

Regulatory Impact Statement: Smokefree Aotearoa Action Plan

| Purpose of Document | |
|----------------------|---|
| Decision sought: | Analysis produced for the purpose of informing Cabinet decisions. |
| Advising agencies: | Ministry of Health |
| Proposing Ministers: | Hon Dr Ayesha Verrall, Associate Minister of Health |
| Date finalised: | 3 November 2021 |

Problem Definition

Smoking is a leading cause of preventable death and disease in New Zealand, killing approximately 4,500–5,000 people per year (equivalent to about 15 percent of all deaths in 2019) and contributing to ongoing health inequity for Māori and Pacific peoples.

New Zealand has a goal to be smokefree by 2025,¹ however projections show that this goal will be impossible to achieve with a ‘business as usual’ approach.

Regulatory intervention is required to change the broader smoking environment for smoked tobacco products – to reduce their availability, addictiveness and appeal to make it much easier for young people to stay smokefree and for people who smoke to quit.

Executive Summary

Most people who smoke begin smoking before the age their brain has fully matured, regret having started, and want to stop but struggle to do so.

Policy to date has focused on influencing individual behaviours to reduce demand for tobacco and denormalise smoking. While this has had success (for some groups more than others), more could be done at a population level to change the broader smoking environment by regulating the availability, appeal and addictiveness of tobacco products.

Smoked tobacco products are highly addictive. Nicotine is the primary addictive component of smoked tobacco, and levels of nicotine in tobacco products available for purchase in New Zealand are currently high. Mandating very low levels of nicotine will remove the most addictive aspect of tobacco.

Design of cigarettes is constantly evolving to increase appeal. Innovations attract experimentation, and then high levels of nicotine quickly lead to addiction. Regulating the design of tobacco products to restrict design features that increase the appeal and addictiveness of smoked tobacco products and minimise the detrimental impact on human health will prevent the tobacco industry from circumventing the reduced nicotine measure.

Creating a smokefree generation means anyone born after a certain date will never be able to lawfully be sold smoked tobacco products. This will explicitly signal that smoking is

¹ In practice this means daily smoking prevalence is less than 5% for all population groups in New Zealand. The prevalence goal is for smoking and excludes vaping and the use of smokeless tobacco products.

not safe at any age. Combined with retail reduction, the effect will be a significant reduction in social supply, which is how most young people access cigarettes.

Given the harms caused by tobacco, regulation of its supply is appropriate. Significantly reducing retail availability of tobacco will signal that tobacco is not a normal consumer good. If tobacco is not ubiquitous, consumers will need to make more effort to purchase it. Making it less accessible in this way will reduce impulse purchases and denormalise the product.

Consultation on *Proposals for a Smokefree Aotearoa 2025 Action Plan* was held from 15 April 2021 to 31 May 2021. Over 5,100 people and organisations engaged with the consultation process, either through a written submission, or by attending a hui or Pacific-focused community meeting organised by Hāpai te Hauora. Many of these face-to-face meetings included community members who smoked or had been affected by smoking in their whānau. The options included in analysis were drawn from those consulted on.

Any single measure will not achieve an equitable Smokefree Aotearoa 2025. The most significant impact comes from a combined package that targets appeal and addictiveness, retail availability and access. Modelling shows that to achieve the goal in the next four years, a comprehensive mutually reinforcing package of actions must be implemented at pace. The Smokefree Aotearoa 2025 Action Plan sets out the actions we will take over the next four years and beyond to achieve Smokefree Aotearoa 2025 and ultimately end the harm caused by smoking.

Limitations and Constraints on Analysis

Most of the measures being considered have yet to be widely implemented internationally, and in some cases, New Zealand would be the first in the world to implement them. There is therefore significant uncertainty in the outcomes. While a strong body of research exists around the theoretical impacts of the various measures, there is a lack of evaluation from comparable markets. Even where there has been comparable implementation and evaluation in overseas jurisdictions, the evaluation is limited. There is no empirical evidence to tell us how the measures will impact equity amongst the New Zealand population.

To fill these gaps in evidence, we commissioned modelling of the impact the measures are likely to have. Modelling results are preliminary and contingent on a scenario with estimated implementation dates. The figures are therefore subject to change.

Potential impact is therefore estimated based on available evidence, modelling commissioned by the Ministry of Health (the Ministry) and expert opinion. This includes consideration of the likelihood that the measures will reduce numbers of people who smoke and the impact on equity where this can be assessed, as well as consideration of potential issues in implementation.

Responsible Manager

Sally Stewart

Manager

Tobacco Control Programme

Ministry of Health

November 2021

| Quality Assurance | |
|-----------------------------|---|
| Reviewing Agency: | Ministry of Health |
| Panel Assessment & Comment: | The Ministry QA panel has reviewed the Impact Statement titled “Smokefree Aotearoa Action Plan”, produced by the Ministry of Health and dated October 2021. The panel considers that the Impact Statement meets the quality assurance criteria. The Impact Statement is clear, complete, considered, consulted and concise. The analysis is balanced in its presentation of the information, reflects consultation on the proposals and the major impacts are identified and assessed. |

Section 1: Diagnosing the policy problem

Tobacco smoking in New Zealand

1. Smoking rates and tobacco consumption have been declining over recent decades, however, around 4,500–5,000 New Zealanders still die prematurely each year from a smoking related illness.²
2. In 2010, the Māori Affairs Select Committee led an inquiry into the tobacco industry in New Zealand and the consequences of smoked tobacco use for Māori. In 2011, in response to this inquiry, the Government adopted the goal of reducing smoking prevalence and smoked tobacco availability to minimal levels, which would essentially make New Zealand smokefree by 2025.³
3. Progress towards this goal has been made across all population groups in New Zealand. From 2006/07 to 2019/20, smoking prevalence reduced from 17 percent to 10.1 percent among the European/other population, 39.2 to 28.7 percent among Māori and 24.8 to 18.3 percent among Pacific peoples. Youth rates have declined, but there are clear disparities across different ethnic and socioeconomic groupings, and over time the gaps between Māori and Pacific young people and other ethnicities have widened.
4. Young people who smoke are more likely to attend lower decile schools. Māori students are over five times more likely to have tried smoking than non-Māori, non-Pacific students.
5. 2017 research on young Māori women who smoke found that they are more likely to live with other people who smoke, more likely to be unemployed or require income assistance, and more likely to have no secondary school qualification. Conversely, young Māori women who have never smoked are more likely to have a higher secondary school qualification, have internet access at home and live in areas of social and material advantage.⁴ Qualitative research associated with this project found that young wāhine who smoked often had complex, challenging lives and used smoking as a coping mechanism for stress and were therefore reluctant to stop. Many feared

² GBD Tobacco Collaborators. Spatial, temporal, and demographic patterns in prevalence of smoking tobacco use and attributable disease burden in 204 countries and territories, 1990-2019: a systematic analysis from the Global Burden of Disease Study 2019. Lancet 2021;(E-publication 31 May).

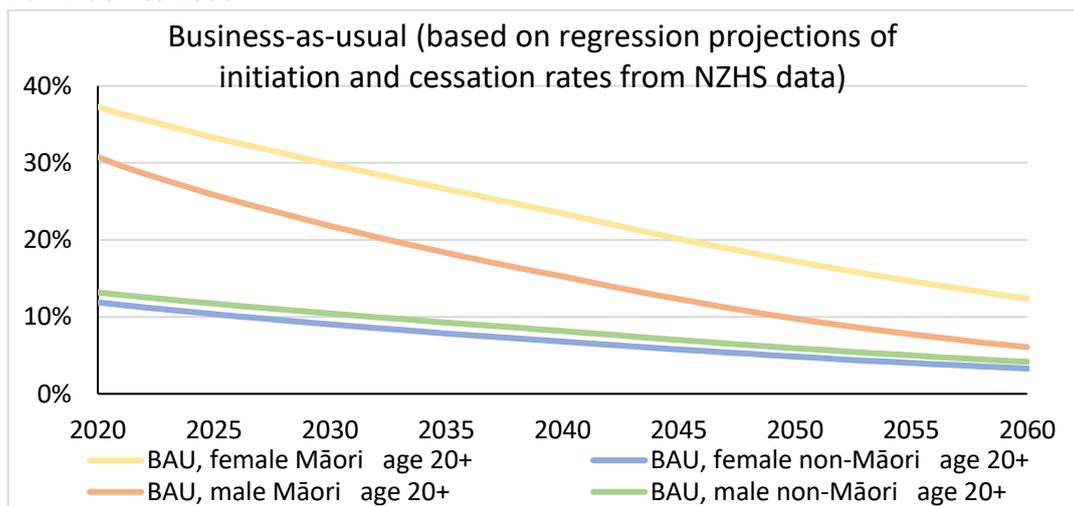
³ https://www.parliament.nz/resource/en-NZ/49DBSCH_SCR4900_1/2fc4d36b0fbdfed73f3b4694e084a5935cf967bb

⁴ <https://www.health.govt.nz/system/files/documents/pages/mws-analytics-technical-report-june-2017.pdf>
<https://www.health.govt.nz/system/files/documents/pages/mws-analytics-single-page-summary-june2017.pdf>

quitting because they had nothing to replace smoking with or were fearful of withdrawal.⁵

6. Disabled people have higher smoking rates than the general population, as do those with mental health needs and people who enter prison.
7. There are marked inequities in health caused by higher smoking prevalence particularly for Māori, Pacific peoples, and those living in the most deprived areas of New Zealand. Smoking mortality statistics must be seen in the wider context of systemic inequity. Health inequities are also influenced by a wide range of social and economic factors, including income and poverty, employment, education, and housing.
8. The impact of these inequities is significant. For example, lung cancer is the leading cause of death for Māori women and the second leading cause for Māori men. Lung cancer mortality among Māori women is over four times that of non-Māori women, and is among the highest mortality rates for lung cancer in the world.⁶
9. Ending the unequal distribution of the harms caused by smoking is necessary to reverse inequity and improve health and wellbeing for all. Reducing the inequities caused by smoking is an essential step towards meeting our obligations under Te Tiriti o Waitangi including achieving equitable health outcomes for Māori.⁷
10. A broad suite of tobacco control initiatives (both regulatory and non-regulatory) has been implemented over the past two to three decades to reduce smoking and to meet governments' wider policy aims. For example, prohibition on sales to under 18-year-olds, tobacco excise tax increases, advertising prohibitions, and legislated smokefree areas.
11. However, modelling indicates that under a business-as-usual approach, daily smoking rates are projected to only reduce to 8.1 percent for non-Māori and 20 percent for Māori by 2025. Pacific peoples are projected to reach 11.7 percent daily smoking by 2025. Māori are not projected to reach five percent until 2061.⁸

Table 1 Projections of age 20+ smoking prevalence (for daily smoking) for Māori and non-Māori to 2060



⁵ <https://www.health.govt.nz/system/files/documents/pages/exploring-why-young-Māori-women-smoke-final-10october2017.pdf>

⁶ https://www.parliament.nz/resource/en-NZ/49DBSCH_SCR4900_1/2fc4d36b0fbdfed73f3b4694e084a5935cf967bb

⁷ The right to be smokefree is entrenched in Te Tiriti o Waitangi. For instance, article 2 guarantees protection of taonga; the right to wellbeing and tiaki whakapapa falls under this. Article 3 sets out the right to equality before the law.

⁸ van der Deen FS, Wilson N, Blakely T. A continuation of 10% annual tobacco tax increases until 2020: modelling results for smoking prevalence by sex and ethnicity. *New Zealand Medical Journal* 2016;129(1441):94-7.

12. The principle of active protection under Te Tiriti requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This means we must go beyond a business-as-usual approach, to ensure the actions we take will increase equity.

What is the policy problem or opportunity?

13. Policy to date has focused on influencing individual behaviours to reduce demand for tobacco and denormalise smoking. Along with health promotion, smoking cessation services and price increases, legislation prohibits smoking in indoor workplaces (including hospitality, schools and early childhood centres), prohibits the display of tobacco products, and requires tobacco products to be in standardised packaging.
14. While this approach has had some success, modelling predicts that doing more of the same will not achieve an equitable Smokefree Aotearoa 2025. More needs to be done at a population level to change the broader smoking environment by considering everything about the product, including what is in it and where it is sold to make it easier for all young New Zealanders to remain smokefree and those who smoke to quit.
15. Population-based measures can increase equity because they do not rely on people's capacity, including the resources available to them, to make changes in their lives, which their circumstances may make particularly difficult. Regulatory intervention is therefore an appropriate response, to reduce the availability of smoked tobacco products and the appeal that they have for people who smoke.
16. Additionally, the emergence of vaping products allows currently addicted adult smokers access to nicotine at a lower level of risk to health than that associated with smoking.
17. The Smokefree Aotearoa 2025 Action Plan (action plan) sets out a vision to eliminate the harm smoked tobacco products cause our communities by transforming Aotearoa New Zealand to a smokefree nation by 2025. The action plan sets out the actions we will take over the next four years and beyond to achieve Smokefree Aotearoa 2025 and ultimately end the harm caused by smoking. To achieve the goal in the next four years, a comprehensive mutually reinforcing package of actions must be implemented at pace.
18. This Regulatory Impact Statement considers the regulatory aspects proposed in the action plan.

What objectives are sought in relation to the policy problem?

19. The proposed action plan is a government priority and focuses on a goal of achieving a Smokefree Aotearoa. This is defined as prevalence of daily smoking of less than 5 percent for all population groups by 2025.
20. The action plan sets out three outcomes:
 - eliminate inequities in smoking rates and smoking related illnesses
 - create a smokefree generation by increasing the number of children and young people who remain smokefree
 - increase the number of people who successfully stop smoking.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

21. The criteria we have used:
- **Reduces inequity:** will the policy reduce inequities in smoking rates and smoking-related illnesses?
 - **Decreases smoking initiation:** will the policy reduce smoking initiation among young people and make it easier for young people to remain smokefree?
 - **Increases likelihood of quitting:** will the policy make it easier for people who smoke to quit?
 - **Ease and cost of implementation:** is the policy able to be implemented with the likely available budget and within the necessary timeframe?
 - **Clear and workable for New Zealand:** are New Zealanders likely to understand, support and champion the intentions, implementation and enforcement of the policy?

What scope will options be considered within?

22. Government direction on the scope of the action plan define the options considered here as follows:
- reduce appeal and addictiveness of smoked tobacco products via:
 - i. reducing nicotine levels
 - ii. removing filters
 - iii. regulating product design
 - reduce availability of smoked tobacco products via:
 - i. increasing age limits for legal purchase
 - ii. reducing retail
 - reduce affordability of smoked tobacco products via:
 - i. setting a minimum price.
23. The Regulatory Impact Statement (RIS) does not consider compliance and enforcement, including any offences and penalties required to support the legislative changes, or the nature of any fees, levies or payments. These matters will be considered, and as required, further advice provided in early 2022.
24. The following policy options were ruled out of scope by the government.
- Further increase in excise tax – as New Zealand has very high retail prices for tobacco products (driven by a high rate of tobacco taxation due to policy over the last decade), and also due to concerns about the financial impact further price increases would have on those who continue to smoke.
 - Vaping and smokeless tobacco products – as these matters were considered by Parliament in 2020.
 - Sinking lid on imports – as there are practical concerns and it may lead to undesirable market behaviour.

- Expanding legislated smokefree areas – as this is unlikely to make a significant contribution towards achieving Smokefree Aotearoa 2025.
- Restricting menthol and other flavours – as this is unlikely to have a big enough impact given the relatively small percentage of people who use flavoured tobacco products.

What options are being considered?

Addictiveness and Appeal

Issue One – *Reduce addictiveness and appeal*

25. The status quo is high levels of nicotine, with few restrictions around appeal and addictiveness. Nicotine levels can vary, however, per cigarette there is approximately 10–15mg of nicotine.⁹ Existing restrictions aim to reduce appeal through removing marketing opportunities and mandating plain packaging. However, there are currently very limited measures¹⁰ that focus on the design of the product itself.

Overview of options

26. The options considered to reduce addictiveness and appeal are to: mandate very low nicotine cigarettes; remove filters; and to provide discretionary powers to regulate product design.

Option 1a Reduce addictiveness by mandating very low nicotine cigarettes

27. Nicotine is the primary addictive component of tobacco products. Once people become addicted, they require nicotine to avoid withdrawal symptoms. In the process of obtaining nicotine, users of combustible tobacco products and bystanders are exposed to an array of toxicants in tobacco and tobacco smoke that lead to a substantially increased risk of morbidity and mortality. Because of nicotine addiction, many people who smoke are unable to choose to stop smoking despite their stated desire to quit.¹¹
28. Significantly reducing the level of nicotine in smoked tobacco products would contribute towards achieving Smokefree Aotearoa 2025 by helping people who smoke to quit and preventing experimenters (mainly young people) from taking up regular smoking.
29. Preliminary high-level results from modelling analysis suggest that mandating very low nicotine levels could come close to achieving the smokefree 2025 goal, when combined with a doubling of media health promotion expenditure and Quitline support. To achieve the goal for Māori, mandating very low nicotine levels would need to be supplemented by further complementary strategies, as proposed.
30. Responses to the smokefree action plan consultation representing those with commercial interests in tobacco and/or vaping products opposed mandating very low nicotine levels policy. When excluding responses from those with commercial interests, most responses were in favour.

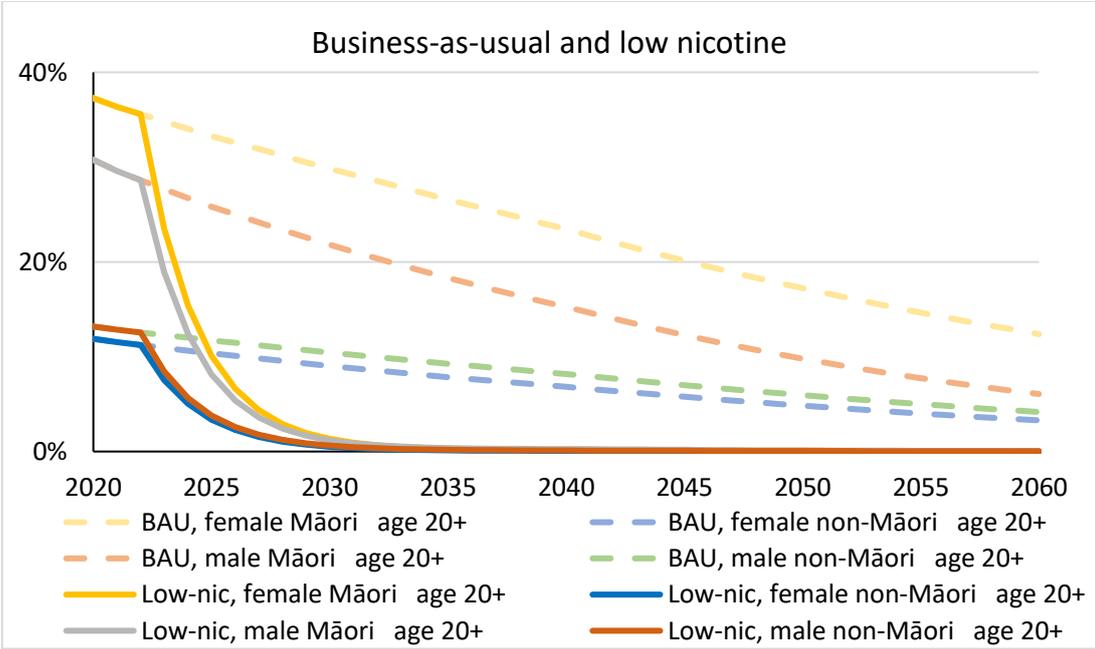
⁹ Benowitz et al, Nicotine & Tobacco Research, 2019, S16–S18 doi:10.1093/ntr/ntz120 *The Role of Compensation in Nicotine Reduction*.

¹⁰ Such as around colour, size and length.

¹¹ [Nicotine Addiction: Past and Present - How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease - NCBI Bookshelf \(nih.gov\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6048441/)

- 31. While feasible (via changes to the Smokefree Environments and Regulated Products Act 1990 and the Customs and Excise Act 2018), this is an innovative and technically challenging policy measure. Challenges include:
 - ensuring that the mandated nicotine level is below the level at which the nicotine present does not produce significant reinforcing effects or sustain addiction in a majority of the population¹²
 - securing testing capability, preferably New Zealand based, to ensure compliance.
- 32. An additional challenge is that this option is likely to incentivise imports of illicit tobacco products. While the current illicit market provides the same product that can otherwise be bought legally, but at a lower price, a future illicit market is likely to offer tobacco with high nicotine content, that cannot be purchased legally. This may result in a higher price being charged for illicit tobacco than currently, making illegal sales a more appealing proposition for organised crime.
- 33. Modelling evidence¹³ shows that this option would significantly reduce daily smoking prevalence. If implemented in 2023, reducing nicotine would reduce prevalence for Māori women over 20 years of age from 37.3 percent to 10.1 percent in 2025, and 1.3 percent in 2030. For non-Māori women and men, this option would reach the 2025 goal of less than five percent daily smoking prevalence.
- 34. This same modelling shows that mandating a low nicotine rate could lead to a gain of 550,000 Health Adjusted Life Years (HALYs).¹⁴

Table 2 Projections of age 20+ smoking prevalence (for daily smoking) for Māori and non-Māori to 2060, comparing business-as-usual (BAU) to low nicotine (Low-nic)



¹² <https://www.federalregister.gov/documents/2018/03/16/2018-05345/tobacco-product-standard-for-nicotine-level-of-combusted-cigarettes>

¹³ Unpublished modelling commissioned by the Ministry of Health, carried out by the University of Melbourne, using the SHINE-Tobacco research platform.

¹⁴ For all ages, by time-line into the future, 3 percent discount rate.

Option 1b Reduce appeal by removing filters

35. Prohibiting filters was also consulted on publicly.
36. Filters contribute to the appeal of cigarettes, with some people who smoke under the misconception that filters mitigate the harm of smoking.¹⁵ Filters can also contain flavour beads or capsules, likely to appeal to young adult non-smokers. Finally, filters cause major environmental harm. Each year, around four trillion cigarette butts are discarded globally, making tobacco product waste the most littered item in the world.¹⁶
37. Overall, most responses to the consultation opposed prohibiting filters in smoked tobacco products. The vast majority of those opposed have commercial interests in tobacco and/or vaping products.
38. However, when generic responses from small retailers were removed, most responses were in favour of prohibiting filters. The main grounds for support were environmental and reducing the appeal of cigarettes, particularly to youth. The remaining grounds for opposition were based on misunderstanding – for example believing filters protect health.
39. Prohibiting filters is likely to make cigarettes less appealing and would remove a vehicle for introduction of new product designs aimed to increase appeal. The option would also remove a source of toxic waste from the environment.¹⁷ However, as compared to option 1a, prohibiting filters is unlikely to have a major impact in achieving the smokefree goal.

Option 1c Reduce appeal by regulating product design

40. Another approach consulted on was a regulatory power to regulate product design. This was popular with many submitters as a proactive way of preventing industry from evolving products in response to, or to circumvent, the other proposed product requirements.
41. Such a power would help to prevent unintended consequences from the other proposed product design measures and prevent manufacturers from developing ways to circumvent other measures. For example, manufacturers of cigarettes may try to develop ways to maintain the addictiveness of cigarettes even with much lower nicotine levels.
42. Using regulations means that faster changes could be made in future, because it would not be necessary to amend the Smokefree Environments and Regulated Products Act 1990 each time. This would future proof the changes we make and ensure the intentions of the action plan are not undermined by industry response.
43. The power could cover additives, ingredients, flavours, substitutes for filters, product size and weight, types of wrappers and inclusions on or with cigarettes or designed to be used with cigarettes and other types of smoked tobacco. It would be a discretionary power.

¹⁵ The 'filter fraud' persists: the tobacco industry is still using filters to suggest lower health risks while destroying the environment, Karen Evans-Reeves, Kathrin Lauber, Rosemary Hiscock Industry watch.

¹⁶ World Health Organization. Tobacco and its environmental impact: an overview. Geneva: World Health Organization, 2017.

¹⁷ Cleaner waterways support te Mana o te Wai – the integrated and holistic wellbeing of the water, which is recognised in the National Policy Statement for Freshwater Management and reflects obligations under Te Tiriti o Waitangi to actively protect Māori rights and interests, which include those relating to fresh water.

How do the options compare to the status quo/counterfactual?

| Key for qualitative judgements: | |
|---------------------------------|---|
| ++ | much better than doing nothing/the status quo/counterfactual |
| + | better than doing nothing/the status quo/counterfactual |
| 0 | about the same as doing nothing/the status quo/counterfactual |
| - | worse than doing nothing/the status quo/counterfactual |
| -- | much worse than doing nothing/the status quo/counterfactual |

Assessment of options to reduce appeal and addictiveness of tobacco

| | Status quo – no measures | Option 1a Mandate low nicotine cigarettes | Option 1b Restrict use of filters | Option 1c Regulatory power to regulate product design |
|---|--------------------------|--|---|--|
| Reduces inequity | 0 No | ++ Modelling suggests this is the only policy that might achieve the Smokefree Aotearoa 2025 goal for Māori | + Particularly strong support for this measure from Māori and Pacific respondents The health of people is intrinsically linked to the health of water | + Removes features arguably designed to appeal to youth who are less aware of risks and therefore more vulnerable |
| Decreases initiation especially for young people | 0 No | ++ Will make cigarettes much less addictive, likely reducing uptake | + Will make cigarettes less appealing, likely reducing initiation | + Will limit innovations (such as crush balls and flavours) having particular appeal to youth and people new to smoking |

| | | | | |
|--|---|---|--|--|
| | | | Removes potential for some product innovations that appeal to youth, such as flavoured crush balls | |
| Increases likelihood of quitting | 0 No | ++ Will make cigarettes much less addictive, likely supporting attempts to quit May increase switching from smoking to less harmful alternatives | + Will make cigarettes less appealing, likely driving attempts to quit | + May make cigarettes less appealing, likely driving attempts to quit |
| Ease and cost of implementation | 0 N/A | -- Technically challenging measure with difficulties that may not yet be understood The costs of testing tobacco to ensure it is appropriately low nicotine could be paid for by importers, and tested by independent laboratories specified by the Ministry of Health | - Could possibly be implemented under smokefree legislation, or alternatively under waste minimisation legislation. May require some additional compliance resource | - Relatively straightforward to implement |
| Would the policy be clear and workable for New Zealand? | 0 Strong calls from public to reduce harm from tobacco | + Support from people who smoke wanting to quit – eg the ITC survey found 80 percent support if other nicotine sources were still available ¹⁸ Likely to lead to increase in illicit market | 0 Removes potential for misleading people who smoke about the harmfulness of cigarettes through use of filters Supported because it removes a significant source of non-biodegradable rubbish and microplastics from environment Significant misunderstanding about protection filters provide – clear communication needed | + Strong support from submissions to restrict industry’s ability to circumvent regulations by innovating |

¹⁸ [Beliefs among Adult Smokers and Quitters about Nicotine and De-nicotinized Cigarettes in the 2016-17 ITC New Zealand Survey https://doi.org/10.18001/TRS.5.5.1](https://doi.org/10.18001/TRS.5.5.1)

| | | | | |
|--------------------|---|--|--|---|
| Overall assessment | 0 | <p style="text-align: center;">++</p> <p>While technically challenging and untested in other jurisdictions, this option is most likely to achieve the 2025 goal, when implemented in conjunction with complementary measures</p> | <p style="text-align: center;">+</p> <p>Reduces appeal – likely to decrease initiation and increase quitting Likely to garner strong support if we can communicate how tobacco industry has misled public on role of filters</p> | <p style="text-align: center;">+</p> <p>Reduces appeal, particularly to youth Future proofs changes and prevents tobacco industry undermining the intentions of the action plan</p> |
|--------------------|---|--|--|---|

44. The preferred options are mandating low nicotine cigarettes and regulating product design, because as a package they work together to reduce the addictiveness and appeal of cigarettes. While technically challenging to implement, with some risks (such as encouraging an illicit market), the likely significant combined benefits will justify the challenges and outweigh the risks. While prohibiting the use of filters is beneficial, further work is needed to determine the best route for implementation.

Availability

Issue Two – Increase age limit to restrict who tobacco may be sold to

45. The status quo is a purchase age of 18 years. Currently 3 percent of those in the 15–17 age group smoke daily (around 5,000 out of 464,000), and 12.9 percent (or 61,000) of those in the 18–24 age bracket smoke daily.¹⁹
46. In New Zealand, social supply plays a much greater role than commercial supply in youth access to tobacco, with an increasing relative influence of family members compared with friends. Māori and Pacific adolescents are more likely to report receiving tobacco in this way.
47. In 2018, students who were currently smoking usually got their cigarettes by giving a person money to buy them (41 percent), being given them by a friend or person their own age (40 percent), buying them from a friend or person their own age (30 percent) and buying them themselves from a shop (18 percent).²⁰

Overview of options

48. Purchase age limit increases will likely be effective for stopping young people starting smoking (most people who smoke begin by age 25).
49. Any age limit measure will have gradual impact (health gains and cost savings are many decades away given they focus on young people) and will not impact most people who already smoke. The measure will limit rights – most age restrictions in New Zealand end at 18 - but any limitation may be justified under the Bill of Rights Act 1990 on public health grounds.
50. An increase in the minimum age of purchase will help to protect younger children from exposure to older pupils in school who smoke and whose behaviour they may want to imitate, as well as removing a potential source of supply within schools. However, as legal access to tobacco becomes more difficult, social supply, where young people receive tobacco from older peers or family and whānau members, becomes more important.
51. Broader social change is therefore needed to reduce smoking among adolescents and young people in families, whānau and communities where smoking is the norm. For example, restricting young people's legal access to tobacco, combined with a substantial reduction in tobacco retail outlets, may reduce social supply, with positive equity effects for Māori and Pacific populations.

Option 2a raise purchase age to 20, 21 or 25 outright

52. Increasing the purchase age limit may be effective in stopping young people from starting smoking, as 80 percent of people who smoke start by the age of 18, while 96.8 percent start before the age of 25.²¹
53. Policies based on increasing ages limits have been considered in other jurisdictions. For example, in the United States and Tasmania,²² increases in the age of purchase to

¹⁹ Ministry of Health 2020.

²⁰ [Smoking and vaping behaviours among 14 and 15-year-olds report2.pdf \(hpa.org.nz\)](https://www.hpa.org.nz/smoking-and-vaping-behaviours-among-14-and-15-year-olds-report2.pdf)

²¹ Bonnie RJ, Stratton K, Kwan LY, editors. Public health implications of raising the minimum age of legal access to tobacco products. Washington (DC): National Academies Press; 2015. Available: <https://www.ncbi.nlm.nih.gov/books/NBK310412/> (accessed 2017 Jan. 25).

²² For US, see <https://tobacco21.org/> For Tasmania see www.tobacco21.com.au/

21 are either under consideration, or recently implemented. Where implemented, it has been found to gradually lower the number of young people initiating smoking.

54. Increasing the age outright would retrospectively outlaw the purchase of tobacco by a cohort of young people who could previously purchase tobacco. This option does not cater to that cohort that are already addicted to nicotine.

Option 2b raise purchase age to 25 gradually

55. With this option the legal age would go up by one year every year, to an endpoint of 25.
56. The brain fully matures around the age of 25 and evidence shows that individuals are less likely to initiate smoking after 24 years of age.²³
57. This option accounts for those young people currently addicted to smoking, while discouraging new groups starting. The Menzies Research Institute in Tasmania found people aged 21 and over were less likely to supply cigarettes to minors than those aged 18 to 20, so this may partially address the social supply issue.²⁴

Option 2c increase purchase age to achieve a smokefree generation

58. A smokefree generation policy increases the legal sale of tobacco by one year, every year. For example, if legislation commenced on 1 January 2023, then people younger than 18 years at that time, or those born after 31 December 2004, would never be able to lawfully be sold smoked tobacco products. This policy would explicitly signal that smoking is not safe at any age.
59. Support for this proposal was strong across all groups other than those with a commercial interest in tobacco. Many submitters regarded the smokefree generation proposal as a strongly pro-equity, innovative policy that could dramatically lower smoking rates progressively, or alternatively as being the most hard-line approach of the proposals in the consultation document.
60. Some retailers were supportive of this proposal, but overall submitters that identified as being a tobacco or vape manufacturer/distributor, as well as small and large retailers, were not in favour of the proposal. There was dissatisfaction with the vagueness of the policy, concerns raised that this was a type of progressive prohibition, that it could lead to increased crime, or that the policy raised issues for individual rights, tourists and migrant workers. Some submitters liked this proposal but wondered how it would work in practice.
61. A survey conducted in New Zealand examining key measures to achieving Smokefree Aotearoa 2025 found strong support for a smokefree generation policy. For example, 78 percent of the total sample supported measures to increase purchasing age, 80 percent of ex-smokers and 77 percent of people who currently smoke supported this policy.²⁵
62. Modelling²⁶ shows only a relatively modest impact by 2025 – 1.2 percent lower smoking prevalence for Māori and 0.4 percent lower for non-Māori (absolute values). The benefits would become quite substantive in subsequent years, however. If well

²³ Edwards R, Carter K, Peace J, Blakely T. 2013. An examination of smoking initiation rates by age: results from a large longitudinal study in New Zealand. ANZJPH, 37(6). <https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12105>

²⁴ [Tasmania could become the first state in Australia to raise smoking age to 21 - ABC News](#)

²⁵ [Support for New Zealand's Smokefree 2025 goal and key measures to achieve it: findings from the ITC New Zealand Survey - Edwards - Australian and New Zealand Journal of Public Health - Wiley Online Library](#)

²⁶ Unpublished modelling by University of Otago, commissioned by the Ministry of Health.

enforced, a smokefree generation policy could halve smoking rates within 10 to 15 years of implementation. The health gains per person would be five times larger for Māori than for non-Māori. This policy would also help to denormalise smoking.

63. The same modelling shows 125,000 HALYs could be gained over the lifetime of the 2020 New Zealand population compared to business as usual (for all ages, by timeline into the future, 3 percent discount rate). This policy would also help to denormalise smoking and would have the most significant impact on social supply. On its own, it would not achieve the smokefree goal for non-Māori until 2040 and for Māori until 2054. However, it would have a dramatic impact on younger age groups, as shown in Table 4. As part of a package of regulatory changes, it will make sure the smokefree goal is maintained long term.

Table 3: Projections of age 20+ smoking prevalence (for daily smoking) for Māori and non-Māori to 2060, comparing business-as-usual (BAU) to smokefree generation policy (Smokefree)

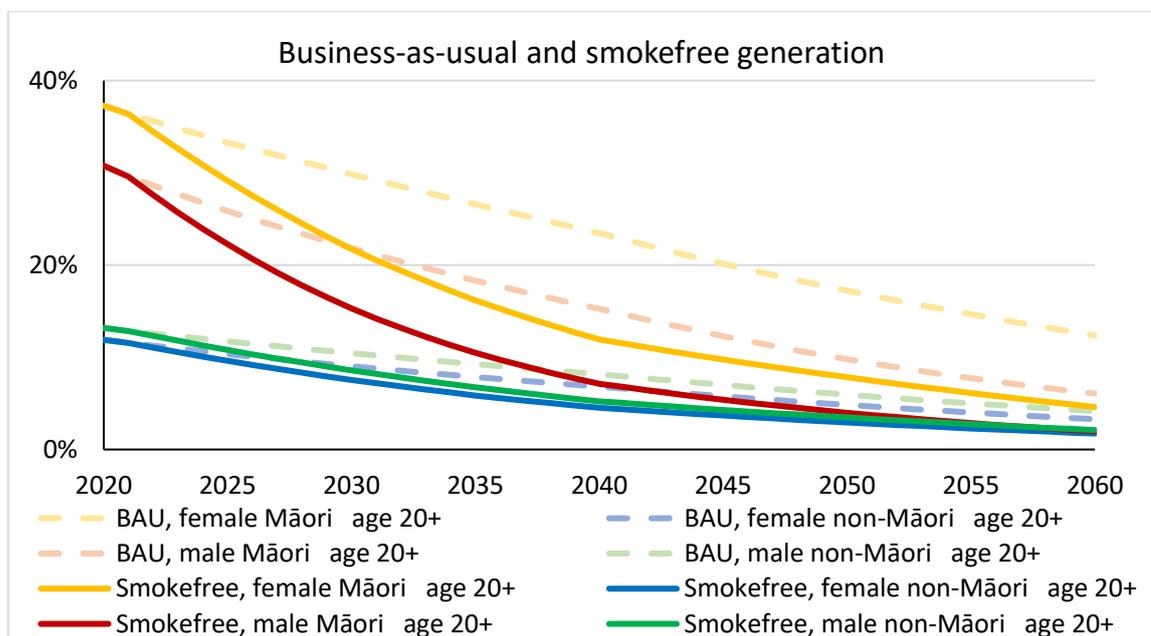
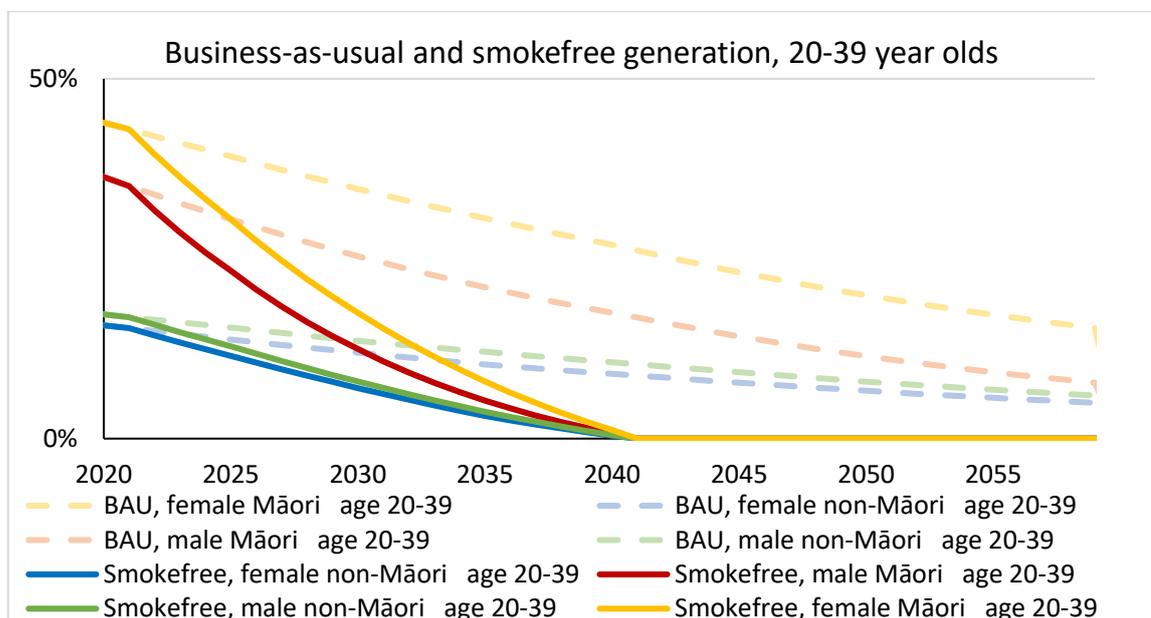


Table 4: Projections of age 20–39 smoking prevalence (for daily smoking) for Māori and non-Māori to 2060, comparing business-as-usual to smokefree generation policy



How do the options compare to the status quo/counterfactual?

Assessment of options for reducing access to tobacco: Age change

| | Status quo: Purchase age is 18 | Option 2a: Increase purchase age to 20, 21 or 25 outright | Option 2b: Increase purchase age to 25 gradually | Option 2c: Increase purchase age to achieve a smokefree generation |
|---|---|--|--|---|
| Reduces inequity | 0 Young Māori smoke at up to 6 times the rate of non-Māori of the same age | + | + | ++ |
| | | Yes – may decrease inequity, due to lower age structure of Māori and Pacific populations, but will impact on existing ability of those aged 18 to legally purchase and could therefore disproportionately impact on Māori who smoke at higher rates than non-Māori | Yes – likely to reduce inequity due to lower age structure of Māori and Pacific populations | Yes – likely to reduce inequity due to lower age structure of Māori and Pacific populations Sends strong signal that smoking is dangerous at any age |
| Decreases initiation especially for young people | 0 | + | ++ | ++ |
| | | Should decrease initiation to varying degrees, as 80 percent of people who smoke started by the age of 18, while 96.8 percent start before the age of 25 May somewhat interrupt social supply in schools | Will decrease initiation, as 96.8 percent start before the age of 25 May interrupt social supply in schools | Will decrease initiation for young people because they will never be able to legally purchase it Will interrupt social supply in schools |
| Increases likelihood of quitting | 0 | 0 | 0 | + |
| | | No – focuses on preventing young people from starting rather than supporting quitting | No – focuses on preventing young people from starting rather than supporting quitting | May somewhat – while focus is to decrease initiation, signalling there is no safe age to smoke, and denormalising smoking which may increase likelihood of quitting |

| | | | | |
|--|---|---|--|---|
| Ease and cost of implementation | 0 | - Relatively simple to implement May require increased compliance and enforcement | - Relatively simple to implement May require increased compliance and enforcement | -- May require increased compliance and enforcement More vulnerable to legal challenge |
| Would the policy be clear and workable for New Zealand? | 0 No – many submissions supported reduced access to tobacco, for youth and people trying to quit | ++ Many submissions supported reduced access to tobacco, for youth and people trying to quit Stakeholder work will be required to explain new age | + Stakeholder work will be required to explain new age and how it will work | + Support for this proposal was strong across all groups that submitted consultation responses, other than those commercially interested in tobacco Will require stakeholder work – may be viewed as prohibition |
| Overall assessment | 0 | + While likely to have some impact on youth smoking, will not adequately address social supply, which is main mode of access for most youth | + While likely to have some impact on youth smoking, will not adequately address social supply, which is main mode of access for most youth | ++ Addresses the various modes of supply for youth in that it increases purchase age to beyond when most people start and will reduce social supply. May also denormalise smoking sufficiently to increase quit attempts among those who already smoke |

64. The preferred option is to increase the purchase age to achieve a smokefree generation. While a stand-alone increase to the age of purchase to 20, 21 or 25 would be easier to implement and may be less vulnerable to legal challenge, it would have a limited effect compared with a smokefree generation policy. Gradually increasing the purchase age to 25 is likely to have a more similar effect to the smokefree generation policy. However, it risks still implying that there is a safe age for smoking.

Issue Three – Reduce availability by significantly reducing retail outlets

65. The status quo is approximately 5,000–8,000 current retailers with no restrictions on who or where smoked tobacco products can be sold. There are nearly four times more retailers in low-income communities, where smoking rates are highest, compared to higher-income communities. The lack of regulatory controls over the sale of smoked tobacco products contrasts with the regulation of other high risk or harmful products, such as alcohol, pharmaceuticals, ammunition, and agricultural products.
66. Tobacco retail is currently a commercial market, driven by profitability.

Overview of options

67. Available modelling indicates that significantly reducing the number of retail outlets that sell smoked tobacco products will have a positive effect by eliminating impulse purchases and increasing travel time and travel costs to obtain smoked tobacco products. It may also have a denormalization effect.
68. Most of the consultation submissions from the retail sector and tobacco importers were firmly opposed to any reduction of the number of retailers, citing the (likely negative) impact on businesses. Some talked about the need for a level playing field or suggested that certain types of stores would be well placed to sell smoked tobacco products if the numbers of retailers reduced.
69. A strong majority of all other submitters were in favour of having fewer retail outlets. This reflects survey data, for example in the 2016/17 International Tobacco Control New Zealand Survey, almost half of respondents (43 percent) supported reducing by 95 percent the number of places that can sell tobacco products. Support was higher from Māori who smoke, and ex-smokers.
70. Three options are considered for the reduction in retail supply of tobacco:
 - licensing tobacco retailers
 - choosing a specific type of retailer
 - introducing a regulated market model.

Option 3a Licencing tobacco retailers

71. A licencing system could require all retailers who wish to sell tobacco to apply for a licence, with a moratorium on new tobacco retail licences. This option does not seek to actively reduce the number of retailers over time but would provide an accurate record of retailers for the purpose of compliance and enforcement.
72. Examples of jurisdictions with licencing schemes include most states in Australia, parts of the United States such as San Francisco and New York state, Finland, Singapore, Hungary, and the Cook Islands.²⁷
73. A strong majority of submitters, including 65 percent of importers and retailers, agreed that a licencing regime for retail is acceptable or desirable. However, they were strongly opposed to retail reduction of any kind.
74. Although published evaluations are limited, tobacco retail licencing schemes appear to increase compliance with youth access restrictions. However, they are unlikely to

²⁷ ASPIRE 2017.

achieve significant retail reduction. Licensing is therefore unlikely to be effective in achieving the smokefree 2025 goal.

75. Introducing criteria (such as proximity to schools) or a capped number of licences to reduce the number of overall retailers was considered but has not been presented in the RIS as a standalone option, as option 3c – introducing a regulated market model – is a more efficient and effective means to achieve a significant reduction in the number of retailers.
76. Option 3a is not a sufficient regulatory response to the harm caused by tobacco. However, having an accurate record of vape retailers would be proportionate to the lesser risk of vaping. Therefore, introducing a requirement that general retailers must inform the Director-General of Health of their intention to sell vaping products will be considered. This requirement would provide information (i.e. location and volume of vaping product sales) for monitoring and compliance purposes. It would also provide a complete view of the retail environment for smoked tobacco and vaping products.

Option 3b Specific type of retailer

77. A potentially simpler way to reduce the number of retailers is to select a store type from the existing retailers and only allow this type of store to sell smoked tobacco products. Options we have considered based on proposals modelled or suggested by academic researchers and submissions are pharmacies, liquor licenced stores, supermarkets, specialist vape retailers (SVRs), and petrol stations.
78. Of the existing retailers, on balance, the use of petrol stations has the most advantages. Petrol stations have an existing nationwide network. The retail footprint is designed around fuel demand (including supply to rural and remote communities), rather than targeted at disadvantaged neighbourhoods. We understand from submissions that petrol stations are generally well-managed with a managed retail programme model and have consistent security and compliance operations. Submissions on behalf of petrol stations also indicated that they would be amenable to selling smoked tobacco products, though particular petrol stations may object. If implemented this would be relatively easy to communicate both to existing retailers and smokers.
79. However, there are problems with singling out petrol stations, including that the option disadvantages small convenience stores and is less precise than other options in how it achieves the reduction in terms of population density, socioeconomic saturation and youth-proximity restrictions.

Option 3c Introducing a regulated market model

80. A more effective approach would be to introduce a regulated market model to reduce the availability of tobacco products throughout Aotearoa New Zealand and result in a corresponding decrease in smoking rates.²⁸
81. Regulatory powers could be drafted to:
 - cut down the current retail market by only allowing tobacco to be sold by approved retailers

²⁸ Initial modelling suggests that reducing retail will result in a decrease in smokers from 14% to 11% in years one to two, with an additional 2% reduction every 10 years.

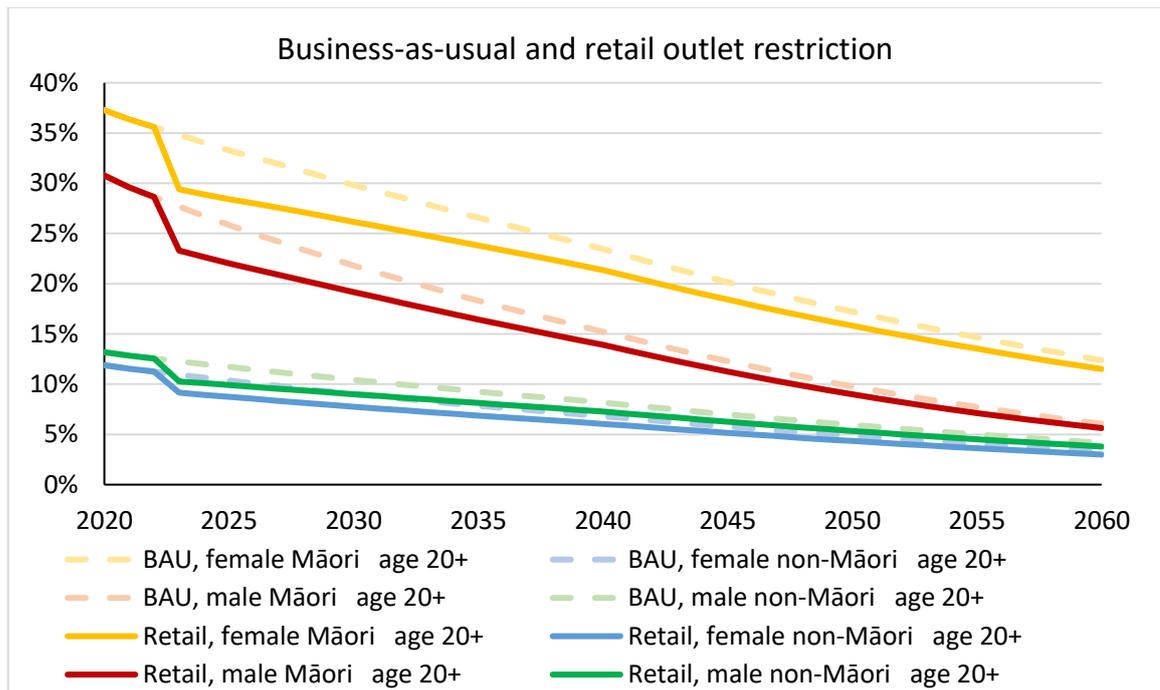
- set controls around store numbers, density, and proximity²⁹ and provide the framework to improve health equity across New Zealand
 - set criteria stores must meet before being considered as approved retailers (for example the ability to provide security, financial and record-keeping/reporting capacity and capability, physical and environmental conditions)
 - provide for robust enforcement and a hierarchy of penalties for breaches.
82. This option intervenes in the existing market rather than creating a fundamentally new market. It will support achieving the smokefree goal without taking more steps than necessary.
83. Other scenarios to give effect to a regulated market model considered but ruled out included establishing an agency or Crown entity to control all imports (effectively becoming the wholesaler of all tobacco in New Zealand) with selected retail stores acting as resellers on behalf of the agency and not keeping profits from sales. This scenario would involve much larger intervention and greater cost to implement. It would also shift the commercial risk of owning and stocking the product to the government. Requiring selected retail stores to own the tobacco products but return any profits from sales to the government would similarly add significant additional complexity and administrative cost with high risk and minimal benefit.
84. This is modelled³⁰ to not reach the smokefree goal for non-Māori until after 2050, and for Māori after 2060 as a stand-alone policy. However, it is an essential part of a combined package as it will reduce initiation, support people to quit and help people who have quit to remain smokefree. It will also address the inequitable burden of a disproportionate number of retailers being based in low socioeconomic areas.
85. The same modelling shows 80,200 HALYs could be gained over the lifetime of the 2020 New Zealand population compared to business-as-usual.³¹

²⁹ Store numbers could be determined by setting a total number or per population or area. Density controls can place minimum distances between approved retailers and proximity controls can mandate minimum distances between retailers and schools.

³⁰ Unpublished modelling commissioned by the Ministry of Health. Assuming reduction to approximately 5% of current outlets, implemented in 2023.

³¹ For all ages, by time-line into the future, 3% discount rate.

Table 5: Projections of age 20+ smoking prevalence (for daily smoking) for Māori and non-Māori to 2060, comparing business-as-usual (BAU) to retail outlet restriction (Retail)



How do the options compare to the status quo/counterfactual?

Assessment of options for reducing access to tobacco: Retailer reduction

| | Status quo – 5,000–8,000 retailers | Option 3a: Licensing tobacco retailers | Option 1b: Choose a specific type of retailer | Option 3c: Introduce a regulated market model |
|---|---|---|---|---|
| Reduces inequity | 0 Four times more retailers in low-income communities | 0 Unlikely to achieve significant reduction or prevent concentration in deprived areas | + | ++ Can achieve retail reduction with most precision to ensure retail supply is not concentrated in the most deprived areas |
| Decreases initiation especially for young people | 0 | + | + | ++ Easier to ban or restrict youth access and ensure underage sales |
| Increases likelihood of quitting | 0 | + | + | ++ Reduced access and more denormalisation More potential to require cessation services |
| Ease and cost of implementation | 0 | - High regulatory burden Medium cost | 0 Relatively straightforward to implement Will need a process to allow for exceptions in areas with poor access | -- Significant investment and set up required May need a process to allow for exceptions in areas with poor access |
| Would the policy be clear and workable | 0 No – many submissions supported reduced access to tobacco, for | 0 Broad support from retailers May not be as obvious what we are trying to achieve | 0 Selection may be seen as arbitrary | 0 May be seen as paternalistic |

| | | | | |
|---------------------------|---------------------------------|--|--|--|
| for New Zealand? | youth and people trying to quit | | Should be clear that we are trying to denormalise tobacco, particularly for youth | Should be clear that we are trying to denormalise tobacco, particularly for youth |
| Overall assessment | 0 | <p style="text-align: center;">+</p> <p>Costly and unlikely to achieve priorities around reducing retailer density and numbers</p> | <p style="text-align: center;">+</p> <p>Arbitrary choice with no guaranteed result</p> | <p style="text-align: center;">++</p> <p>More complex and costly to implement</p> <p>Provides best control of overall reduction in numbers, as well as proximity and density, and ensuring safe supply for those who continue to smoke</p> <p>Least disruptive to the market considering the policy intent</p> |

86. The preferred option is to introduce a regulated market model. While complex and costly to implement, is most likely to be successful in that it gives most control of overall reduction in numbers, as well as proximity and density, and ensuring safe supply for those who continue to smoke, while being least disruptive to the market considering the policy intent.

Affordability

Issue Four – Reduce affordability

87. The status quo is that excise taxes, payable under the Customs Act 2018, were last increased in 2020 (the final increase in a decade-long series of 10 percent annual increases), with no plans for further increases.
88. Increasing the excise tax again was excluded from scope by the Government and only minimum pricing was considered.

Option 4a Minimum pricing

89. Requiring a minimum price prevents manipulation of retail margins to reduce the impact of tax increases on low-end products. Surveys and annual returns by tobacco importers and manufacturers suggest that tax increases have resulted in tobacco companies raising the price of their premium brands disproportionately to their budget brands, thereby propping up the affordability of their budget brands. This has resulted in some consumers switching from premium to budget brands or to roll-your-own, leading to a growth of sales of budget brands. But there is also some evidence that people may be smoking less.³²
90. While support was strong for a minimum price from academics, health care professionals and advocacy organisations, it was mixed from personal submissions. Concerns were raised regarding equity and the fact that any additional costs would be passed to the tobacco industry as profit. Based on minimum unit pricing for alcohol in Scotland, there might be small adverse impacts on food expenditure.³³
91. Further analysis following consultation on this proposal showed that for maximum impact, a minimum price for tobacco would need to be implemented at the same time as other price measures such as increasing excise taxes. As excise taxes are off the table, a minimum price is unlikely to be effective.
92. Decreasing affordability means those who are most price sensitive will respond by quitting, but those who continue to smoke will be impacted financially. The additional costs of continuing to smoke will weigh heaviest on low-income groups, which may further increase inequities. A retailer reduction strategy would indirectly increase the price of all tobacco by increasing travel time and cost. Therefore, no additional price measures are recommended.

³² Tobacco returns and NZ Health Survey.

³³ Kopasker D, McNamee P, Ludbrook A, McKenzie L, Whybrow S. Minimum Unit Pricing for Alcohol: Unintended Consequences for Food Expenditure? International Health Economics Conference (Virtual Conference). 12 to 15 July 2021. Presentation 5025. <https://healthconomics.confex.com/healthconomics/2021/meetingapp.cgi/Paper/5025>.

How do the options compare to the status quo/counterfactual?

Assessment of options to reduce affordability of tobacco

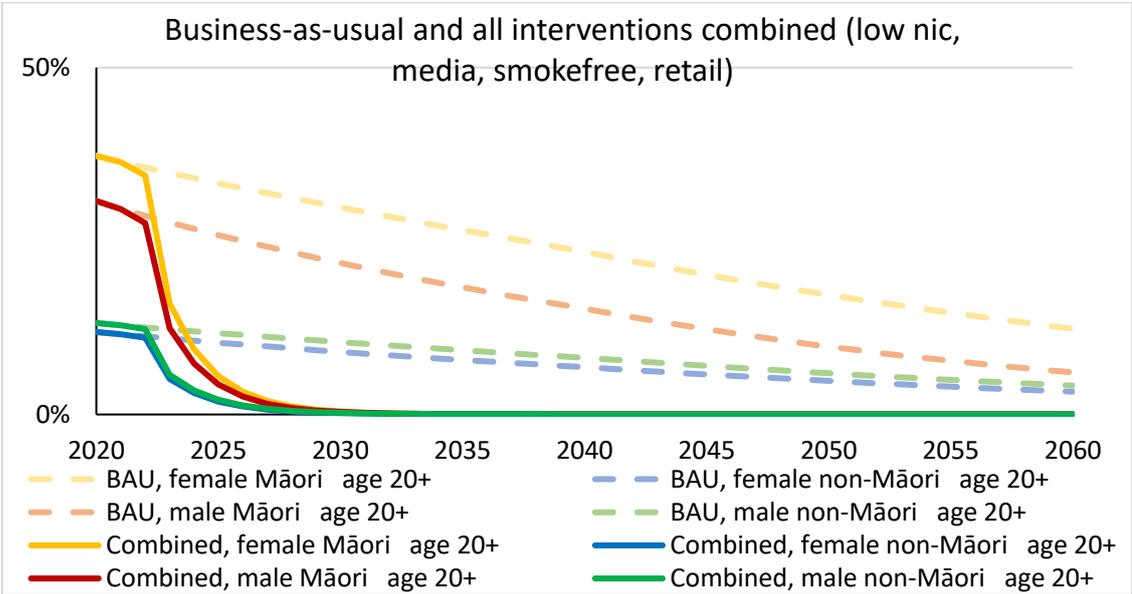
| | Status quo - no further excise tax increases are scheduled | Option 4a: Minimum price |
|--|--|--|
| Reduces inequity | 0 Current levels of excise tax have been shown to have increased prices, which have in turn decreased smoking prevalence No additional financial pressure (other than the CPI adjustment) on those who continue to smoke | + Likely reduce inequity in that it will lower rates of smoking May increase financial hardship and inequities in lower income households |
| Decreases initiation especially for young people | 0 No | + Limits development of low cost brands targeting youth and people who smoke and are on low incomes |
| Increases likelihood of quitting | 0 No | + Limits development of low cost brands targeting youth and people who smoke and are on low incomes |
| Ease and cost of implementation | 0 N/A | - Technically challenging |
| Would the policy be clear and workable for New Zealand? | 0 There is mixed support for raising cost of tobacco versus not causing further hardship to low-income families | - Likely to be seen as unfairly targeting people who smoke and are on low incomes, and increasing hardship Can communicate that it is intended to stop industry circumventing existing price policies |
| Overall assessment | + A retailer reduction strategy would indirectly increase the price of all tobacco by increasing travel time and cost. No additional price measures recommended | - Those who are most price sensitive will respond by quitting, but those who continue to smoke will be impacted financially Unlikely to be fully effective unless implemented with further excise tax increases (not planned) |

93. The preferred option is the status quo. A minimum price is not recommended because it may increase financial hardship and inequity, and in the absence of a resumption of excise tax increases it is unlikely to be fully effective.

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

- 94. Any single measure will not achieve an equitable Smokefree Aotearoa 2025. Implementing very low nicotine smoked tobacco products has the greatest potential for most population groups, however, the most significant impact comes from a combined package that targets appeal and addictiveness, retail availability and access, as follows:
 - reducing the appeal and addictiveness of tobacco products by:
 - i. setting maximum limits for nicotine content in smoked tobacco
 - ii. introducing powers to control product design
 - restrict access to and availability of tobacco products by:
 - i. raising the age of purchase for smoked tobacco via a smokefree generation policy
 - ii. significantly reducing retail availability through a regulated marked model.
- 95. While prohibiting the use of filters is beneficial, further work is needed to determine the best route for implementation.
- 96. The detailed design of these measures is important to obtain the most benefit and minimise undesirable consequences, including the potential for an increase in the availability of illicit tobacco products.
- 97. This combined package, along with media health promotion, is modelled to meet the smokefree goal in 2025 for Māori males and non-Māori males and females. It would come close to meeting the goal for Māori females, with a smoking prevalence of 5.6 percent in 2025. It would meet the goal for Māori females by 2026 (3.3 percent prevalence).
- 98. The same modelling shows 580,000 HALYs could be gained over the lifetime of the 2020 New Zealand population compared to business-as-usual (for all ages, by timeline into the future, 3 percent discount rate).

Table 6: Projections of age 20+ smoking prevalence (for daily smoking) for Māori and non-Māori to 2060, comparing business-as-usual to combined package of regulatory interventions + media (health promotion)



Package of recommended options

| | Status quo | Option 1a Mandate low nicotine cigarettes | Option 1c Regulatory power to regulate product design | Option 2c: Increase purchase age to achieve a smokefree generation | Option 3c: Introduce a regulated market model |
|---|------------|--|--|--|---|
| Reduces inequity | 0 | ++ Modelling has suggested this is the only policy that might, on its own, achieve the Smokefree Aotearoa 2025 goal for Māori | + Removes features arguably designed to appeal to youth who are less aware of risks and therefore more vulnerable | ++ Yes – pro-equity due to lower age structure of Māori and Pacific populations Sends strong signal that smoking is dangerous at any age | ++ Can achieve retail reduction with most precision to ensure retail supply is not concentrated in the most deprived areas |
| Decreases initiation especially for young people | 0 | ++ Will make cigarettes much less addictive, likely reducing uptake after experimenting | + Innovations such as crush balls and flavours particularly appeal to youth and people new to smoking | ++ Yes – will decrease initiation for young people May interrupt social supply in schools | ++ Easier to ban or restrict youth access and ensure underage sales |
| Increases likelihood of quitting | 0 | ++ Will make cigarettes much less addictive, supporting attempts to quit May increase switching from smoking to less harmful alternatives | + May make cigarettes less appealing, likely driving attempts to quit | + May somewhat – while focus is to decrease initiation, signalling there is no safe age to smoke, and denormalising smoking may increase likelihood of quitting | ++ Reduced access and more denormalisation More potential to require cessation services |
| Ease and cost of implementation | 0 | -- Technically challenging measure with difficulties that may not yet be understood The costs of testing tobacco to ensure it meets requirements could be paid for by importers, and tested by independent | - Straightforward to implement | -- May require increased compliance and enforcement Vulnerable to legal challenge | -- Significant investment and set up required May need a process to allow for exceptions in areas with poor access |

| | | | | | |
|--|---|--|--|--|--|
| | | laboratories specified by the Ministry of Health | | | |
| Would the policy be clear and workable for New Zealand? | 0 | <p style="text-align: center;">+</p> <p>Support from people who smoke wanting to quit – eg the ITC survey found 80 percent support if other nicotine sources were still available³⁴</p> | <p style="text-align: center;">+</p> <p>Strong support from submissions to restrict industry’s ability to circumvent regulations by innovating</p> | <p style="text-align: center;">+</p> <p>Support for this proposal was strong across all groups that submitted consultation responses, other than those commercially interested in tobacco</p> <p>Will require stakeholder work – may be viewed as prohibition</p> | <p style="text-align: center;">-</p> <p>May be seen as paternalistic</p> <p>Should be clear that we are trying to denormalise tobacco, particularly for youth</p> |
| Overall assessment | 0 | <p style="text-align: center;">++</p> <p>While technically challenging and untested in other jurisdictions, this option is most likely to achieve the 2025 goal, when implemented in conjunction with complementary measures</p> | <p style="text-align: center;">+</p> <p>Reduces appeal, particularly to youth</p> <p>Future proofs changes and prevents tobacco industry undermining the intentions of the action plan</p> | <p style="text-align: center;">++</p> <p>Addresses the various modes of supply for youth in that it increases purchase age to beyond when most people start and will reduce social supply. May also denormalise smoking sufficiently to increase quit attempts among those who already smoke</p> | <p style="text-align: center;">++</p> <p>While complex and costly to implement, gives most control of overall reduction in numbers, as well as proximity and density, and ensuring safe supply for those who continue to smoke, while being least disruptive to the market considering the policy intent</p> |

³⁴ [Beliefs among Adult Smokers and Quitters about Nicotine and De-nicotinized Cigarettes in the 2016-17 ITC New Zealand Survey https://doi.org/10.18001/TRS.5.5.1](https://doi.org/10.18001/TRS.5.5.1)

What are the marginal costs and benefits of the option?

| Affected groups | Comment | Impact | Evidence Certainty |
|---|--|--|--------------------|
| Additional costs of the preferred option compared to taking no action | | | |
| Regulated groups | <p>Regulated parties (retailers, importers of tobacco products) would see a significant decrease in business</p> <p>For 2020, the estimated annual New Zealand retail sales of smoked tobacco were \$3.1 billion, approx. 5–10 percent of this total represents retail margin. Tobacco industry margins are unknown</p> | Medium-High | Medium |
| Regulators | <p>Implementation:</p> <ul style="list-style-type: none"> - costs to establish and maintain a regulator estimated at \$13.5 million over 4 years - compliance and enforcement costs estimated at \$16 million over 4 years | Estimated in total at \$29.5 million over 4 years | Medium |
| Wider government | <p>Government: Excise taxes are currently \$1.9 billion per annum – while this seems to have begun to decrease, there is likely to be a marked decrease</p> <p>Illicit market likely to increase</p> <p>Legislative proposals may be challenged in relation to New Zealand’s international trade law obligations</p> | Medium-High depending on level of substitution for alternatives to smoking | Medium |
| People who smoke and their whānau | <p>For people unable to quit, there may be an increase in costs in time and travel, as well as direct cost increases. This may have a detrimental impact on low-income households.</p> <p>Changes to nicotine levels and availability may be distressing to some people</p> <p>More people may take up vaping / heated tobacco</p> <p>Some people may be tempted to engage with the illicit market, possibly engaging with organised crime</p> | Medium | Medium |
| Total monetised costs | | Not calculated | Medium |
| Non-monetised costs | | Medium | Low |
| Additional benefits of the preferred option compared to taking no action | | | |
| Regulated groups | Dairies and other small businesses may be less subjected to robberies | Unknown | Unknown |
| Regulators | Retail regulation facilitates compliance | Medium | Low |

| | | | |
|-----------------------------------|---|---|--------|
| Wider government | <p>New Zealand modelling shows that a combined package of low nicotine, retail outlet restrictions and smokefree generation, plus media health promotion, could lead to over 580,000 HALYs³⁵ gained, compared to BAU, over the lifetime of the 2020 NZ population³⁶</p> <p>Estimated savings in health spending</p> <p>Estimated income gain from increased productivity</p> | <p>High</p> <p>\$5.25 billion³⁷</p> <p>\$5.88 billion³⁸</p> | Medium |
| People who smoke and their whānau | <p>For those encouraged to quit, or switch to vaping there will be significant health benefits given that 4,500–5,000 people die per annum from smoking related causes</p> <p>There are also financial savings</p> <p>For 2020 the estimated annual New Zealand retail sales of smoked tobacco were \$3.1 billion. This will decrease significantly as consumption trends down</p> <p>If Smokefree Aotearoa 2025 is achieved, there will be significant tangible and intangible benefits for the smoker, their families and whānau and the wider community/economy</p> <p>Children will be less exposed to second-hand smoke and less likely to take up smoking</p> | High | Medium |
| Total monetised benefits | | At least \$11.13 billion | Medium |
| Non-monetised benefits | Over time a smokefree Aotearoa would significantly improve health and wellbeing, and significantly reduce health inequity. | High | High |

While not all impacts can be costed at this time, those that can suggest that the costs will be significantly outweighed by the benefits. As smoking rates go down, so will excise taxes. The resultant savings in health spending and income gain from increased productivity are estimated to far outstrip the reduced revenue from excise tax.

³⁵ HALYs, or health adjusted life years, for combined interventions, for all ages and ethnicities, by time-line into the future, 3% discount rate. Undiscounted HALY's are 2,210,000.

³⁶ Unpublished modelling commissioned by the Ministry of Health. Over 10 times the HALYs gained from a comparable health intervention – 10% annual tobacco tax increases from 2011 to 2025 for the total NZ population alive in 2011.

³⁷ 3% discount rate, NZD 2020. By timeline into the future, for all ages. Undiscounted this would be \$15.5 billion.

³⁸ 3% discount rate, NZD 2020. By timeline into the future, for 25–64-year-olds. Undiscounted this would be \$16.2 billion.

Section 3: Delivering an option

How will the new arrangements be implemented?

Legislative change

- 99. Implementation of the proposals requires amendments to the Smokefree Environments and Regulated Products Act 1990 and its regulations (including the development of new regulations). Changes may also be required to the Customs and Excise Act 2018 (imports and border enforcement) and the Waste Minimisation Act 2008 (filters).
- 100. A Smokefree Environments and Regulated Products Act amendment bill will be required, with a place on the 2022 Legislation Programme.
- 101. The Ministry will build transitional arrangements into the amendment bill where necessary.

| Milestone/Activity | Estimated Timeframe |
|--------------------------------|--|
| Release action plan | December 2021 |
| Issue drafting instructions | Tranche one: December 2021 Tranche two: February 2022 |
| Introduce Amendment Bill | June 2022 |
| Legislation in place | December 2022 |
| Implement smokefree generation | 2023 |
| Implement retail reduction | 2024 |
| Implement low nicotine | 2025 |

Regulatory powers, functions and duties

- 102. Regulations will set out the required technical details to bring these legislative proposals into full effect. A technical advisory group will be established to inform the regulatory requirements for product design to ensure their reduced appeal and addictiveness.
- 103. Regulatory powers are required in relation to:
 - extending the regulatory powers over the composition of smoked tobacco products (eg, reducing nicotine levels)
 - providing for application and testing requirements of smoked tobacco products
 - setting a progressively increasing age limit for legal sale of tobacco products (eg, introducing a Smokefree Generation policy)
 - significantly restricting where and how tobacco can be sold, including requirements such as safe and evenly distributed supply
 - enabling the Director-General to approve designated sellers
 - enabling the Director-General to notify the criteria, and run a process for issuing approvals

- requiring retailers to comply with the conditions of their approval, which could include providing stop smoking advice and/or referring to stop smoking services as needed.
104. Further development and advice will be provided in 2022 concerning proposals relating to the import of tobacco, compliance and enforcement, the illicit market, any fees, levies or payments, and transitional provisions.
105. The Ministry of Health, as the regulator, will administer any new regulatory functions that the proposed legislative changes create.

Cost and cost recovery

106. The Ministry will consider whether regulatory scheme costs should be recovered from industry through fees and/or levies, consistent with Treasury's Guidelines for Setting Charges in the Public Sector. Detailed work will be undertaken, and Cabinet decisions sought in early 2022.

Offences and penalties

107. New offences and penalties will be required for any new legislative obligations. Further work will be undertaken to identify these, as well as to review the existing offences and penalties set out in the Smokefree Environments and Regulated Products Act. Cabinet decisions will be sought in early 2022.

Enforcement

108. Enforcement of regulatory controls related to the sale and promotion of products, as well as their use in legislated smokefree areas, is the responsibility of Smokefree Enforcement Officers (SEOs) appointed by the Director-General of Health under the Act. The Ministry organises regular training for SEOs which will incorporate any changes to the Act and its regulations. The Ministry of Health is responsible for enforcing other parts of the Act related to vaping (eg, notification of products, adherence to product safety requirements).
109. Further work is needed to determine the scope and cost associated with extending the Act to cover, for example, retail supply reduction and any new smoked tobacco product requirements.
110. The illicit market has been increasing, and recommended policy changes are likely to exacerbate this. Customs will need more resource to enforce border control.
111. An important part of the new regulatory regime will be ensuring that there are enough SEOs in place to enforce these new requirements, and that this workforce has the training and professional support needed to do so.

Communications

112. The Ministry of Health is responsible for communicating changes to stakeholders, including industry and the public.

Risks to be managed or mitigated

Illicit market

113. Importers need a permit to bring tobacco into New Zealand, and they must pay excise tax. Illicit tobacco is that which is brought into the country without a permit or without paying excise tax. New Zealand Customs is responsible for compliance and enforcement at the border, as well as collection of excise tax. Data is collected on Customs' interceptions of illicit tobacco products. However, this is an imperfect measure, as the data only covers goods that are seized and not goods that avoid detection.

114. Customs estimates the illicit market is around six to seven percent of the overall market. Industry-funded research has calculated the illicit market as larger, though independent research suggests industry claims are typically exaggerated.³⁹
115. Customs advises that import of illicit smoked tobacco products has been growing and organised crime is now involved. New Zealand has, by comparison with most of the rest of the world, very high retail prices for legitimate tobacco products largely driven by a high rate of tobacco taxation. Any additional actions that will reduce the supply, availability and appeal of smoked tobacco products will add to the incentives to import illicit tobacco products. Additional resourcing is therefore required for compliance and enforcement.
116. Independent research is required to better understand the size of the illicit market and to measure the impact policy changes have upon it. The Ministry of Health is commissioning research to better understand the size and nature of the illicit market. This will involve establishing what the baseline situation is and then measuring change as the action plan measures take effect.

International trade implications

117. Several of the proposals will require consideration of New Zealand's international trade obligations. The trade agreements to which New Zealand is a Party permit us to take measures for the protection of human health.

Impact on people with mental health needs

118. Smoking prevalence is estimated at 40–50 percent for people with poor mental health (three times the general population rate). The more severe the mental health condition, the more likely the person is to smoke. People with a mental health condition have a 10–20-year reduced life expectancy – smoking is the single largest contributor to this.
119. For some people with mental health needs, cigarette smoking is used as a self-soothing behaviour, so mandating low nicotine is likely to cause stress, anxiety and withdrawal symptoms. However, smoking is not an effective means of managing a mental health condition. Although cigarette smoking reduces nicotine withdrawal symptoms, which are similar to the feelings of anxiety, it does not reduce anxiety or deal with the underlying causes. People with depression often have low levels of dopamine and using cigarettes stimulates the release of dopamine. However, smoking adversely affects the brain's natural mechanism for making dopamine so that, in the long term, the supply decreases. This can lead to increased smoking and may exacerbate depression.
120. For people with anxiety disorders who have made their nearest dairy or petrol station part of their routine, retail reduction might cause them to experience severe anxiety episodes having to travel elsewhere. Needing to travel to purchase cigarettes may add financial stress, or they may not have the means to travel far.
121. Stopping smoking improves physical and mental health, even in the short term. Stop smoking support offered to people with mental health needs has been found to be as successful as that offered to people who smoke in the general population. Studies have also shown quitting does not lead to deteriorated mental health, and successfully quitting can lead to lower anxiety.

³⁹ Stoklosa M, Is the illicit cigarette market really growing? The tobacco industry's misleading math trick. *Tobacco Control* 2016;**25**:360-361.

122. However, for people who were not intending to stop smoking, or who cannot access appropriate support, there may be negative consequences of suddenly having reduced or no access to their usual level of tobacco and nicotine. Exacerbated anxiety, self-harm or violence to families, use of other drugs or alcohol, and resorting to the black market are all risks.
123. We have added people who use mental health and addiction services to the Ministry of Health's priority populations for stop smoking services. Further possible actions include facilitating easier access to nicotine replacement products, and targeted and tailored smoking cessation support – both of which may have associated costs.
124. While people with mental health needs who smoke share many of the same challenges to quitting as other people who smoke, some aspects need to be tailored. For example, tobacco smoke interacts with some psychiatric medication, making it less effective and resulting in increased dosages. A person on Clozapine (an antipsychotic medication used in the treatment of schizophrenia) who smokes, for example, should have medication cut by 25 percent in the first week following a quit attempt. Smoking cessation services would need to be aware of issues such as this to adequately support people with mental health issues who smoke.
125. For some people with more limited mobility, significant retail reduction may have a disproportionate impact on them. For example, elderly, those with disabilities, or with transport limitations. The Ministry will consider how to mitigate or manage this risk in the further development and implementation of the policy.

Impact on small business

126. All the retail reduction options currently being considered will have an adverse effect on the small businesses that currently sell tobacco.
127. Tobacco retailers strongly opposed retailer reduction measures in their responses to consultation on proposals for the action plan. Many told us it would have a severe and possibly terminal impact on their business. However, research suggests this impact may be overstated. Retailers did ask that any retailer reduction measure treats them fairly and creates a 'level playing field'.
128. The Ministry will continue to work with the Ministry of Business, Innovation and Employment to consider the feasibility of providing support to small businesses.

How will the new arrangements be monitored, evaluated, and reviewed?

129. The Ministry of Health has established the Smokefree 2025 Taskforce to oversee the timely implementation of the action plan and to provide advice to the Director-General of Health and the Associate Minister of Health on progress towards eliminating inequities in smoking rates and smoking-related illnesses. The Taskforce is expected to meet at least quarterly up until the end of 2025.
130. The Ministry will continue to monitor emerging evidence on the prevalence of smoking, the impact of the proposed measures and progress towards the Smokefree Aotearoa 2025 goal. However, it may be difficult to disaggregate the effects of concurrent interventions.
131. Currently, the overall trends in tobacco sales are tracked by annual tobacco returns supplied to the Ministry of Health by importers and manufacturers. Data is also collected on interceptions of illicit tobacco products by Customs. Research will be carried out on the baseline size of the black market and measure changes to it once the policies are implemented.

132. Through the proposed regulation of retail outlets, data will be collected on tobacco retail sales, which will allow more detailed evaluation and further targeting of tobacco control measures. Proposals relating to product appeal and addictiveness may require product notification or pre-market approval and ongoing product testing (of nicotine levels). Ongoing compliance activity will also be required to ensure regulated parties adhere with new requirements.
133. The following surveys also contain information that will be useful for monitoring the prevalence of smoking:
- *the Health Promotion Agency's biennial Health and Lifestyles Survey (a nationwide survey on the health and lifestyles of adults aged 15 years and over)*
 - *the Ministry of Health's annual New Zealand Health Survey (a nationwide survey of people aged 15 years and over)*
 - *the annual Action on Smoking and Health year 10 snapshot survey (a survey of 20,000 to 30,000 year 10 students)*
 - *Youth2000 (a nationwide survey of 7,700–8,500 students from secondary schools).*
134. The Ministry will develop a monitoring and evaluation plan to sit alongside the action plan. This will bring all these sources of information together and identify any gaps. Progress will be reported regularly to the Smokefree Aotearoa 2025 Taskforce, the Minister and the public.