SARRAH
Services for Australian Rural and Remote Allied Health

25 March 2022

Attention: National Tobacco Strategy secretariat
Department of Health
GPO Box 9848
Canberra ACT 2601

Email: tobacco.control@health.gov.au

Dear Secretariat,

National Tobacco Strategy 2022-2030: Consultation Draft: SARRAH response

Thank you for the opportunity to provide comment on the draft National Tobacco Strategy (NTS) 2022-30. We provide the attached detailed comments to supplement the on-line submission lodged on 24 March.

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by and as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

In short, SARRAH strongly supports a renewed and updated commitment to Australia's national effort to reduce tobacco use and associated additions. As an overview comment, the draft Strategy provides a clear and coherent basis and approach for continuing this work. We note, however, some stakeholder concerns that the intensity of continued effort may have waned in recent years. With refinement, a commensurate and sustained resource commitment we believe the targets identified in overall reduction of tobacco/nicotine use across the community, and importantly, among those groups of the population at greatest risk of take up and continued tobacco/nicotine use are worthy of strong support.

The draft Strategy clearly describes the significant improvements to date and the importance of continuing Australia's well established and exemplary approach to a broadly-based and preventive approach to improving population health outcomes. As noted, the key issues and driving consideration include:

- Tobacco smoking remains the leading cause of preventable death and disability in Australia;
- Significantly reducing and eventually eliminating tobacco use in Australia would dramatically reduce illness, increase quality of life, and reduce health, social and economic inequalities for smokers;

- It also contributes substantially to long-term economic and fiscal policy objectives, not least through increased workers' economic productivity and reduce the burden on health and social support services and the impacts on individuals who provide care and whose own circumstances may be adversely affected as a result;
- It complements the National Preventive Health Strategy 2021–2030, released on 13 December 2021; the proposed Primary Health Care Plan, proposed National Cancer Plan; the National commitment to Close the Gap and many other current and proposed plans and strategies.

The following comments respond to specific questions put in the on-line consultation.

8. Do you agree with the goals and smoking prevalence targets for the draft NTS 2022-2030?

- Agree.
- Comment:

The approach to tobacco use reduction has proven to be effective and it should continue, with substantial resource commitment. The draft Strategy rightly points to the continued prevalence of smoking among identifiable populations, including some that face considerably greater risk of disadvantage.

The Goal describes the wide, negative impact of tobacco use, while identifying the breadth of policy responses that would contribute to addressing it: *"to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes."*

The Goal also draws a clear link between the use of tobacco, the social determinants of health and other correlating factors, including remoteness.

> ***Other populations with a high prevalence of tobacco use or at a higher risk of harm from tobacco use***
> *Progress in reducing smoking prevalence was also seen across all levels of remoteness in Australia. Between 2011–12 and 2017–18, daily smoking prevalence among adults aged 18 years and over declined from 14.7% to 12.7% among those living in major cities, from 18.5% to 15.4% among those living in inner regional Australia, and from 22.4% to 19% in outer regional and remote areas. (From Page 6)*

The close connection and overlap of identifiable at-risk populations - e.g., lower income; living in remote Australia; Aboriginal and Torres Strait Islander people – could be made more explicit. This may enhance the prospect that the Strategy will be supported as a coherent package of integrated measures, reducing the risk of a more fragmented or piecemeal approach. Coordinated and multi-pronged approaches are more likely to deliver lasting improvements. The breadth of action and approach underpinning the national commitment on Closing the Gap, co-developed and jointly led by Aboriginal and Torres Strait Islander community leaders and First Ministers, is indicative of the sort of broad based and integrated commitment needed.

9. Do you agree with the objectives for the draft NTS 2022-2030?

- Strongly agree.
- No further comment.

10. Do you agree with the guiding principles for the draft NTS 2022-2030?

- Strongly agree.
- No further comment.

11. Do you agree with the priority areas for the draft NTS 2022-2030?

- Agree.
- Comment:

In general, the priority areas warrant strong support. However, some might be amended or built on to maximise outcomes. For example, mass communication campaigns are valuable, but this priority might be strengthened considerably if it were complemented with more targeted communications and engagement campaigns directed more specifically at identified groups at risk. These could be coupled with more nuanced and tailored services, access and interventions to optimise positive results for those groups (e.g. SISTAQUIT). These issues are addressed in more detail below.

12. Do you agree with the actions listed under each priority area for the draft NTS 2022-2030?

- Agree.
- Comment:

SARRAH supports the general thrust and breadth of proposed actions. There are additional components that would complement those actions and improve the overall effectiveness of the Strategy. They include:

- Noting the effectiveness of and access to nicotine replacement therapies; from page 4:

  Nicotine replacement therapies (NRT) for smoking cessation have become increasingly accessible for individuals attempting to quit smoking through the Pharmaceutical Benefits Scheme (PBS), with the additional listing of nicotine gums and lozenges in February 2019. Other pharmacotherapies for smoking cessation, such as varenicline and bupropion, are also available on the PBS.

  The Strategy should aim to improve access to behavioural supports as well as pharamacotherapies.
  - Evidence indicates that the success rate of quitting is much higher when evidence-based behavioural support and smoking cessation pharmacotherapy are used concurrently.
  - Best practice measures should underpin and be promoted through the Strategy.
  - Consequently, access to evidence-based cessation services and support should be made available to support people who use tobacco to quit, and especially for the groups identified as being most at risk, many of whom will not have the personal resources or other circumstances to gain access.

  The strategy notes that tobacco use is strongly associated with social disadvantage and contributes significantly to health and financial inequalities in Australia.
  - *For example, in 2019, Australians living in the most disadvantaged socioeconomic areas were 3.7 times more likely than those in the most advantaged socioeconomic areas to smoke daily.*
  - Cessation support and tobacco dependence treatment might be offered to every tobacco user in every interaction within the health, mental health and alcohol and drug dependence treatment systems.
  - The Strategy could include support for AHPs to conduct intervention at a minimum, and behavioural counselling where appropriate (psychologist, community pharmacist etc).

    Given the downstream economic and other benefits of reduced tobacco use identified in the Strategy, the investment and return value of these interventions should be factored into

government decisions. These might be delivered through the MBS, targeted grants or other mechanisms.

Given the proven success of the NTS to date and the need to continue it in the likely future context of major Budgetary and fiscal restraint, the Strategy should include a clear and detailed program of actuarial assessment and performance monitoring that substantiates the medium to long-term impacts on outlays, service costs averted, personal income generation, revenue and productivity to reinforce the case for continuing investment.

- As regards the media and information campaign strategy:
  - Campaign reach, intensity and duration and the type of message determine campaign effectiveness;
  - The extent to which the campaign is effective will also depend on whether clinical and support services are also accessible and affordable (including allied health);
  - A further shift in messaging to emphasise tobacco use as an addiction and health issue requiring treatment coupled with the existing positive health benefits approach (with less focus on the lifestyle choice) may increase public willingness to engage in the discussion, and the clinician more comfortable in raising the question.

- It is not clear whether the current awareness and use of services such as Quitline are well known and utilised by all health professionals.
  - Quitline services are available for rural and remote Australians to access – including specific services for Aboriginal and Torres Strait Islander people.
  - There may be scope to monitor and report on uptake/use of these services – and develop informed strategies that actively promote & support health professionals to refer people who smoke to these services.
  - More extensive/improved monitoring and reporting on all aspects of the Strategy, with extensive stakeholder involvement could be considered.

- The Strategy notes concerns raised by some stakeholders that increasing the price of tobacco products as a deterrent to use amounts to a regressive tax, when a high proportion of population who smoke have fewer personal resources. Without commenting on the rationale behind this perspective or alternative approaches to deliver a more lasting reduction in social disadvantage, the concern does reinforce the need to ensure effective treatment and support is available and affordable to people with low incomes.
  - It is important to consider the choices and trade-offs people who are addicted to a substance will make. These may not align with other peoples' or theoretical notions of optimal resource allocation. Despite the high cost of cigarettes, many people with low disposable incomes still opt to smoke, despite facing very high stress in meeting housing, food, utilities and other costs. In light of that, any expectation people will access unsubsidised or high out-of-pocket cost services to quit smoking need to be assessed very cautiously.
  - The immediate cost is felt by the individual while the higher long-term costs are shared with them, their families and the community.

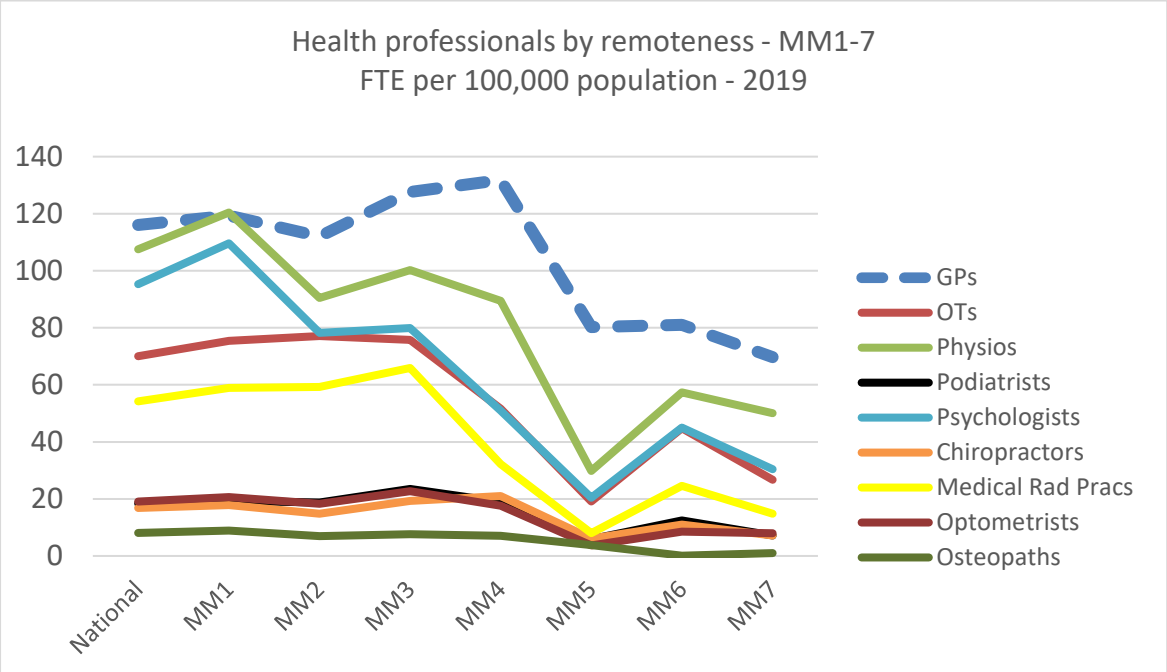
13. Please provide any additional comments you have on the draft NTS 2022-2030.

- Comment:

SARRAH suggests the Strategy include an explicit focus on service access and the workforce required to facilitate it. Plainly, and notwithstanding the availability of service options and supports such as Quitline, many people in the at-risk groups identified in the draft Strategy face significant challenges in accessing health services, compared with the broader community. Considering the number of health professionals available for a given population, it is clear that people living in rural and remote Australia will not have the same level of interaction or opportunity to access health services as people living in metropolitan centres. That is borne out by MBS and other data. This is crucial, as we know:

- The rate of smoking is higher in rural and remote areas – particularly among groups who are low SES, have mental health issues, are Aboriginal or Torres Strait Islander, are unemployed.
- Many people who smoke wish they could quit.
- Every connection with a health service professional is an opportunity to raise the question about a persons' smoking
- One in every 33 conversations about smoking results in a person quitting smoking. So, the more it is raised, the more likely that it will be the conversation that triggers the quit attempt.

For instance, the relative shortage of GPs across rural and remote Australia (mal-distribution) is well known. It reduces access to important primary health care, including treatment to assist in quitting smoking. The same issues exist in relation to allied health professionals (AHPs). Psychologists, physiotherapists, dietitians, speech pathologists are some of the AHPs with direct clinical roles in this area: discussed further below. They too are concerned about and deal with the impacts of smoking on the health of clients/patients, and about whom they often should be treating in conjunction with their medical and other colleagues. contact with other members practitioners treating that person.). The shortage of AHPs in rural and remote Australia is even more severe than for GPs and is evident in the workforce data held by the Department of Health. AHPs mal-distribution / workforce shortages in rural and remote Australia are **about twice as severe as for medical practitioners** with numbers dropping sharply on a per head of population basis with increasing remoteness.
The following graph shows the distribution by remoteness (where MMM1 is inner metropolitan and MMM7 is very remote) of a selection of AHPS and GPs. (Source: Department of Health[1])



[1] https://hwd.health.gov.au/

Clearly, there is a substantial drop off in GP to population numbers beyond regional centres and towns, but less so than for AHPs. In relation to all health professionals, those working in remote and very remote settings trying to provide services to a similar sized population may have to contend with the difficulties of providing services over an area the size of Victoria, compared with a few square kilometres in a major city: this greatly amplifies the challenges of access for rural and remote residents and effective service delivery for any primary health care professional.

We note the absence of sufficient numbers of health professionals will also have a negative impact on the capacity of services providers and other stakeholders to engage with or promote approaches identified in the Strategy, for example (from page 10):

> *New partnerships will be forged between health agencies, social service organisations, mental health care providers, and corrections services to reduce smoking prevalence and exposure to secondhand smoke among populations at a higher risk of harm from tobacco use and other populations with a high prevalence of tobacco use.*

Poor access to health professionals inhibits efforts to quit smoking as with any health issue. Compounding those access issues are direct costs (especially for those with lower income levels), the presence or otherwise of subsidised treatment options (e.g., subsidised GP visits and medications vs unsubsidised treatments by allied health professionals), distance to services, the availability or lack of cultural safety and responsive services and workforce etc.

As a further point on workforce, we note an absence of allied health or related terminology in the draft Strategy (such as “allied health”, “physiotherapist”, “occupational therapist”, “pharmacist” or “pharmacy”, “counselling” or “motivational interviewing”). The breadth of health professionals who are and/or could be involved in progressing the Strategy should be made clear to policy makers, professionals and the general public.

The Strategy will be more effective if it recognises both the potential role of all health professions and identifies structural and contextual factors that inhibit service provision and access (such as workforce distribution and costs). Further, the Strategy could contribute directly or otherwise to:

- highlighting the implications of these inhibitors on service access and health outcomes; and
- providing a framework to help having them addressed.

The following reference material may assist to inform further development of these issues and substantiate the case for building workforce related actions into the Strategy.

- Role of health professionals and social services - Tobacco in Australia
- RACGP - Supporting smoking cessation: A guide for health professionals

  From page 6 - *Effectiveness of treating tobacco dependence*
  The benefits of quitting smoking are well established. Successfully quitting smoking can result in an increase in life expectancy of up to 10 years, if it occurs early enough. There is also substantial evidence that advice from health professionals including doctors, nurses, pharmacists, psychologists, dentists, social workers and smoking cessation specialists helps smokers to quit.

- Psychologists - Psychologists and smoking cessation: Reducing the burden of smoking | APS (psychology.org.au)

- Physiotherapist – COPD, (PDF) The role of physiotherapists in smoking cessation (researchgate.net)

You might also consider the following professional roles and examples:

  - Pharmacist – Nicotine replacement therapy, interaction with other medications (see Pharmacy Guild response)
  - Speech pathologist – head/neck/oral cancers
  - Irish Research "Findings indicate occupational therapy appears to fit well within addiction treatment and assert that occupational therapy is most supportive when interventions go beyond the teaching of skills alone to prioritise occupational engagement and client centred practice."

We hope this submission assists with the further development of the Strategy and its continuing success in reducing the use of tobacco and tobacco products.

Further information about SARRAH is available at https://sarrah.org.au/

Yours sincerely,

Catherine Maloney
Chief Executive Officer