Health Coalition Aotearoa

Submission on Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill

August 2022

Acknowledgements: This submission is submitted by the Smokefree Expert Advisory Group (SEAG), of Health Coalition Aotearoa. Members are Sally Liggins (Chair) – Massey University; Selah Hart – Hāpai te Hauora; Professor Chris Bullen – University of Auckland; Professor Richard Edwards – University of Otago; Professor Janet Hoek – University of Otago; Andrew Waa – Aspire/Eru Pomare Māori Health Research Centre; Ben Youdan – Independent; Rebecca Gilbert – Cancer Society Auckland – Northland; Julia Rout- Stroke Foundation NZ; Catherine Manning – Takiri Mai te Ata Regional Stop Smoking Service; Aporina Chapman – Toi Te Ora BoP DHB; and Leitu Tufuga – Hāpai Te Hauora. Candace Bagnall (Massey University) wrote the submission.

Contents

Health Coalition Aotearoa Submission on Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill 2022

Introduction

Health Coalition Aotearoa (HCA) is a coordinating, umbrella organisation for the NGO, healthcare and academic sectors to achieve the collective vision of health and equity in Aotearoa/New Zealand.

We envision greater health and equity for all New Zealanders through reduced consumption of harmful products (tobacco, alcohol, unhealthy foods and beverages) and improved determinants of health.

Unhealthy diets, high BMI, tobacco, and alcohol contribute about one-third of the overall preventable health loss in New Zealand[1]. As a collective, we strive to prevent harm from unhealthy commodities and work to strengthen the foundations of public health.

This submission was drafted by the HCA's Smokefree Expert Advisory Group, which includes tobacco control academics, smokefree health promotion and community health leaders, and smoking cessation experts. The SEAG submission on the Smokefree 2025 Plan is attached as an appendix to provide more detailed evidence supporting the three key priority measures supported by this Bill.

Health Coalition Aotearoa supports the aim of reducing smoking prevalence to below 5% by 2025, and we note that the scope of this legislation goes well beyond this timeframe, as does the much longer-term vision expressed by it. The new measures, combined with our existing comprehensive tobacco control policies will continue to improve the health of all New Zealanders and reduce inequities for many years to come.

General policy statement introducing the Bill

The Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill ('the Bill') is intended to legislate for changes needed to achieve the Smokefree 2025 goal of reducing daily smoking rates to less than 5% across all population groups by 2025. The Bill enacts the policy direction outlined in the Smokefree Aotearoa 2025 Action Plan ('the Plan').

The general policy statement introducing the Bill states "This Bill amends the Smokefree Environments and Regulated Products Act 1990 and the Customs and Excise Act 2018 as follows:

- *Reducing retail availability*: new provisions restrict the sale of smoked tobacco products to retailers approved by the Director-General of Health, set out the application process and criteria to be an approved retailer, and provide for the Director-General of Health to set a maximum number of retail premises allowed in a certain area. The intent of these provisions is to significantly limit the number of retailers able to sell smoked tobacco products:
- *Amending the age limits for sale of smoked tobacco products*: new provisions allow for the introduction of a smokefree generation policy by prohibiting the sale of smoked tobacco products to anyone born on or after 1 January 2009. The intent of the policy is to prevent young people, and successive generations, from ever taking up smoking:
- *Reducing the appeal and addictiveness of smoked tobacco products*: new provisions require that only smoked tobacco products that meet requirements for constituents will be able to be

[1] Institute for Health Metrics **http://www.healthdata.org/** (as cited in Health Coalition Prevention Brief 2020)

manufactured, imported, or offered for sale or supply, and provide that it will be an offence for any smoked tobacco product to contain constituents exceeding any limits prescribed in, or prohibited by, regulations. A specific provision provides for a regulation-making power to set limits on the quantity of nicotine levels and other constituents of smoked tobacco products. The intent of these provisions is to increase the number of people who successfully stop smoking, and support tamariki/young people to remain smokefree, by making smoked tobacco products less appealing and addictive." [2]

Executive Summary

1. Health Coalition Aotearoa acknowledges the important contribution of the 2010 Māori Affairs select committee members responsible for setting the Smokefree 2025 goal following their landmark Parliamentary inquiry. We support the continuation of their work to improve health outcomes and reduce smoking-related health inequities.

2. We support the commitment to honouring Te Tiriti o Waitangi ('Te Tiriti') principles in the Bill. However, there are other interpretations of Te Tiriti that extend commitments of the Crown such as provisions (kawanatanga, tino rangatiratanga, oritetanga) that refer to the respective acts within Te Tiriti. We would like to see both 'principles' and 'provisions' referred to within the Act.

3. We support the Smokefree 2025 Plan (2021) and welcome this new legislation that will enable implementation of the three priorities identified in the policy statement introducing the Bill: significantly limiting the number of retailers able to sell smoked tobacco products; introducing a smokefree generation policy; and reducing nicotine content to non-addictive levels in smoked tobacco ('the three measures'). Our 2021 submission in support of this plan is attached as an appendix, as it provides a summary of research evidence in support of the three measures.

4. The Parliamentary Counsel Office's explanatory note (General policy statement) clearly states the Government's commitment to reaching Smokefree 2025, and the three priority strategies for reaching this. However, in the purposes sections in **Part 1, Amendments to principal Act** of the Bill at 3A we would like to see wording from the policy statement more clearly linking the three key strategies to achieving the Smokefree Aotearoa goal in this section of new Act. For example, rather than "significantly reduce the retail availability of STPs" (in the Bill), replace with "significantly limit the number of retailers able to sell STPs" (from the policy statement).

5. The three measures are complementary and, together, will significantly strengthen our long-term, comprehensive approach to tobacco control, first legislated for in the Smokefree Environments Act 1990. New Zealand's tobacco programme has been successful in reducing smoking prevalence since that time. The first NZHS data available is from 1992/93 when current smoking in adults was 23.2%[3]. By 2020/21 NZHS figures showed current smoking down to 10.9% and daily smoking at 9.4%[4]. Meeting the Smokefree 2025 goal of less than

[2] Excerpt retrieved 5 July 2022 from https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_125245/smokefree-environments-and-regulated-products-smoked-tobacco

[3] *Shaping Up*: report on results of the 1992-93 New Zealand Health Survey, Ministry of Health 1995.

[4] Ministry of Health. (2021). *Annual Update of Key Results 2020/21: New Zealand Health Survey*. Wellington: Ministry of Health.

5% of New Zealanders smoking is still possible, provided the implementation of the new policies begins early in 2023.

6. We note the importance of reducing the addictiveness of smoked tobacco products as a key priority. Rapid implementation of this measure will be pivotal to reaching our Smokefree 2025 goal. Evidence supports the very low nicotine cigarettes (VLNCs) policy as the 'heavy lifter' in reaching SFA 2025 and in reducing inequities, but new data underlines its primary importance, and also suggests that it is unlikely that Māori will achieve the goal within this timeframe[5]. Clearly, the sooner this policy can be put in place, the sooner we will also see improvements in health equity.

7. Health Coalition Aotearoa is concerned about rapid increases in youth vaping over the last five years or so. We note that 2021 ASH Year 10 data show that regular vaping in this age group is now 20.2%, and for Māori it is much higher, at 35.6%. Our schools, child and youth health professionals, whanau and communities are extremely concerned about the impact of nicotine addiction on children and young people as a result of liberalised access to these products in recent years.

   We are concerned that under current regulations and since the 2020 Act there are many hundreds of convenience stores that have been approved as specialist vape retailers, by sectioning off an area of existing premises. These are stores frequented by children.

   We are also concerned that the purposes sections at 3A and section 49 of the present Act have removed all specific mention of vaping protections for young people. This submission makes recommendations seeking to ensure that entrenching vaping among rangatahi of today and in future generations is not a legacy of the Smokefree Environments Amendment Bill.

8. We agree with HSC members that evidence-based policy is critical and argue that there is strong supporting evidence for these new policies. We also agree that a robust and comprehensive monitoring and evaluation programme should be put in place to allow for the generation of new evidence, inform continuous quality improvement and minimise any unintended adverse impacts. We note that the Ministry of Health has already taken steps to put this evaluation in place.

9. We strongly support the review of current capacity and capability of the Smokefree Environments Officer workforce which was identified as a key action in the SFA 2025 Action Plan. Investment in smokefree workforce development will be essential, especially as Covid-19 has impacted heavily on all public health units' capacity. Some measures could be undermined by poor compliance, such as unapproved sales of tobacco products or the availability of illicit tobacco products. We support increased resourcing to enable adequate monitoring and enforcement, as an urgent priority.

[5] Wilson N, Hoek J, Nghiem N*, et al.* Modelling the impacts of tobacco denicotinisation on achieving the Smokefree 2025 goal in Aotearoa New Zealand. *New Zealand Medical Journal (Online)* 2022;**135**(1548):65-76.

Summary of Recommendations

Health Coalition Aotearoa recommends

1. That Te Tiriti o Waitangi should only be referred to in its te reo Māori form in the new Act to make it clear that any references to obligations to Māori are clearly linked to the te reo Māori text.

2. That Māori *engagement* (rather than consultation) should be included in all aspects of development and implementation of the final legislation, its implementation and evaluation, particularly those measures that will have a significant impact on them.

3. That both 'principles' and 'provisions' of Te Tiriti o Waitangi are referred to within the Act.

4. That an independent Māori governance group is formally recognised in the legislation (including its makeup, roles and term).

5. That the government prioritise the introduction of very low nicotine cigarettes (VLNCs), specify a limit of 0.4mg nicotine per gram of tobacco in the legislation, and begin the implementation of all three measures as soon as possible in 2023 to improve the chances of achieving the 2025 goal.

6. That heated tobacco products (HTPs) are regulated in the same way as smoked tobacco products.

7. That an upper limit for the number of smoked tobacco retailers (STRs) nation-wide is included in the legislation, be no higher than 600 retail outlets selling tobacco and with an expectation that the number will reduce over time.

8. That the STR reduction process commences after denicotinisation has been in place for six months, to allow that policy to reduce smoked tobacco sales.

9. That additional criteria be set to those outlined at 20I which retailers must satisfy before they can become an approved smoked tobacco retailer including:
    - restrictions on proximity to schools, ECE centres, kura kaupapa, wahi tapu, and community-based facilities where children and young people gather, in consultation with Smokefree Officer and other community-based smokefree services
    - avoidance of concentration of STPs in low-income communities
    - requirements to provide STP sales data to assist with monitoring and evaluation
    - no history or record of underage sales
    - proof of age verification requirements for internet sales associated with approved retailers.

10. That a definition of the term “(ii) appropriate premises from which to operate a stand-alone business” is included in the definitions section of the new Act.

11. That this legislation and the regulatory process resulting from it, be considered as an opportunity to adjust regulatory settings to better protect school-aged children from potential harm from vaping, and specifically that of nicotine addiction, as follows:
    - Incorporating vaping into the smokefree generation measure, to become known as a ‘nicotine-free generation’ policy for all smoked tobacco and notifiable products including vaping products and non-combusted tobacco products, except when these are used as an aid to stopping smoking by a person who smokes

- strengthening the approvals process for specialist vape retailers, to prevent convenience stores from gaining approval as SVRs
- a cap on the number of SVRs able to be approved
- SVR approval to include consideration of proximity to schools, kura kaupapa, ECE centres, kohanga reo, wahi tapu, and other venues where children and youth gather, in consultation with Smokefree Officers and other community-based smokefree services
- requiring a 'fit and proper person' test for all vape retailers, as will be required for smoked tobacco retailers
- requiring SVRs to apply age verification processes in sales to young people and all online sales and delivery
- minimum prices set for disposable vapes, with subsidised products available through smoking cessation services
- reducing the upper limit of nicotine for vaping products (currently 50mg/mL) to that of the European Union and UK – 20mg/mL across all notifiable products.

12. That the Purposes sections at 3A and Section 49 are strengthened, not weakened in terms of protecting children and young people from both vaping and STP-related harm, by reinstating Sections (b) and (c) (ii) – (iv) of 3A and the purposes in Section 49 of the 2020 Act.

13. That Section 40 more clearly requires and defines age verification processes for both direct and online sales of smoked tobacco and vaping products to minors.

14. That the stipulation in Part 3 Section 52(b) that STPs are required by regulations to list constituents and their respective quantities present in the product's emissions be put in place for all regulated products including vaping and heated tobacco products. That this information be held and published by the approving agency, but not on product packaging.

15. That the DGH be given authority in the legislation, to place restrictions on the introduction of innovative STP product design features that might increase their addictiveness, palatability, appeal or potential harm to health or the environment, as such features could be subject to legal challenge.

16. That the wording used with respect to the sale or supply of STPs in sections 40A and 40B - i.e. 'knowingly or recklessly' be replaced by the wording in the original Act, which puts the onus of proof on the person charged to prove that they took 'reasonable precautions and exercised due diligence' as this is more practical in terms of enforcement.

17. That the penalties for small-scale non-commercial social supply offences should be less severe than for commercial supply offences and are classified as infringement offences which cannot result in a criminal record.

18. That the Smokefree Aotearoa 2025 Plan (Ministry of Health 2021) be updated for the purpose of implementing the new legislation and include a more comprehensive approach within specified timeframes. The updated plan should integrate new and existing or planned measures (including health promotion, mass media campaigns, surveillance and enforcement, and enhanced smoking cessation activities) with clear commitments to new regulatory and other key activities.

Health Coalition Aotearoa responses to proposed amendments

1. Te Tiriti o Waitangi

Part 3AB – Te Tiriti o Waitangi

This section provides for "the Crown's intention to give effect to the principles of Te Tiriti o Waitangi/the Treaty of Waitangi". It requires the DGH to consult with the Māori Health Authority; each iwi-Māori partnership board; and any iwi or other Māori who the DGH considers have an interest in the application process before determining the application process for the approval of smoked tobacco retailers (STRs). In determining the maximum number of approved STRs in particular areas the DGH, in addition to consulting with all parties above, must also consult "with any iwi whose rohe includes all or part of the proposed area". Systems must be put in place by the DGH to consult with Māori.

Health Coalition Aotearoa acknowledges the Crown's obligations to Te Tiriti o Waitangi and its significance as stated in the Bill. We note additional Crown obligations to protect Māori from tobacco related harm and meaningfully engage with Māori as a signatory to the Framework Convention on Tobacco Control (Preamble and Article 4/2c) and the United Nations Declaration on the Rights of Indigenous Peoples). Finally, we note the whakapapa of this legislation and the 42 Recommendations in the Māori Affairs Select Committee (MASC) report to government in 2010[6].

Exclusive use of Te Tiriti o Waitangi in the Act

Both te reo Māori and English names for Te Tiriti o Waitangi are used in the Bill's text. While they can be seen as a transliteration of each other, the use of the English name creates a potential for different interpretations of the Treaty to be used in relation to the Bill. As is widely known two versions of Te Tiriti o Waitangi (Te Tiriti) were signed during 1840: the original text in te reo Māori; and an English version. There is also an English translation of the Māori text. The original Māori and English versions substantially differ in their interpretation of rights accorded to Māori. We note in previous political debates related to Te Tiriti (e.g. the Foreshore and Seabed Act) both versions were referred to creating ambiguity about the Government's remit in passing legislation affecting Māori.

Under international rule contra proferentem applies and the te reo Māori text of Te Tiriti should take precedence. We strongly believe that Te Tiriti o Waitangi should only be referred to in its te reo Māori form in the new Act to make it clear that any references to obligations to Māori are clearly linked to the te reo Māori text.

Consistent reference and commitment to Te Tiriti o Waitangi throughout the Bill's text

Section 3AB of the Bill states "In order to provide for the Crowns intention to give effect to the principles of Te Tiriti o Waitangi/the Treaty of Waitangi...". The statements that follow appear to be specifically related to clauses in the Bill affecting reduced retail access to tobacco. There do not appear to be any references to Te Tiriti in other key aspects of the Bill including creating a Smokefree Generation, regulating tobacco constituents and, in particular, markedly reducing nicotine content in tobacco. There is reference to the Director General of Health (DGH) taking into consideration the risks and benefits of regulating constituents but no explicit requirement to engage with Māori. We note that Māori advocacy for a tobacco endgame in the mid 2000's and the subsequent 42 MASC recommendations highlighted the need to focus on changing both the supply and nature of tobacco as well as protecting rangatahi. The Bill refers to Te Tiriti o Waitangi obligations across the proposed

[6] New Zealand Parliament. Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee. Wellington: New Zealand Parliament, 2010.

measures inconsistently. We believe that Māori engagement should be included in all aspects of development and implementation in the final legislation, its implementation and evaluation, in particular, those measures that will have a significant impact on them.

'Engaging' rather than 'consulting' with Māori

Te Tiriti o Waitangi related clauses in the Bill commonly use the term 'consultation' with Māori. In the past consultation process with Māori have been characterised as meeting with Māori stakeholders, hearing their views but not including them in final decision making. This does not reflect Te Tiriti partnerships or make best use of Māori potential to support the implementation of legislation that will see the Smokefree Goal achieved. We believe the appropriate term should be 'engage' which implies active partnerships and participation in all aspects of decision making.

Ensuring the structure for Government engaging with Māori reflects a true Te Tiriti o Waitangi partnership

The Bill refers to Te Tiriti principles. This highlights important commitments on the part of Crown. However, there are other interpretations of Te Tiriti that extend these commitments such as provisions (i.e. kawanatanga, tino rangatiratanga, oritetanga) that refer to the respective acts within Te Tiriti. We recommend that both 'principles' and 'provisions' are referred to within the Act.

We strongly support the establishment of *Te Aka Whai Ora* (the Māori Health Authority) and its role in overseeing the implementation of the Smokefree Environments Amendment Act. However, *Te Aka Whai Ora* is an agent of the Crown and therefore care should be taken not to imply it is a Māori 'partner' in relation to Te Tiriti o Waitangi (particularly as ultimate authority in this relationship still resides with the DGH). Therefore, we believe the structure for engaging with Māori should be amended to better reflect a true Treaty partnership. This could be achieved through changing the role of *Te Aka Whai Ora* in relation to the Bill to facilitating Treaty partnerships and establishing an independent Māori governance group to provide input into the development of any regulations and the overall implementation and evaluation of the legislation. This group could be an evolution of the Māori taskforce that has been providing input into the Bill during 2022. The group could then engage with iwi- Māori partnership boards or other Māori authorities and stakeholders as the need arises. As noted we strongly support *Te Aka Whai Ora* but are concerned that some political parties have indicated they will disestablish it if elected. If this was to happen there would be a 'gap' in the legislation that could potentially affect Māori engagement. As a safeguard we believe an independent Māori governance group, that is formally recognised in the legislation (including its makeup, roles and term), will help mitigate this risk.

We recognise the need for the DGH to have the authority to set key regulations in relation to the Bill. However, decisions made by the DGH can be legally challenged. This could be particularly problematic if the challenge came from the tobacco industry or stakeholders with a vested financial interest in selling tobacco. We believe such challenges would contravene the principles and provisions of Te Tiriti o Waitangi. Ideally key aspects (e.g. the amount by which retail access and nicotine content in tobacco should be reduced) should be written into the legislation rather than deferred to regulations to avoid legal challenges to the DGH.

2. Reducing inequities

Modelling studies suggest that the three measures combined would significantly reduce the gap between Māori and non-Māori mortality by 2040 if there were no major policy changes, and under the combined tobacco endgame strategy, with VLNCs accounting for most of the reduction that is

predicted[7]. For those aged 45 years and over, the gap was reduced by 22.9% for Māori females compared to non-Māori females, and 9.6% for males.

Figure 1 below shows the projected effects of the combined interventions on smoking prevalence to be introduced in 2023.

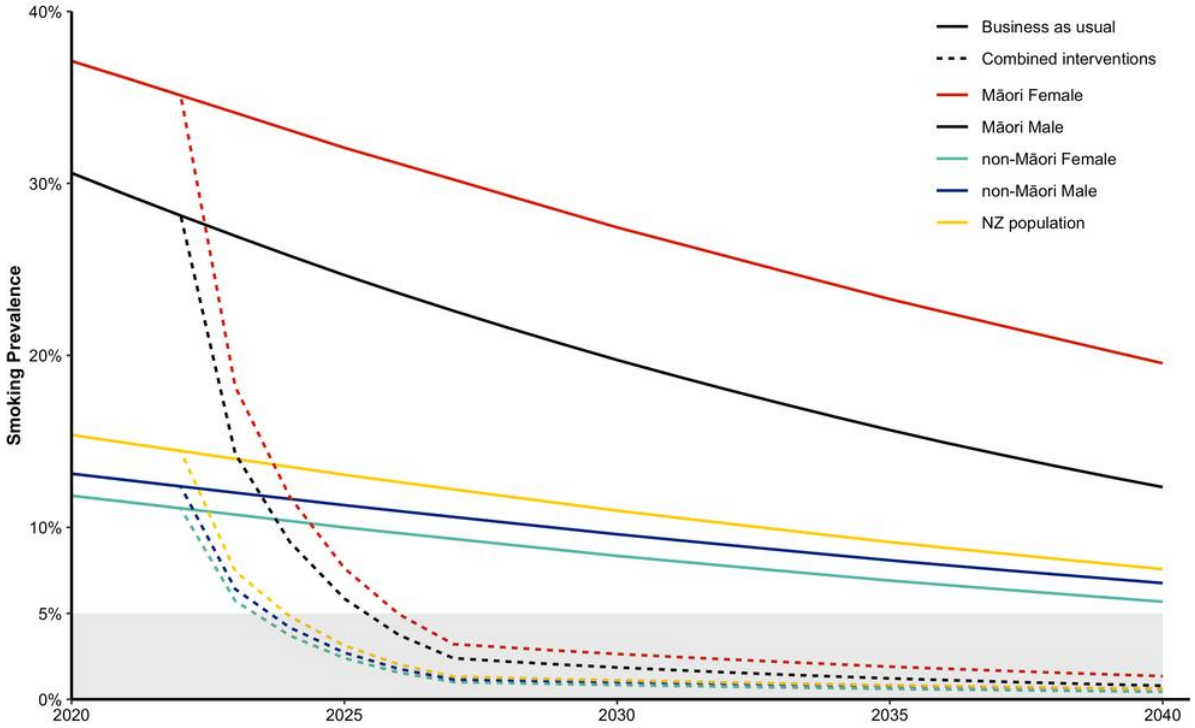

Figure 1: **Projected effects of the combined endgame interventions on smoking prevalence to be introduced in 2023.** Likely delays in implementation will shift the curves to the right commensurately. Blakely, Waa, & Ouakrim.

We acknowledge the concerns of some HSC members that the modelling studies underpinning these innovative interventions may not be robust enough evidence to support the interventions. It is correct that all modelling is based on assumptions, but in this case, these are based on the best available data including evidence from NZ studies cited elsewhere in this submission and in the Appendix. The assumptions are explicitly stated in the models that inform the policy.

We note that many very successful tobacco control interventions that are now accepted in New Zealand, such as smokefree bars and restaurants and changes to cigarette packaging were also largely 'untested' and the results had not been properly evaluated in other countries, at the time of their introduction here. In the case of the three new additions to our tobacco control programme, there is strong supporting theoretical, pre-implementation research and modelling evidence. We are confident that the rationale is sound and note that this type of modelling has been used in other areas, for example, predicting climate change.

We urge the government to prioritise the introduction of VLNCs, and the implementation of all three measures as soon as possible in 2023 to improve the chances of achieving the 2025 goal.

[7] Ouakrim, D. A., Wilson, T., Waa, A., Maddox, R., Andrabi, H., Mishra, S. R., ... & Blakely, T. (2022). Tobacco endgame intervention impacts on health gains and Māori: non-Māori health inequity: a simulation study of the Aotearoa-New Zealand Tobacco Action Plan. *medRxiv*.

3. *The importance of very low nicotine cigarettes*

Denicotinised/very low nicotine cigarettes (VLNCs) are defined as cigarettes having less than 0.4mg nicotine per gram of tobacco.[8]

We acknowledge the concern from some Select Committee members regarding uncertainty about the impact of introducing VLNCs as they have yet to be widely implemented internationally.

Three main concerns are raised about VLNCs:

1. **Compensatory smoking** – *people might smoke more cigarettes or puff more intensely to get the same nicotine dose.* While many studies have found this behaviour for the first few days, people who continued smoking typically show a sustained reduction in the number of cigarettes smoked.
2. *This policy amounts to* ***prohibition*** *and is unfair to people who choose to smoke*. Nicotine is extremely addictive, and choice has little to do with smoking. Studies over many years have shown conclusively that most people who smoke want to quit and wish they had never started. Plus, e-cigarettes and nicotine replacement therapies are easily available in New Zealand as less harmful sources of nicotine.
3. *This and other proposed measures could increase the* ***illicit and smuggled cigarette market*** *and home-grown tobacco use.* We argue that based on previous experience of introducing tobacco control measures, any increase in illicit trade is likely to be minimal (see section 12, p. 21 of this submission).

The idea of reducing levels of nicotine in cigarettes to reduce their addictiveness is not new – 20 years ago, tobacco research commentary[9] was published that coincided with initial attempts by the US Food and Drug Administration (FDA) to regulate tobacco products. Although a reduction in nicotine content was endorsed by representatives of the medical community at the time[10], and the idea has received renewed attention from the World Health Organization (WHO), the Office of the U.S. Surgeon General, and other medical bodies over the last eight years, it has only recently gained traction in the US[11].

Evidence which has informed modelling studies about the potential health gains available from implementing the VLNC measure as a priority was summarised recently by NZ tobacco researchers[12] and builds on a landmark randomised controlled trial[13] which found that reduced-nicotine cigarettes versus standard-nicotine cigarettes reduced nicotine exposure and dependence and the number of cigarettes smoked.

The body of research includes studies undertaken in New Zealand and provides compelling arguments in favour of the approach. For example, early findings of a cohort study of Māori people who smoke suggest that over half would quit smoking (40%) or use e-cigarettes (14%) if VLNCs were

---

[8] Hatsukami DK, Xu D, Ferris Wayne G. Regulatory Approaches and Implementation of Minimally Addictive Combusted Products. *Nicotine Tob Res* 2022;24(4):453-62.

[9] Benowitz NL, Henningfield JE. Establishing a nicotine threshold for addiction: the implications for tobacco regulation. N Engl J Med 1994;331:123-125

[10] Henningfield JE, Benowitz NL, Slade J, Houston TP, Davis RM, Deitchman SD. Reducing the addictiveness of cigarettes. Tob Control 1998;7:281-293

[11] Retrieved 19 August 2022 from **https://www.fda.gov/news-events/press-announcements/fda-authorizes-marketing-tobacco-products-help-reduce-exposure-and-consumption-nicotine-smokers-who**

[12] https://blogs.otago.ac.nz/pubhealthexpert/reducing-nicotine-in-smoked-tobacco-products-a-pivotal-feature-of-the-proposals-for-achieving-smokefree-aotearoa-2025/

[13] Donny, E. C., Denlinger, R. L., Tidey, J. W., Koopmeiners, J. S., Benowitz, N. L., Vandrey, R. G., ... & Hatsukami, D. K. (2015). Randomized trial of reduced-nicotine standards for cigarettes. *New England Journal of Medicine*, *373*(14), 1340-1349.

the only available smoked tobacco product,[14] suggesting potential for reducing smoking in this population. There is also a lot of support for the introduction of VLNCs among all New Zealanders who smoke.[15]

4. Reduction in tobacco retailer numbers

There are many good reasons to reduce access to cigarettes. Significantly reducing the number of tobacco retailers and regulating them will reduce the risk of young people starting to smoke, encourage people who smoke to quit, and reduce the temptation among those who have quit smoking to make an impulse purchase and relapse back to smoking. Of the approximately 6000 retailers currently selling cigarettes in New Zealand, there is a concentration of these in our most disadvantaged areas[16], which acts to perpetuate health inequities. Removing smoked tobacco from many everyday shopping outlets will also help establish that smoked tobacco products are not normal consumer products, and very harmful to those who become addicted to using them.

A large reduction in the number of tobacco retailers, together with the introduction of VLNCs, smokefree generation measures, enhanced, targeted cessation support, increased investment in mass media campaigns and community-based smokefree interventions and an increase in capacity for monitoring and enforcement of new regulations will be far more effective in reducing smoking prevalence than our current smokefree programme. The key measures together with better resourcing of the existing tobacco programme, are well supported by good quality research.

A fair process for retailer reduction needs to be determined, and this needs to allow for the uneven distribution of retailers and ensure that access is not unreasonably constrained in remote and poorly served populations.

5. Approval as smoked tobacco retailer

Heath Coalition Aotearoa supports the process outlined at 20M, and specifically the consultation requirements, for setting of an upper limit of smoked tobacco retailers (STRs) nation-wide. We note Health Select Committee member questions about how to calculate this upper limit and would prefer that direction on this is included in the legislation.

Health Coalition Aotearoa supports an upper limit of between 300 and 600 STRs, or alternatively, a mechanism to achieve the upper limit could be identified as a priority and within a specified timeframe. We support introducing additional criteria to those outlined at 20I that retailers must satisfy before they can become an approved STR including:

- restrictions on proximity to schools, ECE centres, kura kaupapa, wahi tapu, and community-based facilities where children and young people gather, in consultation with Smokefree Officers and other community-based smokefree services
- avoidance of concentration of STPs in low-income communities
- requirements to provide STP sales data to assist with monitoring and evaluation
- no history or record of underage sales
- proof of age verification requirements for internet sales associated with approved retailers.

[14] Waa A, E. J. Unpublished preliminary analysis from TAKe study. 2021

[15] McKiernan A, Stanley J, Waa AM, et al. Beliefs among Adult Smokers and Quitters about Nicotine and De-nicotinized Cigarettes in the 2016-17 ITC New Zealand Survey. *Tobacco Regulatory Science* 2019;5(5):400-09.

[16] Marsh, L., Doscher, C., Cameron, C., Robertson, L., & Petrović-van der Deen, F. S. (2020). How would the tobacco retail landscape change if tobacco was only sold through liquor stores, petrol stations or pharmacies? *Australian and New Zealand Journal of Public Health*, *44*(1), 34-39.

6. Smokefree Generation

Health Coalition Aotearoa strongly supports the introduction of the SFG policy, as one of the three key measures to reach Smokefree Aotearoa 2025, and in recognition of the significant harms that smoked tobacco causes. This includes the premature death of two thirds of people who smoke long-term[17], and the many costs to individuals suffering from smoking-related diseases, their families, and the health sector.

We note there is a drafting error in this section of the Bill (Clause 2) that will undoubtedly be corrected, as it was not intended that the ban on sale of STPs to under 18s not begin until 2027.

Smoking is typically an addiction that results from experimentation among young people. Once addicted, most people make numerous attempts to quit but many cannot overcome their dependence on nicotine.

While rates of daily smoking in Year 10 students are now very low (1.3% in 2021), sociodemographic and ethnic inequities persist. For example, 9.3% of Māori students reported regular (at least monthly) smoking and Pacific students 6% in 2021 compared with 2.7% of NZ European students.[18]

New Zealand Health Survey data for 2020/21 shows that among slightly older age groups, smoking rates were much higher than in 14-15-year-olds – current (at least monthly) smoking prevalence among 18 to 24-year-olds was 11.8%.[19] This suggests a big increase in smoking uptake is occurring after Year 10.

Youth smoking therefore remains a serious problem. Applying prohibition to people born after 1 Jan 2009 means this measure does not become effective until 2027. We support the consideration of earlier implementation of the SFG policy once the other two measures are in place.

Modelling studies estimate the smokefree-generation policy could halve smoking prevalence within 14 years among people aged 45 and younger and achieve a more than five-fold health gain to Māori, compared to non-Māori.[20] While denicotinisation will have the strongest impact on reducing inequities caused by smoking, the SFG will also reduce disparities in smoking prevalence and the health inequities that follow, mainly because of the large disparities in smoking prevalence in younger age groups and the younger age structure of Māori and Pacific populations.

We note that the SFG provisions apply only to the sale or supply of smoked tobacco products, and not to its purchase or use. This minimises the risk of criminalising young people who use STPs. However, we share the concerns of many of our members, and Te Pati Māori, that people such as parents or older siblings, cousins and friends, could also be criminalised for small scale social supply. We support distinguishing between commercial and non-commercial supply of STPs to avoid criminalising non-commercial supply.

---

[17] Banks E, Joshy G, Weber M, Liu B, Grenfell R, Egger S, et al. Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. *BMC medicine*. 2015;13(1):38.

[18] ASH New Zealand. Year 10 Snapshot Survey 2021: Regular Smoking and Regular Vaping. 2022.

[19] Ministry of Health. Annual Update of Key Results 2020/21: New Zealand Health Survey Wellington: Ministry of Health; 2021 Available from: **https://www.health.govt.nz/publication/annual-update-key-results-2020-21-new-zealand-health-survey**.

[20] van der Deen FS, Wilson N, Cleghorn CL*, et al.* Impact of five tobacco endgame strategies on future smoking prevalence, population health and health system costs: two modelling studies to inform the tobacco endgame. *Tobacco Control* 2018;**27**(3):278-286.

We note that the wording used with respect to the sale or supply of STPs in sections 40A and 40B - i.e. 'knowingly or recklessly' - creates an unnecessarily onerous burden of proof for Smokefree Officers to establish that the person *knew they were wrong* and acted recklessly and therefore that an offence has been committed. The wording in the original Act puts the onus of proof on the person charged to prove that they took 'reasonable precautions and exercised due diligence' which is far more workable and practical for enforcement purposes. We therefore suggest that the original wording is reinstated.

Nicotine Free Generation

We note that there has also been a rapid increase in daily vaping in Year 10 students over recent years as discussed elsewhere in this submission (3.1% in 2019 to 9.6% in 2021).[21] Large numbers of young people are continuing to become addicted to nicotine, and this needs to be addressed as an urgent priority. This legislation and the regulatory development associated with it provides an opportunity to do so.

While a 'gateway effect' (whereby vaping leads to smoking) in young people has not been established, we note that systematic reviews suggest greatly increased risk of smoking in young people who vape.[22] We cannot yet be confident that this is not happening in New Zealand, but regardless of this risk, there is no justification for having such large numbers of our rangatahi addicted to nicotine, especially at a time when youth mental health and addiction services are under significant pressure and there are few if any services for those who want to quit vaping.

Health Coalition Aotearoa, and particularly our Māori, Pacific and community-based members, support changing the SFG approach to that of a nicotine free generation, which would provide the government with a mandate and strategy to address the concerns of parents, whanau, and schools who are increasingly alarmed at the number of school students now vaping. This approach aligns more closely with the original *Tupeka Kore* vision of a tobacco free society and could reduce the likelihood that current inequities in smoking prevalence are not simply replaced by growing inequities in vaping prevalence and vaping-related harm.

7. Definition and treatment of heated tobacco products

We note that the term 'notifiable product' includes both vaping and heated or smokeless tobacco products, but the two are quite different. Heated tobacco products (HTPs), use tobacco leaf and we argue they should be regulated in the same way as smoked tobacco products.

Studies conclude these products are more harmful than vaping products and there is no valid evidence of their effectiveness in smoking cessation. A recent Cochrane review[23] concluded that while HTPs have lower exposure to toxicants and carcinogens than STPs, nearly all studies assessed had been undertaken by tobacco companies; the authors also noted that no studies reported smoking cessation outcomes. HTPs should be defined in the legislation as STPs and treated as STPs for regulatory purposes; that is, they should be subject to denicotinisation, retailer restrictions, and smokefree generation provisions.

[21] Figures are from ASH Year 10 fact sheets for 2021.

[22] Chan, G. C., Stjepanović, D., Lim, C., Sun, T., Shanmuga Anandan, A., Connor, J. P., ... & Leung, J. (2021). Gateway or common liability? A systematic review and meta-analysis of studies of adolescent e-cigarette use and future smoking initiation. *Addiction*, *116*(4), 743-756.

[23] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013790.pub2/full

8. Regulation of smoked tobacco and vaping products markets

Part 1B – Regulation of entry into smoked tobacco and vaping products market

Health Coalition Aotearoa has previously argued that retailer licensing is a pre-requisite for reducing tobacco retail availability[24] and provides a tool to manage retailer numbers. We are not sure whether the approvals process outlined in the Bill will be as effective as licensing in other jurisdictions has shown (for example in Finland[25]), as the details will become the responsibility of the DGH to determine and implement.

The Bill provides for a maximum number of approved smoked tobacco retailers to be set by the Director-General of Health, and sales of tobacco will be prohibited via any agent not approved as a smoked tobacco retailer. The DGH will determine and publish the application process and may suspend or cancel approvals.

Heath Coalition Aotearoa would prefer to have the upper limit for the number of smoked tobacco retailers (STRs) nation-wide written into legislation. We support the process outlined at 20M, and specifically the consultation requirements, for setting the upper limit and being set as a priority and within a specified timeframe. There should be no more than 600 retail outlets selling tobacco.

We support introducing additional criteria to those outlined at 20I that retailers must satisfy before they can become an approved STR including

- restrictions on proximity to schools, ECE centres, kura kaupapa, and other community-based facilities where children and young people gather
- avoidance of concentration of STPs in low-income communities
- requirements to provide STP sales data to assist with monitoring and evaluation
- no history or record of underage sales
- proof of age verification requirements for internet sales associated with approved retailers.

Ideally, we would like to see the retailer reduction process commencing after denicotinisation has been in place for six months to allow that policy to reduce STP sales. This sequencing will mean STP demand and sales are likely to be much lower by the time most retailers will need to transition out of selling STPs, giving them time to adapt.

Section 40 Sale and delivery of regulated products to people younger than 18 years prohibited

The proposed amendment at 40 (4) appears to strengthen proof of age restrictions in the 2020 Act. 40 (4) says that proof of having sighted "an evidence of age document of the person to whom the product was sold" is a defence against prosecution, and the insertion of the proposed 40 (4A) further clarifies that the requirements are not satisfied "if the person relies solely on a statement (given orally or in written form) from the person to whom the product was sold that indicated that the person was of or over the age of 18 years."

Health Coalition Aotearoa would like to see Section 40 more clearly require and define age verification processes for both direct and online sales of vaping product to young people.

[24] See Appendix: *HCA Submission on SF 2025 Plan*

[25] Robertson, L., Marsh, L., Edwards, R., Hoek, J., van der Deen, F. S., & McGee, R. (2016). Regulating tobacco retail in New Zealand: what can we learn from overseas. *NZ Med J*, *129*(1432), 74-9.

9. Regulatory settings for vaping

This legislation and the regulatory process resulting from it, provides an opportunity to adjust regulatory settings to better protect minors from nicotine addiction. We support the following:

- a cap on the number of SVRs able to be approved
- strengthening the approvals process for specialist vape retailers, to prevent convenience stores from gaining approval as SVRs
- SVR approval to include consideration of proximity to schools, kura kaupapa, ECE centres, kohanga reo and other venues where children and youth gather, in consultation with Smokefree Officers and other community-based smokefree services
- requiring a 'fit and proper person' test for all vape retailers, as will be required for smoked tobacco retailers
- requiring SVRs to apply age verification processes in sales to young people and all online sales and delivery
- minimum prices set for disposable vapes, with subsidised products available through smoking cessation services
- reducing the upper limit of nicotine for vaping products (currently 50mg/mL) to that of the European Union and UK – 20mg/mL across all vaping products
- introducing a 'nicotine-free' generation policy for all notifiable products including vaping products and non-combusted tobacco products, except when these are used as an aid to stopping smoking by a person who smokes.

10. Changes to purposes of the Act

Health Coalition Aotearoa notes that the new Act will remove many of the protections for youth from vaping-related harms outlined in the purposes section under both Section 3A and Section 49 of the current Act. We consider that these changes will enable the tobacco and vaping industries to continue expanding their products to the youth market.

Proposed changes to Section 3A remove preventing the normalisation of vaping, regulating vape marketing, advertising and sponsorship, and preventing vaping- and smokeless tobacco product-related harm in children and young people) and replace these by (b) which states "to provide for the regulation of notifiable products in a way that seeks to minimise harm".

The table below shows a comparison between the 2020 Act and the Bill.

2020 Smokefree Environments and Regulated Products (Vaping) Amendment Act	2022 Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill
Section 3A Purposes of this Act (1) The purposes of this Act are, in general, as follows: (a) to reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by smoking by others; and (b) to prevent the normalisation of vaping; and (c) to regulate and control the marketing, advertising, and promotion of regulated products (whether directly, including through the appearance of regulated products and packages, or through the sponsoring of other products, services, or events) in order to improve public health by—	**Section 3A amended (Purposes of this Act)** The purposes of this Act are— (a) to provide for the regulation of smoked tobacco products— (i) to prevent the harmful effect of other people's smoking on the health of others, and especially on young people and children; and (ii) to significantly reduce the retail availability of smoked tobacco products; and

2020 Smokefree Environments and Regulated Products (Vaping) Amendment Act	2022 Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill
(i) discouraging people, especially children and young people, from taking up smoking; and (ii) discouraging non-smokers, especially children and young people, from taking up vaping or using smokeless tobacco products; and (iii) encouraging people to stop smoking, vaping, or otherwise using regulated products; and (iv) discouraging people who have stopped smoking, vaping, or otherwise using regulated products from resuming smoking, vaping, or using regulated products; and (d) to support smokers to switch to regulated products that are significantly less harmful than smoking; and (e) to regulate the safety of vaping products and smokeless tobacco products; and (f) to monitor and regulate the presence of harmful constituents found in regulated products and their emissions; and (g) to give effect to certain obligations and commitments that New Zealand has as a party to the WHO Framework Convention on Tobacco Control, done at Geneva on 21 May 2003.	(iii) to prevent young people, and successive generations, from ever taking up smoking; and (iv) to reduce the appeal and addictiveness of smoked tobacco products; and (v) to restrict all forms of advertising and promotion; and (vi) to reduce disparities in smoking rates and smoking-related illnesses between New Zealand population groups, and in particular between Māori and other groups; and (b) to provide for the regulation of notifiable products in a way that seeks to minimise harm; and (c) to give effect to certain obligations and commitments that New Zealand has as a party to the WHO Framework Convention on Tobacco Control, done at Geneva on 21 May 2003.

We note that (d) has also been removed – "to support smokers to switch to regulated products that are significantly less harmful than smoking" and suggest that (d) could also be reinstated, although the term 'switch' is not supported as it suggests simply swapping smoking for vaping, rather than using vaping to quit smoking and then ideally also quitting vaping. The wording could be changed to reflect the use of vaping as a quit tool. Although vaping is clearly less harmful than smoking, it is not harmless – we note growing evidence of respiratory and other health risks associated with vaping, and that the long-term impacts are still unknown.[26]

Section 49 deals with the purposes of that part of the Act which deals with packaging, labelling and constituents of regulated products. It says:

The purposes of this Part are—

(a) to reduce the social approval of smoking, particularly among children and young people:

(b) to reduce the appeal of vaping and the use of heated tobacco products for non-smokers, particularly children and young people:

(c) to require the standardised appearance of regulated products and their packages (including messages and information) in order to—

(i) reduce the appeal of smoking, particularly for young people; and

[26] Balfour, D. J., Benowitz, N. L., Colby, S. M., Hatsukami, D. K., Lando, H. A., Leischow, S. J., ... & West, R. (2021). Balancing Consideration of the Risks and Benefits of E-Cigarettes. *American Journal of Public Health*.

(ii) further reduce any social and cultural acceptance and approval of smoking; and

(iii) reduce the appeal of vaping and use of heated tobacco products for non-smokers, particularly for children and young people; and

(iv) make warning messages and images more noticeable and effective; and

(v) reduce the likelihood of consumers acquiring false perceptions about the harmful effects of smoked tobacco products, vaping products, and smokeless tobacco products:

(d) to discourage non-smokers, particularly children and young people, from vaping and using heated tobacco products:

(e) to reduce some of the harmful effects of tobacco products on the health of users by monitoring and regulating the presence of harmful substances in the products and in tobacco emissions:

(f) to facilitate the harmonisation of the laws of New Zealand and Australia relating to the labelling of smoked tobacco products (including, without limitation, requirements relating to the display of health messages).

We note that this whole section has been removed, without any replacement purposes.

We suggest that these proposed changes to the purposes of the new Act could weaken legislative protections for minors with regard to vaping-related harm, when there is growing evidence that youth vaping is becoming a serious problem in New Zealand.

The ASH Year 10 surveys show that regular (daily, weekly, monthly) vaping in 14-15-year-old students increased from 3·5% in 2015 to 20.2% in 2021[27]. This growth compares with the UK where there was an increase in current (at least monthly) vaping among 11-16-year-olds from 1.2% in 2015 to 4.8% in 2021[28].

Part of the explanation for this apparent difference in prevalence (the data is hard to compare) is that the regulatory settings for vape products in the UK were inherited from the EU and include a longstanding ban on marketing 'new generation products', whereas New Zealand had no such protections in place for several years. The products were aggressively marketed online, by retailers, on youth radio stations, and through sponsorship of youth-targeted events such as music concerts and sports where the products were given away[29]. The EU also limited nicotine levels for all vaping products to 20 mg/mL, compared with our upper limit of 50mg/mL set in 2020. Previously, even higher levels were available and easily accessed by minors.

The rapid increase in daily vaping shown in Year 10 data since 2015 suggests a generation of school children has become quickly addicted to very high levels of nicotine. One 2021 school survey of 3,124 Year 9-13 students from 21 schools in Hawkes Bay found that 9.8% of students vaped daily, and 15% of daily vapers were waking up during the night to vape[30]. This situation argues for further tightening the regulations to protect children.

[27] ASH NZ Year 10 survey data.

[28] Action on Smoking and Health UK. (2021). *Use of e-cigarettes among young people in Great Britain*. From: **https://ash.org.uk/wp-content/uploads/2021/07/Use-of-e-cigarettes-among-young-people-in-Great-Britain-2021.pdf**

[29] Hoek J., Freeman B. BAT(NZ) draws on cigarette marketing tactics to launch Vype in New Zealand. *Tob. Control*. 2019.

[30] *Snapshots of Vaping at Hawke's Bay Secondary Schools* (2021). Unpublished survey of secondary school children vaping in Hawkes Bay. Hawkes Bay DHB, 2021.

The impact of nicotine addiction on school children's behaviour and learning outcomes has received much public attention in recent years. Daily vaping is an indicator of nicotine addiction, and among 14-15-year-olds it increased from 3.1% in 2019 to 9.6% in 2021[31].

As noted above, the purposes of the 2020 Act have been substantially modified in the current Bill, emphasising harm minimisation as the core principle underpinning the Bill. We note that this approach locates smoking as a (Western) biomedical health issue. Māori models of health view harm from nicotine addiction in much more holistic terms (including how addiction impacts whānau, and wairua). In this sense the Bill does not fully recognise Māori perspectives in relation to addressing smoking. While harm minimisation may be appropriate for some smokers who cannot quit (we acknowledge there are a diversity of perspectives on this issue) we are alarmed at the rapid rise of experimentation and daily vaping among rangatahi. Kei te tika te korero o tatou tupuna: Mō tātou, ā, mō kā uri ā muri ake nei (For us and our children after us).

Figure 2 below provides an ethnic breakdown of Year 10 daily vaping prevalence, which shows that Māori vaping in this age group increased significantly from 5.9% in 2019 to 19.1% in 2021, with daily vaping in Pacific youth also higher than NZ European youth.

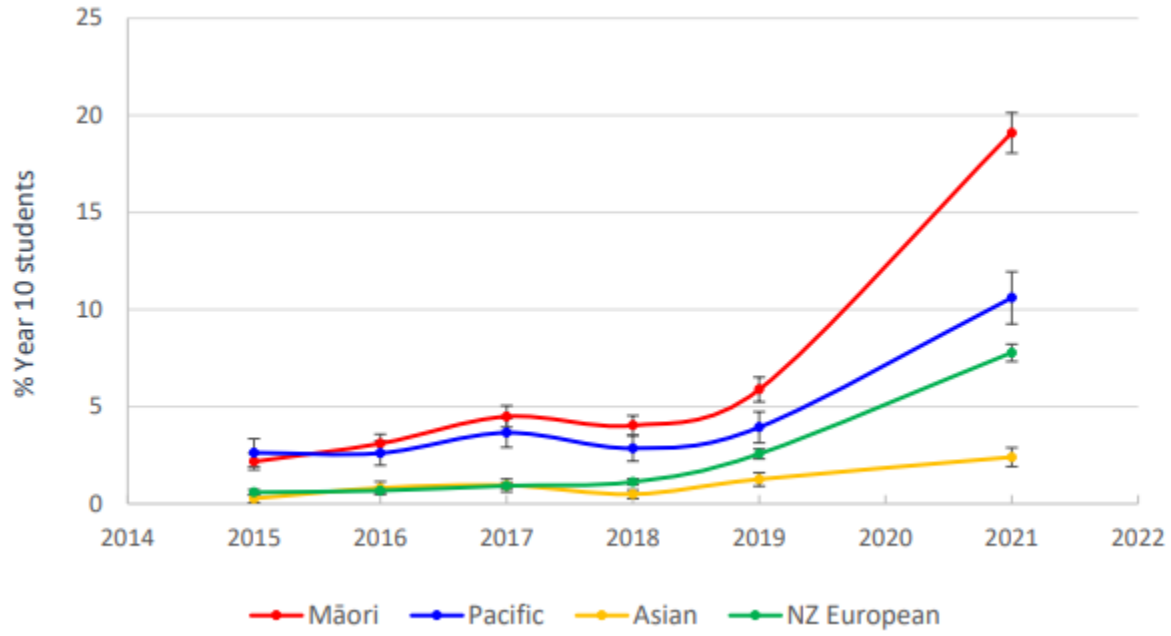

Figure 2: Daily vaping prevalence by ethnicity (2015-2021) *Source: ASH Year 10 Survey 2021*

We must ensure that entrenching vaping among rangatahi of today and in future generations is not a legacy of the Smokefree Environments Amendment Bill. We strongly believe that the purposes and provisions within the Act should include reference to protecting rangatahi from taking up vaping. To this end we endorse calls to modify the 'Smokefree Generation' measure to a 'Nicotine Free Generation' measure.

Health Coalition Aotearoa acknowledges that while it may be possible to restrict digital marketing and sales to minors of both STPs and notifiable products sold by New Zealand businesses (although there has been minimal success to date for vaping products), regulating harmful products online is a

[31] Action on Smoking and Health NZ. (2021). Year 10 Survey fact sheets retrieved August 2022 from **https://www.ash.org.nz/ash_year_10**

major issue globally[32]. Transnational tobacco and vaping companies appear to easily evade country-level regulations. We recognise that global marketing and sales of harmful commodities may be beyond the scope of this consultation, but we believe serious consideration needs to be given to this matter.

11. Approval as specialist vape retailer

Health Coalition Aotearoa notes that under current legislation, SVRs have a primary purpose of selling products that provide a less harmful alternative to smoking and can potentially aid people who smoke to quit smoking.

We note that many dairies and convenience stores have sectioned off part of their stores and appear to have gained approval to operate as specialist vape stores under the current requirements. This change may mean point of sale advertising in convenience stores, and a full range of flavours sold in retail outlets that attract children or are within close proximity to schools. An earlier study of convenience store operators revealed they had a concerning lack of knowledge about the products they sold[33].

The 2020 Act required SVRs retail premises to be 'a fixed permanent structure' and it was also a requirement that "(i) at least 70% of the person's total sales from the retail premises are or will be from the sale of vaping products; or (ii) 60% of the person's total sales from the retail premises are or will be from the sale of vaping products and the Director-General is satisfied that the lower threshold is appropriate in the circumstances; …"

The only change to the 2020 Act restrictions on SVRs appears to be the addition of "(ii) appropriate premises from which to operate a stand-alone business". This additional wording is unlikely to be sufficient to prevent generic retailers from continuing to operate as SVRs and setting up the vaping section of their local dairy as a 'stand-alone business'. The new legislation needs to clarify what is meant by 'appropriate premises from which to operate a stand-alone business' to enable enforcement officers to act when this requirement is not met.

Further investment in surveillance and enforcement is needed, and we note that the Smokefree Aotearoa 2025 Action Plan identified a review of the capacity and capability of the SFEO workforce was planned to start in January 2022. We see this review and action on recommendations arising from it, as an urgent priority for the implementation of the new legislation.

12. Illicit trade concerns

We acknowledge the concerns of several Health Select Committee members regarding the potential for a growth in the illicit trade in cigarettes as a result of restricting access to smoked tobacco. This concern has long been used by the tobacco industry to oppose effective policies such as plain packaging and tobacco tax increases, despite evidence that globally, tobacco control policies are not the principal drivers of illicit tobacco trade. Levels of illicit tobacco have been shown to be higher in

[32] Wadsworth, E., McNeill, A., Li, L., Hammond, D., Thrasher, J. F., Yong, H. H., ... & Hitchman, S. C. (2018). Reported exposure to e-cigarette advertising and promotion in different regulatory environments: findings from the International tobacco control four country (ITC-4C) survey. *Preventive medicine*, *112*, 130-137.
[33] Bateman J, Robertson L, Marsh L, et al. New Zealand tobacco retailers' understandings of and attitudes towards selling Electronic Nicotine Delivery Systems: a qualitative exploration *Tobacco Control* 2020;29:e25-e30.

countries with weaker enforcement and penalties, and greater corruption, allowing more opportunities to organised crime networks.[34]

New Zealand research suggests that illicit tobacco consumption is a very small proportion of total consumption, and there has been little change in illicit trade over the last decade, in spite of quite significant tobacco policies being introduced such as regular increases in tobacco excise tax. This is likely to be due to having no land borders and a highly competent customs force.[35]

We note that the Smokefree 2025 Action Plan provides for greater monitoring of illicit trade, stronger enforcement measures, and monitoring the impact these policy changes might have on the illicit tobacco product market. Further, we note that recent Budget allocations have already provided additional support and build on NZ's tight border controls to maintain biosecurity and geographic isolation.

Health Coalition Aotearoa notes the concerns of some Health Select Committee members that the introduction of the smokefree generation policy will result in criminalising young people to attempt to buy tobacco. This is not the intention of the Bill, which clearly states that prohibition applies to the *sale or supply* of smoked tobacco products (**not** to purchase or use).

We support the legislation addressing supply through organised crime (black market) activities as a criminal offence.

However, we acknowledge the concerns of Te Pāti Māori that supply charges could be used against older siblings or whānau members who supply smoked tobacco to minors in social situations under this legislation. We support this type of activity being retained as an infringement offence which does not go on a personal record and requires a much lower burden of proof to uphold in court than a criminal conviction. The intent of the law ought to be to protect youth not to criminalise them or their families.

We suggest that the use of the term 'knowingly or recklessly contravenes' in the new clauses at 40A (2) and 40B (2) regarding the use of the sale or supply of STP provisions could create an unnecessarily onerous burden of proof for Smokefree Officers to establish that the person acted 'knowingly or recklessly'. The wording in the 2020 Act put the onus of proof on the person charged to prove that they took 'reasonable precautions and exercised due diligence'. We therefore recommend retaining the wording from the 2020 Act.

13. Constituents of smoked tobacco products and notifiable products

We note that the Minister must consider the risks and benefits to Māori of regulating a constituent before preparing regulations on the sale and distribution of STPs.

We recommend that the DGH also be given authority to place restrictions on the introduction of innovative STP product design features that might increase their addictiveness, palatability, appeal or potential harm to health or the environment. Restrictions on such design features ought to be legislated for rather than left to regulation as such features could be subject to legal challenge.

Health Coalition Aotearoa supports the stipulation in Part 3 Section 52(b) that STPs are required by regulations to list constituents and their respective quantities present in the product's

[34] Campaign for Tobacco Free Kids (CTFK). *Illicit Trade of Tobacco: Some Basic Facts*, 2020 Available from: **https://www.tobaccofreekids.org/assets/global/pdfs/en/Illicit_trade_basic_facts.pdf**.

[35] Ajmal, A., & U, V. I. (2015). Tobacco tax and the illicit trade in tobacco products in New Zealand. *Australian and New Zealand journal of public health*, *39*(2), 116-120.

emissions. However, we suggest this information should be held and published by the approving agency and not on product packaging as per FCTC article 11[36], that seeks to prevent such information misleading people regarding the relative harm of a product. The following is the WHO measure of compliance:

> The law prohibits quantitative information on emission yields on tobacco packs, whether as an independent part of the packaging, or as part of a brand or trademark. Any statement about the amount of certain ingredients, even if not expressed as a number, should be considered quantitative information, such as "this product contains reduced levels of nitrosamines", since this may be used to mislead or imply one tobacco product is less harmful than another. For example, tar, nicotine and other smoke emission yields derived from smoking-machine testing do not provide valid estimates of human exposure, but may be used to imply that cigarettes with lower machine-generated smoke yields are less harmful than cigarettes with higher smoke emission yields. "Other smoked tobacco" means all smoked tobacco products excluding cigarettes. "Smokeless tobacco" means all tobacco products except those intended to be smoked.[37]

We have some concerns that lists of constituents on labels might distract from health warnings. We support a similar requirement for all regulated products including vaping products and heated tobacco products.

Health Coalition Aotearoa supports requirements under 57F, for manufacturers and importers of STPs to *"conduct a test to ensure that the constituents of the product, and their respective quantities, comply with any limits or prohibitions prescribed in regulations."* The tests must be undertaken each year by 31 December.

14. Planning and implementation issues

Further to our comments on the purposes sections of the Bill, we note that clear and detailed purposes are necessary to guide and evaluate the implementation of the new policy measures provided for in the legislation, and to support enforcement by providing a clear rationale for enforcement actions. Effective enforcement will be essential for the successful implementation of these measures.

We have made suggestions about the timelines and sequencing of key measures included in the Bill. Specifically, the denicotinisation of STPs should be a priority for implementation as modelling estimates it is likely to be the key measure in reducing demand for tobacco products. We support introducing the very low nicotine cigarette policy ahead of other measures, as research suggests it will be most effective in helping people to quit smoking and reduce health inequities. As smoking prevalence declines rapidly, concerns about how retail reduction measures will affect small businesses will diminish, as smoked tobacco products will generate less and less revenue.

The *Smokefree Aotearoa 2025 Action Plan* (Ministry of Health 2021) provides minimal detail on the implementation of the three new measures. The Plan provides for a technical advisory group to support development of a regulatory scheme. We would like to see the plan updated for the purpose of implementing the new legislation and include a more comprehensive approach within specified timeframes. The updated plan should integrate new and existing or planned measures (including health promotion activities, mass media campaigns, surveillance and enforcement, and enhanced smoking cessation activities) with clear commitments to new regulatory and other key

[36] Retrieved 23.8.2022 from https://fctc.who.int/publications/i/item/9241591013

[37] Retrieved 22.8.2022 from **https://www.who.int/data/gho/indicator-metadata-registry/imr-details/2734**

activities. We would like to see a review of regulatory protections for young people to prevent vaping uptake as part of the planning process.

We are pleased to see that monitoring and evaluation is already being put in place, with at least two funded studies that will track how people who smoke respond, including product transitions and exposure to tobacco and nicotine; some will focus on priority populations. We understand the Ministry has also contracted the University of Auckland to lead a programme of research using best-practice methods for monitoring illicit tobacco trade over the next four years.

We strongly support the review of current capacity and capability of the Smokefree Officer workforce which was identified as a key action in the SFA 2025 Action Plan. Investment in workforce development will be essential, especially as Covid-19 has impacted heavily on all public health units' capacity. Some measures could be undermined by poor compliance, such as unapproved sales of tobacco products or the availability of illicit tobacco products. We recommend increased resourcing to enable adequate monitoring and enforcement.

APPENDIX

HCA SEAG submission to Smokefree 2025 Plan

1. Strengthening the tobacco control system

(a) Strengthen Māori governance of the tobacco control programme

The HCA SEAG strongly supports Māori governance within tobacco control that is guided by the obligations of Te Tiriti o Waitangi. SEAG members note that Māori should be afforded the same rights in decision making, and therefore the same health outcomes, as non- Māori/ tauiwi. While working in the spirit of partnership, SEAG members note that good governance must be guided by those most closely affected by tobacco harm. SEAG members recognise the importance of Māori themselves explaining how Māori governance of the tobacco control programme would most appropriately function. SEAG members also acknowledge the need to ensure 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.

(b) Support community action for a Smokefree 2025

HCA SEAG members recognise the importance of strengthening community action and building on existing support for APDD measures. HCA members who work alongside communities reported findings from their consultations, many of which took place during community events. The voices of Māori from Te Tai Tokerau indicated very strong support for key measures within the APDD, which they believed recognised the devastating effect smoking has had on whānau Māori. Community members expressed a strong desire for their rangatahi and tamariki to be smokefree and saw smokefree communities as crucial to the well-being of future generations and the environments in which their rangatahi and tamariki will live. Community functions provide opportunities for Māori to gather and discuss smokefree questions. Communities have supported many auahi kore movement activities, including kaupapa Māori wānanga, smokefree workplaces and employers, inter-iwi smoking cessation competitions, and smokefree dairies, sports events, and streets. SEAG members noted the importance of providing resources for Māori and Pacific to develop community activities relevant to their peoples and suggested a community-oriented fund, such as the former Innovations Fund, could be an important way of strengthening community action and connecting activities to the wider Smokefree 2025 goal. More generally, SEAG members believe harnessing the existing leadership within whānau, hapū and iwi could make major contributions to government public health efforts. 7

(c) Increase research, evaluation, monitoring and reporting

HCA SEAG members strongly support increasing research, evaluation, monitoring and reporting. We believe monitoring and evaluation must be a core component of all new measures implemented and endorse the proposed Action Plan's clear commitment to invest in research, evaluation and monitoring. We recommend developing and implementing a robust, prospective, and adequately resourced programme of research, evaluation and monitoring. We further recommend that the evaluation plan should assess progress towards achieving an equitable smokefree Aotearoa and eliminating the disparities in smoking and its adverse health effects, which predominantly affect Māori and Pacific populations.

(d) Strengthen compliance and enforcement activity

HCA SEAG members strongly support strengthening compliance and enforcement activity. We recognise that some proposed measures could potentially be undermined by poor compliance, such as continuing sales of tobacco products by unlicensed stores or availability of illicit tobacco products. We recommend increased resourcing to enable adequate monitoring and appropriate penalties for non-compliance. As we discuss in our response to point 5, we recommend strong communications campaigns, which could denormalise social supply (among other topics).

HCA SEAG members strongly recommend independent research to estimate the market share of illicit tobacco.1 2 NZ has limited data on illicit tobacco use, though independent research suggests industry claims are typically exaggerated, as when plain packs were introduced in Australia.3-5 Furthermore there is strong evidence to suggest that the tobacco industry facilitates and promotes illicit trade.6

HCA members recommend taking the following steps to enhance monitoring and compliance :

- Enhanced border surveillance and enforcement actions by Customs and Excise;
- Licensing and monitoring of all importers and distributors of any tobacco products;
- Ratification of the FCTC Protocol to Eliminate Trade in Tobacco Products;
- Participation in the global tobacco track and trace system;
- Collection of robust, independent and credible data on the extent of the illicit market as part of the enhanced research, evaluation, monitoring and reporting described above.

HCA SEAG members strongly believe that industry claims regarding illicit tobacco markets should not deter the introduction of new policy measures. Research shows that the major influences on illicit tobacco markets are regulatory strength, government corruption, tolerance for illicit markets, and a well organised criminal infrastructure.7 8 NZ's strong border control, low levels of corruption, and geographical isolation, will minimise opportunities for illicit tobacco trade. The widespread availability of alternative products, such as vaping products, will also decrease demand for illicit tobacco.

Finally, we note that, as the Action Plan is implemented, smoking prevalence will fall, decrease demand for illicit products and reduce the rewards available through illicit trade. 8

2. Make smoked tobacco products less available

(a) License all retailers of tobacco and vaping products

HCA SEAG strongly supports the establishment of a licensing system for all retailers of tobacco and vaping products (in addition to specialist vape retailers).

Introducing a licensing system would bring New Zealand in line with other countries and states (e.g., Finland and South Australia), and align NZ policy with international best practice. Retailer licensing is a pre-requisite for reducing tobacco retail availability and provides a tool to manage retailer numbers; however, licensing alone will not lead to rapid or substantial reductions in retailer numbers. Other measures are required to complement licensing and reduce the widespread availability of tobacco products.

(b) Significantly reduce the number of smoked tobacco product retailers based on population size and density

HCA SEAG members strongly support reducing the retail availability of smoked tobacco products by significantly reducing the number of retailers based on population size and density. This measure could greatly decrease retailer numbers and thus New Zealanders' exposure to tobacco outlets. Implementation would need to account for differences in baseline numbers of tobacco retailers across different districts, where outlet density may vary, to ensure reductions are sufficient to prompt cessation, and to avoid further increases in the 'full cost' of obtaining tobacco inadvertently contributing to inequities.9

(c) Restrict sales of smoked tobacco products to a limited number of specific store types

HCA SEAG members strongly support reducing the retail availability of tobacco products by restricting sales to a limited number of specific store types (e.g., specialist R18 stores and/or pharmacies). We believe that restricting tobacco sales to a limited number of specific outlets, such as specialist R18 ('adult only') stores or pharmacies would support cessation and, importantly, deter smoking uptake among young people. This measure would also remove cigarettes from outlets where people who smoke usually purchase tobacco and thus could help quitters avoid cues known to trigger impulse buys and relapse. 10 11

SEAG members do not support the sale of tobacco products via alcohol outlets, except in extraordinary circumstances (e.g., where no other supply channel was available in rural areas). International policy precedents now exist as other communities and governments have implemented measures to reduce the number of tobacco retailers. 12

The NZ Government's proposals to reduce tobacco availability will create environments that reduce smoking uptake and support quitting, and are thus likely to improve population health and decrease health inequities.

(d) Introduce a smokefree generation policy

HCA SEAG members strongly support introducing a smokefree generation policy (SFG). Most people who smoke begin when adolescents or young adults and lack full knowledge of smoking's health risks, 13 and when their behaviours are often compromised by peer pressure or alcohol.14 Measures that protect young people from smoking initiation have high public support and will be pivotal to achieving the Smokefree 2025 goal and sustaining minimal prevalence once it is achieved.15 Māori communities strongly favour this measure, which supports their vision of a future where rangatahi and tamariki are not burdened by tobacco use. Recent hui endorsed the words of Dame Tariana Turia who, at the 2021 National Tupeka Kore Tobacco control hui, stated: "The story and history of Tobacco are reflected in our Urupa." Māori attending this hui saw a smokefree generation policy as key to reversing this history. The SFG policy will go beyond minimum age of sale/purchase laws, which do not always effectively reduce youth access to tobacco, given inconsistent retailer compliance and the 'social supply' of smoked tobacco 10 products(e.g., from family and friends). 16

Fixed age laws may also have adverse consequences, for example by inadvertently signalling that there is a 'safe age' for smoking or by framing smoking as a 'forbidden fruit'. The smokefree generation (SFG) proposal overcomes many problems associated with the current minimum age of sale law. It is likely to have a more profound impact on reducing smoking uptake because it gradually eliminates the availability of smoked tobacco products. Modelling data suggests the SFG policy will

be strongly pro-equity,17 with the biggest reductions in prevalence occurring among Māori and Pasifika populations due to their younger age structure and high youth and young adult smoking uptake. HCA SEAG members therefore support implementation of the SFG intervention but recognise that this measure requires complementary measures that catalyse smoking cessation. **We therefore recommend the SFG proposal is implemented as part of a comprehensive action plan to achieve the Smokefree Aotearoa goal.**

Tobacco retailing

HCA SEAG members note the importance of reducing retailer numbers in a way that does not create marketplace anomalies advantaging some retailers over others. We suggest restricting tobacco sales to specialist R18 stores or pharmacies. We advise against proposals such as "grandfathering", which will decrease tobacco outlet numbers too slowly to have a meaningful impact on the Smokefree 2025 goal.

HCA SEAG members recommend an amortization strategy, where existing tobacco retailers are given a reasonable amount of time to phase out their existing stock and cease selling tobacco products, as this approach would bring faster change.18 19

HCA SEAG members note that arguments opposing reductions in the number of retailers permitted to sell tobacco products often lack a logical or empirical foundation. For example, arguments claiming that the loss of tobacco sales would see many small retailers go out of business lack empirical support as tobacco sales do not typically account for a high proportion of overall store turnover and generate very little foot traffic that leads to purchases of higher margin products.20-23

HCA SEAG members further note the very low profit margins associated with tobacco products.24 25 Re-allocating the space occupied by tobacco products to suppliers of higher profit products, could result in greater profitability for retailers. 26 11

3. Make smoked tobacco products less addictive and less appealing

(a) Reduce nicotine in smoked tobacco products to very low levels

HCA SEAG members strongly support the Government in requiring all tobacco products in New Zealand to contain only very low levels of nicotine. Very-low nicotine content (VLNC) cigarettes contain tobacco modified to eliminate most of the nicotine and bring nicotine content below the threshold at which addiction occurs (0.4 mg nicotine per gram of tobacco). 27 However, VLNC are just as harmful as conventional tobacco cigarettes. This point will need to be conveyed to smokers when the policy is implemented. Stopping all tobacco use confers the most significant health benefit to individuals. 28

NZ research has shown that a short course of VLNC cigarettes can help people quit smoking, and prevent relapse back to smoking, by breaking the association between smoking and receipt of nicotine.29 30 When combined with 'clean' nicotine (via NRT or vaping) and behavioural support, people more readily make the transition away from cigarettes as their source of nicotine.

In smokers, VLNC cigarettes decrease nicotine exposure, decrease cigarette dependence, reduce the number of cigarettes smoked per day, and increase the likelihood of contemplating, making, and succeeding at a quit attempt. VLNCs also reduce the risk that experimental smokers become regular smokers.

Concerns about reducing nicotine have not been borne out by research evidence. Compensatory smoking has not been found to be problematic, simply because VLNC cigarettes deliver so little nicotine that it is impossible to compensate effectively.29 30 Dual use of VLNC cigarettes and

conventional tobacco, and stockpiling of traditional tobacco, have also been raised as concerns. A mandated simultaneous, abrupt reduction in nicotine across all combusted tobacco products would be required and research shows this approach has a more significant health benefit than a gradual reduction in nicotine levels. 31

Strategies will be needed to identify how smokers and the tobacco industry may try to circumvent a nicotine reduction strategy. Reducing nicotine in cigarettes will likely motivate smokers to seek alternative sources of nicotine, particularly forms that address the hand-to-mouth action of smoking (e.g., vaping products and nicotine mouth spray). A black market in conventional tobacco would likely see an increase in the price of these products. NZ has robust border controls and surveillance which, coupled with its geographical isolation, make it unlikely that smuggled tobacco will be a significant problem.

HCA SEAG members recommend that, as part of the enhanced monitoring proposed, VLNC cigarettes are tested regularly to ensure they are as low in nicotine content as is mandated. 12

(b) Prohibit filters in smoked tobacco products

HCA SEAG members strongly support prohibiting filters in smoked tobacco products. Members note that many people who smoke believe, incorrectly, that filters reduce the harms of smoking; they further note that filters represent a major source of environmental litter.

Analyses of tobacco industry documents show that tobacco companies understood filters made no meaningful difference to the harms people who smoke face but nonetheless continued to incorporate these in their cigarette products because smokers perceive filters as reducing harm.32 Filters also cause major environmental harm; they comprise poorly biodegradable cellulose acetate that can linger in the environment for many years before eventually breaking down into smaller plastic particles. Each year, around four trillion cigarette butts are discarded globally, making tobacco product waste the most commonly littered item in the world.33 A recent NZ National Litter Audit also reported that cigarette butts were the most frequently identified litter item.34

HCA SEAG members do not agree that the problem of discarded filters can be addressed by providing more litter receptacles or greater education, or by introducing biodegradable filters. These suggestions suit tobacco companies' interests, relocate blame to individuals, and ignore evidence that up-stream interventions, such as changes in tobacco product design, will more effectively reduce the consumer deception and environmental burden of tobacco product waste. 35 36 HCA SEAG members note that banning filters would align with international initiatives (e.g., members of the New York state legislature have proposed a statute banning the sale of single use filters (and e-cigarettes).37

(c) Prohibit innovations aimed at increasing the appeal and addictiveness of smoked tobacco products

HCA SEAG members strongly support allowing the Government to prohibit tobacco product innovations through regulations. As well as creating the deceptive impression they reduce harm, filters have become a vehicle for product innovation. For at least the last decade, filters have carried flavour beads, or capsules, which people who smoke may crush to flavour the smoke they inhale and customise their smoking experiences. A recent NZ study found that flavour-capsule cigarettes appealed more to susceptible young adult non-smokers than to young adult smokers.38 This finding suggests the growth in capsule sales 13 observed internationally is more likely to reflect recruitment

of new, predominantly young "replacement smokers" than it is to demonstrate brand switching among existing smokers.39-41 14 4.

4. Make tobacco products less affordable

(a) Set a minimum price for tobacco

HCA SEAG members support setting a minimum price for all tobacco products as this approach would provide a mechanism for managing the price-shifting that currently occurs (i.e., where tobacco companies shift a higher proportion of excise tax increases to premium brands while maintaining the relative affordability of budget and super-budget brands). This measure should be accompanied by a levy, or other disincentive to discourage tobacco sales and ensure increased revenue from a minimum price strategy does not benefit tobacco companies. As a minimum price strategy will likely have greatest impact on people with lower incomes who typically purchase lower-cost brands, **SEAG members also recommend that a minimum pricing measure must be accompanied by enhanced smoking cessation support for priority populations**. 15

5. Enhance existing initiatives

(a) Increase investment in mass and social media campaigns

HCA SEAG members strongly support enhancing existing initiatives by increasing investment in mass and social media campaigns. We believe these campaigns can promote behaviour change such as smokefree behaviour or switching to alternative sources of nicotine. These campaigns can also create knowledge by exposing industry practices; build supportive environments that support behaviour change, 35 42 and create opportunities to work more effectively with communities affected by unhealthy products, such as tobacco.

HCA SEAG members note with concern evidence that, despite the importance of mass and social media campaigns in achieving the Smokefree 2025 goal, NZ's expenditure on these measures actually declined following the Smokefree 2025 goal's announcement.43

HCA SEAG members also note that evaluating mass and social media campaigns is crucial and should be an integral component of all campaign activity. Evidence from overseas and from within NZ shows that these mass and social media campaigns can be highly effective and highly cost-effective.44-46

We suggest mass and social media campaigns could communicate the goal's meaning and rationale, explain core policy measures, and build support for these. Campaigns could also address misperceptions that may impede use of alternative products, such as confusion between nicotine, which causes addiction, and combustion products, which cause harm.

Finally, campaigns could counter potential tobacco industry activity, and reduce any resulting confusion. We note that successful campaigns require a strategic and integrated approach; campaigns must follow best practice guidelines, particularly with respect to campaign reach, frequency and duration, if they are to have a strong impact.47-49 They must also be designed to eliminate smoking disparities and reflect the needs, priorities and voices of core communities, particularly Māori, whose leaders first proposed a Smokefree Goal in 2010. 16

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

HCA SEAG members strongly support increasing investment in stop smoking services for priority populations. SEAG members note feedback from stop smoking service providers that referrals have

fallen since the annual excise tax increases ceased but are likely to increase, particularly if the final Action Plan reduces nicotine to very low levels and greatly reduces tobacco supply. It is important to ensure stop smoking services are equipped to respond to increased service demand and that resourcing recognises the challenges of meeting demand during periods when staff are reallocated to meet COVID-19 requirements.

SEAG members working with stop smoking service providers have suggested providing dedicated resources in GP clinics with a high population of wahine Māori (e.g., Health Improvement Practitioners and Health Coaches). As well as enabling sufficient staffing to provide high quality advice, active support and sustained follow-up, stop smoking service providers seek improved access to prescription medications and funding to subsidise all nicotine replacement therapy products (e.g., Inhalator and Quit Mist, which are currently unfunded). Investment is also required to ensure stop smoking services are more than programme delivery and smoking cessation providers, but can actively promote themselves within their communities.

SEAG members note service providers have asked that investment in mass and social media campaigns is integrated with local stop smoking services to ensure a co-ordinated, strategic approach. SEAG members also note that many health service providers other than stop smoking services will interact with people who smoke. Members recommend provision of smoking cessation support should be a core activity within all health service providers' roles and embedded within all services interacting with population groups where smoking prevalence peaks.

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

- **HCA members strongly believe the action plan must contain a comprehensive suite of measures**; members recognise that no single measure will realise the 2025 goal and note that concerted action is required to reduce the appeal, affordability, availability and addictiveness of tobacco products.
- **HCA members note the measures that reduce supply and make cigarettes less addictive and less appealing will require assessment to ensure these do not run counter to international agreements**. Our obligation pursuant to the World Trade Organisation Technical Barriers to Trade means that regulations cannot be "…prepared, adopted or applied with a view to or with the effect of creating unnecessary obstacles to international trade." The restrictions are deemed unnecessary and therefore in breach if they are more than is necessary to fulfil a legitimate objective. The assessment is evidence-based. To lessen the likelihood of any case being taken and/or being successful: 1. Articulate the goal of Smokefree 2025 as a legitimate public health objective with the outcomes the smokefree status would achieve. 17 2. Explicitly state the connection, based on scientific evidence, between the public health objectives and each of the proposed measures, such that no lesser alternative measures could achieve the desired result. The Comprehensive and Progressive Trans-Pacific Partnership Agreement (CPTPP) generally means that products legally sold in Australia cannot be restricted in New Zealand and vice versa. There is the possibility of exemptions. The Government should: 1. Notify a denial of benefits of investor state arbitration in relation to tobacco control measures under Art 29.5 of the CPTPP with the introduction of any legislation. 2. Seek from Australia a temporary 12-month exemption for each of the proposed measures and then a permanent exemption to follow. Investment treaties ensure foreign investors cannot be expropriated by the State without compensation. Some of the proposals, while not expropriating the cigarette industry, could be characterised as an equivalent in that they deprive the tobacco companies from at least a substantial amount of their investment. However, where non-discriminatory measures are

designed to protect public health, they will not be found to be a breach. 1. Any legislation be framed as non-discriminatory in application. 2. The measures proposed do not contemplate a ban of the sale of cigarettes or other smoked tobacco products and it is prudent for them not to be characterised as such. 18

References

1. Marshall A, Edwards R, Wilson N, et al. Missed tobacco tax revenue from 'foreign' packs in New Zealand: results from a discarded pack collection study. N Z Med J 2013;126(1386):124-6.

2. Wilson N, Thomson G, Edwards R, et al. Estimating missed government tax revenue from foreign tobacco: survey of discarded cigarette packs. Tob Control 2009;18(5):416-8. doi: tc.2009.031278 [pii] 10.1136/tc.2009.031278 [published Online First: 2009/08/04]

3. Scollo M, Bayly M, Wakefield M. Availability of illicit tobacco in small retail outlets before and after the implementation of Australian plain packaging legislation. Tob Control 2015;24(e1):e45-51. doi: 10.1136/tobaccocontrol-2013-051353 [published Online First: 2014/04/12]

4. Scollo M, Zacher M, Durkin S, et al. Early evidence about the predicted unintended consequences of standardised packaging of tobacco products in Australia: a cross-sectional study of the place of purchase, regular brands and use of illicit tobacco. BMJ open 2014;4(8):e005873. doi: 10.1136/bmjopen-2014-005873 [published Online First: 2014/08/30]

5. Australian Government Department of Health. Post-Implementation Review Tobacco Plain Packaging. Canberra: Australian Government 2016.

6. Rowell A, Evans-Reeves K, Gilmore AB. Tobacco industry manipulation of data on and press coverage of the illicit tobacco trade in the UK. Tob Control 2014;23(e1):e35-43. doi: 10.1136/tobaccocontrol-2013-051397 [published Online First: 2014/03/13]

7. Joossens L, Raw M. From cigarette smuggling to illicit tobacco trade. Tob Control 2012;21(2):230-4. doi: 10.1136/tobaccocontrol-2011-050205 [published Online First: 2012/02/22]

8. World Bank Group. Confronting illicit tobacco: a global review of country experiences: World Bank Group; 2019 [Available from: **http://documents1.worldbank.org/curated/en/677451548260528135/pdf/133959-REPL-PUBLIC-6-2-2019-19-59-24-WBGTobaccoIllicitTradeFINALvweb.pdf**.

9. Marsh L, Doscher C, Cameron C, et al. How would the tobacco retail landscape change if tobacco was only sold through liquor stores, petrol stations or pharmacies? Australian and New Zealand journal of public health 2020;44(1):34-39.

10. Burton S, Hoek J, Nesbit P, et al. "Smoking is bad, it's not cool… yet I'm still doing it": Cues for tobacco consumption in a 'dark' market. Journal of Business Research 2015;68(10):2067-74.

11. Hoek J, Gifford H, Pirikahu G, et al. How do tobacco retail displays affect cessation attempts? Findings from a qualitative study. Tobacco Control 2010;19(4):334-37. doi: 10.1136/tc.2009.031203

12. Robertson L, Marsh L, Edwards R, et al. Regulating tobacco retail in New Zealand: what can we learn from overseas. NZ Med J 2016;129(1432):74-9.

13. Edwards R, Peace J, Carter K, et al. An examination of smoking initiation rates by age: results from a large longitudinal study in New Zealand. Aus NZ J Public Health 2013;37(6):516-19.

14. Gray R. Do young adults make informed choices about smoking? University of Otago, 2016.

15. Gartner CE, Barendregt JJ, Hall WD. Predicting the future prevalence of cigarette smoking in Australia: how low can we go and by when? Tobacco Control 2009;18(3):183. doi: 10.1136/tc.2008.027615

16. Nuyts PAW, Kuijpers TG, Willemsen MC, et al. How can a ban on tobacco sales to minors be effective in changing smoking behaviour among youth? - A realist review. Prev Med 2018;115:61-67. doi: 10.1016/j.ypmed.2018.08.013 [published Online First: 2018/08/26]

17. van der Deen FS, Wilson N, Cleghorn CL, et al. Impact of five tobacco endgame strategies on future smoking prevalence, population health and health system costs: two modelling studies to inform the tobacco endgame. Tob Control 2018;27:278-86. doi: 10.1136/tobaccocontrol-2016-053585 [published Online First: Published Online First: 24 June 2017]

18. Myers AE, Hall MG, Isgett LF, et al. A comparison of three policy approaches for tobacco retailer reduction. Preventive medicine 2015;74:67-73.

19. Ackerman A, Etow A, Bartel S, et al. Reducing the density and number of tobacco retailers: policy solutions and legal issues. Nicotine & Tobacco Research 2017;19(2):133-40.

20. Lawman HG, Dolatshahi J, Mallya G, et al. Characteristics of tobacco purchases in urban corner stores. Tobacco control 2018;27(5):592-95.

21. Marsh L, Cameron C, Quigg R, et al. Is the tobacco 'footfall'argument justified for tobacco purchases in New Zealand convenience stores? Tobacco Control 2020;http://dx.doi.org/10.1136/tobaccocontrol-2020-056032 19

22. Robertson L, Cameron C, Hoek JA, et al. Prevalence and characteristics of tobacco purchases in convenience stores: results of a postpurchase intercept survey in Dunedin, New Zealand. Tobacco control 2019;28(6):696-700.

23. Wood L, Gazey A. Tobacco mythbusting—tobacco is not a major driver of foot traffic in low socio-economic small retail stores. Tobacco Control 2021; doi:10.1136/tobaccocontrol-2020-05631

24. Jaine R, Russell M, Edwards R, et al. New Zealand tobacco retailers' attitudes to selling tobacco, point-of-sale display bans and other tobacco control measures: a qualitative analysis. The New Zealand Medical Journal (Online) 2014;127(1396)

25. Badu E, Fowler E. "If government can't stop the smokes, no way we can stop selling them": why retailers want Government to act. The New Zealand medical journal 2018;131(1482):89-91.

26. Robertson L, Marsh L, Hoek J, et al. Regulating the sale of tobacco in New Zealand: A qualitative analysis of retailers' views and implications for advocacy. International Journal of Drug Policy 2015;26(12):1222- 30.

27. Donny EC, Denlinger RL, Tidey JW, et al. Randomized trial of reduced-nicotine standards for cigarettes. New England Journal of Medicine 2015;373(14):1340-49.

28. Donny EC, Walker N, Hatsukami D, et al. Reducing the nicotine content of combusted tobacco products sold in New Zealand. Tobacco Control 2017;26(e1):e37-e42.

29. Walker N, Fraser T, Howe C, et al. Abrupt nicotine reduction as an endgame policy: A randomised trial. Tobacco Control 2015;24(e4):e251-e57. doi: 10.1136/tobaccocontrol-2014-051801

30. Walker N, Howe C, Bullen C, et al. The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitline care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial. Addiction 2012;107(10):1857-67.

31. Hatsukami DK, Luo X, Jensen JA, et al. Effect of immediate vs gradual reduction in nicotine content of cigarettes on biomarkers of smoke exposure: a randomized clinical trial. Jama 2018;320(9):880-91.

32. Health UDo, Services H. National Cancer Institute: Risks associated with smoking cigarettes with low machine-measured yields of tar and nicotine. Bethesda, MD, National Institutes of Health 2001

33. World Health Organization. Tobacco and its environmental impact: an overview. In: Organization WH, ed. Geneva, 2017.

34. Keep New Zealand Beautiful. National Litter Audit 2019 2019 [Available from: **https://www.knzb.org.nz/resources/research/national-litter-audit/2021**.

35. Hoek J, Jones SC. Regulation, public health and social marketing: A behaviour change trinity. Journal of Social Marketing 2011;1(1):32-44. doi: 10.1108/20426761111104419

36. Novotny TE. Environmental accountability for tobacco product waste. Tobacco Control 2020;29(2):138-39. doi: 10.1136/tobaccocontrol-2019-055023

37. TrackBill. New York S7259 Enacts the tobacco product waste reduction act 2021 [Available from: https://trackbill.com/bill/new-york-senate-bill-7259-enacts-the-tobacco-product-waste-reductionact/1833292/2021.

38. Hoek J, Gendall P, Eckert C, et al. Young Adult Susceptible Non-Smokers' and Smokers' Responses to Capsule Cigarettes Tobacco Control 2018 doi: doi:10.1136/tobaccocontrol-2018-054470

39. Haggart K, Hoek J, Blank M-L. Flavor Capsule Variants' Performance in a "Dark Market": Implications for Standardized Packaging. Nicotine & Tobacco Research 2018;22(5):853-56. doi: 10.1093/ntr/nty158

40. Abad-Vivero EN, Thrasher JF, Arillo-Santillan E, et al. Recall, appeal and willingness to try cigarettes with flavour capsules: assessing the impact of a tobacco product innovation among early adolescents. Tob Control 2016;25(e2):e113-e19. doi: 10.1136/tobaccocontrol-2015-052805 [published Online First: 2016/04/10]

41. Thrasher JF, Islam F, Barnoya J, et al. Market share for flavour capsule cigarettes is quickly growing, especially in Latin America. Tobacco control 2016:tobaccocontrol-2016-053030.

42. Hastings G. Public health and the value of disobedience. Public Health 2015;129(8):1046-54. doi: **https://doi.org/10.1016/j.puhe.2015.03.010**

43. Edwards R, Hoek J, van der Deen F. Smokefree 2025 – use of mass media in New Zealand lacks alignment with evidence and needs. Australian and New Zealand Journal of Public Health 2014:n/a-n/a. doi: 10.1111/1753-6405.12246

44. Murphy-Hoefer R, Davis KC, Beistle D, et al. Impact of the Tips From Former Smokers Campaign on Population-Level Smoking Cessation, 2012-2015. Preventing Chronic Disease 2018;15:E71-E71. doi: 10.5888/pcd15.180051 20

45. Farrelly MC, Nonnemaker J, Davis KC, et al. The Influence of the National truth® Campaign on Smoking Initiation. American Journal of Preventive Medicine 2009;36(5):379-84. doi: **https://doi.org/10.1016/j.amepre.2009.01.019**

46. Holtgrave DR, Wunderink KA, Vallone DM, et al. Cost–Utility Analysis of the National truth® Campaign to Prevent Youth Smoking. American Journal of Preventive Medicine 2009;36(5):385-88. doi: **https://doi.org/10.1016/j.amepre.2009.01.020**

47. Durkin S, Brennan E, Wakefield M. Mass media campaigns to promote smoking cessation among adults: an integrative review. Tobacco Control 2012;21(2):127-38. doi: 10.1136/tobaccocontrol-2011-050345

48. Dunlop S, Cotter T, Perez D, et al. Televised antismoking advertising: effects of level and duration of exposure. American Journal of Public Health 2013;103(8):e66-e73.

49. White VM, Durkin SJ, Coomber K, et al. What is the role of tobacco control advertising intensity and duration in reducing adolescent smoking prevalence? Findings from 16 years of tobacco control mass media advertising in Australia. Tobacco control 2015;24(2):198-204