Use and abuse of statistics in tobacco industry-funded research on standardised packaging

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ABSTRACT

In this commentary we consider the validity of tobacco industry-funded research on the effects of standardised packaging in Australia. As the first country to introduce standardised packs, Australia is closely watched, and Philip Morris International has recently funded two studies into the impact of the measure on smoking prevalence. Both of these papers are flawed in conception as well as design but have nonetheless been widely publicised as cautionary tales against standardised pack legislation. Specifically, we focus on the low statistical significance of the analytical methods used and the assumption that standardised packaging should have an immediate large impact on smoking prevalence.

An increasing number of countries are considering legislation to enforce standardised tobacco packaging (also known as ‘plain packaging’) consistent with the Framework Convention on Tobacco Control provision to prevent false, misleading or deceptive labelling. Tobacco industry resistance to such legislation is increasing, as demonstrated by their funding of two working papers which claim that standardised packaging has had no impact on smoking prevalence in Australia, the first country to have successfully introduced this measure. 2 3

The first working paper focused on children aged 14–17 years and the second on adults. The former has been criticised thoroughly elsewhere, 4–6 but although the authors reject these criticisms, 7 the second shares many of the same flaws and biases. There are two core issues to consider. The first is that the introduction of standardised packaging is not expected to have a sudden impact on smoking prevalence, but rather to impact on the rate of smoking uptake. The second is that both papers are not in fact powered to detect any plausible impact. We examine the arguments in detail and focus on the second paper, on adults, though our observations apply to both.

Both working papers use the Roy Morgan Single Source (Australia) data set, from January 2001 to December 2013, and calculate monthly smoking prevalence over the period. The authors assert that the data for the working paper on children are publicly available, although they have to be purchased. They note that data for the adult working paper were “provided to us by Philip Morris International.”

In both papers, the authors first construct a linear time trend of the decline in smoking prevalence over an extended period before the introduction of standardised packaging, which has been driven by a range of tobacco control measures. The papers then assess whether the observed decline after the standardised packaging measure was introduced significantly exceeds the level predicted by the linear trend. To do so they assess whether the deviations from this trend are different in the year after the legislation compared to the year before, and finally they compute 90% CIs around the monthly prevalence figures to see if these span the extended trend line. These working papers show that the declining trend in smoking prevalence averaged 0.48 percentage points per year at all ages in Australia over the period (and 0.44% for children) and continues to fall at a similar rate after the introduction of standardised packaging. This is interpreted as a lack of evidence for effectiveness of the measure.

Such a continued decline is likely a positive sign given that, as prevalence reaches very low levels, the proportion of more addicted smokers who find it more difficult to quit increases. 8 This therefore means that a continuation of the same rate of decline in this context, rather than a levelling off, in fact likely represents an increase in effectiveness of tobacco control measures. Any determination of statistical power in the analysis presented needs to rest on the assumption that the new legislation would increase the rate of decline, rather than simply retaining it.

A sudden decline in smoking prevalence was not envisaged in this legislation, 9 with any effect expected to be predominantly around initiation of smoking rather than rates of quitting. Experts who had commented on the legislation prior to implementation (in a research paper cited by the authors in their working paper on adults) estimated that even 2 years would be too short a timespan in which to witness the full impact of standardised packaging measures. 10 Hence, the immediate effect being sought is implausible, partly due to these time lags and partly due to the inadequacy of prevalence as a measure in this context. The nature of addiction is such that any impact on quitting is likely to take place over several years and a small increase in the rate of decline may be more realistic than an immediate dramatic fall in prevalence.

Even if the assumption of an immediate decline is accepted, the analysis of statistical power in both papers is opaque. The authors claim that ‘the power of our inference models is remarkably high’, supporting their argument with results of Monte Carlo simulations, and calculating a power of 0.85 to detect a 0.5% reduction in prevalence. These calculations are based on achieving statistical significance in any 1 of 12 tests, and the authors fail to emphasise that these high-power calculations result from considering all tests simultaneously.
The publication of the initial paper on children was in the lead up to the publication of the Chantler review on standardised packaging in England, which, despite this, supported it as a means to reduce smoking. There is a continuing need to guard against such misrepresentations of the evidence as other countries look to Australia to inform their own policies of standardised packaging. Nevertheless, despite such opposition from the tobacco industry the most recent Australian government data show that smoking rates have in fact fallen to a historic low of 12.8%.13 There is also additional positive news in that other countries, including the UK, New Zealand and Ireland, are also now moving towards the introduction of standardised packaging to protect the health of their populations.
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Data sharing statement The data from the original papers comes from the Roy Morgan Single Source (Australia) dataset, which is available for a fee. The data used in this manuscript has been ‘reverse engineered’ from published material—details will be posted on the website of PD.

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