Submission form

Your details

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Role *(if applicable)*: Team Leader, Tobacco Alcohol and Drug team

Additional organisation information

I am, or I represent an organisation that is, based in:

☒ New Zealand ☐ Australia ☐ Other *(please specify)*: Click or tap here to enter text.

I am, or I represent, a: *(tick all that apply)*

☐ Personal submission

☐ Community or advocacy organisation

☐ Iwi/Hāpu affiliated, and/or Māori organisation

☐ Pacific community or organisation

☒ Government organisation

☐ Research or academic organisation – eg university, research institute

☐ Other *(please specify)*: Click or tap here to enter text.

☒ Healthcare provider eg Primary Care provider, stop smoking provider

☐ Professional organisation

☐ Tobacco manufacturer, importer or distributor

☐ Retailer – small, for example a dairy or convenience store

☐ Retailer – medium or large, for example supermarket chain or petrol station

☐ Vaping or smokeless tobacco product retail, distribution or manufacture

Additional statistical information

These questions are not mandatory. We are asking for information, including age and ethnicity information solely for the purposes of helping us to analyse submissions.

Age:

- ☐ Under 18
- ☐ 18 - 34
- ☐ 35 - 44
- ☐ 45 - 54
- ☐ 55 - 64
- ☐ 65 +
- ☒ Not applicable / prefer not to say

Ethnicity/Ethnicities I identify with:

- ☐ New Zealand European
- ☐ Māori
- ☐ Pacific Peoples
- ☐ Asian
- ☐ Other European
- ☐ Other Ethnicity *(please specify)*:

  Click or tap here to enter text.
- ☒ Not applicable / prefer not to say

Privacy

We intend to publish the submissions from this consultation, but **we will only publish your submission if you give permission**. We will remove personal details such as contact details and the names of individuals.

If you do not want your submission published on the Ministry's website, please tick this box:

☐ Do not publish this submission.

Your submission will be subject to requests made under the Official Information Act (even if it hasn't been published). If you want your personal details removed from your submission, please tick this box:

☐ Remove my personal details from responses to Official Information Act requests.

Commercial interests

Do you have any commercial interests?

☐ I have a commercial interest in tobacco products

☐ I have a commercial interest in vaping products

☐ I have commercial interests in tobacco and vaping products

☒ I do not have any commercial interests in tobacco or vaping products

Commercially sensitive information

We will redact commercially sensitive information before publishing submissions or releasing them under the Official Information Act.
If your submission contains commercially sensitive information, please tick this box:

☐ This submission contains commercially sensitive information.

If so, please let us know where.

Click or tap here to enter text.

Protection from commercial and other vested interests of the tobacco industry

New Zealand has an obligation under Article 5.3 of the World Health Organisation Framework Convention on Tobacco Control (FCTC) when 'setting and implementing public health policies with respect to tobacco control … to protect these policies from the commercial and other vested interests of the tobacco industry'.

The internationally agreed Guidelines for Implementation of Article 5.3 recommend that parties to the treaty 'should interact with the tobacco industry only when and to the extent strictly necessary to enable them to effectively regulate the tobacco industry and tobacco products'.

The proposals in this discussion document are relevant to the tobacco industry and we expect to receive feedback from companies in this industry. We will consider all feedback when analysing submissions.
To help us meet our obligations under the FCTC and ensure transparency, all respondents are asked to disclose whether they have any direct or indirect links to, or receive funding from, the tobacco industry.
Please provide details of any tobacco company links or vested interests below.

None

Please return this form:

By email to: smokefree2025@health.govt.nz

By post to: Smokefree 2025 Consultation, Ministry of Health, PO Box 5013, Wellington 6140.

1. Strengthening the tobacco control system

What would effective Māori governance of the tobacco control system look like?

Regional Public Health (RPH) believe that strong Māori leadership is essential in the movement towards a Smoke Free Aotearoa.

RPH recommends that a Māori tobacco control agency be established within the new Māori Health Authority. The Māori Health Authority could then provide the strategy and governance for future Māori tobacco control.

RPH would like to endorse and acknowledge the voice of the National Hui Māori, Tupeka Kore Aotearoa, 18 May 2021. We support their goal and the initiatives they have suggested to achieve it.

RPH will also discuss Māori and the tobacco system later in this document.

What action are you aware of in your community that supports Smokefree 2025?

RPH support the Wainuiomata community in their smokefree activities. This includes the #TAG (Holistic Action Sustainable Health Through All Generations) Wainuiomata youth group. The voices of the hashtags have been heard at select committees and have been influential in the development of recent legislation for smoke-free cars. There is a support base in Wainuiomata, including the #tags that support licensing tobacco retailers, reducing the supply of tobacco and protecting children and young people from tobacco products.

RPH has conducted a survey of people from Wellington CBD, Karori, Porirua, Lower Hutt and Wainuiomata to see if they believed a license was needed for retailers to sell tobacco.

Regional Public Health has recently assisted the local branch of the Cancer Society in its national research on tobacco retail density.

What do you think the priorities are for research, evaluation, monitoring and reporting?

RPH supports the view that continued research, evaluation, monitoring and reporting is required for those populations in harder to reach groups. Among those we see Māori and Pacific women, hāpu women, and mental health consumers, as needing special attention. A Smokefree Aotearoa needs to enable a significant decrease in smoking for Maori and Pacific peoples to ensure they are not over-represented in the 5% smoking prevalence goal.

RPH is aware of growing concern from the public about the increasing number of school age children who have witnessed vaping or have accessed vaping. We recommend prioritising a measure for research, evaluation and monitoring that looks closely at the vape market, tells us more about who is using the products and why, and whether or not more restrictions need to be put in place to protect children and young people from a product that is essentially addictive.

What else do you think is needed to strengthen New Zealand's tobacco control system?

More robust systems for monitoring tobacco retailers and for measuring and monitoring the open areas of smoking in licensed premises are two ways to strengthen New Zealand's tobacco control system. RPH recommend that funding is directed toward strengthening local community action to empower and grow the capacity of our communities to respond to the local tobacco concerns.
In 2003, New Zealand enacted legislation to prevent smoking inside bars, restaurants and cafes. This legislation allowed bars to provide an outdoor open area for patrons to smoke, however the tools for measuring an open area have lacked clear definition. This has led to an encroachment of the open areas into areas that are mostly enclosed. In a study RPH published in 2013, we found that only 21% of bars in the Wellington CBD and entertainment district had open areas that were clearly outside of a covered structure.[1] This has not improved since the move to the 'reasonable person' test. A substantially more robust tool, or legislation, is required to protect patrons and employees from second-hand smoke and further de-normalise smoking.

RPH works across both regulatory and health promotion environments. Increased resourcing for health promotion would enable key insights into community needs and the actions required to reflect community aspirations in the smokefree arena.

2. Making smoked tobacco products less available

Do you support the establishment of a licencing system for all retailers of tobacco and vaping products (in addition to specialist vaping retailers)?

Yes. RPH supports the establishment of a licensing system for all retailers of tobacco products. Currently there is no means of knowing who is selling tobacco and where it is being sold, unless we undertake a physical search. Our evidence shows that there is public support for licensing tobacco retailers (see appendix). Prior to the Covid-19 lockdown of 2020, we undertook a survey in the Wellington CBD and suburbs. We asked our sample of 121 people if they thought that a license was needed to sell tobacco. 52% believed a license was already in place in order to sell. We asked whether there should be a licence for selling tobacco and 85% of respondents believed there should be a licence. These results suggest that the public are already in support of a licensing scheme for tobacco retailers.

Do you support reducing the retail availability of smoked tobacco products by significantly reducing the number of retailers based on population size and density?

Yes. RPH supports reducing the number of retailers based on population size and density. This will assist in the reduction of tobacco retailers, especially in areas of higher socio-economic deprivation. However, a reduction in density alone may be insufficient to assist cessation as there is evidence that the greater the proximity from tobacco retailers the greater the likelihood of long-term continuous abstinence for people trying to quit[2]. Therefore influencing travel distance to the nearest retailer is also an important strategy to implement.

Do you support reducing the retail availability of tobacco by restricting sales to a limited number of specific store types (e.g., specialist R18 stores and/or pharmacies)?

Yes. RPH supports reducing tobacco retail availability to specialist R18 stores. This would ensure tobacco is sold from an outlet in accordance with its health harm risk and assists density reduction in a way that is fair to all retailers of the same type nationally. We are concerned that pharmacies are being considered as a suitable retail outlet for tobacco. Pharmacies normally provide medicines of overall benefit to health. The sale of tobacco would put them in a contradictory role to the one they presently provide in the community of providing access to health care. The USA is currently undergoing voluntary and legislative changes to remove tobacco from pharmacies. In an already pressured environment, it may be difficult

for pharmacies to provide quit advice. Given that pharmacies rely on retail for much of their profits, the sale of cigarettes could provide them with an extra incentive for increased sales, thereby creating a further conflict of interest.

In 2017 Hutt Valley DHB, working with Regional Public Health, incentivised local pharmacies to refer clients who smoke to the local Stop Smoking Service (Takiri Mai Te Ata). Pharmacies were trained in offering advice to clients and offered $20 for each referral made. Following training, few referrals were made and the scheme was stopped. Similarly, Takiri Mai Te Ata piloted a scheme where they located one of their smoking cessation staff in a pharmacy in Wainuiomata. Again, the uptake was poor and the pilot finished without progressing.

Limiting the number of tobacco retailers is desirable as it de-normalises tobacco and sends a clear message regarding the products' safety. Dairies may complain about the impacts on their business, but this needs to be weighed against the immeasurable harm caused by tobacco. One means of lessening inequality of retail sales would be the establishment of specialist tobacco retailers (STR) that only sell smoked tobacco products, and is the **only** outlet allowed to sell tobacco. STRs would need strict regulations to prevent the sale of products, not associated with tobacco. In addition, to further de-normalise tobacco STR stores should have a wholesale ban on displays of tobacco or any other product. Stores should have plain walls and counters; a clinical appearance, and all products, including tobacco papers, lighters, matches and filters if sold, should not be seen by any person entering the store. Given that STRs would be R18 stores, they would enhance the protection of children and young people in Aotearoa/New Zealand from the sale of tobacco.

Liquor outlets might seem an obvious place to sell tobacco. They are restricted to persons over the age of eighteen and there is already a licence scheme for them, to which tobacco could be added. However, tobacco and alcohol are known for their strong behavioural associations and liquor stores may also provide a strong cueing environment. Therefore we recommend keeping the two separated.

Do you support the introduction of a smokefree generation?

Yes. RPH supports the introduction of a smoke free generation policy. This has the potential to improve health equity, particularly for Māori and Pacific communities.

Preventing youth initiation of tobacco is a key strategy to achieving and maintaining Smokefree Aotearoa 2025. A Tobacco Free Generation (TFG) strategy will de-normalise tobacco use and send a clear message that tobacco use is unsafe at any age. The TFG strategy has received strong public support within Aotearoa.

Are you a small business that sells smoked tobacco products?

No. RPH is involved in the monitoring and the education of small businesses that sell tobacco products. We believe removing tobacco product sales from all general retail and introducing specialist licensed stores is the fairest and most effective way of managing changes to tobacco sales.

3. Making smoked tobacco products less addictive and less appealing

Do you support reducing the nicotine in smoked tobacco products to very low levels?

RPH supports reducing nicotine in smoked products to very low levels.

Nicotine is the central psychoactive substance in smoked tobacco that causes the user to become addicted. The tobacco industry also uses additives that make the smoke more palatable and increase the nicotine yield. The reduction of nicotine to very low levels, along with the removal of filters and additives, will make smoking less palatable and far less likely to result in addiction.

The introduction of very low nicotine cigarettes policy needs to result in the total removal of all regular cigarettes. Without this, the majority of smokers will simply experiment with low nicotine cigarettes, as they often do with light cigarettes and vaping, and return to regular smoking.

Historically, there have been many examples of deceit and dishonesty from the tobacco industry in order to increase sales, minimise fears around health consequences, and keep people smoking. This raises concerns regarding potential industry claims around perceived benefits and safety of low nicotine cigarettes. This could lead consumers to falsely believe that low nicotine cigarettes have fewer risks. Studies have shown that even lower levels of smoking are associated with cardio-vascular risk and that smoking between 1-10 cigarettes per day presents an 87% risk or premature death.[3] In light of this, a cautious approach, which prevents tobacco industry utilising marketing tools in such ways, combined with a strong level of awareness raising, would be needed for low nicotine cigarettes to become a part of the market.

Do you support prohibiting filters in smoked tobacco products?

Yes. RPH supports prohibiting filters in smoked tobacco products. Apart from being of little or no protection to the smoker, the cigarette filter presents both a health hazard to the wider population and one of the world's most significant

pollutants. The cellulose acetate filter, found on 90% of cigarettes, threatens human life, marine ecosystems and the wider environment.[4] In Aotearoa/New Zealand, smokers and non-smokers alike, see cigarette filter litter as toxic and support moves to ban filters or reduce their environmental impact.[5]

Do you support allowing the government to prohibit tobacco product innovations through regulations?

Yes. RPH supports allowing the Government to prohibit tobacco product innovations through regulations.

Following the full mechanisation of the machine made cigarette, the tobacco industry experimented with additives to level the pH and make smoke smoother on the throat, easier to inhale and more appealing. More than 2000 additives are known to have been added to cigarettes. The risk of smokers developing lung cancer (specifically adenocarcinoma) has increased since the 1960s. The Surgeon General's report on smoking from 2014 concluded that this increased risk of cancer has been a consequence of the change in "design and composition of cigarettes". For example, the use of additives, ventilated filters and tobacco specific nitrosamines are felt to have contributed.[6] We therefore support the removal of additives and filters alongside a total prohibition of any product innovations related to tobacco. This will enhance protection from harm and will help to deter youth uptake by making smoking less palatable.

4. Making tobacco products less affordable

Do you support setting a minimum price for all tobacco products?

Yes. RPH supports setting a minimum price for all tobacco products. According to the World Health Organisation (WHO), a tax increase is one of the most effective measures any government has at its disposal for reducing tobacco use.[7] The tax increases on tobacco in Aotearoa over the last ten years have helped to reduce the prevalence of smoking. However, tax increase is seen by some as a regressive action; one that hurts those on low incomes including, Maori, Pacific and mental health clients. Perhaps the most useful aspect of price structure would be a government set minimum retail price, for all tobacco products, that aims to reduce manipulation of the retail margins.

5. Enhancing existing initiatives

Of all the issues raised in this discussion document, what would you prioritise to include in the action plan?

Of all the issues raised in this document, RPH would prioritise a license scheme for tobacco retailers; one that allows only R18 specialists retailers to sell tobacco products. The sale of tobacco is a historical anomaly, which requires urgent remedying. Tobacco is the only highly addictive and dangerous drug that kills half of its users and can be sold as a general commodity, by anyone at any time. In this respect, there is little-or-no accountability in the retail sale of tobacco.

The second priority for RPH would be the removal of all additives and filters from cigarettes. The less palatable the cigarette is, the less likely it is that young people will cross the threshold into regular smoking.

Do you have any other comments on this discussion document?

Making the tobacco control/health system work for Māori

The Smoke-free 2025 goal is to have only 5%, or less, of the population as smokers by that time. If we look at todays estimated prevalence of smokers, there are 13.4% of the population smoking and 31.4% of the Māori population smoking. Using the same ratio of these figures, excluding variables or modelling, if we reach 5% prevalence, the prevalence figure for the Māori population will be 11.71%, and 12.69% for Māori females. Using the current daily smoker figures, which are 11.6% of the population and 28.7% for Māori, the current ratio at 5% will mean 12.37% for Māori and 13.79% for Māori females still smoke. RPH supports the use of 'smoking prevalence' over 'daily smoker' figures. Many young smokers are not captured in the daily smoking measure as they do not report themselves as regular smokers. Obviously these figures demonstrate the potential for an ongoing inequitable health outcome for Māori and more is needed to address this.

Studies in Aotearoa/New Zealand suggest the drug Cytisine, (branded Tabex in Eastern Europe), has the potential to be put to good use here, especially for the Māori population.[8,9] Cytisine is a naturally occurring alkaloid that can be found in the yellow –flowering Golden Rain trees, which include our Kowhai trees. For Māori, the native flora of Aotearoa are known for providing Rongoā, traditional medicine. Cytisine has the potential to fit a Te Ao Māori framework of healing concepts, and become accepted as Rongoā, but the current system prevents that.

The principles of the Treaty of Waitangi provide a framework for how we can apply treaty obligations. These include: Tino rangatiratanga, Equity, Active partnership, Active protection and Options which require the Crown to provide for and properly resource kaupapa Māori services and to ensure services are provided in a culturally appropriate way. Therefore, Māori should have the right to choose if Cytisine should become a part of their practice. The smoking cessation drug Varenicline (brand name Champix or Chantix), is a modified analogue of Cytisine, has a good safety profile, and has been approved for use here. We suggest that Cytisine should be approved for use under a like-for-like system and as part of meeting our Treaty of Waitangi obligations. Cytisine has the potential to create business opportunities for Māori, provide more self-determination, and anything that may help to reduce the rate of smoking, and subsequent poor health outcomes, for Māori, has to be worth trying.

Making smoked tobacco products less visible

The New Zealand Government are a party to the WHO's Framework Convention for Tobacco Control (FCTC).[10] Under the FCTC we expect that there shall be no advertising, or promotion of tobacco products. We have also come to expect that people or organisations with any affiliations or associations to tobacco companies declare their interests in order to avoid default association. We believe that, if tax payer funds are going to be used to support the film and television industries in New Zealand, the industries must agree to a clause that prevents them from showing smoking as a part of the characterisation of people in television and film portrayals.

Making more help available to people with mental health conditions who smoke

The consultation document discusses tobacco control systems based on successful international harm reduction models. This model provides a worthwhile degree of protection for the user. However, there are additional controls that may also support change in priority populations. As the prevalence of smoking falls we are left with continuing equity issues for Māori and Pacific populations, as well as for mental health (MH) consumers.

The exact number of mental health consumers who smoke is not known. However, the USA estimates that 44% of mental health consumers are tobacco smokers.[11] Hutt Hospital data shows that our in-patient smoking prevalence in mental health is 56%. From those numbers we can estimate that roughly 50% of MH patients smoke, while current prevalence of smoking in the mainstream population is approximately 13%. Anecdotal evidence suggests that smoking cessation medicines are under used in mental health because of fears of adverse events and contra-indications. The reality is, all medications for smoking cessation are safe for the cohort, within normal risk parameters. A double-blind, controlled study published in the Lancet, showed that varenicline (Champix), was not associated with any neuro-psychiatric adverse events when compared to bupropion (Zyban), nicotine replacement therapy, or placebo.[12]

RPH recommend the development of an awareness raising campaign targeting mental health and addictions services, primary care and care facilities and institutions. This campaign should inform health professionals and associated health workers that mental health patients can quit smoking and that medications, which have almost no significant interactions, can help them to become smoke-free.

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Appendix

Public views on lack of tobacco licensing in New Zealand

Introduction

Smoking presents a significant risk to health from and contributes to inequitable health outcomes for Maori and Pacific people in New Zealand.[1]
Accountability is a core measure for the retail sale of alcohol and medicinal drugs, but is mostly missing from the sale of tobacco. The Smoke-free Environments Act confers a degree of protection by restricting sales to minors, but does not require retailers have a licence.[2]

Although 'sinking lid' and 'supply reduction', which suggest reducing supply reduces demand, have been discussed,[3,4,5] nothing has eventuated on the policy front. Possibly because these discussions propose a limit on trade. If there are trade barriers to supply reduction, these should not necessarily translate into an obstacle for licensing. The benefits of licensing include: bolstering regulations on illicit trade, bolstering restrictions on sales to minors and providing public health intelligence on who is selling tobacco. These benefits overall may be a means to further reduce harm without needing to escalate supply reduction.[6]
We examined licensing from the public's perspective to see if their knowledge corresponds to the current reality of tobacco sales and whether their view could be instructive to future policy.

We aimed to discover if the public were aware a licence was not required to sell tobacco in NZ, and whether they thought there should be a license.

Results

The median age of respondents was 50 and the majority were female. The gender and ethnicity are given in table 1.

Of the 121 respondents, the majority (85%), believed retailers should have a licence to sell tobacco. The majority of respondents either believed a licence was needed to sell tobacco, (52%), or did not know if a licence was needed (26%). Only 22% of the respondents believed a licence was not needed for selling tobacco.

Of respondents who believed there should be a licence to sell tobacco (n=103), 93 provided further explanations for their response.

We found these supplementary responses to question 2b had recurring themes and therefore categorised:

1. Health and harm 33% (the primary concern was health and the danger of smoking)
2. Regulations and restrictions 30% (the primary concern was the need to have regulations that could curb sales to minors, control who sells and monitor the product)

3. Age 24% (the primary concern was age of purchaser)
4. Alcohol 11% (the respondents indicated alcohol is licenced, therefore tobacco should be)
5. Natural assumption 2% (the respondents' indicated it 'should' exist, but did not explain further)

Of the 15 negative answers to question 2a, fourteen participants provided responses. Those reasons were: adequate existing regulations (n=7), a freedom of choice (n=4), smoking enjoyment (n=2) and retailers not advocating smoking (n=1).

Table 1:

Ethnicity		Female	Male	Other
NZ European	98 (81%)	59 (48.7)	38	1
Maori	12 (9.9%)	10	2	
Pacifica	5 (4.1%)	4	1	
Other	6 (4.9%)	2	4	
Total	121	75 (62%)	45 (37%)	1 (0.8%)

Discussion

This survey showed the majority (85%) of the sample believed retailers should have a licence to sell tobacco. This may indicate support for a policy of increased accountability, and is in line with previous research. [3,4,5,6]

The 'Regulations' and 'Age of purchaser', as reasons for a license, are closely related, this may suggest that sale of tobacco to minors is the dominant concern for most of the sample and implementation of licensing may be perceived as harm reduction.

Alcohol licensing and the belief that there was already a license, suggests equalisation with alcohol could be a reasonable consideration for future policy direction. At some point in the future, government are likely to set out regulations for alcohol, e-cigarettes and more. It would seem at odds to remain selective about tobacco when developing policy for other recreational drugs.

Conclusion

This small survey adds to our knowledge of the tobacco retail environment from another perspective, that of the public, and suggests a future policy to include licensing may be a favourable addition to the regulatory environment and a means to further de-normalise tobacco. Given the small sample size of this survey, further research could establish whether the public are generally favourable to licensing tobacco.

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