National Tobacco Strategy 2022-2030 Consultation Team
Australian Government Department of Health

ATODA's submission to consultation questions for the draft National Tobacco Strategy 2022-2030

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Introduction

The Australian Government Department of Health undertook consultations regarding the National Tobacco Strategy 2022-2030 draft review in early 2022. The Alcohol Tobacco and Other Drug Association of the ACT (ATODA) made a submission in response to the National Tobacco Strategy Draft 2022-2030 via a survey through which the Department of Health requested input. ATODA's input to that survey is provided below.

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

Goals and smoking prevalence targets

ATODA broadly supports the goals, targets, objectives and actions of the draft National Tobacco Strategy, but believes that they should place a greater emphasis on subpopulations of the Australian community where smoking rates are still high. The draft National Tobacco Strategy document misses an opportunity to be more strongly grounded in addressing the unresolved 'problem' within tobacco control. While nationally, Australia has been extremely successful at tackling tobacco use, gains have been unevenly distributed across the community.

Australians who smoke are more likely to be part of subpopulations experiencing higher levels of social, economic and health disadvantage. At the same time, subgroups within the Australian community who experience various types of social, economic and health disadvantage have higher smoking rates than other sections of the community. People who access specialist alcohol and other drug services in the ACT, for instance, not only experience health disadvantages, but also various social and economic disadvantages (e.g. homelessness, access to education, unemployment), and have a smoking prevalence rate of 77% - 5.5 times the Australian daily smoking rate. [1,2]. Data also tell us that many of these smokers want to quit, but find it difficult to access the support they need to do so.[7,6]

In order to achieve a smoking rate of 5% or less by 2030 with maximum efficiency of health expenditure, it makes sense that limited resources should be directed to provide targeted interventions to disadvantaged populations where smoking rates are still high. Such targeted interventions can be efficiently and effectively delivered through services or locations accessed for other purposes (e.g. alcohol and other drug services, mental health services, homelessness services, etc).

It is already clear that such a targeted approach in communities experiencing disadvantage works. As noted in section 1.2 of the Introduction to the draft Strategy, the significant specific investment in Aboriginal and Torres Strait Islander tobacco control activities since 2008 has contributed to the decline in smoking rates among Aboriginal and Torres Strait Islander Australians. Similar targeted and funded commitment to other subpopulations within our community could achieve similar success—this is a cost-effective approach to achieving the "less than 5%" target.

Australia has always taken a world-leading, evidence-informed and innovative approach to public health problems. The next iteration of the National Tobacco Strategy should be no exception, seizing the opportunity to achieve smoking rates of 5% or less by 2030 by taking a three-pronged approach:

1. Targeting subpopulations of the Australian community where smoking rates are disproportionately higher than in the general population with prevention activities and with specific interventions to improve availability and accessibility of nicotine dependence treatment and smoking cessation support.
2. Maintain the existing strong taxation, regulatory and legislative tobacco control mechanisms, and continue preventive messages to young people.
3. Respond to new and emerging tobacco-related products (e.g. e-cigarettes) as necessary, including through regulation, preventive activities, and with a particular focus on how these impact on subpopulations with disproportionately high smoking rates.

Tackling smoking inequality and disadvantage should be a central value guiding how this Strategy document is organised. Rather than "populations with high rates of smoking" being an aside, priority populations should be the lens through which tobacco control in Australia is approached. Such a lens will leverage investment into improving the accessibility of nicotine dependence treatment and smoking cessation support for people in these subpopulations who want to quit smoking, but currently lack adequate support to do so.

The comments provided under each of the response questions that follow, all speak to this basic central value.

Comments specific to Part One: Introduction, page 2–7, Consultation Draft National Tobacco Strategy 2022–2030

Populations with a high prevalence of tobacco use or at higher risk of harm from tobacco use are largely absent from the Introduction. The paragraphs that describe progress made against the previous Strategy in relation to these populations describe only Aboriginal and Torres Strait Islander populations, people living in regional and remote areas, and pregnant women. There is no data included on any progress (or lack thereof) towards reducing smoking among other populations with high smoking prevalence. Indeed, it is not until page 19 of the document that these high-prevalence populations are listed.

The lack of data, and the ongoing high smoking rates amongst subpopulations experiencing various types of disadvantage, highlights that there was little progress made in the last Strategy towards reducing smoking rates amongst such subpopulations. The absence of such progress demonstrates the need to specifically include this as the underlying approach of the next Strategy.

Section 1.3 "What Challenges Remain?" dedicates only two sentences to socioeconomic disadvantage. It is almost completely silent on the many population groups experiencing disproportionately high smoking rates that are listed on page 19.

Comments specific to Part Two: The Framework , 2.1 The Goal, page 8, Consultation Draft National Tobacco Strategy 2022–2030

Consistent with the comments provided above, the current wording of the goal of the Strategy does not adequately address the core public health issue of disparities in smoking rates among various sections of the population. It is clear that to achieve the stated goal of improving the health of all Australians limited resources can best be directed to providing

targeted tobacco control interventions to subpopulations where smoking rates are highest. ATODA suggests adding to the goal wording that clearly articulates a specific focus on reducing smoking among populations with high smoking rates: “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, with a particular focus on reducing prevalence among groups with high rates of tobacco use”.

It is admirable to have targets to reduce smoking prevalence in Australia to less than 10% by 2025 and to 5% or less by 2030. ATODA supports these ambitious, yet achievable, targets.

However, applying the ‘groups with high prevalence’-lens described above, the Strategy should also include clear targets that relate specifically to subpopulations of the Australian community where smoking rates are still high (those subpopulations listed on page 19). Appropriate targets should be set to measure success in delivering specific strategies for the identified subgroups. Based on current rates, such targets could include reducing smoking prevalence to:

- 27.5% among people accessing specialist AOD services[1]
- 23.9% among people who are incarcerated in prison[5]
- 13.2% among Aboriginal and Torres Strait Islander people[2]
- 8.6% among people experiencing mental ill health[4]
- 6.8% among people living in outer regional and remote communities[3]
- 6.4% among people in the most disadvantaged quintile for socioeconomic status[4]

Data collection mechanisms need to be put in place to be able to measure changes in smoking rates within specific subpopulations, as well as at a broader population level. To help accomplish this, ATODA supports consideration of the feasibility of including a Census question on tobacco and e-cigarette use (Priority Action 5.9).

Reference to these targets should also be made in Part Five (page 31) of the Strategy.

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

ATODA is in broad agreement with the objectives of the strategy as laid out in Part Two: The Framework, 2.2 The Objectives (page 8). However, ATODA draws attention to the fifth stated objective, “prevent and reduce tobacco use among groups at higher risk from tobacco use, and other populations with a high prevalence of tobacco use”, and the related Priority Area 5 (page 19). These relate to two different types of groups that potentially require different approaches. One is “populations with higher prevalence of tobacco use than the general population” (as listed on page 19). The other is “other populations at a higher risk of harm from tobacco use”, which includes: pregnant women, children and youth, and those living with a chronic health condition—these are groups that do not necessarily have higher rates of use, but the potential health impacts are greater should they smoke.

Although there may be some overlap between these two groups, putting them together into one objective (and corresponding Priority Area 5) diminishes the priority, and conflates the different approaches, that must be given to each. It is natural that attention would be focussed on the relatively easier, and less stigmatised, groups that have been placed in the “higher risk of harm *from* tobacco use” category: pregnant women, children and youth, people with chronic illness.

This detracts from the attention that must be placed on addressing tobacco use among "populations with higher prevalence of tobacco use than the general population" if a real impact is to be made on the overall smoking rate. These populations generally experience greater stigma and marginalisation in the community, and corresponding lower access to health services. There is a risk they will be overlooked if there is no specific objective relating to these populations.

ATODA, therefore, suggests two separate objectives:

1. Prevent and reduce tobacco use among other populations with a high prevalence of tobacco use
2. Prevent and reduce tobacco use among groups at higher risk from tobacco use.

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

In line with the comments already provided, ATODA suggests including commitments to addressing inequality and health inequities, stigma and discrimination as guiding principles of the Strategy. As stated earlier, it is only through commitment to addressing these, including through interventions that specifically target subpopulations living with health, social and economic disadvantage, that there could be a reduction in smoking rates sufficient to achieve the stated target of 5% or less.

Do you agree with the priority areas for the draft NTS 2022-2030? Please provide an explanation for your selection.

Broadly, ATODA agrees with the priority areas. However, in line with the earlier comments (Question 9), Priority Area 5 should be divided into two different priorities in order to avoid diluting the commitment to addressing smoking-related inequities: one action related to populations with a high prevalence of tobacco use; and the other action to groups at higher risk from tobacco use.
Further, these priority areas could be grouped and re-ordered to reflect this commitment:

1. Aboriginal and Torres Strait Islander people (Priority Area 4);
2. populations with a high prevalence of tobacco use (current Priority Area 5); and
3. groups at higher risk from tobacco use (current Priority Area 5).

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

Actions:

Broadly, ATODA suggests ensuring that each Priority Area addresses how it specifically relates to those populations that experience disproportionately higher smoking rates. For several Priority Areas, this is included in the front material, but is not stated in the actual actions. For example, under Priority Area 8 the front material rightly refers to the need to address the higher density of tobacco retailers in disadvantaged areas, yet does not specifically refer to this in the actions. Action 8.6 could include reference to this by adding "with particular attention to communities experiencing social disadvantage".

Specific comments related to actions under Priority Area 5

As discussed in Questions 9 and 11 above, ATODA suggests separating the Actions into the two different priority areas, one relating to populations with a high prevalence of smoking, and the other related to populations at a higher risk of harm from tobacco use.

For Priority Area 5, it is encouraging to see the inclusion of various settings for the delivery of evidence-based smoking cessation programs (Action 5.5). However, ATODA suggests an extension of the wording "and where applicable, explore the feasibility of mandating these programs as a condition of government funding" to add "with sufficient additional funding, training and other resources to properly deliver these programs". Services should not be expected to achieve this within their current funding, and would require additional resourcing to provide programs and treatments, and to train staff to deliver these.

Specific comments related to actions under Priority Area 10

Action 10.6 could be made more specific by adding reference to workforces with higher smoking rates: "Ensure the provision of smoking cessation support services in smoke-free workplaces to encourage and assist employees and employers who smoke to quit, with particular focus on low paid workforces, and people working with subpopulations where smoking rates are high".

Specific comments related to actions under Priority Area 11

A number of actions relate to the provision of Quitline. ATODA is aware that people experiencing various disadvantages also experience difficulties with accessing various health and support services, including those providing smoking cessation support. In ATODA's experience, for instance, Quitline use is low among people who access specialist alcohol and other drug services in the ACT, and it could be anticipated that this pattern is the same across Australia. This is comparable to the experience within Aboriginal and Torres Strait Islander communities that led to the specific resourcing of initiatives to improve access by Aboriginal and Torres Strait Islander people to the Quitline. ATODA would, therefore, suggest that Action 11.1 specifically include reference to populations with high smoking rates, to read: "Conduct an evaluation of smoking cessation services available in Australia, including Quitline services, and monitor innovative approaches to deliver smoking cessation services, with particular focus on groups where smoking rates are high".

Similarly, extend Action 11.3: "Conduct a national workshop to determine best practice approaches to smoking cessation within the healthcare system, with particular attention to improving access to nicotine dependence treatment and smoking cessation supports for groups where smoking rates are high".

And for Action 11.10: "Review restrictions and accessibility of current smoking cessation pharmacotherapies available on the PBS in the context of latest evidence, best clinical practice and cost-effectiveness and enhance the provision of these medications, particularly for groups where smoking rates are high".

Action 11.11 – add State and Territory governments as having responsibility for this action.

CONCLUSION OF SURVEY INPUT