

## Article

# Tobacco and nicotine population health planning for Aboriginal and Torres Strait Islander population growth

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## Abstract

Aboriginal and Torres Strait Islander population growth has important implications for tobacco and nicotine health planning. Using the Australian Bureau of Statistics (ABS) DataLab, we examined weighted estimates of the absolute number of Aboriginal and Torres Strait Islander peoples aged 18 years and over, drawing on the 2012–13 and 2018–19 National Aboriginal and Torres Strait Islander Health Surveys. We compared the absolute number of people who currently smoke, stratified by age, state/territory, and sex. There was a 2.5 percentage point decline in smoking prevalence over this period, but the estimated number of Aboriginal and Torres Strait Islander adults who smoke increased by ~43 000, reaching 211 000 (95% confidence interval: 199 746–221 616) in 2018. This growth is largely attributable to population increases driven by higher birth rates. Absolute increases in both the number of people who smoked and those who did not smoke varied by age group, jurisdiction, and geography, with the largest increases observed among those aged 55–64 years and in areas experiencing the most rapid population growth. These findings highlight the need for programs, policies, and health services—including tobacco and nicotine resistance measures—to be adequately resourced and responsive to changing Aboriginal and Torres Strait Islander population dynamics. While progress is being made in reducing smoking prevalence, the expanding population means that the total number of people impacted by commercial tobacco remains high. This highlights the need for sustained future-focused planning and investment to eradicate tobacco-related death and disease.

**Keywords:** tobacco; epidemiology; population health; public health; public policy; Indigenous; Aboriginal health

### Contribution to Health Promotion

- Aboriginal and Torres Strait Islander population growth means more people are impacted by the tobacco industry and collaborators, despite declining smoking prevalence.
- Tobacco resistance efforts must scale up and adapt to changing community, age, and geographic patterns.
- Structural reforms, including enforcement of retail tobacco laws, are essential to eradicate tobacco-related harms and industry reach.
- Programs and policies should be guided by population trends to ensure equity and cultural safety and improve health and well-being outcomes.
- A future-focused approach is needed to strengthen prevention and protect the health of current and future generations.

## INTRODUCTION

Understanding trends in Aboriginal and Torres Strait Islander population growth is critical for effective public health and

health promotion planning. Between 2016 and 2021, the Aboriginal and Torres Strait Islander population increased by 25%, from 649 171 to 814 728 peoples (2023). This

growth is driven by births and migration, as well as improved Census identification methods (Australian Bureau of Statistics 2023) and improved adjustment for undercounts (Williamson *et al.* 2021). It also reflects a young population structure (mean age = 24 years) and contrasts with aging and population decline observed in many Settler societies (Australian Bureau of Statistics 2022). Population growth, combined with the unique health and demographic profile of Aboriginal and Torres Strait Islander peoples, shapes where public health and health promotion programs are needed and the characteristics of the populations and communities they serve.

Taking into consideration this rapid population growth and unique demographic profile is particularly important for addressing specific health challenges, such as smoking. For example, a reduced percentage in smoking prevalence does not necessarily equate to a lesser need for resources, especially if the absolute number of people who smoke rises. Aboriginal and Torres Strait Islander peoples experience significant health risks from commercial tobacco products due to the lasting and ongoing influence of colonization (Colonna *et al.* 2020), racism (Brady 2002), and the active role of the tobacco and nicotine industry (Waa *et al.* 2020). These factors have contributed to smoking being the leading cause of burden of disease, responsible for more than one-third of deaths among Aboriginal and Torres Strait Islander peoples (Thurber *et al.* 2021).

Despite these factors, smoking prevalence among Aboriginal and Torres Strait Islander adults is declining. By 2018, smoking prevalence reduced to 40%, a reduction of 10 percentage points from 2004. The largest declines in smoking prevalence occurred among younger age groups and those living in urban and regional Australia (Maddox *et al.* 2020). This reduction occurred with Aboriginal and Torres Strait Islander leadership driving smoke-free norms, alongside increased resourcing such as funding and support for tobacco control programs and policies. This has continued the increasing normalization of smoke-free behaviors, with most Aboriginal or Torres Strait Islander peoples who smoke wanting to quit or wishing they never started (Nicholson *et al.* 2015, Kennedy *et al.* 2022).

Declining smoking prevalence within a growing population means the overall number of people who smoke may also change, requiring careful consideration for tobacco and nicotine health programming and policy. Therefore, this study aims to assess how changes in population growth impact the absolute number of Aboriginal and Torres Strait Islander peoples who smoke and to explore the implications for tobacco and nicotine resistance efforts, service demand, and public health planning, implementation, and evaluation.

## METHODS

### Sample

We used data from the 2012–13 and 2018–19 National Aboriginal and Torres Strait Islander Health Surveys (NATSIHS), accessed via the Australian Bureau of Statistics (ABS) DataLab. NATSIHS is a nationally representative survey using stratified, multistage sampling and face-to-face interviews to collect health data of Aboriginal and Torres Strait Islander people across all regions. Based on ABS procedures, the survey samples were weighted to population benchmarks to account for undercoverage (Australian Bureau of Statistics 2019). The population benchmarks were derived from the estimated resident Aboriginal and Torres Strait

Islander population from the Census of Population and Housing, with adjustments made for the timing of each survey. For example, the projected Aboriginal and Torres Strait Islander population at 31 December 2018 was 814 013, and this was used as the benchmark for the 2018–19 survey.

### Measures

Smoking prevalence was assessed using the Currently Smoking Indicator from the NATSIHS. The numerator included Aboriginal and Torres Strait Islander adults aged 18 years and over who reported smoking currently, while the denominator comprised the total adult survey population. Estimates were calculated for both the absolute number and the prevalence of adults who currently smoked (daily or less than daily). These estimates were stratified by age, sex, and state/territory.

### Statistical analysis

We used Stata MP18.0 (StataCorp LLC, College Station, TX, USA) within the ABS DataLab environment to calculate weighted estimates. The analysis first examined trends in Aboriginal and Torres Strait Islander population growth and demographic characteristics between 2012 and 2018. We then assessed the implications of this growth for tobacco and nicotine population health planning by comparing changes in smoking prevalence and absolute numbers between the two surveys. Confidence Intervals (CIs) were estimated using the jackknife resampling method, and all results are specific to the Aboriginal and Torres Strait Islander population.

### Positionality and ethics approval

Understanding the importance of relationality and our roles, responsibilities, and credentials is critical in this work. This awareness requires us to consider our connections, biases, and worldviews, which are time, place, and space specific (Moreton-Robinson 2017). By privileging and adhering to our logics, we develop a better understanding of who we are, who we assert ourselves to be, and who asserts us, as well as how we are interconnected. This is important for our understanding of existence (ontology) and knowledges (epistemology), where our relationships shape the epistemological framework that guides the work. Our contribution to this study reflects this relational approach, emphasizing the interconnectedness of the work and respective communities. This research is supported by Aboriginal and Torres Strait Islander governance through Thiitu Tharrmay, Aboriginal and Torres Strait Islander executive leadership through the Tobacco Free Executive as well as Aboriginal and Torres Strait Islander lived experience (R.L., L.J.W., M.K., and C.C.), Indigenous lived experience (R.M.) experience in Indigenous health research (R.L., C.H., L.J.W., M.K., C.C., and R.M.), Indigenous tobacco research (all authors), and epidemiology (all authors).

We acknowledge the participation and contributions of Aboriginal and Torres Strait Islander peoples in national data collections, including the ABS and other government sources. However, Aboriginal and Torres Strait Islander peoples do not necessarily have oversight, governance, or decision-making authority over these data collections. The Tobacco Free Program upholds and actively engages in Indigenous Data Sovereignty Principles, as articulated by Maïam nayri Wingara and consistent with the World Health

Organization's Framework Convention on Tobacco Control. This includes ensuring Aboriginal and Torres Strait Islander governance, control, and self-determination across the data processes Aboriginal and Torres Strait Islander peoples can control, including developing programs of work, research questions, data analysis, interpretation, use, and dissemination. Aboriginal and Torres Strait Islander peoples were actively involved in the design, analysis, interpretation, and dissemination of findings aligning with established standards for conducting ethical research ([The National Health and Medical Research Council, 2007](#)). This study was also conducted under The Australian National University HREC protocols 2019/654 and 2017/013. Additional ethical approval details are available upon request.

## RESULTS

### Aboriginal and Torres Strait Islander population growth

As shown in [Table 1](#), from 2012–13 to 2018–19, the total estimated Aboriginal and Torres Strait Islander adult population (aged 18 and over) increased significantly by 120 000, from 366 000 (95% CI: 352 000–379 000) to 486 000 peoples (95% CI: 472 000–500 000). This population growth was

consistent for males and females, with increases of 54 000 and 66 000 respectively. Growth was also observed across all age groups, with the largest increases in the 25–34 years (31 000 peoples) and 55–64 years (23 000 peoples) age groups. Among states and territories, New South Wales (49 000 peoples) and Queensland (31 800 peoples) experienced the strongest population growth.

### Aboriginal and Torres Strait Islander tobacco use prevalence

From 2012–13 and 2018–19, the estimated absolute number of Aboriginal and Torres Strait Islander peoples aged 18 years and over who smoke increased by 43 000 peoples from 168 000 (95% CI: 159 667–175 540) to 211 000 (95% CI: 199 799–221 797) peoples. This increase in the absolute number of Aboriginal and Torres Strait Islander people who smoke occurred despite a decline in the proportion of people who smoke, from 45.8% (95% CI: 43.6–48.0) to 43.3% (95% CI: 41.1–45.6). Increases were similar for females (21 200 peoples) and males (22 000 peoples). According to age, the largest increase in people who currently smoke was among those aged 55–64 years (15 300) compared with the smallest increase among those in the 18- to 24-year age band (4000). For states/territories, the largest increases were observed in

Table 1. Number of Aboriginal and Torres Strait Islander peoples who currently smoke and smoking prevalence, 2012/13–2018/19, for all adults by age group, sex, and state/territory.

	2012/13		2018/19		Change from 2012/13 to 2018/19	
	Number of people who smoke/total population ('000s)	Smoking prevalence % (95% CI)	Number of people who smoke/total population ('000s)	Smoking prevalence % (95% CI)	Estimated mean difference in the number of people who smoke ('000s) (95% CI), P value	Difference in the number of people ('000s)
Total adult population	168/366	45.8 (43.6, 48.0)	211/486	43.3 (41.1, 45.6)	43.2 (29.4, 57.0)	120
Age group, years						
18–24	38/85	44.7 (40.3, 49.0)	42/106	39.5 (34.3, 44.7)	4.0 (2.8, 10.8)	21
25–34	47/87	54.6 (50.4, 58.7)	56/118	47.3 (42.3, 52.4)	8.5 (1.5, 15.6)	31
35–44	38/78	48.9 (44.6, 53.1)	42/84	49.8 (44.5, 55.1)	3.6 (–2.2, 9.3)	6
45–54	29/60	48.5 (43.1, 53.9)	37/82	44.9 (39.3, 50.5)	7.5 (2.1, 13.0)	22
55–64	11/35	31.8 (26.8, 36.9)	26/58	45.9 (39.8, 52.0)	15.3 (11.5, 19.2)	23
≥65	4/22	19.4 (14.1, 24.7)	8/40	21.1 (16.1, 26.1)	4.9 (1.8, 6.5)	18
Sex						
Male	85/179	47.4 (44.5, 50.4)	107/233	45.7 (42.0, 49.4)	22.0 (11.8, 32.1)	54
Female	83/187	44.3 (41.7, 46.8)	104/253	41.1 (38.3, 44.0)	21.2 (12.5, 30.0)	66
Jurisdiction						
NSW	49/114	43.2 (38.0, 48.5)	65/163	39.7 (35.0, 44.4)	15.5 (5.6, 25.4)	49
QLD	47/101	46.2 (41.9, 50.4)	60/133	45.4 (40.2, 50.5)	13.6 (5.4, 21.8)	32
NT	22/39	56.0 (51.3, 60.6)	27/47	57.8 (54.9, 62.0)	5.1 (2.3, 7.9)	8
WA	21/48	44.9 (40.4, 49.4)	27/60	45.3 (39.3, 51.4)	5.5 (1.3, 9.7)	12
VIC	12/26	45.3 (39.3, 51.3)	13/36	36.7 (30.3, 43.0)	1.1 (–1.6, 3.9)	10
SA	9/21	44.9 (39.0, 50.7)	10/26	39.9 (32.4, 47.5)	1.0 (–1.3, 3.3)	5
TAS	6/14	43.8 (37.9, 49.6)	7/18	40.1 (36.6, 47.3)	1.4 (–0.2, 2.9)	4
ACT	1/4	32.1 (24.1, 40.2)	1/5	24.9 (14.2, 35.5)	0.049 (–0.5, 0.6)	1

NSW, New South Wales; QLD, Queensland; NT, Northern Territory; WA, Western Australia; VIC, Victoria; SA, South Australia; TAS, Tasmania; ACT, Australian Capital Territory.

NSW (15 500 peoples) and Queensland (13 600 peoples) which also had the strongest population growth.

## DISCUSSION

The strong population growth among Aboriginal and Torres Strait Islander peoples between 2012–13 and 2018–19 highlights the dynamic demographic context within which public health strategies must operate. With an increase of 120 000 adults in 6 years, this growth reflects a young and expanding population, particularly in New South Wales and Queensland and among specific age groups such as 25–34 and 55–64 years. Such rapid growth underscores the need for public health programs that are both scalable and adaptable to address the diverse needs of a growing population distributed across jurisdictions and age groups. The proportion of Aboriginal and Torres Strait Islander peoples has steadily increased in each Census since 2001, rising from 2.4% to 3.8% in 2021 and may be conservative due to several factors. This growth is not solely due to demographic factors but also reflects changes in identification methods, improved Census engagement mechanisms, and adjustments for undercounts, particularly for young children in previous Censuses (Williamson *et al.* 2021).

At the same time, the absolute number of Aboriginal and Torres Strait Islander adults who do and do not smoke is increasing, despite declining smoking prevalence. This paradox is explained by strong population growth: while a larger proportion of the population does not smoke, the total number of people exposed to the harms of the Tobacco and Nicotine Industry continues to rise. These trends highlight the need to consider population growth when planning tobacco and nicotine public health strategies, particularly in areas with strong demographic expansion, highlighting the urgency of increasing efforts to reduce commercial tobacco and nicotine use and mitigate its associated harms, disease, and death (Eades and Chamberlain 2015). Smoking remains a major driver of preventable diseases, including cancer, respiratory disorders, and heart disease (Larsson and Burgess 2022), and the rising number of people exposed to the tobacco and nicotine industry and who smoke will likely exacerbate demands on health services, including the forthcoming National Lung Cancer Screening Program starting in 2025. Aboriginal and Torres Strait Islander and mainstream health services must enhance resources, capacity, and capability to manage and treat tobacco-related illnesses effectively (Taylor *et al.* 2021).

Tailored tobacco resistance programs and policies are essential to address the growing number of Aboriginal and Torres Strait Islander peoples who smoke, as well as those who do not smoke. This includes focused efforts in areas with the largest increases in people who smoke, such as New South Wales and among peoples aged 55–64 years, without reallocating existing resources from other regions to address smoking prevalence. Instead, resources should align with the level of need to ensure programs reach the appropriate scale.

At the same time, a strong focus on prevention is crucial. Those aged 0–19 years make up 75% of the entire population growth (2023). Therefore, investing in youth prevention and exposure reduction strategies is critical. Declining smoking rates among young Aboriginal and Torres Strait Islander peoples demonstrate the success of current efforts and highlight the opportunity to reinforce smoke- and nicotine-free initiatives as young people transition into adulthood (Heris *et al.*

2020). These measures could significantly reduce future smoking rates and improve Aboriginal and Torres Strait Islander health outcomes.

These findings emphasize the importance of finer geographic analyses to better inform commercial tobacco and nicotine resistance efforts. While state and territory-level data highlight key trends, more detailed local-level data collection is critical. Enhanced data collection approaches, such as including tobacco and nicotine use-related questions in census surveys, death certificates, cohort studies, and reporting tobacco sales through retail licensing could improve planning, monitoring and evaluation, including informing tobacco resistance strategies (Wright *et al.* 2018).

Although this analysis used the most recent available data at the time, it does not account for subsequent shifts in smoking trends since the 2018–19 NATSIHS. Analyses with updated data are needed, especially given recent changes and reforms in smoking and nicotine policies. Additionally, the undercount in the Aboriginal Estimated Resident Population data poses challenges for comparing population growth and changes in smoking prevalence.

Despite the increasing number of people who smoke, substantial progress is evident as smoking prevalence continues to decline, and the number of Aboriginal and Torres Strait Islander peoples who do not smoke rises. This progress presents an opportunity to further reduce the number of people who smoke through comprehensive tobacco resistance strategies, including supply and demand reduction measures to eradicate tobacco-related death and disease (Chamberlain *et al.* 2017). Meeting the National Tobacco Strategy's target of reducing smoking prevalence to 27% by 2030 requires accelerated efforts and structural changes. The most recent figures from the 2022–23 NATSIHS report a prevalence of 34.4%, underscoring the urgent need to intensify efforts to meet the target (Australian Bureau of Statistics 2024). Reducing tobacco availability through measures like limiting retail licenses can be pivotal in achieving this goal, especially as declining prevalence can help foster stronger public support and reinforce smoke-free norms.

While our analysis focuses on Aboriginal and Torres Strait Islander population trends in Australia, we recognize that similar dynamics related to tobacco-related harms and population growth are relevant in other contexts. Insights from Indigenous populations in Aotearoa New Zealand, Brazil, Canada, and the USA, e.g., could highlight shared challenges, offer valuable context, and inform the broader relevance and utility of this work. This aligns with the World Health Organization's Framework Convention on Tobacco Control, which emphasizes the central role of Indigenous peoples in the design, implementation, and evaluation of tobacco control policies (World Health Organization 2003). This can help inform local, national, and international efforts to eradicate commercial tobacco-related harms.

More broadly, these findings reinforce the need for structural reform alongside health promotion. Meaningful progress requires strengthening commercial tobacco resistance efforts but also dismantling the commercial systems that continue to profit from addiction, illness, and death (Maddox and Bradbrook 2025). As the number of Indigenous and non-Indigenous peoples affected by the tobacco and nicotine industry continues to grow, responses must be grounded in justice, equity, and systemic change (Maddox and Bradbrook 2025).

## CONCLUSION

This paper underscores the critical importance of understanding shifting Aboriginal and Torres Strait Islander population dynamics for the development, implementation, monitoring, and evaluation of programs and policies. This is vital for initiatives targeting health, well-being, and efforts to close the gap in health outcomes.

As demonstrated in this paper, addressing tobacco and nicotine harms requires a nuanced understanding of population growth, including the absolute number of Aboriginal and Torres Strait Islander peoples who do and do not smoke. The findings highlight an urgent need for structural changes to tobacco supply and the expansion of tobacco resistance and exposure programs and policies.

To effectively meet the current and future health and well-being needs of Aboriginal and Torres Strait Islander peoples, it is crucial to scale up existing processes and tailor strategies to account for the demographic and spatial shifts within this growing population. These shifts must inform targeted approaches to eradicate tobacco-related harms while ensuring policies remain responsive, equitable, and impactful.

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## Author contributions

R.M.T. led the initial drafting of the manuscript. All authors made substantial contributions to the conception and design of the work; the acquisition, analysis, or interpretation of data; and the critical revision of the manuscript for important intellectual content. All authors approved the final version to be published and agree to be accountable for all aspects of the work, ensuring its accuracy and integrity.

## Conflict of interest

None declared.

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## Data availability

The data used in this study were accessed through the ABS DataLab in accordance with ABS protocols and processes. This study recognizes the critical importance of Indigenous Data Sovereignty Principles, which assert that Aboriginal and Torres Strait Islander peoples have the right to self-determination in the collection, ownership, and use of their data. Researchers are strongly encouraged to respect, uphold, and integrate these principles in the design, analysis, and reporting of Indigenous data. Applications for access to ABS datasets can be made by following the ABS application procedures, with detailed information available on the ABS website.

## Ethical statement

Aboriginal and Torres Strait Islander peoples were actively involved in the design, analysis, interpretation, and dissemination of findings aligning with established standards for conducting ethical research (National Health and Medical Research Council 2018). This study was also conducted under The Australian National University HREC protocols 2019/654 and 2017/013. Additional ethical approval details are available upon request.

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