Submission form

Your details

This submission was completed by:	*(name)*	Cherry Morgan
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Role *(if applicable)*:		Health Promotion and Advocacy Leader (Auckland/Northland), Tobacco Issues Lead

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☐ Do not publish this submission.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.

Introduction

The Cancer Society of New Zealand is a non-profit organisation (hereafter "the Cancer Society" or CSNZ) that is committed to reducing the incidence and impact of cancer in the community and reducing cancer inequities. We work across the cancer continuum with a focus on prevention, supportive care, provision of information and resources, and funding of research. We are committed to reducing health inequities. The Cancer Society is made up of six divisions and a national office.

Thank you for the opportunity to respond to the Proposals for a Smokefree Aotearoa 2025 Action Plan Discussion Document. We congratulate Government on its bold and innovative draft tobacco plan. The Cancer Society supports the proposed approach and the measures included in the plan. A comprehensive suite of bold and effective measures is needed to achieve Smokefree Aotearoa 2025. We are pleased that the proposed plan builds on the Māori Affairs Select Committee recommendations from its Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori.

Our divisions have been engaging with communities up to this time, seeking feedback on policy measures they wanted included in the Smokefree plan. A community template to identify support for particular strategies was used to collect feedback at events around the country from early February until April this year, prior to the launch of the discussion document, with 57 also completed online during May. A total of 844 people completed the template, and these are attached as pdfs to our Cancer Society submission.

The template asked people to say why they wanted a Smokefree Aotearoa by 2025 and identify the measures below that they wanted the Government's Smokefree Action Plan to include commitments to:

- reduce the number of places selling tobacco
- lower nicotine levels and make cigarettes less appealing
- raise the age when people can buy tobacco to create a Smokefree generation
- make more outdoor areas Smokefree
- fund more smoking prevention media campaigns
- increase tobacco tax and use that money to support people to quit smoking.

A summary of the community support for these measures is provided in the table below.

Reduce the number of places selling tobacco	**Lower nicotine levels and make cigarettes less appealing**	**Raise the age when people can buy tobacco to create a Smokefree generation**	**Make more outdoor areas Smokefree**	**Fund more smoking prevention media campaigns**	**Increase tobacco tax and use that money to support people to quit smoking**
776	717	726	723	572*	571*
92%	85%	86%	86%	81%*	81%*

*These two policy options were not included in an earlier community template used at Waitangi Feb 6th 2021 (n=135 completed forms) so the percentages have been analysed accordingly.

We hope that these community voices will be given similar consideration to those of other individual submitters. The vast majority of the people who completed our community template would not have completed the official online submission form however their voices are important.

Consultation questions

1: Strengthen the tobacco control system

a). **What would effective Māori governance of the tobacco control system look like?** Please give reasons.

Te Rito O Te Harakeke is a roopu of Māori staff within Te Kahui Matepukupuku o Aotearoa - the Cancer Society of New Zealand. This roopu believe that Māori governance of the tobacco control system should be determined by and with Māori.

Cancer Society Aotearoa is not a Māori entity and will always be supportive of Māori governance and leadership in tobacco control. This is seen as a critical step to ensure real progress is made in reducing the harmful and inequitable impacts of tobacco use on Māori.

Te Rito O te Harakeke feel that a governanace process is best defined through consultation and engagement with Māori communities, their networks, their Iwi leaders, hapu and whānau. A Tiriti-inspired approach would utilise the existing government processes and obligations under Te Tiriti o Waitangi to engage together with Māori in the decision making, determining best practices and appropriate methods to produce successful outcomes in reducing the tobacco use and harm among Māori.

Te Rito O Te Harakeke support the creation of an independent Māori Health Authority (with its own mana and authority) and see this as a potential governance opportunity for the Tobacco Control system in the future. However as the Māori Health Authority is yet to be established, an interim solution will be needed, therefore consultation with Māori on Māori governance is essential.

Cancer Society Aotearoa is committed to reducing the impacts of tobacco use on Māori and Te Rito O Te Harakeke will always support Māori governance and leadership in tobacco control.

b). **What action are you aware of in your community that supports Smokefree 2025?**

All six Cancer Society divisions are actively involved with our communities in working towards Smokefree 2025. We work collaboratively with a range of stakeholders including sector partners, Councils, public health units, schools, concerned public and community organisations. Recent priorities have been:

- advocating for effective tobacco control legislation, vaping regulation and national tobacco control policies
- campaign to reduce the number of tobacco retailers including a petition
- working with Councils and stakeholders across the motu to strengthen Smokefree area policies and implementation.

Other CSNZ activities at a community level include:

- Fresh Air projects (led by Cancer Society) where hospitality premises in many cities and towns have voluntarily made their outdoor areas 100% Smokefree and Vape-free.
- Participation in regional or district Smokefree networks and coalitions – usually made up of a range of NGOs, public health units, Iwi providers, and cessation providers. CSNZ Smokefree networks include Southland-Otago (3), Christchurch/West Coast (4),

Central Districts (2), Waikato/ Bay of Plenty (4), Hutt Valley (1), and Northland (1). Some networks struggle to remain active and sustainable especially in recent years.

Other community action

- Hāpai Te Hauora, holder of the national tobacco advisory service, is a key organisation supporting community action towards Smokefree 2025.
- Tala Pasifika brings together Pacific people working within the cessation and tobacco control sector.
- The national Smokefree Cars Working Group has been operating for some years.
- Aukati Tupeka Aotearoa is a national group advocating for reducing tobacco availability.
- A small national group with representatives from the Cancer Society, some Public Health Units and ASPIRE has focused on working with Local Government NZ (LGNZ) on Smokefree outdoor hospitality areas.
- World No Tobacco Day events have been held in many regions however these have lacked co-ordination nationally especially since Te Hiringa Hauora has reduced its involvement with these events.
- Some DHB public health units support community action.

What is needed to strengthen community action for a Smokefree 2025? Please give reasons.

Many of New Zealand's past Smokefree achievements at a community level have resulted because of:

a) clear national direction

b) collaboration across sectors

c) sufficient funding and capacity.

All these have lessened in recent years. The following are needed to strengthen community action for a Smokefree 2025.

1. Community action efforts are often focused on legislative changes including those in the Proposed Smokefree Aotearoa 2025 Action Plan. For example, we argue that legislation needs to be extended to include smokefree outdoor public places (See Section 5 of our submission). Cancer Society's community action has included a focus on advocating for extending Council smokefree policies in all regions, which has taken up a lot of time and resources. If smokefree outdoor public places were mandated nationally this would provide consistency, align with international practice and free up Cancer Society community-based resources to focus on other Smokefree or tobacco control activities.
2. National leadership is needed to strengthen and make local community action more effective. Communities need to have a strong voice to ensure good public health policies are passed into legislation. Funding for community-level Smokefree co-ordination has previously been available but this no longer seems to be the case.
3. Workforce development opportunities focused on strengthening community action and effective advocacy needs to be better funded.
4. Community action can be more effective alongside long-term national mass media campaigns. Evaluations of NZ models (e.g. *Like Minds Like Mine* which originally funded both national mass media and a network of mental health service user community

activities) have demonstrated long-term effectiveness in changing societal attitudes and behaviour.

5. Good quality evidence reviews should be completed and disseminated regularly to key stakeholders. This will enable people working at a community level to have access to emerging knowledge and support their advocacy efforts. In addition, ongoing detailed analysis of smoking prevalence data across the range of demographics would be useful. ASPIRE's public health blogs are very helpful.
6. Re-establish a smokefree list-serve that is actively and independently managed and moderated and used to provide the latest research, campaign updates, and submission opportunities.
7. Funding of national smokefree services is needed in addition to those provided by Hāpai Te Hauora. In previous years there were several national advocacy groups within the tobacco control sector which were funded to generate community action capacity and a stronger voice e.g., Smokefree Coalition, Te Reo Marama (Māori Smokefree Coalition), Te Ao Hurihuri, and ASH. Only one provider of national tobacco control services remains. Conflicting views on the risks and/or benefits of vaping have weakened and undermined the tobacco control sector.

c). **What do you think the priorities are for research, evaluation, monitoring and reporting**? Please give reasons.

It's difficult for us to comment on how new spend could best be used, without additional information and analysis of existing spend. Overall, Cancer Society suspects that more investment in research, evaluation, monitoring and reporting would be justified. However, lack of recent evaluations or reviews in the public domain of components of the tobacco programme make it difficult for the Cancer Society to identify priorities for adding value to the current service mix through research, evaluation, monitoring and reporting. There is an urgent need for the Ministry of Health to review the current mix of and investment in tobacco control services to ensure that planned expenditure (including new funding identified in Budget 2021) is aligned with evidence-based priorities for reaching SFA 2025. The review should include all currently funded tobacco control services and identify where additional investment could improve effectiveness and add value to the programme as a whole.

An evaluation and monitoring strategy is needed for the whole tobacco programme as part of the planning process that will take place once the key strategies have been agreed. A logic model will be needed that summarises pathways between interventions and desired outcomes in relation to the goal of reducing both overall smoking prevalence and disparities in prevalence between Māori, Pacific and other minority groups.

Before further investment in smoking cessation, we strongly recommend a review of current stop smoking services including Quitline, as a priority (see section 5b) as there is very little publicly available data about them. Significant investment has been made in these services in the last decade, yet little is known about their effectiveness in reaching priority groups and supporting quitting. We note that no information is available about the cost or effectiveness of Quitline services. Homecare Medical receives over $26m a year from the Government for a range of telehealth services yet they have informed CSNZ that they are not subject to the Official Information Act.

Government's investment in harm reduction through promoting vaping as a quit tool has been significant. This approach needs to be monitored and evaluated properly for both the impact on young people and the effectiveness of promoting vaping as a quit strategy. We note that most international health agencies and systematic reviews have concluded there is insufficient evidence that vaping is effective in helping people to quit (Grabovac et al., 2021) or reducing smoking-related risk (Goniewitz et al., 2020).

The monitoring of online sales to minors of both conventional tobacco products and e-cigarettes needs to be addressed as a priority. There are anecdotal reports from schools about how easy it is for minors to access these products online (as well as in generic stores, and even in vape shops), and there appears to have been minimal if any investment in monitoring and surveillance of online sales.

There is an urgent need to increase capacity for tobacco and vaping retailer monitoring and enforcement by Smokefree Officers in public health units for breaches of the SFE Act. This is even more important since schools have reported an unknown number of minors addicted to vaping, and these products are easily accessed in generic stores where children often shop. Enforcement Officers have been unable to do any controlled purchase operations in well over a year due to being redeployed for COVID work.

d). **What else do you think is needed to strengthen New Zealand's tobacco control system? Please give reasons.**

The Cancer Society welcomes additional funding outlined in Budget 2021 of $36.625m over the next four years to support the delivery of Smokefree 2025[1]. This commitment will enable real progress towards meeting this goal in a priority area for improving health outcomes and reducing inequities.

Health

Accelerating Progress Towards Smokefree 2025

This initiative supports the delivery of a Smokefree Aotearoa 2025 Action Plan by providing additional funding to scale up intensive stop smoking programmes for priority populations (Māori, Pacific and pregnant women) and increasing investment in health promotion and social marketing campaigns.

Vote	2021/22	2022/23	2023/24	2024/25	*Operating Total*	*Capital Total*
Health	5.500	10.375	10.375	10.375	36.625	-

Figure 1: From the Wellbeing Budget 2021 - Securing our Recovery (NZ Treasury, p. 79)

It is also positive that additional funding is allocated for both Public Health Units and NGOs working in prevention, which may result in more workforce capacity for tobacco control.

However, we note that there is very limited public information available about current investment in the tobacco programme, which appears to have reduced significantly over the last decade or so. This makes it difficult to understand how much real impact the Budget 2021 increase in tobacco programme funding is likely to have.

CSNZ requested financial information in an OIA in June 2020 about overall expenditure since 2006, but this was unable to be provided. More recently we were given limited recent financial information about some components of the tobacco control programme but none about how much was invested in Quitline services, or for Smokefree enforcement and other activities carried out by Public Health Units.

We suggest this is partly due to ongoing reductions in public health funding during the last decade which have impacted on the whole tobacco programme including capacity in the Ministry of Health. A 50 % reduction in actual dollars spent in public health services (from 3.6% to 2.1% of Vote Health expenditure) has been identified between 2010 and 2018 (Crampton et al., 2020). Many Smokefree providers had their funding stopped leaving only one provider delivering national tobacco control services by 2016 – Hāpai Te Hauora, an organisation

[1] Retrieved on 22 May 2021 from **Wellbeing Budget 2021 - Securing Our Recovery - 20 May 2021 (treasury.govt.nz)**.

established by the Northern Regional Health Authority to provide Māori public health services for Auckland in the late 1990s.

It will be necessary to rebuild tobacco control capacity and operational funding within the Ministry, as well as in Public Health Units if there is to be any real chance of reaching SFA 2025. In particular, investment in monitoring, surveillance and enforcement of tobacco and vape retailer and industry behaviour is urgently needed.

2: Make smoked tobacco products less available

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

☒ Yes ☐ No

The Cancer Society supports a licensing system for all tobacco and vape retailers including generic stores. However, we do not support a licensing system as a stand-alone measure. As the Ministry notes in the RIS, this is unlikely to achieve a significant reduction in the number of retailers which is necessary to accelerate progress towards achieving Smokefree 2025 (van der Deen et al., 2018).

It makes no sense that tobacco, the most harmful consumer product in history, can be sold by anyone and anywhere in New Zealand. Unlike other harmful products there are no regulations relating to tobacco retailing.

Licensing schemes would offer an opportunity to set retailer conditions such as suitability of applicant (knowledge of legislation, character and reputation, training, concerns about previous sales to minors); trading hours; retailer location; proximity to schools, marae, early childhood education centres; proximity to other tobacco or vape retailers and restricting density of retailers in a given area. We would also like to see licences require annual sales returns on tobacco and vape products.

The Allen Consulting Group report (2002) set out the following elements that make up best practice for tobacco licensing schemes:

- Licenses should be held by all wholesalers and retailers of tobacco.
- Compliance with general tobacco control laws should be the minimum operational standard required by a license holder.
- Parties applying for a license should be required to confirm that they have read, understood, and agree to abide by, the applicable laws regarding tobacco sales.
- Tobacco wholesalers should be required to sell only to licensed retailers/wholesalers and to provide the regulatory agency with a list (on request or periodically) of the wholesalers/retailers to whom they have supplied tobacco.
- Retailers should be required to purchase only from licensed tobacco wholesalers.
- Each license should apply to a particular venue.
- The license should be prominently displayed at each tobacco premises.
- License fees should be set to recover only those costs associated with:
    - administration of the licensing regime
    - enforcement of the licenses, including inspections and compliance checks
    - provision of licensing-related information to customers and the public; and

    - provision of information to applicants and licensees to ensure their compliance.
- A license should be able to be refused or withdrawn if a responsible person has been found to have contravened any tobacco control laws.
- Tobacco sales licensing should be seen as a health measure and hence should be controlled by health officials.
- There should be a graduated penalty structure that includes warnings, administrative penalties, prosecutions, license suspension, and scope for license withdrawal (The Allen Consulting Group 2002).

A community study carried out by the Cancer Society Christchurch division over six months (November 2020 – May 2021) found that more retailers were selling tobacco than the District Health Board lists identified. Similar findings were found in other areas. This further illustrates that we don't have an accurate baseline to regulate, monitor and enforce tobacco retailers.

Licenses provide an important mechanism for communicating information and changes to laws to retailers more easily and for monitoring and enforcement. Licenses can be removed for breaches and are therefore powerful legal tools that can be used to improve enforcement of tobacco-related laws. A well-enforced licensing system can help ensure compliance by providing stronger incentives to tobacco retailers to comply with tobacco control laws (Chapman et al., 2009).

Currently we have very limited tobacco retailer information due to the lack of a licensing and reporting regime.

Licensing fees need to be set at levels that adequately cover both the administration of a licensing system and effective monitoring and enforcement by tobacco control enforcement officers nationally, which as we have noted previously needs significant investment.

The Ministry of Health's Regulatory Impact Statement on the Proposed Smokefree 2025 Action Plan notes that licensing could also potentially help to reduce the sale and distribution of illicit tobacco products.

b). **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 ☐ No

A 90 – 95% reduction in retailers will be needed to influence behaviour sufficiently (ASPIRE, 2017). The Cancer Society supports restricting tobacco sales to a limited number of R18 specialist stores and ensuring that the number and density of retailers is based on both population size and density.

The current unregulated market has resulted in our communities being saturated in tobacco retailers. There are an estimated 6000-8000 tobacco retailers nationally (Robertson, 2017) with Auckland alone having an estimated 1800 retailers (communication with Auckland Regional Public Health Services).

Easier access to tobacco retailers is associated with an increase in youth smoking (Marsh et al., 2021; Finan et al., 2019), increased smoking among people who already smoke (Paul et al., 2010) and reduced quitting (Halonen et al., 2014; Chaiton et al., 2018).

A systematic review (Marsh et al., 2021) found an association between tobacco retail outlet density and smoking behaviours among youth, particularly for the density near youths' homes. The study also found a significant positive association between exposure to tobacco retail outlets and daily tobacco use. This review provides evidence for the development and implementation of policies to reduce the density of tobacco retail outlets to reduce smoking prevalence among youth.

Residents within low socio-economic communities are exposed to much higher density of tobacco retailers, about four times greater, than those living in higher socio-economic areas (Marsh et al., 2013; Marsh et al., 2020).

To gain an understanding of what this means for some of our low socio-economic communities, the Cancer Society conducted retailer observations in shopping precincts around NZ between May 2019 and February 2021. This exercise entailed visiting all retailers in prioritised areas and identifying those selling tobacco and vape products in both low socio-economic and high socio-economic areas. Our findings backed up earlier research undertaken by Marsh et al., in 2013.

There were considerably more retailers selling tobacco in the main shopping precinct in low-income areas in Auckland (Manurewa 18, Otahuhu 17 retailers) compared to high-income areas (Remuera 3, St Heliers 2). Furthermore, there were more retailers selling tobacco than bread and milk in both low-income areas visited.

In Newtown North, Wellington (November 2020) there were almost twice the number of shops selling tobacco and vape products than in Kelburn, even though they have a similar population size. The smoking rate in Newtown is almost three times that in Kelburn and higher than the national average smoking rates.

In surveying nearly 600 retailers between November 2020 and May 2021 in both urban and rural areas of Christchurch, a disproportionate number of retailers were found in lower-income areas compared with higher-income areas. The density of retailers was very apparent and further supports the need to reduce overall numbers of tobacco retailers. The survey also found over 50% of all retailers were located within one kilometre of a school.

Capping the number of tobacco retailers to population size and restricting density of retailers could greatly decrease the number of tobacco retailers. Currently there is approximately one tobacco retailer per 800 residents (Marsh et al., 2020) whereas introducing a cap of no more than one tobacco retailer in an area with 10,000 residents would help to substantially reduce exposure to tobacco outlets. Tobacco density would need to be reduced sufficiently in low socio-economic areas, where smoking rates are highest, and people are more at risk of tobacco harm (Luke et al., 2017; Caryl et al., 2020). Failure to substantially reduce the number and density of tobacco retailers in low socio-economic areas will continue to increase inequities.

The Cancer Society would also like to see restrictions placed on the proximity of tobacco retailers to schools, early childhood education centres, marae and health centres. Over half of secondary schools have at least one tobacco retailer within 500 metres of the school, and 83% have at least one retailer within 1 kilometre (Robertson et al., 2016). Four places selling tobacco and six places selling vape products were found within 300 metres of Newton School.

Evidence shows that the more tobacco retailers there are around a school, the more likely students are to have ever smoked, engaged in experimental smoking and be susceptible to future smoking (Adams et al., 2013; Henrikson et al., 2008, Chan et al., 2011, Marsh et al., 2016). Reduced density of the sale of tobacco around schools would reduce curiosity and temptation concerning tobacco, diminish the normalising of smoking in the community, and provide fewer opportunities and cues for adolescents to attempt to purchase tobacco (Marsh et al., 2016).

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

☒ Yes ☐ No

The Cancer Society strongly supports phasing out the retail availability of tobacco so that it is only sold at a limited number of licensed R18 (or higher if the age limit to purchase is increased) specialist tobacco only stores. This is our preferred option.

We have concerns about suggestions limiting tobacco sales to pharmacies or to alcohol outlets. A significant number of pharmacists (26%) do not want to sell tobacco (van der Deen et al., 2018). There are also a lot more than 300 pharmacies nationally so this option would not achieve our target of 95% reduction in tobacco retailers. Restricting tobacco sales to alcohol outlets would reinforce the strong association between alcohol and smoking especially in the 18-24-year age group when smoking initiation is highest, overall smoking rates are high and social smoking is prevalent. Alcohol outlets are also overconcentrated in low socio-economic communities raising equity concerns.

Limiting sales to license R18 specialist tobacco stores would provide the greatest opportunity to substantially reduce the number of tobacco retailers to approximately 300 as has been recommended by ASPIRE (Edwards et al., 2021). Modelling suggests that reducing to 300 outlets (approximately one for every 1,600 people who smoke) could have a positive effect by increasing travel time and eliminating impulse purchases (Pearson et al., 2015). Eliminating ready access to tobacco could enhance success in cessation, since people who smoke experience stronger cravings when they expect to be able to smoke in the near future (Sayette et al., 2003).

Sales restrictions could designate specialist R18 tobacconists or government operated R18 stores as the only suppliers of tobacco products. This approach would stimulate quitting, reduce relapse to smoking among people who have quit, and minimise youth access by facilitating enforcement in underage sales (Edwards et al., 2021). Significantly reducing outlet numbers is also likely to help reduce disparities as tobacco retailers are often concentrated in disadvantaged areas.

Tobacco is the only retail product when used as intended kills as many as two- thirds of its long-time users (Banks et al., 2015) yet it is available anywhere. We need to end the perception that cigarettes are an ordinary consumer product.

Strong public support

There is strong public support (68%) for reducing the number of tobacco retailers nationally (Health Promotion Agency, 2018). Furthermore, New Zealand research in 2018 found the majority (62%) of people who smoke and recent quitters also supported reducing the number of places that can sell tobacco products, that is by 95%, and allow sales only in a limited number and type of stores (ITC project, 2020).

- Over the last few years, the Cancer Society has undertaken a series of actions to gauge and gather public support for reducing tobacco retail availability. In 2019 and 2021 we conducted electronic and paper-based surveys/submissions at our Relay for Life and other events nationwide. In 2019 we found very high support (92% of 1481 submissions collected nationally) for the Smokefree Environments Act to be strengthened to reduce the number of outlets able to sell cigarettes and tobacco. In 2021, of the 844 community submissions collected nationally, between February and May, 92% wanted Government's Smokefree Action Plan to include commitments to reducing the number of places selling tobacco (community submissions are provided in separate attachments). In 2020 we ran an online poll for World No Tobacco Day asking '*Should smokes only be sold in R18 specialist tobacco shops?*' Of the 1200 votes cast, 82% supported restricting tobacco sales to R18 specialist tobacco shops.
- Recently in March 2021, the Cancer Society launched a hybrid **petition** which requests the House of Representatives pass legislation that significantly reduces the number of tobacco retailers, to help reach Smokefree Aotearoa 2025. 7887 people (3563 hard

copy and 4324 online) signed the petition adding more community voices supporting this important measure in the proposed Smokefree Action Plan.

- In May 2021 the Cancer Society used social media to gauge public support for some of the measures within the proposed Smokefree Action Plan. An online poll asked whether they supported reducing the number of shops that sell tobacco. 90% of the 113 votes supported this measure (n=102) while 10% did not (n=11 votes).

In addition to high public support, New Zealand research found that small retailers are likely to support government legislation that permits the sale of tobacco from a few specialist stores that only sell tobacco (Badu et al., 2018). Small retailers said they want a level playing field – they do not want to lose tobacco customers to other retailers nearby.

In unpublished interviews with executives of medium to large tobacco retailers, many signalled that they expect government leadership on reducing tobacco availability and that they just want as much notice as possible (communications with Auckland Regional Public Health Services). Many retailers thought that restricting sales to only R18 tobacco retailers would treat current retailers equally and address the challenge of providing a level playing field.

We do not support a 'grandfathering approach', which exempts current retailers from new policy changes, as the number of retailers would decrease extremely slowly and not achieve the 95% reduction required.

The Cancer Society supports the phasing out of tobacco retailers through the prompt passage of legislation. Legislative changes need to be enacted by this Government as a priority. We accept there would need to be a transition period after Royal Assent for the new legislative provisions to take effect. A transition period will be needed for both consumers and retailers. We support potentially two phases - with the first 'batch' of retailers needing to cease supply within six months, and then a second 'batch within twelve months. Further consideration is needed to identify how to successfully transition from 6,000 – 8,000 retailers to about 300 R18 providers.

As some small retailers may be affected by this policy more than others, Government support or assistance for small business advisors could be considered.

d). **Do you support introducing a smokefree generation policy?**

☒ Yes ☐ No

The Cancer Society supports introducing a smokefree generation policy to restrict the sale and supply of tobacco products from a set date for future generations. Preventing youth initiation of smoking is essential to achieving and maintaining Smokefree Aotearoa 2025. While the rates of smoking have reduced over time in those aged 15-25, the levels of smoking in this age group remains significant (particularly in the group aged 18-25) and is very concerning (see Figure 2 below).

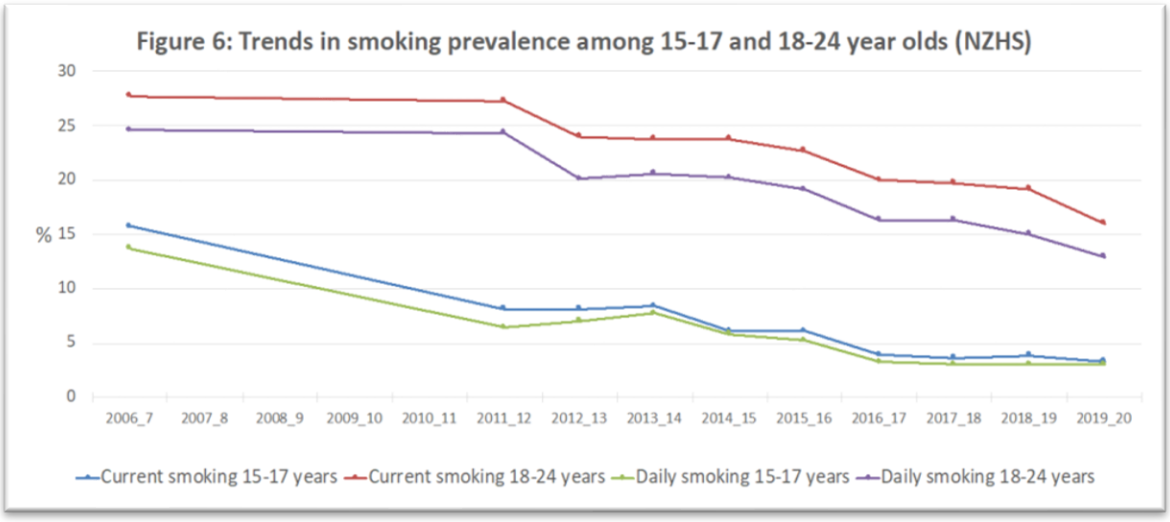

Figure 2: Trends in smoking prevalence among 15-17 and 18-24-year-olds. Source: Edwards et al., 2020[2].

In 2019/20 daily smoking prevalence among 18–24-year-olds was 12.9% (61,000 smoking) and current smoking prevalence 16.0% (75,000 smokers). Current smoking in this group has declined at an average of 1.4% per year since 2011. The patterns of changes in prevalence over time were similar for daily smoking (Edwards et al., 2020).

Longstanding ethnic disparities in smoking prevalence have continued in recent years for Māori youth and young adults. While data for young adults by ethnicity was not available in the NZHS data explorer, the 2018 census daily smoking prevalence among 20-24-year-olds was 15.6% overall but 28.9% among Māori and 21.1% among Pacific peoples.

Youth vaping and smoking

Many systematic reviews have found strong associations between youth vaping and subsequent smoking initiation, and a recent meta-analysis by Chan and colleagues (2021) confirmed earlier findings of a longitudinal association between adolescent vaping and smoking initiation. The Cancer Society's concern is that this association could translate into an increase in youth smoking prevalence, given well-documented and aggressive vape and industry marketing of vaping products to a NZ youth audience for several years prior to legislative change that began to take effect in November 2020.

Our most recent NZ youth data (2019) shows smoking prevalence in school-aged children (14 and 15-year-olds) has levelled off over the last few years but increased slightly during 2019 after being in decline for 20 years, alongside a rapid increase in vaping among young New Zealanders (see Figure 3 below). As the ASH year 10 annual survey was unable to be undertaken in 2020 due to COVID 19, it will not be clear until 2022 when the 2021 survey findings are made public, whether this increase in youth vaping and smoking prevalence has changed.

The 2019 Year 10 survey found substantial disparities in smoking prevalence in 14-15-year-olds by ethnicity, with daily smoking prevalence 2.1% overall, but 5.8% among Māori students (ASH 2020). The increase in Māori smoking prevalence of year 10 students was significantly higher than non-Māori, raising concerns about the possibility of a widening of ethnic inequities in young people, which had been gradually narrowing since 2000 (see Figure 3 below).

[2] Graph retrieved on 20 May 2021 from PHE blog **What does the 2019/20 NZ Health Survey tell us about progress towards a Smokefree Aotearoa? – Public Health Expert, University of Otago, New Zealand**

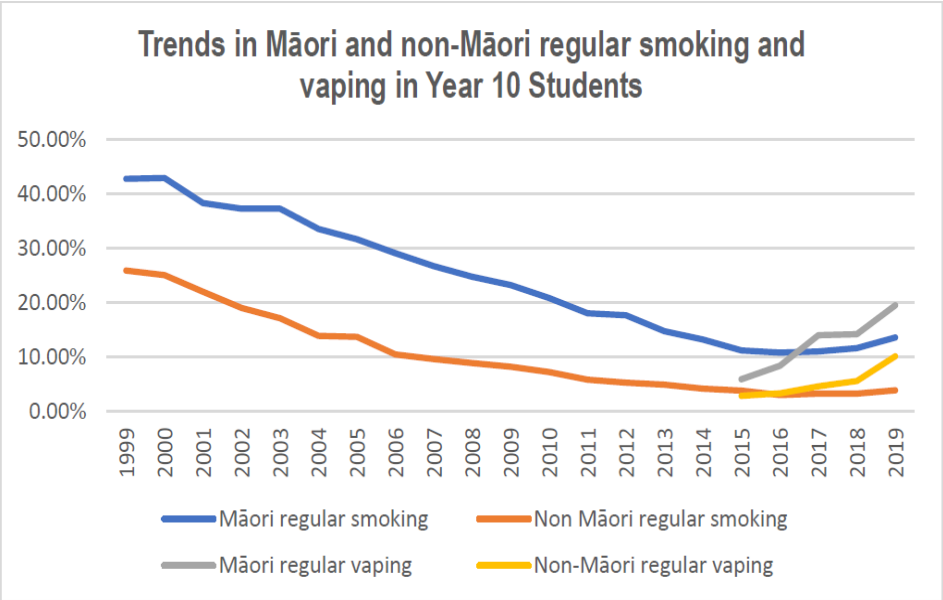

Figure 3. Trends in Māori and non-Māori regular smoking and vaping in Year 10 students
Source: Māori and non-Māori data 1999-2018 obtained from ASH NZ website.

Data from the New Zealand Health Survey (NZHS) shows that daily smoking prevalence among 15-17-year-olds was 3% (5,000 smoking) in 2019/20 and current smoking prevalence (smoked in the last 28 days) was 3.3% (6,000 smoking). Current smoking prevalence roughly halved between 2006/7 (15.7%) and 2011/12 (8.1%) in this age group, then halved again by 2016/17 (3.9%), a reduction of about 0.8% per year. Since 2016/17, current smoking prevalence has remained more or less the same with similar patterns of prevalence over time for daily smoking (Edwards et al., 2020).

The uptake of smoking in young adults continues to contribute to maintaining a substantial level of smoking among the adult population in Aotearoa (Edwards et al., 2019). Edwards and colleagues noted that despite a downward trend, high smoking prevalence among 18-24-year-olds remains a significant barrier to achieving and maintaining the Smokefree 2025 goal (Edwards et al., 2020).

Public support for preventing youth smoking uptake

- There is usually high public and political support for measures to reduce smoking uptake among young people. Cancer Society found significant support from the public for *raising the age when people can buy tobacco to create a smokefree generation.* Of the 844 community submission templates collected at Relay for Life and other community events nationally this year 726 (86%) want Government's Smokefree Plan to include commitments to "raise the age when people can buy tobacco to create a Smokefree generation".
- In May 2021 the Cancer Society used social media to gauge public support for raising the age when people can buy tobacco. 89% of the 82 votes cast supported this measure (n=73 votes) while 11% did not (n=9 votes).

Evidence in support of a Smokefree Generation Policy

The Smokefree Generation policy recognises that young people who start smoking rarely, if ever, make an informed choice (Gray et al., 2014) and a high percentage of youth 15-19 years, particularly Māori (82%), regret starting smoking (Wilson et al., 2009).

New Zealand modelling work has suggested that this policy is likely to contribute substantially to ending smoking disparities for Māori (van der Deen et al., 2018). If well-enforced, this policy

is predicted to halve smoking rates within 10-15 years of implementation and would result in five times' larger health gains per capita for Māori compared to non-Māori. Van der Deen and colleagues found that 'reducing a tobacco-free generation' ranked as the most effective endgame measure for reducing inequities (see Figure 4 below). It is strong pro-equity due to the higher smoking prevalence and the young age structure among Māori and Pacific populations. This approach supports Te Tiriti O Waitangi principles of active protection and equity and would ensure tamariki have the best start to life in a smokefree environment.

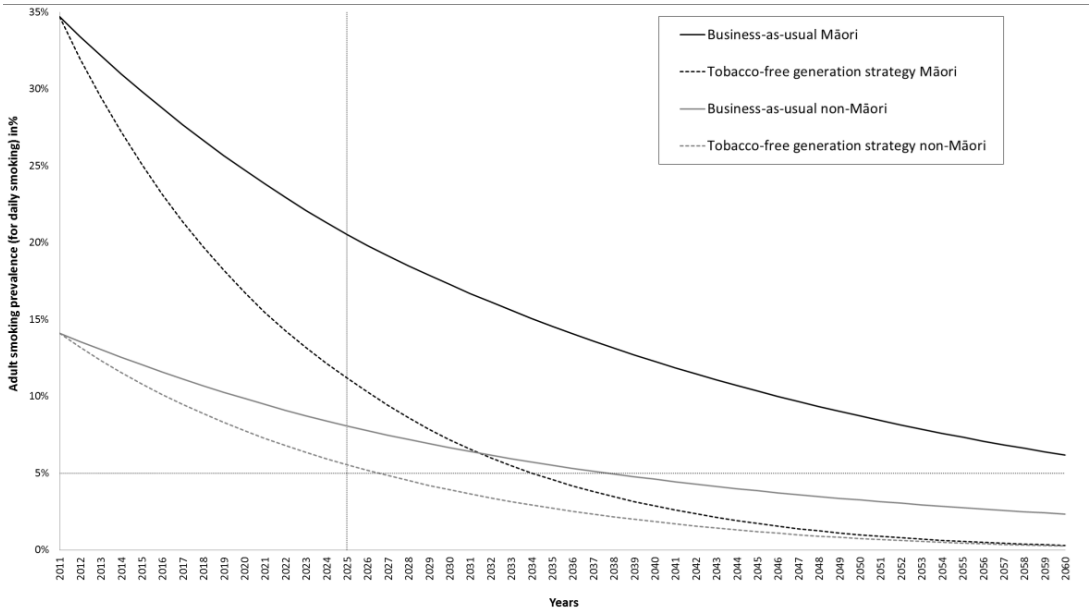

Figure 4. Likely impact of tobacco-free generation strategy on Māori and non-Māori. Source: van der Deen et al., 2017.[3]

A Smokefree Generation is likely to demonstrate that New Zealand is serious about achieving Smokefree 2025 and will provide an environment to support people to remain Smokefree and trigger people who smoke to quit.

The benefits of a smokefree generation will not have immediate impacts on reducing smoking prevalence; however, it will create long-term benefits and support and maintain minimal prevalence of smoking once the Smokefree goal has been attained (Edwards et al., 2021).

However, minimum-age laws are not always successful (Nuyts, 2018), require investment in monitoring and enforcement, and may send a misleading message that there is a 'safe age' for smoking and establish a 'coming of age badge' as a sign of maturity (Imperial Tobacco, 1977).

A smokefree generation policy was introduced in Balanga City in the Phillipines, in 2016, as part of a comprehensive tobacco control package. It resulted in significant declines in youth and adult smoking. However, the tobacco industry put a legal challenge on the grounds that Balanga's policies were stronger than national legislation intended (cited in Ball et al., 2021).

The Cancer Society supports a smokefree generation policy as part of the comprehensive programme. Policy compliance by retailers is more likely if other proposed measures in the plan are introduced – including licensing, strengthening of monitoring and enforcement and restricting tobacco sales to only R18 specialist tobacco shops. Retailers, and especially specialist retailers, are less likely to risk losing their licence for making underage sales. Mass

[3] Graph retrieved on 20 May 2021 from PHE blog **Phasing out smoking: The Tobacco-Free Generation policy – Public Health Expert, University of Otago, New Zealand**

media campaigns will also be important to communicate the policy's aims and generate public and youth support for a smokefree generation approach.

e). **Are you a small business that sells smoked tobacco products?**

☐ Yes ☒ No

The Cancer Society is not a small business. However, we have undertaken recent research on tobacco with small businesses, and we believe the key findings are relevant to this submission.

Cancer Society retailer survey in Northland

In February 2020, we undertook a qualitative survey of 16 Northland retailers who had at some stage chosen to stop selling tobacco. The purpose of the survey was to understand factors which impacted on retailers' decisions about selling tobacco and gauge their support for legislation to reduce tobacco availability. The most common reason retailers gave for choosing to stop selling tobacco was security, followed by the high costs for stocking tobacco (insurance cover), community health and wellbeing, and insufficient profit.

Retailers were told about the Government's Smokefree 2025 goal and were asked what Government regulations or laws they would support. Restricting tobacco to R18 stores only had the most support from retailers interviewed, followed by licensing of all retailers who sell tobacco. Half of the retailers agreed that licensing fees should cover monitoring costs. Two of the three retailers who chose to sell tobacco also supported some form of Government regulation including restricting sales to R18 shops only. None of the respondents supported tobacco being sold only in supermarkets. Backlash from people who wanted to buy tobacco was rarely an issue despite many of the retailers being in rural areas.

Research about retailer concerns

We acknowledge the situation of many small retailers, including their concerns about the potential impact on turnover. However, we are also concerned that some interest groups may put forward claims that independent research does not support. For example, it is sometimes claimed that if small retailers are no longer able to sell tobacco they could lose their business. This argument is also promoted by tobacco companies.

A common argument is that tobacco purchases drive footfall into small retailer premises with customers buying additional products. Research undertaken in Dunedin (Roberston et al., 2019) and later scaled up and repeated in Auckland and Wellington (Marsh et al., 2020) found that most transactions in small retailers do not involve tobacco and when tobacco is purchased, it is most often as a single item, without other groceries. The Dunedin study found that only 14% of transactions contained tobacco with most only buying tobacco. Only 5% of all transactions included tobacco and an additional product. Similar results were found in Auckland and Wellington with 14% of transactions containing tobacco and just 6% of all transactions including both tobacco and other products.

The research shows that while some people buy tobacco from small convenience stores, buying tobacco and other products is uncommon, and these purchases account for only a small amount of the total purchases. International research has supported these New Zealand findings (Wood et al., 2021.) Small retailers' profit margins on tobacco are very low, yet this is rarely acknowledged (Jaine et al., 2014; Badu et al., 2018, Marsh et al., 2020). Tobacco not only provides low returns, it is also expensive to stock and high insurance premiums can be imposed on small retailers because of the risk of burglary.

Recent Australian research (Watts et al., 2020) found tobacco industry covert marketing tactics with retailers, which included financial incentives, experiential incentives such as all-expenses paid events and vacations, and targeting education of retailers to market their products to consumers on behalf of industry. The authors concluded that such strategies had the ultimate objective of increasing market share and driving sales.

3: Make smoked tobacco products less addictive and less appealing

a). **Do you support reducing the nicotine in smoked tobacco products to very low levels?**

☒ Yes ☐ No

Studies have shown that reducing nicotine to very low levels is likely to reduce the number of people starting to smoke, support people to stop smoking, and reduce the number of people who have quit smoking from relapsing, thereby reducing the overall prevalence of smoking (Donny 2015; Donny et al., 2017). This would have a substantial population benefit (Apelberg et al., 2018) therefore being most beneficial to individuals currently most disadvantaged by tobacco companies, i.e. Māori, Pacifica, lower SES communities, and people struggling with mental health.

Nicotine levels would need to be reduced to levels where there are no (or negligible) central nervous system effects – no greater than 0.4mg nicotine per gram of tobacco or per cigarette (Donny et al., 2015; Edwards et al., 2021) to make Very Low Nicotine Cigarettes (VLNCs). There is a large body of research supporting this approach (Benowitz & Henningfield 2013, 2018; Benowitz et al., 2007, 2012, 2015, 2017; Dermody et al., 2015; Ding et al., 2014; Donny et al., 2009, 2015, 2017; Gottlieb & Zeller 2017; Hammond & O'Connor 2014, Hatsukami et al., 2010a, 2010b, 2017; McRobbie et al., 2015; Mercincavage et al., 2016, Smith et al., 2019, 2020; Walker et al., 2012, 2014; World Health Organization 2019).

Conventional cigarettes contain between 10-16mg nicotine per gram of tobacco (Donny et al., 2015). The proposed level (0.4%) may relieve cravings, but is not sufficient to release dopamine, so it does not deliver the 'buzz' people get from smoking (Brody et al., 2009). At this level, cigarettes are also less likely to be addictive in adolescents (Cassidy et al., 2018).

Reducing nicotine only moderately has been shown to be ineffective – studies have found participants used compensatory behaviours instead of decreasing smoking (Hatsukami et al., 2010, Hatsukami et al., 2018, Hammond & O'Connor 2014, Mercincavage et al., 2016). Compensatory measures included smoking more cigarettes and inhaling deeper. Other research has shown that deeper inhalation can increase nicotine uptake potentially 4-fold (Benowitz et al., 2019). However, when the nicotine levels were substantially reduced, people stopped using compensatory smoking behaviours. Indeed, they would need to smoke ten times more VLNCs per day compared to conventional cigarettes – so someone who usually smoked 10 cigarettes per day would need to smoke 100 cigarettes per day to maintain their usual nicotine intake. Studies have found there is only minimal compensatory smoking with the lower level and it if it happened at all it typically lasted for only a few days (Smith et al., 2020a, 2020b; Benowitz et al., 2019). People instead reduced the number of cigarettes smoked and their decrease in exposure to the addictive component decreased in a compounding manner. To be most effective the switch to VLNCs must be swift. Studies with gradual switching found no reduction in daily cigarette use (Hatsukami et al., 2018).

Importantly, very low levels of nicotine lead to the greatest decrease in nicotine excreted regardless of whether the person was motivated or unmotivated to stop smoking (Donny et al., 2015, Delinger-Apte et al., 2016, Hatsukami et al., 2013). Reducing or removing the reinforcing effects of nicotine from smoking will therefore have a three-fold effect; making it easier for people to stop smoking; making it less likely that someone who tries will continue, and by reducing the likelihood of relapses for people who have become smokefree (Donny 2015).

Various studies have shown people in groups using VLNC smoke fewer cigarettes per day than groups using conventional cigarettes. This has been demonstrated across multiple studies with people unmotivated to stop smoking (Bandiera et al., 2015, Benowitz et al., 2012, Cassidy et al., 2019, Donny et al., 2015, Hatsukami et al., 2017, Hatsukami et al., 2018, Higgins et al., 2020, Krebs et al., 2020, Shiffman et al., 2018, Smith et al., 2019, Walker et al., 2015), studies focusing on socially disadvantaged people (Higgins et al., 2020, Krebs et al., 2020), and people with mental health conditions (Higgins et al., 2020; Tidey et al., 2018). These are encouraging findings as they suggest smoking prevalence could be reduced in some of the populations most disproportionately impacted by tobacco companies (Lasser et al., 2000, Hiscock et al., 2012).

Dermody and colleagues (2015) found that smoking VLNC cigarettes predicted abstinence independent of individual differences in baseline smoking, cotinine, dependence, and gender. However, factors that undermine nicotine reduction must be addressed, including the availability and use of cigarettes with normal nicotine content and not sufficiently reducing the nicotine yield of cigarettes (Dermody et al., 2015).

Implementing policy that requires VLNC will be most effective when used in conjunction with other measures. For example, modelling has predicted that smoking rates (inclusive of roll-your-own tobacco) could be reduced to as low as 4.1% by 2025 if nicotine reduction is combined with a 10% annually increasing excise tax, therefore meeting the prevalence target for Smokefree 2025 (Laugesen & Grace 2015). Existing measures to support people to become smokefree will also be crucial. Research with people using VLNC alongside nicotine replacement therapy (NRT) such as patches have been successful and some have even shown greater smoking reductions than with VLNCs alone (Hatsukami et al., 2013, Donny & Jones 2009, Vogel 2014, Smith et al.,.2019). Using VLNCs with NRT (with and without behavioural support) has been more effective than NRT with behavioural support (Walker et al., 2012, McRobbie et al., 2016). While people may find VLNCs less satisfying than conventional cigarettes any withdrawal symptoms from the substantially reduced nicotine will be transient and mild (Dermody et al., 2018, Hatsukami et al., 2018). Furthermore, using NRT helps control withdrawal symptoms, and separates the behavioural association between nicotine and the action of smoking (Donny & Jones 2009, Hatsukami et al., 2013, Hatsukami et al., 2010).

A study of over 1400 participants (Walker 2012), where one-quarter identified as Māori, reported higher long-term abstinence and delayed relapse in those smoking VLNCs combined with NRT versus the group with conventional cigarettes who also had access to NRT. These results were irrespective of ethnicity, thus providing good evidence that a VLNC-inclusive intervention can be successful in supporting Māori to be auahi kore. Furthermore, research by the ITC (International Tobacco Control) found Māori participants strongly supported removing nicotine, and 80% said they would try VLNC or nicotine-free cigarettes (McKiernan et al., 2019).

There is evidence that reducing the nicotine content of cigarettes may decrease their addiction potential in populations that are highly vulnerable to tobacco addiction including people with experience of serious mental illness and those on low incomes. (Higgins et al., 2017).

There is a strong precedent for this reducing nicotine in cigarettes from the USA where the FDA's 2018 Advanced Notice of Proposed Rulemaking recommended developing a tobacco product standard for nicotine levels in cigarettes, which would mandate minimal or non-addictive nicotine levels (Food and Drug Administration 2018).

We also recommend a public education campaign, to explain that removing nicotine reduces the addictiveness of smoked tobacco and that nicotine is not the most toxic constituent of tobacco. This is important to prevent people who want to quit smoking, to be put off from using NRT products or switching to e-cigarettes.

Public support for reducing nicotine levels and making cigarettes less appealing

New Zealand research in 2018 found strong public support for reducing nicotine levels in cigarettes and tobacco by people who smoke (72%) and those who have recently quit (78%) if nicotine was available in other products (International Tobacco Control, 2020).

- Of the 844 community submission templates collected by the Cancer Society this year 717 (85%) wanted Government's Smokefree Action Plan to include 'lowering nicotine levels and making cigarettes less appealing'.
- A May 2021 online social media poll asking the public if they supported reducing the amount of nicotine in cigarettes found 94% (n=82) of the 87 votes cast supported this measure while 6% (n=5) did not support it.

b). **Do you support prohibiting filters in smoked tobacco products?**

☒ Yes ☐ No

As noted in your consultation document, filters do not reduce harm from smoking and have been shown to increase the risk of adenocarcinoma of the lung. Filters are used by tobacco companies to manipulate people into thinking they make smoking safer. In addition, tobacco companies use filters to introduce innovations e.g. adding flavours to cigarettes to attract new people to smoking. Cigarette butts also massively contribute to the degradation of our environment. Any one of these reasons is enough to warrant prohibiting filters in tobacco products but combined, the evidence for support is overwhelming.

Marketing and effectiveness of filters in reducing harm

When lung cancer fears emerged in the 1950s, cigarette companies initiated a shift in cigarette design from unfiltered to filtered cigarettes. Over the following decades, cigarette companies appeared to transition away from mitigating the health hazards of smoking towards the perpetuation of the notion that cigarette filters are effective in reducing smoking toxins and hazards. Filters became a marketing tool, designed to recruit people who smoke and retain them as consumers of these hazardous products (Harris, 2011). Both the ineffectiveness of cigarette filters and the tobacco industry's misleading marketing of the benefits of filtered cigarettes have been well documented.

The US Surgeon General and the National Cancer Institute in the US have found no evidence that filters reduce harm to people smoking (Oren et al., 2020; US Department of Health and Human Services, 2001; US Federal Trade Commission, 2018). In 2014, the Surgeon General's Report on the Health Consequences of Smoking stated: "The evidence is sufficient to conclude that the increased risk of adenocarcinoma of the lung in smokers results from changes in the design and composition of cigarettes since the 1950s" (US Department of Health and Human Services, 2014; Song et al., 2017).

Filters have merely changed where cancer is more likely to develop within the lung (Brooks et al., 2005). Across the time filters have been used, adenocarcinomas have increased while squamous cell carcinomas have remained stable, while both types of cancer remained stable in non-smoking populations (Burns et al., 2011; Marugame et al., 2004). A possible reason for this is that filters allow people to inhale more deeply, so cancer in the distal parts of the lung is much more common than in the mid-twentieth century when it primarily occurred more centrally (Brooks et al., 2005). Squamous cell carcinomas have been replaced by more aggressive adenocarcinoma making smoking with filters more harmful than unfiltered smoking (Brooks et al., 2005; Everatt et al., 2011; Ito et al., 2011).

Tobacco companies' extensive research during the 1950s and 1960s revealed that filters do not reduce harm (Harris 2011). As the public became aware of the risks of smoking (Doll & Hill 1999; Doll et al., 1994, 2004) tobacco companies began to investigate filters for reducing harm. However, when their research showed this was not possible, they moved on to what has been

described as 'the deadliest large-scale fraud' (Evans-Reeves et al., 2021; Hoek et al., 2021) and continued to market filters as making smoking safer (Harris 2011). Tobacco companies took advantage of the public perception of reduced harm from filters via implicit and explicit advertising claims (Hoek et al., 2021; Song et al., 2017; O'Connor et al., 2008). Tobacco companies have also made alterations to the filters to take advantage of this perception.

Because filters made drawing on a cigarette more of an effort, tobacco companies introduced filter ventilation; vents, or small perforations around the filter to make 'dragging' easier (Hoek et al., 2021). Filter ventilation is a crucial design feature creating three main problems for lower-tar cigarettes as measured by official smoking machine testing. Firstly, it misleadingly makes cigarettes taste lighter and milder, and, therefore, they appear less dangerous to people who smoke. Secondly, it promotes compensation mainly by facilitating the taking of larger puffs. Thirdly, for very heavily ventilated cigarettes (that is, > 65% filter air dilution), behavioural blocking of vents with lips or fingers is an additional contributor to compensatory smoking. These three effects are found in industry research as well as peer-reviewed journals (Kozlowski et al., 2002).

Tobacco companies also changed the pH level in the filters which meant they discoloured after smoking, and a researcher working for them noted that while it would have no actual filtering action 'the sales advantages are obvious' (Harris 2011; van Schalkwyk et al., 2019).

Indeed, tobacco companies have not only changed the pH to perpetuate the myth that filters make smoking safer but have used innovations in filters to attract new customers, particularly youth, by using flavoured filters such as menthol, mint, and fruity flavours. Tobacco companies claim they are trying to attract people who smoke other brands (Pollay, 2000). However, given most adults who smoke say taste is the reason they choose their preferred brand (i.e. of non-flavoured cigarettes) this suggests that new non-smoking recruits are the more likely target of these products (Cowie et al., 2014; Moodie et al., 2018). Non-smoking young adults have indeed been more likely to try these products than young adults who already smoke (Hoek et al., 2019; Moodie et al., 2018). These products are proving popular too, sales have grown rapidly even in places like New Zealand where over all tobacco use is declining (Abad-Vivero et al., 2016; Haggart et al., 2018; Thrasher et al., 2016). This growth in sales is very likely to represent recruitment of replacement customers rather than brand switching from people who already smoke. Given that two thirds of tobacco companies' customers die when they use the product as directed (Banks et al., 2015; Pirie et al., 2013), it is no surprise that innovations to recruit new customers is happening whenever possible.

Environmental impacts of tobacco waste

Banning filters also makes sense from an environmental perspective. It is estimated that 4-4.5 trillion cigarette filters are littered globally each year (Evans-Reeves et al., 2021; Hoek et al., 2021; Torkashvand & Farzadkia 2019) easily making them the most commonly littered item worldwide (WHO, 2017). Each year more than six million are discarded in New Zealand (Hoek & Gendall, 2019). Filters are normally made of plastic (cellulose acetate) therefore remain in our environment for decades (Kabasci, 2013) all the while leaching toxins from tobacco into the environment (Novotny & Slaughter 2014; Roder Green et al., 2014; Slaughter et al., 2011; Truth Initiative, 2017). Although the plastic in filters can break down it does not biodegrade fully therefore contributing to microplastic contamination (Moerman et al., 2011; Lee & Lee, 2015). Tobacco waste ends up on beaches and in urban areas, in playgrounds, sports fields, gutters and eventually makes its way via storm water drains to rivers, lakes, and out to sea contributing to plastic islands. There is also evidence that these products are being ingested into the food chain (Moerman et al., 2011; Lee & Lee, 2015; Novotny & Slaughter 2014; Slaughter et al., 2011). Sea creatures and birds risk ingesting discarded butts exposing them to toxic chemicals and plastic trash. A significant proportion of people who litter cigarette butts in Aotearoa New Zealand don't recognise them as plastic or consider it littering. This pollution is

of considerable concern in any country, but in Aotearoa given our obligations as Te Tiriti partners it is especially concerning as waterways are important taonga for tangata whenua, for example as food sources and maintaining wairua.

Like second-hand smoke exposure, tobacco product waste on our streets, bus stops, parks and beaches is a visible reminder of tobacco use (Oliver J et al., 2014; Smith EA, McDaniel PA, 2011; Patel V et al., 2013; Wilson N, 2014). For people who smoke, it may serve to further normalise the ritualised nature of tobacco product waste disposal (Metcalfe et al., 2017).

Sustainable Coastlines report that cigarette butts and filters are 4th in their top 10 categories of litter found across the 224 beach sites their 7,778 citizen scientist volunteers monitor across Aotearoa. Cigarette butts make up 4.8% of the total litter they find in these beach surveys and are easily ingested by marine animals (see attached letter of support for banning filters).

Worth noting also is the large-scale environmental impact of tobacco farming which disproportionally impacts low- and middle-income countries. The impacts include erosion, loss of soil productivity for food crops, acute shortages of wood for construction and fuel for cooking, destruction of ground water resources, sedimentation of rivers, reservoirs and irrigation systems, climate change, species extinction due to habitat fragmentation and overexploitation, as well as negatively impacting the health of people engaged in tobacco cultivation (Lecours et al., 2012; Abdallah & Monela 2007).

Tobacco industry tactics

Tobacco companies have successfully framed people who smoke as the cause of, and only solution to tobacco waste, neatly avoiding their own culpability as product manufacturers (Hoek & Gendall, 2019). They fund environmental organisations like Keep America Beautiful (Wallbank et al., 2017) and locally, Keep New Zealand Beautiful (Hoek et al., 2021) through which they advocate the use of butt bins and volunteer street/beach clean-ups to abdicate their responsibility for this toxic waste product (Smith & Novotny, 2011).

Tobacco companies should be held accountable for the costs incurred from butt waste in the environment.

Tobacco companies may argue that instead of banning filters we switch to use/design biodegradable filters, however we strongly recommended against this. Biodegradable filters will not reduce the risk of adenocarcinoma of the lung. They will still leach toxins into the environment, people will continue to think filters make smoking less harmful, and tobacco companies will use green washing to endear public favour (Hoek et al., 2021; Houghton et al., 2018). Furthermore, internal research obtained from tobacco companies suggests that biodegradable filters will make people more likely to litter as they will believe them harmless to the environment; 'to litter without guilt' (Smith & Novotny, 2011).

Potentially tobacco companies may offer filter alternatives like old-fashioned cigarette holders, therefore policies should ban all merchandise that facilitates smoking including cigarette holders (Hoek et al., 2021). Policies banning innovations and additives in tobacco products will be required in addition to banning filters to ensure tobacco companies do not take advantage of loopholes to keep recruiting new customers (Evans-Reeves et al., 2019). Policies banning filters must also ban any filters sold separately for roll-your-own tobacco.

c). **Do you support allowing the Government to prohibit tobacco product innovations through regulations?**

☒ Yes ☐ No

The Cancer Society supports adding regulatory power to the Smokefree Environments and Regulated Products Act 1990 to enable the Government to quickly prohibit innovations aimed at increasing the appeal and addictiveness of smoked tobacco products. Tobacco companies

take advantage of loopholes and make innovations rapidly (Evans-Reeves et al., 2019, 2020; Hoek et al., 2016; Scollo et al., 2015).

We suggest rather than changing regulations in response to industry innovation, the industry should be required to seek government approval through a clearance process prior to the sale of new products or innovations in New Zealand, so that the onus is on the tobacco industry to prove their new products are safe, rather than on the government to prove they are unsafe.

Recent innovations include:

1. Tobacco companies increased efforts in flavouring innovation in response to standardised packaging legislation, e.g., in Australia (Scollo 2018) and in New Zealand (Haggart et al., 2020). Flavour Capsule and 'fusion' leaf flavours have been used to increase the appeal of tobacco products to young people and non-smokers. The flavourings reduce the harshness of cigarette smoke, make them more palatable and allow people to customise their cigarette's taste (Hoek, 2019). As discussed in 3b these flavour capsules have been most appealing to young people who did not already smoke and are unlikely to appeal to people who have smoked long-term (Cowie et al., 2014; Hoek et al., 2019). This innovation has proven a useful tool for recruiting new customers. Sales have grown rapidly even when smoking prevalence overall is dropping (Abad-Vivero et al., 2016; Haggart et al., 2018; Thrasher et al., 2016).
2. Similarly, when legislation standards in packaging were brought into the UK there was an increase in innovations in roll-your-own accessories (Evans-Reeves et al., 2019) e.g. 'ultra slim' and slim filters and papers, biodegradable filters, and 'menthol tips'.
3. Likewise, in Australia tobacco companies introduced a proliferation of variant names, using words like 'fine', 'rich', and 'smooth' and incorporating colour names. *Pall Mall Amber* for example became *Pall Mall Smooth Amber* and *Pall Mall Blue* became *Pall Mall Rich Blue*. These names also served to displace more of the standardised packaging by taking up more space with text, e.g. *Peter Stuyvesant New York Blend* or *Peter Jackson Hybrid Blue* (Hoek et al., 2016). Value-implying names were used, something we currently see in NZ with variant names *Deals* and *Easy* at very low costs (November 2020 at an Invercargill vape store Easy 20 pack $25.40, Deals 20 pack $24.90, Easy 30g loose tobacco $49.95 Deals 30g loose tobacco $49.95). Descriptors like these especially those suggesting reduced harm, enjoyment, social or sexual success should be banned altogether (Hoek et al., 2016; Scollo et al., 2015).

Menthol flavouring

Menthol flavouring in cigarettes has long been shown to make it easier for people to start smoking and harder for people to quit (Villanti et al., 2017). Menthol masks the unpleasant taste of traditional cigarettes as well as interacting with nicotine to increase its addictiveness (Wickham 2015). Particularly concerning is that menthol cigarettes are more popular among high-school aged Māori and Pacific children (Li et al., 2013).

The WHO recommended a ban on menthol cigarettes in 2016. National and regional governments have been successful in banning menthol in cigarettes, including Turkey, Brazil, Ethiopia, over 20 US states, Canada, the UK and the European Union. The US Food and Drug Administration (FDA) announced in April 2021 that it would be banning menthol flavourings in cigarettes as a high priority. Their decision is based on clear evidence establishing the addictiveness and harm of these products as well as strong public and health sector support. It has been recommended that menthol ingredients, as well as flavours, need to be banned (Glantz, 2021).

Menthol cigarettes also appear to reduce the effectiveness of lowering nicotine in cigarettes. In a study examining smoking cessation people who smoked menthol VLNCs were almost five times less likely to stop smoking than those smoking regular VLNC after the 20-week intervention (Delinger-Apte 2019).

We recommend this measure is used alongside banning all current additives and innovations including but not limited to flavours, additives, variant descriptors, and design features that makes it easier or more appealing to smoke, for example cigarette holders.

4: Make tobacco products less affordable

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

☒ Yes ☐ No

The Cancer Society supports Government's proposal to set a minimum price for tobacco. There is international evidence that the full public health benefit of tobacco taxation is not always reached because of industry circumvention (Whitehead et al., 2018). There is evidence that New Zealand's tobacco companies have been undermining the impact of tax increases by minimising price increases on budget brands and instead strategically shifting price increases onto premium products[4] (Marsh et al., 2016). This 'under-shifting', differential pricing and the introduction of budget and super-budget brands are all attempts to minimise the impact of excise tax increases on smoking prevalence and consumption (Marsh et al., 2016).

A key concern about industry pricing strategies is that they have introduced ultra-budget brands to attract new recruits and keep poorer customers addicted. For example, despite 10% excise tax increases in 2014 the median increase in price from before to after the tax change was only 3% for the budget brand. This contrasted with the median of 8% for the premium brand and 11% for both mainstream and roll-your-own brands (Marsh et al., 2016). This strategy undermines the tax increases intended to motivate people to quit.

Industry tactics undermine tobacco excise tax increases by enabling people who smoke to minimise the financial impacts of excise taxes, hence reducing the stimulus to quit and facilitating continued smoking. The resulting price differential between cheap and premium tobacco may maintain or widen health inequities, undermine cessation and impede the realisation of New Zealand's Smokefree 2025 goal.

Unpublished New Zealand research[5] found the tobacco industry also used annual tax increases as cover for significant voluntary price increases, which significantly increased their profit margin while introducing cheaper ultra-budget brands or subsidising cheaper products. The research found ultra-budget brands like Phillip Morris' Choice and British American Tobacco's Winfield Select $4 cheaper than the average pack of cigarettes.

The Ernst & Young population survey and community focus groups on tobacco tax found that people who smoke switch to budget brands or to roll-your-own tobacco to reduce costs (Ernst & Young, 2018). This finding aligns with a previous qualitative study (Hoek et al., 2016). In addition, there are anecdotal accounts from dairy owners who say that people are buying cheaper cigarettes rather than quitting[6].

[4] Media article: Convenience stores face bleak future unless they change. STUFF Sept 19, 2018 https://www.stuff.co.nz/business/107193424/convenience-stores-face-bleak-future-unless-they-change-experts-warn.

[5] Media article: NZ tobacco companies use tax hikes as cover *Summer Newsroom* 21 November 2019, https://www.newsroom.co.nz/2019/11/21/913218/nz-tobacco-using-tax-increases-as-cover.

[6] Media article 'Tobacco tax fuels black market in Rotorua.' *New Zealand Herald* 10 January 2020. https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12298523

A rapid review on the strengths and limitations of tobacco taxation and pricing strategies found that tobacco floor pricing has significant potential to reduce health inequities by limiting the price strategies used by tobacco companies to circumvent excise tax increases (Whitehead et al., 2018). Floor pricing is based on the final retail price and establishes a minimum price below which sales are prohibited by law (e.g. on a per stick or per pack basis) as is proposed in the NZ Government Proposal.

Regular excise tax increases

We are disappointed that tobacco tax increases have not been included as a proposed Smokefree Aotearoa 2025 action. This is despite the RIS acknowledging that affordability is still a key driver to quitting and preventing people starting to smoke. It also acknowledges that continued price increases are likely to strongly support equity.

There is strong evidence for regular above-inflation tobacco excise tax increases. (Ernst & Young 2018, Cobiac et al., 2015, van der Deen, 2018). Ernst & Young in their review of excise tobacco tax recommended that the government continue with annual increases in tobacco excise tax (above inflation) beyond 2020.

They concluded that increasing the price of tobacco continues to be the single most effective tool for reducing tobacco use and that ***"the weight of evidence is that excise tax increases are an essential part of a package of interventions needed to reduce tobacco consumption and daily smoking prevalence."*** They concluded that after nine years of 10% annual tax increases +CPI, smoking rates had decreased across all age groups, ethnicities, genders and deprivation quintiles.

A 2020 systematic review found price increases have the potential to reduce health inequities (Smith et al., 2020c) with greater impact among lower socio-economic (SES) groups. These results built on a previous 2014 review of tobacco control interventions which also found price/taxation measures as the intervention with the greatest potential to reduce socioeconomic inequalities in smoking (Hill et al., 2014).

Price increases have a greater impact on quit rates and smoking uptake among those in lower socio-economic groups. Māori are more likely to have much higher per capita health gains from tobacco tax increases (van der Deen et al., 2018).

The Cancer Society acknowledges community concerns about the potential increase in financial hardship for lower-income groups who are unable to quit or continue to smoke (and potentially their household). Ernst & Young found evidence that high tobacco prices imposed adverse financial impacts on some people who smoke. However low-income people who quit as a result of tax increases will be financially better off (Ministry of Health, 2021).

Public and health sector support for increasing price of tobacco products

New Zealand research, in 2018, found 78% of people who smoke and people who recently quit supported increasing tax on tobacco if the extra money is used to promote healthy lifestyles, including helping people to quit smoking (International Tobacco Control, 2020). There is a strong social justice and equity case for revenue raised to be used to fund measures to help people to quit and remain Smokefree.

- Of the 709 community submission templates collected by the Cancer Society this year that asked about price increases 571 (81%) wanted Government's Smokefree Action Plan to include commitments to 'increase tobacco tax and use that money to support people to quit smoking'.

Te Tai Tokerau iwi regional cessation provider, Te Hiku Hauora Health Service, has voiced concerns about the discontinued annual tobacco tax increases as they have identified a significant drop in demand for their smoking cessation services this year. Historically in

November and December Te Hiku Hauora raised local awareness about cessation services in anticipation of the influx of self-referrals and ensured whānau were enrolled into a quit programme prior to the January 1 annual tax increase. This year however, the first with no tobacco tax increases for a decade, they received no self-referrals and engaging whānau in cessation programmes has been difficult. The Manager of Te Hiku Hauora found the tax increases a successful driver for whānau to seek out cessation support.

It is important to know whether a similar drop in demand has been noticed in Quitline calls.

If Government does not continue with tax increases the Cancer Society and both Te Tai Tokerau's iwi providers Te Hiku Hauora Health Service and Te Haa Oranga Health Service recommend the Government introduce an industry levy on the tobacco industry with funds directed to community cessation programmes. This would allow for community-based initiatives like peer support and community champion programmes with people who have successfully quit smoking, and support for services to provide more holistic cessation programmes.

The Cancer Society supports reinstating annual excise tax increases, above inflation, combined with introducing a minimum price policy. The Ministry of Health's RIS acknowledges that combining an excise increase with a minimum price will gain the greatest impact. The annual 10% +CPI tax increases have been shown to increase prices which have in turn decreased smoking prevalence and prevented people starting to smoke, and the minimum price will prevent proliferation of budget brands. Both these measures need to be part of a comprehensive plan to achieve Smokefree 2025.

To maximise the impact of these measures we would like to see the additional revenue raised from tax increases used to support low-income people who smoke to quit, by providing more effective wrap-around cessation support services, and/or subsidized effective quitting aids. Tobacco tax increases have saved thousands of lives in Aotearoa. We need them to continue to save lives.

It's important the Smokefree actions are backed up with sufficient enforcement to prevent a black market. For example, Customs would need extra funding to make sure there isn't increased smuggling at the border.

5. Enhance existing initiatives

(a) Increase investment in mass and social media campaigns

CSNZ supports the Ministry's comments and conclusions about the proven importance of mass media campaigns to support both cessation and the prevention of youth uptake as part of our longstanding and successful comprehensive approach to reducing smoking prevalence and tobacco-related harm.

We agree that more investment is needed in mass media activities targeting young people to stay Smokefree and Vape-free.

However, campaign reach, intensity, duration and message type will influence the success of any campaigns implemented. It is essential to achieve sufficient population exposure, especially for lower socioeconomic status people who smoke (Durkin et al., 2012). The usual measure for exposure is TARPS, which is a term used in marketing to measure the reach and frequency of communications. No information about TARPS in recent campaigns was able to be obtained through the OIA process, which limits assessment of these campaigns.

Regardless of limited information, campaigns must be funded adequately to provide high reach and frequency across key population groups.

Table 1 below shows that expenditure on mass media campaigns has fallen quite significantly over the years, which questions whether appropriate exposure has occurred.

Table 1. Comparison of media expenditure in 2008/09 with the years 2015/16 – 2018/19[7]

		2008/9	2015/16	2016/17	2017/18	2018/19
PROVIDER		**HSC**	**HPA**	**HPA**	**HPA**	**HPA**
Prevention of youth uptake	Media/ Production		976,000 268,000	630,000 77,000	643,000 95,000	388,000 27,000
	Total	**2,146,596**	**1,244,000**	**707,000**	**738,000**	**415,000**
PROVIDER		**Quit Group**	**Homecare Medical**	**Homecare Medical**	**Homecare Medical**	**Homecare Medical**
Smoking cessation	Media	1,984,237	594,000	338,000	380,000	282,000
	Production	378,136	370,000	37,000	38,000	26,000
	Total	**2,362,373**	**964,000**	**375,000**	**418,000**	**308,000**

Preventing youth uptake

We note that in recent years, there has been minimal investment in preventing uptake of smoking in young people through mass media campaigns. In this respect, New Zealand has been falling behind other countries such as the US which have been running youth prevention campaigns such as Truth[8] and Real Cost[9] for many years.

The Truth campaign provides an example of how well young people respond to social marketing that exposes tobacco industry tactics. The campaign created a social movement of young people opposed to tobacco and reduced smoking uptake in young people (Allen et al., 2009). The Real Cost campaign was also found to be effective in reducing uptake (Duke et al., 2019). New Zealand has taken a much softer approach to youth social marketing and in recent years has relied more on increases in excise tax to prevent youth uptake of tobacco products. It is timely to reconsider using campaigns that focus on industry tactics, as annual increases in excise tax have been stopped.

New Zealand's recent experience with vaping products being marketed aggressively to children also needs to be taken into account in planning youth social marketing campaigns. Although it is not yet clear to what extent vaping is impacting on smoking behaviour in school students (youth tobacco surveys were not undertaken during 2020, and 2021 data will not be available until 2022), there has been ongoing media coverage of schools' concerns about youth vaping[10]. It is timely also to consider investment in campaigns to prevent vaping uptake in this group.

Investment in social marketing to youth has dropped markedly since 2008. Information obtained by the Cancer Society under the Official Information Act (OIA) showed that for the five-year period 2014/15-2018/19 the Health Promotion Agency (HPA) spent a total of $571,000 on production and $4,146,000 on media placement for preventing youth uptake, an

[7] These figures were obtained through OIA requests made by ASPIRE researchers for the 2008/09 figures and the Cancer Society for the later years. They are best regarded as estimates due to lack of certainty about what was included in the data provided. For example, it is not clear whether the Health Sponsorship Council (HSC) total for 2008/09 included both media and production. By 2015 the Health Promotion Agency (HPA) was responsible for tobacco programme social marketing, and Homecare Medical promoted the Quitline - now part of their services.

[8] **About Truth | truth (thetruth.com)**

[9] **The Real Cost Campaign | FDA**

[10] Media article retrieved on 24 May 2021 from **Vaping problem in schools at 'almost epidemic proportions' | Stuff.co.nz**

average of $943,400 a year. This compares with Health Sponsorship (HSC) expenditure of $2,146,596 in 2008/09 (see Table 1 above). It is not clear whether the HSC figure includes both production and media placement, but clearly there has been a significant drop in annual mass media investment since that time.

These figures suggest it is very unlikely that NZ is making best practice levels of investment in social and mass media campaigns. We are pleased to note that there is proposed additional investment in these areas and note that such campaigns need to be sustained over time and meet minimum exposure levels.

Smoking cessation

No data was available for smoking cessation campaigns for 2014/15, but for the four-year period 2015/16-2018/19, Homecare Medical (Quitline provider) spent $471,000 on production costs and $1,594,000 on media spend, an average of $516,250 a year to promote Quitline. This compares with 2008/9 expenditure by Quitline of $2,362,373 – a major reduction in investment in mass media for promoting smoking cessation.

The Ministry of Health also funded the *Vape to Quit* campaign to a total budget of $1,670,000 for the 2019/20 year – the campaign was put on hold until the legislation passed and has been running since then.

There may be inaccuracies in the data in Table 1, but there is no doubt that expenditure on mass media for both components of the tobacco programme has significantly declined since 2008/09 and certainly does not meet the best practice levels set out by Durkin and others. Expenditure in 2018/19 was a tiny proportion of the expenditure in 2008/9 (even without adjusting for inflation), which raises serious concerns about how well new policies and new social norms have been supported. At the same time, tobacco excise tax revenue has increased substantially since 2011.

Strategic role of social marketing

Social marketing campaigns are most successful when undertaken as part of a strategic and integrated programme of work and sufficiently resourced to meet best practice guidance on campaign reach, frequency and duration (Hoek et al., 2021)[11]. They must also reflect the needs, priorities and voices of communities most impacted by the problems being addressed.

It is heartening that the draft plan has a strong focus on strengthening Māori governance and addressing equity issues. Public commitment to establishing a Public Health Agency and Māori Health Authority will be instrumental in helping address these challenges.

Of the 709 community submission templates collected by the Cancer Society this year that asked about mass media campaigns 572 (81%) wanted Government's Smokefree Action Plan to include commitments to 'fund more smoking prevention media campaigns'.

In conclusion, the Cancer Society recommends much greater investment in mass and social media campaigns – both to promote smoking cessation services (and especially for priority populations) and prevent youth uptake of smoking **and** vaping.

(b) Increase investment in stop smoking services for priority populations

Stop smoking services (excluding the Quitline) cost around $10m per year[12], and as previously suggested, ought to be reviewed before further investment is made (other than for further development and evaluation of services for Māori women). This review needs to include an

[11] Retrieved on 25 May 2021 from **Social Marketing for Smokefree Aotearoa 2025: Reminding, Reinforcing, and Changing Social Norms – Public Health Expert, University of Otago, New Zealand**

[12] Estimate provided by Ministry of Health via email sent 13 May 2021.

assessment of both effectiveness and value for money compared with investment in other activities for reducing prevalence. It also needs to include current Quitline services delivered by Homecare Medical, about which no information appears to be publicly available.

It has been estimated that around 90% of people who stopped smoking, even after NRT became available, did so without assistance (American Cancer Society 1986). Despite years of marketing efforts by pharmaceutical companies and delivery of smoking cessation services in the USA since then, unassisted cessation remains the most common form of quitting, and has been found to produce 2.8 times more successful quit attempts than are attributable to NRT (Chapman & Wakefield, 2013).

There remains very limited evidence on the effectiveness of vaping products in supporting smoking cessation, and recent review studies have found most e-cigarette trials continue to have moderate or high risk of bias (Chan et al., 2021). Furthermore, a recent analysis of NZ Health Survey data (Edwards et al., 2019) found that the introduction and marketing of vaping products in New Zealand since 2015 has had no apparent impact on reducing prevalence.

> "The figures reveal a steady increase in the trial, regular and daily use of e-cigarettes/vaping from 2015/16 to 2018/19. This increase has not been accompanied by any notable acceleration in reductions in smoking prevalence or an increase in quit rates, as might be expected if e-cigarettes were encouraging and supporting large numbers of smokers to quit or transition away from smoking to vaping." *(Edwards et al., 2019)*

It remains to be seen whether investment in 'vape to quit' promotion will impact on smoking prevalence. Evaluation and monitoring will be essential to establish the effectiveness of this approach balanced against the impact of vaping on young people's smoking behaviour.

Is more investment in cessation services the best way to reduce smoking prevalence?

Significant doubts have been raised by NZ researchers about the likely impact on smoking prevalence and health gain of investing more funds into cessation services and their promotion. Modelling suggests it will require a 'massive increase' of funds into smoking cessation to impact on smoking prevalence (Wilson et al., 2018, p. 30). It should be noted that the modelling for this study assumed that additional cessation investment would be accompanied by substantial annual tax increases. Without ongoing tax increases it seems that even more funding would be needed for smoking cessation to impact on smoking prevalence.

The economic benefits and potential health gain of investing in cessation rather than other tobacco strategies was investigated by Nghiem and colleagues (2018), who compared this with other tobacco control interventions using the same multistate life-table model.

We note that the modelling in this study was based on "the intervention package of mass media promotion and Quitline service, as actually used in New Zealand in 2011. That is, the expenditure of $NZ 2.92 million on smoking cessation messages with the Quitline number in the mass media (including the campaign management costs), combined with the running of the national Quitline costing $6.2 million" (Nghiem et al., 2018, p. 435).

(Please note that no recent information about the cost of the current Quitline service is available, and that 2018/19 expenditure on promoting the service was only $308,000 – a fraction (10.5%) of that spent in 2011.)

Nghiem and colleagues found that the health gain for Quitline services (including mass media promotion) for one year was only 7% of that for a modelled multiyear tobacco tax intervention and 16% of that for a modelled tobacco retail outlet reduction intervention (see Table 2 below).

Table 5 Comparison of the results from this study with other modelled tobacco control interventions for New Zealand (ordered by increasing health gain and all using the same BODE[3] tobacco model with a discount rate (DR) of 3%)

Tobacco control intervention	Health gain (QALYs)	Relative per capita QALYs gained for Māori versus non-Māori (age-standardised)	Cost savings ($NZ million)
This study—package of mass media and quitline service for 1 year of routine operation	4200	3.6*	84.0
The most effective of four tobacco retail outlet reduction strategies, that is, limiting sales to 50% of alcohol outlets and nowhere else[8]	26 500	5.3 but not fully comparable (DR=0%, not age-standardised)	525
This study—package of mass media and quitline service but run for 20 years (scenario C)	54 100	3.5	1070
Annual tobacco tax increases for 20 years[7]	57 500	4.9 but not fully comparable (DR=0%, not age-standardised)	1160
The second highest impact endgame strategy (a combination of tax increases, substantial outlet reduction and the 'tobacco-free generation strategy'), as per van der Deen *et al*,[9] including online supplementary material)	119 000	3.3	2600
The highest impact endgame strategy: a sinking lid on tobacco supply[9] (down to zero in 2025 the year of the New Zealand government's smokefree goal[35])	282 000	3.0	5430

*Comparing the per capita QALY gain for Māori compared with non-Māori as in table 3 (2.19/0.729 per 1000 population) gives a result of 3.0. But after age-standardisation, given the younger age of the Māori population, this value is 3.6.
QALY, quality-adjusted life-years.

Table 2. Comparison of modelling of Quitline with other modelled tobacco control interventions
(Nghiem et al., 2018, p. 439.)

The authors concluded that while Quitline services and their promotion appeared to be an effective means to generate health gain, it needed to be compared with other interventions, some of which appeared to be more effective. Given the huge reduction in investment for Quitline promotion between 2011 and 2018/19 the gap in health gain between cessation and the other interventions is likely to now be even wider.

Comprehensive cessation support for populations with higher smoking rates

CSNZ supports the Ministry's comments about the difficulty people have in stopping smoking, and especially for those who 'face complex challenges in their life'. More comprehensive support is needed to help those people who have become addicted to nicotine and find it hard to quit. We acknowledge the efforts of the Ministry to trial such approaches over the years and recently with Māori women. The advent of the Māori Health Authority and Māori governance in tobacco control will hopefully create more opportunities for reducing smoking prevalence in these communities.

We note from the RIS that some formative evaluation and quality improvement processes have been undertaken to make stop smoking services more acceptable to Māori women and that an outcome evaluation is planned. CSNZ strongly supports this work as a priority, with potential to reduce inequities.

We also draw your attention to recent randomised controlled trials undertaken by Dr Nina Scott (Waikato DHB) in successfully providing personalised support for using NRT products with pregnant Māori women.

Support for young people to quit vaping

Walker and colleagues (2020) analysed 2019 Year 10 data and found that daily vaping was 3.1% and identified "a statistically significant increase over time in the proportion of year 10 students regularly using e-cigarettes (from 3·5% in 2015 to 12·0% in 2019)".

The Youth19 survey of 13-18-year-olds (*n*=7,700) found that 38% had tried vaping, 10% were vaping regularly and 6% weekly or more often. Nearly two-thirds (65%) of students who had ever vaped, and nearly half (48%) of regular vapers had never smoked cigarettes.

Because there is no 2020 youth data it is not known whether the upward trend for both daily and regular vaping in young people has continued but given aggressive industry marketing up until the legislation was passed in November 2020, it is very likely.

New Zealand now has a cohort of young people who have had easy access to pod vapes with very high levels of nicotine (up to 60mg/ml) for at least two years. There are recent anecdotal reports from school principals[13] and from school counsellors of children who are heavily addicted and experiencing vaping-related mental health issues including anxiety and depression.

New Zealand has a very different regulatory context from that in Europe and the UK, where nicotine levels have been limited to 20mg/ml and much less aggressive marketing has been allowed.

It is important to make every effort to protect young people until there is more information about vaping and smoking prevalence, and what impact vaping is having on young New Zealanders.

Consideration also needs to be given to helping both children and adults to quit vaping.

Final questions

a). **Of all the issues raised in this discussion document, what would you prioritise to include in the action plan? Please give reasons.**

The Cancer Society supports all the measures consulted on in the Proposals for a Smokefree Aotearoa 2025 Action Plan. We agree that a comprehensive suite of measures is needed to reach and maintain Smokefree Aotearoa 2025. New Zealand has made good progress in reducing smoking prevalence over the last few decades by adopting a comprehensive approach, and we suggest that these new measures will support and reinforce the current programme. The Cancer Society, based on available evidence, supports the following key priorities for immediate commitment:

- Significantly reducing the number of retailers selling tobacco to around 300 R18 licensed specialist tobacco retailers through a planned process
- Reducing the nicotine to very low levels in smoked tobacco products.

If these two priorities are effectively implemented, it will result in significant and rapid reductions in smoking prevalence and result in major health gains, health system cost savings and reduce health inequities. There is high public support for these measures.

The following measures are needed to support and complement the above key interventions and ensure New Zealand achieves Smokefree 2025:

- Increase investment in effective mass media (including social media) campaigns to prevent youth uptake of smoking and vaping, promote quitting and promote understanding and support for the Smokefree 2025 goal and the policies needed to achieve it.
- Extend legislation to ensure outdoor public places are both Smokefree and Vape-free. This would align with overseas jurisdictions where they have enforceable regulations and would create consistency nationally, rather than having 67 territorial local authorities working separately on Smokefree outdoor places (refer to section below).
- Introduce a Smokefree Generation Policy to prevent youth smoking uptake, as it is likely to reduce inequities.

[13] Retrieved 24 May 2021 from **Vaping problem in schools at 'almost epidemic proportions' | Stuff.co.nz**

- Ban tobacco industry product innovations that are designed to appeal to young people.
- Prohibit filters in smoked tobacco products as it will make smoking less palatable, and filters are not effective at reducing the risk of adenocarcinoma of the lung and other diseases. Plus this initiative will reduce the significant environmental pollution caused by butt litter.
- Set a minimum price for tobacco to prevent tobacco industry undermining prices and reinstate regular price increases as an industry levy with money generated used to support people to quit smoking.
- Phase out the sale of vaping products from all generic retailers.
- Support effective smoking cessation initiatives particularly for priority populations.

The following measures are essential for the effective implementation of the action plan:

- Strengthened Māori Governance of the tobacco control programme.
- Significantly strengthened monitoring, compliance and enforcement of the Smokefree Environments and Regulated Products Act and all associated regulations (and any new legislation/ regulations that arise from the Government's Smokefree Action Plan).
- Increased support for community action to promote and support the Smokefree Aotearoa 2025 goal and the measures needed to achieve it.
- Review the current tobacco programme service mix, allocation of resources and effectiveness to assess where value can be added to existing services.
- Develop a comprehensive evaluation and research plan to assess progress towards achieving and maintaining the Smokefree Aotearoa 2025 goal.
- Strengthen workforce development across the sector.

It is possible that some of the plan's proposed measures may increase online purchase and importation of overseas tobacco. We encourage the Government to take appropriate measures to ensure the intent of policies are not undermined (from both underage or adult purchases online from overseas).

Where changes do not need legislative change (e.g. increased mass media campaigns) these could be implemented on a faster timescale. We need to get cracking to achieve Smokefree 2025.

b). **Do you have any other comments on this discussion document?**

Legislate smokefree outdoor public spaces

The Cancer Society was very disappointed to see that mandated Smokefree outdoor public places was not included in the Proposed Smokefree Aotearoa 2025 Action Plan. Currently the only nationally legislated Smokefree outdoor areas (as of 2004) are schools, kura, early childhood centres, and kōhanga reo (Wilson et al., 2016). In 2020 these also became Vape-free. Internationally we are now far behind in providing enforceable Smokefree outdoor spaces to support people trying to quit smoking, protecting workers and public from tobacco smoke, and reducing smoking visibility to children and young people (Marsh et al., 2014; Murad et al., 2019; Thomson & Wilson, 2021; Wilson et al., 2007).

Given that there is 'no safe level of exposure to second-hand tobacco smoke' (WHO, 2007) a prime motivation for introducing Smokefree public spaces has been to reduce people's exposure to second-hand smoke and prevent children and young people from viewing smoking as desirable or aspirational. Indeed, children and young people who see smoking around them

are more likely to start to smoke and smoking visibility makes it harder for people to remain Smokefree after quitting (Ivory et al., 2015; Zablocki et al., 2014; Chaiton et al., 2016).

Regional and local Smokefree initiatives have been driven by NGOs (including Cancer Society), DHBs, iwi authorities, local marae, local government authorities both city and district councils (see Smokefree Mapping NZ Councils). However, these locally driven Smokefree outdoor policies are largely unenforceable (Edwards et al., 2021), and without central government legislation they are inconsistent across the country, varying from one area to the next. The lack of central government support has been a barrier to further extensions of Smokefree polices (Marsh et al., 2014) and has made some local councils reluctant to use bylaws for Smokefree outdoor spaces (Thomson & Wilson, 2017).

Clearly 'it is likely to be far more efficient to develop national legislation (within an overall tobacco control plan), rather than have 67 territorial local authorities working separately on Smokefree outdoor places' (Thomson, 2017).

Loval Government NZ wants legislation for outdoor hospitality areas

Local Government New Zealand (LGNZ) has been seeking national legislation for Smokefree outdoor hospitality areas since 2015 when over 70 % of local councils supported a remit: 'That LGNZ requests that the government develop and implements legislation to prohibit smoking outside cafés, restaurants and bars' (Thomson & Wilson, 2017). People trying to quit smoking need places where being smokefree is normal, and to be in outdoor hospitality areas without reminders about smoking. The outside areas of bars and cafés remain one of the most dangerous places in Aotearoa for someone quitting (Thomson et al., 2021). International evidence indicates that Smokefree outdoor hospitality areas increase quitting attempts and reduce relapses (Chaiton et al., 2016).

Public support for more legislated Smokefree and vapefree outdoor public areas

Public support for Smokefree outdoor spaces is well substantiated. A 2013 survey in Auckland found high levels of support for each of these spaces to be Smokefree: 96% for playgrounds, 84% for building entrances, 82% for bus stops and train stations, 76% for outdoor hospitality areas, 72% for outdoor music and sports events, 69% for parks and sports grounds, 67% for footpaths outside local shops, 63% for outdoor town centres, and 54% for beaches (Wyllie, 2014). Similar findings have been found across New Zealand including a repeat Auckland study by Wyllie in 2016 and a Wellington study (Thomson et al., 2017).

- In 2019 CSNZ conducted 1481 electronic and paper-based surveys and submissions at our Relay for Life and other events nationwide to gauge public support for extending legislation to include Smokefree outdoor public places. There was very high support for legislation to cover outdoor areas ranging from 89% to 97% support (see Table 3). Areas asked about were playgrounds, outdoor areas of cafés, bars and restaurants; bus stops, train stations/transport hubs; and whether Smokefree areas should also be Vape-free.

Table 3: Support for extending Smokefree areas across New Zealand (Cancer Society 2021)

	All playgrounds	Outdoor areas of cafes, bars & restaurants	Bus stops, train stations, transport hubs	Smokefree areas to be Vape-free
New Zealand n=1481	**98%**	**92%**	**95%**	**89%**

- Of the 844 community submission templates collected by the Cancer Society this year 723 (86%) wanted Government's Smokefree Action Plan to include commitments to 'making more outdoor areas Smokefree' (submissions attached).

Research looking at the views of people who smoke found that Māori, Pasifika, and Asian peoples who smoke were more likely to support Smokefree outdoor spaces than other ethnic groups (Thomson et al., 2011). The NZ tobacco sector's Achieving Smokefree Aotearoa Plan (ASAP, 2017) recommended that government extend Smokefree environment legislation to include specific outdoor areas, to prohibit smoking in all outdoor hospitality areas, building entrances and outdoor recreation areas, parks, playgrounds and all sporting and recreational facilities (ASPIRE, 2017). We strongly support this measure, as it would offer consistency of Smokefree policy across Local Authority areas for residents and visitors alike.

Smokefree outdoor hospitality area initiatives

Voluntary initiatives such as the Fresh Air Project (a Smokefree and Vape-free outdoor dining initiative) have encouraged more hospitality venues to implement Smokefree-Vape-free outdoor dining. The Fresh Air Project began in Christchurch 2016. Support from customers visiting the venues was high with 95% of the 1,861 customers who gave feedback, in support of Smokefree outdoor dining (Fresh Air Project, 2017). Since the pilot in Christchurch several other regions have implemented these initiatives and Fresh Air venues can now be found in Selwyn, North Canterbury, Mid Canterbury, South Canterbury (Mackenzie and Geraldine) Nelson and Tasman, Otago-Southland, Wairarapa and Whangarei. Evaluations found similar results to the Christchurch project in these regions. Otago-Southland had 94% support from 1542 customers, Whangarei had 94% support from 442 customers (Fresh Air Project, 2018, 2019). A total of 206 Fresh Air venues are currently operating across NZ regions (this does not include hospitality venues who are Smokefree but have not joined the Fresh Air Project). Evaluations found that many businesses wanted a 'level playing field' and this has been found in other surveys of businesses on the topic (Thomson et al., 2017).

Palmerston North City Council, under its Signs and Public Places Bylaw 2015, requires all premises with footpath trading permits to display Smokefree signs and not to provide ashtrays. 95.4% of people surveyed said they would be more likely, or as likely to visit outdoor dining areas if they were Smokefree. The permit condition also helped to reinforce Council's Smokefree Policy, which is widely supported by hospitality managers (Gendall, 2017).

Why legislated Smokefree public places need to be a priority

We urge government to include Smokefree public places as a key area of action in the Smokefree Aotearoa 2025 Action Plan. Overseas jurisdictions in similar countries (Australia, Canada, and the USA) have had effective legislation for a range of Smokefree outdoor areas. Queensland, for example, has had a Smokefree outdoor dining law since 2006 (Grace, 2019).

Where legislation has been put in place for outdoor spaces, compliance tends to be high. Research conducted on behalf of the Queensland Government following the introduction of new amendments to strengthen Smokefree legislation in 2006 revealed that most people who smoked (85%) reported they had 'completely stopped smoking in all areas where it is illegal to smoke at all times' and two-thirds (67%) were 'smoking less in public spaces' (Queensland Health, 2007).

Disparities in Smokefree outdoor space policies tend to exacerbate existing health inequities (Lowie et al., 2018). Legislated Smokefree outdoor areas could help reduce these inequities.

Cancer Society urges government to legislate to support best practice in implementing Smokefree outdoor areas and disallow smoking and vaping in:

- all outdoor hospitality areas, and **not allow** designated smoking areas.
- grounds surrounding all Government or publicly owned organisations including tertiary education and health facility campuses
- grounds surrounding transport hubs including airports, bus exchanges and bus shelters and train stations

- all sporting and recreational facilities and grounds
- music, sport or cultural events
- outdoor recreation areas, parks, playgrounds, and beaches

In addition, Government should legislate to:

- Require effective and visible Smokefree/Vape-free signage for Smokefree outdoor public places.
- Provide local authorities with more effective power to make Smokefree bylaws. This should be for special areas where local needs are extra to national Smokefree legislation, not a substitute for such legislation.

Phase out vape products from generic retailers

The Cancer Society wants the national tobacco plan to include a commitment to phase out all vaping products from generic retailers. This needs to be a planned process aligned with timeframes removing conventional tobacco products from most retailers. A key argument given for selling vaping products in generic stores was that it was inappropriate to have tobacco products, which are more harmful, more available than vaping products. Once conventional tobacco is phased out of generic retailers this will no longer be a legitimate argument for continuing to sell vaping products in generic stores. This will reduce the potential harm to young people by making the products harder to access.

As previously mentioned, for the first time in 20 years, smoking prevalence in 14- and 15-year-olds increased rather than decreased during 2019, and this reversal occurred alongside a rapid increase in vaping among young New Zealanders (see Figure 5 below). As the ASH year ten annual survey was unable to be undertaken in 2020, it is not known whether this increase in regular vaping and smoking prevalence has continued.

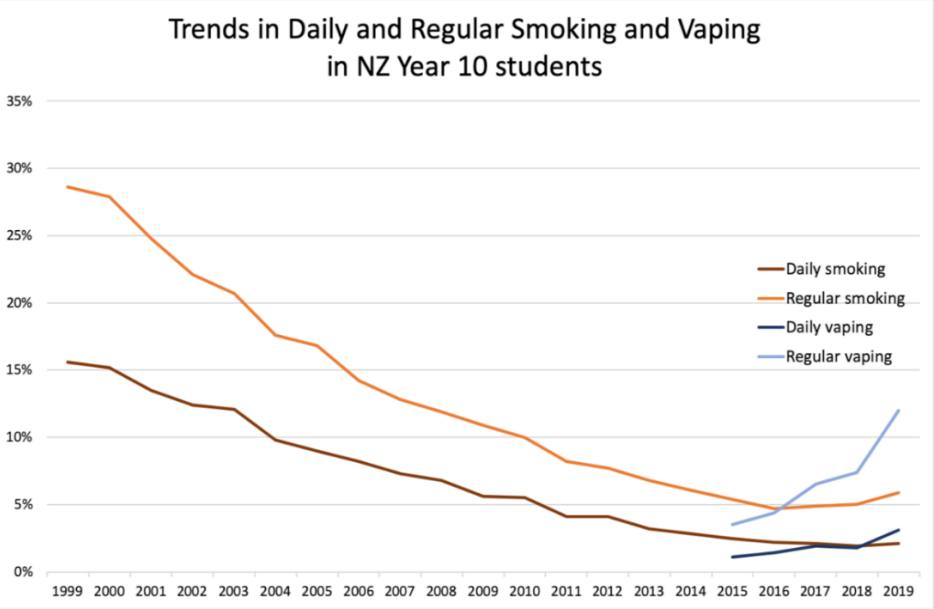

Figure 5. Trends in daily and regular smoking and vaping in NZ Year 10 students *Source: Daily and regular smoking data 1999-2019 and vaping data 2015-2019 obtained from ASH NZ website.*

These early indications ought to be taken seriously. Instead, vaping products continue to be openly displayed and sold anywhere, alongside sweets and other groceries in local dairies and corner stores. New Zealand's experience with tobacco products suggests that generic stores are unlikely to enforce R18 restrictions on these products, and public health units report that

with reduced capacity, they have carried out minimal if any Controlled Purchase Operations over recent years.

Submissions process

We note that people wanting to make submissions on this draft plan were asked whether they had the following commercial interests in tobacco:

- 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

The Cancer Society suggests counting and reporting of those with commercial interest separately from those without.

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