Legislative Council Sessional Committee
Government Administration A
Sub-Committee

Rural Health Services Inquiry

Inquiry Secretary:
Ms Jenny Mannering
Phone (03) 6212 2249
Email: rur@parliament tas.gov.au

Terms of Reference:

To inquire into and report on health outcomes and access to community health and hospital services for Tasmanians living in rural and remote Tasmania, with particular regard to:

1 Health outcomes, including comparative health outcomes;

2 Availability and timeliness of health services including:

a. Ambulance services;
b. Primary care, allied health and general practice services;
c. Non-GP specialist medical services;
d. Hospital services;
e. Maternity, maternal and child health services;
f. Pain management services;
g. Palliative care services;
h. Pharmacy services;
i. Dental services;
j. Patient transport services;
k. 'After hours' health care;
l. Indigenous and culturally and linguistically diverse (CALD) communities;
m. Mental health services;

and n. Other.

3. Barriers to access to:
a. Ambulance services;

b. Primary care, allied health and general practice services;

c. Non-GP specialist medical services;
d. Hospital services;
e. Maternity, maternal and child health services;

f. Pain management services; g. Palliative care services;
h. Pharmacy services;
i. Dental services;

j. Patient transport services;
k. 'After hours' health care;
l. Indigenous and culturally and linguistically diverse (CALD) communities;
m. Mental health services; and

n. Other

4. Planning systems, projections and outcomes measures used to determine provision of community health and hospital services;

5 Staffing of community health and hospital services;

6 Capital and recurrent health expenditure;

7 Referral to tertiary care including:

a. Adequacy of referral pathways;
b. Out-of-pocket expenses;
c. Wait-times; and
d. Health outcome impact of delays accessing care;

8 Availability, functionality and use of telehealth services; and

9 Any other matters incidental thereto.

The importance of tobacco harm reduction in improving public health in Tasmania

(1) I wish to respond mainly to the first term of reference: 'Health outcomes, including comparative health outcomes'. However, my submission relates to many other terms of reference as smoking related deaths and disease are such an important part of public health.

(2) Tasmania has the shortest life expectancy of all Australian states. It also has the lowest per capita income of all Australian states. Smoking accounts for 21,000 deaths in Australia each year, more than the combined deaths from alcohol plus prescription drugs plus illicit drugs plus road crashes plus HIV plus suicide. Up to two of every three smokers will die from a smoking-related condition. Almost a third of smoking related deaths occur among people of working age. People dying from a smoking related condition lose an average of 10 years of life. Smoking also causes a lot of non-fatal disease so many smokers have a poor quality of life.

(3) Tasmania usually has the highest smoking rate of all Australian states. However in the 2019 National Drug Strategy Household Survey, the smoking rate in Tasmania was the second highest after Queensland. A few years ago Tasmania set targets for an accelerated decline in smoking rates. Importantly, these targets were not met and the actual smoking rate was much higher than the target.

(4) Deaths from smoking are highly correlated with smoking rates. These smoking-related deaths involve cancers, heart, cardiovascular and lung disease. The smoking rate is about twice as high among the lowest income quintile in Australia as it is among the highest income quintile. Thus smoking exacerbates income inequality and also increases the gap in health between high and low-income populations.

(5) The smoking rate in Australia declined steadily for some decades but since 2013, the smoking rate in Australia has only declined very slowly. The decline in the smoking rate in the UK and US since 2013 has been much faster than in Australia. The slow recent decline in the Australian smoking rate has occurred notwithstanding Australia having far more vigorous tobacco control policies than the UK and US including the highest cigarette prices in the world, early implementation of plain packaging and many other measures. But importantly, vaping rates are much higher in the US and UK than Australia.

(6) The single measure that could do most to accelerate the decline in the Tasmanian smoking rate would be to make it easy for Tasmanian smokers to switch to much lower risk options for consuming nicotine than cigarettes. It is very difficult under current national policy for smokers to switch to a much lower risk option such as vaping. This is because nicotine liquid for vaping in Australia is already quite restricted and will become even more restricted on 1 October 2021 when new arrangements begin operating. Nicotine will then move to Schedule 4 of the Poison's Standard. A doctor's prescription will be required for possession and use of nicotine liquid for vaping. Possession and use of nicotine liquid for vaping without a valid doctor's prescription will attract a fine of up to $220,000. The states and territories maintain their own Poison's Standard and these usually follow the Commonwealth Poison's Standard. But this is not obligatory. Tasmania could, and I would recommend that Tasmania should, move nicotine liquid for vaping to Schedule 2. This would mean that nicotine liquid for vaping could be purchased from specific outlets such as vaping stores and tobacconists.

(7) Moving nicotine liquid for vaping from Schedule 4 to 2 in Tasmania may not be popular in some circles. But the new arrangements for nicotine liquid for

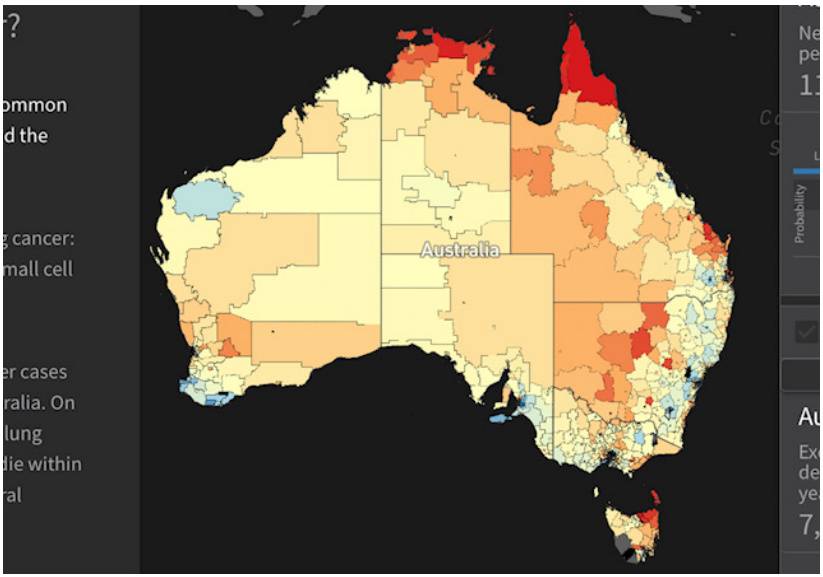
vaping commencing on 1 October are most unlikely to be successful for the following reasons:

- The Therapeutic Goods Administration has done little to train doctors or encourage doctors to support the new arrangements;
- Compliance by doctors is likely to be poor as many doctors are indifferent, scared or hostile;
- Many pharmacists are also unenthusiastic;
- The overwhelming majority of Australia's almost 3 million smokers and over 520,000 vapers have little interest in obtaining nicotine liquid for vaping from doctors or pharmacists.

(8) Therefore there is a strong chance that the new system will not be sustainable. This would make it easier for Tasmania to follow a policy which is best for Tasmanians. The estimated number of Australians vaping increased from 238,000 in 2016 to 520,000 in 2019.

(9)Tasmania's smoking and vaporing policy should also be influenced by economic considerations. An Australian smoking 20 cigarettes a day now spends $12,500 per year on cigarettes. Vaping generally costs less than $2,000. As smoking is more common among low-income and disadvantaged groups, and these groups smoke more cigarettes per day than higher income groups, the restrictions on vaping availability in Australia exacerbates the large and growing income and wealth inequality in Australia. It is estimated that in the UK and US, people with mental illness purchase 40% of the cigarettes consumed. This is likely to also be the case in Australia. Australia has had sluggish wage growth for almost a decade. During that period, the tax on cigarettes in Australia, a commodity disproportionately consumed by poor people, was increased 25% in 2010 and 12.5% eight times (2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020).

(10) Accelerating the decline in smoking rates in Tasmania will benefit heart and cardiovascular disease before it benefits cancer and lung disease. A reduction in these conditions will also reduce the demand for health care. The north east of Tasmania has very high incidence of lung cancer as can be seen in this screenshot from the National Cancer Atlas. Smoking is by far the most common cause of lung cancer.



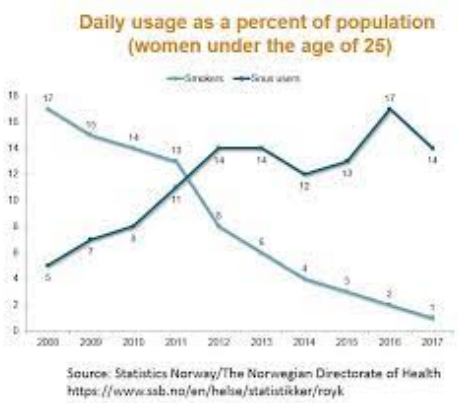
Australia is the only western democracy which requires a medical prescription for nicotine for vaping. An estimated 68 million people in dozens of countries now vape. The estimated number of people vaping is now increasing rapidly. Hon Lik, a Chinese pharmacist developed a commercial form of vaping in 2003. This came to market in the US in 2007 and started becoming popular in 2010. Although 7-8

million people die from smoking world wide every year, there have been no certain deaths from vaping. Deadly cigarettes are readily available from an estimated 20,000 outlets in Australia while much safer vaping and nicotine liquid is severely restricted. The much easier access of a much more dangerous product and the increasingly restricted availability of a much safer product can only be defended by Jesuitical casuistry.

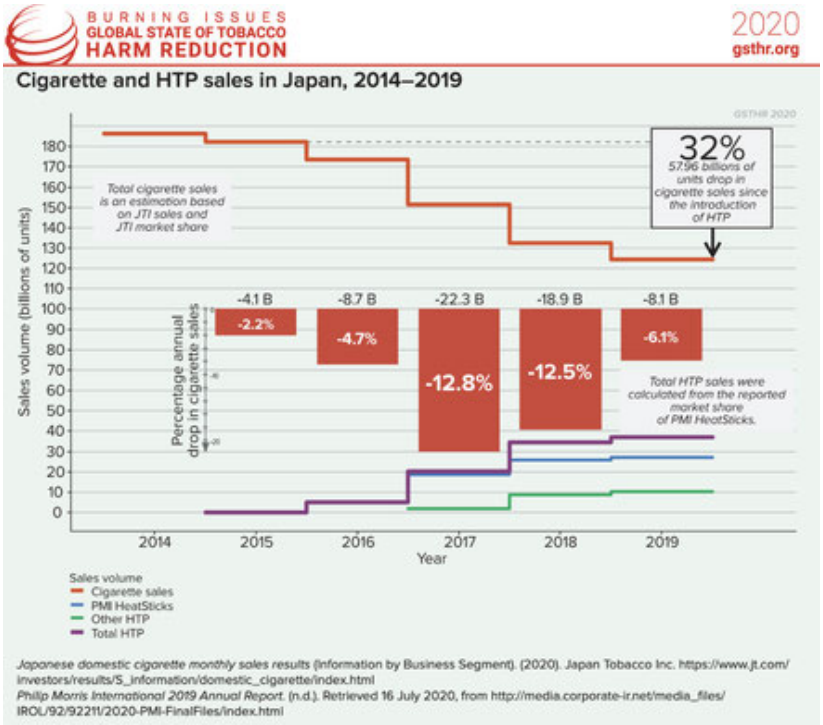
(11) The end goal of policy should be to make switching from smoking to vaping as easy as possible in Australia. This would mean that responsibility for regulating vaping would ultimately be shifted from the TGA to the Australian Competition and Consumer Commission (ACCC) with vaping then regarded as a consumer good rather than as a medical intervention.

(12) There are now a growing number of tobacco harm reduction options apart from vaping. All tobacco harm reduction options avoid the inhalation of tobacco smoke. Heated Tobacco Products (also known as Heat Not Burn) involve the gentle heating of specially prepared tobacco sticks with inhalation of the vapour produced. Snus is a pasteurised moist oral tobacco contained in a pouch placed between the upper lip and the gum. Nicotine pouches are a tobacco free product otherwise similar to snus.

(13) In countries where nicotine consumers can easily switch from cigarettes to lower risk options, many do. Thus much lower risk harm reduction options substitute for much higher risk cigarettes. In 2008 17% of Norwegian women under 25 smoked while 5% used snus. By 2017, only 1% smoked but 14% used snus.



(14) Heated tobacco products were introduced to the Japanese market in 2016. Cigarette sales in Japan have fallen by almost 10% per annum since then and are now more than 40% below the level of cigarette sales in 2016. Cigarette sales were falling before 2016 but the decline has accelerated after these products became available in Japan.



Japanese domestic cigarette monthly sales results (Information by Business Segment). (2020). Japan Tobacco Inc. https://www.jt.com/investors/results/S_information/domestic_cigarette/index.html

Philip Morris International 2019 Annual Report. (n.d.). Retrieved 16 July 2020, from http://media.corporate-ir.net/media_files/IROL/92/92211/2020-PMI-FinalFiles/index.html

Smoking was estimated to cost the Australian economy $136 billion in 2015/16. Accelerating the decline in smoking in Tasmania will reduce the cost of smoking to the Tasmanian economy. It is possible that reducing the restrictions on vaping in Tasmania could result in the development of a new Tasmanian industry which might service much of Australia.

(15) Summary: Smoking has such a huge impact on death, disease and well being that it deserves to be included in this inquiry. The advent of a growing range of attractive, effective, much lower risk ways for people to consume nicotine instead of inhaling smoke from burning tobacco is one of the greatest advances in public health. So far Australia has rejected tobacco harm reduction even though it is explicitly endorsed in the National Tobacco Strategy. As the Australian state with the shortest life expectancy, the lowest income, usually the highest smoking rate, a policy that is not delivering anywhere near target smoking rates, it is time to consider new and exciting options. Vaping should be regulated in proportion to its risk. The aim should be to make vaping readily available for older smokers but hard to obtain for young people who have never smoked.

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Brief biography of Dr Alex Wodak AM

I am a physician and was Director of the Alcohol and Drug Service, St Vincent's Hospital, Sydney from 1982 until I retired in 2012. Together with colleagues I helped establish Australia's first needle syringe program (1986) and first drug consumption room (1999) when both were pre-legal. I also helped establish the National Drug and Alcohol Research Centre (1987) which is Australia's major

alcoho and drug research centre, the Australian Society of HIV Medicine (1989) and the NSW Users AIDS Association (1989). I was the Foundation President of the International Harm Reduction Association (1996-2004). My retirement projects are drug law reform and tobacco harm reduction. I have published about 300 papers. I worked with most UN and international agencies with responsibility for drugs in about 30-40 low and middle-income countries in Asia, South America and the Middle East.

I have no conflicts of interest to declare. Superannuation has been my only income since I retired. I worked in government hospitals in Melbourne, London and Sydney for 40 years and assume that my salary was partly funded by governments recycling revenue they derived from tobacco taxation.

Dr. Alex Wodak AM

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Dr. Alex Wodak AM,
Emeritus Consultant, Alcohol and Drug Service, St Vincent's Hospital
Director, Australian Tobacco Harm Reduction Association
Chair, Australia21
Darlinghurst, NSW, 2010
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