Submission: Smokefree Aotearoa 2025 Action Plan

May 2021

Organisation	Auckland Regional Public Health Service in partnership with Auckland District Health Board, Counties Manukau Health and Waitematā District Health Board ('the Auckland metro DHBs'). This submission was developed in consultation Te Rūnanga o Ngāti Whātua.

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 Ministry of Health has sought comments on the following proposals for a smokefree Aotearoa 2025.

You can find more information about these proposals in the discussion document which can be downloaded from - **https://www.health.govt.nz/publication/proposals-smokefree-aotearoa-2025-action-plan**.

Focus area 1: Strengthen the tobacco control system

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

Effective Māori governance of the tobacco control programme must enable active Māori leadership and partnership across all levels of decision making, development of policy, legislation, and design, as well as the implementation and operations of services.

There are great Māori leaders in the smokefree public health space and it is important that they head Māori governance of the Smokefree 2025 Action Plan alongside ministerial appointements, a taiohi (youth) representative and Māori public health experts. Furthermore, regional leadership of iwi, hapū (sub-tribe), marae, and whānau must be established to work with the central Māori governance group that must have significant support, funding, and resourcing through the Māori Health Authority and Health New Zealand in a co-commissioning partnership.

This submission acknowledges previous and current Māori leadership and governance in this space and we call for further effective Māori governance to include (but not limited) to, the following aspirations and principles of Te Tiriti o Waitangi:

<u>Te Tiriti o Waitangi</u>

Te Tiriti o Waitangi articles, and principles as outlined in the WAI2575 Report(1), to be embedded into governance, through to management, operations, delivery and across the tobacco control programme including policy and legislation. This will require:

Kawanatanga (Governance)

- strong Māori leadership and participation across all levels, especially decision making as well as governance and management levels
- to set health outcomes, key roles and responsibilities through active consultation and partnership with iwi, hapū and Māori health providers to effectively reduce health inequities. This includes transparent annual planning, accountability to iwi Māori, and priority setting.
- resourced and equitable performance reporting and monitoring led by the Māori Health Authority.

Tino Rangatiratanga (Self-Determination)

- Tangata whenua, iwi, hapū, health providers, and whānau including kaumātua, to exercise tino rangatiratanga and mana motuhake through key participation in the design of tailored services for Māori by Māori, that are effective and responsive to the needs of each region
- a whānau and mātauranga Māori centred, flexible approach that responds to the needs and aspirations of whānau and that works towards a state of Pae Ora (healthy futures for Māori)(2)
- increased opportunities and equitable funding for Māori leadership, participation and workforce development, to design and deliver kaupapa Māori Smoking Cessation Services including the provision for growth.

Oritetanga (Equity)

- Equity must be at the forefront of all decisions, actions and the impact of any tobacco control interventions, to reduce systematic inequalities in health determinants, health outcomes and health service operation
- Māori Health Authority be adequately enabled to monitor the Crown regarding Māori health equity and Māori health outcomes.

Te Ritenga (Rights to beliefs and values)

- fundamental tikanga and mātauranga Māori application at every step, including procurement, development, delivery, monitoring and evaluation of services, to create a model of care that prioritises Māori. This includes sanctioning Kaupapa Māori Cessation Programmes, such as traditional the practices of rongoā Māori (traditional Māori healing and medicines).

Implementing Rongoā Māori: Cytisine

Broader health and social issues can be supported by incorporating rongoā Māori into kaupapa Māori (Māori approach) smoking cessation services. This inculdes rākau rongoā (native herbal preparations), mirimiri (massage), karakia (prayer), whakapapa (family links) to address the holistic physical, mental, spiritual and whānau (family) aspects of hauora, that may resonate with more Māori to quit smoking.

We recommend further Māori led research and funding to be designated to the application of rongoā Māori within smoking cessation, such as Cytisine, the plant extract found in the New Zealand Kowhai. A recent trial in the Lakes District Health Board, Bay of Plenty and Tokoroa, found Cytisine to be at least as effective as varenicline, with less self-reported adverse events, for smoking cessation among Māori and whānau of Māori, who smoked daily and were motivated to quit[1].

Innovative Kaupapa Māori Services: Heru & Hapū (Patrick Salmon)

We also recommend increased resourcing and funding to Māori providers to deliver innovative support, using technology and tikanga to engage with whānau Māori. For example, the Heru & Hapū kaupapa Māori cessation programme led by Patrick Salmon combines traditional taonga of wooden heru (combs) with a smartphone app KAIRUA, to provide traditional wisdom about the protective power of heru, and a connection with tūpuna (ancestors). This high-tech approach, supported with digital wānanga, helps wāhine to empower themselves, and is designed to help hapū māmā stay smokefree. Of 30 wāhine from Waikato that participated in the trial in 2020, 90 percent were able to stay smokefree while hapū.[2]

<u>Cross-Sector Collaboration</u>

Collaboration and increased Māori representation is required across all government sectors to address the broader health and social determinants that contribute to health inequities,

1Walker N, Smith B, Barnes J, Verbiest M, Kurdziel T, Parag V, Pokhrel S, Bullen C. Cytisine versus varenicline for smoking cessation in New Zealand indigenous Māori: a randomized controlled trial. Addiction 2019, 114(2):344-352

[2]Ward, S. (2020). Combing out the power of addiction.

including Māori smoking prevalance. This includes sectors such as housing, employment, education, mental health and social services, as proposed by Tā Mason Durie in his Te Rūnanga Whakapiki Mauri the Ultimate Māori Health and Wellbeing Authority model[3], and is in line with Whakamaua: the Māori Health Action Plan[4].

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

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

Community-based action has long been a part of New Zealand's smokefree movement. It can successfully change social norms about smoking and influence policy and legislation. For example, initiatives over many years at local and regional levels have promoted smokefree vehicles carrying children, and some of them have received community partnership grants funded by Te Hiringa Hauora (Health Promotion Agency). This work supported a change in social norms and contributed to legislative change.

In 2020, Parliament passed the Smokefree Environments (Prohibiting Smoking in Motor Vehicles Carrying Children) Amendment Act. As part of the implementation of this Act, the Ministry proposes to support community action, in addition to a national-level campaign. More recently, the Cancer Society and Hāpai te Hauora, which holds the national tobacco control advocacy contract, have been supporting local action to curb the retail supply of tobacco.

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

Community action is defined as *'expanding the resources and capacity of communities to make decisions and take collective action to increase their control over the determinants of their health'*.[5] In Tāmaki Makaurau (the geographical areas covered by Auckland District Health Board (ADHB), Waitematā District Health Board (WDHB) and Counties Manukau (CM) Health) there are a range of community based activities (defined as services delivered in the community) and community actions currently being undertaken to support Smokefree 2025. Further to the success of community led action in this space, there is an opportunity for recognition of iwi and Māori led action that supports community work and

[3] Durie, M. (2020). Te Rūnanga Whakapiki Mauri. Presentation at Toitū Hauora Summit, Wellington, New Zealand.

[4]Whakamaua: Māori Health Action Plan 2020-2025

[5]Ottawa Conference Report. (1986c). Strengthening communities. Health Promotion International, 1, 449–451.

that iwi and hapū models of action and work are used as examples of best practice for Māori whānau.

Stop Smoking Services in Tāmaki Makaurau carry out a variety of community based activities, some of which have led on to community action. Some examples are outlined below:

- smoking cessation programmes in South Auckland workplaces, including promotion of smokefree outdoor environments (resulting in approximately 30 referrals/month to Stop Smoking Services (SSS)
- smokefree health promotion and delivery of smoking cessation advice at events such as Polyfest
- smokefree health promotion and provision of smoking cessation services in South Auckland schools
- provision of smoking cessation services in South Auckland community drop in clinics, leading to the growth of community champions
- the *'Snapped Out' – Snap out of it, smoking is not cool!'* social media campaign on Facebook and Snap Chat which led to a community led art exhibition and a doubling in quit dates set by young people receiving stop smoking support in CM Health
- smokefree Pacific Church Quit Groups – training community champions and SSS providing incentivised quit groups in Pacific churches, members to begin their quit journey and supporting enforcement of smokefree environments
- smoking cessation group based therapy at Kava groups for Tongan men – supported by smokefree community champions
- the Tivaevae project supporting pregnant Pacific women to begin their smokefree journey, through coming together to work on tivaevae for new babies, and creating talanoa (conversation) around smoking cessation and other areas of health promotion including SUDI prevention
- mental health and addiction community quit groups – SSS Practitioners co-facilitate quit groups with non-government organisation mental health & addiction staff that are tailored to the needs of clients; including incentives for participation as well as low carbon monoxide readings, longer period of support and starting with reducing rather than quitting.

There are also other community activities in Tāmaki Makaurau that Auckland Regional Public Health Service (ARPHS) and the three Auckland metro District Health Boards (DHBs) are aware of but are not directly involved with:

- Auckland Council - smokefree public areas and events (in progress under the Council's Smokefree Policy Implementation Plan 2017 – 2025)
- Te Hā Oranga and Hāpai Te Hauora Tāpui (Hāpai) – Engaging with communities, particularly Māori and Pacific peoples to gather voices in consultations regarding smokefree and vaping legislation, encouraging whānau to write submissions, and

workplace and event Smokefree policies *[see Te Hā Oranga Community consultation case study pages 10-11]*

- Te Hā Oranga hapū māmā workshop, encouraging overall hauora and mama to be smokefree and have smokefree homes through holistic support smoking cessation support
- smokefree Māori sports and tournaments including touch, netball, and waka ama (outrigger racing).

Within Tāmaki Makaurau, there have been a number of community action activities to support Smokefree Aoteaora 2025:

- the growth of community champions in South Auckland carrying out 'community activation' and setting up drop in clinics based on the communities needs and preferences
- the growth of community champions in Pacific churches, supporting smokefree environments and smoking cessation
- the introduction of smokefree environments in marae in South Auckland, which de-normalise smoking, promote quitting, protect people who have quit smoking from relapsing, and protect tamāriki and rangatahi from the effects of second hand smoke and smoking uptake
- smokefree Otara Town Centre (established in 2009)
- Hāpai National Tobacco Control – National advocacy, amplifying community voices through social media and radio, leading the World Smokefree Day Campaign and supporting regional services with resources and workshops
- iwi and hapū led Matariki (Māori new year) quit smoking challenges and support
- Hāpai SUDI prevention – Wanānga wahakura (traditional bassinets) across the country to ensure matauranga and best practice is being passed on/shared with other weavers
- Tūpuna Maunga Authority declaring all Tāmaki Makaurau maunga alcohol and smoke free to respect the spiritual, cultural and community significance of Tūpuna maunga (ancestral mountains)
- Ready Steady Wāhine – Creating positive and empowering communities to encourage hapū māmā and wāhine to stay smokefree, whilst providing life skills workshops to address broader determinants that may contribute to smoking.

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

The following elements have been identified in health promotion literature[5,6] in enabling community action and are discussed in the context of smokefree health promotion:

1. Engage communities to share priorities

[6] Laverack, G.; Mohammadi, NK (2011). *What remains for the future: strengthening community actions to become an integral part of health promotion practice*. Health Promotion International, vol 26, S2. doi:10.1093/heapro/dar068.

- Value local intelligence and a strong community voice in consultations, including the design, delivery and evaluation of smoking cessation services as well as tobacco control policy and legislation
- Build and strengthen the knowledge base about what is effective for priority groups. For example, as a priority group, Pacific peoples are made up of more than 16 culturally and linguistically distinct ethnic groups, but are too often grouped together as one homogenous group(3). Tailoring action carefully will ensure actions meet the needs of the different subgroups within the Pacific community.

2. Build community capacity

This section provides key points for increased access and support to funding for community, hapū and iwi action led projects:

- support the development of capacity-building through increasing the knowledge, skills and competencies of the community. This may include raising awareness of smokefree legislation and changes, how community can write submissions/make complaints, and supporting the growth of community champions; and
- improved systems transformation and development that better aligns with community capacity and capability as well as whānau aspirations towards Pae Ora (Whakamaua; Māori Health Action Plan 2020-2025).

3. Mechanisms for flexible and transparent funding

- develop suitable prototypes for flexible and transparent funding outside a conventional programme design
- set tobacco control/smoking cessation service contracts so that a fixed percentage is allocated to supporting community, iwi and Māori led action

- dedicate funding and resource to support Māori and Pacific community-led and owned action.

Te Hā Oranga Community Consultation

To gather community insights, Te Hā Oranga carried out a Smokefree Aotearoa 2025 Workshop with 35-40 community members from the Kaupapa Māori based, addiciton recovery group, 'He Waka Eke Noa (whakatauki (proverb) that speaks about unity) Recovery.' This consultation was based around bridging the gap that exists between the community and policy, as well as encouraging the rōpū (group) to actively be a part of achieving the Smokefree Aoteroa 2025 goal.

As a part of the workshop, participants were split into four groups and asked to discuss and write down their ideas for the following questions:

1. *"We want a Smokefree Aotearoa because…."*
2. *What needs to be done, or changed, to achieve Smokefree Aotearoa 2025? What will help whānau to quit?*

During this exercise, common themes for wanting a Smokefree Aotearoa were:

- for our future babies/protecting our babies during pregnancy
- to be a better role model for our whānau and future generations
- to live longer and be healthier – healthy bodies, healthy minds
- to breathe easier, including no more second-hand smoke
- less cancer and whānau dying
- to break the cycle and stop intergenerational trauma being passed onto the next generation
- to save money/more money for our mokopuna (grandchildren)/addiction is taking away from our kids
- more time with our kids instead of smoking

For question 2: *What needs to be done, or changed, to achieve Smokefree Aotearoa 2025? What will help whānau to quit?* Suggestions included:

- reduce stores selling tobacco/reduce the supply of smokes in New Zealand
- offering whānau that smoke more support to quit. Including incentives, vouchers and food parcels
- giving people that successfully quit jobs, funding, or incentives to be Community Champions that mentor others to quit – leading to a domino effect
- raising more awareness via TV, shops, newspapers, rehabs etc of the effects that smoking has on our whānau and environment
- whānau are getting sick, and they are not aware of what is actually in cigarettes (educating around the content of cigarettes)
- more educational groups, quit smoking therapy (not just Quitline), support groups and community health centres
- make smoking cessation services more accessible
- more support and awareness to mothers during pregnancy and fathers.
- More self-care methods/teaching alternative stress relief through support programmes
- addressing racism
- subsidised vaping products
- addressing poverty and increasing wages
- limit smoking areas
- ban cigarettes and stop importing them into Aotearoa New Zealand.

This consultation identified that community members want a Smokefree Aotearoa primarily for their hauora (health), to have healthier lifestyles for themselves, their tamāriki especially, and for future generations. Cancer was a common theme, in which participants identified that too many whānau members were passing away from smoking related illnesses. The rōpū also identified smoking as an intergenerational cycle that needs to be broken.

A range of ideas were identified to achieve the Smokefree Aotearoa 2025 goal, including significantly reducing the number of cigarettes available in Aotearoa, by reducing tobacco import and stores. A common suggestion was more variety and access to smoking cessation support services, educational groups, community centres and alternative stress relief. Support was raised for those who quit smoking to be given an incentive or a job to become cessation mentors, using lived experience to encourage others to quit. Hapū māmā and safe pregnancies were also a common theme for both questions, with the rōpū identifying that more support is needed for both mothers and fathers to become smokefree.

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

All smokefree research, evaluation, monitoring and reporting must be equity led and have a values and rights based approach with a specific focus on Te Tiriti o Waitangi. Māori Governance of the Smokefree 2025 programme must be included in decision making to set key roles and responsibilities; on how the data is used, and how information is presented, furthermore, how to prioritise what research that is undertaken. This submission supports more Kaupapa Māori and matauranga Māori methodologies to be used for research, evaluation, monitoring and reporting. There is an opportunity with this action plan to provide a strong and clear pathway between smokefree research, evaluation, monitoring, and reporting through to decision making, policy development and implementation.

Key areas

Commitment to Te Tiriti o Waitangi to accelerate improved health responsiveness for Māori

To date, the tobacco control system of Aotearoa has failed at reducing smoking rates for Māori and the national action plan needs to have robust measures to ensure the policies being enacted are contributing to eliminating in smoking rates for Māori to move towards Pae Ora. Further to the points made in the Māori Governance section of this submission, the following points are made in relation to research, evaluation, monitoring and reporting:

Kawanatanga (Governance)

- strong Māori leadership and participation across all continuous quality improvement initiatives to ensure iwi, hapū and whānau voices and matauranga are utilised respectfully and that activities are resourced adequately
- the Māori Health Authority have a lead role in the performance and equity monitoring and reporting for the action plan.

Tino Rangatiratanga (Self-Determination)

- iwi, hapū, health providers, and whānau including kaumātua, exercise tino rangatiratanga and mana motuhake through key participation across research, evaluation, monitoring and reporting in the decision making and design of tailored services for Māori by Māori, responsive to the needs and aspirations of whānau in each region.

Oritetanga (Equity)

- it is an expectation that Māori health equity is a priority in the research, evaluation, monitoring and reporting of the activities and interventions from the Smokefree Aotearoa 2025 Action Plan that enables accurate and timely data and information for better decision making and policy development as inadequate public health policy contributes to inequity[7]

- it is critical that purposeful and strong Māori health equity measures are developed to inform robust system improvements, accountability of performance and

[7] Waitangi Tribunal Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry 2019.

monitoring frameworks in particular for new initiatives, additional funding or targets to help reduce the smoking rate amongst young wāhine Māori as a priority.

Te Ritenga (Rights to beliefs and values)

- tikanga and mātauranga Māori are prioritised as critical ideologies and fundamental in the approaches to Smokefree Aotearoa 2025 research, evaluation, monitoring and reporting. Furthermore, these approaches such as Kaupapa Māori and the respectful use of te reo Māori, must be fully enabled, respected and encouraged to be utilised appropriately

- that the profile of a te ao Māori tirohanga (Māori world view) of hauora (health) is elevated and this context is used to measure mana motuhake, and mana tangata.

Equity responsiveness

- equity must be at the forefront of continuous quality improvements of the health system where population data is high quality, accurate, timely and includes ethnicity, deprivation, age, gender, disability and location details
- the effectiveness of the plan needs to be frequently measured and reported to ensure positive outcomes for priority groups (3,4). This will also help to support effective reporting from cessation services.
- research should involve identifying how to create programmes that are more tailored to priority groups in particular Pacific peoples relation to acceleration of health equity
- ethnic-specific data need to be collected to inform action that meets the diverse needs of priority groups. As a priority group, ethnic-specific data need to be collected for Pacific peoples, who are culturally and linguistically distinct, but are too often grouped together as one homogenous group(3). This will help ensure the needs of subgroups within the Pacific community such as Tokelauan, Cook Islands and Niuean adults whose smoking rates are particularly high are met(5).

Data collection, sharing and operational delivery

- representatives from all priority groups, should be involved in the design and implementation of data collection and sharing mechanisms, as well as monitoring the performance of the plan, to ensure that they will support improved outcomes for their communities
- a centralised database which allows those in the provider arm to accurately capture activity and have easy access to dashboards and monitoring platform.
- data including training provided to retailers, sales volumes, numbers accessing cessation services and the number of retailer closures must be gathered and shared both nationally and internationally, as this would be a landmark undertaking in tobacco control internationally.

Community-led action

- the community has played an important role in advancing tobacco control and cessation initiatives and need to have all the tools possible at their disposal to continue to support their whānau to reach Smokefree Aotearoa 2025. These include mechanisms in place to allow sharing between communities of effective actions and

clear pathways for the community to influence decision making, policy development and implementation.

- use systematic and routine community-led monitoring to identify where the national action plan requires improvement to support people to switch from, quit, or never start smoking. For example, to know how effective the point-of-sale cessation support is, how accessible are cessation services, including for different individuals and groups, and surveys of public understanding and support of new Smokefree laws. Importantly, this will help identify what barriers different groups face in accessing, both initially and long-term, these services.
- dedicate specific funding and resource for Māori, Pacific peoples, and other priority groups to lead and own actions and projects which support their achievement of Smokefree Aotearoa 2025.

Reducing the access to, the addictiveness and normalisation of tobacco products

- reducing the access to tobacco products, their addictiveness and their normalisation will be integral to the success of the plan. Any monitoring, evaluation, and reporting framework should include baseline and post-implementation measurements of these domains. For example, the effectiveness of the tobacco-free generation policy and extension of smokefree areas on reducing youth uptake of smoking through reduced access and de-normalisation or the effect of reducing nicotine levels on nation-wide quit success rates.

Focus area 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

Please give reasons:

Auckland Regional Public Health Service (ARPHS) and the three Auckland metro District Health Boards (DHBs) support a positive licensing system for the retail of all tobacco and vaping products and agree it is a vital mechanism to achieving the 2025 goal alongside other retail reduction measures. This would be a system where retailers apply for a license, rather than the product being licensed.

ARPHS and the Auckland metro DHBs would support the implementation of a positive licensing system where a limited number of licenses are awarded upon application provided the retailer successfully meets the licensing requirements. We would like to see requirements that include:

- staff training in stop smoking support
- annual reporting requirements
- density and proximity measures as detailed in the following question
- licensing fee set greater than that for specialist vape retailers to signal the greater harm of cigarettes and entirely cover the costs of monitoring, enforcement, education and training of new tobacco retailers
- a robust tobacco licensing system, reflecting the harms of the product.

The reasons for our support of licensing are outlined below:

- **the market is saturated with tobacco:** there is currently no government control on how many stores can sell tobacco or who can sell and this is problematic. This unregulated market has resulted in our communities being saturated in tobacco retailers, with an estimated 5,000 retailers nationally and 1,800 retailers in Tāmaki Makaurau alone. Due to the lack of a licensing system it is impossible to know the full extent of tobacco retail availability in Aotearoa – our information is derived from databases kept by our compliance officers, which is liable to change frequently. Easy access to tobacco retailers facilitates smoking uptake and increases difficulty with quit attempts(6–10). Licensing regimes already exist for other products and practices including food, alcohol, vaping and gambling – many of which are less harmful to health than tobacco use. This alone should justify implementing a positive licensing system for tobacco retailing.

  "There are lots of tobacco retailers especially in low-income areas, making access too easy for our whānau. Reducing availability will make it harder to buy smokes etc and hopefully a bit easier to quit". – Young Pacific female from Manurewa.

- **licensing will help to de-normalise and monitor tobacco sales:** At present the ubiquity of tobacco in the retail environment is synonymous with the normalisation of this deadly product and increased harm to its users(11). This normalization is a

significant barrier to people who smoke successfully quitting and increases the likelihood of relapse and initial uptake among consumers(6,7). Strong licensing measures will help to reduce supply and curb the normalisation and attempts at glamorisation by the tobacco industry signalling of tobacco products, which in turn may help to curb the social supply of tobacco. Licensing retailers reinforces that selling tobacco is a responsibility and privilege, rather than a right(12), and appropriately reflects the harmful nature of this product.

- **there is strong public support**: There is strong public support for tobacco supply reduction in New Zealand even among those who smoke, particularly when framed as a measure to protect youth(13). A large recent national survey found 68% support for further tobacco supply reduction initiatives(14).
- **we cannot rely on retailers to voluntarily stop the sale of tobacco:** Retailers are discouraged from voluntarily withdrawing from tobacco sales for reasons including: big tobacco's influence through incentives, investment in marketing and relationships with retailers, the density of competitive tobacco retailers in urban areas, the retailers slim profit margins and the lack of any incentive beyond ethical considerations for retailers to stop selling (15–18). Further to this, the tobacco industry fuels a perception that businesses will not survive without tobacco footfall sales (17). However, research has demonstrated that this perception is unsupported due to the little profit being derived from purchases additional to tobacco and that many retailers have successfully maintained their business without tobacco sales (15,19,20).The perceived necessity of tobacco sales to small retailers is similar to the historic perception surrounding the restriction on the sale of fireworks; however, retailers have made changes to their business models and survived fireworks regulation. Changes to business models in relation to tobacco restrictions would be possible too.
- **retailers are open to regulation.** Smaller tobacco retailers have signalled a willingness to go tobacco free provided it was a level playing field (i.e. other similar retailers in close proximity also stopped selling)(21). In unpublished interviews with executives of medium to large tobacco retailers, many signalled that they expect government leadership on supply reduction to be inevitable, and just want as much notice as possible(22). Despite anticipating this change, all tobacco retailers we consulted with have clearly indicated they will not undergo this change themselves and expect this change to be government driven(9).
- **licensing provides greater monitoring and enforcement mechanisms:** The lack of any accurate records of tobacco retailers creates challenges for monitoring and enforcement. Due to the small monetary fines and low probability of detection for selling to minors, retailers under the current system are unlikely to comply with regulations(12,23). Licensing can be used to promote responsible retailing by facilitating enforcement of other laws such as point-of-sale laws and providing up-to-date information about retailers(12,24). With the significant financial threat of loss of licence (where few licensees exist and these are specialist stores), licensing supported by compliance monitoring is very likely to provide a more effective way to control the illegal sale of tobacco products to minors(8,12,15). There is precedent for revoking licenses following non-compliance in New York where lottery and alcohol licensing can also be revoked as well as in San Francisco where it has survived two legal challenges already(24). Under such a system a license can be

revoked through a simple administrative proceeding without the prohibitively costly and time consuming criminal court proceedings currently required to penalise any retailers breaching the law in New Zealand. This will further facilitate retailer compliance and make litigation much easier(24). Lastly, having license laws requiring retailers to comply with all tobacco control laws future proofs the system so that newly adopted tobacco control laws are automatically incorporated.

- **licensing will enhance equity:** Tobacco retailers tend to be more prevalent in low socio-economic areas, including in New Zealand(25,26). In New Zealand Māori and Pacific peoples also live predominantly in these retailer saturated areas. Licensing with proximity and density measures will result in a greater reduction of retailers in these communities which currently experience a greater burden of tobacco-related harm. This will help to even out the levels of harm to create more equitable outcomes.
- **the limited cases of licensing being implemented internationally have been successful:** Subnational policies govern tobacco retailer licensing in Australia, Canada and the USA. Singapore, Hungary, France and Finland have also implemented licensing nationally(27–30). While research is limited, licensing has been shown to be effective at decreasing sales to minors and reducing tobacco supply where it has been trialled in areas of the United States(12,31,32) and Australia(23,33). This has been most effective when introduced along with a raft of other actions, including education and enforcement. New Zealand modelling has shown that licensing alone will leave us far from reaching our 2025 goal(34,35).

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

Please give reasons:

ARPHS and the three Auckland metro DHBs are supportive of placing density measures in license requirements to significantly reduce the number of retailers. As seen in figure 1 below, Tāmaki Makaurau is currently saturated with tobacco retailers. Retailer proximity also needs to be considered alongside density requirements. Studies have found that outlet density was associated with individual-level smoking among adults and youth and that proximity was associated with smoking among youth and reduced cessation among adults(6,7,36).

We are supportive of the 95% reduction in tobacco retailers recommended in the ASAP plan(13). For Tāmaki Makaurau this would be a reduction from approximately 1800 to 90 retailers. At present over 50% of Tāmaki Makaurau tobacco retailers have another tobacco retailer within 100 metres(37). We propose that specialist tobacco retailers are spread evenly geographically across the region to reduce the current clustering of retailers and to ensure no single suburb is too far from a retailer. This would mean that retailers are not within an estimated 4km from another. We would not be supportive of locating these based on population density or smoking rates, as this is will serve to maintain existing density inequities and could create access issues for those who are addicted to tobacco in more remote areas of Tāmaki Makaurau.

If this retail supply reduction were to be done through a phased implementation, due to the minimal time until 2025, we would request that this reduction takes no more than 12 months. We would also recommend that larger tobacco retailers including supermarkets and petrol stations be phased out of tobacco sales prior to smaller retailers.

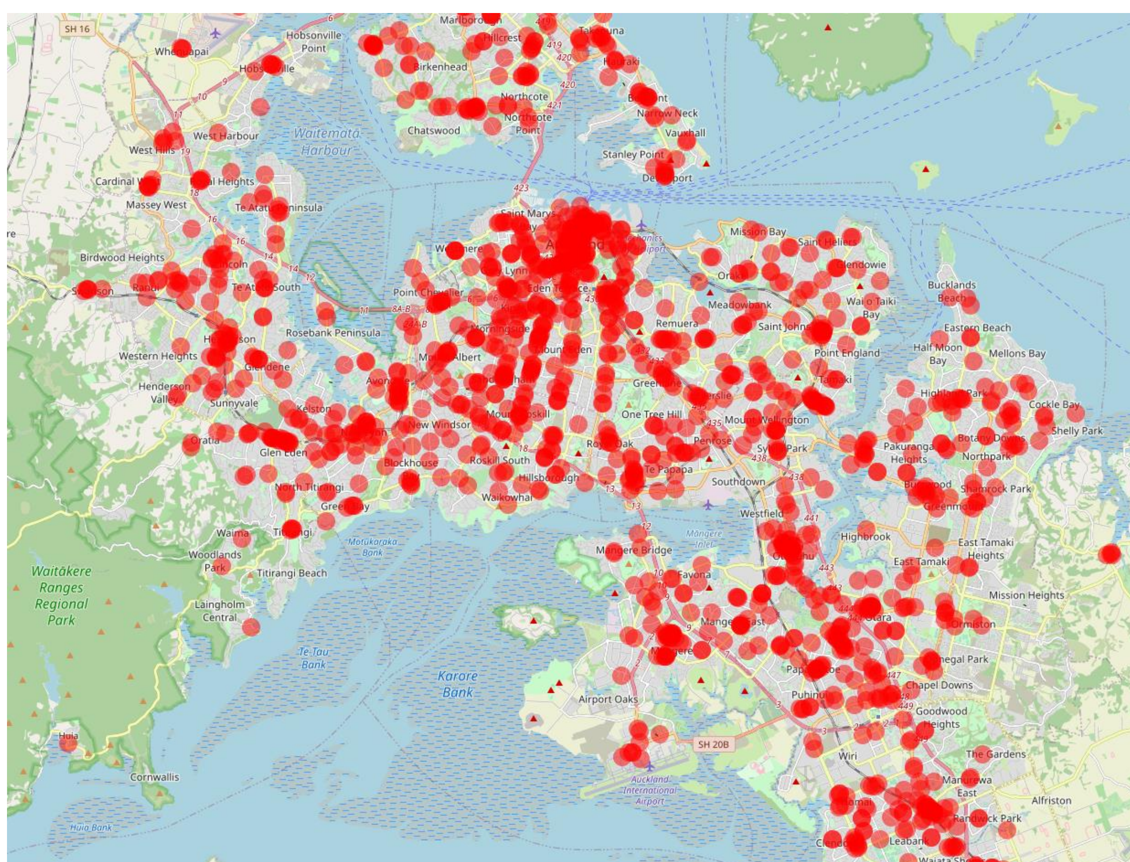

Figure 1: Distribution of the known current tobacco retailers across Tāmaki Makaurau

Suggested Density considerations:

- set a maximum number of licenses to be issued nationally
- set a sinking lid on licenses, whereby a license cannot carry across with the sale, relocation or change of ownership of an existing licensed retailer or premises
- prioritise licenses for retailers on main roads or in commercially zoned areas. This is to strike a balance between ensuring ease of access for those who wish to purchase cigarettes and to also avoid unnecessary exposure to youth and families if retailers exist in residential areas
- require that no tobacco retailer is within a 4 km radius of another specialist tobacco retailer
- ensure all staff are quit trained and have clear relationships with smoking cessation providers for referrals
- where multiple applications are received for the same area prioritise giving the license to the retailer furthest from any school or in a less residential area
- that consideration is made for those living in remote areas with regards to tobacco retailer access.

While we share support of removing retailers near schools with the New Zealand public(15), in Tāmaki Makaurau, and likely in other urban areas, this would leave too few locations where retailers could exist. We therefore support the density measures outlined above over

proximity measures to ensure those addicted to tobacco are not unfairly disadvantaged by where they live. The approach of placing retailers based on geographic spread is supported by UK research which found it is more important to reduce overall density than focus on schools or youth zones(11). While use of proximity and density measures in licensing is a relatively untested mechanism, it has been utilised in some jurisdictions in the U.S and has resulted in notable reductions in the retail supply of tobacco in those jurisdictions(31).

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

Please give reasons:

ARPHS and the three Auckland metro DHBs are supportive of limiting tobacco sales to age restricted specialist outlets only, preferably Government owned. We support this approach, or any similar approach which removes the commercial interest aspect from tobacco retailing for the following reasons:

- age restricted specialist outlets help to restrict youth access
- commercial profit from tobacco sales provides continued incentive for retailers to promote and sell this harmful product
- government owned specialist retailers with no commercial interest in tobacco sales would not protest a store closure and would not require a lengthy lead-in time for such changes. This will help to facilitate a sinking lid approach to retail supply reduction or a future phase out of tobacco retail.
- this model supports ensuring training for staff around quit support, which replicates a key strength of the pharmacy model
- there is precedent for this from Hungary
- there is a low level of interest from pharmacies in selling tobacco: New Zealand based research indicates that less than a third of pharmacies felt they would be likely or very likely to sell tobacco if they were made the only permitted type of outlet(38). This may also lead to areas where no tobacco is available as local pharmacies are not participating in sales.
- there are ethical considerations with selling a deadly harmful product at pharmacies which are a health focused store
- the Government owned model would reduce the current need for profitability and would allow the full mark up on tobacco to be transferred back to tobacco control interventions. Public support for tobacco control interventions increase significantly when the profits from tobacco are re-invested in tobacco control(39).
- the government model would also reduce administration costs due to not requiring licencing applications.

If tobacco were to be sold at pharmacies, we would want the following provisions included:

- pharmacies being able to decide if they sell tobacco
- tobacco sales should be not-for-profit simply covering the retail training, retail and licensing costs
- the area in which tobacco is sold at a pharmacy is physically separated as much as possible from health focused goods

- pharmacies must not advertise that they sell tobacco products but could be listed on a register
- tobacco products must not be visible inside or from outside the store and retail must meet the requirements of the Smokefree Environments and Regulated Products Act 1990
- pharmacy staff would be required to be quit trained and also offer smoking cessations services.

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

☒ Yes ☐ No

Please give reasons:

ARPHS and the three Auckland metro DHBs support introducing a smokefree generation policy to increase protection for youth and future generations from tobacco related harm.

Preventing youth initiation of tobacco is a key strategy to achieving and maintaining Smokefree Aotearoa 2025. Almost 90% of people who smoke start by 18 years of age, and are biologically more vulnerable to nicotine addiction(40,41). The prevalence of smoking in youth aged 18 – 24 years has declined over 7% in the last five years (16% in 2019/2020 cf. 23.8% in 2014/2015) but remains significantly higher than in those aged 15 – 17 years (3.3%), indicating smoking initiation occurs in this age group(42). There are large inequities in smoking prevalence, particularly for Māori youth and young adults. In Counties Manukau, the prevalence of smoking in Māori aged 20 – 24 years is twice that of the total population (30% cf. 15%) (5,43). This rises further in the 25 – 29 year group, with 40% of Māori smoking, compared with 19% of the total population (5,43). Similar rates and inequities are seen nationally(5,43). These statistics highlight the need to focus on factors which reduce youth initiation to eliminate inequities in smoking rates and achieve Smokefree Aotearoa 2025.

A smokefree generation strategy will de-normalise tobacco use, sending a clear message that tobacco use is unsafe at any age, and avoid the 'rite of passage' which can occur with a fixed minimum age law. The smokefree generation strategy has received strong public support within Aotearoa and in other countries both from tobacco control experts and from youth(44,45). As previously mentioned, New Zealand modelling studies suggest the TFG strategy will result in a halving of smoking prevalence in those aged less than 45 years within 10 – 15 years(46). This strategy is strongly pro-equity, due to the young age structure of Māori and Pacific populations and higher smoking prevalence in these populations, and was rated as the most equitable in the New Zealand modelling studies. This approach supports Te Tiriti o Waitangi principles of active protection, partnership, and equity. It is also aligned with a focus on an early year's approach by ensuring tamāriki have the best start to life in a smokefree environment.

The smokefree generation strategy will be relatively easy and low cost to implement as the Government can re-word existing minimum age legislation to include people born on or after a certain date(44). A precedent for the smokefree generation legislation has been set through the phasing out of opium smoking in colonial Taiwan and British Ceylon in the early part of the 20th century(44)The smokefree generation legislation would be easier for retailers to reinforce than existing minimum age legislation as retailers will not have to calculate age based on the current date and date of birth, rather just having a single birth date after which people are not eligible to purchase tobacco(44).

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

☐ Yes ☒ No

Please explain any impacts that making tobacco less available would have on your business that other questions have not captured. Please be specific: n/a

Focus area 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

Please give reasons:

ARPHS and the three Auckland metro DHBs support a mandated nicotine reduction policy to restrict the sale of tobacco to Very-Low-Nicotine-Content (VLNC) products, as nicotine is a highly addictive chemical compound and is the main addictive constituent of tobacco products.

To make tobacco products less addictive, the optimal level of nicotine for reducing addictiveness should be less than 0.4mg per gram of tobacco, which approximates to a 95-98% reduction in nicotine compared to what is currently in cigarettes available for purchase, which often contain closer to 10mg nicotine per gram of tobacco(47). This policy aligns with the 2010 Māori Affairs Select Committee inquiry findings which recommended a mandated nicotine reduction policy as an effective harm reduction strategy to help achieve the proposed Smokefree Aotearoa 2025 goal(48).

The highly addictive nature of nicotine makes it difficult for people who smoke to quit and stay quit, and for young people who experiment with smoking, makes it more likely to progress rapidly to regular smoking and long term addiction. With the absence of regulation to address the nicotine in tobacco products, the industry has continually made cigarettes more addictive by controlling and increasing the nicotine levels and enhancing the impact of nicotine. There has been confirmation of a statistically significant upward trend in nicotine levels in cigarette smoke, between 1997 and 2005 in products from all major cigarette manufacturers and across cigarette types(49).

Although no country has yet implemented a nicotine reduction policy, there is growing New Zealand and international evidence and modelling that shows mandating the sale of tobacco products to VLNC would reduce uptake, support quitting and lower smoking prevalence substantially. A historical modelling study estimated that if the industry has introduced VLNC's in the 1960s when the health effects of smoking were established, millions of lives would have been saved(50).

Studies have shown that the participants who were assigned VLNC cigarettes often cut down on the number of cigarettes smoked after finding them unsatisfying, experienced fewer withdrawal symptoms, elicited only limited compensatory smoking, made more quit attempts and were more likely to successfully quit when compared to participants who used conventional cigarettes(51–53). The evidence also appears to favour increased

abstinence for those who were motivated to quit and used nicotine replacement therapy alongside VLNC cigarettes(54,55).

New Zealand research has shown that a VLNC policy would help increase cessation rates markedly, and to a far greater extent than introducing e-cigarettes as a cessation tool(56). The 2018 New Zealand International Tobacco Control (ITC) study found that people who smoke expressed their desire to quit but had failed and believed that removing the addiction component of smoking will increase their autonomy and ability to successfully quit. Thus combining a VLNC policy with other interventions, particularly expanding access to alternative nicotine-delivery products such as e-cigarettes, nicotine patches and gum, is likely to enhance the effectiveness of each of these measures(57). It will also make a mandated VLNC policy more acceptable by ensuring alternative nicotine-delivery products are available for those who can't, or do not want to, quit nicotine.

New Zealand evidence has shown strong public support for a mandated nicotine reduction policy including from people who previously smoked, people who currently smoke and from Māori and Pacific peoples(58). Responses in the ITC survey showed that mandated removal of nicotine from cigarettes garnered the greatest support from Māori of any tobacco control intervention and almost 80% of the Māori respondents said they would try VLNC or nicotine-free cigarettes(58). It also found that 80% of those who smoked want the addictiveness of cigarettes to be removed, provided nicotine replacement therapy is made available in other products to help alleviate withdrawals(58). A participant in the CM Health consultation on the Governments proposed action plan also expressed support for reducing nicotine in cigarettes:

"Yep, nicotine is the part keeping us addicted so reducing nicotine in cigarettes will make it better + reduce our cravings". – Young Pacific female from Manurewa.

New Zealand's strong broader controls and surveillance, along with further strengthening surveillance and enforcement which the action plan is proposing, will make it unlikely for smuggled tobacco to be a major problem in New Zealand. The most recent study estimated that from 2013 only 1.8-3.8% of the New Zealand market was made up of illicit products (59) and that illicit trade is likely to be modest and will therefore not undermine the positive effects of a VLNC policy in reducing smoking prevalence in New Zealand(60).

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

☒ Yes ☐ No

Please give reasons:

ARPHS and the three Auckland metro DHBs support the prohibition of cigarette filters as part of a broader package of measures to reduce the appeal of tobacco products, particularly to adolescents and young adults. Filters increase the palatability of cigarettes, which makes them easier to inhale, particularly for those starting to smoke(61).

When the initial reports of lung cancer and its association with cigarette smoking emerged in the 1950s, the tobacco industry introduced cigarettes with filters claiming they were less harmful as they reduced the amount of tar and other toxicants from entering the lungs, with the very name 'filter' suggesting reduced harm(62–64). Before 1950, only 0.6% of cigarettes were filtered(61). Now filtered cigarettes represent the majority of the New Zealand market and throughout the world(65). However, the overwhelming majority of independent research has shown that all cigarettes cause harm with or without a filter(62–

64,66). Despite the evidence, a number of international studies have found that people who smoke still believe filtered cigarettes are less harmful and offer some health benefits compared to unfiltered cigarettes(63).

Prohibiting the use of filters will also remove product innovations such as capsules or ‘crush balls’ that can contain flavoured beads which when popped change the taste of the cigarette. Flavourings can further contribute to the appeal of tobacco products with evidence showing that experimentation has a gateway effect to more regular smoking(67,68).

Filters are also an environmental hazard and prohibition will remove a significant source of non-biodegradable rubbish and microplastics from the environment. Cigarette filters or ‘butts’ were the most frequently identified litter item nationally in 2019, with 39 butts collected per 1,000 m2(69). The tobacco industry is now exploring the possibility of creating biodegradable filters(63). However, biodegradable filters would still be an environmental hazard if discarded improperly and, the innovation could be used as another corporate social responsibility marketing tactic and should therefore be regarded with caution(63).

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

☒ Yes ☐ No

Please give reasons:

ARPHS and the three Auckland metro DHBs support the establishment of regulations to prohibit future constituent and design innovations of tobacco products, which would make them more addictive, palatable and appealing, particularly to adolescents and young adults.

Tobacco product regulation is a critical component of the action plan and has the ability to help reduce tobacco-related attributable death and disease by removing the industry’s free-rein to innovate and develop new ways to appeal to new users and keep existing users addicted. This will mean fewer people take up smoking, and when people who smoke try to quit, they are more likely to be successful. New Zealand surveys have repeatedly shown public support for strong regulatory measures such as this, including among people who smoke and Māori and Pacific peoples(58).

With the absence of legislation to regulate the structure of tobacco products, the industry has ensured that their tobacco products are highly addictive, palatable and appealing through the use of various additives, design innovations and flavourings(70). This interferes with the motivation and ability of people who smoke to quit and stay quit and, increases the likelihood of young people’s initiation and experimentation with tobacco products to rapidly persist to regular smoking(71).

Tobacco products can contain a range of flavour additives that are designed to enhance their palatability and appeal by masking the unpleasant characteristics of cigarette smoke. This makes it easier to inhale and the pleasurable taste can act as a sensory cue, thus reinforcing smoking behaviour. Flavourings can be particularly appealing to people who are experimenting, such as adolescents and young people(72–74). Flavoured cigarettes have been linked to addiction, with users showing greater signs of nicotine dependence and less success in quitting. The 2019 ITC NZ study found that a substantial proportion of the participants who smoked used flavoured tobacco products, with use particularly high among females(58). It also found that participants who used menthol flavoured tobacco

products were more likely to report smoking their brands because of taste(58). Just under half (45%) of those users reported they would quit smoking entirely if menthols were banned and a further quarter (25%) reported they would switch to a non-menthol brand(58). Surveys have also shown that menthol flavoured cigarettes are particularly appealing among Māori and Pacific adolescents(67). These findings suggest that flavour additives play an important role appealing to people to experiment and reduce the ability for people who smoke to choose to quit and stay quit.

Focus area 4: Make tobacco products less affordable

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

☒ Yes ☐ No

Please give reasons:

ARPHS and the three Auckland metro DHBs support a minimum unit pricing policy set at the average cost of a budget brand in 2021. This would prevent price shifting and discounting tactics designed to keep people who smoke consuming larger volumes and thus sustaining heavy addictions. We acknowledge that tobacco addiction has a significant economic impact on people who smoke and we would not want to see any further taxation increases which would place further financial burden on these people.

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.

No single intervention will have us reach our 2025 target. A raft of actions is required. To achieve a below 5% smoking prevalence by 2025, there will need to be additional averages of an extra 8,400 Māori long-term quitters per year (5.2 times BAU average) and 8,800 extra non-Māori quitters per year (1.9 times BAU average)(34). Relying on personal responsibility alone is clearly inadequate to reach our 2025 goals and does a disservice to those who smoke. We are supportive of the multi-faceted approach with the full suite of interventions suggested in the proposed action plan. A key priority in achieving this will be implementing legislation as quickly as possible. We are very close to 2025 and many of these changes will require some time to implement, so legislation to support them must come quickly to hasten this process.

Smoking remains a leading cause of health inequity in Aotearoa and while smoking prevalence has declined, high rates of smoking continue to undermine the health of specific population groups(75), including Māori, Pacific peoples and people experiencing greater deprivation(35,75). A key priority is to ensure smoking rates among these population groups decline considerably by ensuring equity is at the forefront of all decision making and any intervention that is implemented needs to specifically measure whether or not they reduce tobacco-related inequalities.

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

ARPHS and the three Auckland metro DHBs also request the following actions to be included in the action plan as critical in achieving the Smokefree Aotearoa 2025 goal:

Pacific peoples

Pacific peoples in New Zealand have the second highest smoking rates after Māori(4). There has not been any material decline in the prevalence of smoking among Pacific adults in the last 10 years(4) which highlights that the tobacco control system has failed to meet the

needs of Pacific peoples (3,4,35,75). Therefore, urgent and effective action to reduce smoking rates among Pacific peoples in Aotearoa is paramount to achieving the Smokefree Aotearoa 2025 goal. To ensure the action plan is effective for Pacific peoples we propose the following actions:

- implementing a national campaign on reducing smoking prevalence among Pacific peoples
- ensuring that Pacific leadership is prominent at all levels of the design, delivery and evaluation of all tobacco control policy, legislation and programmes including governance, decision making and management
- health services are fair, sustainable, culturally responsive and relevant to the health needs of Pacific peoples including timely access to effective and quality smoking cessation services
- dedicated funding is needed to extend, amplify and enhance Pacific specific programmes as well as fund future programmes to reduce smoking prevalence among Pacific peoples
- the health workforce is understanding of Pacific people's world views, cultures and knowledge systems to ensure services are culturally safe and responsive to the diverse needs of Pacific peoples
- funding is allocated to ensure there is an equitable representation of Pacific peoples in the smoking cessation workforce relative to the proportion of people who smoke
- ensure all tobacco control interventions demonstrate in planning and reporting documents their will contribution to reducing smoking rates among Pacific peoples.

A vaping endgame strategy

We recommend the future development of a vaping end-game strategy which recognises vaping as a quit device, but that it should not be intended for ongoing use. Protecting the health of people vaping, in particular Māori, Pacific peoples and young people, must continue to be a priority and work must start on ensuring these population groups are not simply migrated onto another addictive, and potentially harmful product. The position of ARPHS and the three Auckland metro DHBs on vaping has previously been communicated in our submission in April 2020 on the Smokefree Environments and Regulated Products (Vaping) Amendment Bill.

Effective compliance and enforcement

In order to achieve thorough effectiveness of all Action Plan interventions, a robust compliance and enforcement system needs to be established.

This system should be underpinned by tobacco licencing which would support compliance by:

- providing an accurate list of premises to inform the activity of Smokefree Enforcement Officers (SFEOs)

- utilising the opportunity to significantly reduce retailer numbers. This would allow SFEOs to undertake best practice compliance where premises are visited more regularly(76) than what is currently possible.
- establishing a clearer process for community involvement including identifying non-compliance.

Adequate national and regional resourcing

Sufficient resourcing is required at both national and regional levels. This resourcing needs to be increased as the remit of smokefree compliance increases, for example as the complexity of compliance increases with the Action Plan implementation. We would discourage repeating the process where vaping and heat not burn legislation was added to current PHU responsibilities with no increase of funding but a significant increase in workload.

There should be strong national leadership and clear regulatory direction from a central agency ideally within the provisional Health New Zealand, with co-governance with the Māori Health Authority. This model would include coordination between enforcement officers and the legal apparatus that may take proceedings against offenders. There will need to be strong links between national and regional offices to ensure that local knowledge is considered in regulatory decisions, including licence granting. The roles of national and regional staff would need to be clearly established to ensure efficiency.

The national and regional compliance teams should be a part of a multi-disciplinary unit which includes strong legal, research and health promotion functions being integrated with enforcement functions to ensure a joined-up approach to tobacco control. A dedicated smokefree intelligence function should also be sited within the same unit so that up-to-date monitoring of the determinants, distribution, patterns and harms of tobacco use is available to all other functions of the tobacco control system.

Strengthened smokefree enforcement powers

Public health must be prioritised over all commercial gain in decision making. For example, the rebuttable presumption should sit with retailers or premise owners, rather than on government enforcers.

Smokefree Enforcement Officers should be empowered to give on-the-spot infringement notices to increase the efficiency and timeliness of the regulatory process for all areas of the Smokefree Environments and Regulated Products Act (SERPA), not just for sale to minor offences in controlled purchase operations (CPOs). This would be similar to Council officers with parking tickets and the Police officers with traffic infringements. Being able to address issues at the time would provide an increased deterrent effect to retailers and premise owners. Infringement notices should be issued to the retail/premise owner rather than the employee as it is the owner's responsibility to ensure their staff comply with SERPA. This would reduce administration as the status quo often includes multiple site visits, each with follow up letters encouraging compliance before prosecution file requirements are met which is resource intensive for both PHUs and the Ministry of Health. If the infringement fine did not act as a deterrent and a reoccurrence of the same offence is identified, officers could then prepare a prosecution file for the Ministry of Health to action.

The current model of using the criminal legal system 'beyond reasonable doubt' test is not in line with the intent of the Smokefree Environments and Regulated Products Act. Instead

the civil law test of ‘the balance of probabilities’ should be used. This was recommended by Judge Sainsbury in the Drewmond Hard Hospitality (Longroom) decision where he stated that the criminal law model ‘provides an unnecessary hurdle to successful enforcement’ and suggested a licencing regime as a ‘more sensible way of regulating smoking areas’(77).

Extension to the current SFEO powers would also help to strengthen enforcement efficiency. This includes allowing officers to search for products, for example to look in a retail cabinet or under a counter, to address the current limitation where inspection is what you can see on front of you, where some products are hidden outside of view. Secondly it is recommended to extend the powers to request identifying information to all areas of the SERPA which would support an infringement process, increased from only being able to do so with sales to minors in CPOs.

It is recommended that Customs Officers and Police Officers should receive the same retailer and wholesaler enforcement powers as SFEOs as professions that regularly come across SERPA issues. Customs officers for example, intercept cigarettes in non-compliant packaging; if designated, they would be able to address this issue directly rather than needing to refer it to a SFEO. Delegating Police Officers would help close a current area of uncertainty in enforcement where CPOs cannot be conducted at of-licence alcohol retailers by SFEOs as that would breach the Sale and Supply of Alcohol Act by sending a minor into a licenced premise, however Police can, but are unable to authorise a minor to purchase cigarettes as they don’t have smokefree enforcement powers. Delegating Police would also enable them to enforce SERPA in regional communities which might be easier than awaiting a SFEO visit.

Equity focussed compliance

The current reactive model of smokefree complaints and resourcing limitations has proven to be inadequate for implementing and equitable, best practice model. As many communities are unaware of the complaints process, we find that the majority of complaints are received from areas which have lower smoking related harm. Between 2013-2018 61.7% of all complaints were received from residents of the central Auckland Local Board areas of Albert-Eden and Waitemata whilst only 9.8% were from the 5 South Auckland Local Boards. Increased community education, licensing and a simpler complaints process could resolve this, but in order to ensure an equitable approach targeted compliance activity is required.

ARPHS piloted a proactive enforcement project which demonstrated potential for equitable improvements to SERPA compliance at licenced premises. The project focussed on suburbs with high Maori and Pacific populations and high smoking prevalence, where all on-licenced premise open areas were checked. Throughout this pilot, 9% non-compliance was discovered in the South Auckland suburbs of Papakura, Manurewa and Mangere which otherwise would not have been discovered.

The upcoming roll out of the SERPA regulations will require a much higher level of enforcement with 2,952 licensed (club and on-licence) premises in Auckland having to adhere to a new open areas definition. The opportunity for PHUs to conduct proactive compliance is dependent on capacity, which in Auckland is challenging with the team already being under-resourced to maintain reactive workloads.

Flexibly to approach CPOs is also required. Compliance resource is not sufficient to test all premises within the Auckland region. We have been applying a targeted equity approach in

recent years, but this leaves most of Auckland unchecked. Research shows the more frequently premises are checked, the higher the compliance for all aspects of smokefree legislation(76).

Workforce development

Regular workforce development and training is a key component of an enforcement system particularly as new regulations come into force – an in-depth updating process will be required if the actions in this plan become law.

Mass media

We support the continuation of evidence-based mass media campaigns including social media and would encourage the addition of complementary localised content to campaigns. A particular focus on culturally appropriate media for Māori and Pacific peoples is required.

Effective campaigns must be well informed and developed alongside priority populations to achieve the Smokefree Aotearoa 2025 goal. Media campaigns should be bold, strong and cutting edge that uses technology to its full potential and across multiple types of media including electronic platforms like mobile phone applications, telecommunications such as text messaging and various social media outlets.

Adequate investment into mass media is required and it should be agile enough to move and adapt to support and empower improved up take of key messages. Consideration should be given to groups of people that have never smoked, wanting to quit and have quit.

Industry responsibility

Whenever possible we would like to see the greatest responsibilities, costs or disadvantages of any future tobacco control interventions placed on the tobacco industry rather than on the consumers of this addictive product. Sale of tobacco products generates huge profits for tobacco companies, yet the negative externalities created, including the economic, social, and health costs, are borne by individuals, whānau and society. Individuals who are addicted to tobacco, the tax-payers of New Zealand, and New Zealand society more broadly should not have to pay for the costs of this addictive and lethal product.

Increase funding for Stop Smoking Services

ARPHS and the three Auckland metro DHBs would like to see increased funding for Stop Smoking Services including multi-session behavioural support and help for people who smoke to access and use a range of stop-smoking medicines (nicotine replacement therapy, bupropion, nortriptyline, varenicline). Cochrane systematic reviews of these interventions conclude that they help people who smoke to quit and maintain this long term(78–80). From 1st July 2016 to 30th June 2020 52,471 people who smoke who enrolled into a MOH contracted face-to-face Stop Smoking Service set a quit date, and almost half of these (47%) were successful at quitting. Quit rates are as high as 70 - 80% in some DHBs in New Zealand(81). Stop Smoking Services are also successful at equitably enrolling and supporting Māori and Pacific peoples who smoke in an equitable manner *[see Counties Manukau Case Study]* (81).

Stop Smoking Services have been shown to be cost effective both internationally and in New Zealand(82). The cost of providing Stop Smoking Services is significantly less than the health costs of tobacco related diseases(82). A New Zealand modelling study has estimated that a targeted stop smoking support intervention that costs $100,000 a year would only need to support three to four people who smoke to quit to break even ($25 - $33,000/quitter). The Ministry of Health contracted face-to-face Stop Smoking Services currently cost significantly less than this, ranging from $988.61 - $13,637.31 per quitter in Quarter 4 2020 (median cost $4473.68)(82).

Funding for a range of stop smoking services require an increase in funding to be able to support greater numbers of people who smoke to quit, to train and recruit more stop smoking practitioners, and to allow the development of additional services for priority populations. In the 2018/2019 New Zealand Health Survey, 14.2% of the New Zealand adults (aged 15 years and over) reported being people who currently smoke, an estimated 558,000 adults(42). There is currently a significant gap between the number of people who smoke and the number who can be supported to quit (noting that not all people who smoke wish to quit, and that some may be accessing alternate services). Demand for Stop Smoking Services will also increase as additional measures are put in place to reduce the availability and appeal of tobacco as part of the Smokefree Aotearoa 2025 Action Plan.

Regional health services should routinely be funded to deliver both tobacco control and smoking cessation support to reduce drop-off in engagement following referrals between service providers (for example, from secondary services to an external smoking cessation service). Contract lengths should also be increased to three plus years (or added to regional health service baseline funding) to improve retention of experienced smokefree practitioners.

Mental health and addiction service users should be added to the Ministry of Health’s priority populations (alongside Māori, Pacific peoples and pregnant women) for stop smoking services. Mental health and addiction service users have very high rates of smoking. For example, approximately 43% of Waitematā DHB’s service users (total population) are people who smoke, rising to approximately 70% for Māori and 59% for Pacific peoples. Mental health and addiction service users need a tailored approach (with a longer and more intensive period of support) delivered by skilled practitioners to help them to quit.

Stop Smoking Services must be tailored to priority populations and provide responsive, flexible and holistic services which support the broader needs and life goals of clients and their whānau. This includes improving access to prescription medications (for example, through pharmacy prescribing of stop smoking medications or funding of primary care visits and prescriptions) and e-cigarettes (through discounts or funded vape products when used for smoking cessation). Pharmac should also subsidise all nicotine replacement therapy products (for example, Quit Mist, an oral spray which is currently unfunded and, improving access and options for rongoā Māori for assisting in cessation).

Provision of smoking cessation advice and treatment within primary and secondary care and other settings such as pharmacies also needs to be strengthened through training and on-going support from Stop Smoking Services. Pharmacy provision of smoking cessation

support has been shown to be cost effective and is a good option for rural communities that may not have easy access to services(83).

Workforce representation and national resources

It is essential that services are delivered in a culturally appropriate and whānau centered way to support priority populations through their smoking cessation journeys. This requires a culturally diverse and competent workforce with strong linkages between Stop Smoking Services, Kaupapa Māori and Pacific health services and other community organisations (for example, those that provide housing or income support*) [see Counties Manukau Health case study]*. Increasing funding for training and recruitment of stop smoking practitioners (particularly Māori and Pacific practitioners) and contract lengths will facilitate this. The stop smoking practitioner workforce also requires strengthened provision of training at a national level, with development of additional national resources for practitioners to utilise in their work. These need to include content on working with mental health and addiction clients, including how to tailor the stop smoking journey to meet their needs.

Case Study: Counties Manukau (CM) Health

CM Health is currently funded by the Ministry of Health to provide both core tobacco control activities and the provision of Stop Smoking Services and, is the preferred model for Tāmaki Makaurau. CM Health employs a team of 8.5 FTE who provide tobacco control leadership, planning and strategy, analysis, support to achieve health targets, delivery of a triage service, health promotion, and national service development work. The Living Smokefree Service (LSS) employs a team of 10 FTE and delivers stop smoking services in individual, whānau or group settings with face to face, phone or digital support. The service currently receives approximately 7000 referrals per annum and aims to increase this to 11000 per annum.

The prevalence of smoking in the CM Health population aged ≥15 years is estimated to be 13-14%, a significant reduction from 22% in 2006(84,85) Māori and Pacific peoples have much higher smoking rates than other ethnic groups in CM Health. The LSS has one of the highest quit rates in New Zealand, with a 76.4% CO-validated quit rate at four weeks in 2019/2020[8]. The cost per quitter for the period 2017/18 to 2019/20 was $1275.73, significantly less than the national average(81). The LSS is successful at equitably enrolling and supporting priority populations who smoke (Māori, Pacific peoples, pregnant women, people with mental illness and/or addictions, youth.

The collaboration between core tobacco control activities and the LSS service is a key enabler of the services success. This ensures that a whole-of-systems approach is used to implement smokefree Asking Brief Advice Cessation support (ABC) in primary, secondary, maternity, mental health, community health and non-health settings. The core tobacco control advisors have strong relationships with staff in these different settings, support workforce development and training, and provide clinical supervision. Achieving equity is a key focus area for the LSS, and this is achieved through a focus on the priority populations previously outlined, and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau. This includes

[8] Quit rate denominator - people who smoke who set a quit date

employing a holistic approach to addressing the broader health, social, and cultural needs of whānau. Services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services. The LSS also champions innovative approaches for smoking cessation, including unique contracting (for example outcome based contracting with incentives for community providers), incentive based programmes, and the use of e-cigarettes in smoking cessation.

Smokefree outdoor open areas

ARPHS and the three Auckland metro DHBs would encourage the Government Smokefree Aotearoa 2025 action plan to include provisions to increase legislated smokefree areas. Smokefree indoor areas have significantly reduced public exposure to second hand smoke (SHS) (86–88) and the action plan should build on this success to further protect the public from the harms of SHS. ARPHS and the three Auckland metro DHBs would support all areas being smokefree, by default, and at a minimum smokefree areas should be extended to include all workplaces, parks, beaches and other outdoor recreational spaces. Several surveys in Tāmaki Makaurau, Christchurch, Hawke's Bay, and Wellington have found significant public support for such an expansion of smokefree areas (89–92). Areas which are not designated smokefree would be available for use by those who smoke.

Although indoor smokefree policies have been effective, SHS is still a problem in the surrounding public outdoor spaces, particularly those which are semi-closed (93–102). A Wellington study found that outdoor areas of hospitality venues had mean concentrations of particulate matter 2.5 (PM2.5) of 72 μg/m3 (51-284 μg/m3) that would exceed WHO guidelines for mean exposure to PM2.5 over a 24-hour period (25 μg/m3) within 7.2 hours and the annual guideline of 10 μg/m3 within 1.8 hours (103). Another study in New Zealand found that SHS exposure was harmful in more public areas like bus and train station platforms (99). Indoor air quality continues to be compromised due to smoke drift from adjacent outdoor environments to indoor areas, undermining indoor smoking bans (93,94,96,103).

Outdoor smokefree policies will not only help to protect the public from the harms of SHS but will also reduce the normalisation of and exposure to smoking of young adults which poses risks for uptake in young adults (104–111). A recent New Zealand study found the social setting of a bar normalised, integrated, and reinforced smoking as an essential element of a 'night out' (110). It also reinforces the many linkages between tobacco and alcohol use, which should be decoupled if we are looking to reduce harm from both these drugs. The Auckland Council's Smokefree Policy 2017-2025 recognised the need to address this normalisation of smoking in public outdoor areas (112) but optimal compliance has not been achieved without the regulatory support legislation provides.

Finally, under the current model a significant amount of time can go into investigating whether an establishment is compliant or not. ARPHS has recently been involved in two court cases to determine whether an area was considered internal or external: The Longroom and Speakers Corner, which took an estimated 188 and 282 hours of Compliance Officer's time, respectively. Any amendments to what constitutes an "open area" will still

result in confusion. The fairest option which will also be the most effective at protecting the health of the public is to expand the legislated smokefree areas.

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