future policies to prevent alcohol related harm? What strategies are most effective?

CONCLUSION

The value and importance of a collaborative consultative approach to research priority settings is well-recognised. The development of a priority-driven research agenda for the prevention of alcohol related harm has the potential to improve the effectiveness of policies and programs to prevent alcohol related harm, and ultimately contribute to improved population health and safer communities.

This report identifies those research questions judged by experts who participated in the process to be most important and relevant to inform policies for the prevention of alcohol related harm over the next decade.

Research should not only generate more knowledge but also help to translate knowledge into action through innovative approaches. It is anticipated that the priority research questions described in this report will be of interest to all those in alcohol prevention related research, policy and practice. It is hoped that linking future research efforts to the set of priorities developed through this consensus process will concentrate future research efforts, and focus attention on the most policy-relevant questions as well as generating new and important evidence for the prevention of alcohol related harm in Australia.

LIST OF EXPERTS IN THE PREVENTION OF ALCOHOL RELATED HARM WHO GENERATED THE RESEARCH QUESTIONS

Of the 53 alcohol researchers and other experts invited to participate, 32 generated research questions for the project.

Professor Steve Allsop
Dr Tom Carroll
Dr Jenny Chalmers
Professor Tanya Chikritzhs
Professor Mike Daube
Ms Sondra Davoren
Professor Wayne Hall
Dr Devon Indig
Professor Sandra Jones
Mr Gary Kirby
Dr Michael Livingston
Professor Dan Lubman
Dr Nyanda McBride
Detective Superintendent James Migro
Professor David Moore
Mr Geoff Munro
Professor Jake Najman
Mr Barry Newell
Mr Roger Nicholas
Ms Paula O'Brien
Dr Colleen O'Leary
Professor George Patton
Professor Simone Pettigrew
Dr Ken Pidd
Dr Alison Ritter
Professor Robin Room
Professor John Tombourou
Professor Tarun Weeramanthri
Dr Vicki White
Professor John Wiggers
Dr Celia Wilkinson

**Professor Billie Giles-Corti submitted a question relevant to the prevention of alcohol related harm and obesity prevention.*

LIST OF EXPERTS IN THE PREVENTION OF ALCOHOL RELATED HARM WHO PARTICIPATED IN THE RANKING PROCESS

Of the 36 alcohol researchers and other experts invited to participate, 24 participated in the ranking process.

Professor Steve Allsop
Dr Tom Carroll
Dr Jenny Chalmers
Professor Kate Conigrave
Professor Tanya Chikritzhs
Ms Sondra Davoren
Dr Devon Indig
Mr Martin Jackson
Professor Sandra Jones
Dr Nyanda McBride
Detective Superintendent James Migro
Professor David Moore
Mr Geoff Munro
Professor Jake Najman
Mr Roger Nicholas
Ms Paula O'Brien
Dr Colleen O'Leary
Professor George Patton
Professor Simone Pettigrew
Dr Ken Pidd
Professor Alison Ritter
Professor Robin Room
Professor John Toumbourou
Dr John Wiggers

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The National Preventive Health Research Strategy 2013-2018 is a national guide for preventive health research, policy and best practice.

The Strategy provides a vision for carrying out applied research to enable evidence-informed activities by governments, health care systems, individuals, and by civil society and private organisations in the areas of preventive health.

The Strategy advocates for a research system that seeks solutions to problems, and that is undertaken in a collaborative integrated model involving researchers and decision makers.

This Strategy is accompanied by three Priority-driven Research Agenda annexes that have been developed to support evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol use and tobacco control.

The Research Agendas identify those research questions judged by Australian and international subject matter experts in the fields of obesity, harmful alcohol use and tobacco control to be most important and relevant to inform preventive health policies over the next decade.

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