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Barriers to evidence-
based tobacco control
in Tasmania:
A case study

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**This thesis is dedicated to tobacco-control policy
advocates everywhere,
who bravely stand up and speak, study, research,
write and agitate against the forces of darkness –
the
diabolical death-dealing
international tobacco industry.**

Abstract

Tobacco-smoking is by far the biggest single killer of Tasmanians, exceeding all motor vehicle accidents, illicit drugs, alcohol, suicide, homicide, fires and assaults combined. The tobacco industry is the vector of multiple chronic and deadly diseases caused by smoking, which can affect every organ of the body. Tasmania has higher smoking rates than all other states in Australia, and for a decade in the 2000s, the smoking rate in Tasmania did not fall at the same speed as other states. Tobacco control in Tasmania has been characterised by a strong legislative reform agenda, but weak commitment to allocation of resources for mass-media campaigns and cessation-support services.

This thesis was triggered by professional concerns about these issues, and examines barriers to the funding of evidence-based tobacco control in Tasmania. The hypothesis is that there are specific barriers to implementing evidence-based tobacco-control measures in Tasmania.

The initial proposal and research questions related to: evidence transfer to politicians and bureaucrats, and how such evidence is used and influenced; the role of policy entrepreneurs; factors influencing resource allocation; and does it matter if a politician is a smoker? The theoretical framework used was that of Kingdon, and agenda setting.

The work began with a literature search focusing on evidence and knowledge transfer, and then progressed to requests for documents from the Department of Health and Human Services (DHHS) and other relevant agencies. In the early stages there was considerable cooperation from the DHHS, including access to files. In the later stages, with follow-up as the documents were read and analysed and more questions arose, DHHS and other departments insisted on formal requests in conformity with the relevant right to information legislation. A 1970s case of corruption and cronyism involving the tobacco industry was discovered at an early stage, and recently released archived files were examined to give a historic context to recent issues.

Initially it had been intended to conduct interviews with bureaucrats, politicians and non-government leaders. However, as the researcher and all supervisors were embedded in the Tasmanian health community, it became clear that the small-scale nature of Tasmania meant that the answers given would almost certainly be confounded by

familiarity. Further, a vast amount of information was available in documents. Therefore, it was decided to examine what people said and did as documented contemporaneously.

The first major finding was that crony capitalism involving the tobacco industry was deeply embedded in the Tasmanian political system, and had been for decades. In the 1970s a tobacco company had managed, through corrupt processes, to eject an unsupportive Tasmanian government from office. No noteworthy ideological differences between the major political parties on tobacco control were found, as their actions appeared to be personality-driven. “Conservative white males” dominated governments, and it was not until 2013 that a bloc of progressive female political leaders finally broke the impasse, and allocated adequate funding to tobacco control.

Senior politicians were poorly informed about the importance of tobacco control, and the evidence on how to reduce smoking rates. Many of the significant politicians who rejected the evidence were smokers. Politicians and bureaucrats refused to allocate earmarked funding to tobacco control in the years when states controlled taxation revenue streams, which perpetuated disadvantage in Tasmania.

The myriad bureaucratic barriers to effective tobacco control were substantial, and included primacy of the “rescue culture” that prioritized acute care and illicit drugs use. There were silo effects in resource allocation; confused accountability, with complex internal committee systems; failure of key public servants to believe the evidence; failure to transfer evidence to Parliament and ministers; and importantly, a lack of resources for support, monitoring and evaluating anti-smoking services.

It was found that although there were a number of anti-smoking non-government organisations (NGOs) active in Tasmania, these were small, under-resourced, and lacking research and advocacy expertise. There were individuals who lobbied hard, but no policy entrepreneurs of the stature of leaders in some other Australian states.

Small jurisdictions are vulnerable to crony capitalism and tobacco industry interference, and national governments, the World Health Organisation (WHO), philanthropists and national NGOs have a responsibility to provide assistance to achieve and implement evidence-based tobacco-control measures. To be effective bureaucrats need to streamline their operations and consultations. Accountability mechanisms need to be

unambiguous. Decision-making structures, which incorporate illicit drug and alcohol policy-making, overwhelm tobacco control as a priority. Tobacco control requires persistence and planning. Governments that do not adopt a priority approach for tobacco control across all agencies and ministries will find that internecine spats strangle reform. The apparent success of progressive women in breaking through these barriers needs to be tested in other contexts.

Evidence is vital to underpin policy, but opportunities to develop new charismatic tobacco-control endgame ideas should not be dismissed, simply because the evidence is minimal at the start of a new initiative. There are times when executing rational ideas can gain traction, while evidence can only be ultimately gained through implementation.

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Chapter 1 Introduction

The hypothesis of this thesis is that there are barriers to evidence-based tobacco control in Tasmania.

This thesis addresses the failure of governments to keep pace with evidence about effective measures to improve public health. It provides a study of Tasmania, and tobacco control public policy and implementation in that state. It is a not-uncommon phenomenon in public health that a government might, as Fafard observes, “routinely reject the best available evidence and prefer other considerations and concerns” (Fafard 2015, p.1).

Fafard expands on this:

“Evidence-based public health (EBPH), how could it be otherwise? The claim that practices, programmes and policies in public health should be based on the best available evidence seems like an obvious and self-evident claim. Yet we routinely observe that public health decisions are made that do not reflect the best available scientific evidence” (Fafard 2015, p.1).

The thesis examines the main barriers that existed within the context of Tasmania and provides three case studies to illustrate the theoretical considerations. The first is described in Chapter 5 and surrounds the events of the demise of a Tasmanian government in the 1970s, engineered by British Tobacco. The second and third case studies are more recent, since the 1990s, and deal with political and bureaucratic barriers to effective evidence-based tobacco control, and are explained in Chapters 6 and 7.

It is somewhat frustrating for scientists who conduct a carefully crafted study to find that their work, and that of colleagues producing similar results, is apparently ignored. Indeed scientists’ “... belief in rational decision making may lead them to mistakenly believe that simply providing more data or citing more scientifically credible studies will be more persuasive when communicating information to audiences” (Nelson 2009, p.15). The processes for implementing evidence-based practice in clinical medicine

should not be dictated by politicians, except where economic decisions about public purchase and availability of equipment or approval of drugs are a consideration. However, although the politician is peripheral in clinical medicine, politicians and bureaucrats are central to the practice, approval and implementation of public health measures. For clinicians the process of public policy-making is mysterious, because there is sometimes no resemblance to the evidence, and occasionally policy takes different directions in separate jurisdictions, in response to the same evidence (Dobrow 2006). To political scientists the phenomenon of divergence of policy from scientific evidence is quite explicable, and unfortunately all too normal.

Public health action has been “nominally” based on epidemiological principles for well over a century, and a sound scientific evidence base has been fundamental to sending signals to the polity about what action should take place. However, politics and public health are inextricably linked, and public health officials are subject to political influences. As a 2007 editorial in the *Lancet* pointed out, even such eminent authorities as the US Surgeon-General are subject to political “interference” (*The Lancet* 2007, p. 193).

When Dr John Snow, in 1854 discovered that a group of deaths from cholera had occurred within a short distance of a pump in Broad Street, Soho, London, he went to:

“...the Board of Guardians of St. James parish on the evening of 7th inst [Sept 7] and represented the above circumstances to them. In consequence of what I said, the handle of the pump was removed on the following day” (Brody et al. 2000, p65).

Snow thought that cholera was transmitted by drinking water. This was not the prevailing view at the time. Snow did not conduct randomized double-blind clinical trials. He did not have a microscope to be able to demonstrate the existence of pathogens. He simply made careful observations about patterns of disease, locations and sources of water supplies, and locations and timing of deaths.

In this historic case the route from hypothesis to action was swift, even if the evidence available to him was not that which would stand up to modern independent scientific scrutiny, but Snow had “good science” for the time. It was well educated guesswork. In fact the cholera epidemic was abating before the pump handle was removed, but

political action promptly followed scientific identification of a problem and effective advocacy from a credible scientist.

How would John Snow's approach have fared in the 21st Century, and especially in Australia? It is possible that the route from hypothesis to action could be much longer.

In a recent case where an outbreak of the potentially fatal Legionnaires' disease in Rapid City, South Dakota was found to have been transmitted by a decorative fountain in a restaurant, investigative action was careful, meticulous and painstaking, before the fountain was shut down, as reported by O'Loughlin et al. (2007).

“We conducted a case-control study that included the first 13 cases and 52 controls randomly selected from emergency department records and matched on underlying illness. We collected information about activities of case-patients and controls during the 14 days before symptom onset. Environmental samples (n = 291) were cultured for Legionella. Clinical and environmental isolates were compared using monoclonal antibody subtyping and sequence based typing (SBT)” (O'Loughlin et al. 2007, NP).

Public health action is informed by evidence, but the bar has been lifted considerably since 1854. The speed at which public health officials can act has been curbed, and the administrative and political processes are immensely complex. The possibility of a single doctor, in one meeting, being able to persuade an administrative authority to instantly take action, which may upset local business or the community, is unimaginable in modern industrial societies. In the case of tobacco, the evidence about the adverse health effects has been available for many years. However, only one country, the tiny kingdom of Bhutan, with a similar population to Tasmania, has seen fit to shut down the tobacco industry and ban the sale of tobacco (Ahmad 2005; Ferrence 2003; Ugen 2003).

Closing down tobacco sales is a far cry from removing a pump handle or turning off a fountain. Yet these issues are all about public health, and about preserving, maintaining and protecting the populace from illness and disease. The action required is ultimately political. The debate on phasing out tobacco sales is developing and endgame proposals are proliferating (Malone 2013). However, this thesis is concerned with the historic response to the scientific evidence about effective measures to reduce tobacco

consumption, which have been within the control of the Tasmanian government, and indeed other state and territory governments in Australia. It addresses the issue of the vagaries of transfer of scientific evidence through various channels, and political processes, to eventual action. The thesis considers the issues of policy failure and nondecision-making. The argument advanced is that there has been a failure to transfer evidence into action on tobacco control in Tasmania.

“The clear message from the literature is that research evidence must compete with individual, organisational, institutional, political, economic, and ideological factors for the attention of policy-makers and practitioners” (Lewig, Avery & Scott 2006, p18).

Whilst the focus is on the Tasmanian government, nevertheless divergence or lag effects from evidence-based public health policy is a phenomenon observed in many countries, including the United States, as McGinnis observes:

“Despite compelling evidence of the potential for many preventive interventions to reduce the occurrence of disease, thwart needless suffering and improve the health and vitality of populations, the uptake of these interventions often lags far behind the potential” (McGinnis 2001, p391).

Comprehensive tobacco control policies are recognised as those which include a number of measures, and ideally should be implemented together (Joossens & Raw, 2006, p. 247). Referring to the World Bank (World Bank, 2003) list of effective interventions Joossens and Raw itemize the six key interventions as,

- “price increases through higher taxes on cigarettes and other tobacco products
- bans/restrictions on smoking in public and work places
- better consumer information, including public information campaigns, media coverage, and publicising research findings
- comprehensive bans on the advertising and promotion of all tobacco products, logos and brand names

- large, direct health warning labels on cigarette boxes and other tobacco products
- treatment to help dependent smokers stop, including increased access to medications. (Joossens & Raw, 2006, p. 247)”

Australian state and territory jurisdictions do not control price (since 1996) nor packaging, and share with the Commonwealth responsibilities for consumer information, mass media campaigns, advertising and promotion (states/territories control point of sale only) and treatment through cessation services and access to medication (although the Commonwealth controls the cost of medication). The only intervention controlled almost exclusively by states/territories is bans on smoking in public places and work-places (although the /Commonwealth has sole jurisdiction over federal properties such as airports). See Table 9. Tasmanian governments have acted on smoking bans in public places, and were the first Australian jurisdiction to ban smoking in pubs and clubs. Secondly, Tasmania pioneered bans on advertising and display of tobacco products at point of sale (Laugesen et al, 2000). However, Tasmania failed, until 2010 to adequately fund cessation support services (see Chart 18) and until 2013, to implement sufficient evidence-based mass media campaigns. The Commonwealth undertook some overarching mass media campaigns across the nation, but all other states implemented their own supplementary campaigns. These two gaps in program delivery and funding in Tasmania are the missing links in a comprehensive program of tobacco control. Without both these interventions, a state tobacco control program does not meet the standard of being ‘comprehensive’.

One of the most important areas of public health in the US where patient advice and counselling has gone undelivered relates to smoking. McGinnis outlines the reasons why he considers that the “bar is higher for prevention”. McGinnis describes: the invisibility of public health measures, and the public focus on high-power technical interventions; the “primacy of rescue”; short time horizons; the need for immediate expenditure outlays versus long-term gains; double standards about low-cost health interventions; disease complexity; multiple loci of control and multiple funding streams; “lifestyle drift” and emphasis on individual rather than corporate responsibility; a technophilic culture; and countervailing economic interests. This set of ideas is outlined

in more detail in Chapter 2 on policy typology and literature, as it provides a useful set of explanations that *prima facie* are similar to what has prevailed Tasmania (McGinnis 2001).

The vexed question of what effective “evidence” entails in the public health context is one of the central themes of this thesis. There is a great deal of literature on this issue, particularly emanating from Canada, and a large portion is devoted to finding ways of improving the communication between scientists or researchers, and those who would implement policies related to the evidence that is produced. A Canadian “Systematic review of conceptualizing and combining evidence for health system guidance” conducted by Lomas et al. found three types of evidence:

“There are differing views on what the “evidence” in evidence-based healthcare should be. This systematic review uncovered three categories of evidence: medical effectiveness research (context-free scientific evidence); social-science oriented research (context sensitive scientific evidence); or the expertise, views, and realities of stakeholders (colloquial evidence). These views of evidence are not incompatible and each has a role to play in producing evidence-based guidance for the health system” (Lomas et al. 2005, p5).

This is a useful frame of reference for the examination of the ways in which “evidence” has been used, absorbed, considered, and deliberated on in relation to the development of tobacco-control policy. Chapter 2 provides a detailed examination of the policy typology and literature relating to evidence-based research and policy transfer or utilisation.

Tasmania is not unique in the world in having a government or health department, which is oriented to acute care, and which struggles to find funding for public and population health and disease prevention strategies. In their review of the role of government in public health Lin et al. identify the comments of the World Health Organisation (WHO), which criticises ministries of health world-wide as;

“... being too oriented to short-term results, having a narrow focus, and giving insufficient attention to policy implementation. Governments are said to be more focused on the public hospitals and medical care, rather

than other health-care providers or the health needs of patients and the population in general” (Lin, Smith & Fawkes 2007).

The methodology for this thesis as set out in Chapter 3 was primarily based on analysis of documents. These included internal documents from government agencies sought and obtained under freedom of information provisions, as well as public documents on websites and hard copies in libraries and disseminated to the public and those interested in health and tobacco control. Newspapers records, archive documents from both the Tasmanian and national libraries were accessed. Parliamentary transcripts, called Hansards, both online and hard copies, and older documents from the Tasmanian Parliamentary Library were examined and analysed. Where it was possible to digitize documents these were entered into QSR International NVivo and sorted and coded to enable more detailed analysis and comparison of themes, processes, political and bureaucratic policies and programs.

Initially it was planned to conduct interviews; however, as the accessing of documents proceeded and the politicians and bureaucrats became aware of the study, the likelihood of extracting meaningful unbiased information from the actors in Tasmania became more remote. The author and all supervisors were at various points involved in the processes of policy-making as observers, advisors, clinicians, critics or advocates. Therefore, the probability of “participant observer bias” was deemed to be too likely to conduct effective interviews. Tasmania is so small that all the researchers, physicians, politicians, public servants and health organisation officials are well known to one another, their views, ideologies and biases understood, and therefore any interviews would almost certainly have been tainted by participants saying what they thought the interviewer wanted to hear, or would find acceptable. Retrospective self-justification of past actions (or inaction) was inevitable in this environment. A study in NSW by Hooker and Chapman encountered a similar difficulty, but the researchers were able to conduct interviews because the first author and interviewer was a non-activist impartial historian, even though the second author was a well-known public health professional academic and activist (Hooker & Chapman 2006). By 2010 the amount of material, data and documentation amassed was so enormous that it was considered unnecessary, and almost certainly counter-productive to proceed with interviews. The thesis therefore relies on what actually happened, according to the record, what was in documents and what was said publicly and on the record.

The history of what has happened in Tasmania in relation to tobacco control is outlined in Chapter 4, and that chapter also provides many visual guides to events over time through the use of charts, graphs, figures and tables. The story of smoking rates and interventions is described so that the reader can gain an impression of the events in the context of the timeframe of several decades. Whilst the focus of the thesis is mainly on the period since 1997, nevertheless previous important events shaped Tasmania's tobacco control history, particularly the relationship of governments to tobacco industry executives and companies from the late 1960s: these have coloured more recent events and influenced politicians in their approach to challenging the tobacco industry. The fact that a tobacco company was able to destroy a Tasmanian government using bribery has left its mark on the Tasmanian political psyche, and may have contributed to defensive legislation such as that which prohibits the tobacco industry from telling lies about the health effects of its products and about tobacco-related legislation more generally (*Public Health Act 1997*, Sections 74 and 74AA).

The political environment in Tasmania and the way it impacts on public policy and its processes is a central theme. Tasmania has a very small economy, vulnerable to being influenced by large powerful corporations. This is not unique to Tasmania and is a characteristic of many jurisdictions, although Aligica and Tarko (2014) argue that it takes different forms in wealthy countries to that which operates in emerging economies. "Crony capitalism" can flourish in such an environment and has done so in Tasmania, but this is not confined to small economies and Macey argues that it is even a threat to the USA (Macey 2014). Macey defines crony capitalism as:

“... an economic and political environment in which pursuing and obtaining government favors is part of everyday life and a necessary protocol for succeeding in business. Where crony capitalism exists, notions of meritocracy have been displaced by notions of cronyism or kleptocracy or something similar” (Macey, 2014 p5)

The question of crony capitalism is explored in a detailed case study of the events of the 1960s and early 1970s in Tasmania, Chapter 5, and relates to the close relationship between the tobacco industry and its front organisations, politicians and senior bureaucrats.

Crony capitalism, described by Aligica and Tarko as essentially a corruption of the political process by business interests:

“... is not just a redundant term, a mere substitute for “rent seeking” or just a vague, ethically charged label. It designates a sui generis phenomenon, a polymorphic, elusive but powerful reality. Its features suggest that it has a real potential for expansion, consolidation, and relevance in the contemporary world. As such, it may be emerging as one of the most important challenges to democratic market capitalism (be it in the neoliberal or social democratic form)” (Aligica & Tarko 2014, p173).

Crony capitalism differs from normal interest group politics in that it is an economic system in which the profitability of business “depends on political connections” (Holcombe, 2013 p.542), not on its own merits, nor its competence, nor its entrepreneurial ability, nor the competence of its work-force, nor its business acumen.

“Firms increase their profits through government favors, and in exchange they support the politicians who provide the favors. That relationship is cronyism” (Holcombe, 2013 p.544)

In this thesis the term crony capitalism means excessively close and inter-dependent relationships between business and politicians to the detriment of the community, the exclusion of minority ‘outsiders’ and harm to democracy. The term crony capitalism does not imply an exchange of money to politicians, such as overt bribery, more accurately designated as corruption. However, crony capitalism can lead to corruption, as the exchange of favors between business and government leaders’ borders on, or leads to the exchange of resources. The structure of the Tasmanian economy makes it vulnerable to both crony capitalism and institutional corruption (Petrow, 2006).

As crony capitalism is a potential serious threat to ethical governance everywhere, it is important to devote some efforts to examine its existence, pervasiveness, social construction and the fact that it appears to be tolerated. It is also argued,

“...that nations decline when interest groups become well established in the political process so that firms gain more from their political connections than their economic productivity” (Holcombe, 2013, p 546)

United States legal expert Jonathan Macey is convinced that crony capitalism is rife in his country and he puts forward the notion that, “Crony capitalism has ebbed and flowed in our history, and it seems as though today it is on the rise” (Macey 2014). Even more disturbing is that according to Kurer (2001) and Hay (1976), corrupt politicians are often re-elected.

The next subject to be considered is what exactly is evidence and how is it transferred to policy makers and implemented? In Chapter 6 the political barriers to evidence-based-policy in tobacco control Tasmania are closely examined and analysed. The issues examined are: crony capitalism; corruption; cognitive dissonance of smoking politicians and the activities of various ministers and other politicians in relation to agenda setting; and the failure of crucial aspects of tobacco control to gain the attention of decision-makers. Paradoxically, in some areas, Tasmania was a leader in legislative reforms and several politicians were at the forefront of these reforms. However, other politicians were “blockers” and prevented or delayed reforms from moving forward. The entire decade of the 1980s was marked by a complete lack of innovation in tobacco control in Tasmania, and this can be attributed to close relationships with the tobacco industry. The chequered history of tobacco taxation and business franchise fees is discussed in Chapter 6, with some extraordinary stories of events in the 1970s engineered by state politicians seeking revenue sources, but entirely disinterested in tobacco control or reducing smoking rates. Some politicians seemed to be unaware of the evidence around tobacco control, whilst others were well informed. Some were driven by libertarian ideology and concerned about over-regulation, with “nanny-state” perceptions and beliefs about an individual smoker’s “right to choose”, whilst others were motivated by a truly altruistic desire to improve the health of the population. The tobacco industry’s effective use of front organisations such as the Australian Hotels Association (AHA) and retailer organisations to lobby politicians is discussed, including some vitriolic exchanges that were recorded in the early 2000s.

The concept of the “conservative white male” as a blocker for tobacco-control reform is outlined in the chapter about political barriers, and the development of the notion that women politicians are more successful reformers on tobacco control, as has been found elsewhere in Australia (Hooker & Chapman 2006), is explored.

The bureaucratic barriers to tobacco control are discussed in Chapter 7. This chapter contains the most discussion derived from a forensic examination of many hundreds of pages of documents provided by various government agencies, as well as analysis of other papers and reports. The chapter investigates and describes: the structural barriers and confusion about accountability; lack of skills and priorities within one of the key government service-delivery sections; the lack of evidence transfer to ministers and Parliament; irrational and prejudicial disbelief amongst senior decision-makers that mass-media campaigns would be effective, despite considerable evidence to that effect; complex delaying processes with excessive internal iterative “consultation”; “primacy of rescue” culture oriented towards immediate-lifesaving acute service delivery, rather than preventative programs; indifference and active obstruction from other government agencies and a “siloes” and isolated health department.

A short Chapter 8 on the role of NGOs is included, as these organisations played an important role in tobacco-control reforms in Tasmania but were constrained by lack of resources, and in many cases dependency on government for funding. Despite these obstacles many NGOs have been active over the last two decades in moving the tobacco-control agenda forward. Perhaps if they had more tobacco-control expertise, funding, resources and staff, these organisations would have been able to overcome some of the resistance within the political and bureaucratic spheres to providing adequate funding to tobacco-control measures, in particular mass media and community education campaigns. The role of advocacy of NGOs in tobacco control nationally and especially in Tasmania has declined since 2014 with the abolition of the national organisation Action on Smoking and Health (ASH) and the merger of Quit with the Tasmanian Cancer Council. Tasmania has never had policy entrepreneurs operating in tobacco control of the calibre of Nigel Gray in Victoria, nor NGOs as well funded as the Cancer Councils and Heart Foundations in other states. Whilst there have been intermittent sporadic advocacy efforts by individual physicians and occasionally the Australian Medical Association (AMA), the culture of advocacy by local physicians is not on a par with Victoria and NSW, and one can only assume that this is a product of Tasmania’s small size, and the fact that local physicians are fully engaged in clinical work, including private practice, and have little free time to spend on advocacy.

The final chapter sets out the conclusions to this study and sums up what was found in the process of looking at tobacco control, and barriers to reform in Tasmania. The role

of bureaucrats, politicians, the media, the tobacco industry and advocates and the influence of structures and the “windows of opportunity” that were opened and those that remained firmly shut, are discussed in this chapter.

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Chapter 2 Policy Typology

Introduction

This chapter will primarily examine the literature relating to policy decisions, the use of research evidence, knowledge transfer, knowledge utilisation, the role of advocates or “policy entrepreneurs”, and the public policy-making process. The first area discussed is various aspects of policy typology, theory, knowledge transfer, access to evidence, how it occurs, and whether or not knowledge is used. Having access to evidence is not enough to ensure that it is utilized and adopted by policy-makers. The thesis considers the issues of policy failure, in particular failure of some evidence-based policies to gain traction on the political agenda, and nondecision-making.

The theoretical framework adopted is that of Kingdon, in particular the role of agenda setting, and how issues attract the attention of policy-makers. The idea of “windows of opportunity” will be examined in this chapter and guided the collection of data for this thesis (Kingdon 1995).

Secondly, the literature on policy entrepreneurs is considered, as these individuals may have an important role in tobacco control. Internationally and in Australia some key individuals have been influential in tobacco control and therefore the literature on such involvement is worthy of examination.

Finally, the role and importance of structural arrangements and policy processes on tobacco control is considered, as the ways that government and relevant departments are organised can make a difference to how issues are dealt with.

Tobacco control is recognised by the Australian government as a “wicked problem”, i.e. one that has complex issues, and is beyond the capacity of any individual organisation to resolve (APSC 2007b). There may be disagreement about the causes and solution to the problem. A wicked problem is not inherently ‘evil’ but more like ‘tricky’ (Gibson 2003b). Whilst tobacco control is a wicked problem, there is actually evidence and agreement about what is effective in reducing smoking prevalence, which ought to make decision-making easier (WHO 2003). An unpublished Australian Government Report says:

“In reality, many policy problems lie somewhere on a continuum between tame and wicked. They may display some but not all of the characteristics of wicked problems. Some policy problems move along the continuum over time. Tobacco control is a good example. In Australia, there is broad agreement among all levels of government and NGOs on the scope of the problem of tobacco use and the shape of the comprehensive strategy that needs to be implemented to successfully control it” (APSC, 2007).

This chapter considers advocacy coalition framework (ACF), which explains policy stability, and policy entrepreneurship (PE) model, which explains dynamic policy change (Mintrom & Vergari 1996).

Policy typology

Little attention has been given to a theoretical approach in tobacco control. Donley Studlar is one of the few who has addressed the issue, and he asserts that “.....tobacco control has never been categorized in a policy typology” (Studlar 2002, p.199). He also notes that, “Political science research in health policy more broadly has almost completely ignored tobacco” (Studlar 2002, p. 62)

Despite an extensive literature on tobacco control, little attention has been paid to evaluating failures to implement policy. Most literature on tobacco-control policy in the USA, for example, explains the failure of governments to implement effective evidence-based policy in terms of the influence of the tobacco industry (Dearlove & Glantz 2000; Givel 2006, 2006a & 2006b; Givel & Glantz 1999, 2001, 2004 & 2004-5; Glantz 1996).

There are two separate bodies of literature on tobacco control science and public policy, which Larsen examines and compares (Larsen 2008).

“It is very obvious that the actual development of tobacco control has not followed automatically from scientific facts, a situation which makes it all the more difficult to understand why the literature has not conceptualized the intermediaries of this long process more thoroughly” (Larsen 2008, p. 760).

There is an obvious gap between the emergence and publication of scientific ‘facts’ and their implementation through political processes, the “lag effect” referred to by Davies and Nutley (Davies & Nutley 1999; Lin 2003). Case studies that looked at policy transfer across countries have noted that geographical proximity, policy entrepreneurs and informal policy communities are important in facilitating and sponsoring or encouraging the transfer of science into policy (Mossberger & Wolman 2003).

Cost benefits - and economic approaches

The lack of political typology attention occurs despite the economics of tobacco control. It would seem obvious that the adverse economic effect of smoking would spur governments to implement effective tobacco-control measures. The costs of smoking in Australia far exceed the costs of other drugs such as alcohol and illicit drugs. Work by Australian health economists Collins and Lapsley (2008) has evaluated the costs to the community, and estimated that the social costs of tobacco use/abuse represent 56.2% of the proportion of all drugs, a total of just over \$31 billion per annum.

Table 1 Total social costs of drug abuse, 2004/05

	Alcohol (\$m)	Tobacco (\$m)	Illicit drugs (\$m)	Alcohol and illicits together (\$m)	All drugs (\$m)	All drugs adjusted for health interaction (\$m)
Tangible	10,829.5	12,026.2	6,915.4	1,057.8	30,828.9	30,489.8
Intangible	4,488.7	19,459.7	1,274.5		25,222.9	24,683.0
Total	15,318.2	31,485.9	8,189.8	1,057.8	56,051.8	55,172.8

	Alcohol (\$m)	Tobacco (\$m)	Illicit drugs (\$m)	Alcohol and illicits together (\$m)	All drugs (\$m)	All drugs adjusted for health interaction (\$m)
Proportion of unadjusted total	27.3%	56.2 %	14.6%	1.9%	100.0 %	

Source: Collins and Lapsley 2008, p 65.

Societal costs of smoking include not only health and productivity costs, but also the serious impact of involuntary or passive smoking on children. For children under 15 in 2004/05, involuntary smoking accounted for 25 per cent of deaths, 96 per cent of hospital bed-days and 91 per cent of hospital costs (Collins & Lapsley 2008, p.54).

The effective measures needed by governments and communities to reduce smoking rates through tobacco control are not mysterious or even especially difficult, and can be implemented with some confidence based on well-researched evidence. Economic evaluations of tobacco control have demonstrated a range of interventions that are effective in reducing smoking rates, including mass media: raising taxes (not an option open to the Australian states); bans on advertising and the promotion of tobacco; publishing and disseminating research results on the adverse health effects of tobacco; and improving cessation-support programs (Chaloupka et al. 2005; Dilley et al. 2007; Grosse, Teutsch & Haddix 2007; Jha et al. 2006; Murphy-Hoefer, Hyland & Higbee 2008; Stephen 2003).

Given the benefits, why have even greater political moves towards tobacco control not eventuated?

The Tasmanian government has recognised that smoking rates in Tasmania are not declining in line with other Australian states, and one government Health Minister expressed some frustration at the lack of progress.

“In many respects we are at our wits' end as to how you [can]. We have been putting more funding into this area but we have not seen the decrease” (Hansard 2009).

Whilst the government expresses concern about smoking rates in Tasmania, nevertheless all the effective, evidence-based measures to control tobacco have not been put in place.

Evidence, knowledge transfer and knowledge utilisation

A central theme of this thesis is that evidence or knowledge transfer has not occurred, and that the evidence has been at least partly ignored or rejected in Tasmania. Research knowledge or information is evidence. Defining any barriers to evidence acceptance and then transfer is essential to the understanding of why evidence about effective tobacco-control initiatives has not been adopted and implemented.

There may be a different focus of researchers and policy-makers, and positive efforts are needed to effect action. Lin says:

“Researchers are often interested in cause and effect, while policy-makers may be more focused on means and ends. While research results may help raise awareness and understanding of issues, they may be met with denial and indifference as well as with concern by policy-makers. Where concern is raised, action may or may not be taken. More active approaches are required for research to be translated into policy action” (Lin 2003).

The role of politics in implementing policies on tobacco control is important as scientists cannot effect the change on their own. Thus, key mechanisms for policy action lie within the realm and control of politicians. Unless politicians are prepared to act, smoking rates will continue to rise. Oliver explains that politics is essential to the process:

“Science can identify solutions to pressing public health problems, but only politics can turn most of those solutions into reality” (Oliver 2006, p. 195).

There is a fundamental value judgment aligned with this theme: that it is better for governments to adopt evidence-based policies in public health. Whilst this may seem an obvious statement to those operating from a scientific, rational perspective, to those with a political science perspective it is a more problematic question. Fafard suggests that political science offers explanations that help us understand the paradoxes of the gaps between evidence and policy (Fafard 2015).

Not only should policy be based on sound evidence and lead to more effective outcomes, it should also avoid unintended or adverse outcomes (Lewig, Arney & Scott 2006). But there have been cautionary notes sounded about the use of evidence-based policy in funding medicine, suggesting that there can be attempted power plays by epidemiologists and managerialists to control public policy and funding arrangements, thus enabling greater control of medical professionals (Willis & White 2003). Others have suggested that the evidence-based movement is an example of “microfascism” (Holmes 2006).

Nevertheless, this thesis is informed by the value perspective that application of evidence will lead to reductions in smoking prevalence and the belief that sound evidence should be the primary motivator of a decision-maker expending public funds on tobacco control.

Policy-making is bound up with values and pressures on those in decision-making positions, as well as the ideas in the community, commercial pressures and interests, and other external demands. The question of what is “evidence” is different for policy-makers and researchers. The importance of evidence in health care generally has risen as a dominant paradigm over the last 50 years (Davies & Nutley 1999). Knowledge transfer is the process by which information, evidence or knowledge travels from a researcher to use by a health professional or policy-maker. This thesis considers the utilisation of evidence on populations, not individuals.

There are a number of terms used to describe the transfer of knowledge, including knowledge utilisation, knowledge diffusion, evidence transfer and research utilisation, and the boundaries of these concepts are unclear (Graham et al. 2006; Thompson, Estabrooks & Degner 2006). These concepts are based on the idea that personal contact facilitates information exchange and knowledge transfer (Thompson, Estabrooks & Degner 2006).

Some writers have suggested that *research utilisation* is too narrow a term confined to science, whereas *knowledge utilisation* is a wider concept and includes other sources of data and information Dobrow, Goel & Upshur 2004. This thesis looks at and explores differences in ways that evidence is used in the process of policy-making. The “evidence” that is used by politicians may be entirely different to the scientific evidence used by researchers. It may be that the quality of that evidence, its sources and the subjective weight put on it by policy-makers are the key to decisions to take action on tobacco control.

The use of research is highly dependent on the user’s effectiveness in finding information, researchers’ ability to adapt their research to a form that is useful to the end user, and the personal contact and relationship between the researcher and the end user (Landry, Lamari & Amara 2003; Landry et al. 2006).

The role of a *knowledge broker* may be important in ensuring that knowledge is “translated” into a usable form for consumers – in this case, policy-makers. If it is true that knowledge utilisation is to a certain extent dependent on its clear understanding by users, then the need for simplification is crucial (Dobbins, DeCorby & Twiddy 2004; WHO 2004; Lin, Smith & Fawkes 2007; Oh 1996).

In recommending systematic reviews as a way of overcoming some of these knowledge utilisation problems Dobbins et al. say:

“The most significant barriers to incorporating research evidence into public health decision-making include limited time, expertise, and resources to identify, retrieve, read, synthesize and translate the best available evidence into practice” (Dobbins, DeCorby & Twiddy 2004, p.121).

Significant barriers within public sector policy-making might mean that there are insufficient people with the right skills, or it could be lack of time allocated to the issue, as well as the priority placed on it by management in the allocation of policy-making resources. The accessibility of evidence to policy-makers and bureaucrats is clearly important in whether or not evidence is recognised and utilized. How has research in Australia about effective tobacco-control policies and programs, been disseminated and to whom? A comprehensive study to try and provide some answers to this question was

conducted by Cherney (2015) and found that in Australia accessibility of academic research is dependent on a number of factors, including: the culture of the organisation and whether research is valued; the ease of access “and the level of association with the agency, entity or individual from whom information is accessible matters a great deal”; and the existence of a knowledge infrastructure within the agency (Cherney 2015, p.176). Clearly organisational culture is a vital ingredient.

In addition to these organisational barriers, local level policy-making in tobacco control can be influenced by political polarizing and local political orientation. Whether or not policy-makers are smokers can have an important adverse impact on tobacco-control policy-making (Satterlund et al. 2010).

Evidence-based public health

Utilisation of evidence is important in public health – however, it is not as simple as it seems, as there are often complex social and behavioural dimensions that do not lend themselves easily to more traditional quantitative scientific measures such as clinical trials. Some important writers such as McDonald prefer to use the term “evidence-informed” rather than evidence-based (McDonald et al. 2009).

Kohatsu et al. proposed a new definition of evidence-based public health (EBPH) as

“... the process of integrating science-based interventions with community preferences to improve the health of populations”
(Kohatsu, Robinson & Torner 2004, p.417).

The Kohatsu model integrates the role of the community and politicians into the process.

Table 2 Comparisons of EBPH

Definition 1	Definition 2	Definition 3
Jenicek (1997)	Brownson (1999,2003)	(Kohatsu, Robinson & Torner 2004)
EBPH is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of communities and populations in the domain of health protection, disease prevention, health maintenance and improvement (health promotion)	EBPH is the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems and appropriate use of program planning models.	EBPH is the process of integrating science-based interventions with community preferences to improve the health of populations.

Source: Kohatsu, Robinson & Torner 2004, p418-419

The Kohatsu et al definition of evidence-based public health is also useful in thinking about tobacco control. Kohatsu et al. said “Decisions and policies in public health are frequently driven by crises, political concerns, and public opinion” (Kohatsu et al. 2004, p. 417). Kohatsu et al. also recognised the importance of sciences other than epidemiology, to the development of evidence-based public health, and they included “political science” as one of those sciences (Kohatsu et al. 2004).

The integration of evidence-based clinical and community strategies to improve health was examined by Ockene et al. 2007. Tobacco provides an example of where both

clinical and community strategies have strong evidentiary support. The Massachusetts tobacco control program (MTCP) 1993-2002 provided an example of best practice in tobacco control (Ockene et al. 2007).

The MTCP included

“(1) an innovative media campaign to change public opinion and community norms around tobacco use, (2) community mobilization to change local laws and health regulations and (3) comprehensive tobacco treatment programs based in clinics and community settings modelled after CDC and PHS guidelines to reduce tobacco use” (Ockene et al. 2007).

Evidence-based public health policy can be influenced by health impact assessments, systematic reviews or a portfolio of tools to improve community “fit” and feasibility. For example, systematic reviews in the US showed that providing effective cessation therapies improved smoking quit rates, and this strategy was recommended by a government task force (Fielding & Briss 2006).

Political ideology

Research evidence does not necessarily “*speak for itself*” and the deliberations that lead to public policy are especially political and relate to values and ideology (Lawrence 2002, p. iv). The political ideologies of governing parties in OECD countries affect some indicators of population health. It has been found that political parties with egalitarian ideologies tend to implement redistributive policies, and that this has a marked influence on health indicators (Navarro et al. 2006). The role of politics in public health in the USA has historically been so important that widespread effective public health programs have been curtailed because of the prevailing political values, particularly as public health has been seen in conservative quarters in the USA as “socialistic” and even part of a communist conspiracy (Fee & Brown 2002). Ballard explored the differences between political ideologies on tobacco in Victoria and NSW (Ballard 2004), and it would be useful to look at this issue in Tasmania. Ballard found that NSW had a more libertarian culture, whereas Victoria had a progressive social and political establishment, in which physicians are prominent in public health advocacy.

McGinnis identifies that the bar is higher for prevention (than treatment).

Evidence does not necessarily lead to action. In the case of smoking-cessation aids, a large minority of smokers do not receive any support (McGinnis 2001).

“Despite the fact that prevention was the major contributor to the health gains of the last century, with only 5 of the century’s 30 added years of life expectancy attributable to advances in clinical medicine, most studies of health expenditures indicate that less than 5% are devoted to prevention” (McGinnis 2001, p. 392).

First, there is the invisibility of results with prevention, what McGinnis called “stealth results”. For example, many people are alive because of various public health measures, such as reduction in heart attacks due to management of blood pressure, yet the public is mesmerized by such interventions as heart transplants, which have high-cost, long-term high failure rates.

Second, the “primacy of the rescue” focuses our attention on rescuing victims in crisis. Attention is given to rescuing someone from a diabetic coma, yet little attention is given to the obligation to promote dietary and physical activity programs that would reduce diabetes and coma. This particular focus is discussed in later chapters in more detail, and in an article on bureaucratic barriers to tobacco control (Barnsley, Walters & Wood-Baker 2015).

Third, our “blunted time horizons” mean that we are impatient and cannot wait for the years of effort to produce beneficial results. The benefits of dietary change or quitting smoking may not be observable for some months or years. Short time horizons are compounded by the “tyranny of electoral cycles” (Van Der Weyden 2008), which are notoriously short for outcomes of public policy-making and planning purposes.

Fourth, the expenditure immediately on preventative measures is visible and imminent, whereas the results are not, so the perceived “opportunity costs” are visible from the outset. Future benefits may accrue to others, and existing ministers gain no credit from actions or expenditure with long-term health benefits.

Fifth, there are “double standards” applied to life-saving treatments for individuals versus preventative measures.

“Application of a life-saving cardiac pacemaker for a heart attack victim coming through the emergency room doors with a serious arrhythmia may need to meet the test of safety and effectiveness, but not cost-effectiveness. On the other hand, a smoker coming in for a routine checkup may well be greeted with a blind eye and a deaf ear when it comes to assistance. The fact that smoking cessation programs may have effectiveness rates of greater efficacy than treatment rates for many chronic relapsing conditions is often disregarded unless some economic advantage is also manifest for the providing institutions. Prevailing standards put this potentially life-saving service in the discretionary column” (McGinnis 2001 p. 393).

Sixth, the complexity of diseases targeted by prevention measures means multiple causes of disease must be targeted, and in the “fog of complexity” (McGinnis 2001, p. 393) it is easier to focus on a single disease, its treatment and outcome.

Seventh, there are multiple loci of control in prevention issues. For example in preventing road trauma, many institutions and individuals are involved, such as road safety experts, traffic engineers, law enforcement agencies, schools, car manufacturers, community organisations, the media, health-care providers and insurance companies. It is difficult for any particular politician at a particular time to claim credit. However, for the individual traffic accident victim, there is a potential immediate high-profile therapeutic gain.

Eighth, there can be multiple funding streams. In Australia the mix of federal and state funding is complex, and not easily accessed by those promoting preventative activities. Furthermore, national political changes in recent years have initially emphasised and then downplayed prevention efforts. This is discussed in later chapters, as it is particularly relevant to states such as Tasmania. A good example at a national level was the high-profile National Health Promotion Commission set up by the Rudd Government, which was recently scrapped by the Abbott Government.

Ninth, there is a “paradox of self-responsibility” in health promotion and prevention. Smokers individually can quit and improve their health and are blamed if they don’t or cannot. However, their individual circumstances may conspire to work against such efforts to quit. They may live in a household with many other smokers, may be

homeless or suffering a mental disorder, have other risk factors or illnesses and the attention given to quitting smoking is far from their minds, as the problems caused by smoking are more distant than their day to day anxieties and immediate problems. The issue of the social determinants of health is recognised in Tasmania (Taylor 2013), yet the tendency of policy slippage towards individual responsibility, and what has been labelled “lifestyle drift” (Glasgow & Schrecker 2015) is related to this paradox, or as Popay, Whitehead and Hunter describe it,

“‘lifestyle drift’—the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors” (Popay, Whitehead & Hunter 2010, p. 148).

This “lifestyle drift” can be seen in some Tasmanian Department of Health and Human Services population health documents where there is sometimes no mention of corporate regulation or responsibility and all the emphasis is on encouraging healthy individual behaviour and healthy lifestyles, for example Taylor and Frendin (2010).

Tenth, the emphasis on a “technophilic culture” means that society is more interested in gadgets and innovations that can be applied to such individuals, rather than those interventions that concentrate on broad populations groups. The humorous example of this is the “machines that go ping” popularized in a comedy program, Monty Python, where machines are revered ahead of patients. Politicians, clinicians and hospital managers can be dazzled by new technology, and ignore individual patients as well as population needs (Lothian & Grauer 2003).

Eleventh, the counterveiling economic interests working against population health measures are a key problem in prevention in general and tobacco control in particular. The tobacco industry has been identified many times as a key barrier to focusing attention on tobacco control, and the World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) (WHO 2003) devotes an entire section to it. In politics, most decision-making for prevention lies outside medical care and is determined by politicians (McGinnis 2001).

All of these points outlined by McGinnis are significant, and might help to explain the problem of barriers to evidence-based tobacco control in Tasmania.

Forms of evidence

Another issue is the type of evidence that is available and that will be seriously considered by policy-makers. The idea of “colloquial evidence” is quite a foreign concept to most scientists undertaking research in tobacco control. Individuals expressing ideas/experiences and anecdotal story telling becomes a form of evidence. It has been argued that it is reasonable and proper to consider this type of evidence in “political” decision-making processes. Lomas et al. suggest that there are

“... three forms of evidence:

- Medically oriented effectiveness research (context-free scientific evidence);
- Social science-oriented research (context-sensitive scientific evidence): and
- The expertise, views, and realities of stakeholders (colloquial evidence).

We argue that each form of evidence has a role to play in producing context-sensitive, evidence-based guidance for the health system” (Lomas et al. 2005, NP).

Another way of looking at evidence transfer is the “diffusion model” of uptake of evidence, or “diffusion of innovations” (Nutley & Davies 2000, p. 35), which identifies health advocates as critical to the success of initiatives across jurisdictions. This is consistent with consideration of policy entrepreneurs as important to the process (Shipan & Volden 2004).

However, the classical diffusion model is a centralized one, where innovation flows down the system in a relatively hierarchical way. It can range on a continuum from centralized to decentralized and will be influenced by personal characteristics (such as innovators, early adaptors and laggards), social networking of the adopters, innovation attributes (such as adaptability, compatibility, complexity) and the leadership characteristics of those who are promoting an innovation. This particular model does not appear to be useful in identifying barriers or blockers. It seems more of a linear

approach, and is essentially rationalist. This may not be particularly helpful in the Tasmanian context (Nutley & Davies 2000).

What variables do policy-makers consider?

Researchers and clinicians often focus on the effectiveness of a particular measure to inform the debate on health policy. However, policy-makers will take into account other variables, such as “...cost effectiveness, feasibility to implement, cultural appropriateness and effects on health inequalities” (WHO 2004, p. 113).

Other influences on tobacco control are policy copying, policy learning, policy emulation, policy convergence, policy transfer, policy borrowing and lesson drawing (Studlar 2006, 2007). These terms can be applied to the transfer of policy from one country to another, or across jurisdictions within a country. Globalisation has been important in transferring ideas, policies and programs, thus facilitating some measure of policy convergence in tobacco control (Studlar 2006).

In community health decision-making, decision-makers need access to appropriate information as policy-makers may be physically and intellectually far removed from research settings. An important writer on knowledge transfer, Maureen Dobbins, says that

“...consistent barriers to knowledge transfer in all settings are:

- Lack of access to current research literature,
- Limited critical appraisal skills,
- Excessive literature to review
- Work environments that do not support research transfer and uptake,
- Lack of decision-making authority to implement research results,
- Organisational decision-making processes that are not conducive to research transfer and uptake,
- Resistance to change, and

Limited resources for implementation”

(Dobbins et al. 2007 p. 2).

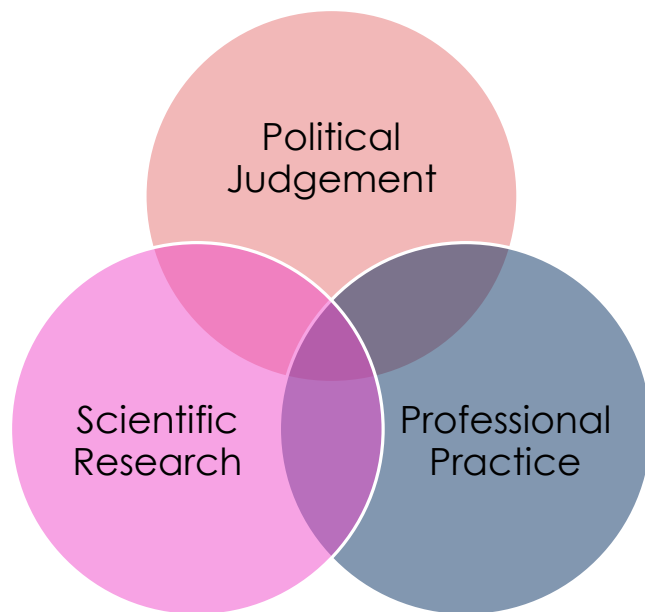
Policy-makers will be looking for broader population health gains, but will also be strongly influenced by policy copying (Sheldon, Guyatt & Haines 1998) especially from influential jurisdictions.

How is this evidence brought to bear on policy decisions?

A study conducted in a clinical setting in Wales showed that whilst there is often good will towards using the best evidence available, and to transfer that knowledge, there continues to be, in some circumstances, excessive caution about implementing them in practice. Fears about bureaucracy, and time and money to learn new skills act as barriers to implementation (Surender et al. 2002).

It has been argued in Australia by Brian Head that there are three lenses of evidence-based public policy: political knowledge, scientific knowledge and practical implementation knowledge (Head 2008). Political knowledge includes the know-how of political actors: tactics, strategies, agenda setting, advocacy, political spin, building support, and negotiating trade-offs. Scientific knowledge is the systematic analysis of data. Practical implementation knowledge is that gained from the day to day experiences of those in the communities of practice.

Chart 1 The three lenses of evidence-based public policy in Australia



Source: Head 2008, p 6.

Sometimes scientific evidence is ignored because of the way the government has chosen other priorities or values. Head explains,

“...some policy positions are ‘data-proof’ or ‘evidence-proof’, in the sense that their evidence ‘base’ has been narrowed and buttressed by political commitments, perhaps closely linked to the values and ideological positions of political leaders or parties. Some policy preferences allow only certain kinds of ‘evidence’ to be noticed.” (Head 2008, p5).

The presentation of clear concise executive summaries is important to public health decision-makers, who have little time to read original research. In fact decision-makers rarely read scientific journals (Rich & Oh 2000; WHO 2004).

“In this national study, public health decision-makers indicated that what they needed most from public health researchers were two-page executive summaries that clearly communicated the issue from a local context, highlighted available evidence, and identified specific practice and policy implications for each evidence point” (Dobbins et al. 2007, p10).

Even then, its use is influenced by policy-makers who occupy different cultures and have different world views and priorities from researchers (Lin 2003). Furthermore, individual attitudes, defensiveness and negativity are “as common as cooperation” (Head 2008, p.9).

Reasons outlined by Black and Donald as to why research evidence may not be utilized, and why it may have “little influence on service policies” include:

- Policy-makers have goals other than clinical effectiveness (social, financial, strategic development of service, terms and conditions of employees, electoral);
- Research evidence is dismissed as irrelevant (emanates from different sector or specialty, practice depends on tacit knowledge, not applicable locally);
- Lack of consensus about research evidence (complexity of evidence, scientific controversy, different interpretations);
- Other types of competing evidence (personal experience, local information, eminent colleagues’ contradictory opinions, medicolegal reports);
- Social/political environment not conducive to policy change; and
- Poor quality of “purveyors” (Black & Donald 2001, p. 276).

Overlying all of these issues

“...some policy positions are ‘data-proof’ or ‘evidence-proof’, in the sense that their evidence ‘base’ has been narrowed and buttressed by political commitments, perhaps closely linked to the values and ideological positions of political parties or leaders” (Head 2008, p 5).

If this is true, then it would not matter what the scientific evidence base is, politicians are not going to listen to the arguments or proposals couched in terms of the evidence if there are strongly conflicting values, and especially if the field is contentious. Head (2008) gives the example of climate change in relation to this notion. Marshall puts forward a similar view in relation to the way many of us ignore climate change (Marshall 2014).

Acknowledging the importance of knowledge transfer, the WHO initiative of its Framework Convention on Tobacco Control (FCTC) has a strong emphasis on information sharing and exchange. Article 20 sets out the undertakings of Parties (mostly governments) to

“...develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control” (WHO 2003).

Temporal effects

A further complication of the transfer of scientific knowledge is the impact of time. Evidence-based practice may have a delay of up to ten years before it comes into common usage, even when the evidence is absolutely clear (Davies & Nutley 1999).

Perhaps the best example of this comes from the 200 years from the time James Lancaster observed that lemon juice prevented scurvy, and when the British Navy made citrus fruits available on its ships. In the meantime, two million sailors died of scurvy (WHO 2004).

A lag effect is seen in evidence-based population health initiatives such as tobacco control, as in clinical interventions. The evidence about tobacco-related harm was published by Sir Richard Doll and others in the 1950s, but it was not until the 1970s and 1980s that serious tobacco-control action was taken in Australia (Lin 2003).

Good-quality versus poor-quality studies

A further difficulty for public health decision-makers is sorting out the high-quality studies from those of poor quality, or even elucidating what the results mean in terms of practical applications (Fahey, Griffiths & Peters 1995). It is not enough to have access to evidence, if the decision-makers are unable to distinguish between those studies that are of high quality and really mean something, versus those that are poorly designed or have other methodological faults. The implications are that sound evidence will not always be followed, and decision-makers may be side-tracked or confused by poor-quality research work. If the decision-makers do not even read journals, then the problem is compounded.

These issues were reflected in clinical practice. By the 1980s it was estimated that “only about 15% of medical practice was based on sound scientific evidence”. However, there is now keenness to absorb science and research into clinical practice and to follow what has become known as evidence-based practice (Greenhalgh 1996, p. 957).

Determinants of knowledge utilisation

While some writers have asserted that health policy is more ideologically than evidence-based driven, others say this assertion does not seem to have been tested (Ham, Hunter & Robinson 1995).

Attempts to analyse the determinants of knowledge utilisation use the following model, adapted from Belkhodja et al. (2007):

Table 3 Determinants of Knowledge Utilisation

The Determinants of Knowledge Utilisation				
Model	Key attributes	Criticisms	Utilisation Determinants	Past studies
Science push model	<p>Researchers are the source of ideas.</p> <p>Users are the receptacles of research.</p> <p>Linear sequence from supply to utilisation.</p>	<p>Transfer of knowledge not automatic.</p> <p>No-one responsible for transfer.</p> <p>Raw research not usable.</p>	<p>Content attributes efficiency, compatibility, complexity, observability, trialability, validity, reliability, divisibility, applicability and radicalness.</p> <p>Types of research include basic/applied, general/abstract, quantitative/qualitative, particular/concrete, research domains and disciplines.</p> <p>No relation between technical quality of</p>	<p>Edwards, Lomas, Dearing and Meyer, Machlup, Huberman and Thurler, Rich, Oh, Dunn, Huberman, Lomas, Landry.</p>

The Determinants of Knowledge Utilisation				
Model	Key attributes	Criticisms	Utilisation Determinants	Past studies
			research results and utilisation.	
Demand Pull model	Users are the major source of ideas for directing research. Linear sequence starts with the identification of the research problems by users.	Focus on the instrumental use of research. Too much stress on users' interests. Omits the interaction between producers and users.	Organisational structures, rules and norms.	Yin and Moore, Rich and Oh, Landry.
Dissemination model	Dissemination mechanisms used to identify useful knowledge and transfer it to potential users.	Potential users are neither involved in the selection of the transferable information, nor in the production of the research results.	Types of research results and the dissemination effort.	Maclean, Oh and Rich, Lomas, Huberman, Leung, Landry.
Interaction model	Interaction and relationships	Can lead to a selective use of research. Can be	Explanatory factors identified in the prior models.	Dunn, Yin and Moore,

The Determinants of Knowledge Utilisation				
Model	Key attributes	Criticisms	Utilisation Determinants	Past studies
	existing between researchers and users at different stages of knowledge production, dissemination and utilisation.	difficult to establish due to time and turnover issues. Overcomes the criticism of previous models.	Four categories of actors are: Types of research and scientific disciplines, needs and organisational interests of users, dissemination, and linkage mechanisms.	Huberman and Thurler, Nyden and Wiewell, Oh. Landry

Adapted from page 382 Belkhdja et al. (2007)

This interactive model is useful in unravelling knowledge utilisation and has been part of the well-constructed Canadian attempts to deal with research and policy gaps.

Health researchers are urged to involve decision and policy-makers in the process of developing and implementing programs, and to pay attention to context and external validity. By external validity, Glasgow et al. mean moderating factors that potentially limit the robustness of interventions in particular circumstances (Glasgow, Lichtenstein & Marcus 2003). For example, the social factors that influence behaviour and behaviour change such as ethnicity and social status can influence the outcomes. Local decision-makers need to feel that a study will have local relevance, and yield results that will fit their situation, while policy-makers at a more macro level will be looking at wider applicability of the evidence (Glasgow & Emmons 2007).

Research evidence has to compete with a range of other “evidence” to gain the attention of policy-makers. There are also “individual, organisational, institutional, political, economic and ideological factors”, which influence the policy process (Lewig, Arney & Scott 2006, p. 18). But first, policy makers have to be able to access the evidence to use it and this is not easy when so many journals charge fees to access an article, which may turn out not to be relevant to a time-poor and budget-conscious public servant.

Accessibility of scientific evidence and journals to policy-makers

An Australian study by Cherney et al. (2015) found that whilst it was important for researchers to make their key messages available, nevertheless it is also important that the information be physically and cognitively accessible. They concluded that, “If academics are interested in ensuring their research has an influence, they need to build close relationships with public officials” (Cherney et al. 2015, p. 183). This has been emphasised many times in the literature, but it seems a somewhat “big-city centric” interpretation in that outlying states and territories such as Tasmania and the Northern Territory, which have the highest smoking rates and small bureaucracies, are unlikely to be closely engaged with key researchers on issues affecting policy-making.

Researchers are urged to ensure that;

“...the research they produce is accessible, in the sense that it can be comprehended by public officials, is transferable, and also searchable and accessible through open access repositories and via web-based search engines” (Cherney et al. 2015, p. 184).

The accessibility of research and evidence through open-access repositories and via web-based search engines is especially crucial for low-income jurisdictions, with poor bureaucratic policy infrastructure, such as Tasmania, and would be even more important in Oceania, many other developing countries and small states and provinces throughout the world. In 2004 Africa only had 1% of global internet access, most of which was in South Africa (WHO 2004).

The research-policy divide

In Canada there has been much interest and research into knowledge and evidence transfer, into collaboration between research and practice, including the role of NGO activists, advocates and policy entrepreneurs (Anderson 2000; Denis et al. 2003; Dobbins, DeCorby & Twiddy 2004; Dobrow et al. 2006; Lavis 1999; Lavis et al. 2000; Lavis, Robertson et al. 2003; Lavis, Ross et al. 2003; Lavis et al. 2004; Lavis et al. 2006; Lomas 2000b; McDonald & Viehbeck 2007; Nathanson 2005; Ouimet et al. 2007; Pralle 2003; Richard et al. 2004; Simpson & Lee 2003; Studlar 1999, 2002; Thompson, Estabrooks & Degner 2006).

The Canadian literature tends to focus on the ‘two communities’ concept, that researchers and policy-makers occupy essentially different environments, and that a major barrier to knowledge transfer is communication between the two. However, Australian health policy writer Gibson says that the ‘two communities’ notion is inadequate to explain knowledge/research transfer, and that the situation is even more complex. Gibson believes public health policy in Australia has three theoretical lenses, the Advocacy Coalition Framework (ACF), the Policy-making Organisation Framework (PMOF) and the Governmentality Framework (GF) (Gibson 2003c). In a book chapter on a similar theme Gibson (2003a) explains that the ‘two communities’ model has descriptive but not explanatory power. Similarly, one of the key writers on knowledge transfer, John N Lavis, observed that:

“Rarely do processes exist that can get optimally packaged high-quality and high-relevance research evidence into the hands of public policy-makers when they most need it, which is often in hours and days, not months and years” (Lavis et al. 2006, p. 37).

But Canadian researchers have suggested that knowledge brokers or translational scientists can help bridge these gaps. Whilst scientists are concerned about evidence from studies, policy-makers will also look at:

“... poll results, opinion surveys, focus groups in marginal electorates, anecdotes and real life stories” (Choi et al. 2005, p. 633).

Furthermore, sometimes a tension and lack of respect between these two communities exists, resulting in mutual blame allocation. Policy-makers accuse researchers of producing irrelevant or overly complex products, lacking patience with legislative processes, while researchers worry about political expediency, “irrational outcomes”, and what they see as uninformed political hacks, incapable of comprehending technical issues (Coburn 1998; Lomas 2000a, 2000b). The differing world views of these two communities may be due to the cultures in which they operate (Lin 2003). Choi et al. argue for greater cooperation between scientists and policy-makers and suggest that organisations might need a “Chief Knowledge Officer”, as well as chief administrative officer or chief executive officer to act as a go-between for the two communities (Choi et al. 2005, p. 635).

The context of decision-making

In addition to the presence or absence of evidence, it has been suggested that the context of the decision-making process is important and itself may lead to different outcomes. This has been noted in cancer-screening programs across different countries where the same evidence resulted in different policy approaches. A study by Dobrow et al. in Canada looked at the development of policy recommendations for breast, cervical, colorectal and cancer prostate screening in Ontario. They found that the:

“... [the] central challenge for evidence-based policy is not to develop international evidence, but rather to develop more systematic, rigorous, and global methods for identifying, interpreting and applying evidence in different decision-making contexts The application of evidence must also acknowledge different policy objectives, appropriately employing rule-based grading schemes and agreement-based consensus methods that are sensitive to the nature of the evidence and contexts involved”
(Dobrow et al. 2006, p. 1811).

Dobrow’s solution was to suggest the application of more rigorous technical approaches to decision-making. Whilst this may be a useful tool for sound evidence-based policy-making, it seems unlikely that this could overcome the political, financial and other pressures and contexts in which governments and bureaucrats make decisions, as discussed above.

Similarly, in Europe, an examination of the use of health technology assessment (HTA) and health policies in eight countries in relation to screening for breast cancer, prostate cancer and routine use of ultrasound in pregnancy, found that;

“In fact, policy is often made with little or no reference to assessment and to a scientific analysis of benefits, risks and costs ...

“As illustrated by the cases of ultrasound screening in pregnancy and PSA screening, the public seeks technologies that are not proven to be of benefit” (Banta, Oortwijn & Cranovsky 2001, p. 416).

Decision-making in health policy is not a linear rational process, because people who make the decisions are also influenced by subjective processes and public demand.

Thus, other factors such as “groupthink”, individual biases, personal experience, positive or negative attitudes to risk-taking and heuristics can all influence public health policy-making (McCaughey & Bruning 2010). McCaughey and Bruning explain ‘heuristics’ thus,

“Heuristics are cognitive processes where full information processing requirements are bypassed and mental shortcutting occurs. Heuristics are mental 'rules of thumb' that make decisions easier by reducing the complexity of information processing. They operate through the use of categorization to interpret information. New information is categorized based on familiar knowledge drawn from memory bins and results in more automatic processing than would normally be required”
(McCaughey & Bruning 2010 p. 8).

The Banta et al. study recommended a more rational objective approach to decision-making ensuring public access to high-quality information, to ensure the general public does not continue to seek technologies that are not beneficial (Banta, Oortwijn & Cranovsky 2001).

But clear evidence of a failure to use evidence includes the Ottawa Charter (WHO 1986), which is familiar to anyone working in the field of health promotion, but is rarely cited, often unknown, and sometimes “derided” by those in positions of power to make decisions about public funding of prevention activities and programs. The Ottawa Charter is designed to provide health for all and to promote social justice. Even the National Tobacco Strategy does not mention it (Lin & Fawkes 2007).

In Australia, health systems organisation, federal and state responsibilities, and complicated funding arrangements may also complicate policy (Lin & Fawkes 2007). It seems that in Australia as elsewhere, those involved in health promotion activities, such as tobacco control, struggle to be heard at the policy-making table. Lin discussed the social determinants of health, and observed that;

“...health promotion practitioners are seldom at the centre of policy development” (Lin & Fawkes 2007).

The role of the general community in determining what happens in public health cannot be under-estimated. Politicians and policy-makers take into account the views of the

community in determining policy, and in making decisions. The political dimension to public health policy-making means that,

“Decisions and policies in public health are frequently driven by crises, political concerns, and public opinion” (Kohatsu, Robinson & Torner 2004, p. 417).

Leapfrogging

Studlar, one of the few writers who have written extensively on the politics and policy of tobacco control, says that more attention needs to be paid to “leapfrogging”;

“....that is, the tendency of jurisdictions either within one country or across countries not only to adopt each other’s policies, with some reinvention, but also to achieve similar ends – in this case, the reduction of tobacco consumption” (Studlar 1999, p. 77).

Diffusion of tobacco-control ideas seems to occur through scientific findings and their communication within the tobacco control community nationally and internationally, but politics is a variable that “intervenes” and can stop or distort the process” (Studlar 1999, p. 77).

It is sometimes difficult to adhere to the evidence, when adapting to local circumstances, because of the tension between a central and idealized “norm” of conforming to the evidence-base (Nutley & Homel 2006, p. 23). Furthermore, sometimes there is uninformed transfer of evidence, sometimes incomplete transfer and sometimes inappropriate transfer, leading to policy failure in the adopting jurisdiction (Dolowitz & Marsh 2000).

Understanding the flow of ideas through systems is important to understanding of the direction of evidence-based policy in public health. The impediments and barriers include lack of “....contact between researchers and policy-makers, lack of timeliness of research, mutual mistrust, power and budget struggles, poor quality of research, political instability and debates about what constitutes evidence” (Armstrong et al. 2006, p. 386).

Evidence-agenda map

Work by Rychetnik and Wise in Australia proposed an “evidence-agenda map” to assist advocates of evidence-based policy to link policy goals to the evidence (Rychetnik &

Wise 2004 p. 254). The map is useful for areas of health policy-making where the evidence is somewhat confused or lacking, although in the case of tobacco control that is not the case. Tobacco control evidence is quite strong. Rychetnik et al. observe that scientific evidence is:

“... used in policy settings like any other type information: to argue prevailing agendas and justify ideological positions” (2004, p. 254)

Furthermore, Rychetnik and Wise say that advocacy is more effective and evidence is more likely to be used if it coincides with a ‘window of opportunity’ when politicians suddenly become interested in a topic, after a media outcry or some other ‘focusing event’ (Rychetnik & Wise 2004, p. 254). This fits with Kingdon’s theory of agenda setting (Kingdon 1995).

The “shield” model of knowledge transfer

Another model proposed by Gano et al. 2007 is that of a merging of the engineering (science “push”) and socio-organisational models of knowledge transfer into a model that “shields” the knowledge production and transmission process from political interference. The authors found that their respondents, who were researchers within government organisations, academic institutes, budgetary agencies and non-government organisations, but not final decision-makers, placed a high value on the quality of the research, and the engineering model. However, these decision-makers reported some influence of inter-personal contact with other researchers (Gano, Crowley & Guston 2007).

The “shield” model suggests, “...that a strong network of shared professional values shelters the research arena from political pressures” (Gano, Crowley & Guston 2007, p. 57).

Table 4 Three models of knowledge transmission

Three models of knowledge transmission			
Framework	Defined Action	Catalyst	Output
Engineering or “science-push”	When the imperatives of technological advance are too great to ignore, new knowledge transmission occurs.	Progress, technical virtuosity	High-quality scientific advice
Socio-organisational	Positive oral and written communication between individuals and groups facilitates knowledge transmission.	Social linkages, engagement	Social capital
Shield	Commonly valued norms about objective research shelter knowledge transmission.	Impartiality, objectivity, and productive tension between	Continuity (for research and social programs)

Three models of knowledge transmission			
Framework	Defined Action	Catalyst	Output
		technical and social goals.	

Adapted from Gano, Crowley & Guston 2007

A problem with the shield model is that it does not seem to deal with situations where the end-user or decision-maker is a completely political operator, with no research skills, background or networks. However, in terms of closed systems where higher political levels of decision-making are not required, the model might work quite well, but this is speculation.

Other writers have identified risks to evidence-based policy through efforts to politicize or silence objective scientific research (Rosenstock & Lee 2002).

“In their efforts to squelch unwanted scientific findings, vested interests have also been known to harass investigators, federal agencies, and even the scientific and policy-making processes themselves” (Rosenstock & Lee 2002, p.16).

Despite tobacco industry efforts over many decades to recruit scientists, and to influence or discredit research this appears less of a problem for tobacco-control-based research, and the evidence around effective measures to reduce smoking. The tobacco industry has largely accepted that smoking is damaging to health, and has recognised this on its websites, although it still entertains contrary arguments about the dangers of passive smoking.

Policy entrepreneurs, champions, charismatic leaders and advocates

In his discussion of the “policy primeval soup”, Kingdon (1995) talks about the role of policy entrepreneurs. These are influential, often prominent, people who can drive the agenda forward and advocate for particular policy positions. They may be in

government, the non-government sector or research (Kingdon 1995). The concept as Kingdon generally used it is in relation to those who are seeking change as a force for progress. However, it may be that key individuals amongst the pro-tobacco forces should also be considered policy entrepreneurs as they propose and advocate from their perspective. Heroic or charismatic leaders are often needed in order to articulate ideas and mobilise opinion and action (Nadler & Tushman 1990).

“While various words have been used to portray this type of leadership, we prefer the label ‘charismatic’ leader. It refers to a special quality that enables the leader to mobilise and sustain activity within an organisation through specific personal actions combined with perceived personal characteristics.” (Nadler & Tushman 1990, p. 82).

Dr John Snow is an early example of a public health policy entrepreneur, who was effective in working at all levels of the policy, research and implementation process. Policy entrepreneurs in tobacco control have been both energetic and often charismatic. Charismatic leaders can mobilise tobacco-control directions with new ideas (Fafard 2015; Smith 2013). Policy entrepreneurs can be advocates, health bureaucrats or ministers (Hooker & Chapman 2006). As has been said earlier in this chapter, the advocacy coalition framework (ACF) usefully explains policy stability, and the policy entrepreneurship (PE) model explains dynamic policy change (Mintrom & Vergari 1996).

The use of the term “policy entrepreneur” is to distinguish it from the more limiting term of “advocate”. For this thesis, the term policy entrepreneur means a person who is able to meld a number of roles of advocacy: leadership, political persuasion, interpretation of scientific literature, framing of arguments. A policy entrepreneur has a research background, understands universities and other research institutions, but also understands how policy processes work and can work well with policy-makers and community groups (Lomas 2000; Oliver 2006; Oliver & Paul-Shaen 1997).

The policy entrepreneur can work at several levels in the process of transforming tobacco control literature into public policy, from working with advocates and researchers, to public sector policy-makers and politicians. Policy entrepreneurs can also “sell” a policy across the world (Dolowitz & Marsh 2000). A leading Australian example of an effective policy entrepreneur in tobacco control is Dr Nigel Gray, whose

close working relationship and understanding of political processes, as well as a medical background in tobacco control, led to the establishment of VicHealth in the 1980s. This is an important health promotion foundation, which has provided a strong support for tobacco-control research and advocacy not only in Victoria, but in Australia more generally, and has provided a valuable hub of research and advocacy support internationally. Dr Gray went on to work with WHO, and remained influential internationally until his death in 2014 (Ballard 2004, Cancer Council Victoria 2014).

The tobacco-control policy entrepreneur needs knowledge of the literature and research, the ability to keep up to date with it, as well as ability to “work” the political and bureaucratic processes. Such an entrepreneur networks at several levels: good contacts with researchers are essential, and links to international thinking through conferences, and tobacco-control organisations as well as access to electronic sources are essential to the process of keeping abreast of the evidence. Policy transfer from one country to another or one jurisdiction to another is accelerated by use of the internet (James & Lodge 2003). Exchange of information in Australia, and with other English-speaking countries with similar systems of government such as Canada and New Zealand is accelerated by “Globalink”, a tobacco-control network established by the WHO, and more recently transformed into a Facebook social media networking group (Ballard 2004).

While an advocate may take a similar path, they will often be more time-constrained, and less multi-dimensional in their approach. The policy entrepreneur is utterly embedded in the process of moving from research to policy, while an advocate is on the outside looking in; a policy entrepreneur has cachet in policy-making circles and is consulted.

The term “knowledge broker” seems to convey a similar meaning to policy entrepreneur; however, it implies a more passive stance than that of policy entrepreneur, who would be a person driven on a crusade or quest for outcomes (Choi et al. 2005). The existence and role of policy entrepreneurs, not only acting as knowledge brokers, but as advocates and have the ability to work at all levels of government, could be a key to success or failure of knowledge utilisation. However, it may also be that middle-ranking bureaucrats are acting as knowledge brokers, but have not been acknowledged as part of the process. For example, it is common for government reports or discussion

papers in Australia to have no mention of the name of the writer(s). The name of the sponsoring senior public official may be given in a foreword, and that person has accepted responsibility for the document, but they have not written the paper (APSC 2007a, 2007b; Taylor 2006).

It is possible that there is a “third community”, in that middle-level public servants act as knowledge brokers, are essentially invisible to those externally viewing the policy process. It may be that the ‘two communities’ model is missing this link, that of the middle range bureaucrats.

The role of policy entrepreneurs in knowledge transfer has been important in the development of tobacco control, and global leadership by such people as Dr Gro Harlem Brundtland, Director-General of WHO for one term until 2003, has been essential to the process internationally in recent years (Lee 2006). Dr Witold Zatonski is recognised in tobacco-control circles as having been immensely influential in bringing effective tobacco-control measures to Poland. He is an experienced medical practitioner, an epidemiologist and a talented political activist in an exceedingly difficult political climate (Malinowska-Sempruch, Bonnell & Hoover 2006; Zatonski 2003).

In Australia, tobacco-control entrepreneurial leaders such as respiratory physician Dr Cotter Harvey in NSW, Dr Nigel Gray and Professor David Hill in Victoria and Professor Mike Daube in WA, Anne Jones (ASH) and Professor Simon Chapman in NSW, have been important in penetrating the bureaucracy, and working with politicians, and non-government organisations to advance the messages about effective tobacco-control mechanisms.

In a negative vein, it has also been suggested that the activities of policy entrepreneurs can undermine democratic accountability. It is argued that key actors, who have power and authority, can shape agendas and policy to suit their own ideas and plans. Where there is centralized power, elite domination and fragmentation of responsibility the opportunities for policy entrepreneurs certainly exist. These elite policy entrepreneurs can close out other approaches through:

“... the exclusion of rivals, and tight control of information flows within and between networks – in short, efficient political management” (Greenaway, Salter & Hart 2007, p. 734).

On this basis, policy entrepreneurs can potentially be a force for harm if their ideas are “bad”, creating a playing field that is neither level nor democratic. The policy entrepreneur in a powerful position can drive the policy through various veto or clearance points, irrespective of the views of others who might otherwise have been consulted (Greenaway, Salter & Hart 2007). Greenaway et al. caution about the role of policy entrepreneurs seems to be more applicable when the powerful policy entrepreneur is embedded in the bureaucracy itself, and not when the individual is located outside the system.

In order to integrate evidence-based clinical and community strategies to improve health measures such as reducing tobacco consumption, leaders must advocate for more effective interventions and policies, as well as adopting a collaborative approach (Ockene et al. 2007). The role of individual policy entrepreneurs, working within non-government organisations, has been important around the world in tobacco control, and more especially in Australian states.

Medical professionals as policy entrepreneurs

Elite medical professionals, particularly academic males, have had a well-documented strong influence on the development of health policy in Victoria, and this is likely to be the case in other Australian states (Lewis & Considine 1999; Lewis 2006).

In the USA, a succession of surgeons general has advocated strongly for tobacco-control measures, and their reports and pronouncements have been influential not only in the US but internationally (Henningfield 2003). Also in the USA, leaders of health organisations and medical societies are able to influence politicians to take action on tobacco-control measures (Gottlieb et al. 2003).

It has been suggested that in the USA, states with fewer medical practitioners proportional to the population are less likely to have sound cancer prevention policies, including programs to reduce smoking rates (Greenberg 1987).

On the other hand it has been argued in a scathing condemnation, that the American Medical Association was silent or complicit on smoking and tobacco-control issues for many years. A former editor of the Journal of the American Medical Association (JAMA) was working with Phillip Morris to design marketing campaigns in the 1930s.

JAMA continued to print cigarette advertisements until the 1950s. Until the 1980s the American Medical Association Members Retirement Fund owned substantial tobacco shares (Nathanson 1999; Wolinsky & Brune 1994).

The experience in the UK seems to be different from the USA. The British Medical Association was highly active in campaigning for indoor smoking bans including pubs and clubs, to the extent that it has been said that; “Tobacco took up a disproportionate amount of BMA time”, and individual medical practitioners applied pressure on their local members of Parliament (Cairney 2007, p. 63). It has also been suggested that dentists could play a greater role in tobacco-control advocacy internationally (Beaglehole, Tsakos & Watt 2005).

Qualities of a public health policy entrepreneur

Taking the information available about key high-achievers in the area of tobacco-control advocacy who seem to fit the definition of a policy entrepreneur, it appears a policy entrepreneur:

- Is driven by a ‘crusading’ desire to achieve positive outcomes for public health;
- Is a person with leadership qualities, or charisma, or strong networking skills;
- Has credibility at all levels of the policy-making community;
- Has sound understanding of the science and the research;
- Is able to interpret science in a simple easy-to-understand way to policy-makers, the community, colleagues and/or the media – acting as a knowledge broker;
- Understands political processes in some depth, including party politics, parliamentary systems, cabinet processes, ministerial minders, budget processes, influences on political actors and policy-makers;
- Is sensitive to mood, pressures and nuances of politicians and their parties;
- Provides extra backgrounding for key policy-makers who have a personal interest, affected family member, or personal experience of the public health problem, and provide them with scientific arguments and research to advocate for the cause;
- Has flexibility and the ability to go ‘venue shopping’ when foiled by a barricade or other impediment;
- Seizes the moment when a ‘window of opportunity’ (see Kingdon 1995) opens;

- Is able to galvanize action by supportive relevant health organisations or academics at key moments in the policy cycle;
- Understands mechanisms for countering the arguments of public health ‘enemies’ (such as the tobacco industry and their ‘front’ organisations);
- Has persuasive ability and can ‘sell’ ideas;
- Is patient, persistent and not easily dissuaded from continuing to pursue goals;
- Can see long-term benefits over years, even decades, and is not overly discouraged by short-term set-backs; and
- Never gives up!

Non-government organisations (NGOs) and advocacy

NGOs have been influential in Australia and elsewhere in promoting tobacco-control measures, and have been monitored and shadowed by the tobacco industry, which is aware of the immense influence these organisations can have (Knight & Chapman 2004a; Malinowska-Sempruch, Bonnell & Hoover 2006).

Paul Sabatier developed the notion of the “advocacy coalition framework” (ACF). This framework assumes that the policy change will take a decade or more; that the best way to analyse this is to hone in on policy subsystems, that is the people with an interest in the policy area; and that public policies can be thought of like beliefs or values, or goals, with assumptions about the best way to go about achieving those ends (Sabatier1988). The key people involved in the ACF are people from NGOs interested in the issue at stake, as well as “policy brokers”, who are those who try to reduce conflict between people or groups. Sabatier described the concept of the advocacy coalition framework as a critical vehicle for understanding public policy processes (Sabatier1988). This is a particularly useful analytical frame of reference as it includes not just the interest groups, public servants and politicians involved in policy-making, but also journalists, analysts and researchers. However, it does not appear to be particularly helpful in analysing policy failure, which is the case under consideration in this thesis.

Tobacco control is an interesting area when viewed through the ACF lens, because the level of conflict and disagreement between the tobacco industry and NGO health groups is so high, that there is no possibility of compromise. In addition, the distribution of economic power and resources at their respective disposal is asymmetrical, with the

tobacco industry commanding billions of dollars and health groups struggling for the charity dollar.

The ACF is a mechanism for departure from previous models of looking at policy-making such as the “iron triangle”. The concept of the iron triangle is the three way split between the executive government, the bureaucracy and interest groups. However, public policy researchers in the US, such as Michael Givel and Stan Glantz, remain convinced that the power wielded by the tobacco industry, and its influence on governments, remains more appropriately analysed as an iron triangle (Givel & Glantz 2001).

In Australia, the key NGOs advocating for tobacco control in the last decade have been the Australian Council On Smoking And Health (ACOSH), based in Perth West Australia; Action on Smoking and Health (ASH) based in Sydney; QUIT; The Cancer Council of Australia, with branches in all states; National Heart Foundation, all states; Asthma Foundation(s); Australian Medical Association (AMA); Public Health Association (PHA); Thoracic Society of Australia and New Zealand and the Australian Lung Foundation.

The three leading tobacco manufacturers in Australia are British American Tobacco Australia (BATA), Philip Morris and Imperial Tobacco. These manufacturers also set up “front” organisations from time to time. These include the Butt Littering Trust (funded by BATA); The Tobacco Institute of Australia, (now defunct but formerly headed by federal former Liberal MP and former Tasmanian Richard Mulcahy, head of the Australian Hotels Association in the 1990s); retailer organisation Australasian Association of Convenience Stores Incorporated (AACS)(funded by BATA), and Healthy Buildings International (HBI) (funded by Philip Morris) (Carter 2003a; Chapman & Penman 2003; Dearlove, Bialous & Glantz, 2002; Harper 2006). There are other smaller operators and importers, but they rarely lobby state governments.

Community involvement in grass-roots advocacy

In the USA, grass-roots social movements have been identified as important in reducing smoking rates, that it has been important in articulating smoking as a strong credible threat to public health to have the ability to “mobilise a diverse organisational

constituency”, and that there is an association with the “convergence of political opportunities with target vulnerabilities” (Nathanson 1999, p.421). This convergence has been more important since the association with passive smoking and ill-health was established. Non-smokers were galvanized to seek government and legislative protection from tobacco smoke in public places and work places (Nathanson 1999). This sort of grass-roots movement is rare elsewhere, including in Australia.

Two of the most important and prolific Australian writers on tobacco control, both internationally recognised, are Simon Chapman and Melanie Wakefield. In 2001 in their reflections on tobacco-control advocacy they said:

“Advocacy in Australia has been driven by a relatively small group of people working from an even smaller group of nongovernmental organisations (NGOs) and grassroots community groups” (Chapman & Wakefield 2001, p. 279).

When asked their views, the general public in Australia would like to play a greater role, and be consulted more about health priorities, and particularly about funding allocations (Wiseman et al. 2003). There is a recognition that tobacco-control advocacy in Australia has rarely if ever arisen spontaneously from the “community”. This advocacy has been led by health non-government organisations and policy-oriented researchers (Chapman & Wakefield 2001).

Bureaucrats as invisible policy entrepreneurs

Chapman and Wakefield are amongst the few writers to recognize the important advocacy role that public servants can play within the bureaucracy. They are also aware that these public servants often do not think of themselves as advocates (Chapman & Wakefield 2001). As an example, Gibson identifies the role of “faceless bureaucrats” working within the Australian public sector state systems who relentlessly advocated for Needle and Syringe Programs in Australia in response to the HIV/AIDS epidemic threat (Gibson 2003).

The role of bureaucrats as policy entrepreneurs has not been studied extensively in Australia, probably because their role is usually hidden from public view. The role of a public health official has been described as that of a determined idealist, a cunning

political strategist and agent of redistribution from the wealthy to the poor, with the latter role in grave danger of extinction (in the US at least) (Mullan 2000).

Studlar also identified tobacco-control policy entrepreneurs from the public sector in the USA and Canada, although he considers they should more appropriately be designated as advocates. Government employees Donald Shopland in the US worked for 40 years on tobacco control; Murray Kaiserman in Canada, John Garcia in both countries, Neil Collishaw in Canada and in WHO, and all these men could all be described as policy entrepreneurs (Studlar 2002). Public health professionals who can work at both political and research levels are more effective at finding windows of opportunity, understanding the limitations of government, and designing effective policies and implementing programs (Oliver 2006).

Satterlund et al. point out that it is easier in more affluent communities to "... find 'champions' with a history of proactive tobacco control work who were willing to join well-mounted campaigns than it was in rural counties where tobacco use was more prevalent and still relatively acceptable" (Satterlund et al 2011, p621). In contrast, even in the more affluent communities policy proposals can be subverted by a small group of organized smokers (Satterlund et al. 2011).

Advice to advocates

Tobacco-control policy advocates do not have to look far for advice about how to proceed with their lobbying efforts. It is important to emphasise the science, the health issues, counter tobacco industry criticisms, "mobilise new voices", and to coordinate their efforts (Bero et al. 2001; Bryan-Jones 2004; Bryan-Jones & Chapman 2006).

Tobacco-control advocates have also been urged to monitor government tobacco control education programs at a detailed level, and continue to press for effective programs (Bialous & Glantz 1999). Advocates are told to engage in the process, be clear and precise with their language about the research and to lobby on behalf of the regulators and policy-makers.

"Policy makers suggested that tobacco-control advocates should: present science in a format that is well organised and easily absorbed; engage scientific experts to participate in the regulatory process; and lobby to

support the tobacco control efforts of the regulatory agency” (Montini & Bero 2001, p. 218).

The effective use of health statistics in “marketing” by advocates is critical to the process of convincing policy-makers of the importance of their case (Walker, Bryce & Black 2007).

All this advice is no doubt helpful for advocates; however, it does not solve the problem if there are few of them, if they are under-resourced and if they do not have ready access to the data themselves. This applies to both bureaucratic entrepreneurs as well as those who are more visible, such as the non-government spokespeople.

There is little information about how policy entrepreneurs and/or advocates in tobacco control think and behave in Australia. There are inhibitions on some organisations engaging in advocacy, especially if they are funded by governments, which many NGOs are. More conservative governments make charity status a criterion for eligibility for tax deductibility of donations, which means such organisations cannot theoretically engage in any advocacy role. Politicians do not like being criticized and may punish groups by reducing funding. This poses a huge dilemma for public health NGOs, and this means that independent academic organisations must bear a greater load of the advocacy task, because their NGO colleagues may be constrained from public comment (Chapman 2004).

Industry duplicity

Highlighting the deviousness and duplicity of the tobacco industry is often mentioned as a key issue that tobacco-control advocates should target, because this is effective in reducing smoking rates (Carter 2003b; Carter & Chapman 2003; Hammond et al. 2006). Exposing the links between the tobacco industry and politicians is also important (Givel & Glantz 2001). The tobacco industry will attack and undermine organisations dedicated to tobacco control (Ibrahim, Tsoukalas & Glantz 2004; Hiilamo 2003; Mandel & Glantz 2004; McDaniel, Smith & Malone 2006). Attacking the tobacco industry as an effective form of advocacy was not really publicly acceptable until the 1980s (Nathanson 1999).

The provincial government of British Columbia in Canada has explicitly adopted exposing and denormalising industry conduct, as part of its measures to implement tobacco control in that state. Canada has taken a lead role in attacking the tobacco industry and refusing to be cowed by industry litigiousness. In this case the governments themselves are taking an advocacy role (Thomson & Wilson 2005a). In Hong Kong there has been increasing political support to resist the lobbying of the tobacco industry (Knight & Chapman 2004b). The tobacco industry will make every effort to undermine even very local-level interventions that it sees as a threat (MacKenzie et al. 2004; White & Bero 2004). The industry has challenged the way carcinogens are identified; and in the process in the USA “it produced a particular legal precedent for judicial review that is favorable to all regulated industries” (Cook & Bero 2006, p. 747). The tobacco industry has not demonstrated any moral conscience, remorse or acknowledged responsibility for the harm caused by its products. The industry has been described as the “intelligent vector” of cardiovascular disease by promoting its products and opposing tobacco-control measures (Barnoya, Bialous & Glantz 2005).

Furthermore, in the United States tobacco industry lawyers have also been identified as “disease vectors” through their questionable behaviour, and similar tactics have been employed in Australia to discourage litigation and hide the truth.

“Tobacco-related diseases have proliferated partly because of tobacco company lawyers. Their tactics have impeded the flow of information about the dangers of smoking to the public and the medical community. Additionally, their extravagantly aggressive litigation tactics have pushed many plaintiffs into dropping their cases before trial, thus reducing the opportunities for changes to be made to company policy in favour of public health” (Guardino & Daynard 2007, p. 224).

The tobacco industry has been linked to political donations, and has spent millions of dollars in lobbying politicians in the USA (Goldman & Glantz 1998). Tobacco industry donations have also influenced legislative outcomes, in favour of the industry (Luke & Krauss 2004; Monardi & Glantz 1996, 1997, 1998a, 1998b, 1998c). In Australia, similar behaviour has seen tobacco industry political donations favouring the Liberal

Party, and a former NSW Liberal Premier Nick Greiner went on to Chair British American Tobacco Australasia (Ballard 2004).

The European Parliament has been severely criticized in *The Lancet* for its association with British American Tobacco, and particularly giving credibility to BAT's pretensions to 'corporate social responsibility' (Hyde 2007).

Union officials as advocates

The role of union officials in tobacco control has been highlighted by several writers, and it would be useful to see how important their role has been in Tasmania. The effectiveness of the cabin stewards' unions, combined with tobacco control NGOs was important in eliminating smoking from airlines (Barbeau et al. 2005; Barbeau et al. 2007; Holm & Davis 2004; Smith 2008).

Framing

In Canada it has been found that support for tobacco-control measures varied by political party and the beliefs of politicians about the role of government in health promotion. Ideology is influential in the way tobacco control is seen by politicians. Therefore the way tobacco-control policies are 'framed' has been shown to have resonance with politicians and tobacco-control advocates need to be cognisant of this, so as to increase the knowledge amongst legislators of the health effects of tobacco and ways to reduce consumption (Cohen 1999; Cohen et al. 2002; de Guia, Cohen, Ashley & Ferrence et al. 2003; de Guia, Cohen, Ashley & Pederson et al. 2003).

Role of the media

The media can play a useful role in the process of translating research and can have a powerful influence on public servants, policy-makers, clinicians, industry and the public (Lavis, Ross et al. 2003a; WHO 2004; Lin, Smith & Fawkes 2007.) The public, which includes politicians and public sector policy-makers, gets more information about public health from electronic media sources than from general practitioners or other health workers (Greenberg 1992).

In a quantitative analysis of the most important influences on public-place restrictions on smoking in Canada, Asbridge identified the media and health advocacy as playing

the strongest roles in the development of policy, more important even than scientific research and parliamentary debate. The role of the US Surgeon General as an advocate was particularly important, as his pronouncements and publications have international cachet, credibility and influence. However, the scientific evidence provided a basis for the Surgeon-General and secondarily the media to present arguments in favour of secondhand smoke regulation, and therefore added legitimacy to these approaches (Asbridge 2004). Asbridge concluded that models of

“... law making and policy formation must consider the interplay of multiple policy inputs” (Asbridge 2004, p.13).

Advocates are also urged to be aware of the issues and “angles” that are important to the media, and to use media outlets to good effect in their tobacco-control advocacy efforts (Durrant et al. 2003; Smith et al. 2005; Lin, Smith & Fawkes 2007).

Letters to the editor of newspapers in Australia are one way that advocates can get across messages about tobacco and smoking issues (Smith, McLeod & Wakefield 2005). The importance of evaluating media advocacy efforts and targeting them effectively is also important for advocates (Stead, Hastings & Eadie 2002). The effective use of health statistics in public “marketing” by advocates is critical to the process of convincing policy-makers of the importance of their case (Walker, Bryce & Black 2007).

Politicians are influenced by public opinion and the media is often seen as a reflection of public views. In order to take action on an issue, politicians need to be convinced of both the scientific evidence, and also that there is public support for any action. Sometimes Health Ministers, such as John Reid in the UK in the early 2000s, can be “blockers” of tobacco-control reforms, and advocates find themselves with a need to do some venue shopping, i.e. seeking out different institutions or individuals, to bypass “blocking” ministers (Albaek, Green-Pedersen & Nielsen 2007; Arnott et al. 2007).

One of the problems faced by tobacco-control advocates as identified by Pollack and Jacobson is that it is easier to be caught up in advocating for new policies and new legislation, because that creates media interest and public discussion, than it is to closely monitor existing policies and regulations. The media hype surrounding new and interesting forms of regulation tend to overshadow the importance of affirming extant

programs (Pollack & Jacobson 2003). The role of “blockers” of current tobacco-control measures within the bureaucracy should also be looked at if they can be identified, and there seems to be no literature on this. This is examined in some depth in Chapter 7.

Survivor advocacy

A successful advocacy program for survivors of tobacco-related diseases was developed in North Carolina, the largest tobacco-growing state in the USA. Being involved in advocacy can be empowering for the individuals, who may otherwise feel demoralised by living with a tobacco-related disease (Mathew, Goldstein & Hampton 2008). Social marketing theory suggests that:

“... messages delivered by survivors and victims of tobacco use are highly effective as they are intensely personal, convey the serious health consequences of tobacco use and evoke negative emotional responses”
(Mathew, Goldstein & Hampton 2008, p.6).

Unfortunately, so much stigma, guilt and shame is attached to lung cancer that patients often conceal their illness as long as they can, so it can be difficult for them to act as advocates (Chapple, Ziebland & McPherson 2004; LoConte et al. 2008) .

The moral dimension of tobacco control

It has also been suggested that there is a moral dimension in campaigns by advocates against tobacco smoking, as there was in the temperance movement against alcohol (Pennock 2002). Studlar also discusses an idea that “protestant moral populism” has facilitated the anti-tobacco advocates’ ability to influence governments in the English speaking countries of Australia, Canada and New Zealand. However, he concludes that the key element is not so much Protestantism as “rugged individualism”, which characterises tobacco control laggard states or provinces such as Alberta and the Northern Territory (Studlar 2007).

The framing of tobacco smoking by anti-tobacco campaigners as a “social hygiene” issue was one way of overcoming the attitude of personal responsibility pervasive in the US, in other words smokers saying “it is my body, and I will smoke if I choose to”. Firstly, the framing argument was directed at the rights of children and other non-smokers to protection from smoke, and secondly the addictive nature of nicotine meant

that there was no informed choice for smokers (Bailey 2004). The moral issues associated with tobacco consumption have been prevalent for many years, even from early in the 20th Century (Studlar 2006). Furthermore messages about families, such as preventing younger siblings from smoking, are apparently effective in making smoke-free homes acceptable and normal (Mathew, Goldstein & Hampton 2008).

Public policy-making; structures and culture

Politics, for better or worse, plays a critical role in health affairs

(Oliver 2006 p.195).

As discussed at the beginning of this chapter, tobacco control has never been adequately categorized, according to one of the foremost writers on the subject, Donley Studlar (Studlar, 2002, p.199). Whilst there is a great deal of literature on tobacco control, much of it is descriptive, and little is about public policy-making. Recently Fafard said political science can offer a rich body of theory to explain “the varying relationship between evidence and policy in public health” (Fafard 2015, p.1)

Structures are important

Internationally it has been recognised that decentralized pluralist government systems such as Australia have more comprehensive tobacco control than their unitary counterparts (Cairney, Studlar & Mamudu 2012). Hooker and Chapman (2006) found in NSW that political structures, including party structures and parliamentary committees, are important in framing tobacco-control policies. In several cases the least powerful players – minor parties, backbenchers, independent Upper House members, women and party activists – were able to influence policy. The tobacco lobby tended to be able to gain access to ministers, the Premier and Treasurer, but were less successful in influencing these more independent-minded groups and individuals (Hooker & Chapman 2006).

Protecting children – an advocacy-framing device

In a quantitative analysis of politicians and political parties in Canada, all supported, irrespective of their ideological position generally, the proposition that governments had a role to discourage youth from smoking. The parties differed along ideological lines on other health-promotion and smoking-related issues (Ashley et al. 2001). This is consistent with US studies that show public support for initiatives aimed at reducing smoking or preventing uptake in children, but ambivalence about other measures where initiatives may impinge on what is seen as personal choice by adults (Batra et al. 2002).

Some policy-makers are attracted to the concept of preventing smoking in children, however leading tobacco-control research economists, Jha et al., warn that;

“... a strategy aimed solely at deterring children is not practical and would bring no significant benefits to public health for several decades. Most of the tobacco-related deaths that are projected to occur in the next 50 years are among today’s existing smokers. Governments concerned with health gains should therefore consider adopting broader measures that help adults quit” (Jha et al. 1999, p10).

Further, Jamrozik claims that driving down adult smoking rates is the most effective way of reducing smoking amongst children (Jamrozik 2004). Jamrozik comments “Already evidence shows that young people in communities with active and prominent general programmes of tobacco control are beginning to realise that saying ‘no thanks, I’ve given up’ is more ‘adult’ than accepting the offer of a cigarette”(Jamrozik 2004, p.1008). The tobacco industry frames arguments around “individual adult choice”, whereas the tobacco-control movement tends to frame arguments around collective responsibility and public health, including protecting children and costs to the health system. Individual choice values resonate strongly in the USA, but is less a hegemonic value in other English-speaking countries such as Canada, New Zealand and Australia. This may be a partial explanation for more successful tobacco-control legislative reforms in the latter three countries, and a greater reliance on litigation in the USA to achieve similar outcomes.

Policy failure

In an excellent study of failure of the tobacco-control policy process in Texas, Shillis et al. (2003) identified the processes undertaken by the Tobacco Prevention Task Force, tasked by government with developing an appropriate tobacco-control strategy, with funds from the Master Settlement Agreement, an agreement reached with the tobacco industry following litigation, to provided funds to selected states. The group worked well and produced a comprehensive plan, but,

“The unity built by science crumbled once the game changed to politics”
(Shillis et al. 2003, p. 783).

The allocation of funds to effective tobacco-control measures, even when there is a large pool of designated funds available, is frequently dissipated by the political process (Shillis et al. 2003).

Shillis et al. make the comparison between evidence-based medicine and public health process with this analogy:

“A plan from medicine using watered down drugs, because not enough money was available for a dosage that would work, would be publicly contested. Yet, public health professionals have functioned on limited budgets that force watered-down practices that go against the grain of experience and knowledge” (Shillis et al. 2003, p.784).

Shillis et al. underscore the critical need for leadership, and for advocates to be skilled in the use of politics as well as an understanding of the relevant science. Navigation of the political processes is a key to success in advocating for tobacco control (Shillis et al. 2003).

It has also been argued by some that scientists should not take a publicly political or public advocacy role, as this could undermine their objectivity. However, the political arena cannot be avoided in the field of health promotion. Indeed, it is essential that the players in that arena understand the rules and the processes and have skills to handle the structures, the people and the processes of politics. However, public health officials talk about prevention, but often baulk at moving into the political amphitheatre (Shillis et al. 2003).

There is some complexity in defining policy failure, firstly because as McConnell points out, “...there is a relative paucity of writings on policy failure” (McConnell, 2015, p. 223). For the “..rationalist, scientific tradition, policy outcomes can typically be measured and assessed against original goals....” (McConnell, 2015 p. 223) within which framework this thesis is located. The fact that Tasmanian male smoking rates did not fall for a decade, in comparison to mainland states, and overall smoking rates were not declining at the same rate, was a trigger for examination of the causes of this failure. See Charts 4, 9, 10 and 11. McConnell recognises the “messiness and contestability of failure” (McConnell, 2015 p.230) and puts forward the following definition, “A policy fails, even if it is successful in some minimal respects, if it does not fundamentally

achieve the goals that proponents set out to achieve, and opposition is great and/or support is virtually non-existent” (McConnell, 2015 p.230)

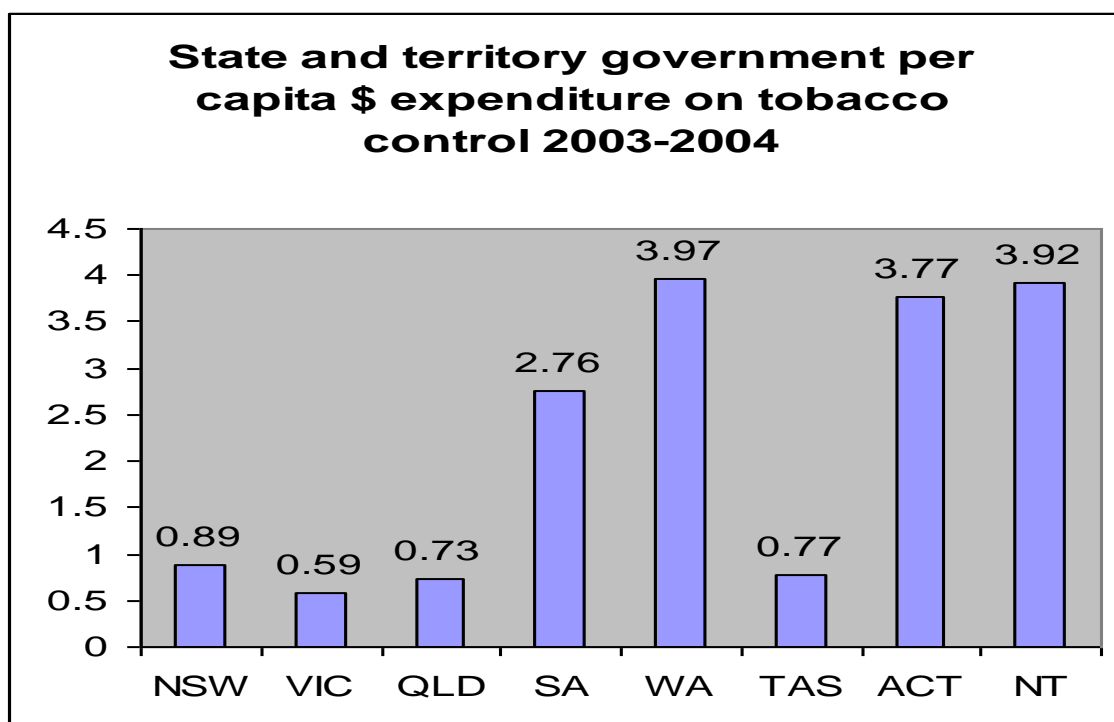
This definition of policy failure is useful, because it encompasses the Tasmanian situation where some evidence-based policies were introduced, but the package was incomplete, and therefore substantial reductions in smoking rates were not achieved.

Had Dr John Snow in 19th century London avoided entering the political sphere and gone away to publish a paper, rather than seeking the immediate removal of the pump handle, then 19th Century cholera epidemics may have continued (Brody et al. 2000).

Hypothecated taxation as a mechanism for allocating resources to tobacco control

Lin et al. (2007) made the important observation, highly relevant to this thesis, that hypothecated taxation was significant in developing health promotion, including that dealing with tobacco control, in Victoria and West Australia. Hypothecated taxation or ‘earmarking’ as it is sometimes termed, means allocating funding from a taxation measure, directly to off-setting the ill effects of the policy. This allocation has persisted long after the original source of the funding dried up following the 1997 High Court (Ha 1997) decision preventing states from raising revenue from tobacco and other excises. WA and Victoria still (in 2003-2004) had the highest funding allocations for health promotion activities, although as a proportion of all health funding, health promotion funding is tiny (Lin et al. 2007).

According to figures provided to the NSW Cabinet Office in 2007, the proportion of funding devoted to tobacco control was much smaller in Tasmania, Victoria, WA and NSW compared to other states and territories. NSW subsequently increased its expenditure on mass-media campaigns and successfully reduced its smoking rates as a result. At various points states have reduced their funding, found that smoking rates increased and increased funding again.

Chart 2 State and Territory Expenditure on tobacco control

Graph based on figures submitted to NSW Cabinet Office, and the 2004 National Drug Strategy Household Survey, State and Territory supplement, AIHW, June 2005, p. 12 (figures as at June 2004) Note: Unfortunately more recent data is not available as governments are reluctant to release statistics about expenditure on tobacco control, record them in different ways, and include different inputs, which may explain the low figure reported for Victoria, which traditionally has had a large allocation.

Voluntary agreements with the tobacco industry - a useless endeavour?

One method of policy orientation is using voluntary agreements with industry. The legislative corporatism approach, which inevitably involves governments consulting with the tobacco industry leads to ineffective voluntary agreements. It was a feature of the Howard government in its approach to tobacco industry “regulation”, as well as in other countries such as Denmark (Albaek, Green-Pedersen & Nielsen 2007).

The Howard government, as a conservative Liberal government, had a much more individualistic approach to governance of tobacco issues than federal Labor governments, which have been much more proactive about regulating the industry. This legislative corporatism approach was a feature of Tasmania in the late 1980s, when voluntary agreements about advertising were in favour with the then state Liberal

government, however, such agreements do not appear to have been relevant to tobacco policy within the last decade.

Research not the complete story

Research does not give a complete story to decision-makers and policy-makers (Weiss 1982). Weiss says:

“Rather, research provides a background of data, empirical generalizations, and ideas that affect the way that policy-makers think about problems ...

“As the ideas from research filter through, officials test them against the standards of their own knowledge and judgment ... they have many sources of information other than social science, ranging from their own firsthand experience to systematic and unsystematic reports from the field. ... the extent to which they accept a research idea, or give it at least a provisional hearing, depends on the degree to which it resonates with their prior knowledge. If it ‘makes sense’, if it and make sense of their earlier knowledge and impressions, they tend to incorporate it into their stock of knowledge” (Weiss 1982, p.622).

This observation resonates with the experience in Tasmania. Judgments about what will work in Tasmania, an entity that is sometimes seen as “different”, will probably only be incorporated into practice if they are meaningful in relation to other beliefs and values. The impact of research over time is often mediated through sources other than the individual researchers themselves, and their contact with decision-makers. The media is influential in highlighting issues (Levin 2004).

Policy-makers’ decision-making processes

It has been found that decision-makers’ information searching processes are not always rational, logical or effective, with such processes likely to have an adverse outcome in policy-making (Rich & Oh 2000).

“Overall, the results show that the decision-makers’ information search processes are biased and skewed” (Rich & Oh 2000, p.184).

So, how do policy-makers make decisions? It is possible that even the decision-makers themselves do not understand, or articulate, all the processes associated with the way they reach a decision.

As Weiss said in the 1980s:

“An investigator going out to study the uses of policy research quickly finds out that respondents have great difficulty disentangling the lessons that they have learned from research from their whole configuration of knowledge. They do not catalog research separately; they do not remember sources and citations. With the best will in the world, all they can usually say is that in the course of their work they hear about a great deal of research and they’re sure it affects what they think and do. They can’t give specific illustrations of their use of a specific study, because that is not how they work” (Weiss 1982, p. 623).

Policy-makers are also likely to be looking more to short-term solutions. Political timeframes are often not beyond the next election, whereas public policy commitments need to be made in a longer-term basis (Stephen 2003).

Rich and Oh (2000) found in their study of decision-making in the mental health field, that decision-makers behaviour does not conform to a “rational actor model”. Whilst there seems to be a desirable relationship between research or scientific knowledge and its applicability to policy, this is not always the case. Rich and Oh found that;

“...decisionmakers more often search for information from their own agencies rather than seeking information from a variety of sources ... bureaucratic secrecy and monopolistic control of information may make decisionmakers less likely to share information with other decisionmakers outside their agencies. This is, to a large extent, because they do not want to share sources of potential power with others.

Furthermore, at the stage of information utilisation, even valid and reliable information is little used by decisionmakers” (Rich and Oh, p199) [emphasis added].

Rich and Oh’s finding that “internal sources” are the most preferred form of information, and consulted more than anything else, including academic sources (Rich

& Oh, 2000), might contribute to “groupthink” and repetition of errors within government agencies. The rationality perspective is not the tool that best explains individual decision-making (Rich & Oh 2000, p. 203). Furthermore, “Concerned over bureaucratic secrecy and fear of how others might use information, if it were to be shared with them, bureaucrats tend to seek monopolies over control of information” (Oh & Rich, 1996, p. 7).

Decision-makers will trust information from internal sources because they believe it will support their existing policy position or that of their agency. If the information is not in keeping with the agency’s goals or existing policies, then decision-makers will not use it. Knowledge utilisation, therefore, is not the result of individual rational action, but a much more complex internal and cultural political activity. The organisational interest perspective appeared to have more explanatory power in this study than the rational actor or communication (two communities) perspective. This model is located within the Weberian tradition that bureaucracies, once established, seek to reinforce their own power and autonomy (Rich and Oh 2000), and indeed beliefs and thinking/accepted wisdom.

Non-decisions

The idea of non-decisions is also useful in the context of this thesis as it is unclear whether there has been any deliberate decision at any stage not to provide additional funding for tobacco control. This is of particular relevance. Stone suggests that the power relationships and the resources available to particular groups contributes to the protection of imbalances, rather than challenging them, and that this can be described as elements of a “nondecision” process (Stone 1982, p. 275).

Hancock (1983) asserts:

“To date, most analysts have focused on what governments do; the absence of government policy in a given area has typically been cited as a nondecision and a corresponding indicator of either lagging national development or differences in the scope of government. Yet the absence of overt government activity does not necessarily mean the absence of policy activities. So-called non-decisions may well mask a significant array of private social and economic policies by corporations, charitable

organisations, unions, and other non-government actors. Such activities are eminently worthy of systematic comparative investigation” (Hancock, 1983).

Non-decisions could easily be as much of a barrier to evidence-based tobacco control, as the positive or action-oriented decision-making process.

Can the burden of disease explain differences in funding for tobacco control?

In the US, studies on state variation in tobacco-control funding showed that tobacco-induced burden of disease did not explain differences. A study by Austin-Lane (2003) reported that the factors that were linked to higher funding allocations for tobacco control were: the existence of a Democratic governor with a high degree of control over funding; and citizen liberalism, that is, public opinion oriented towards tobacco control. States that had a high degree of tobacco industry activity and lobbying and where tobacco growing was significant were less likely to allocate funds for tobacco control (Austin-Lane 2003).

“These results imply that a strong scientific case for tobacco control is not sufficient to secure prevention funding at the state government level. Attention to political and economic aspects of the state budget process could lead to increased tobacco-control funding” (Austin-Lane 2003, p. 3).

What is the role of public servants or bureaucrats in tobacco control?

Earlier in this chapter the potential role of public servants as internal advocates seeking tobacco-control policy actions was examined. However, the question needs to be considered whether or not these bureaucratic resources even exist. Studlar acknowledges that the existence of bureaucratic resources:

“... may also be important for tobacco control, but they are difficult to measure” (Studlar 2007, p. 167).

Institutional structures and contexts do matter when it comes to tobacco-control measures, and policy-bargaining processes can include many actors, including even citizens groups with little organisational structure (Licari 1997).

Small states

Small states have trouble implementing some broad-based strategies on their own, and leadership needs to be taken by national governments (Greenberg 1992). It is a strong possibility that some of the impediments to action on tobacco control and other population health initiatives in small jurisdictions are those that relate to small size and lack of infrastructure support within the bureaucracy.

Bell refers to “public sector research units” in her paper on influencing holistic health policy (Bell 2007). There is an assumption in some of the literature, as in this Bell article, that there are people employed within the public sector to synthesize research and to channel that information to the policy-makers. What if there are no researchers or policy analysts doing this work in relation to tobacco control? The absence of such staff could influence how policy-makers perceive or receive information or research data. Lin touches on this issue when she says that there must be sufficient expert staff to interpret all the information, and render it explicable to decision-makers (Lin 2003).

Role of Cabinet

In Australia the hierarchical political system in the states is such that Cabinet ministers have the most influence on the policy agenda. But even here there is a pecking order. A study into second-hand smoke restrictions in NSW confirmed the superior role of economic ministers in over-riding health ministers on matters where revenue or expenditure was involved.

“Due to business and economic concerns, many participants indicated that the Minister for Health is not as powerful when compared to the Premier, Treasurer, and other business-oriented Ministers. A Minister for Health ... who (ignored) a more business-oriented Minister would be doing so at his own peril” (Bryan-Jones 2004, p. 65).

Similar restraints exist in the United Kingdom where health ministers used voluntary agreements with the tobacco industry to create an illusion of progress in dealing with smoking, with the Treasury watching over events to make sure they went no further (Cairney 2007). Smith described the way tobacco-control advocates developed increasingly sophisticated economic arguments around tobacco-control measures, much to the chagrin of the tobacco industry (Smith 2013).

In a later published article Bryan-Jones said:

“SHS restrictions have been delayed by several broad factors: the influence of industry groups successfully opposing regulation; issue wear-out; and political perceptions that there is not a salient constituency demanding that smoking be banned in bars and clubs” (Bryan-Jones & Chapman 2006, p. 192).

In New South Wales in an examination of the period 1955 to 1995, Hooker and Chapman identified factors that delayed tobacco-control policies as:

- the conservative stance of premiers;
- commitments to unanimous federal action; and
- rivalry between the political parties (Hooker & Chapman 2006).

Particular premiers in NSW, of both major political parties, opposed legislative measures for tobacco control. The role of premiers in determining public policy on tobacco control, particularly if they are also the Treasurer, seems to be crucial in determining outcomes.

In the US, governors have a strong influence on expenditure on tobacco control and in some cases the non-government anti-tobacco organisations considered that governors were more interested in crime, education and roads and highways than in public health issues, including tobacco control (Harris 2006).

Political or ministerial advisers - minders

Political advisers in ministers’ offices act as gatekeepers and information filters (Bryan-Jones 2004). Many respondents to the Bryan-Jones study commented that tobacco control public servants within the health agency needed stronger

“... leadership from within the government and the Health Department for their recommendations to be supported and rely on their relationship with tobacco-control advocates to perform the advocacy they cannot openly perform” (Bryan-Jones 2004, p 68).

There was a view amongst some political advisers that tobacco-control bureaucrats were “zealots” because of their dedication and passion, but that the forms of communication

they used were too technical and obscure to be easily understood (Bryan-Jones 2004; Bryan-Jones & Chapman 2006).

Clearly there is evidence in Bryan-Jones' work of a frequent tension between the roles played by bureaucrats and their political masters on the issue of tobacco control. Bureaucrats walk a fine line between advocating for tobacco control, and meeting the political needs of their ministers, not offending them and not speaking out publicly. They are required to be troglodytes, operating in a subterranean community, working as a go-between for ministers and using advocacy groups to publicly campaign for particular tobacco control goals.

Former Prime Minister of Australia, Kevin Rudd, was at one time a ministerial adviser and his view about the role is expressed in this way:

“By contrast, ministerial advisers must also be mindful of a different set of interests. Advisers must analyse the prospective political impact of any given policy proposition in terms of the likely response of the rest of the ministry, the governing party (both in its parliamentary and organisational capacities), the parliamentary Opposition, significant interest groups such as the business community and the trade union movement, community opinion in general, as well as the media” (Rudd 1992, p. 91).

Rudd articulated the pressures on a ministerial adviser (and indeed minister him/herself) and the issues that have to be taken into account. Notably, the question of scientific evidence does not even rate a mention in this list of interests that must be considered.

Rudd goes on to say;

“Good policy is invariably the product of multiple inputs presenting the range of interests which advisers and officials are responsible for reflecting. These are the ingredients of a healthy policy process” (Rudd 1992; p. 98).

Senior public health officials in the USA have reported being muzzled by successive administrations, and prevented from advocating and speaking out on particular issues. Surgeons General Carmona, C Everett Koop and David Satcher all reported political

interference in speaking out on such issues as HIV/AIDS, needle-exchange programs, sexual behaviour and tobacco control.

“The responsibility for achieving neutrality falls partly in the Administration's lap; it is essential that politicians allow public-health officials to release the best evidence-based information available without political interference. But responsibility also rests with the surgeon general, to speak out about such interference while he is still in a position of power, and to stand up and resist the pressure to censor scientific information ...

“... Affected agencies include the Food and Drug Administration, the Fish and Wildlife services, and the Centers for Disease Control and Prevention (CDC), predominantly with respect to politically sensitive issues such as childhood lead poisoning, toxic *Mercury* emissions, climate change, nuclear weapons, and reproductive health” (*The Lancet* Editorial 2007, p. 193).

Corruption and crony capitalism

In Tasmania there is a history of corruption in government, and allegations of politicians being offered financial incentives. One such event related to Kevin Lyons MHA who was allegedly given money by British Tobacco in 1972, and who was accused of bringing down the Bethune Liberal Government as a consequence. However, the charges were never proven by a police enquiry (Hay 1976; Petrow 2006; Quarmby 2006). Crony capitalism and corruption have been identified as a characteristic of Tasmanian governments continuing to the present day by Beresford (2010, 2015) and Flanagan (2004, 2007). Chapter 5 of this thesis describes in more detail how these events unfolded, and why the concept of “crony capitalism” is essential to an understanding of Tasmanian policies and governance. How close more recent governments are to the tobacco industry is difficult to ascertain, but such relationships would be a barrier to tobacco-control reforms and have been specifically singled out by the WHO in Article 5.3 of the Framework Convention on Tobacco Control (FCTC) as relationships to be avoided (WHO 2014).

Economics

A state's economy and its revenue base can have a significant effect on funding for smoking prevention and tobacco control (Harris 2006). Indeed, this raises the very basic question of how and why funding decisions are made in relation to tobacco control? In Australia, health ministers control their budget allocations for tobacco control; however, they are constrained by the actions, priorities and interests of Cabinet and department of Treasury and Finance in making decisions through the budget process (Lin, Smith & Fawkes 2007). Treasury is always interested in minimising new expenditures, and can act as a constraining "dead hand" on any new initiatives. This view tends to be very short-term.

Goel and Nelson (2006) attempted an economic analysis of the effectiveness of anti-smoking legislation and other non-price controls (health warnings and bans on workplace smoking and advertising), as well as price measures (higher taxes) across many countries. This has not proven to be very helpful. It was too difficult for the researchers to separate the variables to give a very clear picture (Goel & Nelson 2006), or it is perhaps not surprising that Treasurers tend to stand off this area.

Women and independent politicians

Hooker and Chapman found however, that women politicians from all political parties were a source of bipartisanship in advocating for tobacco control, and they also found that independent MPs were important in promoting reform (Hooker & Chapman 2006, p. 10).

Conclusion

Tobacco control is a wicked problem in Australia and elsewhere. Smoking causes high long-term economic and social costs to the health system and to societies as a whole. There is ample evidence to support various initiatives that have been found to be effective to reduce smoking rates, and which work well in most countries.

Despite this, little attention has been given to tobacco control in the policy literature. This thesis adopts the Kingdon (1995) theoretical model of "agenda setting" as a way of considering how tobacco control has been considered, or left off, policy-making agendas.

The central theme of this thesis is that either evidence or knowledge transfer has not occurred, or it has been ignored, in relation to tobacco control in Tasmania. The value orientation of the thesis is that it is better for governments to adopt evidence-based policies in relation to public health issues such as smoking and tobacco control, and to have a long-term view of this.

Policy-makers adopt a different set of parameters to evaluate ‘evidence’ than that which is adopted by scientists, and will consider such things as colloquial advice, the media and ideas from political constituents.

There are several models of evidence transfer, detailed in this Chapter, none of which offers a complete answer, but which are all useful for thinking about the way knowledge is transferred and utilized, and the barriers to knowledge utilisation.

The role of “policy entrepreneurs” has been important in tobacco control, and the term is used in a wider sense than the term “advocate”. Leaders and influential members of non-government organisations, senior bureaucrats, union officials, the medical profession and the tobacco industry itself have all sought to influence tobacco-control policy. Many would argue that the tobacco industry has been the most effective agency in this regard, as it has effectively delayed or prevented many reforms over many years and across the world.

In the case of policy failure, it may be that the absence of adequate resources, including people and access to information, within the bureaucracy or NGOs could be a factor in not progressing evidence-based reforms. Governments in Australia are under constant pressure to reduce the number of bureaucrats, and to increase the number of workers directly delivering services, thus diminishing institutional and corporate memory and wisdom in decision-making.

The structures of government in Australia as a federal system can act as a brake on reform in many areas including tobacco control. Policy-makers’ decision-making processes are constrained by the structures in which they find themselves. The roles of political minders, of Cabinet processes and political pressures on public servants and ministers all influence the way policy is made, and can overwhelm the influence of scientific “evidence”.

All the factors outlined in this review of the literature will be considered in the thesis, as part of the analysis of data gathered on political and bureaucratic influences on tobacco-control policy.

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Chapter 3 Methods

Introduction

Consideration of the method for conducting research for this thesis was based on discussions with all supervisors and a great deal of background reading. In particular, several books on conducting qualitative research were consulted and were useful in providing a guide (Patton 2002; Grbich 1999; Hansen 2006; Wolcot 2009; Bell 2010).

As the hypothesis is that there have been barriers to evidence-based tobacco-control policy in Tasmania, the method is designed to elucidate the barriers using a number of different sources of data. It rests on an assumption that there are barriers to using evidence to determine policy, because of evidence for the lack of implementation or adequacy of key interventions.

The theoretical framework adopted is that of Kingdon's approach to agenda setting in the public sector, through a study of the political and bureaucratic decision-making processes associated with funding for tobacco control in the public sector (Kingdon 1995).

The key themes are, firstly, "windows of opportunity", agenda setting, and how policy entrepreneurs and advocates might attract the notice of policy makers, leading to the allocation or non-allocation of resources.

Secondly, the process of transferring evidence or knowledge from the scientific or research sector relating to tobacco control, into the sphere of government decision-making.

The third theme is that of examining the structural and bureaucratic infrastructure and resourcing available within the Department of Health and Human Services, for developing policy frameworks relating to tobacco-control measures.

The methodological approaches used in this thesis are based on a modified, or expanded, grounded theory approach (Patton 2002, p. 125, Hansen 2006, p. 63) using a collection of published and unpublished documentation, including newspaper, electronic media reports, Hansard transcripts, archival records and documents found in the

Tasmanian State library, the Parliamentary Library and government files. An iterative thematic analysis was adopted; using a 'realist' approach which involve moving iteratively back and forth as data found was used to "adapt and re-focus research questions" (Hansen 2006, p. 139).

As Hansen says, "The process of 'coding' is a key feature of grounded theory (Hansen 2006, p64)", in the tradition of Strauss and Corbin, (Strauss and Corbin, 1994) and not all documents obtained were amenable to coding. The grounded theory approach was modified in that not all documents were coded. Those that were not coded were scanned to see if they bore any relationship to the data obtained through those documents that were scanned. This provided an iterative approach to the coding process and allowed addition of documents where they shed light on the theories and findings that had emerged. The type of research adopted in this thesis tries to "get to the truth of the matter" and to try to "identify processes, experiences" or "reasons" why people "behave" in a certain way (Hansen 2006, p. 140). It does not use discourse or narrative analysis, which is used to produce an account that is satisfying to the participants and the researcher. Central to this approach is coding of data as it is collected and analysed and as explained later.

There is no formal recorded field work. No interviews were conducted for several reasons, as explained in previously in the introductory chapter. Essentially, as the accessing of documents proceeded and the politicians and bureaucrats became aware of the study, the likelihood of extracting meaningful unbiased information from the actors in Tasmania became more and more remote. The author and all supervisors have been at various points involved in the processes of policy-making as observers, advisors, clinicians, critics or advocates. Therefore, the probability of significant "participant observer bias" was deemed to be probable.

Tasmania is so small that all the researchers, physicians, politicians, public servants and health organisation officials are well known to one another, their views, ideologies and biases understood, and therefore any interviews would almost certainly have been tainted by participants saying what they thought the interviewer wanted to hear, or would find acceptable. Retrospective self-justification of past actions (or inaction) was inevitable in this environment. A study in NSW by Hooker and Chapman encountered a similar difficulty, but were able to conduct interviews because the first author and

interviewer was a non-activist impartial historian, even though the second author was a well-known public health professional academic and activist (Hooker & Chapman 2006). By contrast, Viehbeck chose to study within her own Canadian tobacco research community, however, the lens and familiarity brought advantages in that the application of a “constructivist” perspective was perceived to have improved the meaning of the project (Viehbeck 2011).

Document analysis

In this thesis, a document analysis, although considered one of the most demanding forms of qualitative research (Bell 2010), was adopted as the most effective and balanced way to proceed. Bell (2010) says the document analysis approach demands,

“...sophisticated understanding of, for example, the ways in which sub-texts operate, and how the same words can mean different things or vice versa over the history of evolution of a policy argument.”(Bell, p. 91)

By 2010 the amount of material, data and documentation amassed was so enormous that it was considered unnecessary, and almost certainly counter-productive to proceed with interviews, even if the potential problems of bias could have been overcome. The thesis therefore relies on what actually happened, what was recorded and what was said publicly and on the record. Many of these records were not publicly available, and were provided by government agencies. The rich data obtained included for example, copies of internal emails, which showed that people within the agency were confused and unclear about the status of a particular document, where it was, who was responsible, and where it should go next. These emails highlighted issues of accountability that would never otherwise have been available to researchers. There seems to be little evidence in the literature of such a comprehensive documentation study in this context.

Using many sources, including government files, newspapers, archive documents, and Hansards enables triangulation of data to check on validity of the observations and collections. A thesis by Mark Lawrence at Deakin University on folate fortification provided a useful model for a case study of public health policy-making in Australia. Some ideas from the structure of his methodological approach was adapted in this thesis. Lawrence used Sabatier’s Advocacy Coalition Framework (ACF) as a theoretical framework (Lawrence 2002; Sabatier 1988).

The thesis uses the Kingdon theoretical framework, because it aims to delve into policy failure, rather than mapping a successful policy approach using an ACF Sabatier type analysis. Kingdon recognises the importance of policy entrepreneurs and their role as part of a policy community. He discusses how ideas float around in the “policy primeval soup”, some are taken up and others drift away. Smith too recognises the importance of “ideas” in tobacco control, throwing out a challenge to the extent that;

“Sometimes research evidence must lag behind policy interventions and that is one reason why a narrow obsession with “evidence-based policy can be restrictive” (Smith 2013, p. xi).

The role of ideas, and the impact of policy entrepreneurs is difficult to incorporate into a methodological approach, when such ideas may go beyond existing evidence. The key research questions are therefore important in grounding the research in time and place, and in actual events, activity and outcomes.

The research questions and themes

The three major research questions or themes considered, concern evidence/knowledge transfer, policy entrepreneurs and structural issues. There are many questions within these three major themes and are linked to the Kingdon model.

Evidence/knowledge transfer

The first question is what has prevented Tasmania implementing mass media campaigns, community education and funding of tobacco control efforts on a scale that is considered by the literature to be necessary in order to achieve a reduction in smoking rates?

The second question is has the evidence about the importance of funding and mass-media campaigns in reducing smoking prevalence, been transmitted to higher bureaucratic and political levels in Tasmania prior to 2008?

Thirdly, if the evidence has been conveyed – has action been “blocked”? (e.g. by Senior health bureaucrats Treasury/Premiers/ministers)

Policy entrepreneurs

Fourthly are there policy entrepreneurs in tobacco control in Tasmania? If so, what influence have these policy entrepreneurs had? Is their role crucial or influential in moving the agenda forward in tobacco control?

Structural issues

Finally, the question of structural issues is addressed. What influence has the Tasmanian political and bureaucratic structural system had in relation to tobacco smoking prevention initiatives? How does it compare with other state structural systems for dealing with tobacco control at a policy level? The role of Ministerial Council on Drug Strategy (MCDS), the Inter-governmental Council on Drugs (IGCD) and the Tasmanian Tobacco Coalition will all be considered under this theme.

Record examination

Records in the public domain were examined, using specific search terms, to see if there were any records of funding decisions about tobacco control, how and to whom the scientific evidence has been accessed and transferred; who has prepared policy advice, their position and what happened to any such advice within the system. (See also coding on Page 120 below)

The records searched and analysed were,

- Hansards, the transcript of Parliamentary proceedings as well as Estimates committees, which is available online, was searched for data about legislation reform, funding decisions, views expressed by politicians about effective methods of reducing smoking prevalence and tobacco-control measures generally.
- Department of Health and Human Services and Department of Treasury and Finance records of processes relating to tobacco control initiatives, measures, and records of any representations made by the tobacco industry or their associated organisations were sought. The Department of Health and Human Services; Department of Premier and Cabinet and Department of Primary Industries, Parks, Water and Environment (which includes Lands) provided

many helpful and relevant documentary records. The Department of Health and Human Services provided documents in pdf format and allowed access to the relevant files. The Department of Treasury and Finance refused access to records.

- Tasmanian daily newspapers since 1996 through search engines such as ANZ Reference Centre to online Australian newspapers. In addition, newspapers on microfiche at the State Library of Tasmania from earlier periods in the 1970s were examined for relevance to the policy-making process.
- Archival records at the Tasmaniana Library and the State Library of Tasmania relating to the British Tobacco bribery allegations of the 1970s.
- Archival file records from the national archives from the 1970s concerning inter-government machinations, political decisions, and a tobacco tax.
- Records of Tasmanian Television News ABC, WIN and Southern Cross were sought but were not available.

The following Table 5 provides more detail about the number and types of documents obtained. The table does not include all documents that were read or searched during the course of the study. Only those documents that were retained, because of their relevance, either in hard copy or digital format are recorded here. Many are specifically referred to in the thesis, and annotated or referenced accordingly.

Table 5 Documents searched, analysed and retained in either hard copy or digital format.

Type of document *¹	Source	No of documents²
Letters, reports, memos, handwritten notes, legal advice, meeting notes. Primarily from the 1960s, 1970s and 1980s.	Tasmanian State Archives, LINC.	65
Mercury reprints 1974, repealed legislation.	Parliamentary library (Tasmania)	11
Extracts from Australian Political Chronicle -1972 - 1974	Parliamentary library (Tasmania)	4
Notes, letters, reports – tobacco industry documents. Various years 1975 onwards	Truth tobacco industry (Legacy) documents - UCSF Library and Center for Knowledge Management USA.	80
Statistics and graphs	ABS, AIHW, DHHS, Parliamentary Library.	165
Maps	Department of Primary Industries and Water (DPIPWE)	10
Minutes of meetings, reports, surveys, state of public health reports, ministerial briefings, internal emails, letters, agendas, reviews, evaluations, tobacco action plans, strategies, discussion papers.	Department of Health and Human Services (DHHS)	433

¹ Documents used in this study, and retained. Many other documents were examined. Documents were not saved, if not used. For example, many government budget papers and annual reports were searched and discarded, not recorded or returned, if nothing relevant or useful relating to tobacco control was found.

² Number of pages of these documents vary from one page (mostly individual news clippings and maps) to multiple pages well over 100 (in the case of reports and internal confidential government reviews).

Newspaper clippings. Transcripts of media reports.³	State Library (Tasmania), LINC & Newsbank	213
Political Parties annual returns	Australian Electoral Commission	54
Miscellaneous NGO publications, statistics, graphs, documents – including “Dirty Ashtray” summaries and calculations.	Public Health Association, Cancer Council, Heart Foundation. QUIT, AMA, ACOSH, Pharmacy Association.	43
Commonwealth reports	ANPHA, DOHA, NPHP,	21
Other state government Departments documents and reports. Emails, letters. Some sections redacted with notation “Internal working deliberative information removed” or “personal information removed”.	DPIPWE, Auditor-General, DOTAF, Premier and Cabinet (DPAC).	167
Hansards – extracts copied. Most coded in NVivo. Around 123 pages each. Approx. 35,000 pages.	Parliament of Tasmania, Hansard	289
Letter, list.	National Library	2
Research reports and appendices	Australian Parliament	2

Data Collection and analysis

A qualitative data analysis of the role of the bureaucracy was conducted, using documentation obtained from various sources from 1997 to 2010, with particular emphasis on agenda-setting, knowledge-transfer and organisational structures.

³ Newspaper clippings- the digitized version of these are grouped in sets of months [eg 2005 (Oct 27-Dec 12)], so “1 newspaper clipping” may represent 10 or more articles/stories/letters to the editor or “clippings”.

Documents relating to tobacco control were sought from: Health and Human Services (DHHS), Primary Industry Parks and Water (DPIPWE), Treasury and Finance (DOTAF), and Premier and Cabinet (DPAC). Some documents were provided by non-government organisations (NGOs). Some documents were difficult to obtain and/or took a long time to be provided. For example, a file requested from the national archives took a year to be provided, because it involved controversial internal political correspondence during the 1970s between the Commonwealth and Tasmanian governments, including Treasurers, Premiers and the Prime Minister, and had to be approved for release as a public document. A few documents contained redacted sections.

Parliamentary Hansards were searched, then the relevant pages copied as documents into Microsoft word and later entered into NVivo, and coded. The same process was used with newspapers or on-line articles.

Digital documents were analysed and coded using NVivo. Other documents were sorted and analysed manually. Grey literature searches included published government reports, newspaper reports, government websites and tobacco industry document websites, mainly the Legacy Library, Truth Tobacco industry documents held and managed online by the University of California San Francisco Library.

The data collected is from several sources, which enabled “triangulation” to occur to determine whether there were discrepancies or agreement between what people are saying, and a relationship or otherwise to the outcomes or the written decisions (Patton 2002; Hansen 2006).

Other documents such as the pages from the files copied from the Archives do not lend themselves well to incorporating into NVivo, so these were examined and sorted and analysed separately. The paper used in the 1960s and 1970s in the files examined for the Chapter 5 were different shapes and sizes, some in a fragile state, and many of them foolscap, a paper size used commonly before A4. Older newspaper clippings were on microfiche, and had to be found, and then printed from the microfiche equipment at the State Library, and were not always clear or readable by digital readers, and had to be collected and analysed and sorted manually. This was a very laborious and time-consuming process, as each set of newspaper files for each few weeks’ period had to be loaded into the reader and scrolled through to find the relevant item. The library index

systems were initially on cards at the beginning of the data collection period in 2007. Later by 2014 the index system had been digitized and it was easier to find documents. However, the initial data collection for the first few years of this thesis was painstaking and slow. Over 200 source documents, many over thirty pages, were incorporated into NVivo. These were coded into 94 cases, 38 free nodes, and 14 tree nodes.

The bulk of the document data that could be managed in digital format comprised lengthy Hansard extracts. This was invaluable in drawing together the threads of various arguments, opinions, and statements made by the key individuals, particularly politicians and senior public servants involved in the decision-making processes. The collection of data from separate types of sources enabled triangulation and verification of events, decision-making processes, ideas presented, and actions of policy entrepreneurs and advocates both within the public sector and outside it.

Coding

The coding process began with the first documents until “saturation” was reached, to the extent that nothing new was materializing, and no new themes were emerging. The primary key term used for searches in both newspaper and Hansard transcripts was “tobacco”. Early attempts to use the key search terms ‘smoke’ or “smoking” generated multiple thousands of “hits”, because in Tasmania the use of forest burn-offs means that these terms appear many times. The relatively unsophisticated search engines available in the Parliamentary and state libraries at the time this study began in 2006 to about 2009, meant that forestry burns could not be eliminated from the searches. Therefore, the key term “tobacco” was used throughout, which still successfully generated large amounts of data. Entering the term “tobacco” on the Parliamentary website as at mid-2015 generates 13,841 “hits” in 1,625 documents. It is unlikely that any important debates were missed.

The coding process was inductively derived following the approach suggested by Patton (Patton, 2002 p.462-466). Later, deductive analysis was implemented once the framework, patterns, themes and categories were established (Patton, 2002 p. 453-455) Firstly, key phrases and themes in the Hansards and were identified, and later by identifying and coding references in the other digital written records. Secondly, individuals’ and organisations’ statements were coded to cases, so that they could later

be identified and discussed in context of particular epochs, ideas, reforms or themes. All politicians who spoke in any detail on tobacco-related issues were listed, and extracts of their speeches coded. All organisations identified, that made media statements, including NGOs, and tobacco industry and their associates, were recorded and coded. Some of this was repetitive and duplicates were not included, for example if a statement appeared in two newspapers. There were 200 “source” documents, however each individually may have included a number of documents, for example ten or more extracts from newspaper clippings may have appeared on one NVivo “source” document, and many pages of transcript from Parliamentary records may only be recorded as one “source” document. As an example, the Wednesday 10 December 1997 House of Assembly debate on the Public Health Bill 1997 (No. 106) ran to 49 pages and 19,472 words. For the purposes of NVivo this was recorded as only one source document, but it generated a significant amount of coding, for individual politicians and themes.

There were 94 “cases” that were mainly names of individual politicians, tobacco companies and their front organisations, senior public servants, NGOs and academics or activists. Thirty-eight “free nodes” and 14 “tree nodes” were generated and coded. The free nodes included themes such as ‘addiction’ (8 references), “passive smoking” (188 references), “smoking rates” (23 references), “litigation” (51 references). The tree nodes were such themes as “children smoking” (62 sources and 89 references) and “tobacco companies’ behaviour” (46 sources and 76 references).

The trustworthiness of the research approach was improved not only by the breadth and depth of data obtained, but by engaging in self-reflexivity throughout the process, and triangulation of reflexive enquiry more generally (Patton 2002, p 495). Advisors and supervisors were from differing politico/social perspectives, academic disciplines and research specialties, which worked to ensure that interpretations were reasonable.

Table 6 Tree Nodes coded in NVivo

Tree Nodes	Sources	References
Cabinet	16	24
Children smoking	62	89
Civil Liberties arguments	8	10
Costs of tobacco smoking	8	9
Funding	26	33
Legislation	66	116
Political party funding by tobacco industry	18	26
Sport	20	27
Taxation	39	78
Teachers pay	7	20
Tobacco companies' behaviour	46	76
Treasury	4	8

Figures for the Cases and Free nodes contents are not included here because of their large size.

Data Interpretation

The data were interpreted through the lens of Kingdon's theoretical approach. This included the role of policy entrepreneurs; the content of the "policy primeval soup" in

the context of Tasmanian public sector policy-making in tobacco control; the policy community; consideration of “windows of opportunity” – which ones opened and closed and why; budget constraints and what has happened over time (a decade or so); and the “coupling” of problems to solutions and how that happens.

This thesis is looking for something that was missing – adequate tobacco-control funding – and lack of other evidence-based policy implementation, as well as looking at the events surrounding the making of tobacco-control policy. The data sought were: what was written, what was said, what was actually done, and the barriers and impediments that slowed or prevented reforms or the allocation of resources. Therefore Kingdon’s concept of the ‘windows of opportunity’ was the key to interpreting data in this thesis.

References Chapter Three

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Chapter 4 Tasmania – a brief history of tobacco control

Introduction

This Chapter provides material about the various smoking rates reported by different statistical measures over time, as well as a record of the major initiatives designed to reduce smoking rates. Both AIHW data and ABS data are shown, and although they were collected in different ways and at different times, the trends give a picture of what has happened, even though the exact numbers may differ.

Australia has been a world leader in tobacco control (Beaglehole, 2015, p. 459, Chapman et al, 2003). Comprehensive tobacco control strategies have been in existence nationally and at most state and territory levels for many decades, and smoking rates have fallen considerably. However, the nature of the Australian federation is such that states control certain aspects of tobacco control and federal government control other measures. For example, until 1996, states could realize some control over the price of cigarettes, but after that date it became the responsibility of the Commonwealth, see Table 9.

Tasmania has always had higher smoking rates than other Australian states, just as it has higher unemployment and lower average socio-economic status (SES). Only the Northern Territory has a more disadvantaged profile, and that is mostly as a result of indigenous disadvantage in that jurisdiction. Smoking rates are associated with socio-economic status, and therefore the higher smoking rates in Tasmania are unsurprising. However, it is also true that smoking rates can be reduced in all SES groups (Durkin, 2009) provided that effective measures are implemented. Furthermore, in Australia mass media campaigns are effective overall. Durkin et al conclude

“Mass media campaigns to promote quitting are important investments as part of comprehensive tobacco control programmes to educate about the harms of smoking, set the agenda for discussion, change smoking attitudes and beliefs, increase quitting intentions and quit attempts, and reduce adult smoking prevalence. Jurisdictions should aim for high reach

and consistent exposure over time with preference towards negative health effects messages.” (Durkin et al, 2012)

Sometimes in Tasmania it appears efforts to reduce smoking rates are dismissed for the very reasons that should spur greater incentives to do so. A kind of collective despairing hand-wringing has occurred, characterised by comments such as from one health minister who declared she was at her “wit’s end” as to how to reduce smoking rates as if this was some extraordinary “act of God” she could not affect (Giddings, in Hansard 2009). The reasons for this nihilism and barriers to effective action are explored in detail in the other chapters.

Tasmania was late onto the Australian scene in implementing tobacco-control measures. There was little significant local effort by governments to reduce smoking rates until the late 1990s. While states such as Victoria had led the way in the 1970s and 1980s with significant reforms (Ballard 2004), there was little discernible influence in Tasmania from health NGOs nor a visible or energetic culture of public health advocacy on smoking until the mid-1990s. Despite slow beginnings, Tasmania has had a long history of innovative individuals bringing forward legislation in tobacco control, not always successfully, recorded as early as 1894 in a Sydney newspaper.

In 1907 there was even an attempt to ban sales of cigarettes to women (Editor, 1907). And even earlier 1894 attempts to eliminate juvenile smoking.

“Tasmania’s Counterblast. Juvenile Cigarette Smoking..... Tasmania, long looked upon by her more pretentious neighbours as a quiet little place, and only too often dubbed 'Sleepy Hollow,' has at last set her bigger sisters an example of prompt action that is worthy of notice. The move that the quiet little island is now agitating itself with is the suppression of the juvenile cigarette smoker. A bill has been presented to the Assembly by Dr E. L. Crowther, providing that any child under the age of 16 found smoking in the streets shall be required by any constable witnessing the indulgence to supply his or her name and address, presumably with a view to communication with parents or guardians”
(*Evening News* 1894, p. 5).

Smoking rates

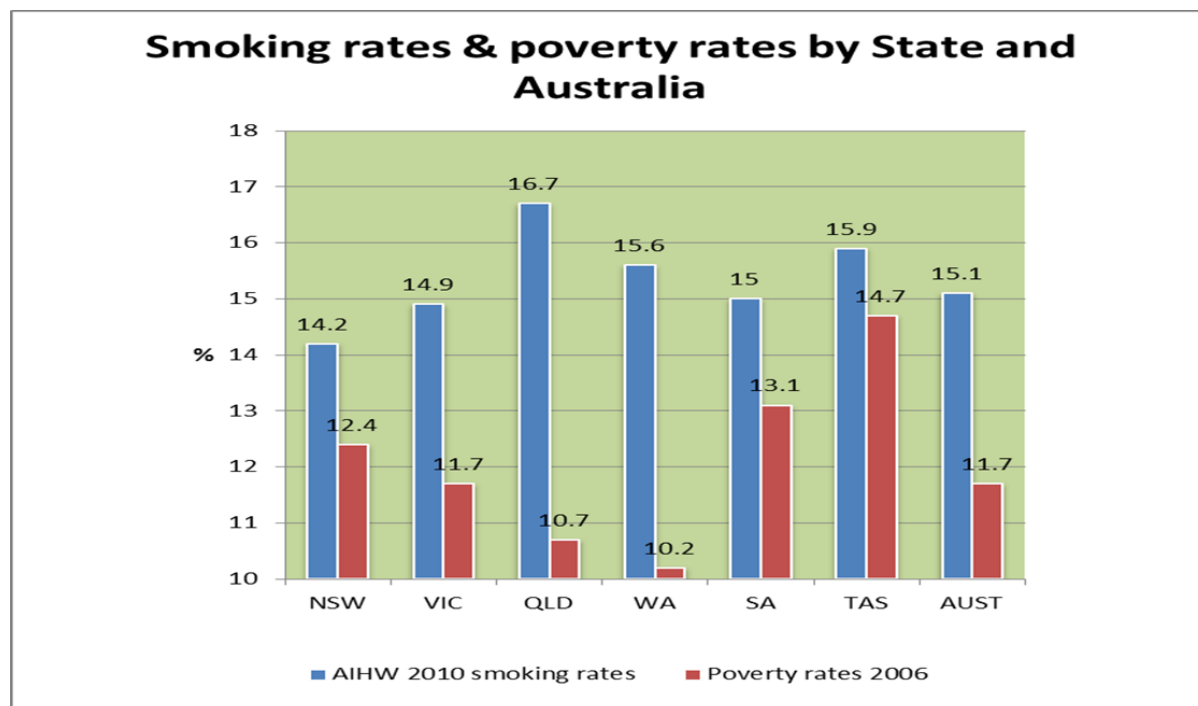
ABS data has shown for many years that Tasmanian smoking are higher than other states, although the 2010 AIHW data showed that the smoking rate is actually lower in Tasmania than in Queensland (Chart 3). (See also Chart 9 at the end of the chapter).

Smoking rates have declined in Tasmania since 2009, with the most significant decline in female smoking rates. Male smoking rates have fallen very little since 1995 and are slightly higher than in 2001 (See Chart 4). (See also Charts 8 and 9 at the end of the chapter).

The other notable feature of the trend in smoking rates in Tasmania is a plateau in the declining smoking rates between about 2001 and 2009. This thesis was precipitated by the alarming lack of a decline in smoking rates in Tasmania.

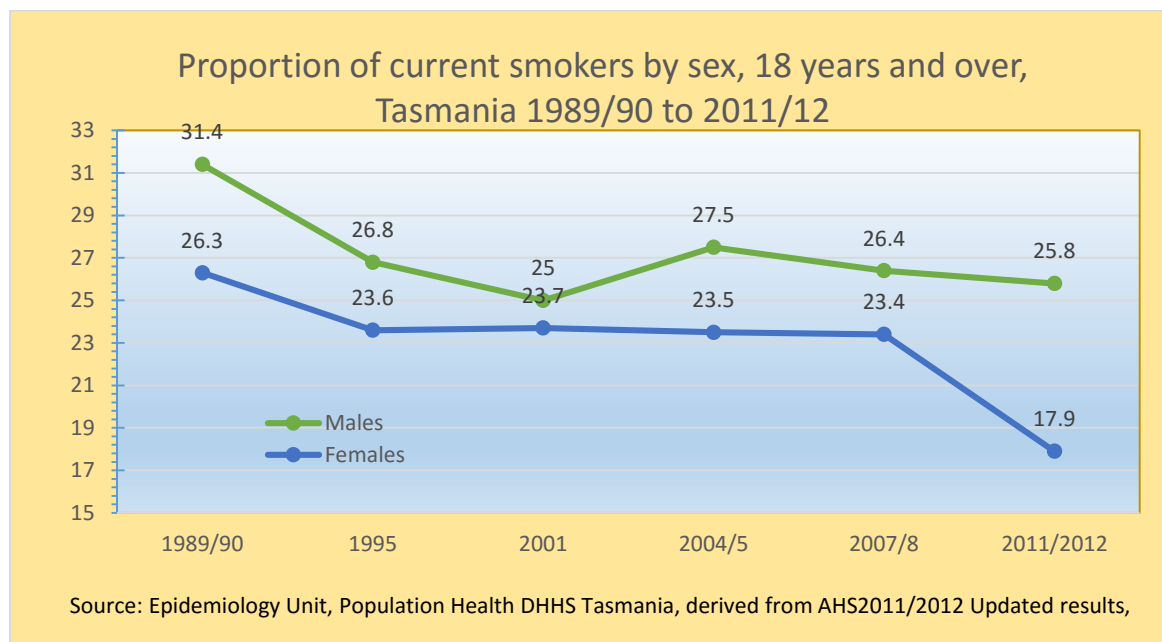
Population Health Surveys conducted in 2009 by Menzies Research Institute, (Menzies, 2009) and 2013 by the DHHS (DHHS, 2014) show that smoking rates for both men and women apparently fell across all age groups, but the only significant declines were for males aged 45-54 and for females 35-44. The fall in female smoking rates was quite dramatic in both these groups, and in the ABS data, which suggest that this was a real decline. The age cohort is also important in that it is in the child-bearing years that women's smoking rates are declining. Male smoking rates in these age groups are not falling as fast.

Chart 3 Overall population smoking rates and poverty rates by State and Australia



Source: Australian Institute of Health and Welfare (AIHW) 2011, p. 30; Kryger 2009.

Chart 4 Proportion of current smokers by sex, 18 years and over, Tasmania 1989 - 2012

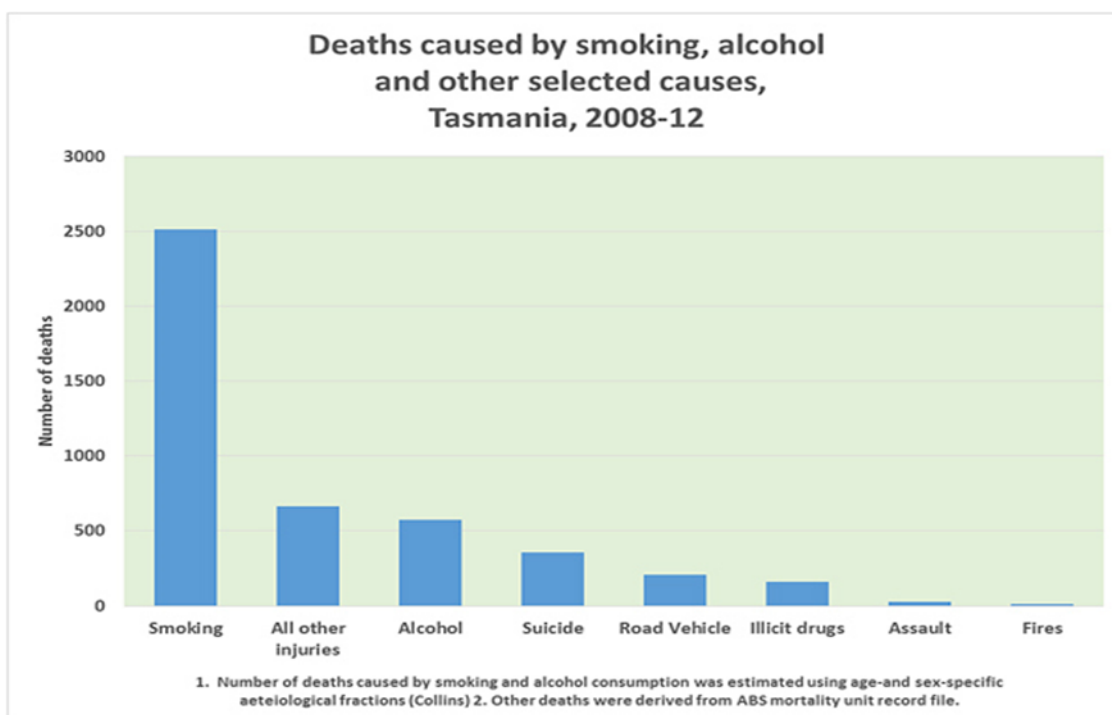


Source: Epidemiology Unit, Population Health DHHS Tasmania, derived from AHS2011/2012 Updated results,

Mortality

Tobacco smoking kills more Tasmanians than alcohol, suicide, all other injuries, road vehicles, illicit drugs assault and fires combined. The following estimates were provided by the Epidemiology Unit of the Department of Health and Human Services prior to the study by Banks et al, which showed that two-thirds of smokers die from tobacco related illnesses. Therefore, it is likely that smoking deaths the following graph would be adjusted upwards by another third, in future.

Chart 5 Deaths caused by smoking, alcohol and other selected causes Tasmania 2008-2012



Source: DHHS Epidemiology Unit, Public Health, 2015, unpublished data.

Poverty and socio economic issues

Tasmania has higher poverty rates than other states (Chart 3), which is important as lower socio-economic status is considered to be a major contribution to higher smoking rates (Taylor 2013; Mackenbach et al. 2008).

The State of Public Health Report for Tasmania (2013) noted that,

- “• In December 2012, Tasmania had the highest rate of unemployment (7.3%) of all jurisdictions.
- Additionally, the estimated long-term unemployment rate for Tasmania (1.5%) was the highest in the country, as was the estimated under-employment rate (9.3%).
- Tasmania has the highest proportion of people living below the poverty line, as a result of very low median incomes and a high reliance on government income support payments”

And

- “• In 2011, Tasmania had the second highest proportion (after the Northern Territory) of single parent families (17%) among the jurisdictions, with the national average rate being 15.9%. The higher proportion of sole parents also contributes to Tasmania’s higher poverty rates.
- Education levels have increased in Tasmania, from 31.3% of Tasmanians aged 15 years and over completing Year 12 in 2006 to 36.5% in 2011. However, Tasmania is still behind other jurisdictions ... in Year 12 school retention rates” (Taylor 2013, p. 24).

Whilst it has been known for some years that smoking rates can be reduced in low SES groups (Durkin, Biener & Wakefield 2009; Niederdeppe et al. 2008), this did not occur in Tasmania until late in 2013. Although many legislative reforms were introduced in Tasmania during the 1990s and 2000s, it was not until 2013 that sufficient funds were allocated to social marketing campaigns, in accordance with the national and international evidence, and the reasons for this are explored in other chapters (Tobacco Coalition 2013).

The Director of Public Health recognised in his 2013 report that,

- “...more must be done. In particular, there is a need to further increase resources for and diversification of social marketing measures against

smoking in Tasmania as it appears the states with the greatest declines in smoking rates in recent years have been those that invested the most in sustained social marketing campaigns” (Taylor 2013, p. 43).

The Tasmanian Tobacco Action Plan year 3 Review, completed in 2013 stated:

“The most significant achievement for tobacco control in many years is the recent increase in funding for social marketing campaigns supported by both Tasmanian and Australian governments. **For the first time ever in Tasmania**, this will enable campaigns to be implemented at the level the evidence says will have an impact” (Tobacco Coalition 2013, p. 6) [emphasis added].

It is difficult to obtain accurate information about poverty rates in Australia, however in 2011 a researcher at the Parliamentary Library in Canberra published a paper that provided some useful estimates of poverty in 2006 by Australian electorates. Smoking rates for Tasmania have been used in Chart 3 to give a picture of the smoking rates compared to poverty rates in each state. Tasmania has had both the highest poverty rate and the highest smoking rate. Whilst the actual smoking rates for the year 2010 as recorded by AIHW may have some anomalies, nevertheless it provides a way of looking at the situation, and may have some explanatory power.

Tobacco control efforts and interventions

Taxation

Tasmania was at the forefront of attempts to introduce tobacco taxation in Australia, and the Bethune Liberal Government had legislation drafted to this effect in 1972. The Reece Labor government introduced a franchise fee in 1973, but soon abandoned it. James states:

“The first (Australian state) attempt at introducing a business franchise fee occurred in Tasmania in February 1973 in respect of tobacco. The legislation imposing the fee was challenged in the High Court, where it was found to be valid, although certain technical flaws with the legislation, especially in regard to a consumption tax element of the

scheme, were identified. The State redrafted its legislation to overcome these but before it could be retested in the High Court the fee was suspended following the negotiation of revised financial arrangements with the Commonwealth. The collection of licence fees was suspended from 1 July 1974” (James1997).

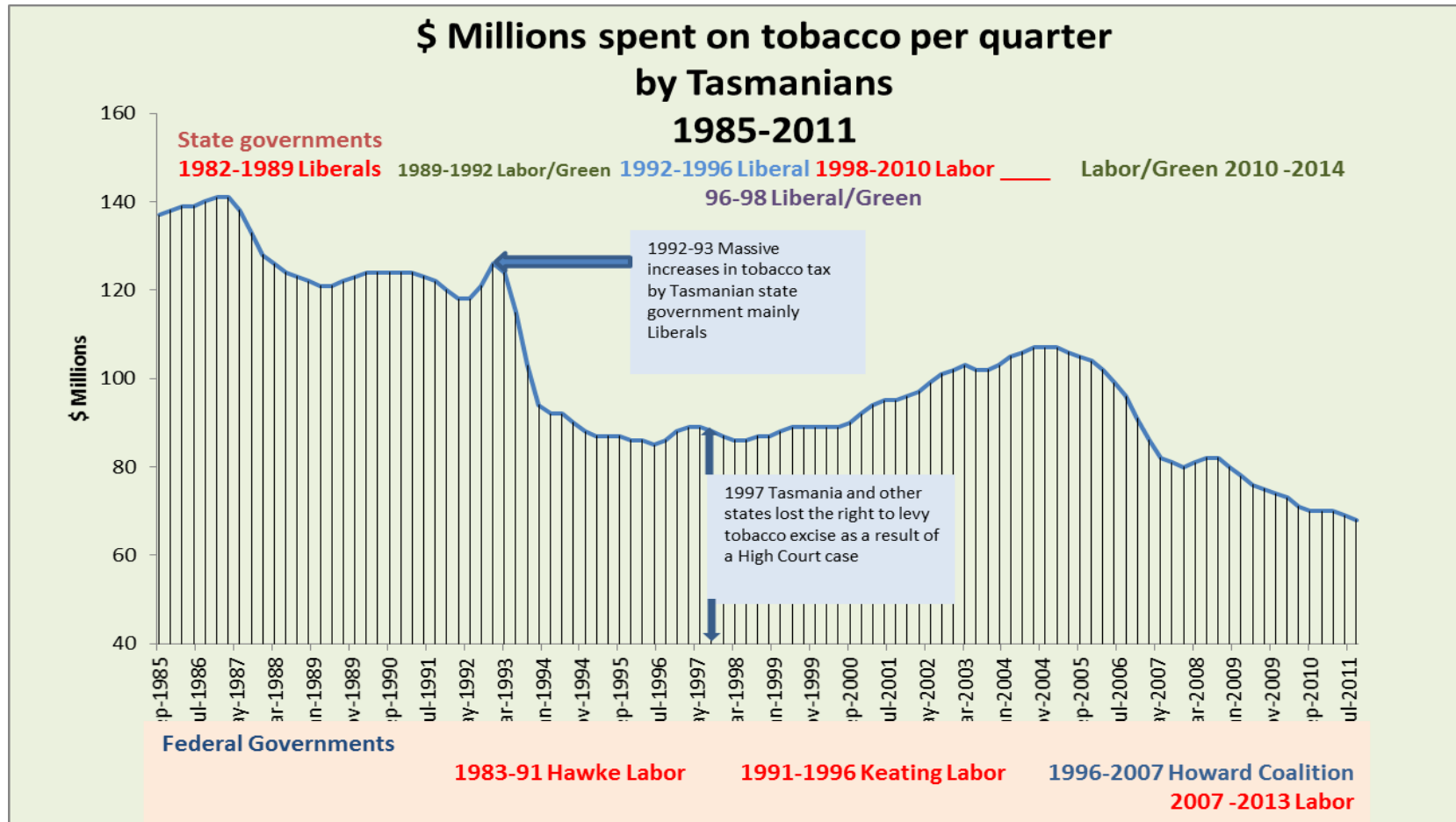
A more detailed explanation of this story is contained in the Chapter 6.

While none of these taxation measures was aimed at reducing smoking rates, the intention was purely revenue raising, nevertheless they would have had the effect of reducing smoking rates. In the early 1990s the state Liberal government increased the tobacco tax, which reduced the amount spent on tobacco.

Chart 6 shows how much Tasmanian smokers spent on cigarettes and other tobacco products during the period 1985 to 2011. It also depicts which government was in power at a state and federal level, and what tobacco control interventions took place at each point in time. This particular figure does not necessarily equate to smoking rates, because some smokers switched to cheaper brands when taxes went up, but it is useful for looking at trends. (See also Chart 7, which shows a comparison of expenditure on tobacco between states).

Expenditure on tobacco in Tasmania has been declining at the same rate as Australia in general since the 1980s, with a couple of exceptions. During the period from around the early 1990s then from 1999 to 2005 expenditure in Tasmania increased against the national trend. After 2009 this improved and expenditure on tobacco declined in Tasmania at a similar rate to the rest of Australia.

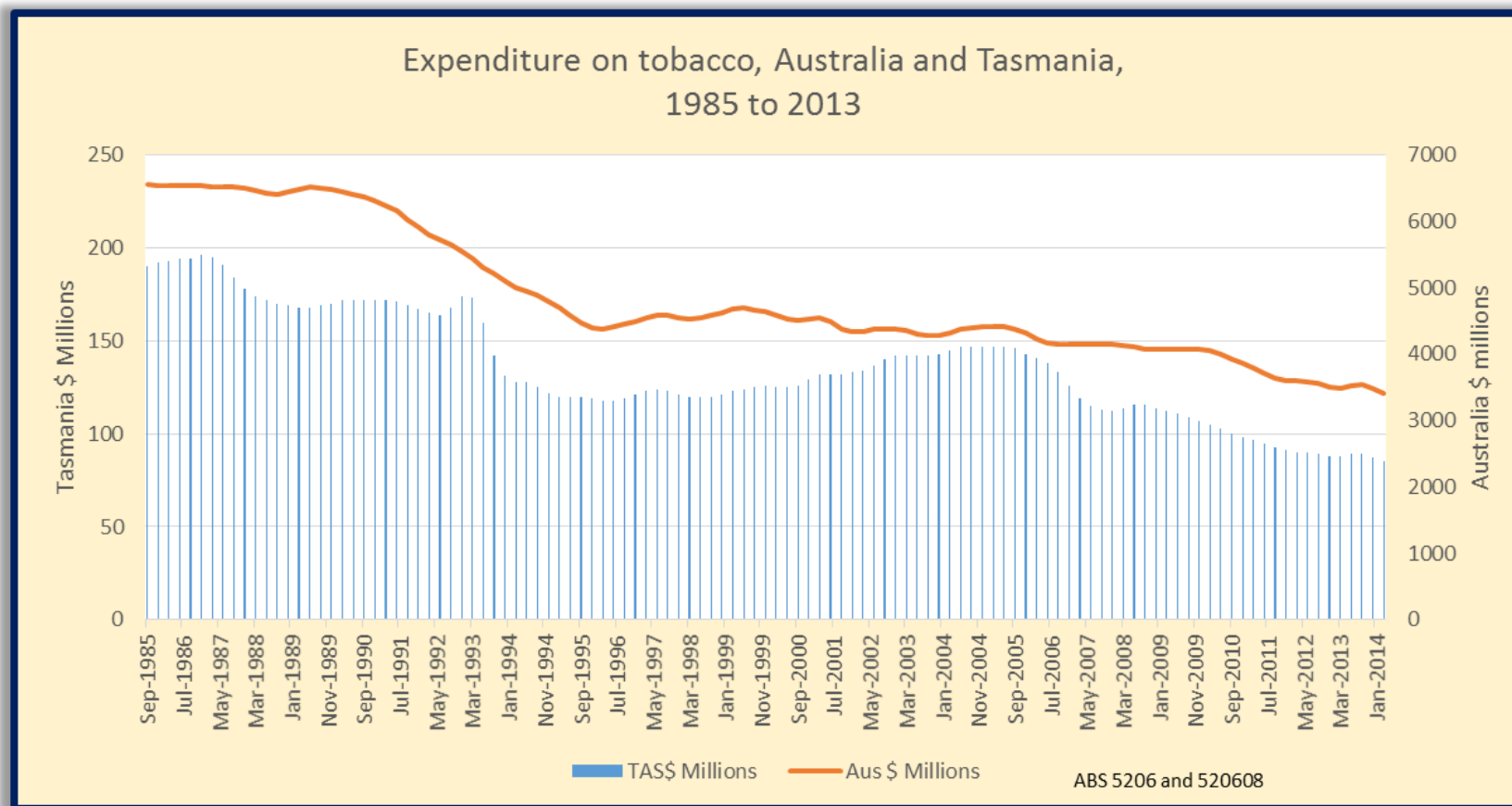
Chart 6 \$ Millions expended on tobacco per quarter by Tasmanian smokers 1985 – 2011



Source:

Derived from ABS 5206 Household final consumption expenditure (HFCE) Table 8.

Chart 7 Expenditure on tobacco, comparison between Australia and Tasmania 1985 to 2013



Source ABS. 5206 and 5206 Table 8.

History of tobacco control interventions and laws in Tasmania

Interventions in Tasmania in tobacco control differed from mainland states in two important ways. Tasmania was an early adopter of legislative reforms, but a late adopter of adequate funding for both cessation services and for social media campaigns. This dichotomy is significant and at the core of this study. The barriers to allocation of funds, and delays to legislative reform, are explored in detail in subsequent chapters.

The chronological history of tobacco control interventions, laws and funding arrangements is listed chronologically in Tables 5 and 6 at the end of the Chapter.

As described in Chapters 5, 6 and 7 the tobacco industry was a significant barrier to taxation and legislative reforms at all stages, to the extent that it was prepared to engage in corrupt behaviour and dispose of an elected government. However, there is no evidence that the tobacco industry was a barrier to allocation of funding, except to the extent that it was trying to control the media, politicians and community perceptions of tobacco, and to downplay the health effects.

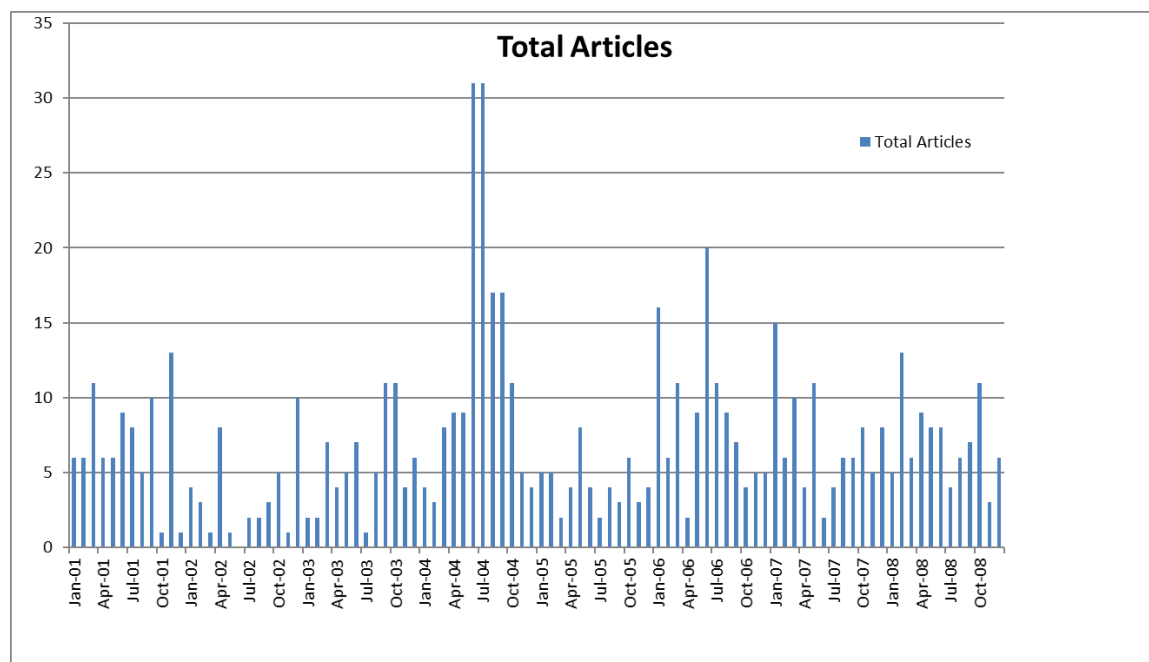
The association between particular tobacco control interventions and smoking prevalence is not always clear as there are always many variables and unclear trends in operation, both nationally and at a state level. Even international reports from for example the Surgeon General may have an impact on community awareness of the health effects of tobacco.

Wakefield et al. have provided some useful analysis of the effects of tobacco control interventions in Australia over the years 2001 to 2011. They found that increased tobacco taxation, more comprehensive smoke-free laws and increased investment in mass-media campaigns played substantial roles in reducing smoking prevalence in adult Australians (Wakefield et al. 2014). The Wakefield study did not include Tasmania, and was confined to capital cities elsewhere. As the writers noted, time series analysis tends to detect “the more immediate and direct effect of interventions and is less able to detect longer-term priming effects or indirect effects of policies or mass-media campaigns” (Wakefield et al. 2014, p. 419). As legislative reforms are tabled in Parliament and discussions about the health effects of tobacco appeared in the media, debates between health organisations and hotel, tobacco or retailer organisations were made public,

caused controversy and discussion and may well have had an effect on the social acceptability of smoking, but such a subtle change would be difficult to measure.

Stories about tobacco in the Hobart Mercury peaked in 2004, which was the year premier Jim Bacon died of smoking related lung cancer.

Chart 8 Tobacco-related newspaper articles in Tasmania- Mercury/Sunday Tasmanian 2001 to 2008



Source: Cancer Council Victoria, courtesy of Prof. Melanie Wakefield.

Smoking restrictions in public places were first mooted by Minister Peter McKay in 1996 (Rogers 1996), and he issued a strong warning to the tobacco industry that legislation would follow if the pubs and clubs, which had been agitating to continue self-regulation, did not take action to protect staff and customers from tobacco smoke pollution.

The first truly significant efforts to introduce tobacco control in Tasmania began in 1996 with the establishment of Quit Tasmania and the development and enactment of the Public Health Act 1997. The Director of Public Health, Dr Mark Jacobs, his staff and the Liberal Minister for Health Peter McKay began that process. Dr Jacobs' contribution was widely recognised by members of parliament (Hansard, 1997). Peter McKay's contribution was recognised in 1998 by the AMA and ACOSH, when Tasmania was awarded the "Clean Ashtray" award for the best performing state on

tobacco control that year (Diwell 1998). These first reforms were significant as they not only prohibited the sale of tobacco products to children under 18 years of age, but also restricted vending machines and tobacco displays in shops. Manufacturers were also prohibited from providing false information to any person about tobacco-control legislation or the health effects of tobacco products, the first jurisdiction in the world to do so. The tobacco industry challenged some of the guidelines issued under the legislation, which prompted the government to initiate further reforms and greater restrictions on tobacco display provisions.

The Department of Health and Human Services acknowledged the lack of resources allocated to mass-media campaigns and cessation support, and that legislation has been used to compensate for this (Taylor & Frendin 2010, p. 72):

“Tasmania has always had strong tobacco-control legislation but this is largely to compensate for a lack of resources available for health education and clinical interventions, particularly at the level provided by other Australian jurisdictions. Legislation on its own however is not sufficient to reduce smoking rates and this is the main reason why Tasmania has the second highest smoking rate in Australia, which has not decreased since 2001” [emphasis added].

This is a very important statement from the Department because it shows that at least some senior officers in the agency were well aware that insufficient resources had been allocated to tobacco control, and that this was a likely cause of higher smoking rates. It seems likely smoking rates in Tasmania could have been reduced, had sufficient effort been made by the government.

Over the subsequent years from 1997 to 2013 smoking prohibition in public places both indoors and in many outdoor areas was established in Tasmania through continuing incremental legislation amendments to the *Public Health Act 1997*. These changes were always opposed by the tobacco industry and the Australian Hotels Association (AHA). The health NGOs, the relevant unions whose members were affected and the DHHS supported the reforms. This process is described in detail in other chapters.

Smoking in cars with children

Other reforms such as banning smoking in cars with children in 2008 proceeded with almost no public opposition, although there were concerns expressed by the Police about enforcing these provisions (Hine 2010). The tobacco industry for reasons known only to itself did not oppose his legislation, but presumably because they had no way of countering evidence that smoking in small spaces such as a car is dangerous to children. There is also the possibility that any opposition would have created a backlash against the industry, and finally they may not have been concerned because they thought it would not affect overall sales of tobacco products. However, this is speculation, though it is possible that the sharp decline in smoking in young women of child-bearing age after this legislation was passed in 2008 may be attributable to this particular ban (See Chart 4) Interestingly, there was no decline in male smoking rates in this age group. This contrast has not been investigated to our knowledge and would be worthy of study.

Summary

The following graphs, charts and tables give a collated visual description of what happened in Tasmania in terms of smoking rates, interventions by year, comparisons with other states, mortality, interventions by year and by elected government and revenue collected over time. The roles and responsibilities of federal and state governments in relation to tobacco control are set out in Table 9.

Each chapter provides a more detailed description and analysis of what occurred in Tasmania in the context of tobacco control.

Tables and Charts

Table 7- Catalogue of tobacco control interventions by year

Year	Action
1894	A Bill presented to the Assembly Tasmania to prevent juvenile smoking.
1900 - 1907	Juvenile Smoking Suppression Act, 1900. This Act appears not to have been enforced, or perhaps never received Royal Assent. Another attempt was made in 1907 to introduce legislation to prevent sales to minors.
1934	Ban on the sale of cigarettes to children under 16 years of age under the <i>Police Offences Act 1934</i> . There were no recorded prosecutions under this legislation for around sixty years.
1972	Bethune Government launches criminal charges against the head of British Tobacco. Bethune Liberal Government drafts tobacco tax legislation but is ousted from office before it can be introduced. See Chapter 5 on Crony Capitalism.
1973-1974	Tobacco Tax established by Reece Labor government in 1973 but traded off and not collected, in exchange for additional funding of \$15 million from the federal government and withdrawal from Grants Commission processes.
1985	Tobacco Business Franchises collected in Tasmania from 1985, not as a health measure but as revenue raising and under the control of the Treasury, not the Health Department.
1996	Quit Tasmania established and funded by the Health Department.
1996-1998	Liberal government's <i>Public Health Act 1997</i> commenced including bans on tobacco advertising, the sale of cigarettes to children under 18 years of age self-service vending machines and display restrictions in retail shops. Manufacturers

Year	Action
	and suppliers were also banned from providing false information to any person about tobacco-control legislation or the health effects of tobacco products.
1998	<p>Guidelines for tobacco products incorporating the tobacco product vending machine code</p> <p>Guidelines for display of tobacco products</p> <p>Guidelines for packaging and labelling of tobacco products</p>
1999	Further sale and display restrictions in retail shops introduced following, and in response to, the tobacco industry legal challenge to guidelines.
1999	Guidelines for non-tobacco cigarettes
2000	Regulatory Impact Statement published – <i>Smoke-free public places and work places for Tasmania: a review of the potential impact on business, and the costs and benefits of environmental tobacco smoke restrictions</i> (PEHS 2000).
2000	Regulatory Impact Statement published: <i>Tobacco sellers' licencing system</i> (PEHS 2000)
2000	Tobacco licensing system introduced to ensure retailer compliance with the <i>Public Health Act 1997</i> and funding for enforcement activity. Licensing now under the control of the health agency.
2001	<p>Guidelines released for smoke-free areas (snacks)</p> <p>Guidelines for proof of age (tobacco products) 2001</p>

Year	Action
September 2001	<p>Workplaces and enclosed public places become smoke-free. This includes areas such as shopping centres, restaurants, factories, hospitals, corridors and toilets.</p> <p>Further smoke-free areas are introduced:</p> <ul style="list-style-type: none"> • within 3 metres outside entrances and exits • within 10 metres from ventilation equipment • work vehicles where another person is present • in reserved seating at cultural and sporting venues.
November 2003	Graphic health warning notices become mandatory in shops that display tobacco products.
April 2004	Tobacco Coalition holds its first meeting.
January 2005	Gaming areas, nightclubs and 50 per cent of outdoor dining areas become smoke-free.
January 2006	Liquor venues, such as pubs and hotels, become smoke-free inside.
2006	<i>Tasmanian Tobacco Action Plan 2006-2010</i> released.
May 2006	DHHS releases Discussion Paper: <i>Strengthening Measures to Protect Children from Tobacco</i> . (DHHS 2006)

Year	Action
2007	Establishment of cessation services at three locations around Tasmania by the Alcohol and Drug Service. The sale of split packet cigarettes is banned.
January 2008	Smoking is banned in cars where children (under the age of 18) are present.
2008	Sale of fruit and confectionery tobacco products is banned.
June 2008	Tobacco displays in retail shops are reduced to one square metre.
2009	Trebling of funding for social media campaigns. <i>[NB an important move, but not sufficient to meet evidence.]</i> Guidelines for price tickets and other matters (tobacco products) 2009 released. (DHHS 2009)
February 2011	Tobacco displays are banned in general retail shops.
2011	<i>Tobacco Action Plan 2011-2015</i> (DHHS 2011)
March 2012	Extensions to smoke-free areas: <ul style="list-style-type: none"> • playgrounds • patrolled beaches • pedestrian and bus malls

Year	Action
	<ul style="list-style-type: none"> • bus shelters • 100 per cent of outdoor dining areas • competition and seating areas at sporting events • other large public events. <p>Tobacco displays are banned in specialist tobacconists.</p>
November 2012	Carols by Candlelight events required to be smoke-free.
January 2013	Selected markets, food and wine, and music festivals are required to be smoke-free or have designated areas for smoking.
May 2013	Agricultural shows organised by the Affiliated Societies of the Agricultural Show Council of Tasmania are required to be smoke-free or have designated smoking areas.
September 2013	Sufficient funding allocated to social media campaigns to meet evidence-based standards.

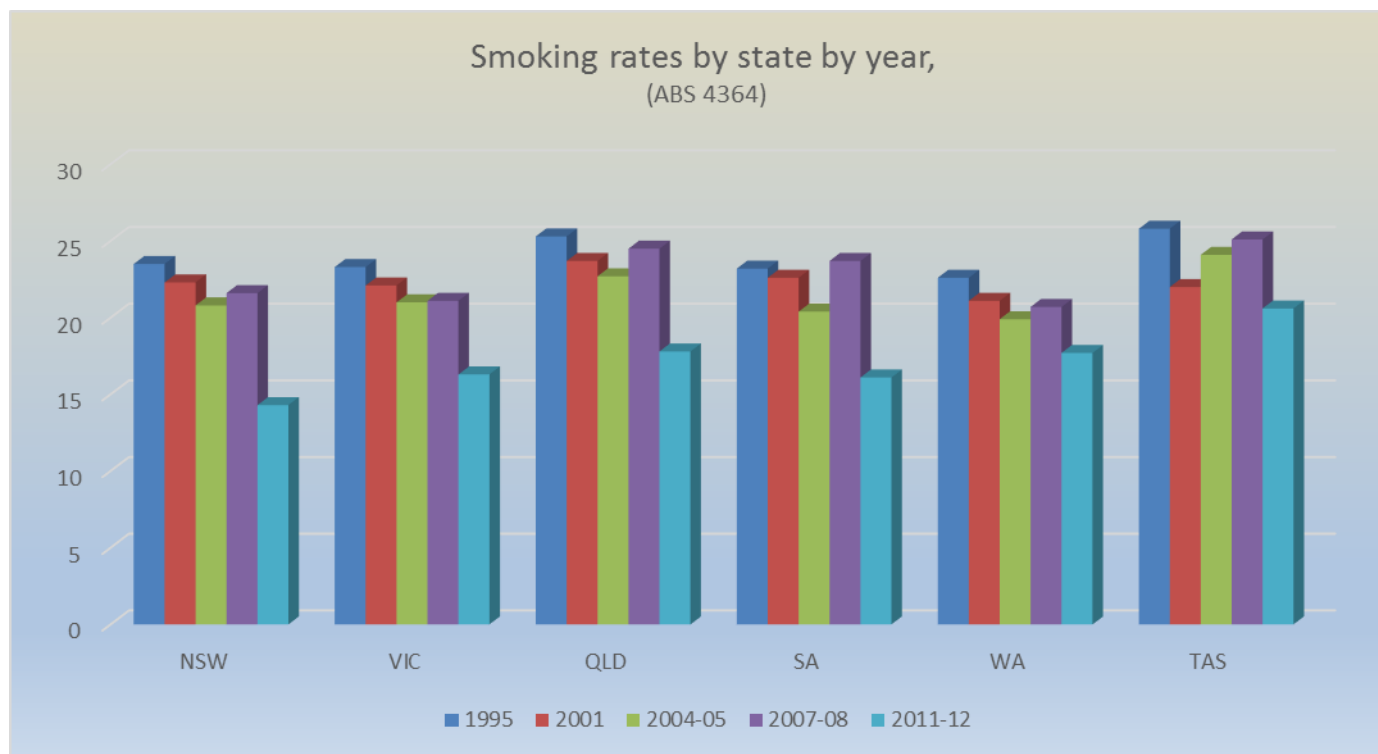
Table adapted from DHHS website: http://www.dhhs.tas.gov.au/peh/tobacco_control/smoke-free/history

Table 8 Federal interventions since 1973

The Commonwealth Department of Health lists interventions in Australia since 1973 as follows:

- 1973 – Health warnings first mandated on all cigarette packs in Australia;
- 1976 – Bans on all cigarette advertising on radio and television in Australia;
- 1986 to 2006 – phased-in bans on smoking in workplaces and public places;
- 1990 – Bans on advertising of tobacco products in newspapers and magazines published in Australia;
- 1992 – Increase in the tobacco excise;
- 1993 – Tobacco Advertising Prohibition Act 1992 prohibited broadcasting and publication of tobacco advertisements;
- From 1994 to 2003 – bans on smoking in restaurants;
- 1995 – Nationally consistent text-only health warnings required;
- 1998 to 2006 – bans on point-of-sale tobacco advertising across Australia;
- 2006 – Graphic health warnings required on packaging of most tobacco products;
- 2010 – 25% increase in the tobacco excise;
- 2011 – First complete State or Territory ban on point-of-sale tobacco product displays;
- 2012 – Introduction of tobacco plain packaging, and updated and expanded graphic health warnings;
- 2013 – Changes to the bi-annual indexation of tobacco excise and a further 12.5% excise increase on 1 December; and
- 2014, 2015 and 2016 – further 12.5% excise increases on 1 September each year (Tobacco in Australia, 2015b)

Chart 9 Smoking rates by state by year

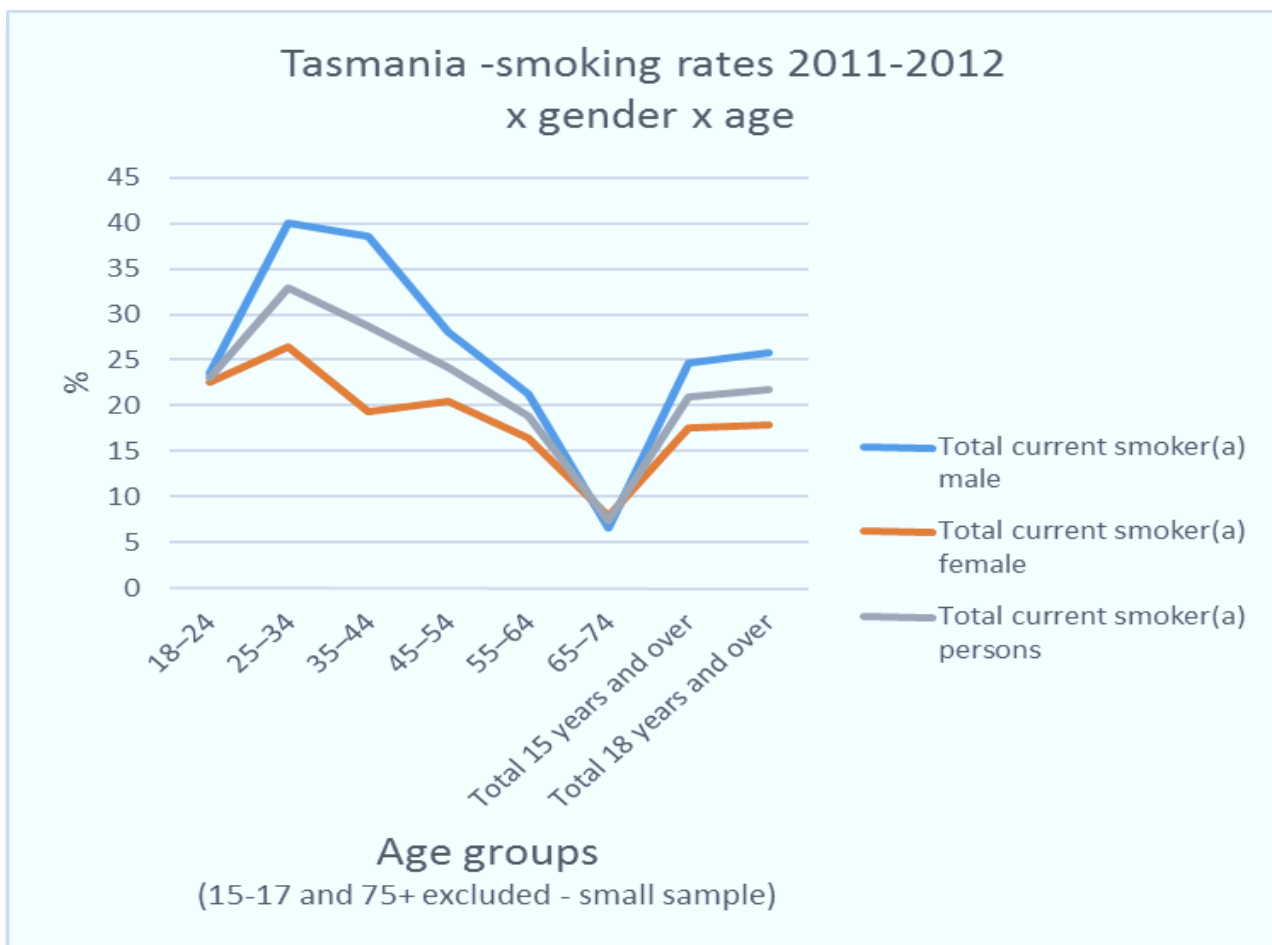


Source: ABS (2013).

Table 9 - Respective responsibilities and roles of state and federal governments in Australia in relation to tobacco control

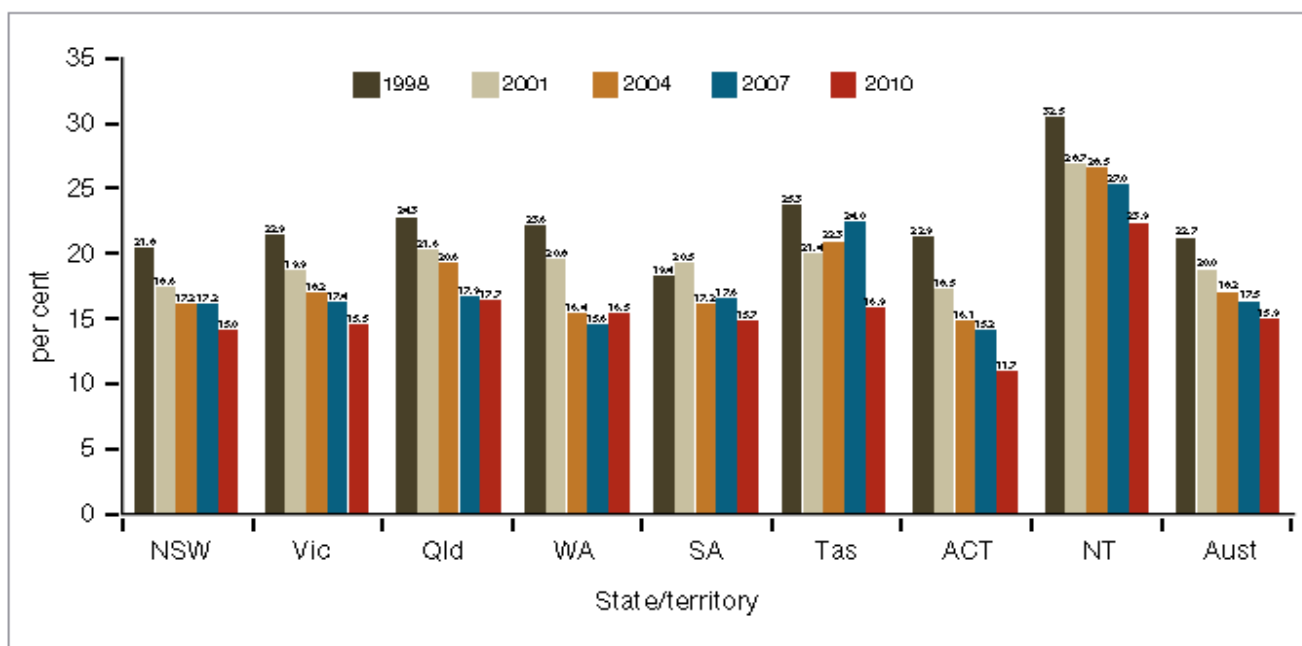
Sphere of influence and responsibility	
Australian government	State governments
Taxes and excises (collects revenue)	Bans on advertising at point of sale
Bans on advertising in mass media	Control of product displays at point of sale
Labeling	Licensing of tobacco retailers
Graphic pack warnings/plain packs	Controls of sales to minors
Control of ingredients or regulating products – e.g. ban on “lights”; fruit cigarettes	Controls on smoking in public places, workplaces and cars and outdoor areas.
Disclosure of ingredients – on national website	QUIT campaigns
Counter advertising – e.g. National tobacco campaign	Cessation support services in hospitals and health clinics and for special groups.
Control of internet; movies; trade; tax-free products at airports	Control of illicit and pharmaceutical drugs including nicotine
Customs services/Border Force	No revenue from tobacco
Controls on smuggling	
Funding of doctors under Medicare	
Foreign policy – e.g. FCTC	<i>Local government can also ban smoking on beaches, streets, playgrounds, sporting venues, parks, and in outdoor shopping malls.</i>
Control of RIP(RFR) cigarettes	
Control of national drug approvals and subsidies under PBS	
Overlaps:	
Both national and state governments can conduct advertising campaigns; fund Quit groups; fund cessation programs for indigenous, low-income, youth, or disadvantaged groups; fund or conduct research	

Chart 10 Tasmania- smoking rates 2011-2012 by gender by age



Source: ABS (2013).

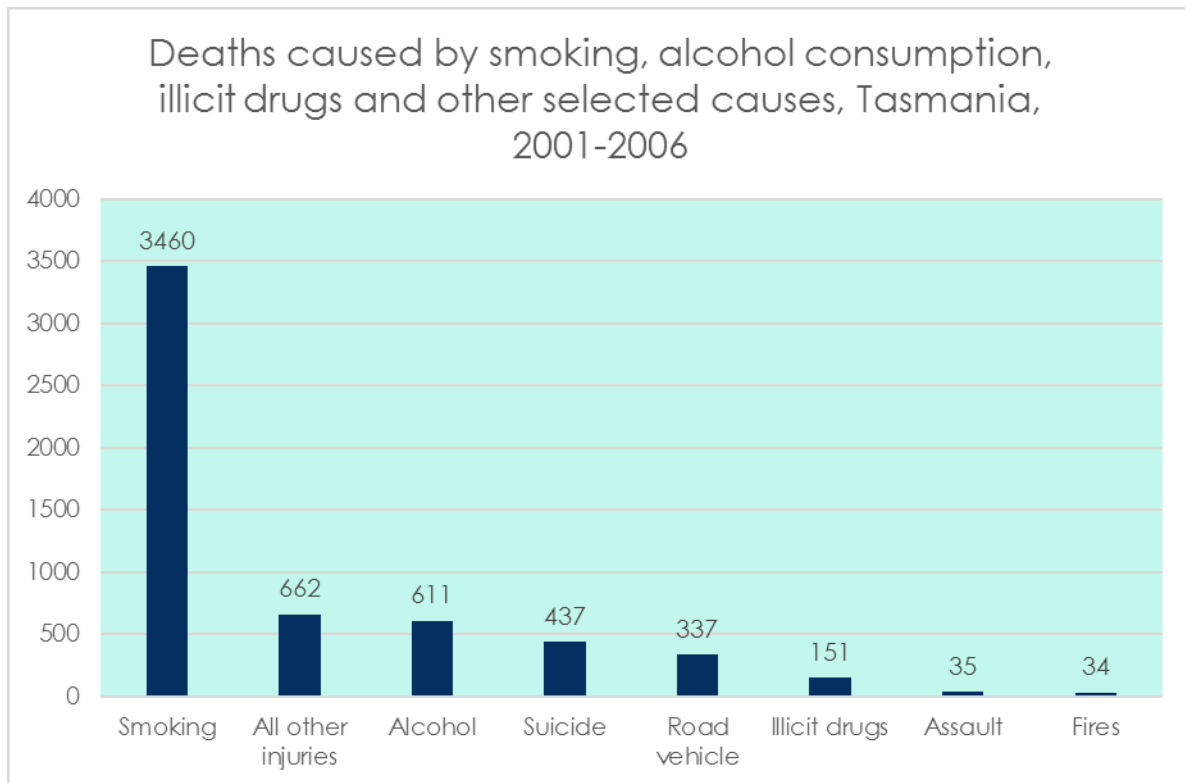
Chart 11 Changes in daily smoking status of Australians aged 18 years and older by each Australian state and territory, 1998, 2001, 2004, 2007, and 2010



Source: AIHW (1998, 2001, 2004, 2007 and 2010). Extract from National Tobacco Strategy 2012-2018.

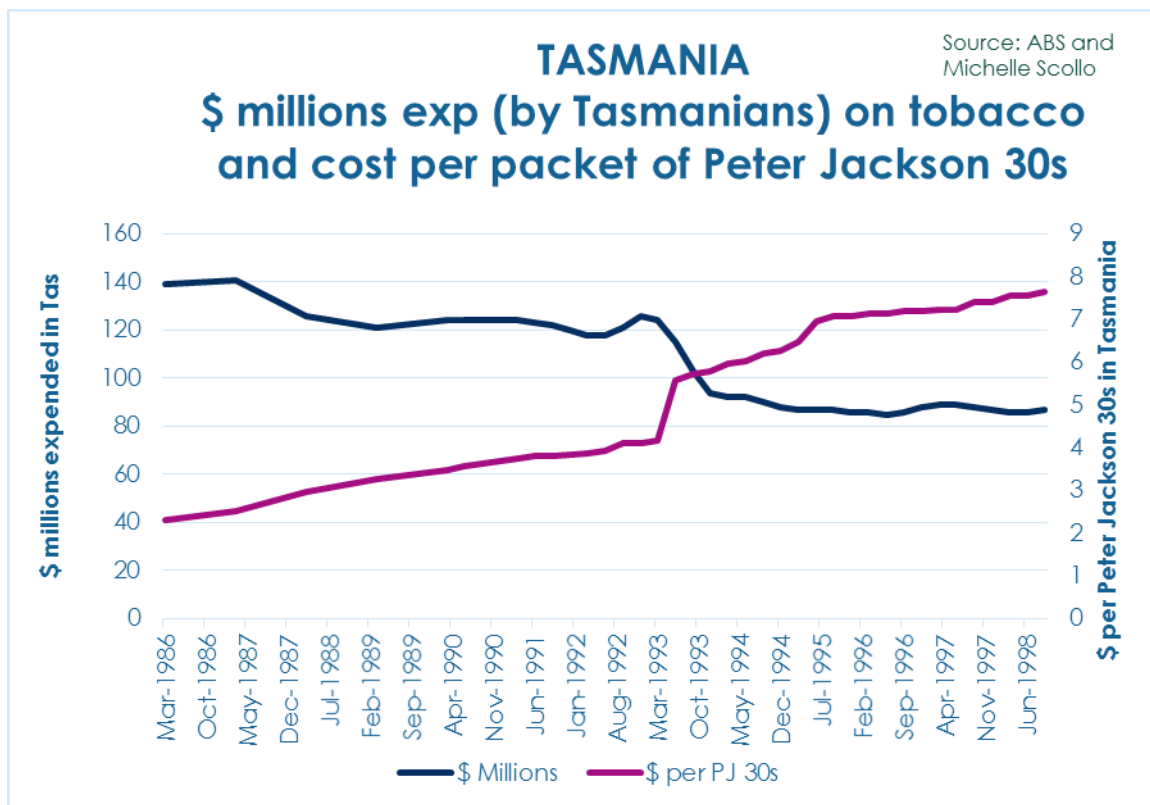
Australian Institute of Health and Welfare figures from the national drug strategy showed a rise in smoking rates in Tasmania from 2001 to 2007, against the national trend, then a dramatic fall recorded in smoking rates in 2010. This is consistent with other data that show Tasmanian smoking rates rising in the early 2000s and then starting to fall in 2009.

Chart 12 Deaths caused by smoking, alcohol consumption, illicit drugs and other selected causes, Tasmania, 2001-2006



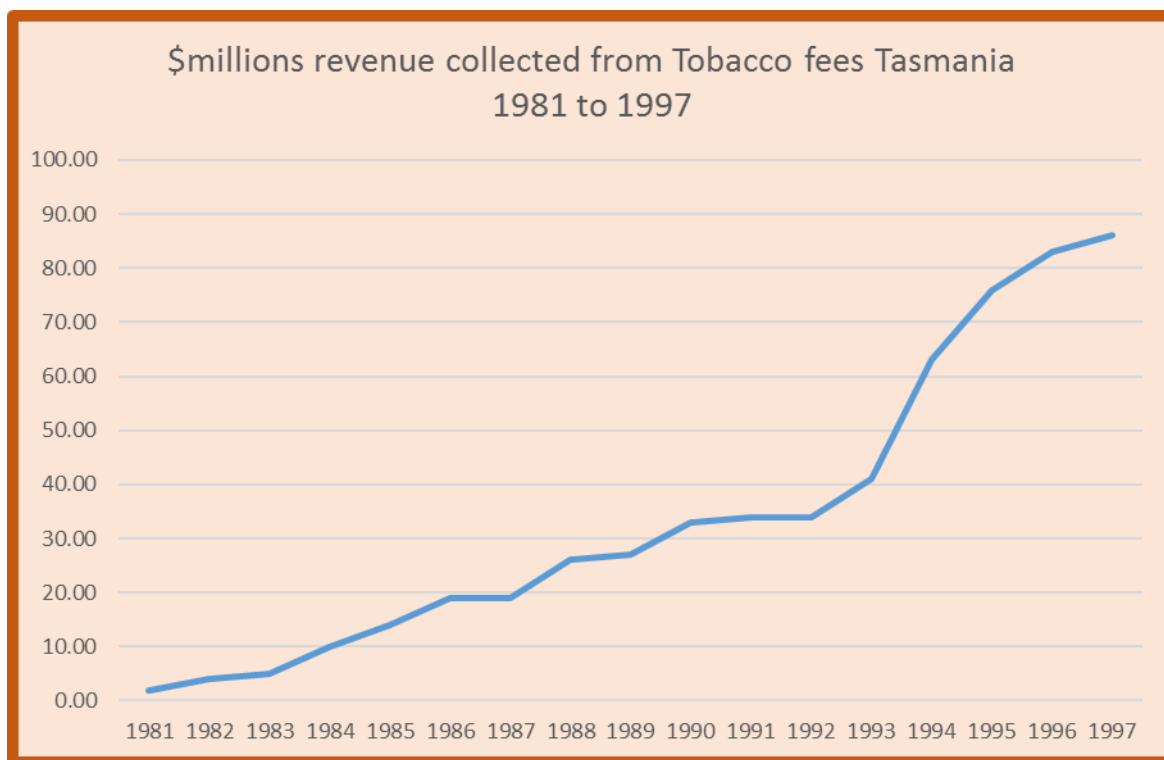
Source: DHHS Epidemiology Unit, Population Health, unpublished data.

Chart 13 \$ millions spent on tobacco in Tasmania compared to the cost of a packet of Peter Jacksons 30s cigarettes



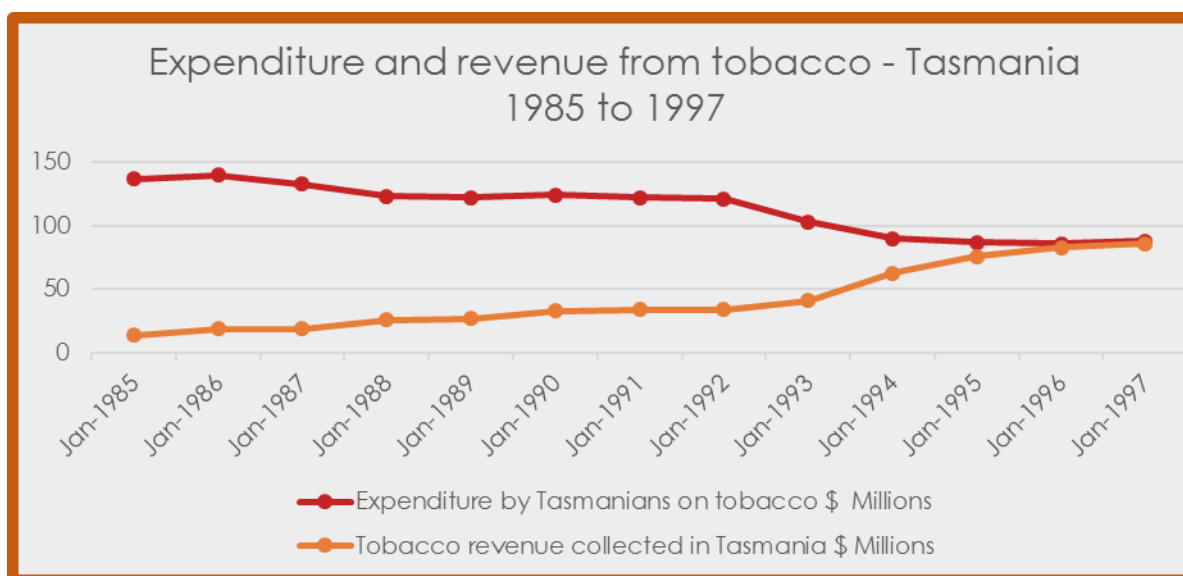
From 1981 until 1997 the Tasmanian Government levied an excise on tobacco, increasing it dramatically in 1993. As a result of the *Ha v New South Wales (1997) 189 CLR 465* High court case, states lost the right to levy these taxes. The above graph shows the effect on tobacco consumption as prices rose in Tasmania in the 1990s. Peter Jacksons were a particularly popular brand with around 36.4% of the mainstream brand share in 2010 (Scollo & Winstanley, 2015) Notes: Dr Michelle Scollo (personal communication) supplied the price data relating to Peter Jackson 30s. The dollar consumption figures are from ABS Cat series. 5206.0 – Tasmania. There are some gaps in the data, and this graph should be viewed with caution, but it is useful for looking at trends.

**Chart 14 \$Millions revenue collected from tobacco business franchise fees
Tasmania 1981 to 1997**



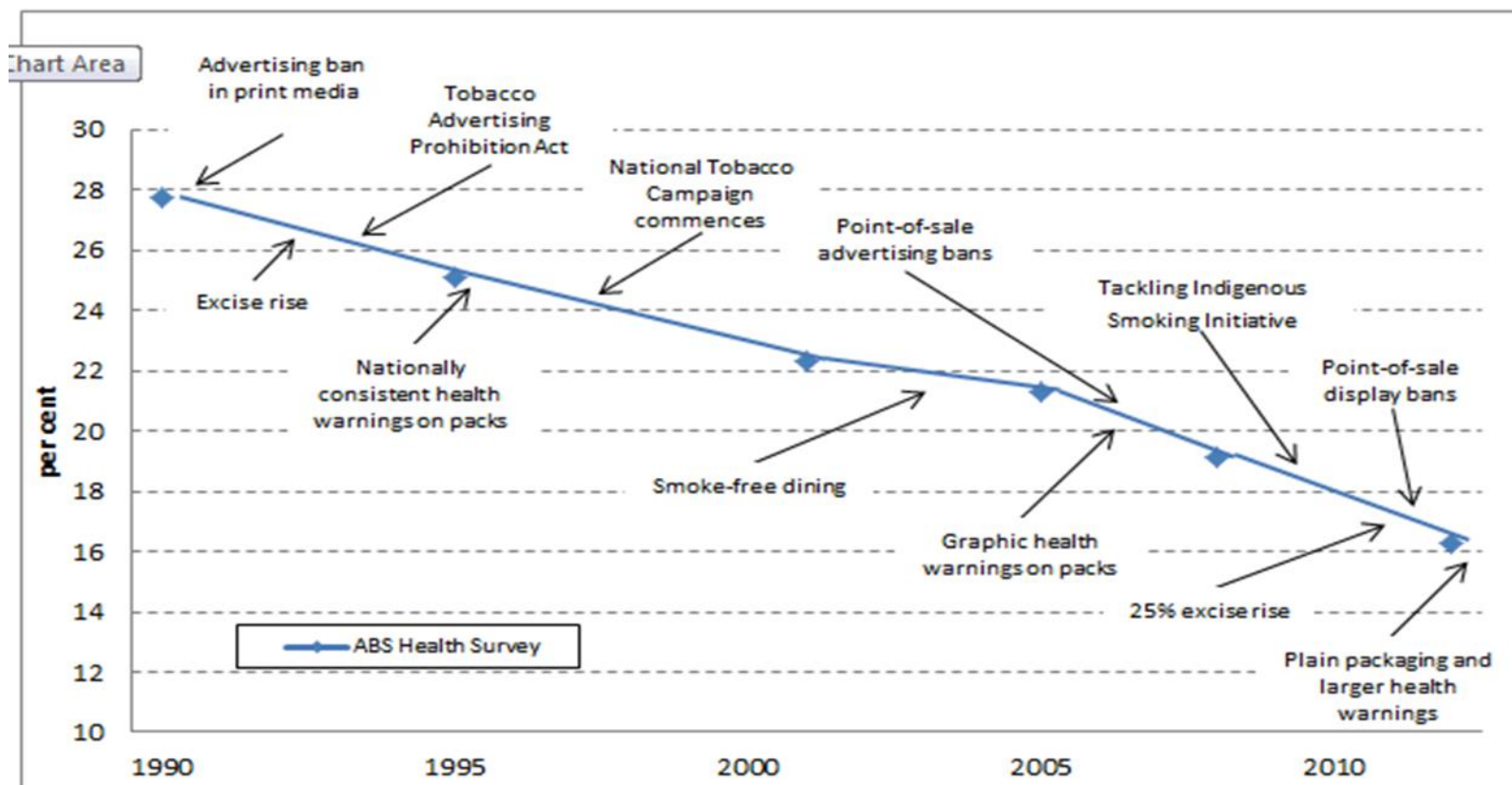
Source: Derived from Scollo (2008).

**Chart 15 Expenditure and revenue from tobacco \$ millions 1985 to 1997
Tasmania**



Sources: Derived from Scollo (2008) and ABS Sept 2013 5206.0

Chart 16 Smoking prevalence rates and key tobacco-control measures implemented in Australia since 1990



Source: Commonwealth Department of Health (2014).

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Chapter 5 Crony capitalism and corruption: British Tobacco's obliteration of an ethical Tasmanian Government in the 1970s

Note: Most of this chapter has been published in *Tasmanian Historical Research Association, Papers and Proceedings* (Barnsley 2011).

Introduction and Synopsis

At an early stage in the research for this thesis, and in the process of searching local publications about public policy and politics in Tasmania, a brief mention of events in the 1970s involving British Tobacco was found in a thesis by Hay (1976). Hay described events surrounding alleged corruption involving British Tobacco, and the Minister for Lands to transfer "... a large section of land in northeastern Tasmania in contravention of the Crown Lands Act." Hay stated that the "alleged transaction can best be described as "bureaucratic patronage" (Hay 1976, p.200). Today this might be titled "crony capitalism".

This inspired curiosity and a process of further research, which involved going to the State Archives to find the Lands Department files relating to these events. These documents were not made available to the public for many years, until the 1990s. It is likely that few people knew of their existence or availability, and they were certainly not available to Hay in the 1970s at the time his thesis on corruption in Tasmania was written. Discovery of this extensive file uncovered the full story of the British Tobacco crony capitalism and corruption saga set out in this Chapter.

In the 1960s and early 1970s Tasmanian politicians became embroiled in events relating to land deals with British Tobacco, allegations of bribery, and the demise of a Liberal minority Government. The story is important because it reinforces the close relationships (some) governments in Tasmania have had with the tobacco industry over many decades, with the

strands of such corruption and crony capitalism running through the politics of tobacco control in Tasmania.

There are a number of different names of tobacco companies involved as British Tobacco was engaged in mergers with other companies around this time. Therefore, the names Amatil, British Tobacco and WD and HO Wills Pty Ltd appear at different times in documentation during the late 1960s and early 1970s. All were associated with or were part of the same company, and in this Chapter the term British Tobacco is used. However, some of the direct quotes and references use the other names.

The story unfolded from 1969 when, after 35 years of Labor Government, a minority Liberal Government was elected in Tasmania. In order to govern, the Liberals formed a coalition with the Centre party, the sole elected member of which was Kevin Lyons MHA.

The incoming Government investigated actions of the previous government. In the 1960s, as a result of arrangements with the Labor Government, British Tobacco had amassed extensive leased landholdings in North-East Tasmania. The new Liberal government investigated these land transactions and found that there were breaches of the law. The law had been designed to assist small landowners, not large companies, and the incoming Liberal Government proceeded to prosecute the perpetrators of this law breaking. The scandals associated with these proceedings were front page news in Tasmanian daily newspapers. Criminal charges were laid against eminent Australian citizens, including: the Chairman of British Tobacco, TJN (Noel) Foley, BT legal executive William McComas; a former Labor Minister for Lands, Douglas Cashion; a prominent local grazier Ernest Mills and the former Secretary for Lands, Frank Miles (*Mercury* 1971a).

These charges were dropped in 1972 when the Liberal government found that British Tobacco had marshalled international resources and would be likely to escape conviction. The Attorney-General, Max Bingham, dropped the charges after receiving legal advice from a Melbourne law firm that:

“... In my opinion. it is in the public interest that the charges against all defendants, should be withdrawn at this stage. The factors which have weighed most heavily in leading me to that conclusion are the absence of financial corruption, the good character of the defendants, and the fact that it does not appear that any of the defendants regarded himself as

acting morally dishonestly. I do not think that it is possible to differentiate between the defendants in this respect. Another factor is that it would not be in the interests either of the defendants, the Crown, or the public in the circumstances of this case to conduct long criminal proceedings where convictions are not likely to result” (McGarvie 1972 in Hay 1976, p. 201).

In January 1972, a British Tobacco executive warned the Liberal Premier that Kevin Lyons was willing to bring down the government, for a price. In the same year Kevin Lyons was paid \$25,000 (equivalent to \$250,000 in today’s currency) by British Tobacco for his memoirs. This fact was not disputed. The memoirs were never published and probably not written.

In March 1972 Kevin Lyons, who held the balance of power, resigned, thereby bringing down the government and causing an election to be held, which the Liberals lost to the Labor Party.

Prior to losing office the Liberals had prepared legislation to impose a tobacco tax. The tobacco industry had always strongly opposed tobacco taxes, as it adversely affects their revenue. This opposition continues to the present day.

A somewhat disingenuous police enquiry cleared Kevin Lyons of bribery and corruption. Mr Dawson QC, who conducted the inquiry, said that British Tobacco was willing to pay for the memoirs, because it was likely that the memoirs would refer to senior officers of the company (Hay 1976, p. 296). Dawson established the existence of conflict of interest, but no further action was taken. A special Act of Parliament was initiated by the Reece Labor government, and enacted in November 1972, to retrospectively validate the actions of British Tobacco and the government and to indemnify all the participants against prosecution in relation to the land deals. Agitation for a Royal Commission was not successful and no public enquiry was ever held.

Method

This Chapter is based on a search of Tasmanian newspapers, *The Mercury* and *The Examiner*; original documents held in the State Library of Tasmania archives; the Tasmanian

Parliamentary Library; the Tasmaniana Library, and maps held by the Department of Primary Industries, Parks, Water and Environment.

Very few of these documents are online, and few are digitized. Hansards are available online from 1992. In the period in question (the 1960s and early 1970s) there were no Hansard records, but the *Mercury* newspaper recorded the events in Parliament and these records were collected and retained in the Parliamentary Library. These newspaper records are mainly on microfiche in the State Library of Tasmania. Some other newspaper records of Parliamentary proceedings and debates relating to the period prior to Hansard being established are available in paper form in the Parliamentary Library.

Original correspondence from British Tobacco is in a 1960s to 1970s Lands Department file released for public scrutiny, and available on request for perusal *in situ* at the Archives Office of Tasmania. This file also contains records of meetings between ministers and company entities, memoranda and reports relating to the land deals and subsequent events.

An online search was also undertaken of the online Legacy Truth Tobacco Industry Documents Library held at the University of California San Francisco; however, none of the correspondence found on file in Tasmania is in the UCSF records. It may have been destroyed as part of the document destruction process undertaken by British American Tobacco (Australia) (Lieberman 2002). Some relevant records are referred to in the Legacy Library, but none of the actual correspondence.

Background

The structure of the Tasmanian economy makes it vulnerable to crony capitalism and, some have argued, to institutional corruption (Petrow 2006). Tasmania is a small state, with a few dominant industries, which inevitably develop close associations to politicians and the political process. It is hard to prove corruption (Petrow 2006, p 1).

This inability to “prove” things was a feature of events described here.

Petrow (2006) and Beresford (2010) both identify the potential for institutional corruption in Tasmania (Beresford 2010). Beresford says:

“Crony capitalism is prone to corruption because it is based around an imbalance of power and lack of transparency in the government-business relationship” (Beresford 2010, p. 213)

In 1969 the Liberal and Labor Parties each won seventeen seats in the 35- member House of Assembly. Kevin Lyons of the Centre Party won one seat and therefore held the balance of power. Kevin Lyons had considerable political experience and was a son of former Premier of Tasmania and Prime Minister of Australia, Joseph Lyons and Federal Minister Dame Enid Lyons. Kevin Lyons agreed to support the Liberal party. A Liberal government was therefore in power after 35 years of Labor government (Bingham 2003).

At the time of the events recorded here, there were few administrative checks and balances, nor transparency of government operations in Tasmania. There was no Ombudsman, no freedom of information legislation, no Hansards, no public records of political donations and no Integrity Commission. The Director of Public Prosecutions was not independent, and prosecutions were within the control of the Attorney General, a politician and Cabinet member. Events in Parliament were recorded in the *Mercury* newspaper, but not in full, and were sometimes recorded in other newspapers. A chronology of events can be found at Table 10.

Criminal charges against British Tobacco executives and others

Soon after gaining office in 1970, key members of the Liberal Government became concerned about the way substantial British Tobacco land holdings in North East Tasmania had been allocated and acquired, and suspicions arose in the public service that correct legal processes had not been observed. As the former Attorney General said, “It looked like a case of public property being used for the private gain of a privileged few” (Bingham 2003, p. 152). The *Crown Lands Act 1935* precluded large companies from leasing or purchasing the land in question as it was intended for small farmers. A “dummying” process was employed that meant that employees of British Tobacco, including some Directors, were applicants for the land. The relevant provisions of the Act had been designed to encourage small landholders to take up and develop land, and therefore allowing a large company to do so was against both the letter and spirit of the law. An internal inquiry was held that led to criminal charges of conspiracy being laid against two British Tobacco executives, TJ N (Noel) Foley and William McComas; a former Labor Minister for Lands Douglas Cashion; a prominent local grazier Ernest Mills and the former Secretary for Lands, Frank Miles (Caldwell 1971; Caldwell, Thorp & Coatman 1971; Foley 1971, 1972; *Mercury* 1971a, 1971b).

The Premier, Hon WA Bethune, met with British Tobacco executives on 25 January 1971 and cautioned them regarding a pending legal investigation. The Chairman of British Tobacco T J N Foley responded in writing the next day:

“In complete good faith we have put to the State government a plan of land development in an area which was previously classified as almost useless and which had been held on lease for many years by other persons without any significant improvements being carried out. The Government of the day approved the plan and you and your Government have since on several occasions endorsed it as being for the good of the State. Now, because of a suggested breach of a section of the Crown Lands Act by the method of leasing and freeholding approved and operated by your predecessors in Government and administered by the Lands Department, we are to be presented publicly as alleged breakers of the law – in the words of your Attorney-General – and subjected to investigation. For a company such as ours with a high reputation for probity and so much in the public eye, this would be most embarrassing and damaging, even though at the end of the inquiry it were declared free from wrong-doing” (Foley 1971, p.3).

In September 1971, charges of conspiracy to “obstruct, prevent, pervert, or defeat the administration of the law” or to “cheat or defraud the public” or “to obtain for WD & H O Wills Aust Ltd ... lands of the Crown” and various other criminal charges were lodged against Foley, McComas, Cashion, Mills and Miles. These charges were front page news in local newspapers (*Mercury*1971a, 1971b).

However, British Tobacco said that they had received a “very strong welcome” from the previous Labor Premier Eric Reece, Lands Minister Cashion and later the Liberal Premier Mr Bethune regarding the controversial 130,000 acres for land development in Tasmania in 1963 (*Mercury*1971a). Subsequently Labor Premier Eric Reece dismissed all these allegations of corruption. Reece said that “...there was not one word in the allegations which would provide sufficient proof for a royal commission”. Mr Bingham responded that, “if these allegations are true, then the conduct of the people concerned came to the verge of sedition”, and “Mr Reece had attempted to stifle debate” and “[the ALP] were trying to sweep it under the carpet.” (Crawford 1973b, p. 2).

In February 1972, the Liberal Attorney-General Max Bingham decided to drop the charges because as he expressed it with considerable hindsight some thirty years later,

“The Company naturally rallied its world-wide resources, and produced from Britain some documentation I had not previously seen. I forget the details, but it seemed likely to raise doubts about the guilt of the Company officials, as if they had been led astray by the wicked Tasmanians” (Bingham 2003, p152).

The British Tobacco Company and its executives seemed likely to escape any legal liability. It was considered by the legal advisers to the government that the only people who would eventually be convicted were relatively minor players in the land scheme (Bingham 2003). No further legal action either civil or criminal can be taken against any of those involved in this scheme.

In November 1972 British Tobacco provided advice on how to validate the land scheme and ensure that the land deals were retrospectively legal. Validating legislation was subsequently passed by Parliament under the auspices of the newly elected Labor government. The validating legislation, the *North East Land Development Act 1972*, provided indemnity against criminal or civil legal proceedings for all the people. Section 8 states “... no action or any other legal proceeding whether civil or criminal, shall be instituted by or against any person in respect of any declaration or statement made, or any act matter, or thing done [in relation to the land transfers]”. Therefore, these 1960s land transfers are now considered to have been lawful. The legislation was passed through Parliament before it became public knowledge that Kevin Lyons had received money from British Tobacco. Whilst the indemnity would not have covered corruption, the fact that the donation to Lyons was not known at the time meant that the legislation went through relatively easily without close scrutiny. The Parliament was unaware of these events, so did not question the legislation closely (Bingham 2003).

What were the land deals?

In the early 1960s British Tobacco, under the auspices of WD &HO Wills, and with the strong support of the Labor government, developed extensive land and pastoral interests in North-East Tasmania. This land was not used for growing tobacco but was used for pastoral purposes. The government was keen to see bulldozers move in and clear the land. At one time

up to 130,000 acres (52,610 hectares) of land was involved in the land deals between British Tobacco and the government. This is a substantial landholding in Tasmania (Caldwell 1971; Quarmby 2006). In 1972 some of this land was removed from British Tobacco by the Bethune government and placed as a reserve within Mt William National Park (Quarmby 2006).

The *Crown Lands Act 1935* did not contemplate the prospect of large companies acquiring land in this way and so in order to provide legal certainty to British Tobacco an amendment to the Act was considered, but rejected by the government. The Labor Premier Sir Eric Reece and Minister Cashion "... were against any such step because they could not see parliament agreeing to Wills or BT having a privileged position". Premier Reece specifically asked Minister Cashion if the scheme could be carried on under the Act as it stood, and was advised that it could. The rationale for this opinion is difficult to understand. The Premier was therefore poorly advised, and presumably remained unaware of the illegality of the scheme for some time (Foley 1970; Caldwell, Thorp & Coatman 1971).

In the 1960s British Tobacco was associated with various other companies including Naroo, WD & H O Wills and Amatil. British Tobacco became associated with large properties in North East Tasmania known as Rushy Lagoon, Icena Estate and Miegunyah (Foley 1968; Amatil 2009). The company used for the purpose of the development of the land was WD & H O Wills (Australia) Limited, "... which at the commencement of the venture and for many years previously had carried on an extensive tobacco business in Tasmania" (Foley 1968, p 4).

The public servants involved in approving the land transactions were directly involved in the conspiracy. One senior public servant explained in 1971 that after a meeting of officials with tobacco executives it was recognised that it was "highly undesirable" for any persons other than those associated with the tobacco company, to be able to access land grants in the designated area. Therefore, the Company ensured that:

"... applications made by persons acting on behalf of the company should be marked so that they would be recognised by myself and the Surveyor-General. It is my belief that the sole purpose of marking the applications was to ensure that no person, not connected with the Company would receive a grant of land in the subject area. I am of the belief that the sole purpose of marking of the application was to enable

administrative effect to be given to the scheme as a whole” (Thompson 1971, p.2).

The initials of William McComas, “WRM”, solicitor for the company, were placed in the top left hand corner of every Wills application (Caldwell, p.11).

This is an extraordinary document as in it the public servant involved in facilitating this scheme has placed on record the mechanism for achieving the purpose of the company acquiring the land, and ensuring that ordinary members of the public were excluded from this opportunity, directly against the spirit and letter of the relevant law. This illustrates the two factors identified by Beresford that can lead to corruption, a powerful business lobby with close ties to government, and a lack of transparency in government processes (Hay 1976; Beresford 2010).

British Tobacco knew at an early stage that their leases were potentially unlawful, but were apparently given verbal assurances by senior government officials and the minister that there would be no difficulties. The Company wanted written assurance from the Government that these legal problems would be overcome. In April 1968, TJN Foley, the Chairman of British Tobacco, wrote to the Surveyor-General and Secretary for Lands. In this letter he said *inter alia*, “These then are the matters which are concerning us and on which we need your help, we appreciate that there are technicalities in the law governing this matter but as you indicated in Hobart it should be possible to overcome these without great difficulty” (Foley 1968, p. 7). Foley assured the government that development of the land was proceeding at a fast pace, and British Tobacco was anxious to acquire more land. Foley said “At this date we have reached the stage where our bulldozer crews will complete clearing on all lands now surveyed within the next few days” (Foley, 1970 p. 2), and he added “our estimates indicate that by the end of October 1971 we will have over 5,000 head of cattle and about 35,000 sheep on Rushy Lagoon”.

The scheme became public knowledge, and was widely reported in newspapers, when the incoming Liberal Bethune government came into office. They began investigating the matter, and the Attorney-General launched a prosecution action against these major public figures. As already mentioned, the Government was subsequently forced to withdraw the action on legal advice.

As a consequence of this very public scandal and mutual criticisms, the Bethune government was not enamoured of the British Tobacco Company and some of the British Tobacco land was resumed by the Bethune government for a national park. Quarmby says this may have been done because:

“... ill-feeling over the issue of corruption under the earlier Labor Government possibly influenced the Bethune Government to support the Parks Service’s interest in resuming 6,880 hectares from the British Tobacco Company’s allocation” (Quarmby 2006, p.184).

This action would no doubt have further annoyed the British Tobacco Company management.

Bethune Liberal Government is brought down

Kevin Lyons MHA had been a member of the Liberal Party but left when prevented from achieving his ambitions to be Leader or a federal politician like his parents. He then established the Centre Party. The relationship between Lyons and Bethune had been fraught with difficulty for many years. Lyons had reportedly continued to try to undermine Bethune’s leadership, and have him replaced by another MP (Crawford 2000).

In March 1972, Kevin Lyons MHA resigned his positions as Deputy Premier, Chief Secretary and Minister for Tourism and Immigration and advised the Governor, Premier and Parliament that he would no longer support the government. The government was thus forced to resign, Parliament was dissolved and an election called. A Labor government was elected.

In 1972 British Tobacco paid Lyons \$25,000 (the equivalent to \$AUD 250,000 in 2015) to write his memoirs (*Mercury* 1973a). In 1973 British Tobacco (Amatil) denied that it had anything to hide in connection with the purchase of the memoirs of Kevin Lyons MHA, but did not dispute that it had paid him the money (*Mercury*1973b). No memoir was ever published.

According to a report in the *Mercury* newspaper in 1973 regarding Mr Bethune’s meeting with an unnamed British Tobacco director:

“Mr Lyons at that time deputy to Mr Bethune, had told British Tobacco he would resign from parliament and bring down the Tasmanian

Government if it was made worth his while, according to the director”
(*Mercury*1973c, p. 1).

This story was backed up by a member of the Premier’s staff, who was told the same story by the British Tobacco director (Crawford 1973a). The former Attorney-General in the Bethune government says:

“... It looks as though the charges precipitated the deal which saw Kevin bring the government down” (Bingham 2003, p. 153).

British Tobacco had therefore reportedly warned the government in advance that Kevin Lyons was open to destroying the government, and that he was allegedly open to bribery. The unnamed British Tobacco director had made a special trip to see Premier Bethune on January 6 1972 to talk about these issues, but he had died by the time the matter became public knowledge (Examiner 1973b). British Tobacco Chairman T J N Foley denied these allegations and, after the prosecution was dropped, counter-accused the Liberal Party of seeking donations from British Tobacco. Mr Bethune said these accusations were “scurrilous” and accused the Chairman of making misleading and inaccurate statements (*Examiner* 1973a, 1973b; *Mercury*1973c, 1973e). British Tobacco shut down the debate when its manager of corporate relations and public affairs refused to comment any further on former Premier Bethune’s statements in Parliament (*Mercury*1973e).

The Bethune government had also had a bill drafted to impose a tobacco tax. Tobacco taxes are an anathema to tobacco companies, as they cut into their profits and reduce smoking rates. Indeed, tobacco companies in Australia have always vigorously opposed any increase in tobacco taxes (*Mercury* 1972; Bible 1993; Smith, Savell & Gilmore 2013).

There was public pressure for a Royal Commission to be held to enquire into the allegations of graft and corruption relating to British Tobacco payments to Kevin Lyons and others, but the Melbourne QC Mr D Dawson, who was asked to investigate these events, said that he did not believe there was anything questionable in the deal over the memoirs. Mr Bethune said that Mr Dawson was “naïve” (Crawford 1973; *Mercury* 1973d).

The police report cleared Kevin Lyons of bribery charges. Peter Hay commented:

“... reaction to the police report was mixed”... “In all the ensuing furore over the report, no attention was paid to the problems of conflict of

interest which it revealed” (Hay 1976, p. 294). “Mr Dawson said there was evidence that British Tobacco was willing to pay for the memoirs to have some control over them because it was likely the memoirs would refer to senior officers of the company” (*Examiner* 5 December 1973, cited in Hay 1976, p. 297).

Hay argues that Tasmanians are less aware of, and less concerned about, conflict of interest as it occurs in practice, than perhaps those in other states (Hay 1976).

Hay points out that,

“As Mr Lyons held the balance of power in a Government whose Attorney-General had embarked on prosecutions potentially injurious to British Tobacco, it is very easy to conceive of an interest which British Tobacco might have had in the resignation of Mr Lyons” (Hay 1976, p. 297).

***Mercury* Photograph 1 Kevin Lyons**

Photo 1 Kevin Lyons



Photo of Kevin Lyons printed with permission of the *Mercury*.

Kevin Lyons died in May 2000. He always denied the charges of bribery and corruption (Crawford 2000). The unnamed British Tobacco executive who paid Kevin Lyons is believed to have died in February 1972. No memoir was ever published.

Sir TJN (Noel) Foley was an eminent Sydney company director and influential in national politics. He was knighted in 1978, and died in 2005. His obituary, written by Gerard Henderson of the Sydney Institute, listed Foley's many accomplishments, including as Chairman of the Boards of CSR, Westpac, British Tobacco and other organisations (Henderson 2005a, 2005b). He was a public supporter of Liberal John Howard, and a lifelong conservative but never a member of the Liberal Party. He was proud of his tobacco company and regarded it as having a "high reputation for probity" (Foley 1971, p. 3). It is unlikely that he would have taken kindly to being embarrassed and humiliated, or impressed over possible damage to his company reputation in the Tasmanian and national media, having company land resumed for a national park, nor having a tobacco tax levied on his profits. The suppression of legal proceedings would have suited him well, and of course he was very well connected to be able to put influence into very high places.

Sir Angus Bethune died in 2004 in Hobart, and was recognised for his achievements, his brilliant mind, his strong ethics, sound financial management, humanity and his highly reformist government (Hansard 2004).

British Tobacco and WD & HO Wills no longer exist as companies as they did in the 1970s, and their succeeding companies are no longer associated with Amatil.

Conclusion

There is a potential for crony capitalism to lead to corruption. The proceedings of the 1960s and 1970s demonstrate the difficulties faced by a small government in dealing with a powerful multi-national company, and this is a characteristic of crony capitalism. It is also very difficult to obtain evidence to "prove" anything.

Events in the 1960s involving tobacco-company land deals in Tasmania led to a criminal prosecution being launched by the Liberal Attorney-General against British Tobacco

executives, public servants, a former Labor Minister and other eminent citizens in the 1970s, with resultant public humiliation for both the company and its leading directors. The charges were eventually withdrawn, but there was consequent antipathy between the Tasmanian Liberal politicians and the British Tobacco company executives.

Photo 2 Sir Angus Bethune



Photo printed with permission of the *Mercury* newspaper.

A key politician, Kevin Lyons MHA, who held the balance of power in the Tasmanian government, was known to have been paid a substantial sum by British Tobacco for his memoirs that were never published. This politician brought down the Liberal government, which had attempted to prosecute British Tobacco executives, resumed land for a national

park which had been previously allocated to the company, and was about to impose a tobacco tax. Clearly the company had good reason to hope for the demise of the Bethune Liberal government. This raises the question of whether or not British Tobacco was implicated in the downfall of a government in Tasmania. The definitive answer to this may never be known. A police enquiry at the time “cleared” Kevin Lyons of wrongdoing, but circumstantially the episode was highly bizarre and incriminating.

Most of the key senior tobacco executives and politicians involved in these events are now deceased, no Royal Commission was held, and therefore any hope of discovering more than that which is already on the public record, is unlikely.

However, as Petrow commented:

“Close relations between government and big business or other sectional interests will always provide opportunities for corruption in the insular world of Tasmanian politics and, incompetence apart, will always be difficult to prove” (Petrow 2006, p. 1).

Table 10 Chronology of political events relating to British Tobacco

Political events relating to British Tobacco activity in Tasmania 1969 to 2005	
<i>Date/Year</i>	<i>Events</i>
1934-1969	Labor government in power – 35 years.
1960s to 1970s	British Tobacco develops land in North East Tasmania through leasing arrangements with the government.
1969 May	Bethune minority Liberal government elected. Holds office because it has the support of Centre Party member Kevin Lyons, who is made Deputy Premier and Tourism and Immigration Minister.
1970 October	Serious breaches of the lands legislation involving British Tobacco are reported to the government. An investigation commenced.
1971 January	The results of the investigation, which revealed serious breaches, were reported to the Attorney-General. This was referred to the police.

Political events relating to British Tobacco activity in Tasmania 1969 to 2005	
<i>Date/Year</i>	<i>Events</i>
1971 August	The police report was received by the government.
1971 September 15	Charges of conspiracy laid under the <i>Criminal Code Act 1924</i> against British Tobacco executives TJN and William McComas; as well as Douglas Cashion, a former Labor Minister; Frank Miles, former Secretary of Lands; and Ernest Mills, a grazier.
1972 January	An unnamed British Tobacco executive warned Angus Bethune that Kevin Lyons was willing to bring down the government, if it were made worth his while. The BT executive reportedly died five weeks later. BT Annual Report in 1972 refers to the death of one of its directors Mr WS Bengtsson on 14 February, so it is possible that he is the executive referred to.
1972 February	Criminal charges against British Tobacco executives and others are dropped.
1972 March	Kevin Lyons MP withdraws support for the Bethune government. The government falls on 15 March and Parliament was dissolved and an election called.
1972 April	British Tobacco alleged they first heard that Kevin Lyons would write his memoirs.
1972 April 22	Election date. Reece Labor government (re)-elected.
1972 May	British Tobacco allege they offered to pay Kevin Lyons for his memoirs.
1972 June	British Tobacco alleged the contract was signed with Kevin Lyons for \$25,000 for his memoirs. This was not known to the public.
1972 November	The <i>North East Land Development Act 1972</i> was enacted to validate the actions of BT and the government and to indemnify all from prosecution.
1973 December	It was publicly revealed that Kevin Lyons had been paid by British Tobacco.
1973 December	Calls for a Royal Commission not heeded.

Political events relating to British Tobacco activity in Tasmania 1969 to 2005	
<i>Date/Year</i>	<i>Events</i>
2000	Kevin Orchard Lyons died.
2004	Sir Angus Bethune died.
2005	Sir TJN (Noel) Foley died.

Sources: *Mercury*; *Examiner*; Sydney Morning Herald newspapers, Parliament of Tasmania website <http://www.parliament.tas.gov.au/>; Tasmanian Electoral Commission website

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Chapter 6 Political barriers to evidence-based tobacco control in Tasmania

Most of this Chapter is incorporated in an article that has been accepted by the Journal *Evidence and Policy*. Publication in May 2016.

Introduction

This chapter follows on sequentially from the history of crony capitalism and corruption that occurred in Tasmania in the 1970s, but is primarily focussed on the period from the early 1990s to around 2013. Other periods and initiatives are briefly mentioned, for example in relation to taxation, but the primary areas of tobacco reform in Tasmania occurred from 1996 onwards.

Tasmania has a population of fewer than 500,000 people, yet it led Australia and the world in some areas of tobacco-control policy and legislative reform in the period 1997 to 2010. The renaissance of reform in the late 1990s followed decades of inaction, and in a few instances thwarted action, possibly as a legacy of the torrid times in the 1970s.

In the 1990s and 2000s there were three important evidence-informed areas of tobacco control reform in Tasmania on the political, NGO and community agenda; namely elimination of tobacco displays, fostering smoke-free public areas and funding of mass-media campaigns. All of these were subjected to identifiable political and bureaucratic impediments and delays (Barnsley, Walters & Wood-Baker 2015). The tobacco industry and its front organisations were lead instigators in these delaying tactics. Further impediments were political cronyism; the conservative ideology of some politicians, based on libertarianism, individualism and beliefs in “choice”; a bias towards retailers and profit rather than public health; the classic cognitive dissonance of smoking politicians, including a rejection of preventative measures; and finally an emphasis on acute hospital funding as a priority. Additionally, there was a lack of understanding or sense of urgency regarding the scientific research evidence, or the damage to individuals, families and society that was occurring from the effects of smoking.

The initiatives that evidence supported as being effective and thus should have been put in place in the health agenda at this time, were to reduce or eliminate tobacco advertising, in

particular displays at point-of-sale, eliminate smoking in public places and work, and finally as a priority allocate adequate funding for tobacco-control mass-media campaigns and individual cessation-support services (“quitting”), such as Quit Tasmania. Effective tobacco control requires a multi-pronged approach, with adequate expenditure on all. To achieve this needed political will, which was lacking in Tasmania at the time. While politicians in Australia have always taken much of their advice from the government bureaucracy, as Head observes, there has been increased contestability in the provision of information from an array of sources (Head 2013). In policy areas such as crime and corrections, Head (2013) writes that “Policy-making in the real world is linked to public opinion” (Head 2013 p399). Yet in the area of tobacco control, public opinion has, with the exception of smokers themselves, been ahead of reforms, such as of smoke-free areas in public places. These differences between policy domains require analysis of power politics and the influence of industry on politicians, and this chapter examines the political circumstances that existed at various times, and limited evidence-based progress on tobacco control.

Method

To clarify the barriers to evidence-based tobacco policy in Tasmania, a forensic document analysis was undertaken. There is considerable evidence on record about words and actions of political actors and their advisers. As discussed in the Method Chapter 3 interviews were not conducted. Bryan-Jones used interviews in her examination of delays in implementation of smoke-free area restrictions in NSW (Bryan-Jones 2004). She found that,

“SHS restrictions have been delayed by several broad factors: the influence of industry groups successfully opposing regulation; issue wear-out; and political perceptions that there is not a salient constituency demanding that smoking be banned in bars and clubs” (Bryan-Jones & Chapman, 2006 p. 192).

Bryan-Jones was able to use interviews for her research regarding second-hand smoke restrictions in NSW because she was not well known to the participants or interviewees (Bryan-Jones and Chapman 2006). However, this was not possible for this study because of the size and social connectedness in Tasmania.

As outlined in Chapter 3, a qualitative data analysis was conducted, using documentation obtained from various sources for 1997 to 2010. Documents relating to tobacco control were sought from Health and Human Services, Primary Industry Parks and Water, Treasury and Finance, and Premier and Cabinet. Some documents were provided by NGOs. Digital documents and Hansards, which are transcripts of parliamentary proceedings, for the period 1997 to 2010 were examined, sorted, recorded and analysed using QSR International NVivo. Other documents were sorted and analysed manually. Grey literature searches included published government reports, newspaper reports, government websites and tobacco industry document websites, including the important online Truth Legacy Library, an archive of 14 million documents created by tobacco companies about their advertising, manufacturing, marketing, scientific research and political activities, hosted by the University of California San Francisco (UCSF) Library and Center for Knowledge Management.

The theoretical framework used for this research is that of Kingdon (1995) with particular emphasis on agenda-setting and knowledge-transfer. In public health the agenda-setting processes outlined by Kingdon rely on three policy windows of opportunity to be open simultaneously as a precursor to progress (Mannheimer, Lehto & Ostin 2007) :

- recognition that a problem exists;
- agreement on the way forward; and
- a lack of boundaries between the politicians, civil servants and advocates.

All three appear to be precursors to progress (Mannheimer, Nehto & Ostin 2007).

The role of policy entrepreneurs, another key factor outlined by Kingdon was considered, but little evidence was found of significant policy entrepreneurs of the stature of those identified by Ballard (2004) in Victoria and NSW, in this regard.

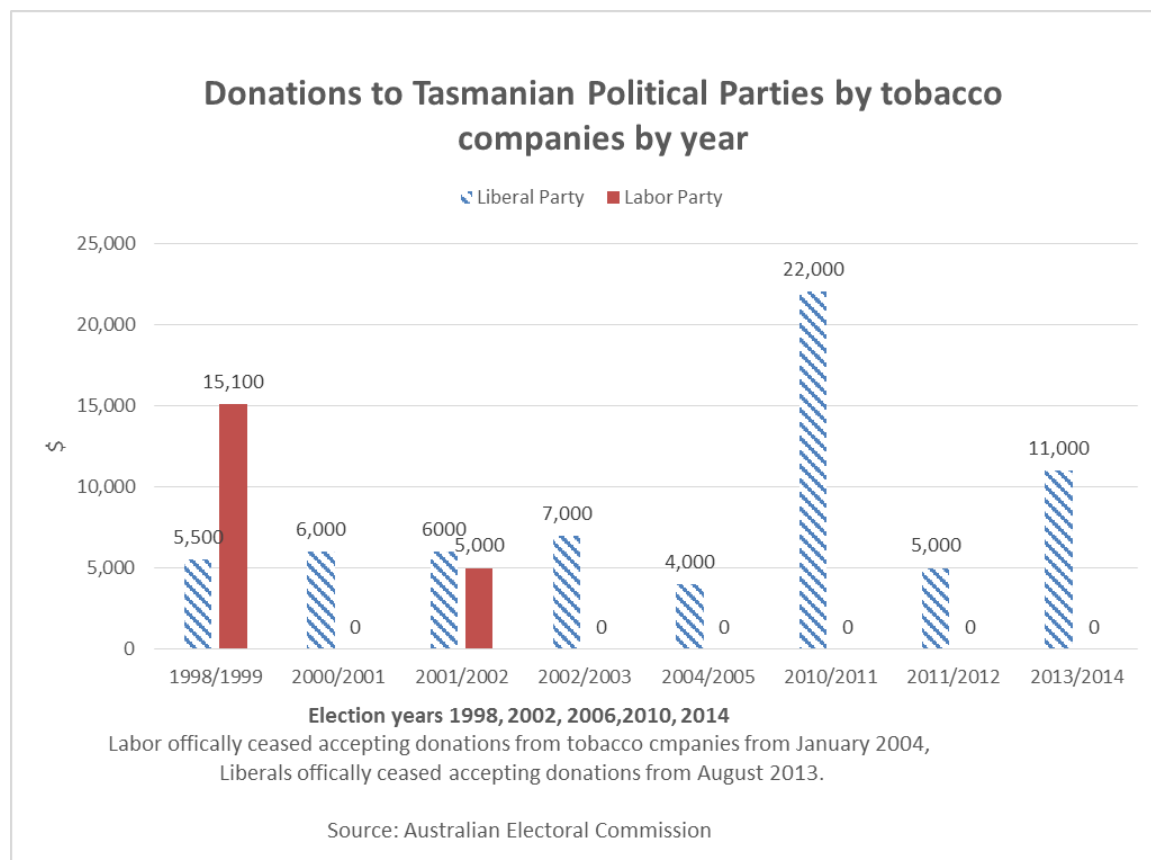
Results

The tobacco industry, cronyism and political donations

Throughout the 1990s and into the 2000s the tobacco industry denied evidence for the detrimental health effects of tobacco, engaged researchers to back up their arguments, and lobbied against any reforms (Francey & Chapman 2000). Misuse of health research by

politicians, and denial of the adverse health effects of passive smoking occurred (Thomson, Wilson & Howden-Chapman 2007). In Tasmania the tobacco industry lobbied hard against all the proposed major legislative reforms, collaborating with like-minded organisations such as the Australian Hotels Association (AHA) and tobacco retailers to do this, and making substantial strategic political donations (See Chart 17). The industry and their associates publicly and privately attacked individual public servants, as well as taking legal action against the government to disallow parts of the legislation (Legacy Library 1999a; Hansard 1999c; Rogers 1997b, Pos 1997). Crony capitalism in Tasmania is characterised by structural weaknesses in the economy which make the political system vulnerable to powerful business groups. Beresford described crony capitalism in the Tasmanian context as “... prone to corruption because it is based around an imbalance of power and lack of transparency in the government–business relationship” (Beresford 2010, p. 213).

Political donations by the tobacco industry to the main political parties continued through the 1990s and 2000s, as it had for many decades, to both the Liberals and ALP, but this did not apply to the Greens. Larger donations were made in election years to both major parties. The last donation was for the Liberals for the 2013 State election (Australian Electoral Commission 2013-14). The affiliated gaming and alcohol industries, concerned about bans on smoking in their premises, falsely argued that their businesses would be decimated, which also influenced government, and delayed implementation of tobacco-control measures (Stevenson 2000; Rose 2003; Dearlove, Bialous & Glantz 2002). The Labor government eventually acted, despite these concerns, and finally ceased accepting tobacco industry donations in 2004 (Rose 2003), but the Liberals only in 2013. In 2012 the Labor government moved to legislate to prevent donations by the tobacco industry to political parties, however this move was defeated in the Legislative Council whose members were concerned that tobacco was being “singled out”, and that alcohol and gaming were just as bad (Bolger & Arndt 2012). The Greens have never received donations from the tobacco industry, and have always criticised the major parties for so doing. The extent of these donations is additional evidence of the cronyism that has existed in Tasmania.

Chart 17 Donations to Tasmanian political parties by tobacco companies by year

Cronyism and the Australian Hotels Association (AHA)

The first hints of a determination to regulate smoke-free areas in public and workplaces, came from a Liberal Health Minister, Hon Peter McKay, a member of the Legislative Council in the 1990s. McKay issued a Discussion Paper associated with the development of the Public Health Bill 1996, and warned the hospitality industry in media stories that the government would legislate if self-regulation did not result in fewer smoking areas, particularly targeting hotels and restaurants (Dally 1998). McKay was strongly anti-smoking, and as an ex-smoker, he referred to the tobacco industry and retailers as “sellers of death” (Hansard 1997c). As a member of the Upper House Legislative Council, McKay was not subject to the same electoral pressures as members of the Lower House of Assembly, as he had a six-year term of office. This meant he was able to be more courageous in his reforms and more outspoken than many health ministers, and maintain his distance from the tobacco and hotel industries.

However, continuing in the tradition of cronyism in Tasmania (Barnsley 2011), Labor leader Paul Lennon was not so circumspect. The responsibility for delays in implementation of smoke-free areas legislation in Tasmania can be attributed to the tobacco industry, in association with the AHA, and in particular their influence over Paul Lennon, as the key Labor politician. Indeed, a memorandum of understanding was signed by Lennon on behalf of the Labor Party and the AHA prior to the 1998 election, which promised that the government would not legislate to ban smoking in hotels. Paul Lennon told the media in 1998:

“... the Labor-AHA memorandum of understanding would be honoured in full. It also includes: No sale of alcohol in supermarkets. Smoking in hotels will not be banned, but self-regulation will continue” (Dally 1998).

When Lennon became Premier in 2004, he employed former AHA chief Daniel Leesong as his Chief of Staff, continuing the tradition of cronyism. Despite this, subsequent Health Ministers Judith Jackson and David Llewellyn, with considerable advocacy and public pressure from health groups and in face of opposition from successive Premiers, managed in 2006 to bring in smoke-free areas in pubs, the first state in Australia to do so. Advocacy coalitions, such as the framework outlined by Sabatier, were extremely important in keeping governments on track with legislative reform, but they appeared to have no influence on allocation of funds, nor on placing anti-smoking resources on the agenda as a priority (Sabatier 1988), as the power to do so lies with a layer of politicians and bureaucracy above the level of health minister and his/her advisers.

Indifference of governments to tobacco as a priority

The issue of placing tobacco control on the public agenda is a problem in many countries. As Mannheimer et al. say,

“The problem seems to be that public health is not prioritized high enough on the political agenda (Mannheimer, Lehto & Ostin 2007, p. 308).

Whether this almost universal lack of priority is ideological, or whether there are other factors at play is an important question. Liberal governments in Australia have traditionally had close ties, classifiable as cronyism, with the tobacco industry, although in Tasmania this

has varied over time. Indeed, as discussed at length in Chapter 5, the Liberal Bethune Government of the 1970s was destroyed in part because of its actions in opposing British Tobacco interests (Barnsley 2011). As previously mentioned, in contrast, the Liberal Gray Government of the 1980s was supportive of big tobacco, and apart from big tax increases on the product, attempted no inroads on tobacco control. Premier Robin Gray was reported in Philip Morris correspondence to have a “good relationship” with tobacco industry executives, and was censured by a Tasmanian Royal Commission on corruption (Legacy Library 1993a; Carter 1991). During this 1980s period Liberal Health Minister Roger Groom signed weak self-regulation agreements with the tobacco companies (Legacy Library 1989), and former federal Liberal member for Bass, Warwick Smith, assisted the tobacco industry in representations to the WA State Premier, Court, to torpedo efforts to upgrade national health warnings on tobacco products (Legacy Library 1993b).

However, some individual Liberal MPs have shown distinct antipathy to the tobacco industry, including Brett Whiteley, Dr Frank Madill and Rene Hidding. Rene Hidding MHA [1996 – present] strongly supported bans on smoking in prisons in 2005, and precipitated a split with the AHA in 2004 when the Liberals, under his leadership, supported a ban on smoking in pubs and clubs; at that point the AHA told the Liberals that all contact was over. In August 2004 reporter Ellen Whinnett wrote in the *Mercury*,

“There's been a lovers' tiff between those cosy bedfellows the state Liberals and the Australian Hotels Association.

“Seems AHA head honcho Daniel Hanna was peeved when the Liberals made a surprise backflip and called for a total ban on smoking.

“Hanna responded with a volley on radio, which prompted Liberal leader Rene Hidding to also take to the airwaves and lob a hand-grenade back, saying the AHA shouldn't be advocating unsafe workplaces.

“Apparently Hanna was quickly on the phone to the Libs, telling them all contact was over” (Whinnett 2004, p. 29).

Donations to the Liberals from tobacco and hospitality industries were, not surprisingly, decreased substantially in 2004 compared to preceding years (Rose 2005; Whinnett 2004).

The Labor Party (ALP), when in office, also failed to expend sufficient funds on tobacco control, particularly for cessation-support services and media campaigns. Health groups regularly criticised the government for not providing such sufficient funding (*Mercury* 1998; Rogers, 1997). The annual “Dirty Ashtray”, awarded by the AMA and ACOSH to the worst performing state minister on tobacco control, regularly recorded Tasmania’s failure to provide adequate funding (AMA & ACOSH 2000–2010). In 1999 Dr Madill, a Liberal, questioned the ALP Minister Jackson on whether the government was going to honour an election promise to provide additional funding for Quit, and she replied, “... the Government is not in a position at this stage to honour all of its election promises. This has had to be deferred” (Hansard 1999b). Reasons were never given by successive ministers, beyond the pressures of their budgets, for failing to provide adequate funding for tobacco-control measures, nor for failing to prioritise tobacco control.

Similarly, in 2009 Greens MHA Cassie O’Connor questioned the Health Minister, Lara Giddings, at length about funding for tobacco control programs, and the Minister was clearly unable to answer the question adequately. She claimed to have put funding in place, although seemed unaware that it was inadequate to meet the need to achieve change in smoking rates, and yet claimed to be at her “wit’s end” at the failure of Government to decrease these rates (Hansard 2009). Finally in 2013 Health Minister Michelle O’Byrne and the Commonwealth allocated adequate funding (Tobacco Coalition 2013).

Cognitive dissonance – smoking politicians

Smokers generally reinforce their behaviour, rationalise it, and believe that the risks are lower than understood by those who do not smoke or who have quit smoking. In a large study conducted across several countries, Fotuhi et al. (2013) found that smokers’ perceptions can change depending whether or not they have recently quit, or have had a failed attempt. It is therefore not surprising that smoking politicians have irrational beliefs about the risks of smoking, and act and speak accordingly in their party rooms, cabinet or in Parliamentary debates. Smoking has long “been the poster child for cognitive dissonance” since it was discussed in Festinger’s book on the theory (Festinger 1962).

In a 2001 scathing editorial the *Mercury* asked “Would the legislation have been stronger if the smokers in Cabinet had all managed to quit cigarettes before deciding the issue?” (*Mercury* 2001, p.16). The editorial summed up the problems contained in that legislation.

“The State Government has run out of puff on the question of protecting the public from the health dangers of tobacco smoke.

“The new anti-smoking legislation, rather than a breath of fresh air, is a real stinker.

“The Government has chosen the path of expediency rather than responsibility by exempting bars and gaming venues from a total smoking ban.

“Health Minister Judy Jackson's statement, that Tasmania is not ready to accept a total ban, is unconvincing. It is more a case of some ministers not being prepared to put altruism ahead of their own and others' tobacco addictions which result in people inhaling clouds of second-hand smoke. The new legislation will be an administrative can of worms. ...

“The Liquor Hospitality and Miscellaneous Workers Union is understandably unhappy with the legislation. Bar and gaming room workers will still have second-hand smoke blown in their faces. ... Cabinet deserves credit for at least banning smoking in enclosed public and work places, and in reserved seating areas of outdoor sporting or cultural events. ... In the interim, hotel staff will have to cope with disgruntled smokers who are unclear about where and when they are able to light up. This uncertainty will not please smokers and non-smokers alike.

“The Government has obviously concluded that in this important area of community health, half a smoking ban is better than none. It has judged that long-suffering non-smokers will be grateful for even this degree of relief from those who generate second-hand smoke.

“But it is a pity that Cabinet has shown such a lack of willpower when the public was gasping for a stronger ban” (*Mercury* 2001, p. 16).

Robin Gray represented both the more individualistic neo-liberal ideological position associated with conservative politics and the cognitive dissonance of a smoker. He said in Parliament when speaking against a motion to ban smoking in Parliament House,

“I think we are losing sight of the right of individuals. There are just as many people who die through other lifestyle-related illnesses, or spend time in hospitals as a result of the bad diet that they have had, or the alcohol that they have consumed, as there are people who are in there or suffering as a result of having smoked”(Hansard 1994).

Similarly, his federal Coalition counterparts were “... inactive on tobacco control from 1976 to 1983, and provided no funding for education programs” (Ballard 2004 p. 95), as was Gray. As Ballard says about this period of politics,

“In line with Coalition ideology, the prevailing federal government view depicted smoking as a problem of individual behaviour rather than a public policy issue – a position warmly supported by the tobacco industry” (Ballard 2004, p. 95).

Whilst smoking politicians in Tasmania had a poor record on tobacco reforms compared to non-smoking ministers, Labor’s Judith Jackson was an exception, and she took the proposal for smoking bans to Cabinet six times before it was approved (Jackson 2015 – personal communication). Indeed the strongest opponents of reform were smoking Premiers, Gray (Liberal), Bacon (Labor) and Lennon (Labor), and smoker backbenchers mainly in the Liberal Party. These backbenchers engaged in name-calling and insults, such as the “Neo-fascist anti-smoking juggernaut” (Hodgman, in Hansard 1994). These epithets are common amongst pro-smoking advocates around the world. Leading contemporary anti-tobacco expert Robert Proctor points out:

“..... charges that nico-nazis and tobacco fascists want to jackboot us into a world where no one has any fun. Tobacco prevention is made to look like the priggish obsession of nanny-state naysayers, a backwater of the meddling, have-no-fun puritanical crowd” (Proctor 2011, p.2).

The following Table (8) records what happened in tobacco control over time, from the 1950s when nothing much happened, to the 1990s when there was a flurry of legislative reforms, and the 2000s in Tasmania. It records who were ministers and which parties were in power at the relevant dates. Premiers are particularly powerful and can make or break legislation reforms and the allocation of funds, and indeed many of them held the

office of Treasurer as well at the same time. Notations are included as to whether or not particular people were smokers during this period.

Premier Jim Bacon publicly blamed himself for his lung cancer, just prior to his death, rather than placing any responsibility on the tobacco industry. His declaration “I am an idiot” was front-page news in Tasmanian newspapers (Whinnett & Sayer 2004).

Exposure of atrocious behaviour by the industry has been effective over time in galvanising public opinion, as well as influencing the views of politicians to regard the tobacco industry as “immoral”. Writing on climate change, and why so many politicians and members of the public ignore it, Marshall suggests that immorality is one of the factors likely to trigger public attention (Marshall 2014). MLC Cathy Edwards said she was disturbed by the fact that the tobacco industry had paid the AHA to produce a very expensive information package and CD for parliamentarians, “...and some research by UMR Research was underwritten by Philip Morris” (Hansard 2001). Labor MHA Peter Patmore reported that he had been threatened by the tobacco industry: “Now, Mr Speaker, if I ever had any doubts about not supporting this bill, those doubts went straight out the door when these people who lie for a living and sell drugs to children, threatened me” (Hansard 1997b).

Acute awareness of at least a few politicians of the immoral behaviour of the industry is evident in Hansard, Parliament of Tasmania transcripts, from this and many other references.

Conservative “white male” effect of limited risk perception?

Most of the opposition in the Tasmanian Parliament to strengthening laws restricting smoking has come from conservative men, while many of the reforms have been initiated by female ministers. Tasmania has a very culturally homogenous population, and this is reflected in State Parliament. In Tasmania, all state politicians are white and most are male, around 80 per cent, varying only slightly over the period studied. Conservative white males, who are in positions of power, perceive less risk even in identified public health problems, including climate change and smoking. McCright identifies the significance of the dominant elite of conservative white males in endorsing climate changed denialist views (McCright & Dunlap 2011). Palmer also studied US populations and reported that:

“... white males tend to perceive health and technology hazards as having low risk because their worldview is one of trust in institutions and

authorities. These findings suggested that the ‘white male’ effect—that is, a preponderance of white males judging risks to be low—is explained, at least in part, by sociopolitical factors” (Palmer 2003, p. 71).

Adequate funding for tobacco control was finally achieved in Tasmania only in 2013, at a unique conjunction in time, when there was a female federal Prime Minister, female Premier, and female health ministers at both federal and state levels. The idea of conservatism in Tasmanian politics was examined but not found to be particularly influential, as both major parties have been labelled as conservative on particular issues and at particular times. Tasmania’s political landscape is complicated by a strong Greens presence, a homogenous population, a formidable and independent Legislative Council, a powerful Treasury bureaucracy, crony capitalism and an intractably inadequate state economic base. This contrasts with libertarian traditions in Sydney, and progressive social establishment (with physicians prominent in advocacy and as policy entrepreneurs) in Victoria, as described by Ballard (2004). The restricted ability of conservative male Tasmanian politicians to perceive and accept the risks of tobacco smoking has been a key factor in the issue’s failure to gain traction on the political agenda: they have slowed reform and refused to allocate adequate resources.

The following table outlines the events and reforms over time in Tasmania by political party, minister and premier.

Table 11 Tasmania - Tobacco reforms by political party, Premier and Minister for Health 1958-2015

Years	Premier	Health Minister	Parties in government	Tobacco control initiatives
1958-1969	Reece, Eric	Everett, Mervyn (1964-1969)	Labor	No tobacco control initiatives.
1969-1972	Bethune, Angus	Abbott, Nigel (very reformist on road safety)	Liberal/Centre Party	Drafted a tobacco tax. Lost office due to tobacco industry - probably bribery. See (Barnsley, 2011)
1972-1975	Reece, Eric	Foster, Alan (1972-1974)	Labor	Tobacco tax introduced, but it failed and was repealed.
1975-1977	Neilson, Bill	Farquhar, Hedley (1974-1976)	Labor	No substantial reforms
1977-1981	Lowe, Doug	Barnard, Michael (1977-1980)	Labor	No substantial reforms
1981-1982	Holgate, Harry	James, Gill (1980-1981)	Labor	Tobacco Excise introduced.
1982-1989	*Gray, Robin	Cleary, John (1982-1986) Groom, Roger (1986-1989)	Liberal	Massively increased tobacco taxes to 100%, but did not allocate funds to smoking prevention. (Groom signed a deal on self-regulation of advertising – with four tobacco companies) (Bacon et al.) Gray was regarded by the tobacco industry as a friend, and found to have engaged in “improper conduct” by a Royal Commissioner in relation to a failed bribery attempt. (Carter, 1991)
1989-1992	Field, Michael	White, John	Labor/Green	No tobacco reforms
1992-1996	Groom, Ray	Roger Groom (1992-1996)	Liberal	Established “Quit”.
1996-1998	Rundle, Tony	McKay, Peter (1996-1998)	Liberal – in minority with Green support	First smoking restrictions. Public Health Act 1997. First inroads on tobacco displays and marketing at point-of-sale, raised smoking age, banned “lying” by tobacco industry. Discussion paper on smoke-free areas.
1998-2004	*Bacon, Jim (<i>died lung cancer 2004</i>)	*Jackson, Judy (1998-2002)	Labor	First smoke-free indoor area laws, workplaces, eating areas, and some limited pub bans 2001.
		Llewellyn, David (2002-2006)	Labor	Nightclub and gaming smoking ban 2005, pub smoking ban 2006
2004-2008	#Lennon, Paul			
2008-2011	Bartlett, David	Giddings, Lara (2006-2010)	Labor (Greens included from April 2010)	Ban on smoking in cars with kids, fruit flavoured cigs banned, reduction in size of POS 2007, Trebling of tobacco control funding 2007
2011-2014	Giddings, Lara	O’Byrne, Michelle (2010-2014)	Labor/Green	Elimination of tobacco displays at point-of-sale 2011 and tobaccoconists 2012. Extension of outdoor smoking bans. First

Years	Premier	Health Minister	Parties in government	Tobacco control initiatives
				allocation of sufficient resources to undertake evidence informed education campaigns (2013). Proposal for Tobacco Free Generation referred to the Children’s Commissioner. Ban on smoking in prisons commenced.
2014-present	Hodgman, Will	Ferguson, Michael	Liberal	Ban on smoking in prisons completed.
<i>* Smoker. #Smoker – quit whilst in office.</i>				

Expenditure on tobacco control – impediments and delays

The first significant tobacco taxation reform was in 1973, but in reality the motivation was not about reducing smoking rates. Rather it was purely a revenue-raising measure (NAA 1975b). Tasmania was the first state to attempt to impose such a tobacco business franchise fee, followed later by other states. However, the initial attempt in 1973 was a debacle, as part of a peculiar deal between Labor Premier, Eric Reece, who lost power soon after these events, and the Prime Minister Gough Whitlam, to make Tasmania independent of the Grants Commission. The federal government, in particular Treasurer Bill Hayden, later persuaded Tasmania to abandon this tax, in return for an additional \$15 million, because federal Labour was about to face an election in May 1974, in which Tasmanian marginal seats would be crucial and bad publicity could jeopardise re-election (NAA 1975b). Furthermore, the fee was challenged in the High Court, where it was found to be flawed, though valid, and redrafted with bizarre provisions that required individual purchasers of tobacco to fill out forms and send the money to Treasury. This of course was totally impractical and the initiative was abandoned after much satire and hilarity in the media (*Mercury* 1974a, p. 3 & 1974b, p. 6).

Photo 3 Prime Minister Gough Whitlam and Tasmanian Premier Eric Reece pictured in Whitlam's office 1975



Source: NAA 1975a.

Business franchise fees were re-introduced in Tasmania in the 1980s, but finally declared invalid by the High Court in 1997 (James 1997; Hansard 1996).

Attempts were made to link tobacco taxation revenue to increases in health funding, or health education. The Liberal Health Minister John Cleary wrote to the Treasurer in 1983 recommending that an increase to tobacco taxation be incorporated in the budget. He said:

“While historically Treasury’s views on the hypothecation of revenue are quite clear, if you consider it is appropriate to increase the revenue from business franchise taxation on tobacco wholesalers, I believe it would be important, from a political point of view, to ‘sell’ the decision by an increased allocation to the health area in general or to the [public] health education area in particular” (Cleary 1983, p2).

In May 1985 the Premier and Treasurer Robin Gray wrote that the government recognised that relationship of smoking to disease and that it was,

“... reasonable to expect smokers to make a significant contribution towards meeting these costs” (Gray 1985b).

However, a few days later in another letter he said, seeming to contradict himself, that,

“... there are a number of factors influencing government actions in regard to license fees for tobacco products. The more important of these now include the budgetary position confronting the State and the limited taxation areas available” (Gray 1985a).

The second example of tobacco taxation (business franchise fees), which the Liberal government freely admitted being imposed to fund measures other than health, related to the teachers’ pay case in 1993. Labor member Paul Lennon criticised them:

“... the Government has forgotten that it used the tobacco tax to pay for the teachers' pay rise. How short its memory is. We all remember the teachers’ pay tax – the tobacco tax that came rushing in here the day after the Industrial Commission decision was handed down” (Hansard 1993a).

In 1992-93 the Liberal government had increased the tobacco franchise fee revenue from \$34 million to over \$50 million, but as Labor member Michael Field (Hansard 1993a) pointed out

“... the government has chosen to exploit an addiction in order to increase its revenue without offering anything to reduce that addiction”. Furthermore, the revenue increase occurred at the same time as the teachers’ pay rise. Field (Hansard 1993a) went on to say:

“...the Government announced this revenue measure the day after the teachers received their pay rise. I know many teachers are quite bitter about this because they think they have been scapegoated by the fact that this tax was brought in and the increase in tobacco (sic) is directly related to their pay rise”.

There were many discussions about hypothecation of tobacco business franchise fees and taxes to tobacco-control measures, and moves to establish a Health Promotion Foundation, similar to the successful one which had been established in Victoria (Hansard 1996; Borland, Winstanley & Reading 2009). A Health Promotion Foundation was established for a short time, but never adequately funded. In Tasmania, the powerful head of the Treasury Department was able to intimidate the government, and prevented the revenue being hypothecated to tobacco control, referring to the idea as a “hypothecation disease” (Hansard 1996; Hansard 1998). The business franchise fee in Tasmania was therefore always used for other purposes (Hansard 1993b).

Governments not adequately informed by bureaucrats

Furthermore, government ministers were not always well informed by their bureaucrats. Within the Tasmanian bureaucracy:

“Confused accountability and complex processes and excessive internal ‘consultation’, contributed to policy proposals for action being ‘jammed up’ and never reaching an outcome or an authoritative decision. Cultural barriers included a close relationship between governments and the tobacco industry, lack of ‘belief’ in particular evidence-informed programs, primacy of the [illness] ‘rescue’ culture, and passive and active obstruction from several key government agencies” (Barnsley et al. 2011, p.12).

The health bureaucracy (Taylor 2010) has openly acknowledged that legislation has been used to offset lack of resources allocated to tobacco control, and that the latter has led to

continuing high smoking rates. The following quote has been included in Chapter 4, however, it is repeated here because it is both fundamental and directly relevant to an understanding of the awareness of the reasons for Tasmania's high smoking rates, and the failure to address the key issues,

“Tasmania has always had strong tobacco-control legislation but this is largely to compensate for a lack of resources available for health education and clinical interventions, particularly at the level provided by other Australian jurisdictions. Legislation on its own however is not sufficient to reduce smoking rates and **this is the main reason why Tasmania has the second highest smoking rate in Australia, which has not decreased since 2001**” (Taylor 2010) [emphasis added].

Point-of-sale tobacco display restrictions

The next reform where Tasmania did lead Australia, and the world, was in the restriction of cigarette displays at point-of-sale, (Laugesen et al. 2000) which the tobacco industry had expanded to huge sizes known as “power walls” (Dewhirst 2004) to replace conventional advertising as it disappeared. The tobacco industry acted swiftly to deal with this proposal and whipped up fear in retailers. A vitriolic name-calling public slanging match ensued, culminating in the retailers calling for the dismissal of the Director of Public Health, Dr Mark Jacobs and the Health Minister Peter McKay. McKay enraged the tobacco industry and retailers by calling them “peddlers of death”, and the industry responded (Pos 1997) by calling Dr Jacobs an “overzealous bureaucrat”. The AMA and Cancer Council called Liberal member Bob Cheek an “apologist for the tobacco industry” (Hansard 1999c). Taunting of tobacco-control reformers is not new, nor unique to Tasmania, and the terms “fascists” and “nazis” were epithets used to mock health campaigners in the Parliament and elsewhere (Hansard 1994). Cheek was later to become leader of the Liberals in 2001–2002. Cheek's Chief of Staff, Andrew Gregson, was in 2014 appointed head of corporate affairs at Imperial Tobacco. Nevertheless, the initial display restriction measures in 1997 were enacted by a cadre of committed independent-minded strong politicians and bureaucrats, particularly Peter McKay and Mark Jacobs, and in subsequent years progressively tightened, including removing loopholes after they were subjected to legal challenge by the tobacco industry.

McKay was plagued by opposition to his reforms from his own Liberal backbench, in particular the staunchly pro-business Tony Benneworth, Bob Cheek and Michael Hodgman. The latter, known to Canberra journalists as the “mouth from the south” – a smoker, former federal member and a Minister (but not in cabinet) in the Fraser government (Maccallum 2013), died of smoking-related emphysema. Despite his strong legislative reforms, McKay did not allocate sufficient funding to tobacco control, and in 1997 in response to the Australian Medical Association call for more money to be spent on anti-smoking education “Health Minister Peter McKay brushed the call for increased smoking education funding aside, saying the Government needed money to run hospitals” (Rogers 1997a, p. 6). This was a classic case of prioritising treatment over prevention, which has continued to have a devastating effect on health services and expenditures (Tobacco Coalition 2013).

During the debate on legislation to reduce tobacco displays, Liberal Brett Whiteley said in Parliament:

“Our problem here is that the Government has caved in to the retail lobby. The minister herself admitted that the profits of retailers trumped health outcomes in terms of the total ban on retail cigarette displays when she answered my question in Parliament on 30 October 2007. We intend to rectify that situation in our amendments” (Hansard 2007a).

The tobacco industry was, throughout all those changes, very concerned about reductions in tobacco displays, and took legal action against the Department’s guidelines in 1998. This necessitated amendments to the *Public Health Act 1997*. At the same time the government decided to strengthen the laws, and introduce a tougher regime in relation to tobacco displays. In 2000 the government (Labor) leader in the Legislative Council Michael Aird said:

“... cigarettes should be separated from confectionery on display because ... children are obviously attracted to the confectionery. I am advised that one supermarket removed confectionery from their tobacco counters in stores in both northern and southern Tasmania and replaced it with Disney videos - that is, children’s videos....We must make sure that children are not the subjects of marketing and promotion of cigarettes” (Hansard 2000).

He went on to describe how the tobacco industry used tobacco product packaging as a way of encouraging young women to smoke.

“... one document about packaging produced by the research firm, Colmar Brunton for Philip Morris has evidence of personality profiling of young Australian women who smoke Alpine. The 'typical Alpine gal' is described in patronising terms as being physically timid, no daredevil and she has a great capacity for clichés. This document provides detailed advice on how to package Alpine to sell more cigarettes” (Hansard 2000).

It took many years after this to finally eliminate the display of tobacco products at point-of-sale. Greens Leader Peg Putt questioned Health Minister Lara Giddings in Parliament in October 2007:

“Why have you squibbed the vital measure of banning display of tobacco products for sale in your upcoming smoking amendment legislation, despite the fact that your Government's discussion paper on smoking law changes strongly supported this ban? Are you aware of the strong condemnation of this failure by antismoking advocates and doctors? Is there any truth in claims that you were rolled in Cabinet on this important measure, and what was considered a higher priority than banning display? Was it profits from tobacco sales?” (Hansard 2007a).

Ms Giddings responded later in this exchange with Nick McKim:

“Ms GIDDINGS - Mr Speaker, I am very supportive of the fact that legislation I bring to the Parliament will be decreasing the size of displays from four metres to one metre.

“Mr McKim - Why not just get rid of them entirely?

“Ms GIDDINGS - It is a positive step forward in terms of reducing the amount of space. As I have said publicly on a number of occasions now, there have been some concerns from small businesses, and I expect members from all parties would have been lobbied by various elements

of the small business community about their concerns about this proposed legislation.

“Mr McKim - Ah, so it's the money” (Hansard 2007a).

Peg Putt highlighted the hypocrisy when she suggested the government had caved in to the retailers,

“Our problem here is that the Government has caved in to the retail lobby. The minister herself admitted that the profits of retailers trumped health outcomes in terms of the total ban on retail cigarette displays when she answered my question in Parliament on 30 October 2007 ” (Hansard 2007b).

On retailers’ and their lobbyists’ hypocrisy Ms Putt made the comment earlier in 2006 that,

“They come in and say, 'We want people to stop smoking, we do not want to support the habit, we believe that it is an obnoxious habit and it pains us to be selling these products to people'. They appear to be genuine when they say it. They then turn around and say, 'However, we do not want any restrictions on display that might reduce the amount of profit that we can make by people being unaware of the range of cigarette products that we have for them that they can buy'.

“In response, I put to them: if you actually believe that it is important to reduce smoking rates in Tasmania, then you must accept that that will inevitably lead to a drop in sales and a drop in profits from cigarette sales; there is no other logical outcome. To come to members of parliament and say, 'We want to maintain the profits but we claim to be concerned about the impact of smoking' is an extraordinary thing to do. That is about the point at which our meeting got somewhat explosive” (Hansard 2006).

The final eradication of tobacco displays was wrought through the Legislative Council, which amended the government’s legislation to eliminate tobacco displays entirely. The initiative did not come from Cabinet, which did not heed Health Department advice.

Licensing of retailers

Licensing of retailers in 1999 was a significant reform, another early initiative that has still not been enacted in several other states, which enables governments to keep track of retailer locations, to ensure that retailers are kept informed of changes to legislation, and to monitor compliance with sales to minors and display restrictions. An important mechanism is that the regime is self-funding, as fees obtained from retailers are allocated to enforcement administration (Hansard 1999a), which has helped to ensure the high rate of compliance of 99 per cent (Tobacco Coalition 2013).

Boundaries between key policy makers, and political dynasties

One of the factors Kingdon identified as being important, that is, a lack of boundaries between the politicians, public servants and advocates, is very strongly evident in Tasmania, and may be a factor in success in legislative reforms (Kingdon 1995; Mannheimer, Lehto & Ostin 2007).

In Tasmania boundaries between key people influencing policy are equally slight, because of the small population, a small number of “elite families”, and inevitable interactions between them. Newman records many political dynasties in Tasmania, and lists nine pages of details in his book on Tasmanian political representation (Newman 1994). There are many examples of fathers, sons, daughters and brothers either being elected to successive or neighbouring seats of Parliament. Liquor Union (LHMU) Secretary Darren Matthewson shared a house with an adviser to the Health Minister. His successor as LHMU Secretary was David O’Byrne, who became a convenor of Advocacy Group SmokeFree Tasmania. David O’Byrne was elected to Parliament in March 2010 as a Labor member, and appointed to Cabinet. His sister Michelle O’Byrne was elected as a Labor MP in 2006 and in 2011 was appointed Health Minister. Both Jim Bacon and Michael Hodgman have had sons elected to Parliament, and Michael’s father and brother were also MPs. Scott Bacon became a minister and Will Hodgman became Premier in 2014. So, it is not uncommon in Tasmania for MPs’ sons and daughters to be elected to Parliament and many family names can be seen to be repeated in succession in electorates (Tasmanian Parliamentary Library 2015b). These characteristics of a close-knit community are an ideal crucible for change and opening windows of opportunity, however, they are also an ideal way of closing doors if the prevailing views of a powerful political family are opposed to change.

In Parliament in 2004 Michael Hodgman voted not to support a ban on smoking in pubs. Michael Hodgman's son Will Hodgman, also an MP and current Premier and leader of the Liberal Party, also voted against this bill (Hansard 2004b). Michael's father William Hodgman senior, a leading member of the Legislative Council from 1966 to 1974, took a similar stance in 1975, rejecting health warnings on cigarette advertisements (Legacy Library 1975). The Hodgman family has never supported tobacco-control reforms in Parliament. In contrast, Jim Bacon's son Scott Bacon, whose father died from lung cancer, has been an MP from 2010 and has supported anti-smoking measures, such as the bill to ban political parties receiving donations from the tobacco industry.

Smoke-free areas debates, debacles, and hypocrisy

An interesting insight into public policy-making and who is responsible for putting forward policy – governments or bureaucracy – is highlighted in the debate on smoke-free areas that began in the late 1990s. There are suggestions that the bureaucrats in health were cowed by the actions of ALP leader Paul Lennon and his agreement with the AHA, a Memorandum of Understanding not to proceed with smoke-free areas legislation, and too frightened to put forward proposals for smoke-free areas. An exchange was recorded in 1999 between Greens leader Peg Putt and Health Minister Judy Jackson, in which the minister tried to avoid the question of the Labor deal with the AHA. The leader of the Greens tried to elicit a response from the Health Minister as to whether the Minister or Department of Health were constrained from putting forward proposals for smoke-free legislation, because of the attitude of Paul Lennon and his deal with the AHA, and whether she had asked for advice from the Department.

“Ms PUTT - With respect to passive smoking, is it correct that it is the policy of this Government not to enact any further legislation to restrain passive smoking – that is, not to enact legislation to restrict smoking in restaurants or hotels?

“Mrs JACKSON - I cannot look into the future. There is nothing at the moment for the Government to do that, but whether or not there is in the term of this Government -

“Ms PUTT- Do you receive advice from your department about things like the impact of passive smoking and possible legislative action or other action that could be taken?

“Mrs JACKSON - I have not, no.

“Ms PUTT - Would that normally be a function that the department would look for with respect to that?

“Mrs JACKSON - Well, I am sure if I asked them they would. I admit I have not asked for that information - so no, I have not received any.

“Ms PUTT - You would have to trigger it by asking?

“Mrs JACKSON - Not always, no. I have not either asked for it or it has not been offered to me.

“Ms PUTT - It has not been offered to you. There is no comparison between what we have here and what the other States have in terms of that sort of legislation.

“Mrs JACKSON - I have some idea myself but not the department, no.

“Ms PUTT - What I am wondering is whether you are actually constrained in coming forward with initiatives by a deal that has been done by another government minister with the hotels.

“Mrs JACKSON - You would have to address that. I can only tell you what has happened in my area and what I have done. I have not asked and I have not received, and I do not think the department feels constrained by any other minister” (Hansard 1999b).

By March 2001 the Labor Government introduced a Bill to ban smoking in workplaces and public places, but which provided some exemptions for hotels and bars. The Bill was passed and came into effect in September 2001.

In February 2002, the Department of Health and Human Services Smoke-free Areas Review (DHHS 2002) recommended:

- All bar and gaming areas plus York Park and Bellerive Oval be made smoke-free;

- half of the state's outdoor dining areas should become smoke-free;
- more funding should be allocated to enforce anti-tobacco laws; and
- smoke-free areas be reviewed again in two years (Hansard 2003).

In November 2003 a letter to the editor of the Hobart *Mercury* from the Greens spokesman said:

“Your editorial (October 30) is quite correct. The Government's latest go at making venues smoke-free is policy-making at its worst. The Greens suspected as much and introduced a Bill into Parliament on Tuesday to fully implement the recommendations of the smoke-free areas review which would provide for an effective and immediate ban.” The Greens pledged “We will continue to campaign alongside Quit Tasmania, the Cancer Council and the hospitality union until we create smoke-free venues and workplaces” (Morris 2003).

Accusations were made by the Greens and others that the perceived need for revenue from poker machines was preventing the government from acting to eliminate smoking from gaming revenues, because revenue fell in Victoria following action:

“A similar ban on smoking in Victoria's pokies venues cut \$190 million from that state's gambling take”(Rose 2003). Mr Morris said: “We know these recommendations are currently sitting before Cabinet, and we urge a swift decision to implement them fully -- or an explanation for the continual delay. Is the Government putting its own addiction to pokies revenue above the welfare of hospitality workers and patrons?” (Rose 2003)

By late 2003 there was still no legislation and the Greens criticised the government for not acting to ban smoking in gaming areas. Greens MHA Tim Morris said in September 2003 that the reforms had been recommended in February six months previously and accused “... Health Minister David Llewellyn of stalling because such bans would affect the State Government's \$70 million annual revenue from gaming” (Rose 2003, p23; Hansard 2004b). In June 2004 the Greens introduced their own Bill to try to get the government to move forward on the issue. MHA Tim Morris taunted Minister Llewellyn for failing to proceed, with the complexity and compromises in the government Bill, and for winning the

ACOSH/AHA Dirty Ashtray award, which is given to the State Minister for the worst performing government in Australia.

“Your bill languishes on the Notice Paper as if you are ashamed to bring it on - and you should be ashamed. It is a pathetic piece of legislation that does next to nothing to protect Tasmanians from the poisonous effects of tobacco smoke. Your bill is ridiculous. Take the one-metre rule for example - what do you think that is going to do? What a farce - why bother? Since the 2001 bill, you have done nothing. In your time as Minister for Health and Human Services you have done nothing, not a thing. ... You have had reports done by your own department that show you should be bringing in total bans and what have you done? Nothing, except putting a half baked idea on the Notice Paper which you were too embarrassed to debate. Next, you recently won the Dirty Ashtray award. Well done!” (Hansard 2004b).

Both the Liberals and Greens introduced Private Members’ Bills in 2004 to expand these areas to bars, but the government Bill was finally passed in 2004 and came into effect with a ban on smoking in gaming areas in January 2005 and bars in January 2006.

As Bryan-Jones (2004) found, there may have been a perception of a salient constituency advocating for this reform. Smoke-free public places engage community anger, discussion, media and advocacy because individuals can see and feel the smoke, and are affected by it. Funding for public education campaigns, although effective, is more abstract, does not affect individual constituents and voters, and is not a front-of-mind issue at elections, and so the ability of health groups to engage public imagination and political action for such funding is limited, despite the fact that the tobacco industry does not specifically oppose it.

Smoking in cars with children present

There were few obstacles experienced by government in banning smoking in cars with children present in Tasmania. Thomson looked at policy makers’ views about such laws in 2008-2009 and found,

“We found very strong themes of policy maker concern for the vulnerability of children and the need for their protection from

secondhand smoke. There were mixed reactions to the idea of a smokefree law for cars with children in them. These themes and mixed reactions spanned both the ‘left’ and ‘right’ political parties” (Thomson et al. 2010, p. 970).

In Tasmania local lobby groups including the AMA, SmokeFree Tasmania and the Asthma Foundation lobbied the government to support such a ban. The proposal was made in a Department of Health and Human Services Discussion paper in 2006, followed by legislation and implementation in 2007 (Taylor 2006; Freeman, Chapman & Storey 2008). The proposal was supported by the Police Department, which had carriage of enforcement, and was strongly supported by the public (Brown 2009). There is no recorded opposition from the tobacco industry in Tasmania to this particular reform. It may be that it did not directly affect revenue or sales, and any opposition would have been represented as the tobacco industry supporting damage to children’s health, so they kept quiet about it. The tobacco industry was very vocal about other bans on smoking in public and domestic spaces and at times argued that environmental tobacco smoke (ETS) was not a danger to health, but in this particular case they were remarkably silent (Freeman, Chapman & Storey 2008). There seems to have been no opposition from any politician in Tasmania to this proposal, and the key influencing feature appears to have been the lack of lobbying from any sector of industry.

Mass-media campaigns, and the evidence transferred to members of Parliament, or not

Members of parliament from all political parties and independents know that mass-media campaigns were effective in reducing smoking rates. During the debate on the Public Health Bill 1997 Liberal MHA Bob Cheek said:

“I probably will not be too popular for saying these things and I know the budgetary restraints ... but the fact is other States do have 6 per cent of their total tobacco taxes and we have about 0.5 and ... we get \$91million in taxes and more should be spent on anti-smoking campaigns and education programs ...” (Hansard 1997b).

Labor MHA Fran Bladel added,

“... Now in this State we are really kidding ourselves if we hope to make a big dent in anti-smoking campaigns unless we are prepared to steer that money into areas where it will be most useful” (Hansard 1997b).

Members of the Legislative Council were aware that well-funded mass-media campaigns were essential for reducing smoking rates. These Legislative Council briefings were given by the government, so there was clearly an awareness of the evidence relating to social marketing and mass-media education. During the debate on the Bill regarding reduction of tobacco displays and other measures in 2000, the Liberal Leader in the Legislative Council, Tony Fletcher asked:

“Will the Government, when it brings down the Budget in just a month or so's time, have the funds available to adequately address the campaigns that need to be followed in regard to addressing the issue, not only of (a) tobacco product being available and used by people under an age, but also by people of society generally using tobacco products to their detriment?

“We were told in a briefing session recently that the best outcomes are achieved by high-profile State-funded, State-based publicity campaigns that encourage people to turn away from the use of tobacco products. We have seen none of that for quite a number of years now; the reason why we have seen none of that is because the funds have not been available to do it” (Hansard 2000).

Liberal MHA Dr Frank Madill, a medical practitioner, questioned the Health Minister about smoking rates and funding tobacco control during Estimates Committee hearings in 1999

“... I see that the overall amount has been decreased and there has been a shift of funds from it to administered payments. What I want to know is ... what is the Government doing about this issue? Is there money in this budget specifically for a campaign to try to stop people from smoking?” (Hansard 1999b).

Greens consistently reformist

The only political party with an impeccable and consistent track record on tobacco-control reforms and implementation is the Greens, as both the Labor and Liberal Parties varied widely in their approach over the decades of the 1990s and 2000s. Variations of commitment to tobacco control within the major parties seem to have been related to personalities, and interests of the particular individual Health Minister, as well as their ability to convince Cabinet colleagues to take up measures of reform, or to allocate funding. Many passionate speeches have been made in Parliament, with a great deal of detail about the evidence and health effects of tobacco, by the Greens MPs Peg Putt, Gerry Bates, Mike Foley, Di Hollister, Paul O'Halloran, Tim Morris and Cassie O'Connor. Tasmania's Hare Clark voting system for the House of Assembly, with multi-member electorates, is very fair and democratic, and leads to minority governments regularly being elected, as smaller parties often have members elected (Tasmanian Parliamentary Library 2015a). At various times since the late 1980s the Greens supported Liberal or Labor minority governments, which has positively affected the pace of anti-tobacco legislation, but very importantly not resource allocation, again because this power lies with the very highest layer of politician/bureaucrat (See Table 11).

Private Members' Bills and other legislation

There have been sporadic, and unsuccessful Private Members' Bills introduced over many years. One that worried the tobacco industry was tabled as early as 1983 by Mac Le Fevre, an Independent Member of the Legislative Council, who introduced legislation to regulate tobacco advertising. Tobacco Company Philip Morris (PM) monitored this Bill carefully, and their representatives regularly reported to management in the USA on its progress (Legacy, Batten 1984; Legacy, Simper 1983; Legacy, Sporton 1984).

A handful of Private Members' Bills were introduced in the 1980s to 2000s by Greens, Liberals or Independents, but all were defeated or lapsed on the prorogation of Parliament. Dr Gerry Bates, Greens, introduced Bills in 1990, 1991 and 1992 to regulate the sale, supply, purchase and promotion and advertising of tobacco products and to establish a Health Promotion Foundation, similar to that which had been achieved in Victoria. Tim Morris, Greens, in 2004 introduced a Bill to expand the definition of smoke-free areas, and similarly Sue Napier MHA, Liberal, in 2004 and 2005. Labor when in government attempted in 2012

to ban donations from the tobacco industry to political parties, but this was defeated in the Legislative Council.

Legislative Council

Whilst the Legislative Council is generally a conservative upper house, on two occasions it has shown that it has been prepared to initiate more radical reforms than the government of the day is prepared to consider in relation to tobacco control. In 2007, the Legislative Council strengthened a government Bill, which was designed to reduce tobacco product displays; and in 2012 it passed a motion in support of the Tobacco Free Generation (TFG). The TFG is a proposal to phase out the sale of tobacco products to any person born after the year 2000 (Berrick 2013; Walters 2015). There were some passionate debates over the years on tobacco-control legislation, for example in 1997 Councillor Peter Schulze made a very strong speech mourning his daughter Suzie who died of lung cancer in her thirties, and criticising the tobacco industry (Hansard 1997c; Hansard 2000).

“I was phoned up by the tobacco lobby that has worked so hard and effectively for so many years across this nation and across the world, to talk to them. I quickly told them my position and that it was not likely to change, particularly, but if they still wanted to come and see me in my office, I was prepared to talk to them and have them there and listen to them. I would have shown them photos of my daughter who died of lung cancer last year and she was a smoker” (Hansard 1997c).

In 2007 the Public Health Amendment Bill was introduced into the Legislative Council. It included clauses to ban smoking in cars when children are present, and to ban fruit-flavoured cigarettes as well as to reduce the size of tobacco displays. Legislative Councillor Jim Wilkinson pointed out that the Minister for Health Lara Giddings had supported a complete ban on tobacco displays, by seconding a motion, which was carried, at the 2006 Labor Party State Conference. Clearly the Minister had not been able to get this through Cabinet as it was not in the Bill. Jim Wilkinson and Ruth Forrest successfully moved an amendment to phase out all tobacco displays by 2011, with the exception of those in specialist tobacconists. The government supported the amendment as it would have been embarrassing to defend an untenable position, given that the Minister herself had publicly supported a complete ban on displays (Hansard 2007c).

In 2012, Legislative Councillor Ivan Dean successfully moved a motion to support the Tobacco Free Generation. This was carried unanimously by the Council, and resulted in considerable publicity for Tasmania (Daynard 2013; Schriever & Pedder 2012; Corderoy & Darby 2012; Thomas 2012). The Government referred the matter to the Children's Commissioner for consideration, but the report was not released prior to the 2014 election, and no permanent Children's Commissioner was re-appointed. An amendment bill for a Tobacco Free Generation, introduced by Ivan Dean MLC is before the Tasmanian Legislative Council (Walters & Barnsley 2015). This proposal is in the realm of the Weberian analysis of "charismatic ideas" as outlined by Smith (2013). Hooker and Chapman have also noted the importance of politically independent members of Parliament in moving the tobacco-control agenda forward in Australia (Hooker & Chapman 2006).

Tobacco taxes had a dramatic effect in Tasmania on expenditure on tobacco products, and when the states lost the power to control this source of revenue tobacco sales increased (See Chart 6, Chapter 4). Expenditure on tobacco generally declined under Labor Governments and rose under Liberal governments, with the exception of the dramatic decline in the early 1990s when tobacco business franchise fees were doubled by a Liberal government.

Discussion

As Studlar and others have established, "lesson-drawing" or copying across jurisdictions in tobacco control is common, particularly in English-speaking jurisdictions (Studlar 2002; Farquharson 2003; James and Lodge 2003; Duina and Kurzer 2004; Shipan & Volden 2004; Studlar 2007). Tasmania has led Australia, and in some cases the world, in some areas of tobacco-control legislation, such as the removal of tobacco displays at point-of-sale (Laugesen et al. 2000). There were few other international precedents for this legislative action, so it was a brave step for a small state to take. In the 1970s, a progressive Tasmanian Liberal government lost office due to political interference by the tobacco industry as outlined in Chapter 5 (Barnsley 2011). However, the paradox is that those steps have been taken in order largely to avoid the expense of public education campaigns in spite of the knowledge that there are effective in decreasing smoking rates.

Tasmania was in lock-step with other Australian states in eliminating smoking in public places but not in public education campaigns. There were impediments to such reforms in all states as the tobacco and hospitality industries campaigned against such reforms, engaged in

subversive undermining of bureaucratic organisations and intimidated politicians. Tasmanian Senior Medical Officer in the Department of Health, Dr Martin Bicevskis was particularly singled out for criticism by the tobacco industry for his “intemperate” comments (Legacy Library 1999a). Dr Bicevskis wrote to Standards Australia in February 1999 commenting on a draft ventilation and air-conditioning standard. The tobacco industries had infiltrated this committee and were attempting to alter the Australian standard so that air conditioning could be seen as an effective way of controlling indoor tobacco smoke, as they had done in the USA (Legacy Library 1999b; Bialous & Glantz 2002; Harper & Martin 2002). The tobacco industry also issued a legal challenge against the tobacco guidelines under the *Public Health Act 1997*, forcing the government to amend the legislation.

All the efforts of the tobacco industry and the impediments it engineered, as outlined above, conspired to reduce evidence transfer to the political domain. Bureaucrats are responsible for providing evidence-based information to ministers and the Parliament and this too effectively failed in Tasmania. The failure to provide evidence was due to structural and process problems within the public sector; a set of cultural beliefs that did not accord with the evidence; unclear accountability; and indifference to tobacco control from the senior decision-makers (Barnsley, Walters & Wood-Baker 2015).

Despite these impediments it is clear that many individual politicians from all parties and independents were aware of the evidence around effective tobacco control, yet these people were not the major influencers able to implement policy change, nor did they have sufficient power or seniority in the system to convince governments to act on the evidence. Premiers and senior bureaucrats and to a lesser extent health ministers were the key players, though with some exceptions. Awareness and recognition of tobacco smoking as a problem by these most powerful politicians was never a top priority. Many politicians from all political parties and several independents were conscious of the issue, were well informed and often passionate about achieving reforms. However, a succession of state premiers, powerful cabinet officials and the key advisers in the public service such as the head of the Treasury Department were not convinced, and either opposed the allocation of resources, or directed it be spent elsewhere. Overall, they confounded the best efforts of the better informed and more motivated, less powerful, political figures.

Thus, the key factors for agenda-setting outlined by Kingdon, that is, recognition of the problem, agreement on a way forward and a lack of boundaries between the politicians,

advocates and public servants, were thwarted by various barriers. The environment for knowledge transfer was contaminated by the tobacco industry. From as long ago as the 1960s and continuing into the first years of the 21st Century the tobacco industry has interfered in Tasmanian politics, lobbied politicians, engaged in unethical behaviour, undertaken legal action against the principle statute law, and made large political donations to the major parties at times when an election was about to be held or a tobacco control reform was in the pipeline. The tobacco industry has also strategically used front organisations to pursue its agenda, and to pressure politicians, particularly in more recent years when the community and most politicians had gained an awareness of the toxic nature of the tobacco industry and its lobbyists. The last identifiable recorded direct tobacco industry donation to the Liberals was in 2013, just prior to their election as the current government.

A number of senior Tasmanian politicians have had brazen and unapologetically close ties with the tobacco industry and its front organisations. Importantly, many of these were smokers and all were white males. The close relationships between many of this cadre of politicians with the hotel industry, including gaming venues, as well as retailers, significantly delayed legislative reforms. However, this was counterbalanced by other reforming politicians who questioned these alliances, and were concerned about tobacco smoking. Eventually these reformers were, with the support of public opinion and active health organisations, able to introduce legislative measures to control tobacco against the tide of industry pressure, but they were not powerful enough to influence the funding for social marketing that was also needed, as this was controlled by the very top of the political pyramid.

Taxation, or later titled “business franchise fees”, on tobacco sales commenced briefly in Tasmania in the 1970s, was abandoned, but resumed in the 1980s, and was finally overthrown by the High Court in the late 1990s. The revenue obtained from such excises was never directed to tobacco control, despite pleas from many backbench politicians. A powerful Treasury Department prevented every government of any political persuasion from undertaking such hypothecation of revenue to tobacco control.

Thus, the continuing failure in the 2000s to allocate sufficient resources to evidence-based mass-media campaigns and cessation of quitting support services were the major impediment to reducing smoking rates in Tasmania. There was always another priority identified on which to spend money, such as the 1993 teachers’ pay rise, or public hospitals in 1999.

Tobacco smoking never rose to the top of the government's agenda. The bureaucracy did not inform the key ministers sufficiently of the importance and effectiveness of mass-media campaigns, although there was an awareness amongst many other politicians that this was indeed a crucial factor, and they said so on many occasions. Amongst politicians the "cognitive dissonance" characteristic of smokers and the "conservative white male" effect of impaired risk perception, continually operated as an obstacle to reform and resource allocation.

A unique conjunction of female leaders at both a state and federal political level provided a vital short "window of opportunity" for reform and allocation of sufficient funding in 2013. Some studies have also indicated that female policy-makers are "more likely to use research evidence" (Oliver 2014; Brownson 2011). It is worth considering that female political leaders are generally less likely to be engaged in "cronyism" and corruption in liberal democracies, therefore less likely to be captured by industry, and are also more risk averse, especially in public health domains (Esarey & Schwindt-Bayer 2015).

A female political leader in Tasmania could not go out alone to dinners with captains of industry without exciting salacious comment, unlike male leaders such as Paul Lennon, who famously dined publicly with a forestry industry leader to stitch up a deal to build an enormous pulp mill (Beresford 2015). Former Premier Lara Giddings would have found it unwise to be seen unaccompanied by minders in a public place arranging such a deal, because she was a young female. Nor could she go unaccompanied to the pub, the horse races, gaming venues, play golf, go fishing or go to exclusive all-male clubs, where the fabric of crony capitalism is formed and flourishes. The exclusion of female leaders from the bastions of crony capitalism, coupled with female politicians' greater awareness of public health "risk" compared to males, and their greater propensity to use research evidence would contribute to an explanation of why reforms suddenly occurred when a critical mass of female leaders were in power.

Tasmania's push to ban advertising and displays of tobacco products at point-of-sale, was met with fierce resistance from the retailers' lobby and the tobacco industry. The reforming health minister and public servants in the late 1990s and early 2000s were subjected by opponents to abuse, name calling, insults and calls for their resignation. Licensing of tobacco sellers has been a key administrative tool since 1999 for managing enforcement of sales to minors and display restrictions, and in comparison to other reforms was able to be regulated

without significant tobacco industry obstruction. Similarly, banning smoking in cars with children also encountered no industry resistance, presumably because they saw this of little threat to sales, and essentially a lost cause.

Ideological differences between the major political parties proved less important in tobacco control than the personalities, power structures and underlying characteristic cronyism of politics in Tasmania. Some Liberals were highly civil libertarian and sympathetic to individualistic approaches, and prepared to blame smokers for their own fate, while many male Labor politicians were close to industry leaders and small business, and unprepared to upset these powerful interest groups. Both political parties were led at various times over the decades by premiers with very close ties to industry.

Conclusion

Most factors slowing legislative reforms in tobacco control in Tasmania have stemmed from the influence of the tobacco industry, and the willingness of senior politicians to engage with big tobacco and its associated front organisations. Crony capitalism has been embedded in Tasmanian political culture, including alcohol, gaming and forestry as described by writers Beresford (2010, 2015) and Flanagan (2004, 2007) and has acted as a barrier to challenges to powerful industry groups. The main antidotes appear to have been rare female leaders, and some male leaders such as McKay who are somewhat outsiders in the cronyism culture, and therefore more able to initiate reform unencumbered by strong personal and social ties to industry.

The major world-leading legislative reforms in Tasmania in tobacco control in a number of areas that were pushed through against the odds by a small number of insightful, determined and socially progressive decision-makers, were offset by successive governments' failures to allocate resources to evidence-based public educational initiatives, causing a lag effect in reducing smoking rates in this state, from which it is still suffering both socially and economically. This reflected the ability of the hyper-elite to control the money, and those were par excellence the "cronyists".

The unwillingness of Tasmanian politicians to allocate resources to evidence-based tobacco-control measures such as mass-media campaigns and cessation support programs was essentially a product of the cognitive dissonance of key leaders who were smokers,

compounded by: a failure of the bureaucracy to adequately inform them of what actions would be effective in reducing smoking rates; a refusal by Treasury to consider hypothecation of tobacco taxes, coupled with a failure of successive governments to challenge the tight financial hegemony of Treasury; and a lack of a real sense of the real impact and the level of risk that tobacco smoking has posed to Tasmanian society due to their unique socio-cultural position as conservative white males with strong ties to industry. The result of all this has been enormous health costs, public hospitals that cannot cope with the current burden of illness, smoking-related in large part, and a financially hampered government.

Tasmania has outstanding research capacities at the University of Tasmania including the Menzies Research Institute, School of Medicine, Health Sciences and School of Social Sciences. There are many non-government organisations interested in tobacco control. Medical fraternities and colleges have a wide range of competencies and insights. An enhanced and more formal association between government, the academic research sector, medical practitioners and non-government organisations could improve knowledge translation and evidence-informed public policy making by focussing attention on “wicked problems” such as tobacco control. Canadians have made efforts to “...build bridges between research and public policy making processes” (Lavis, 2006 p.42) and lessons could be learned from adaptation in Tasmania of such ideas and processes.

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Chapter 7 Bureaucratic Barriers to Evidence-based Tobacco-control policy

Most of this chapter is incorporated in an article published in the *Universal Journal of Public Health* (Barnsley, Walters & Wood-Baker 2015)

Introduction

This Chapter examines and analyses bureaucratic barriers to implementing strategies for tobacco control in Tasmania. Documents provided by government agencies under Right to Information legislation, documents provided by non-government organisations (NGOs), newspaper reports and websites relevant for the period 1997 to 2010, were forensically examined.

Relevant Tasmanian bureaucratic organisations have had a culture of avoiding responsibility for high smoking rates, their processes being excessively complex, under-resourced in expertise and, very importantly, having poor accountability mechanisms, failing to adhere to international standards in dealings with the tobacco industry, failing to follow evidence-based public policy despite being aware of its existence and being distracted by immediate needs. They also experienced passive and active obstruction from other government agencies, and did not adequately inform the Parliament about measures that might reduce smoking rates. All in all, the operation and culture of the Tasmanian governmental bureaucracy has been a significant barrier to evidence-based tobacco control public policy. This deficiency was not confined to the Department of Health and Human Services, but importantly also included the Departments of Premier and Cabinet and Treasury. This led to major barriers to evidence-based tobacco control existing within the bureaucratic systems in Tasmania throughout the period 1997 to 2010. They were excessively process-driven with complex structures, a lack of “evidence transfer”, antipathetic in culture, and had scant resources. Similar barriers exist in some other jurisdictions. All this served to undermine the effectiveness of public health expert-driven action.

This chapter examines some of the bureaucratic barriers to evidence-based tobacco control, particularly relating to the use of mass media anti-tobacco campaigns and cessation-support services in Tasmania from 1997 to 2010. Tasmania initiated several international and

Australian “firsts” in tobacco legislation reform through personal commitment of certain politicians, such as the removal of tobacco advertisements at point-of sale (Ballard 2004). However, several evidence-based initiatives, which required funding or resources were shelved, or substantially delayed. There is no detailed comparison with other states in this study. The related roles of politicians and NGOs are examined in other Chapters.

Results and discussion

The search results

There were 2192 hits for the word “tobacco” in 289 Parliamentary Hansard documents; each document had approximately 123 pages, and approximately 35,000 pages were examined. Relevant records were copied and coded into NVivo using Microsoft Word. Older newspaper reports were obtained from microfiche records at the State Library of Tasmania, via a card index system using the keywords ‘tobacco’ and ‘smoking’. More recent newspaper reports were obtained from online Newsbank by searching the keywords ‘tobacco’ and ‘smoking’ through Linc of the State Library of Tasmania. Major bureaucratic barriers to evidence-based tobacco-control policy were identified. The following sections discuss these themes. Table 12 at the end of this chapter summarises the findings.

The policy environment

The leading international writers on tobacco-control policy and governance, Studlar, Cairney and Mamudu recognise the importance of the policy environment. They state that the “... strength of tobacco control may be linked to the power of the health department and the extent to which it takes the lead within government” (Cairney, Studlar & Mamudu 2012). Thus, the role of government agencies is key to implementation of tobacco-control policies, and any restrictions on the power and influence of the health agency can operate as a brake on reform, as it has in Tasmania. Cairney and Mamudu also observed that in almost all countries some

“... economic incentives and litigation - are less likely to be introduced than others” and that “implementation involves much more than generating evidence -based objectives and policy instruments” (Cairney & Mamudu 2014, pp. 508-509).

Thus, it is not enough to have the evidence accessible and available, it also has to be believed, and transferred to those who can implement policy. It is absolutely clear that even in a middle-income jurisdiction (such as Australia) "... the policy environment is as important as the policy instruments designed to eradicate tobacco use" (Cairney, Studlar & Mamudu 2012).

Structural Barriers and Accountability

The first barrier identified in the analysis was the split between policy-making and service-delivery arms in government, i.e. the Public and Environmental Health Service (PEHS) on the one hand and the Alcohol and Drug Service (ADS) on the other. PEHS is responsible for tobacco regulation (and enforcement), whereas ADS is responsible for cessation service delivery, but its focus has been on dealing with illicit drugs and alcohol (DHSS 2006). At the same time statutory responsibility for tobacco-smoking control was and continues to be vested in the role of Director of Public Health, under the *Public Health Act 1997* but without practical executive policy authority in this domain. ADS controlled all drug policy, was the conduit to the health minister, and national ministerial and intergovernmental committees for any drug policy advice, including that on tobacco. However, there was a distinct lack of clarity regarding activities that are statutory requirements and those which are non-statutory.

Processes were sluggish and unwieldy. The Inter Agency Working Group on Drugs (IAWGD) (DHSS 2004) comprised representatives of the Departments of Health and Human Services, Police, Education, Premier and Cabinet, Treasury, Justice, and the Alcohol, Tobacco and Other Drugs Council (ATODC), and provided advice to the national Ministerial Council on Drugs Strategy (MCDS) and the Inter-Governmental Committee on Drugs (IGCD). However, the MCDS and IGCD gave primary attention to illicit drugs, with little attention given to tobacco, and were slow and cumbersome. All Tasmanian representatives were from Police or ADS, not from PEHS, and had no tobacco interest (IAWGD 2008; DHSS 2010). The 2009-2010 IGCD Annual Report to the Ministerial Council on Drug Strategy concerning Tasmania contains about three times as many references to alcohol as tobacco (IGCD 2010).

Nationally, structures act to downplay, filter and sideline research evidence. McDonald, a key drug policy reviewer, said:

“In recent years the IGCD/MCDS advisory structures have been explicitly and intentionally structured to filter the information inputs, one result of which is that the research evidence receives less attention, in policy considerations, than it should' (D McDonald, pers. comm.).

McDonald said of Australian Drug Policy

“This pattern of resource allocation does not adequately reflect an evidence-informed policy orientation in that it largely fails to focus on the drug types that are the sources of the most harm (tobacco and alcohol rather than illicit drugs), and the sectors for which we have the strongest evidence of the cost-effectiveness of the available interventions” (McDonald 2011, p96).

The committee system and the perceptions each had of its role, was a significant factor in the bureaucratic barriers as a result of the complex web of public sector agencies given authority to deal with drugs issues, but with little focus on smoking.

Priorities and Skills in the ADS

Although responsible for clinical delivery of smoking cessation support, the ADS had little expertise in tobacco-control policy. In 2006, the Clinical Director of ADS resigned from the Department citing concerns about management structures and lack of funding, resulting in headlines in the Hobart Mercury newspaper, where he was quoted as saying “... there seemed to be layers of management for management's sake ...” (Mather 2006). The Tobacco Coalition was the principle Committee dealing with tobacco issues (see later) and reported in 2006:

“Alcohol and Drug Services ... would not be able to ‘evaluate effectiveness, efficiency and accessibility of cessation services in clinical, community and regional areas’ (Tobacco Coalition 2006b).

The Department of Health and Human Services commissioned a review of Tasmanian tobacco cessation services by a New Zealand consultancy firm, Global Public Health, which found in 2007 that:

"Smoking cessation is not a priority in the Alcohol and Drug Services" and "The culture of smoking in mental health and alcohol and drug services limits smoking cessation interventions and addressing of smoking by staff" (Global Public Health 2007 pp. 10 & 19)

Documents consistently revealed that the lack of priority given to smoking cessation by the ADS became a barrier to reform and initiation of effective programs; one departmental document records that concerns were raised regarding:

"... the decrease in cessation services provided by Alcohol and Drug Services particularly at the Royal Hobart Hospital" (Tobacco Coalition 2006a).

As a result of the review ADS obtained additional funding in the 2009 Budget and from that time the Department's major emphasis was on the provision of clinical smoking cessation services, but notably not on anti-smoking media campaigns, which are known to be highly effective, and indeed specifically recommended as a priority by the Review (Wakefield & Chaloupka 2000; Sly, Trapido & Ray 2002; Bala, Strzeszynski & Cahill 2008; CDC 2007; Wakefield et al. 2008; Population Health 2010). So, the rather odd Tasmanian neglect of effective media campaigns continued.

Lack of "Evidence Transfer"

The Director of Public Health is required by law to produce a report to Parliament every five years on the state of public health and reports were produced in 2003 and 2008 (Taylor 2003, 2008). Both these reports dealt with the issue of smoking rates in Tasmania, but neither report mentioned the strategic importance of mass-media educational campaigns. In the 2008 report the Director said in his recommendations that:

"A further major priority for new investment must be the establishment of a robust smoking cessation program for Tasmania, in accordance with the recommendations made by the Department of Health and Human

Services following a recent review of smoking cessation interventions in Tasmania” (Taylor 2008, p. 34).

This focus on clinical services ignored the fact that the report also recommended that effective community mass-media campaigns be a priority. Significantly, the 2008 report listed the practical activities undertaken to reduce smoking rates, namely graphic health warnings at point of sale, increased prosecutions for sales to minors, extending smoke-free areas to bars, prohibiting: split packets, the sale of fruit- and confectionery-flavoured cigarettes, smoking in cars with children present and reduction in the size of tobacco displays. But again the report did not list the strategy of mass-media campaigns as a priority, despite this having been a major recommendation of the very review the Director was quoting. He rejected,

“... educational approaches or ‘health messages’ alone” and added that “The challenge now is to improve investment in smoking cessation support” (Taylor 2008, p. 31).

It was not until 2013 that the report promoted the need for mass-media campaigns (Taylor 2013). The Parliament was not advised until 2013, in the major report by the key statutory office holder on Tasmanian Public Health that mass-media campaigns are important in tobacco control, in spite of overwhelming evidence of their effectiveness for decades before that (Taylor 2013, p. 43).

Complex Processes

The complex committee system in Tasmania stifled progress, as three separate committees dealt with tobacco control and acted as a conduit to the minister; the Tobacco Coalition (TC), the Alcohol Tobacco and Other Drugs Steering Committee (ATODS) and the Inter-Agency Working Group on Drugs (IAWGD).

The TC was the lowest ranked and least influential tobacco control committee operating from 2004 within the DHHS. This was a stakeholder group comprised of representatives from the local DHHS, Education Department, representatives of Commonwealth Health and Ageing (DOHA) and NGOs. The TC was intended to “... enhance coordination and communication between government Departments and service providers” (DHSS 2011). This strategy failed mainly because after brief initial involvement the State departments’ representatives hardly

ever attended the meetings! By 2009 the TC was buried under another layer of bureaucracy, with access to the minister only through the ATODS, (a DHHS group including senior officers from Mental Health Services, Alcohol and Drug Service, PHES and a Service Development representative), then through the Inter-Agency Working Group on Drugs (IAWGD) (DHSS 2010).

The IAWGD was established in 2004 as a cross-agency working group to coordinate the service delivery of drug-related initiatives, and to act as the principal advisory group for drugs-related policy in Tasmania. Tobacco control initiatives from the TC were filtered through this group, whose membership comprised the Departments of Health, Police, Premier and Cabinet, Treasury, Infrastructure, Education, Justice, Local government, Alcohol Tobacco and Other Drugs Council and the Commonwealth. The focus was on illicit drugs, and it was clear from Minutes of the meetings that tobacco had little priority. It was not until 2008 that a suggestion was made that the Director of Public Health be invited to the committee. Typically despite being responsible for all tobacco control since 1996, the Director had been excluded for four years from the “principal advisory group” (IAWGD 2008).

The results of the complex internal processes are epitomised by the development of the 2006–2010 *Tasmanian Tobacco Action Plan* (DHHS 2006), which took six years to develop in total. Some of the confusion about the development of the plan can be seen in internal e-mails between the ADS and the PEHS in 2003.

"I already forwarded the documents to [X] on 4 June 2003, but here they are again." And "... whatever group had steered the process ... I don't know which group that was ...", and "We have no idea of who has the final documents" (Owen, D'Silva & McKeown 2003).

The original national plan was approved by the federal and state ministers in 1999, but a Tasmanian Plan did not arrive in the minister's office for approval until 2004, which was after the scheduled completion date of the original national plan. Even after the plan was approved by the minister it had to traverse more committees. A ministerial briefing indicated that the document had to be forwarded through a myriad of bureaucratic groups:

"... for final endorsement via the Inter-Agency Policy Coordination Committee to the Cabinet Social Policy Sub Committee" and "... once

endorsed the Plan will be provided to the inter-governmental committee on Drugs (IGCD) and the Tobacco, Drug prevention and Youth Policy Section of the Commonwealth Department of Health and Ageing” and “... will also be provided to the Healthy Lifestyles Interdepartmental Committee for noting” and “... is aligned with the Tasmania Together Healthy Lifestyle cluster group coordinated by the Population Health sub-division” (Bent, Brkic & Ramsay 2003).

Similarly, the Implementation Plan, Target 16, of the *Tobacco Action Plan 2006-2010* took three years to reach the ATODS and the health minister (in 2009 – a few months prior to the expiry of the main plan) for final approval (Tobacco Coalition 2009). However, these approval processes are mirrored in the national drug strategy policy processes, which have also been criticised for exceptional sluggishness (Siggins Miller 2009). Furthermore, the plethora of such Tasmanian preventative health strategic plans was criticised by the then Auditor-General, Mike Blake when he said:

“It was very difficult to get a sense of what interventions and programs were being undertaken by the department or on what basis. The difficulty was largely due to the considerable number and volume of strategic planning documents, lack of clear linkages between and within documents and evaluation deficiencies” (Blake 2013).

This seems to be an international problem, with the US Food and Drug Administration regulation of tobacco products also receiving similar criticism “... action is sometimes sacrificed to process” (Zeller 2012, p.2)

Cultural Barriers

Cultural barriers within the bureaucracy may be the prime reason for lack of progress in tobacco control in Tasmania. Key lead agencies on the IAWGD, namely the Police and ADS, deal with the “primacy of rescue”, i.e. immediate and visible public alarm, in particular public alcohol abuse and illicit drug use (McGinnis 2001). Their focus is not on long-term prevention (Hine 2010). Police have opposed the Tobacco Coalition having any public advocacy role, because of perceived potential conflict of interest:

“Following concerns raised by (the Police Representative) ... it was agreed that the Coalition would not make comment in the media or be used as a public advocacy group” (Tobacco Coalition 2004).

As McGinnis wrote in his essay on evidence-based policy, strong evidence can still lead to weak preventative action (McGinnis 2001). During 2009, mass media marketing for anti-smoking campaigns “fell off” the agenda. For example, the “Future Service Directions for ATOD”, a five year plan from 2008/09 to 2012/13 mentions as the first initiative potential investment in media campaigns. However, in the subsequent 2009 project management reports to the Alcohol Tobacco and Other Drugs Steering Committee (ATODSC) this item had disappeared. Thus a potential key evidence-based mechanism for reducing smoking rates in Tasmania vanished from the agenda of the only committee that could make recommendations through the IAWGD to the health minister (ATODSC 2010).

The second major cultural barrier has been the passive and active obstruction from agencies external to the DHHS. The fact that DHHS has been nominally the lead agency on tobacco control meant that it became, as described by Isett, “siloe[d]” and consequently “elicit[ed] little aid in implementation from other agencies that may have a stake in the policy outcome” (Isett 2013). Two central agencies, the Department of Premier and Cabinet (DPAC) and Department of Treasury and Finance (DOTAF) played a vital coordinating role in government policy. Within DPAC, the (now defunct) Tasmania Together 2020 program, the Policy Division and the Social Inclusion Unit, would all be expected to be areas with an interest in tobacco control. However, there was no indication that reducing smoking rates was ever a priority for DPAC. The *Ten Year Review of Tasmania Together* blandly notes that smoking reduction targets were unlikely to be achieved (Tasmania Together Process Board 2011). Yet a “will” to implement changes is fundamental for governments to achieve improvements in tobacco control (Mackebach & McKee 2013). Similarly, the department with considerable influence over resource allocation, DOTAF, at no stage publicly evinced any concern about smoking rates in Tasmania (Lypka, Taylor et al. 2004). Mackebach and McKee wrote

“Substantial health gains can be achieved if all countries would follow best practice, but this probably requires the removal of barriers related to both the 'will' and the 'means' to implement health policies” (Mackebach & McKee 2013).

A recent review reported similar problems of cultural resistance in Britain:

“We encountered a deeply engrained culture of resistance to change and found this group was either unable or unwilling to set priorities”
(Davoudi 2012).

Thus, cultural barriers such as a pervasive apathy and disinterest in tobacco control demonstrate that key Tasmanian government agencies acted as barriers.

Finally, within the DHHS itself there was indifference about tobacco control from key sections of the agency (Frohman 2005). Significantly, there was a prevailing belief in the senior decision-making ranks that mass-media campaigns would not work to reduce smoking rates within low socio-economic status (SES) groups in Tasmania. Although completely contrary to international evidence, in March 2004 an influential senior official Peter Hault, was reported to have said that the effectiveness of community education strategies “is overplayed” (Lypka, Taylor et al. 2004). The fact that this particular key official did not support this approach meant that it would have been doomed at any discussion of budget initiatives. Davoudi wrote that power determines what “counts as knowledge”, and power appears to have been overwhelmingly influential in this case (Davoudi 2012). The intrusion of the personal beliefs and values of powerful individuals into the bureaucratic and committee process influenced the extent that evidence was believed (McCaughy & Bruning 2010). Court and Young have written that research is more influential in policy-making if it fits into the values and beliefs of the policy makers, is presented in such a way to be interesting to them, and there are shared networks, trust and good communication, noting that “these conditions are rarely met in practice” (Court & Young 2006, p. 89), which was certainly been true in Tasmania.

Influence of the Tobacco Industry

The Tasmanian government has continued to be influenced by the tobacco lobby, receiving services and money from a tobacco industry “front organisation”, refusing to provide details of meetings with the tobacco industry unless they were specifically requested under legislation, and stating that it was not obliged to observe the provisions of the WHO Framework Convention on Tobacco Control (Pickin 2009; WHO 2005). The WHO condemns governmental association with tobacco industry front organisations (WHO 2014, p13), yet the Acting Director of Public Health, on behalf of the Premier, in May 2009 said

that the government considered Article 5.3 of the Convention; "... to be aimed more at improving transparency in third world countries rather than jurisdictions such as Tasmania where meetings with the tobacco industry are infrequent and [information is] obtainable under Freedom of Information" (Pickin 2009). In 2009, one of the Department of Primary Industries, Parks, Water and Environment's sub-agencies received \$29,000 from the Butt Littering Trust (BLT) and the Secretary of the Department naively explained in a briefing to the Environment Minister that the BLT although "... funding is largely donated by the tobacco industry, it operates as an independent entity" (Gadd 2009). Tasmania has a history of crony capitalism and corruption involving politicians, in relation to dealings with the tobacco industry in Chapter 5 (Barnsley 2011), but these examples indicate an inability of the supporting bureaucracy to understand and advise about international obligations and the need to maintain distance from the tobacco industry in order to effectively implement tobacco-control reforms.

Resource Constraints

Funds within DHHS exist in separate specific "silos" and it has been perceived by staff as difficult to transfer unexpended funds from one area to another, or especially to access funding for new initiatives within the Population Health portfolio, as it has a very small budget compared to that for hospitals. There has been very little discretionary funding available (Blake 2013). In the 2000s there was only one officer in the DHHS responsible for tobacco-control policy and located in the Population Health Division. In 2006, a budget submission was prepared within the DHHS to address the question of pregnancy and smoking, but there was thought to be little likelihood of it being funded, despite known high smoking levels amongst pregnant women in Tasmania and the huge amount of money being spent on the health consequences. While this created concern, but there was no positive funding outcome (Tobacco Coalition 2007). However, four positions were created in ADS in 2009 for nurses who were primarily concerned with clinical cessation services, but again no additional funding for mass-media campaigns occurred until 2010, and not sufficient evidence-based funding until 2013 (Chart 18).

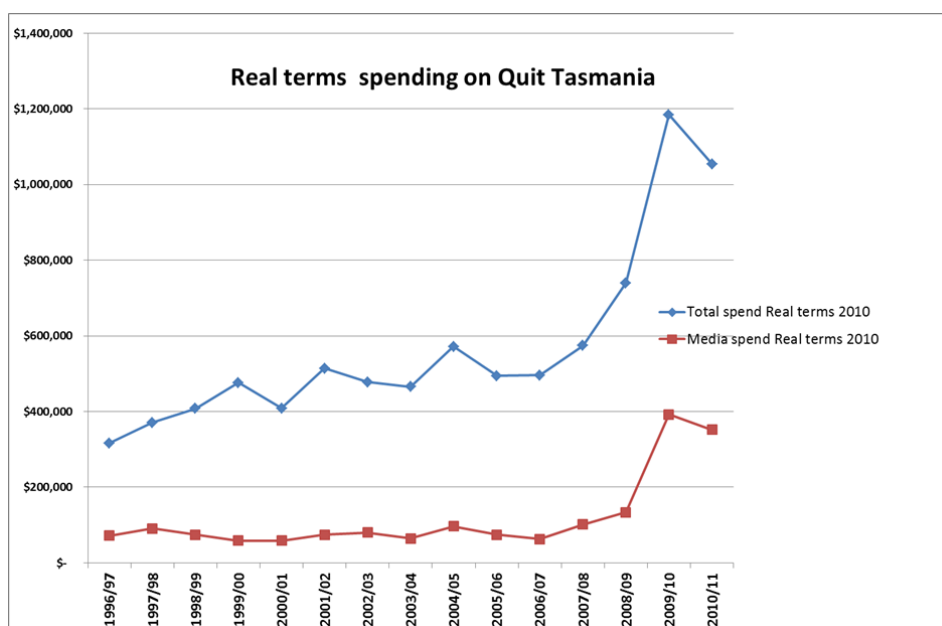
In a briefing to the Director of Population Health from the State Manager of the ADS, it was recommended that a review of Quit Tasmania (QT), the primary non-government smoking cessation organisation, be undertaken, and she said "... currently there are no surplus funds available ... to allocate to Quit Tasmania" (D'Silva & McKeown 2002). The ADS also

expressed concern about whether they were getting value for money from the Tobacco Coalition, and that

“...general concensus (sic) is that we do not address the [tobacco control] problem well, the problems are fairly unique and complex. Certainly there is no coherent plan for managing the problem and nobody could identify a positive impact from the current investment” (Fjeldsoe et al. 2005).

Lack of funding for Quit over time was a definite constraint to deliver adequate programs and was a key barrier to effective tobacco control in Tasmania. The delays in evaluation and monitoring of Quit are linked to the inadequacy of its funding, and also some misdirection of funds, not dishonestly, but compounded by a lack of oversight by the DHHS (PHAIW 2009).

Chart 18 Funding for Quit Tasmania (\$Aus-2010)



Source: Quit Tasmania

Evaluation Delayed

Quit Tasmania (QT), the primary NGO delivery agency for cessation support, mass media and education campaigns, and advocacy, fully funded by DHHS was not evaluated at all during the period from its establishment in 1995 until 2009, although the ADS recommended such in 2002 and 2005. There were continuing misgivings amongst bureaucrats about the

operation of QT in the early 2000s, including concerns about it failing to fulfil its undertakings, some items of financial expenditure, failure to work effectively with the aboriginal community, and failure to undertake surveys (D’Silva & McKeown 2002). When the Review of QT was finally undertaken in 2009, very serious criticisms of the organisation emerged (Tobacco Coalition 2005). Conducted by Professor Mike Daube and the Public Health Advocacy Institute of Western Australia (PHAIWA 2009), the review recommended sweeping changes to the Quit service, including significant restructuring, developing effective partnerships with other key organisations, restructuring of the Board, establishing a health promotion plan and mass media program, ceasing of delivery of extraneous non-evidence-based services, revising the strategic plan and redeveloping the Quit website.

QT had also been reluctant to run effective media campaigns, for rather paradoxical and personal reasons. Meeting Minutes recorded, “... Quit Tasmania have not yet committed to running the [media] campaign [because of] the negative public reaction given that the images are deliberately hard hitting” (Tobacco Coalition 2005). The research evidence supports properly devised social marketing campaigns as being effective for low SES groups, although this group is otherwise difficult to engage (Niederdeppe et al. 2008). The 2009 review of QT makes mention of the fact that the emphasis on clinical cessation-support services by Quit was a detriment to media campaigns (PHAIWA 2009). The Reviewers said “There is a lack of evidence-based best practice across the range of services offered by Quit”. Similar observations had been made in the earlier 2007 independent review of cessation services in Tasmania. Recommendations were made in both reports that additional funding was needed for mass-media campaigns to trigger quit attempts. The effectiveness of media campaigns was acknowledged in internal government documents, but was not “encultured” in the system, and not translated into action or commitment of funds.

The failure of QT to achieve a level of effectiveness was primarily the result of government ineptitude and poor oversight, not the workers within QT (Tobacco Coalition 2005). Indeed members of the government Steering Committee (ATODS) in 2009 considered that the DHHS “...should take some responsibility for the findings of the report” (ATODSC 2009).

Limitations

For this section of the study, government documents were made available to the author through the *Right to Information Act 2009* and its predecessor Act. Some of these documents

contained redacted sections, for example relating to the review of QT. Few ministerial briefings and no internal budget documents were provided. Many documents could not be coded because of their bulk or format but were sorted, read and analysed individually. Treasury refused to provide any documents at all. More requests were made over time to DHHS for more detail, for example as to whether there were any documents relevant to the budget process about tobacco control, but these were not provided.

Conclusions⁴

The process of establishing tobacco control as a major priority in Tasmania, (1997-2010) was subverted by various forces operating within the government bureaucracy. The transfer of knowledge or evidence to senior decision-makers, and parliament, was patchy and in some cases non-existent. Confused accountability, complex processes and excessive internal “consultation”, contributed to policy proposals for action being “jammed up”, and never reaching an outcome or authoritative decision. Cultural barriers included a close relationship between government, including elements of the bureaucracy, the executive and the tobacco industry, lack of “belief” in particular evidence-informed programs, primacy of the “rescue” culture, and passive and active obstruction from several key government agencies.

Reviews conducted by expert external consultants highlighted the need for mass-media campaigns in Tasmania, and made strong recommendations about necessary funding, but these recommendations were not adequately implemented. Additional funding was provided, but allocated only to clinical services rather than more comprehensively including evidence-based mass-media campaigns, as recommended internationally (Bala, Strzeszynski & Cahill 2008; Wakefield & Chaloupka 2000; Farrelly et al. 2005; Biener et al. 2006; Wakefield et al. 2008; Daube 2013; CDC 2007). The Evaluation of Quit Tasmania (PHAIWA 2009) found many problems and commented (although it was outside the terms of reference) that Tasmania should “reduce funding for personalised smoking cessation activity and devote as

⁴ Author’s note: Since 2010 a number of changes have occurred including: increased funding from the federal government for mass-media campaigns; changes in staffing at the Alcohol and Drug Service; restructure of Quit Tasmania and its merger with the Cancer Council Tasmania; acceptance that mass-media campaigns are beneficial in reducing smoking rates; a change of government; and reform of national drug strategy processes.

much of this funding as possible to media programs” (Tobacco Coalition 2005). Again this was ignored.

Structural impediments, inducing cumbersome decision making for evidence-based tobacco control, are not confined to Tasmania, or other states in Australia. Australian structures have been identified as failing to deliver evidence-based tobacco control and “... advisory structures have been explicitly and intentionally structured to filter the information inputs, ... (so) ... research evidence receives less attention, in policy considerations, than it should” (McDonald 2011). The same impediment was found in local-level tobacco control in California. Satterlund et al. found that the “... bureaucracy ... as well as the lengthy decision-making processes, tended to slow down or hinder the policy campaigns of local projects” (Satterlund et al. 2010, p. 618). Zeller identified similar issues within the US FDA (Zeller 2012). But all of these impediments have been especially prominent in Tasmania and a catalogue of errors in public policy-making characterised its tobacco-control activities, including failure to follow or transfer evidence, over-complex decision making structures, and a government-wide indifference to reducing smoking rates. No advice was given to Parliament about effective measures or instituting appropriate priorities. Passive and active obstruction from some government agencies, resource constraints and ongoing relationships with tobacco industry front organisations, all contributed to a failure to implement evidence-based policy.

In the late 1990s and most of the 2000s there was an absence of focus in government on mass-media campaigns as important for tobacco control in Tasmania. Individual bureaucrats worked to achieve sound results in legislative reforms and in later years in clinical cessation-support services, but the “whole of government” commitment to funding for vital mass-media campaigns remained absent. There was a set of cultural beliefs operating within the bureaucracy that mass-media campaigns were specifically inadequate to assist low SES groups, despite evidence to the contrary. There was also a lack of clarity on governmental roles and accountability on tobacco issues. There was a lack of discretionary funding within the responsible government department, which impeded initiatives. The final major impediment to implementation of a comprehensive evidence-based strategy for tobacco control in Tasmania was a lack of bureaucratic engagement, monitoring, evaluation and support for the principal service delivery arm of anti-smoking services, Quit Tasmania.

In summary, Tasmania continued to have a disproportionately high smoking rate that was not falling in the 2000s at the same rate as the rest of Australia. Whilst there were many legislative reforms, there was a failure to provide adequate resources for mass media cessation programs and educational campaigns from 1997 to 2009. Knowledge transfer about evidence-based programs from the bureaucracy to government and Parliament and commitment to cessation-support services did not occur until the late 2000s. These failings can be attributed to structural and process problems; a set of cultural beliefs that did not accord with the evidence; unclear accountability; indifference to tobacco control from the senior echelons of government; and a lack of resources, support, monitoring and evaluation of the major cessation anti-smoking services.

Implications

There are a number of actions that could have been taken to ensure that Tasmania, and other jurisdictions, responded effectively to the smoking pandemic over the period from the 1960s to the 2000s – these would also have relevance for what should be done now. Firstly, the cabinet should have publicly endorsed reducing smoking rates as a priority for the government, allocated adequate funding, which may have required additional funds from the federal government for this purpose, and gained genuine commitment from ministers and departments across government. Secondly, elimination of iterative internal circular “over-consultation” processes that have bogged down decision-making on tobacco control should have been essential; and policy processes either should have given equal weight to tobacco control or be structurally separated from illicit drugs and alcohol policy and machinery. Thirdly, small scale external evaluations and reviews of tobacco-control programs should occur frequently, including prioritisation of initiatives to achieve no more than three practical outcome-focussed and measurable targets. Such initiatives need to be fully funded and evaluated. Finally, closer relationships between the government, non-government organisations and research centres in Tasmania could be enhanced, as outlined in the previous Chapter at page 204.

Table 12 Summary of results

Results and discussion - summary	
Structural barriers and accountability	Responsibility split between the Alcohol and Drug Service (ADS) and Public and Environmental Health (PEH). Too many committees. Confused accountability.
Priorities and skills in the Alcohol and Drug Service (ADS)	No statewide expertise in clinical delivery of cessation services. No interest in tobacco control. Too many layers of management. Many staff were smokers. Decrease in services to the main hospital.
Lack of “evidence transfer”	Reports to Parliament did not mention the importance of mass-media campaigns. Key senior officers did not believe that media campaigns were effective.
Complex processes	Complex and slow committee systems. Excessive internal iterative circular “consultation”.
Cultural barriers	“Primacy of rescue” dominated drug policies and committees; alcohol and illicit drugs elicited priority action. “Siloed” Health agency received no support, and some active obstruction, from other key agencies. Indifference from other sections of health agency, such as mental health services.
Influence of the tobacco industry	Insufficient distancing from the tobacco industry, particularly from departments other than health. Some bureaucrats worked with “front” organisations. Lack of transparency – naïvely considered more a “third world” problem, not here.
Resource constraints	Difficulties in obtaining funds for tobacco control, because of resource “silo” effect. Tasmania has limited resources, due to a small tax base, and reliance on the federal government for its revenue.

Evaluation delays	The principal service delivery arm, Quit Tasmania, was not evaluated from its establishment in 1995 until 2009. Many problems were found, but not implemented for another two years.
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Chapter 8

Non-government organisations (NGOs)

Background and Context

The third arm of the policy triangle in tobacco control is that of non-government organisations. In Tasmania this includes health organisations, unions, researchers, churches, professional organisations and advocacy groups. The tobacco industry is not considered an NGO in this context. The role of the tobacco industry is considered and interweaved within all the Chapters. The role of non-government organisations has long been important at an international level in tobacco control, and was particularly important for the development and implementation of the Framework Convention on Tobacco Control (FCTC) (Lencucha, Kothari & Labonté 2001). In Australia the NGOs concerned with heart disease and cancer have been at the forefront of driving change and reform in tobacco control. The Cancer Council and the Heart Foundation have led the advocacy agenda, with other organisations taking a role from time to time on particular issues.

In Tasmania the leading organisations influencing tobacco-control reforms have been the Cancer Council of Tasmania (CCT), the Heart Foundation (HF) and Quit Tasmania (QT). The Australian Medical Association (AMA), Asthma Foundation, Liquor Hospitality and Miscellaneous Union (LHMU – since 2011 known as United Voice), Seventh Day Adventist Church, Pharmaceutical Association, Australian Lung Foundation, Diabetes Tasmania, Menzies Institute, Kidney Foundation, Cystic Fibrosis Tasmania, Thoracic Society of Australia and New Zealand, and the Alcohol Tobacco and other Drugs Foundation (ATDC), Tasmanian Chronic Disease Prevention Alliance (TCDPA) have all played a key role at different times in tobacco control. Part-time volunteers run many of these smaller organisations, with professionals working off the side of their desk, or single paid staff working on their own, with a small board. The allocation of time by individuals and organisations seems to have been dependent on the appointment of particular staff, or the actions and interest of the CEOs, and has varied in commitment, according to the issue, in the period from the early 1990s to 2010.

SmokeFree Tasmania was established in 1996 as an advocacy group incorporating the major health organisations and individuals including doctors and public servants from the Department of Health. Whilst this was an awkward model at times, as public servants could not be quoted in minutes of meetings, it nevertheless functioned effectively from 1996 until 2013, at which time it was reconstructed as an association of tobacco-control experts, rather than organisations.

Cairney and Mamudu (2014) assert that the policy environment is just as important as the evidence and the policy instruments. They also say "... that medical and anti-smoking public health groups must be consulted, while ignoring tobacco interests" (Cairney & Mamudu 2014 p.510). The importance of removing tobacco companies from the policy-making process is important, and has still not happened in Tasmania. Tobacco companies continue to be given hearings by the Parliament and the government on the latest initiatives for a tobacco free generation (Legislative Council 2015).

Nationally, as mentioned in other Chapters, the AMA and ACOSH produced an annual Dirty Ashtray Award and a Clean Ashtray Award. Ministers were proud to receive Clean Ashtray awards and boasted about them in Parliament. For example, Health minister Judy Jackson acknowledged the role of NGOs when she proudly announced in 2001 on Tuesday 29 May,

"I am delighted to advise the House that Tasmania has indeed won the national tobacco scoreboard, the Clean Ashtray Award for 2001. This prestigious award is an initiative of the national Australian Medical Association and the Western Australian Action on Smoking and Health, and is presented each year to the State with the best performance on tobacco-control issues. Tasmania jumped to the top position this year after finishing in fifth place last year. Tasmania's achievement in legislating the Tasmanian *Public Health Amendments for Smoke-Free Areas Act 2001* to protect employees and the public from environmental tobacco smoke earned the State the award.

"This legislation takes Tasmania to the forefront of tobacco control in Australia, and credit for the award goes to the many people who work tirelessly to ensure that the legislation passed through Parliament last month. This includes the staff of the Department of Health and Human Services and non-government organisations such as the Cancer Council,

Quit, Heart Foundation, SmokeFree Tasmania, AMA divisions of general practice, and the Liquor and Hospitality and Miscellaneous Employees Union. This kind of cooperative approach to sensitive public health issues such as tobacco is in itself a major achievement. To attain national recognition for it is indeed a bonus” (Hansard 2001).

In 2004 AMA federal President Bill Glasson met with the Health Minister, David Llewellyn, “to push for a total smoking ban in public places”. Dr Glasson went on to say,

“... the AMA would continue to campaign for an immediate and total ban on smoking in all public venues, and he urged politicians not to be swayed by industry groups and tobacco company donations.

“It's the power of the hotel lobby groups, the cigarettes companies, it's the big-end-of-town dollars which are holding this up," he said.

“If there was no money involved it would be changed overnight” (Whinnett 2014).

Clearly NGOs are a major force in developing tobacco-control measures, a fact that is acknowledged by politicians basking in reflected glory

Silencing Dissent

Politicians were not universally enamoured with the actions of NGOs, and nationally efforts were made to silence the advocacy role of the not-for-profit sector under the Howard government. There were three mechanisms employed to achieve this:

- “Gagging” organisations by preventing them from undertaking advocacy, which might be critical of government;
- Defunding the organisation;
- Attempting to remove the tax deductibility status of an organisation as a charity.

In the period from the late 1990s to the late 2000s, under the Howard government, a shift in federal government attitudes to funded non-government organisations became apparent (Maddison, Denniss & Hamilton 2004). Government service agreements with funded organisations began to include paragraphs that precluded the organisation from public

comments or criticism of government. This trend was reversed by the Labor government and finally the *Not-For-Profit Sector Freedom to Advocate Act 2013* was enacted in 2013, which prevented federal government agencies from inserting clauses in funding agreements that might restrict a non-government entity from "...commenting on, or advocating support or opposing a change to any matter established by law, policy or practice of the Commonwealth" (Seccombe 2014).

However, removal of the "gag" clause option does not prevent the Commonwealth from defunding an organisation, or using other mechanisms to silence it, including attempts to remove its tax deductibility status and potentially criminalising it. For example advocating for boycotts of certain products might become unlawful, if the secondary boycott provisions of the *Competition and Consumer Act 2010*, which exempt consumer and environment groups, were removed.

In 2014 the Abbott government attempted to abolish the Australian Charities Commission and its associated legislation in the name of reducing "red tape" (Andrews 2014).

The Tasmanian non-government health sector remained relatively protected from these national predations on their autonomy, because the Labor government in Tasmania did not apparently attempt to crush dissent by non-government organisations. Under the state Liberal government elected in 2013 it appears to have acted similarly in relation to health NGOs at least, although environmental NGOs may have not been treated as kindly. On the contrary, there is evidence of consultation with key leaders in public health, such as the appointment of Graeme Lynch CEO of the Heart Foundation to the Health Council and similarly Dr Tim Greenaway CEO of the AMA. Both of these leaders have supported the innovative tobacco free generation proposal.

Lack of financial resources

As referred to in Chapter 6 on Political Barriers, hypothecation of tobacco revenue did not occur in Tasmania, mainly because of the powerful oppositional role of the Secretary of Treasury, Don Challen, and the failure of politicians to challenge him on this issue. Mr Challen referred to "the hypothecation disease, or the hypothecation virus" (Hansard 1996). The importance of adequate funding is illustrated by the VicHealth Centre for Tobacco control, built on hypothecated funding and which has endured as a well-funded organisation

even after states lost the ability to retain tobacco excise revenue in 1997, after the High Court decision. “On 5 August 1997, the High Court of Australia brought down a combined decision in the cases of *Walter Hammond and Associates v the State of NSW and others* and *Ha and anor v the State of NSW and others*” (James 1997). Even though the cases heard related to the imposition of franchise fees on tobacco, the decision has effectively declared all current State business franchise fees to be constitutionally invalid. WA and SA have also retained funding arrangements beyond the 1997 court case. Tasmania, NSW, Qld and the Territories did not have hypothecated tobacco funding for tobacco-control measures. While it is almost impossible to explicate the funding detail provided by governments to the Victorian Cancer Council, nevertheless in 2012/2013 the figure provided on the organisation website was:

“The Victorian Government has committed \$59.6 million over the next four years through the Victorian Cancer Agency to fund research into cancer. This funding is recurrent with \$14.9 million available each year after 2016/17” (Cancer Council Victoria 2014).

Such funding is many orders of magnitude beyond that allocated by government to the Cancer Council Tasmania (CCT). The CCT says it is 90 per cent funded by public donations, and reported government grants of \$1.4 million in 2013, however, this was mainly for Quit service delivery and mass-media campaigns (Cancer Council Tasmania 2014). The CCT lists 35 staff in its 2012 Annual Review, and acknowledges its work on tobacco control and with SmokeFree Tasmania (Cancer Council Tasmania 2012a) and reported:

“In March 2012, new legislation was introduced to further reduce smoking consumption in public places and imposes greater restrictions on the sale of tobacco products across the state. This move has positioned Tasmania at the forefront of Australian jurisdictions in its tobacco-control agenda. The work of Cancer Council Tasmania, in conjunction with SmokeFree Tasmania, has been effective in driving and supporting change to address one of the most modifiable cancer risks in the community” (Cancer Council Tasmania 2012a, p. 8).

Also in 2012 the Cancer Council made a detailed submission to government seeking additional funding for mass-media campaigns, and this submission was successful. This was the only submission amongst all the documents found in this study, that adequately put the

case for additional funding (Cancer Council Tasmania 2012b). The submission acknowledged past inadequacies:

“The research is clear on a key determining factor in this failure to achieve change: Tasmania has not invested adequately in social marketing programs at a level that both evidence shows to be effective and the practical reality of other jurisdictions confirm. Similarly, Tasmania has not had the capacity to focus on low SES groups nor has it had the data to understand the population better and align efforts with the realities of the priority groups” (Cancer Council Tasmania 2012b, p6).

However, by the following year, 2013, both the Heart Foundation and Cancer Council severed their links with SmokeFree Tasmania, and no longer gave advocacy in tobacco control a priority.

The Heart Foundation received \$3 million in 2013, mostly from donations and bequests, with a few grants for specific purposes were made by government (Heart Foundation 2013). According to their annual reports, this compares to around \$10 million in Victoria and Queensland, \$14 million in WA and \$6 million in SA.

In WA the Australian Council on Smoking and Health (ACOSH) receives around \$238,000 per annum (HealthWay Annual Report 2013/14) and has been funded for many decades, primarily as an advocacy organisation. The ACOSH website describes its history thus:

“ACOSH was formed in 1965 in New South Wales by Dr Cotter Harvey, President of the Medical Board of NSW, and also President of the National Tuberculosis and Chest Association ... Dr Harvey was a pioneer in the campaign against tobacco, having seen first-hand the growing incidence of lung cancer. In spite of a strong campaign by tobacco denying a causal link between smoking and disease, Dr Harvey persisted, persuading others to join the campaign. ... Branches of ACOSH were established in other States including, in 1971, Western Australia. Dr Bob Elphick was elected the founding president of ACOSH in 1971 and remained a driving force in tobacco control and advocacy throughout his life. In 1978, the Sydney branch of ACOSH ceased to

exist, and the national direction of the organisation passed to WA”
(ACOSH 2016).

ACOSH is now solely located in Subiaco, WA, and is very influential in tobacco-control policy advocacy. There is no equivalent organisation to this remaining in Australia since the demise of ASH Australia, and certainly Tasmania has never had advocacy resources on this scale.

The Asthma Foundation Tasmania only had eight staff, mostly part-time, in 2013 and most of its income came from donations and bequests (Asthma Foundation of Tasmania 2014).

All of these Tasmanian organisations are dwarfed by the Victorian Health Promotion Foundation, which has a revenue base around \$37 million. This is almost entirely due to the efforts of the early campaigners such as Dr Nigel Gray who built the organisation and its reputation for excellent research and health campaigns, and his successors Dr David Hill and Todd Harper. These policy entrepreneurs were able to maintain consistent government funding even after the hypothecation of tobacco taxation revenue ended in the 1990s. Tasmania has never managed to develop such a critical mass of NGO funding and expertise in tobacco control.

Expertise and Research Skills – another missing link

None of the Tasmanian NGOs had a dedicated tobacco-control research capacity, nor an officer working full-time on tobacco-control advocacy issues. This contrasts to organisations in other states like ACOSH in WA, ASH in NSW, QUIT in South Australia and the VicHealth Centre for Tobacco Control in Victoria, which all had resources available for lobbying, research and advocacy. Quit Tasmania had some resources, but was totally government funded and was therefore not in a position to criticise governments publicly nor to advocate strongly in a way that might jeopardise its funding. Quit had no research capacity or expertise, and relied on interstate counterparts, particularly in Victoria, for information.

The results of this were that:

- It was not until 2012 that the Tasmanian Cancer Council employed a full-time tobacco control expert as a researcher.

- None of the NGOs employed a health economist or person able to prepare professional or expert submissions to Treasury and government that could put a coherent case forward to acquire funds for tobacco-control measures, until 2012.
- In relation to tobacco control, there was a research and economic expertise capacity vacuum in NGOs in Tasmania.

Policy entrepreneurs – the key missing dynamic

The missing driver in Tasmania for tobacco control was a lack of policy entrepreneurs. There were many advocates who worked at various times on particular issues, and all of them were associated with non-government organisations. However, there was no equivalent figure to Dr Nigel Gray, the key person who encouraged the Victorian Government to establish the *Victorian Tobacco Act 1987*.

Dr Gray was a towering figure in the Australian tobacco control landscape. He was head of the Anti-Cancer Council of Victoria (ACCV) from 1968–1995), a medical practitioner, and a researcher.

“The Victorian Tobacco Act was the first government instrument in the world to hypothecate a tax on tobacco products for funding health promotion activities. It did so through creating a new organisation, the Victorian Health Promotion Foundation (Vic Health), which has become an internationally important precedent as a model for promoting health” (Borland, Winstanley & Reading 2009, p. 1623).

A window of opportunity had opened up in Victoria in 1987 when Nigel Gray was able to persuade the minister, who was in turn able to persuade the Treasurer, the Premier and Cabinet of the need to proceed with this course of action. Furthermore, the Opposition was also persuaded by Dr Gray to support the legislation and hypothecation. He also worked with the *Age* newspaper to run a series of articles on smoking, at the same time that Cabinet was considering the proposals. All of the stars were aligned and the Bill was given support (Borland, Winstanley & Reading 2009).

As John Ballard said of Australia “Medical prestige was a significant force in mobilizing political support for anti-tobacco measures” (Ballard 2004, p. 96). Dr Nigel Gray, Dr Cotter Harvey and Dr Arthur Chesterfield Evans all played a significant role in reforms in Australia

(Ballard 2004). There was not an equivalent or comparable figure in Tasmania to Dr Gray. The CEO of the Cancer Council of Tasmania and the CEO of the Heart Foundation, whilst influential, and with media expertise, were not medical practitioners, nor closely aligned with political figures.

The leaders of SmokeFree Tasmania and other organisations, whilst a few were medical practitioners, were not closely aligned with any political party, and there was little illegal direct action undertaken by doctors like the graffiti work undertaken by Dr Chesterfield Evans in defacing tobacco industry billboards. Some local medical practitioners privately admitted to the author to defacing tobacco billboards in the 1970s, but none would go on record, nor were prepared to be quoted in this study. Dr Richard Wood-Baker undertook to convene SmokeFree Tasmania in the 1990s and engaged in media campaigns. Lawson Ride CEO of the Cancer Council of Tasmania, was a leading advocate for smoke-free areas, and organised the “stunt” event, with Michael Wilson from Quit, with the “barman” in gas mask referred to in Photographs 4 and 5. The AMA and the Asthma Foundation were involved in the campaign for smoke-free cars with children. Other health professionals and advocates in Tasmania included union official David O’Byrne, who led SmokeFree Tasmania as efforts were being made to make hotels smoke-free, as his members were hospitality workers. Quit Tasmania, the Heart Foundation and the Cancer Council were the key members of SmokeFree Tasmania, as well as individuals from the Department of Health including Dr Martin Bicevskis and Kathryn Barnsley.

Issues

There was some success in a limited number of areas, when there were adequate numbers of people able to be rallied to engage in lobbying government. At times the planets aligned, and windows of opportunity opened, but only when there was a concerted effort on the part of NGOs.

Smoke-free areas

Non-government organisations were crucial in the drive to establish smoke-free indoor public places in Tasmania. This was one of the most important areas of reform for anti-smoking lobbyists.

Evidence about the detrimental effects of passive smoking was mounting in the 1980s, culminating in a report in Australia by the NHMRC in 1987 (NHMRC 1987). Much later, in 1994:

“... the Commonwealth, State and Territory ministers for health agreed to target the year 2000 for enclosed public places to become smokefree. They recommended that State and Territory governments introduce legislation to achieve this (CDHSH 1994)” (National Public Health Partnership and Legislative Reform Working Group 2000).

Tasmania was the first state in Australia to ban smoking in all indoor public places, including bars in January 2006. The most influential and committed organisations in the campaigns for smoke-free areas in Tasmania, were SmokeFree Tasmania, Quit, the Heart Foundation, Cancer Council, Lung Foundation and the Public Health Association. There were essentially two campaigns and two sets of legislation, because the first legislation in 2001 only covered indoor workplaces, restaurants and limited areas of bars. It was not until 2006 that the complete eradication of smoking indoors in bars was achieved.

The earliest serious impetus for smoke-free areas in Tasmania began in 1996 when the Government issued a discussion paper on the topic, associated with its exposure draft Public Health Bill. Liberal Health Minister Peter McKay, in a front-page *Examiner* story on June 20 1996 (Rogers 1996) foreshadowed a complete ban on smoking in all public places including pubs and clubs. In the *Mercury* on December 24 1997 he said

“If there are no real gains and a significant improvement in the way people do business [by July 2003] obviously Parliament would have to introduce legislation” (Rogers, 1997, p. 3).

SmokeFree Tasmania led the charge on reducing smoking in public places in the late 1990s, and was reported to have encouraged a voluntary arrangement in some restaurants for a smoke-free environment in 1998. A card was made for diners to give to restaurants to show their appreciation of such environments (Lamb 1998).

Smoke-free areas legislation was in some ways an easier target for reform as it engaged public opinion. As there was more and more debate about the health effects of passive smoking, and information in the media from authoritative sources, such as the NHMRC and Surgeon General (Satcher 2000).

Funded by the Heart Foundation, the visit to Tasmania of Dr James Repace to Tasmania in 1999 initiated intense media interest and debate on smoking in pubs and restaurants. This appears to have been a pivotal point in the anti-smoking campaigns for public places.

The trade union that had the most members affected by smoking in bars was the Liquor Hospitality & Miscellaneous Workers Union (LHMU – now named United Voice), and its Secretary Darren Matthewson played an important role in influencing public opinion to support the first significant smoke-free areas legislation in 2001.

Physicians joined forces with the NGOs to lobby for change. The *Mercury* newspaper reported in 2000 (Paine 2000):

“TASMANIA'S most influential doctors have declared war on smoking in all enclosed public places, saying they aim to be a force in new state laws.

“Yesterday doctors and health groups launched a push for smoke-free working conditions, particularly in the hospitality industry.

“The alliance, Smokefree Tasmania, attacked the Australian Hotels Association for opposing a total ban on smoking in all restaurants and bars.

“And it said an “insidious” tobacco industry was behind campaigns against bans.

“The State Government will be drafting legislation governing smoking in public places in the next few weeks.

“The doctors, representing Asthma Tasmania, the Cancer Council of Tasmania, the Australian Medical Association, general practitioners and the National Heart Foundation, backed last week's Liquor, Hospitality and Miscellaneous Workers Union call for smoking to be banned in all restaurants, bars, casinos and hotels.

“Smokefree Tasmania said hospitality workers were suffering discrimination because they were forced to inhale environmental tobacco smoke, with lawsuits against employers inevitable.

“Professor Ray Lowenthal said the AHA's claims of economic losses were unfounded.

“‘Studies around the world show an increase overall in the number of people attending restaurants and in income,’ Professor Lowenthal said.

“‘It's irrelevant if the staff member is willing to work there, because an employer owes a duty of care to their staff.’

“‘He said no ventilation was good enough to prevent smoke moving through a building and many of the most lethal chemicals were colourless and odourless.

“‘Dr Rob Walters said employers and owners should beware of the trend toward legal action over environmental tobacco smoke.

“‘It will happen here. We have to have an all-or-nothing approach,’ Dr Walters said.

“‘Dr Mike Loughhead said Tasmania had the highest rate of coronary heart disease in the country and smoking, or smoke, was a key factor.

“‘If a non-smoker is married to a smoker, they are 25% more likely to have a heart attack,’ Dr Loughhead said.

“‘Also members of the alliance are Quit Tasmania, the Public Health Association of Australia, Adventist Health, the Australian Lung Foundation, the Association of Cystic Fibrosis and the Thoracic Society of Australia and New Zealand’ (Paine 2000, p7).

Accompanying this story were two pictures by *Mercury* photographer James Kerr, which depicted some of the most eminent and influential doctors in Tasmania.

Photo 4 Senior Tasmanian doctors supporting SmokeFree Tasmania



Mercury: James Kerr – photographer September 2000

Pictured left to right: John Davis (GP & AMA President), Michael Loughead (Cardiologist & Heart Foundation Board member), Ray Lowenthal (Oncologist & Cancer Council Board member), Collin Sherrington (Cystic Fibrosis - Respiratory Physician), Rob Walters (GP & Cancer Council President) – positions held September 2000.

Photo 5 The "barman" with gas mask

Photo: *Mercury* (Kerr 2000).



Photo: *Mercury* (Kerr 2000).

This picture (above) was set up to demonstrate the effects of tobacco smoke in a bar, and the “barman” is Quit CEO Michael Wilson and others pictured are members of SmokeFree Tasmania or employees of the Health Department. It elicited considerable publicity.

Captions for photographs in the *Mercury*: “Serving up trouble: a barman pours drinks in a gas mask to dramatise the adverse health effects of a smoke-filled environment. Tasmanian doctors are campaigning for smoke-free workplaces” (Kerr 2000, Paine 2000).

Pubs and clubs smoke-free – 2006

The campaign for smoke-free pubs and clubs was the longest and hardest fought campaign by NGOs and was resisted strongly by the AHA. The AHA argued that country hotels in Tasmania would be hit hard by a total ban on smoking in public places (*Mercury* 2003).

“General manager Daniel Hanna said yesterday a survey of AHA members revealed turnover at country and outer-suburban hotels would drop by about 34 per cent if more stringent smoking controls were introduced” (*Mercury* 2003, p. 9).

But Liquor, Hospitality and Miscellaneous Workers Union state secretary David O'Byrne accused the AHA of exaggerating:

“The AHA has suggested there would be a fall in revenue and that jobs would go but what is more likely is that they would become family friendly venues and revenue would increase. About 2000 members of the union were affected by smoke and some had respiratory problems as a result” (*Mercury* 2003, p. 9).

Premier Jim Bacon would not divulge the tenor of the previous day's Cabinet discussion but said "... any decision would be made in the interest of all Tasmanians" (*Mercury* 2003). Sadly, Premier Bacon died of lung cancer within a year of this statement, and his cabinet colleagues acted on this issue soon after his death.

The Royal Australasian College of Physicians President Luke Galligan pointed out that:

“The inability of ventilation or separation to completely clear the air of second-hand tobacco smoke means non-smokers are also at risk ... That exposure has been found to increase the risk of developing coronary artery disease by 25 per cent and lung cancer by 30 per cent” (*Mercury* 2003).

There were many newspaper stories similar to this one and the arguments raged back and forth. The NGOs and the unions continued to campaign strongly for reform, and the AHA continued its opposition, until smoke-free areas in pubs and clubs were finally implemented. Medical practitioners were strongly supportive of this campaign, and there were many different doctors involved in public advocacy at various points in time in the process.

Removing Tobacco displays and advertising in shops - commenced 1998 - completed 2012

Tasmania was the first place in the world to remove advertising from point-of-sale in shops (Ballard 2004). The campaign to undertake this was strongly assisted by Sydney-based Action on Smoking and Health (ASH), and ASH also provided a great deal of printed material for the campaign to eliminate tobacco displays in retail outlets. The key ASH workers were CEO Anne Jones and media expert Stafford Sanders. Anne Jones made many visits to Tasmania and assisted in lobbying politicians, with media and strategic planning.

Greens MP Peg Putt mentioned a letter from ASH on behalf of 60 Tasmanian and national NGOs in her speech on the Public Health Amendment Bill 2007:

“I have had a letter from Action on Smoking and Health on behalf of a coalition of more than 60 Tasmanian and national organisations saying that while the proposed legislation contained some welcome features, including a proposed ban on smoking in cars carrying children, there were a number of shortcomings. Of greatest concern is the failure to completely ban retail display of tobacco products. Research they enclosed – and I will come to that – shows compelling evidence that retail display normalises tobacco to children and predisposes them towards smoking. If every child smoker is one too many, then every square metre of tobacco display is a square metre too much” (Hansard 2007).

Ten years earlier in 1997 the Heart Foundation and the Australian Medical Association managed to annoy the leader of the Opposition, Liberal Bob Cheek, as he declared, during the debate on the Public Health Bill 1997 (No. 106):

“Then, of course, the orchestration was cranked up and once again I am not blaming the Health officers over here, but by the public relations department from the Department of Community and Health Services, and you had other people, Australian Medical Association and the National Heart Foundation, coming out and almost blaming us for the fact that we were in with the tobacco lobby and trying to stop this legislation going through. All we were trying to do was point out the impracticality of having one packet of cigarettes put there. Now we have got five and that is a lot better, that is all we were trying to do, and yet this whole campaign was cranked up as though we were in league with the so-called pedlars of death and the other fourteen retailers were and it was so stupid, as I said, and so far from the truth” (Hansard 1997b).

Ban on sale of tobacco products to children under 18 years – 1996–1998

The amendments to the Public Health Act in 1996 were the first substantive piece of tobacco-control legislation in Tasmania and the forerunner to the Public Health Act 1997, which contained comprehensive anti-tobacco provisions.

The *Public Health Act 1997* commenced in 1998 and included: bans on tobacco advertising, the sale of cigarettes to children under 18 years of age and self-service vending machines; and display restrictions in retail shops. Manufacturers and suppliers were also banned from providing false information to any person about tobacco-control legislation or the health effects of tobacco products.

The ban on sale of cigarettes to children under 18 years of age was not driven by non-government organisations, and appears to have had the support of the tobacco industry. However, restrictions on tobacco displays and other bans were supported and advocated for by non-government organisations including ASH Australia.

Banning smoking in cars with children – 2008

This initiative was pursued by SmokeFree Tasmania, the AMA and the Asthma Foundation, and encountered almost no resistance from anyone, with the exception of some initial reluctance by police to enforce it. The tobacco industry did not oppose this measure, presumably because it would not actually reduce smoking rates, and it would have harmed their public image to be seen to be advocating for children to be exposed to tobacco smoke.

More outdoor smoking bans – 2012 to 2013

Non-government organisations were interested in extending outdoor smoking bans but did not pursue these vigorously. Most of the initiative came from within the Department of Health who were interested in pursuing de-normalisation of smoking. NGOs supported these initiatives within the framework of the Tobacco coalition, but did not go out of their way to campaign publicly for such measures.

The government moved to extend outdoor smoking bans from 2012, to playgrounds, patrolled beaches, pedestrian and bus malls, bus shelters, 100 per cent of outdoor dining areas, competition and seating areas at sporting events and other large public events. Carols by Candlelight events were required to be smoke-free. Selected markets, food and wine, and music festivals were required to be smoke-free or have designated areas for smoking. Agricultural shows organised by the Affiliated Societies of the Agricultural Show Council of Tasmania were required to be smoke-free or have designated smoking areas.

Conclusion

There have been many successful campaigns for legislative reform in Tasmania in which NGOs, medical practitioners and unions have played a crucial role. These campaigns included smoke-free areas, removal of tobacco product displays and bans on smoking in cars with children. NGOs in Tasmania are not well funded in comparison to their mainland counterparts, and their capacity to undertake advocacy and lobbying has been limited by lack of resources, and in some cases, expertise. Many of the effective mainland organisations commenced in the 1970s or earlier. The Tasmanian Cancer Council was not established until the 1990s, although the Heart Foundation had existed for some years prior to this. Tasmania simply lacked a critical mass of NGOs with expertise in tobacco control, until the late 1990s, and even then there was little funding, and no staffing for tobacco advocacy roles. Quit was also established in the 1990s and was permitted some role in advocacy, but it was a creature of government, totally funded by the public purse, and therefore constrained from being more than mildly critical of governments. Similar to Victoria there were many physicians who campaigned at various times on particular issues, but apart from Dr James Markos in Launceston and Dr Richard Wood-Baker in Hobart, who consistently advocated for tobacco-control measures for decades, most physicians only engaged intermittently in the public domain. Other individuals, such as Lawson Ride at the Cancer Council worked consistently for many years, but had no specifically allocated staffing to conduct advocacy, therefore the work had to be fitted in between fundraising, service delivery and other activities. Fundraising is particularly important for NGOs in Tasmania, and is a major time-consuming preoccupation of CEOs.

The most significant area in which NGOs have been unable to galvanise support from government has been in the allocation of resources to mass-media campaigns and cessation-support services, until very recently. It is probable that the lack of a health economist, or government budget process expert, available to these organisations has meant that the case for increased funding has not been adequately stated, until 2012. The only document that was provided, or was found in the process of undertaking this study, that delivered a comprehensive argument for increased resourcing, was produced by the Cancer Council in late 2012 for the 2013/14 budget consultation process. No other documentation has been found, or was made available.

In summary, NGOs have made valiant efforts over many years since the mid-1990s in Tasmania to push governments to take action on tobacco control, and have been very successful in many legislative reform areas. However, the lack of infrastructure and staffing resources for advocacy has hampered their efforts in comparison to their wealthier colleagues in other Australian states. Furthermore, there is no history or critical mass of community or other support for tobacco control from the 1970s onwards that enabled the building of NGO infrastructure as occurred in other jurisdictions. Legislative reform has consequently been easier to achieve than financial and resource allocation. This has been a contributing factor to the barriers to evidence-based tobacco control in Tasmania.

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Chapter 9 Major findings and conclusion

The major findings of this thesis are that tobacco industry interference, crony capitalism, complex bureaucratic systems, poor accountability, cultural beliefs, inadequate leadership, cognitive dissonance of smoking politicians, lack of commitment from ‘conservative white male’ leaders, lack of resources for non-government organisations, lack of grassroots dynamism and a dearth of strong independent policy entrepreneurs, all contributed to inadequate resourcing of tobacco control in Tasmania from the 1960s to the 2000s. No evidence was found of influence of political ideology by the major political parties having a substantial effect on tobacco control. Both major political parties were, at times over the years from the 1960s, led by males with close ties to the tobacco industry or front organisations. It appeared that the personalities of individual politicians were more influential than whether or not they belonged to a particular political party. Green Party politicians, some independents and a few backbenchers from both major political parties were persistent in questioning government about tobacco control, and many quoted research studies and demonstrated a sound understanding of the issues. Other politicians were not only sceptical and critical of tobacco reforms, but used abusive and insulting language to hector reformers.

My research suggests that the most important barrier to evidence-based tobacco control was the activity and influence of the tobacco industry, together with crony capitalism of conservative white males. Tasmania’s decline in smoking rates lagged behind other states of Australia in the late 1990s and 2000s. It was clear that something was seriously wrong with tobacco-control measures in Tasmania, because all other states and territories were subject to the same taxation regimes and industry influences. The author and a number of other members of the scientific and health community were concerned about smoking rates thus it was decided to embark on this study, to see if it was possible to uncover the barriers to reform and implementation of evidence-based policy. A literature review and document analysis were conducted, with a view to conducting interviews at a later time. A large amount of data was collected from many sources including internal government documents, archival materials, newspaper reports, Hansard transcripts, reports and reviews, from which it became clear that it would be undesirable to conduct interviews. Firstly, because it was possible to triangulate data using a number of sources, to track events and to see what views had been expressed by the actors at the time events occurred. Secondly, because Tasmania is a small place and the author and a number of her supervisors, colleagues and co-authors were well

known, and indeed integrated into the Tasmanian tobacco control system and society. Potential interviewees included activists, commentators, researchers, and advisers to government, and therefore, it was considered impossible to conduct interviews that would have yielded unbiased responses. The respondents would have felt a need to justify themselves for various actions or inactions, reportage would have been coloured by personalities and perceptions, and recall bias would have been a problem due to the passage of time. Therefore, in order to achieve an accurate and rigorous approach to the research, it was decided to rely only on records of what people said and did, rather than what they thought they might have said and done.

My research suggests that tobacco control in Tasmania has been characterised by a strong legislative reform agenda and weak commitment to resourcing community education, mass-media campaigns and cessation-support services. The Tasmanian political landscape is plagued by crony capitalism, documented by other writers (Beresford, 2010, 2015) as well as in this thesis, and that is particularly acute in the operation of close relationships between influential politicians and the tobacco industry, their “front” organisations and industries closely associated with the industry. This close relationship was most notable in the 1960s and 1970s (Barnsley, 2011). The tobacco industry was so successful that in 1972 it managed to eliminate a Tasmanian government and have it thrown out of office (Barnsley, 2011). In ensuing years through into the 1980s the industry established close relationships with Liberal politicians (Legacy Library 1993b), which ensured that Tasmania had no tobacco reforms, and no tobacco legislation to control the industry during that period. During the 1990s and 2000s the tobacco industry was, through the hotels association, also able to gain a memorandum of understanding with a Labor government not to proceed with banning smoking in pubs (Dally 1998). Both Labor and Liberal governments were at fault. My research suggests that this close relationship with industry of crony capitalism was, and continues to be, a major contributor to preventing evidence-based tobacco control in Tasmania.

A series of political blunders in the 1970s, and bureaucratic intransigence in the 1980s and 1990s through failure to hypothecate tobacco taxes (sometimes titled business franchise fees) to tobacco-control measures., entrenched Tasmania in a long-lasting financial abyss relating to tobacco control, out of which it did not climb until recently. The states that allocated a portion of tobacco taxes to tobacco control in the 1980s and 1990s were cushioned, because their commitments to tobacco control were embedded, and too politically risky to unwind.

The 1997 High Court decisions deprived the states of the ability to collect this revenue, but Victoria, South Australia and West Australia had firm funding commitments to tobacco control, so adequate resourcing of tobacco-control measures continued even when hypothecation ceased. My research found that in contrast, Tasmanian public health officials scraped around for funding for tobacco control for decades, and that this was a moderately important factor in barriers to reform. Such lack of funding could have been overcome, and was eventually successfully allocated, by strong female political leaders who were concerned about tobacco control, and prepared to follow the evidence.

Few case studies have managed to obtain such a comprehensive range of internal government documents, including memoranda, some ministerial briefings and emails. The availability of these documents in Tasmania ensured that it was possible to scrutinise in detail the policy processes underlying actions on tobacco control. My research suggests that flaws in the Tasmanian health bureaucracy which have been disclosed in various government and independent reviews, reports and audits, were important, but not the principal factors in preventing the adoption of key evidence based tobacco control measures. This study further exposes details of the tobacco-control policy-making shortcomings. In the 1960s bureaucrats assisted the tobacco industry, and were inextricably involved in perpetrating a criminal conspiracy to subvert land allocation laws. These bureaucrats almost certainly received no financial advantage from the tobacco industry, so they were not “corrupt”, but undoubtedly engaged in cronyism. Tobacco-industry initiated crony capitalism penetrated the bureaucracy, and this was the most outstanding example. In the 2000s the bureaucracy failed to adequately inform successive governments of the depth and extent of tobacco-control research evidence. Many politicians failed to grasp the enormity of the effects of tobacco smoking on the health of Tasmanians. Furthermore, those who did understand the catastrophic effects on health systems and the community, failed to implement effective interventions. Some government agencies were unhelpful, and even obstructed tobacco control efforts. These agencies were not brought into line by a whole-of-government approach to health measures. The distinctive silo effects operating within the health agency and within government overall, contributed to a lack of cooperation. Ironically the multiple government committees, which might have resolved these impediments, in fact made the whole system slower, less efficient and more complicated.

My research found that there were many examples of individuals and health organisations advocating for tobacco reforms in Tasmania. However, there were no outstanding persistent

policy entrepreneurs of the eminence of leaders such as Victorian Dr Nigel Gray (Daube 2015). Tasmanian non-government organisations (NGOs) are small by comparison to the larger states, and lacked policy development and advocacy resources. In most NGOs the CEO was the person who conducted public advocacy. Their main focus had to be on fundraising, management and implementation of the service-delivery aspects of the organisation, leaving little time for advocacy. Few medical practitioners and specialists could spare the time for public advocacy, as they were fully engaged in clinical and research work. Until the late 2000s, none of these organisations had staff employed to undertake tobacco-control advocacy, policy research or the drafting of submissions or correspondence to government to seek additional resources for tobacco control. Quit Tasmania was able to undertake some of these tasks, but was not funded to employ a policy or research officer. A more effective advocacy role by NGOs and medical practitioners might have influenced government, however, my research found that this was a less important contributing factor to overall policy failure, than that of cronyism and tobacco industry interference, or bureaucratic inadequacies. Furthermore, as noted by Chapman and Wakefield (Chapman & Wakefield, 2001, p.279), “Advocacy in Australia has been driven by a relatively small group of people working from an even smaller group of nongovernmental organisations (NGOs).” Grassroots support was lacking in Tasmania, with the exception of reforms relating to smoke-free areas indoors and outdoors. This fits with the more general Australian experience, whereby, Chapman and Wakefield maintain that,

“Tobacco control advocacy in Australia, then, did not emerge spontaneously out of the community except in some small, if important, instances. Rather, it has mostly been initiated by professional advocates who took the recommendations of the early expert reports on reducing the tobacco epidemic and the results of relevant local policy-relevant research and advocated for changes to be adopted. While today there are countless examples of citizens joining in this advocacy the leading edge of contemporary advocacy for tobacco controlis still being driven almost wholly by health NGOs and policy-oriented researchers.”
(Chapman & Wakefield, 2001)

My research suggests that when they came to power at both a national and state level, a group of progressive female politicians were able to overcome all other impediments and allocate sufficient resources to tobacco control. None of these women were evidently engaged in cronyism with the tobacco industry. Federal minister Nicola Roxon was given international recognition and awards for her leadership on introducing plain packaging (Myers, 2015). The key factor appears to be that there must be a group of progressive women in all major leadership roles, because individual health ministers struggle to convince cabinet colleagues to undertake tobacco control measures (*Mercury* 2001, p. 16, Hansard, 2007a). When she was Health Minister, Lara Giddings MHR (Hansard, 2009) was seemingly unable to introduce adequate evidence-based measures, but once she became Treasurer and Premier, together with a progressive colleague Michelle O'Byrne as Health Minister, they worked with federal MPs Health Minister Tanya Plibersek and Prime Minister Julia Gillard to allocate resources for tobacco control in 2013 (Tobacco Coalition 2013, p. 6)

Limitations

The limitations of the study include: availability of all documentation; the involvement of the researcher and all supervisors in Tasmanian health, and some political interactions and processes; the lack of access to comparative data or records from other states; and a lack of in-depth study of the role of the media. Not all Tasmanian government documents were made available to the author, despite repeated requests. Treasury refused to supply any documents at all. A challenge to the Ombudsman may have overturned this refusal, however it was considered unproductive to spend time on such an endeavour, as there was an abundance of other documents and Hansard reports, which told the story of Treasury's role.

This is one interpretation of events, but this interpretation is justified given the breadth of data, documents and reports discovered and analysed. Externally reviewed articles emanating from this study were published in journals from three different academic disciplines, history, public health and politics.

The limitation on the study in relation to the effect of the media is problematic. Although efforts were made to obtain electronic media reports, these were not available. It is possible that cuts to the ABC in regional areas of Australia, especially news and current affairs investigative programs, and the decline of regional newspapers and retrenchment of many print journalists, have contributed to a lack of scrutiny of crony capitalism in Tasmania in

recent years. Furthermore at least one Tasmanian newspaper editor had been listed as a consultant to the tobacco industry (Legacy Library 1975) and another former newspaper and media proprietor was jailed for political bribery and corruption (Darby 2002). The role of the media has been found to be important in other international tobacco control studies (Wakefield 2012), however, for reasons of inability to access sufficient material, this was not pursued. There may be other impediments to evidence-based tobacco-control policy which remain unidentified; however, the myriad of barriers identified in this study is indeed clearly sufficient to slow reform.

Future action

The engagement of community based organisations and grassroots support in addition to established non-government organisations would assist in moving tobacco control initiatives onto the public and political agenda. Tasmania has outstanding research capacities at the University of Tasmania including the Menzies Research Institute, School of Medicine, Health Sciences and School of Social Sciences. A greater advocacy role by medical practitioners and their associated colleges and organisations could improve knowledge translation and evidence-informed public policy making by focussing government attention on tobacco control. Involvement of the highly respected Tasmanian academic community would also assist. Tasmania could learn much from the Canadian efforts to engage these groups in a cooperative approach.

Integrated knowledge translation (IKT) offers some potential for pursuing such processes, however, it must be well-defined, evaluated and reported Gagliardi et al were unable to "...identify thematic areas across the studies to recommend particular IKT strategies or ideal contextual conditions." (Gagliardi et al, 2016, p11). A more promising approach is that of deliberative dialogues, "a group process that emphasizes transformative discussion, and may be informed by research evidence" (Boyko et al, 2012, p.1939), as it appears to be more precisely articulated and defined, supports capacity building, and could be operationalised in a small jurisdiction like Tasmania. This approach is more sophisticated, focussed and structured than the usual consultation processes undertaken by government. Furthermore, it provides opportunities for policy alternatives, capacity to advocate and engage in agenda-setting, consistent with the major themes of this thesis, including emboldening policy entrepreneurs.

The Framework Convention on Tobacco Control (FCTC) is relevant to this study and two important themes stand out. Firstly, the need for all governments, including Tasmania, to properly observe the provisions of Article 5.3, the Guidelines for which provides inter alia,

“Recommendations

2.1 Parties should interact with the tobacco industry only when and to the extent strictly necessary to enable them to effectively regulate the tobacco industry and tobacco products.

2.2 Where interactions with the tobacco industry are necessary, Parties should ensure that such interactions are conducted transparently. Whenever possible, interactions should be conducted in public, for example through public hearings, public notice of interactions, disclosure of records of such interactions to the public.”

Furthermore, the FCTC emphasises the importance of knowledge transfer, and has a strong emphasis on information sharing and exchange. Article 20 sets out the need to “...develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control” (WHO 2003). This study points to the need for future research into the hypothesis revealed; that it is conceivable that governments led by a number of progressive females, might be more inclined than “conservative white males” to follow evidence-based public policy, and to act on appropriate recommendations. The events that signalled this theory occurred after the main collection of data and examination of documents took place, and therefore it was not examined in any depth, tested or compared with other jurisdictions. In the context of significant global policies such as climate change action and public health initiatives, this is a particularly salient concern. The construction of evidence-based policies implemented by groups of progressive female leaders, and whether there are gender and political orientation differences, should be studied in other countries, provinces and states. Commonwealth governments must take a greater interest in small states and territories such as Tasmania and the Northern Territory, which both have very high smoking rates. The small size of these jurisdictions means that they lack resources to undertake tobacco-control measures. Small jurisdictions lack research resources, well-funded independent advocacy organisations, and the bureaucratic infrastructure, including legal resources, to combat the tobacco industry. Australia should not leave small rural and remote jurisdictions in the wake of big cities, for their populations to suffer immensely greater health

problems than mainland capitals. Furthermore, small Pacific countries experience similar problems with tobacco control, tobacco industry interference, lack of resources, lack of support from non-health government agencies and lack of NGO support (Martin 2013); and larger more powerful and resource-rich neighbouring countries such as Australia should assist. Additional provision of resources, including infrastructure, to smaller states and territories must be a priority to ensure fairness of health outcome for all Australians.

Perhaps the time is right for in-depth consideration of the role of ideas in tobacco-control policy, rather than relying entirely on the transfer of evidence. Smith found that evidence has limited traction in policy debates and, "... it is the ideas and concepts generated through public health research that travel into public health policy" (Smith, 2013). Smith says that politics has been portrayed as a barrier to rational decision making. This study certainly found that politicians have proved to be a barrier to evidence-based tobacco-control policy. Maybe "charismatic" and "chameleonic" ideas (Fafard 2015) such as the tobacco-free generation proposal (Berrick 2013; Walters 2015), which was endorsed by 2015 World Conference on Tobacco or Health (WCTOH 2015) might take centre stage in tobacco control in the future. It could be that such ideas take root and transform the tobacco-control environment, and engage the imaginations of politicians and the community, without abandoning the imperative for comprehensive evidence. New ideas have to be tried somewhere, then evaluated. Plain packaging had a very strong but limited evidence base before being introduced, because it had never actually been implemented. The reduced appeal and increased health warning effectiveness of plain packaging proved successful (Wakefield 2015). The research on plain packaging led the push for its adoption. Therefore, the idea that sound research can act as a prompt to stimulate charismatic or new ideas is worth pursuing.

Politicians must make an effort to seek out and act on the best advice, not just from bureaucrats, but from researchers and scientists. They must be prepared to listen to independent qualified experts, new ideas, and not be swayed by "junk science" provided by self-interested industry bodies (Samet 2001). Premiers and cabinet ministers must genuinely endorse healthy public policies within all government agencies, and not allow distractions of immediate crises and emergencies to divert them from such goals. Independent politicians and backbenchers should be encouraged by evidence that they can influence policy on tobacco control, as being persistent, asking pertinent questions, using research, and being involved in parliamentary committees has an effect (Hooker 2006). Bureaucrats must ensure that their systems are flexible, innovative, and flow smoothly without the constant speed-

bumps of unwieldy committees. Consultation is necessary, but repeated iterative consultation processes should be curtailed. Well-funded national non-government organisations should recognise that their smaller state bodies cannot support or sustain significant research, advocacy and infrastructure, and must provide support and assistance in order to achieve nationally fair and equitable health outcomes for all Australians.

It is vital in Tasmania to adopt healthy public policy, prevention measures and address the social determinants of health. However, such policy instruments will not be adopted unless the corporate vectors of disease, including the tobacco industry, are held at arm's length from decision making, and venal industry agendas exposed, tackled and overthrown.

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Glossary Tasmanian Government committees and departments, and other acronyms

Acronym	Organisation or explanation
<i>ABS</i>	Australian Bureau of Statistics. Collects Australian statistics on many topics. Differs from AIHW.
<i>ACF</i>	Advocacy Coalition Framework. A concept – not an organisation.
<i>ACOSH</i>	Australian Council on Smoking and Health (ACOSH). An independent, non-government, not-for-profit tobacco-control advocacy coalition of prominent West Australian health, education, community, social service and research bodies. Mainly operating in Western Australia.
<i>ADS</i>	Alcohol and Drug Service
<i>AIHW</i>	Australian Institute of Health and Welfare. A national agency. Produces health and welfare information and statistics. Differs from ABS.
<i>AHA</i>	Australian Hotels Association
<i>ALP</i>	Australian Labor Party, also known as Labor.
<i>AMA</i>	Australian Medical Association. Also an acronym for the American Medical Association, however, this is differentiated in the text.
<i>ANCD</i>	Australian National Council on Drugs
<i>ASH</i>	Action on Smoking and Health, Australia. A major tobacco-control advocacy organisation. Based in Sydney and provided advocacy for the eastern states and NT. Now defunct. Provided much support to Tasmanian NGOs during the 1990s and 2000s until it was abolished in 2013.
<i>ATODC</i>	Alcohol Tobacco and other Drugs Council (a peak NGO funded by government with only one tobacco-control organisation member).
<i>ATODSC</i>	Alcohol Tobacco and other Drugs Steering Committee – a Department of Health and Human Services Committee, which dealt with all drugs issues including tobacco, alcohol and illicit and reported to the IAWGD.
<i>BATA</i>	British American Tobacco Australia.
<i>BLT</i>	Butt Littering Trust. Front organisation for the tobacco industry. Now defunct.
<i>BT</i>	British Tobacco. Also formerly part of or known as WD and HO Wills, Amatil.

Acronym	Organisation or explanation
<i>CDC</i>	US Centers for Disease Control and Prevention.
<i>DOTAF</i>	Department of Treasury and Finance, Tasmania
<i>DHHS</i>	Department of Health and Human Services, Tasmania.
<i>DOHA</i>	Department of Health and Ageing, Commonwealth.
<i>DPAC</i>	Department of Premier and Cabinet, Tasmania.
<i>DPEM</i>	Department of Police and Emergency Management. Structurally included the Fire Service and the Police Department. Tasmania.
<i>DPIWE/DPIPWE</i>	Department of Primary Industry Parks Water and Environment. This Department has changed its name and composition several times during the period examined by the thesis. Parks and Environment Divisions have been moved to and from other Departments. Tasmania.
<i>EBPH</i>	Evidence-based Public Health.
<i>ETS</i>	Environmental tobacco smoke. Also known as second-hand smoke (SHS); passive smoking; tobacco smoke pollution.
<i>FCTC</i>	Framework Convention on Tobacco Control. WHO Framework Convention on Tobacco Control (WHO FCTC) is the first international treaty negotiated under the auspices of WHO. It was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. Australia ratified it in 2004. Article 5.3 is particularly relevant to this thesis, and concerns the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry.
<i>FDA</i>	U.S. Food and Drug Administration.
<i>HBI</i>	Healthy Buildings International, a tobacco industry front organisation.
<i>HLCG</i>	Healthy Lifestyle Cluster Group. A Tasmania Together Committee
<i>HLIDG</i>	Healthy Lifestyles Inter-Departmental Group. Not sure how this differs from similarly named groups. Mentioned in memo to Minister from Mary Bent 10/12/2003
<i>HTA</i>	Health Technology Assessment
<i>IAPCC</i>	Inter-Agency Policy Co-ordination Committee
<i>IAWGD</i>	Inter-Agency Working Group on Drugs.
<i>IDHWCG</i>	Inter Departmental Health and Wellbeing Cluster Group – formerly the Healthy Lifestyle Cluster Group

Acronym	Organisation or explanation
IGCD	Inter-Governmental Committee on Drugs
LHMU	Liquor and Hospitality and Miscellaneous Workers Union, now United Voice.
MCDS	Ministerial Council on Drug Strategy
MHA	Member of the House of Assembly, Tasmania. The House of Assembly is the Lower House and provides the government for Tasmania. It is dominated by political parties, Labor, liberals, Greens. Legislation is initiated in this House.
MLC	Member of the Legislative Council. The Legislative Council is the Upper House, and mainly comprises independents and a few members of political parties. It primarily reviews government legislation emanating from the House of Assembly, and has been described as the most powerful Upper House in the world, as it can defeat money bills. Members can introduce their own legislation, Private Members' Bills, but this is rare. Occasionally a government will appoint one of its members as a Minister.
MP	Member of Parliament. A non-specific term that means a member of any house of parliament in any jurisdiction in Australia.
MTCP	Massachusetts Tobacco Control Program (USA)
NAA	National Archives of Australia
NDS	National Drug Strategy
NGO	Non-government organisation.
NTS	National Tobacco Strategy
OECD	Organisation for Economic Co-operation and Development
PHAIW	Public Health Advocacy Institute of Western Australia. Established in 2008. PHAIWA is an independent public health advocacy and research organisation based within Curtin University.
PEHS	Public and Environmental Health Service. Included in Population Health Services within DHHS.
PHA	Public Health Association
PM	Phillip Morris – tobacco company
SES	Socio-economic status
SPU	Social Policy Unit. Section of DPAC.
TAP	Tobacco Action Plan
TC	Tobacco Coalition. DHHS Committee, which includes stakeholders from health groups, and independent experts. Some other government agencies are

Acronym	Organisation or explanation
	occasionally represented. It produces the Tobacco Action plan. Secretariat support is provided by an officer from PEHS.
<i>TCGG</i>	Tobacco Coalition Governance Group, sometimes just called the Governance Group – oversees the operation of the Tobacco Coalition
<i>UCSF</i>	University of San Francisco California. UCSF Library and Center for Knowledge Management host the Truth (also known as Legacy) Tobacco industry documents, an archive of 14 million documents created by tobacco companies about their advertising, manufacturing, marketing, scientific research and political activities.
<i>WHO</i>	World Health Organisation

END