Impact Summary: Proposals for a Smokefree Aotearoa 2025 Action Plan

Section 1: General information

Purpose

The Ministry of Health (the Ministry) is solely responsible for the analysis and advice set out in this Regulatory Impact Statement, except as otherwise explicitly indicated. This statement has been produced to accompany a Cabinet paper that seeks agreement to publicly consult on options for legislative change to achieve a Smokefree Aotearoa by 2025, and to accompany the public consultation document.

Key limitations or constraints on analysis

A Smokefree Aotearoa 2025 Action Plan is a government priority (Ministry of Health 2019). It is well established that smoking is both harmful to health and addictive, limiting the ability of smokers to make rational choices to limit this harm. Partial or complete deregulation is therefore not considered. An outright ban on smoking or on importing tobacco has also been ruled out. Non-regulatory options outlined in the discussion document are not considered in detail.

This Regulatory Impact Statement therefore considers a range of options that could be implemented under the Smokefree Environments and Regulated Products Act 1990[1] and the Customs and Excise Act 2018. It does not consider replacing or revoking existing measures.

Most of the measures that we are considering are not yet widely implemented internationally and, in some cases, New Zealand would be world leading in implementing them. For this reason, there is significant uncertainty of the outcomes. While a strong body of research exists around the likely impacts of these measures, comparable markets have not evaluated them extensively and modelling of their effect is limited.

For example, strong evidence indicates that removing the nicotine from tobacco makes it unattractive to many smokers. Very low nicotine cigarettes are available and have been for some years, making this policy technically feasible. However, no country has mandated this change to date, so there would be implementation difficulties to overcome, and evaluation from comparable markets is lacking.

Potential impact is estimated based on available evidence, modelling by New Zealand researchers where available and expert opinion. This includes considering how likely it is that the measures will reduce the prevalence of smoking and the impact on equity where this can be assessed, as well as potential issues in implementation. We have used previous consultation and consumer research in related areas to inform likely public opinion on measures.

We will undertake consultation on the draft action plan discussion document and will use that feedback to inform the final Regulatory Impact Statement.

[1] The name of this Act changed on 11 November 2020. It was formerly known as the Smoke-free Environments Act 1990.

Responsible Manager (signature and date):
Sally Stewart Manager, Tobacco Control Programme Population Health and Prevention Ministry of Health

To be completed by quality assurers:

Quality Assurance Reviewing Agency:
Ministry of Health
Quality Assurance Assessment:
The Ministry of Health QA panel has reviewed the Impact Statement titled “Proposals for a Smokefree Aotearoa 2025 Action Plan”, produced by the Ministry of Health and dated March 2021. The panel considers that the Impact Statement **meets** the quality assurance criteria.
Reviewer Comments and Recommendations:
The Impact Statement is clear, complete, considered and concise, and suitable for a consultation paper. The analysis is balanced in its presentation of the information and the major impacts are identified and assessed.

Section 2: Problem definition and objectives

2.1 What is the policy problem or opportunity?

Tobacco use is the single biggest cause of premature death and ill health in New Zealand. An estimated 4,500 New Zealanders die from smoking-related illnesses each year. The health impacts linked with tobacco use include lung cancer, respiratory disease and cardiovascular disease. Smoking-related illnesses disproportionately affect Māori and Pacific peoples and contribute to significant health inequities. For example, Māori women have some of the highest mortality rates for lung cancer in the world (New Zealand Parliament 2010).

It is well established that smoking is not just harmful, but also highly addictive because of the effects of nicotine. Smokers often state that they wish to quit, but in reality find they cannot. Regulatory intervention is therefore an appropriate response as a way of reducing the availability of tobacco products and their appeal to smokers.

We have made progress in reducing the harms from smoking but there is still opportunity for improvement. In 2011 the Government set a goal for a Smokefree Aotearoa by 2025. We have taken actions to support this goal, but additional measures are needed.

Several policy opportunities exist within the legislative system. The tobacco control programme has focused primarily on reducing demand and denormalising smoking through influencing consumer choice and behaviours. While this approach has had some success, more could to be done at a population level to change the broader smoking environment by considering the availability, appeal and addictiveness, and affordability of tobacco products.

Additionally, the emergence of vaping products could provide a way for adult smokers to access nicotine without facing all the risks associated with using combustible tobacco products. It also provides a new context for considering regulation of combustible or smoked tobacco products, and the harm they cause.

2.2 Who is affected and how?

The purpose of the policy measures we discuss in the following section is to decrease the number of smokers in New Zealand. In 2019/20, 11.6 percent of adults overall were daily smokers (28.7% of Māori; 18.3% of Pacific peoples; 10.1% of European/Others; 7.4% of Asian). On average, each smoker smoked 9.4 cigarettes per day in 2019/20, down from 11.2 in 2011/12 (Ministry of Health 2020a).

Broadly, rates of smoking have been declining. However, Māori have the highest smoking rate of any population group in New Zealand and have the poorest overall health status. Over time the percentage gaps between Māori and Pacific young people and other ethnicities seem to have widened (ASH 2019).

Māori women have New Zealand's highest smoking rates. The largest inequities are among Year 10 girls (aged 14 to 15 years): in 2019, 6.3 percent of Māori girls smoked daily compared with 0.9 percent of non-Māori, non-Pacific girls in Year 10. These inequities have increased in recent years as the smoking rate for non-Māori, non-Pacific girls of this age has decreased much faster than the rate for Māori girls.

These inequities carry through into young adulthood, including during pregnancy. For example, among pregnant Māori women who presented to a lead maternity carer for the first time in the first quarter of 2020/21, 35 percent smoked.

Quitting provides clear health and financial benefits to smokers and their whānau. It also brings benefits to New Zealand's health system more broadly.

Given tobacco is sold commercially(sales amounted to $3.2 billion in 2019), decreases in sales will affect retailers and importers of cigarettes. The Government also collects

around $2.1 billion in excise taxes each year on tobacco. Retailers who sell vaping products may benefit if smokers choose to swap to less harmful vaping products rather than quitting altogether. Conversely, the number making this swap will affect the extent of any negative financial impact on retailers who offer tobacco products only.

Any measures that affect the availability, appeal or addictiveness, or affordability of tobacco products are likely to be linked to increases in attempts to import illicit tobacco products. This trend is particularly likely with measures related to affordability, but all measures we consider in the next section could potentially lead to an increase in illicit trade in tobacco. The New Zealand Customs Service advises that issues with imports of illicit tobacco are growing, and considers that such imports could be around 6 to 7 percent of the overall market.

For more information on the context of tobacco smoking in New Zealand, see the appendix.

2.3 What are the objectives sought in relation to the identified problem?

A Smokefree Aotearoa 2025 Action Plan is a Government priority and focuses on an objective of achieving a Smokefree Aotearoa. It interprets this objective as achieving a prevalence of daily smoking of less than 5 percent. The discussion document also suggests three outcomes: eliminating inequities in smoking rates and smoking-related illnesses; increasing the number of children and young people who remain smokefree; and increasing the number of people who successfully stop smoking.

Section 3: Options identification

3.1 What options have been considered?

We have a variety of regulatory options available to address smoking rates. These can be broadly categorised into three themes: access to tobacco; the availability and addictiveness of tobacco; and the affordability of tobacco.

Theme One: Access to tobacco

Tobacco is widely available in New Zealand. There are no restrictions on who may retail tobacco, and anyone over the age of 18 years may purchase it, in any quantity. However, the Customs and Excise Act 2018 requires anyone importing tobacco products to have a permit issued by the New Zealand Customs Service.

Currently tobacco is available in at least 5,000 retail outlets (which amounts to around one for every 100 smokers) and the total could extend to as many as 8,000 outlets. An estimated 80 percent (or more) of these outlets are convenience stores, service stations, on-licensed premises and supermarkets. Fifty-four percent of secondary schools have at least one tobacco outlet within 500 metres of their location (Marsh et al 2013). Outlets are also highly concentrated in disadvantaged neighbourhoods. Evidence further indicates that smoking rates are higher in areas where the density of stores selling tobacco is higher.

Licensing tobacco retailers

Unlike other high-risk or harmful products such as alcohol, some pharmaceutical products, and firearms, tobacco products have no regulatory measures relating to retailer licensing.

Based on the few published evaluations that are available, tobacco retail licensing schemes appear to increase compliance with youth access restrictions and may also reduce the availability of tobacco in retail outlets, even if that was not the primary intention of the scheme. Examples of jurisdictions with licensing 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 (Thornley et al 2017a).

Licensing could also potentially help to reduce the sale and distribution of illicit tobacco products.

Measures to significantly reduce retail outlets

Modelling suggests that reducing the number of retail outlets to 300 (approximately one for every 1,600 smokers) could have a positive effect by increasing travel time to outlets and eliminating impulse purchases (Pearson 2015).

Measures to reduce the number of retail outlets can involve either a managed reduction process or limiting sales to specific retailers. A phased reduction process could take place over three to five years – possibly by first allowing current retailers to opt in to registration, then imposing criteria over time by not allowing new retailers to enter the market, and then including additional population density measures to prevent clustering of outlets. A further option would be to add specific requirements such as limiting the proximity of outlets to schools or playgrounds, or restricting sales of retail tobacco in on-licensed premises. Grandfathering existing outlets[2] without imposing additional criteria such as population density would not be enough to reduce outlets by the target of about 95 percent.

An alternative approach would be to limit supply to specialist retailers. One suggestion is that pharmacies could fill this role. However, a survey found that only 26 percent of pharmacists were likely or very likely to want to take on this role (van der Deen and

[2] This would mean that existing retail outlets would be allowed to continue but no new licences would be issued

Wilson 2018)). Modelling has also examined the impact of restricting sales to liquor stores (R18) (Marsh et al 2020a).

The drawback of using specialist suppliers is that all current retailers will need to exit the market. This approach may disadvantage small retailers and, for this reason, stakeholders preferred a phased reduction or sinking lid over this approach (Thornley et al 2017a). However, it could also minimise losses to existing retailers, as newly licenced retailers would not be competing for sales of food, beverages and other items commonly bought alongside tobacco.

Impacts on small stores may be overstated, however. Recent research shows that only around 14 percent of sales include tobacco, and of those only 6 percent include both tobacco and other products. Further, profit margins on tobacco products may be small; for example, a study in the United Kingdom indicates a 5 percent profit (Marsh et al 2020b).

Measures to limit the availability of tobacco to particular age groups

Currently 3 percent of daily smokers are aged 15 to 17 years (around 13,920 out of 494,000 total smokers). Another 12.9 percent or 63,926 people are aged 18 to 24 years (Ministry of Health 2020a).

Increasing the purchase age limit may be effective in stopping young people from starting smoking (most people who smoke begin by the age of 26 years). Van der Deen et al (2018) undertook modelling studies of stand-alone policies to achieve a Smokefree Aotearoa. They found a smokefree generation policy that increases the age of purchase by one year every year would achieve this goal most quickly: if the policy had been implemented in 2011, it would have achieved a Smokefree Aotearoa by 2027 for non-Māori and 2035 for Māori. Implementing this policy would mean young people aged under 18 years at the time of implementation could never legally be sold smoked tobacco.

Policies based on increasing age limits have been considered in other markets internationally. For example, in parts of the United States, increases in the age of purchase to 21 years are either under consideration or have recently been implemented. This measure was also considered in Tasmania but has not been implemented.[3] An alternative option is therefore to make a stand-alone increase to the age of purchase to 20 or 21 years. This measure, however, would have a limited effect compared with a smokefree generation policy.

Age limit measures will only gradually take effect, and not impact existing smokers. They will limit rights but it may be possible to justify this limitation under the New Zealand Bill of Rights Act 1990 on public health grounds. The public may have mixed views on these options; for example, they may see the smokefree generation policy as a type of prohibition. It would be important to be clear that the policy focuses on sale only, and uses a harm reduction approach, rather than taking a punitive approach to low-level offending. Some young people may still continue to take up smoking where they are able to obtain cigarettes from friends or whānau.

Table 1 summarises the pros and cons of the options discussed to address the issue of access to tobacco. This finds that the most effective options are combinations of licencing and restriction of retail outlets or a smokefree generation policy.

[3] For US, see https://tobacco21.org/ For Tasmania, see www.tobacco21.com.au/

Table 1: Comparison of options for reducing access to tobacco

Options	Pros	Cons
Option 1: Status quo 5,000 to 8,000 retailers Purchase age 18	Some measures in place to ensure that rangitahi under 18 are not able to purchase tobacco.	Will not achieve Smokefree 2025.
Option 2: Introduce retailer licensing	International precedent for this approach. Denormalises smoking. Supports compliance activity and monitoring.	Will not achieve Smokefree 2025.
Option 3: Licensing and phased reduction of retail outlets	Likely to have a strong impact. Reduces opportunities for smokers to purchase cigarettes, potentially eliminating impulse purchase. Could stop cigarette retailers clustering in lower-income areas, and sales of cigarettes alongside alcohol in on-licensed premises, or close to schools. Phased reduction may take time to implement and have an impact.	Requires a licensing system and criteria to identify and manage retailers. From a business perspective, restricts potential for market growth. Smokers who cannot quit or switch will have increased travel costs.
Option 4: Licensing and specialist retailers	Likely to have a strong impact. Reduces opportunities for smokers to purchase cigarettes, potentially eliminating impulse purchase. International precedent for this approach. Could lead to a faster reduction to a low number of retail outlets.	Does not treat all retailers the same (ie, not a level playing field). Smaller retailers may be financially disadvantaged if no longer able to sell tobacco. Pharmacies or other specialists may not want to sell tobacco.
Option 5: Increase purchase age to 20 years	May reduce number of young people smoking. International precedent for this approach	Will not achieve Smokefree 2025. Does not affect existing smokers.
Option 6: Purchase age increases: smokefree generation	Modelled potential to reach Smokefree Aotearoa as a stand-alone measure. Effective to reduce numbers of young people starting smoking.	May have a negative response from stakeholders as 18 is generally considered the appropriate age of majority in New Zealand. Does not affect existing smokers.

Theme Two: Appeal and addictiveness

An underdeveloped area of tobacco control policy in New Zealand is regulation of the product itself. Recent amendments through the Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020 enable product safety standards to be set for vaping and smokeless tobacco products and require pre-market notification of these products.[4]

In contrast, New Zealand has no effective controls on how smoked tobacco products (the most harmful form of nicotine delivery) are designed and manufactured, or on their constituents or emissions. Regulating tobacco products has the potential to contribute to reducing tobacco-related disease and premature death by reducing the attractiveness, addictiveness and overall toxicity of tobacco products.[5]

Nicotine levels can vary between brands. In addition, the tobacco industry uses a range of features and ingredients to enhance the appeal of tobacco, such as menthol and other flavour additives, as well as filters with or without flavoured crush balls. Through such measures, it can maximise the appeal and addictiveness of tobacco products to encourage uptake by young people and minimise the number of smokers who quit.

Reducing addictiveness by mandating very low nicotine cigarettes

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 substantially increase their risk of morbidity and mortality. Because of nicotine addiction, many smokers are unable to choose to stop smoking despite their stated desire to quit.

Significantly reducing the level of nicotine in smoked tobacco products would likely contribute towards achieving Smokefree 2025 by helping smokers to quit and preventing experimenters (mainly young people) from becoming regular smokers.

Studies have compared use of control cigarettes that have 15.8 mg nicotine per gram of tobacco with use of cigarettes that have only 0.4 mg/g nicotine among smokers who are not currently interested in quitting. The results indicate the use of the cigarettes with a lower level of nicotine leads to decreased nicotine exposure, decreased cigarette dependence, fewer cigarettes smoked per day and increased likelihood of contemplating or making a quit attempt (Donny et al 2017; Robert Wood Johnson Foundation 2018).

Some studies have also showed that switching to very low nicotine cigarettes results in a reduced number of cigarettes smoked per day, reduced nicotine dependence and minimal evidence of withdrawal distress or increased depression. On the other hand, other researchers have reported the use of very low nicotine cigarettes did not change the number of cigarettes smoked per day, but they observed reductions in cotinine and carbon monoxide levels (Food and Drug Administration 2018).

In a 2018 study, participants were assigned very low nicotine or standard cigarettes. After six weeks the participants were asked to stop smoking their assigned cigarettes overnight. The participants who were using very low nicotine cigarettes reported less intense withdrawal symptoms the following morning than those smoking cigarettes with normal nicotine content (Sardin 2018).

Low nicotine cigarettes have been available since the 1970s and can be manufactured using three main methods – degradation, extraction and genetic engineering. Examples of these products are the Moonlight brand and Phillip Morris 'Next'[6] cigarettes.

However, while feasible, this policy measure is innovative and technically challenging. Challenges include the need to:

- clarify the potential to include cigarillos and cigars in the measure, and if they cannot be included, take steps to mitigate any unintended consequences

[4] More information on law vaping reform is available on the Ministry's website https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/vaping-smokefree-environments-and-regulated-products

[5] https://www.who.int/fctc/guidelines/Guideliness_Articles_9_10_rev_240613.pdf

[6] Philip Morris produced Next brand de-nicotinised cigarettes in the 1980s. This brand name is still used, but for lower-price standard nicotine cigarettes in some overseas markets.

- set the mandated level, making sure it is below the level at which the nicotine present sustains addiction in a majority of the population (Food and Drug Administration 2018)
- have testing capability, preferably New Zealand based, to facilitate compliance.

Internationally, the United States regulator, the Food and Drug Administration, has announced plans to reduce nicotine levels in combustible cigarettes to make them minimally or non-addictive. In March 2018, it issued advance notice of proposed rulemaking, 'Tobacco product standard for nicotine level of combusted cigarettes' (Food and Drug Administration 2018), to obtain information for consideration in developing a tobacco product standard to set the maximum nicotine level for cigarettes.

Restrict use of menthol or other additives

Menthol has a minty flavour and a numbing effect when inhaled, making the experience of smoking tobacco less harsh and irritating, which in turn leads to greater absorption of nicotine through deeper inhalation (WHO 2016, p 37).

Menthol cigarettes represent 10 percent of the cigarette market across 40 countries and are more likely to be used by children and young adults, women and ethnic minority groups (WHO 2016, p 18). In New Zealand, menthol cigarette sales accounted for 9.8 percent of the total cigarette market in 2018. Thirteen percent of smokers in the 2016/17 International Tobacco Control (ITC) study reported using menthol cigarettes, similar to the level in the 2007 ITC study (McKiernan et al 2019).

Use of menthol cigarettes is linked with addiction, particularly among children and young people, as menthol smokers show greater signs of nicotine dependence and less success in quitting smoking. This association, combined with menthol's anaesthetic properties (which reduces the harshness of cigarette smoke), may make it a more significant public health risk than non-menthol cigarettes (WHO 2016).

We note that many other countries have moved to regulate flavoured tobacco products, primarily because characterising flavours have been linked to the appeal and uptake of tobacco, particularly among young people. For example:

- Canada prohibits the sale of all flavoured cigarettes, blunt wraps (wraps made from tobacco) and little cigars, including menthol cigarettes
- Brazil has banned all tobacco product flavours and additives, including menthol
- the European Union bans flavourings including menthol in cigarettes and roll-your-own tobacco, and flavoured capsules in tobacco products (European Parliament 2014; FCTC WHO Framework on Tobacco Control Secretariat 2016)
- several Australian states (New South Wales, Victoria and South Australia) and the Australian Capital Territory (ACT) have legislation that enables the prohibition of tobacco products or classes of products that have a distinctive fruity, sweet or confectionery-like character and/or might encourage a minor to smoke.

Evaluations on the impact of removing additives are limited because this is a newly emerging area of tobacco control (Thornley et al 2017a). However, this option has a strong rationale. It is highly plausible that additives enhance the appeal and palatability of cigarettes, particularly for young people and those trying to quit. They may also make smoking more addictive.

Reducing appeal by removing filters

Filters contribute to the appeal of cigarettes, with some smokers under the misconception that these mitigate the harm of smoking. For this reason, a ban on filters is also proposed as a part of a broader package of measures reducing appeal. It can be implemented quickly, will make cigarettes less palatable, and removes a source of toxic litter and microplastics from the environment (Gersberg et al 2011; Keep New Zealand Beautiful 2019). The ban will also remove a key source of innovation in cigarette product design in that many filters also contain flavourings through the use of 'crush balls'.

Cigarette filters were created in the mid-twentieth century to keep loose tobacco out of smokers' mouths. Subsequent epidemiological research linking smoking to lung cancer led the tobacco industry to make filters a standard feature of cigarettes and promote this as a harm reduction feature. This led, in turn, to a shift in products marketed and used. In 1960, 51 percent of all cigarettes sold in the US were filtered; by 2005 this figure had increased to 99 percent (Wallbank et al 2016).

Filters, however, have no health benefits; more than that, they can result in greater harm (Harris 2011). Filters increase risk, first, by reducing health concerns, so that more people take up smoking and more postpone their quit attempts. Second, deeper inhalation of filtered cigarettes produces elevated levels of nicotine, which has resulted in a shift in cancer diagnoses from squamous cell carcinomas to more aggressive adenocarcinoma as the most common form of lung cancer in much of the world (Brooks et al 2005; Ito et al 2011).

Discarded filters or 'butts' are made of non-biodegradable cellulose acetate. This litter is a source of contamination in waterways and contains a variety of toxic chemicals such as arsenic, lead, copper, chromium, cadmium and polycyclic aromatic hydrocarbons.

Removal of filters also effectively removes a key source of product design innovation. Many filters now contain flavoured crush balls, which can provide menthol and other flavours. Other flavourings are also available internationally such as sweet or fruity, coffee and alcohol based. These flavourings can undermine efforts to reduce the use of these products, with evidence showing that experimentation has a gateway effect, leading to more regular smoking (Huang et al 2017).

Prohibit product innovations

Including a broad regulatory power to prohibit product innovations would substantively remove the ability of manufacturers to innovate or develop ways to sidestep regulatory measures. This power could cover additives, ingredients, manufacturing methods, types of wrappers and inclusions on or with cigarettes or designed to be used with cigarettes. How much this power would impact on smoking rates would depend on how it was used.

Table 2 summarises the pros and cons of the options discussed above to address the issue of the appeal and addictiveness of tobacco.

Table 2 Comparison of options to reduce the appeal and addictiveness of tobacco

Options	Pros	Cons
Option 1: Status quo No measures	From, a business perspective, manufacturers are free to design innovative products.	Will not achieve Smokefree 2025.
Option 2: Mandate low nicotine cigarettes	Will make cigarettes much less appealing, likely driving attempts to quit and reducing initiation/uptake of smoking.	Technically challenging measure with difficulties that may not be understood. May require a product notification system. From a business perspective, restricts potential for market growth.
Option 3: Restrict use of filters	May increase switching from smoking to less harmful alternative. Removes potential for misleading smokers about the harmfulness of cigarettes through use of filters. Removes potential for some product innovations such as flavoured crush balls. Removes a significant source of non-biodegradable rubbish and microplastics from the environment.	Is complementary to other measures – will not achieve significant reduction in smoking as a stand-alone measure. From a business perspective, restricts potential for market growth.
Option 4: Restrict use of menthol	May increase switching from smoking to less harmful alternatives. May reduce initiation/uptake of smoking.	Is complementary to other measures – will not achieve significant reduction in smoking as a stand-alone measure.
Option 5: Provide regulatory power to prohibit product innovations	Will allow regulators to make additional changes to limit new product innovations if necessary.	Decreases in tobacco appeal or usage depend on how it is used. Is reactive so does not enable us to get in front of innovations to increase uptake and keep smokers smoking.

Theme Three: Affordability

Excise tax increases

Excise tax increases and other financial measures can still have an impact. The 2017 evaluation by Ernst & Young concludes that excise increases are the single most effective tool currently used. A broad range of evidence supports the efficacy of tobacco price increases in preventing smoking. For example, the World Bank estimated that a 10 percent rise in the cigarette price results in a decrease in smoking of 7 percent among young people and 4 percent among adults (Thornley et al 2017a). Ernst & Young (2018) found a price elasticity relationship of –0.5, meaning that for every extra dollar collected in excise tax, people spent 50 cents less on cigarettes. Yet modelling by the University of Otago shows that, while additional 10 or 20 percent increases will have a substantial effect on smoking rates, it will not achieve Smokefree 2025 without other policy intervention (Thornley et al 2017a).

Low-income smokers who quit as a result of tax increases will be financially better off. Conversely, the financial burden on those who struggle to quit smoking will increase. Some research suggests that hardship may have increased in low-income smokers following recent tax increases. Affordability measures are therefore only recommended if stop smoking services and social marketing programmes are also scaled up. The Ernst

& Young report found divided views among stakeholders: while some supported continued tax increases due to their demonstrated effectiveness, others felt that perhaps a tipping point had been reached at which the negative impacts, such as financial burden on vulnerable community members and their families, now outweigh the positive impacts of this policy. Additionally, cigarette prices in New Zealand are now relatively high in comparison with those in some other countries.

The New Zealand Customs Service also reports that tax increases over time seem to correlate with increasing illicit tobacco activity, in turn increasing the level of resourcing required to manage illegal tobacco imports.

Minimum pricing

Requiring a minimum price for cigarettes could prevent manipulation of retail margins to reduce the impact of tax increases on low-end products. It could also act as a stand-alone measure to reduce potential development of new low-price cigarettes.

Surveys and annual returns by tobacco importers and manufacturers suggest that tax increases have been linked to switching between premium and budget brands or to roll-your-own, and the growth of sales of budget brands, but there is also evidence that people may be smoking less (Ministry of Health 2020a). We will seek further information through consultation to determine an optimum level for a minimum price.

Other financial measures not recommended

Alternative financial measures that could be considered are requiring a minimum mark-up and setting a price cap. We do not recommend either of these measures. The retail price alone would not clearly show whether a retailer was complying with a minimum mark-up; instead it would be necessary to disclose commercially sensitive information around wholesale and retail pricing. Equally a price cap may depress the effect of ongoing excise tax increases.

Table 3 summarises the pros and cons of the options discussed above to address the issue of the affordability of tobacco.

Table 3 Comparison of options to reduce affordability of tobacco

Options	Pros	Cons
Option 1: Status quo Excise tax is payable under the Customs and Excise Act 2018. No increases are scheduled.	Current levels of excise tax have been shown to increase prices, which have in turn decreased smoking prevalence. No additional financial pressure (other than the Consumer Price Index adjustment) on those who continue to smoke.	Will not achieve Smokefree 2025.
Option 2: Continue excise increases	Affordability is still a key driver to quitting and preventing new smokers starting, so likely to be successful. Previous measures have shown that a price/purchase elasticity of around -0.5. Likely to strongly support equity.	For low-income smokers who are unable to quit, increasing prices contribute to hardship. May lead to increases in the illicit market, requiring additional compliance resources.
Option 3: Minimum price	Likely to be effective and strongly support equity. Limits development of low-cost brands targeting youth and low-income smokers.	Effectiveness depends on the price level set. May lead to increases in the illicit market, requiring additional compliance resources.
Option 4: Continue excise tax increases, along with a minimum price	Combining an excise increase with a minimum price will gain the greatest impact from increases by preventing the development of new low-price variants in response to tax increases. Overall impact will be determined by the size of the increase and the level of the minimum price.	Smokers who are unable to quit will face additional costs. May lead to increases in the illicit market, requiring additional compliance resources

3.2 Which of these options is the proposed approach?

The discussion document identifies options considered most likely to achieve the goals of a Smokefree Aotearoa 2025 Action Plan. We have decided on the options using the available evidence base, such as New Zealand modelling and international best practice. It is likely that manufacturers and retailers of tobacco products will oppose the proposed measures. Smokers and their whānau are likely to have mixed views about them. Health promotion and community interests will likely be in favour.

Many of the options considered will strongly contribute to the goal of a Smokefree Aotearoa. However, none will achieve Smokefree Aotearoa by 2025 as a stand-alone policy. A package of options addressing each of the issues discussed in this section (availability, appeal and addictiveness, and affordability) may together allow New Zealand to meet the goal of a Smokefree Aotearoa.

Table 4 lists options presented in the discussion document.

Table 4 Options to achieve the goals of a Smokefree Aotearoa 2025 Action Plan

Issue	Status quo	Options included in consultation
Access to tobacco	• 5,000 to 8,000 retailers • Purchase age 18 years	• Significantly reduce retail outlets through a phased reduction process or by limiting to specific retailer types (includes licensing of retailers).
		• Implement purchase age measures to enable a smokefree generation.
Appeal and addictiveness	• No measures	• Mandate very low nicotine cigarettes/smoked tobacco.
		• Ban the use of filters.
		• Provide regulatory power to address product innovations.
Affordability	• Excise taxes, last 10 percent increase 1 January 2020	• Require a minimum price.

A coordinated approach with a number of policy measures implemented as part of a larger programme is most likely to achieve a Smokefree Aotearoa. Indicative modelling by van der Deen et al (2018) shows that age limit increases, tax increases and a substantial reduction in outlets will each have an effect, but that the greatest effects occur with a combined approach.

Some of the options suggested, such as reducing retail outlets, can be implemented in a variety of ways, and the final impact will depend on the method chosen. We will refine the final options using stakeholder input through consultation as well as additional modelling (where required).

We will amend the analysis in this Regulatory Impact Statement following consultation, using feedback on the discussion document to finalise proposals for Cabinet to consider. This will include further consideration of impacts on retailers, smokers unable to quit or swap to a less harmful option, and how the illicit market might respond to these preferred options.

Section 4: Impact analysis (proposed approach)

4.1 Summary table of costs and benefits

Affected parties	Comment	Impact	Evidence certainty
Additional costs of proposed approach, compared with taking no action			
Regulated parties	Regulated parties (retailers, importers of tobacco products) would see a significant decrease in business.	Medium–High	Medium
Regulators	Implementation costs – estimated as a total of $1-2 million over 5 years. This includes: • costs to establish and maintain a regulator • compliance and testing costs (other than border related compliance costs).	Low	Medium
Wider government	Excise taxes are currently $2.1 billion per year. Overall excise tax take may vary over time depending on the impacts of policies.	Medium–High depending on level of substitution for vaping and smokeless tobacco products	Medium
Other parties	Smokers unable to quit may experience an increase in time and travel costs, as well as in direct costs, which will impact on them and their whānau.	Medium	Medium
Total monetised cost		Not calculated	Low
Non-monetised costs		Medium	Low
Expected benefits of proposed approach, compared with taking no action			
Regulated parties	Dairies and other small businesses may have fewer robberies.	NA	
Regulators	Licensing facilitates compliance and may help with identifying illicit trade.		
Wider government	NA		

Other parties	Smokers encouraged to quit or to switch to vaping will gain significant health benefits, as well as financial savings. If Smokefree Aotearoa is achieved, there will be significant tangible and intangible benefits for the smoker, their families and whānau and the wider community and economy.	Intangible benefits – at least $3.11 billion* Tangible benefits $2.5 billion in 2014 dollars**	Medium
Total monetised benefit		At least $5.5 billion	Medium
Non-monetised benefits		High	

Note:

* The intangible costs have been estimated as between $3.11 billion (using Treasury's recommended $38,110 per quality-adjusted life year (QALY)) and $11.2 billion (using $137,500 per QALY) with 81,650 QALYs lost. Intangible costs include lost life-years due to tobacco-induced premature mortality, and lost health-related quality of life due to tobacco-induced morbidity. For more information, see Cabinet Office Circular (2016) at: https://www.health.govt.nz/system/files/documents/pages/cabinet-paper-8-april-2016.pdf

** Tangible or economic benefits include: improved workforce production (due to reduction in smoking-induced premature mortality and illness, lower absenteeism and higher employee productivity); stopping the loss of resources to addictive consumption, ie, those resources consumed in smoking solely because of the addictive properties of nicotine; and a gain of resources used to treat smoking-induced diseases and their consequences.

4.2 What other impacts is this approach likely to have?

The various measures impact differently on smoking prevalence. For example, de-nicotinising cigarettes could significantly reduce the appeal of cigarettes for existing smokers, while raising age limits will have no effect on existing smokers but may delay or prevent young people from starting to smoke. Overall, as a package, the measures are proposed to strongly contribute to a Smokefree Aotearoa, and particularly contribute to health equity for Māori and Pacific peoples.

There is an illegal market for tobacco in New Zealand. Previous tax increases may have contributed to increases in smuggling of tobacco. It is likely that the measures proposed will increase requirements for compliance and enforcement relating to illegally imported smoked tobacco products. However, no evidence clearly links the tax rises to dairy robberies (Ajmal and U 2015). Additional measures to limit the number or type of retailers of tobacco products available may reduce the risk of robberies.

Measures to reduce the retail supply of tobacco may affect small businesses, such as dairies, by reducing the number of customers visiting their premises. However, the most recent evidence available suggests that this effect may be overstated, as only around 5 percent of sales are for both tobacco and non-tobacco products together, and margins from tobacco sales are low (Marsh et al 2020b).

Options to reduce smoking and remove or restrict the use of filters in cigarettes support healthy environments (WHO 2017) and the National Policy Statement for Freshwater Management.

Section 5: Stakeholder views

5.1 What do stakeholders think about the problem and the proposed solution?

Stakeholders include:

- health sector agencies and district health boards, health practitioners and their representative bodies, non-governmental organisations, academics, stop smoking service providers, and Māori and Pacific providers
- smokers
- tobacco and vaping product industry representative bodies, manufacturers, importers and retailers, including small retailers and specialist vaping retailers.

Consultation on the proposed measures is planned for 2021. Hāpai te Hauora and Tala Pasifika are working with the Ministry to engage Māori and Pacific communities respectively in the consultation process.

Previous community engagement

Previous engagement with stakeholders has informed the development of this Regulatory Impact Statement and the related proposals.

In developing its report *Achieving Smokefree Aotearoa by 2025* (Thornley et al 2017b), ASPIRE[7] consulted with 30 experts in tobacco control and 100 health and community stakeholders on potential interventions that would contribute towards Smokefree 2025. The extent of this consultation indicates broad support for the measures under consideration.

Māori and Pacific peoples were strongly represented in the engagement hui carried out for the ASPIRE report. In phase two, for example, two of the three Auckland groups at the hui were specific Māori or Pacific groups.

Some health and community stakeholders have recently communicated dissatisfaction with the length of time it has taken to develop an action plan, and a desire for the Government to take action.[8]

Tobacco manufacturers and importers are likely to be opposed to some of the measures proposed. Retailers and other commercial interests, such as vaping suppliers, may have mixed views.

Opposition to the Smoke-free Environments (Tobacco Standardised Packaging) Amendment Act 2016 came primarily from tobacco companies and retail groups with substantial vested interests in tobacco sales. Most opponents of the Bill, including tobacco industry submitters, acknowledged health risks were associated with smoking to at least some degree. But they saw these risks as no different from other risks that adult consumers might choose to take. Others who were against the Bill asserted that tobacco is a legal product and that Government should rely on existing tobacco control measures, and only take further steps such as education campaigns that do not interfere with a business's right to sell it. They believed awareness of the dangers of smoking is already sufficiently high (Ministry of Health 2014).

Submissions on amendments to the Smokefree Environments and Regulated Products (Vaping) Amendment Bill in 2020 shared concerns about tamariki and rangatahi, the

[7] ASPIRE2025 is a research collaboration focused on tobacco control. Partner agencies are the University of Otago, Massey University, Tala Pasifika, Whakauae Research and the Health Promotion Agency (https://aspire2025.org.nz).

[8] Fleming Z. 'Smokefree 2025: Government hasn't even finished draft for anti-smoking plan.' *Stuff*, 16 December 2020. URL: https://www.newshub.co.nz/home/politics/2020/12/smokefree-2025-government-hasn-t-even-finished-draft-for-anti-smoking-plan-after-9-years.html (accessed 12 March 2020).

colonial context of smoking, and the need for proportionate regulation of cigarettes (ie, it should be more stringent than the regulations for vaping) (Ministry of Health 2020d).

Stakeholder feedback on particular measures

A review of research on retail measures indicates support for reducing the number of tobacco retailers among the majority of smokers, the general adult population and those aged 14 to 15 years. The majority of smokers also supported restricting places that sell tobacco to premises that exclude children and that make cessation products available (Edwards et al 2012). Li (2016), reviewing data from the 2014 Healthy Lifestyles survey also found that 67.8 percent of the overall population supported restricting retailers, but only 35 percent of current smokers. We will seek further feedback on the proposals as part of the upcoming consultation process and amend them for the final Regulatory Impact Statement.

Stakeholder views of nicotine reduction policies may be mixed. In a 2014 study, Walker et al (2014) argued that resistance to a nicotine reduction policy would not be strong, given that 85 percent of New Zealand smokers wanted the addictiveness of cigarettes reduced. Li (2016), also found that 81 percent of the overall population and 69 percent of smokers supported reducing nicotine. Most smokers (74%) in the 2016/17 ITC survey were interested in trying low nicotine or nicotine-free cigarettes and 80 percent supported introducing a law to reduce nicotine in cigarettes and tobacco if nicotine was available through alternative products (McKiernan et al 2019).

However, in a 2017 study that sought input from smokers, tobacco control sector experts and government officials, the authors found that the majority of respondents did not support a very low nicotine cigarette policy or were concerned about implementation (Fraser and Kira 2017).

Section 6: Implementation and operation

6.1 How will the new arrangements be given effect?

Legislative change

Implementation of the proposals requires amendments to the Smokefree Environments and Regulated Products Act 1990 and its regulations (including the development of new regulations). Amendment to other Acts, such as the Customs and Excise Act 2018 may be required.

An amendment bill will be required, and a place on the Legislative Programme is being sought for this purpose.

The Ministry will build transitional arrangements into the amendment bill where necessary. We will refine these following consultation with stakeholders on the discussion document for a Smokefree Aotearoa 2025 Action Plan.

Regulatory powers, functions and duties

New powers and duties under the Smokefree Environments and Regulated Products Act 1990, along with regulation-making powers, will be needed to implement these proposals. Relevant compliance and cost-recovery powers will also be needed.

Offences and penalties

New offences and penalties will be required, including offences relating to retailing tobacco without a licence, and for importing or selling tobacco that has an excess of nicotine or that has banned features (for example, a filter).

Enforcement

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 officers appointed by the Director-General of Health under the Smokefree Environments and Regulated Products Act 1990. The Ministry organises regular training for smokefree officers, which in the future will incorporate any changes to the Smokefree Environments and Regulated Products Act 1990 and its regulations.

The New Zealand Customs Service carries out compliance and enforcement activity at the border, as well as collecting excise tax. It is likely to require additional resourcing to support its work in addressing any increases in illicit activity that may result from the proposals in the Smokefree Aotearoa 2025 Action Plan.

The Ministry of Health would be responsible for enforcing some aspects of the regulatory controls – for example, licensing systems for retailers. Further work is needed to determine the scope and cost associated with this work.

Communications

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

Section 7: Monitoring, evaluation and review

7.1 How will the impact of the new arrangements be monitored?

The Ministry of Health will continue to monitor emerging evidence on the prevalence of smoking, the impact of the proposed measures and progress towards the Smokefree 2025 goal. However, it may be difficult to separate out the effects of these measures from those of other interventions that are already under way.

Currently, we track the overall trends in tobacco sales using annual tobacco returns that importers and manufacturers supply to the Ministry of Health. In addition, the New Zealand Customs Service collects data on its interceptions of illicit tobacco products; however, this is an imperfect measure as the data covers only goods that are seized, not goods that avoid detection.

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 and ongoing product testing (of nicotine levels). Ongoing compliance activity will also be required to make sure that regulated parties follow the new requirements including surveys of retailers. We also recommend updated research to quantify the size of the illicit market.

The following surveys also contain information that will be useful for monitoring the prevalence of smoking:

- 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).

7.2 When and how will the new arrangements be reviewed?

The Ministry will continue to monitor progress towards the Smokefree 2025 goal. We will also carry out an overall evaluation of the Smokefree Aotearoa 2025 Action Plan after it is implemented. We consider it useful to include a review clause in the amended Act to require a review, for example, five years after the implementation of the action plan begins.

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Appendix: Tobacco smoking in New Zealand

Smoking rates and tobacco consumption have been declining over recent decades. However, around 4,500 New Zealanders still die prematurely each year from a smoking-related illness.

In 2019/20, 11.6 percent of adults were daily smokers (28.7% of Māori, 18.3% of Pacific peoples, 10.1% of European/Others and 7.4% of Asian).

On average, each smoker smoked 9.4 cigarettes per day in 2019/20, down from 11.2 in 2011/12 (Ministry of Health 2020a). Broadly, rates of smoking have been declining in youth. In 2006, 8.2 percent of Year 10 students smoked daily, while in 2019 this figure had fallen to 2.1 percent. However, clear disparities across different ethnicity and socioeconomic groupings continue. Further, over time the gaps between Māori and Pacific young people and other ethnicities seem to have widened, with a much faster decline in smoking rates for Pākehā students (ASH 2019).

Young people who smoke are likely to be attending lower-decile schools. In 2019, 13.5 percent of students at decile 8–10 schools had ever tried smoking, compared with 34 percent of students at decile 1–4 schools. Māori students are over five times more likely to have tried smoking than non-Māori, non-Pacific students.

In 2017, research on young wāhine Māori who smoke found that they are more likely to live with other smokers, be unemployed or require income assistance, and 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 (Ministry of Health and NOOS Consulting 2017a, 2017b). 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 are therefore reluctant to stop. Many fear quitting because they have nothing to replace smoking with or are fearful of withdrawal (Ministry of Health in collaboration with ThinkPlace 2017).

Tobacco control and Te Tiriti o Waitangi

Māori have the highest smoking rate of any population group in New Zealand and have the poorest overall health status.

Smoking is a significant, preventable cause of illness and premature death for New Zealand, which has a greater impact on Māori and Pacific peoples and contributes strongly to health inequity for those populations. A Waitangi Tribunal inquiry into health services and outcomes for Māori (WAI 2575) specifically includes tobacco use by Māori as a source of health inequity (Walker 2019).

Wāhine Māori have New Zealand's highest smoking rates. The largest inequities are among Year 10 girls (aged 14 to 15 years). In 2019, 6.3 percent of Year 10 Māori girls smoked daily, compared with 0.9 percent of Year 10 non-Māori, non-Pacific girls. These inequities have widened in recent years as the smoking rate for non-Māori, non-Pacific girls of this age has decreased much faster than the rate for Māori girls.

These inequities carry through into young adulthood, including pregnancy. For example, 35 percent of pregnant Māori women who presented to a lead maternity carer for the first time in the first quarter of 2020/21 smoked.

A Smokefree Aotearoa supports Government priorities

Achieving a Smokefree Aotearoa will contribute to *Whakamaua: Māori Health Action Plan 2020–2025* (Ministry of Health 2020b) and *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025* (Ministry of Health 2020c) by supporting equitable health outcomes for Māori and Pacific peoples, respectively.

The *New Zealand Cancer Action Plan 2019–2029* (Ministry of Health 2019) identifies smoking as a leading cause of preventable cancer. It also highlights that achieving a Smokefree Aotearoa by 2025 is a leading way of reducing cancers in New Zealand.

Achieving a Smokefree Aotearoa contributes to the *Child and Youth Wellbeing Strategy* (Department of Prime Minister and Cabinet 2019), especially to the wellbeing outcome: that children and young people are happy and healthy.

A Smokefree Aotearoa supports the Government's priority to improve New Zealand's waterways, including improving water quality through reducing pollution. 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.

The measures considered are also consistent with New Zealand's international treaty obligations and commitments under the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) (WHO 2003).

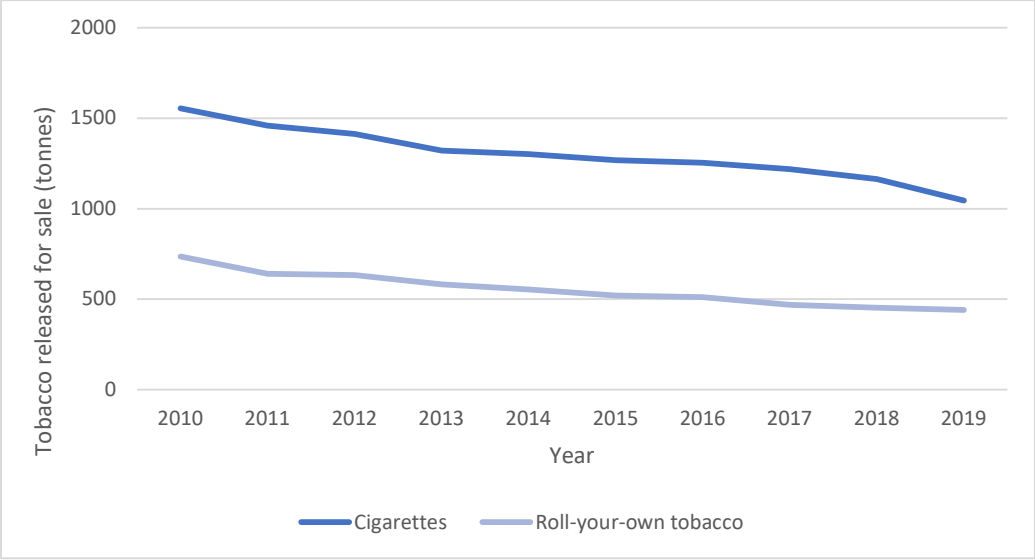
The tobacco industry

Each of the three larger importers of tobacco into New Zealand has a number of brands and types. As a group, they dominate the tobacco market. The approximately nine smaller wholesalers often specialise in more niche products, such as cigars and pipe tobacco.[9]

Retail sales for tobacco products are widely distributed, with between 5,000 and 8,000 retail outlets for tobacco. Retailers include supermarkets, service stations, dairies and convenience stores, and on-licensed premises (bars).

Overall, sales of tobacco are gradually declining (Ministry of Health 2019), as Table 5 shows.

Table 5 Cigarettes and roll-your-own tobacco sales 2010–2019



Tobacco is sold either as cigarettes, in packs of 20 or 25 and occasionally larger volumes (packs of 50), or as loose tobacco – roll-your-owns. Smaller volumes of pipe tobacco, cigars and cigarillos are also sold.

Many cigarette brand variants are described based on colour – for example, 'Classic Red', 'Gold' or 'Blue' – which are generally correlated with now-banned variant descriptors such as 'low tar' and 'mild'. Variants are also distinguished by whether they include menthol or rum

[9] From Ministry of Health, 2019 tobacco returns.

flavouring in the tobacco, as well as in their use of generic descriptors such as ‘mellow’, ‘fine’, ‘rich’, ‘fresher’ or ‘fuller’.

Cigarettes can be further differentiated by design features such as filter and filter paper design. Variations can include product features such as printing on filters and filter vents (tiny holes). A recent innovation is flavoured crush balls, which are filled with a liquid flavouring – often menthol, but in overseas markets these can be fruity or other flavours. One or two crush balls will be included inside the filter and are activated by the user crushing the ball.

Vaping and other alternatives

Vaping products are electrical devices that produce a vapour, rather than smoke, by heating a solution (vaping liquid) that the user inhales. Vaping liquids are available with or without nicotine and are usually flavoured. The liquids and devices can be sold separately.

A wide range of smokeless tobacco products is used internationally as alternatives to smoked tobacco. One example is heated tobacco products (devices that heat, rather than burn, manufactured tobacco sticks).

Vaping products and smokeless tobacco alternatives are not risk free but are considered less harmful than cigarettes. Vaping devices and the liquids (‘vape juice’) are sold in a range of retailers, such as dairies and service stations, as well as specialist vape retailers. The liquids used in vape devices are available in a range of variants – including tobacco and menthol, but also fruity flavours such as ‘strawberry watermelon bubblegum’. Regulations under the Smokefree Environments and Regulated Products Act 1990 that would control some of the constituents of vaping products are currently being considered.

It is also possible that some people may choose to grow their own tobacco as an alternative to smokeless tobacco or vaping products.

New Zealand’s tobacco control programme

New Zealand’s tobacco control programme is based on international best practice, consistent with the World Health Organization’s Framework Convention on Tobacco Control (WHO 2003).

As well as government action through the Ministry of Health and Te Hiringa Hauora (Health Promotion Agency), community-based action provides significant support for tobacco control in New Zealand. Key organisations in this space are the Cancer Society, Hāpai te Hauora and Action for Smokefree 2025 (ASH).

Further, local government has a role in setting local outdoors smokefree and vapefree areas. District health boards also have a role in supporting the smokefree goal and, through their public health units, ensuring compliance with current requirements.

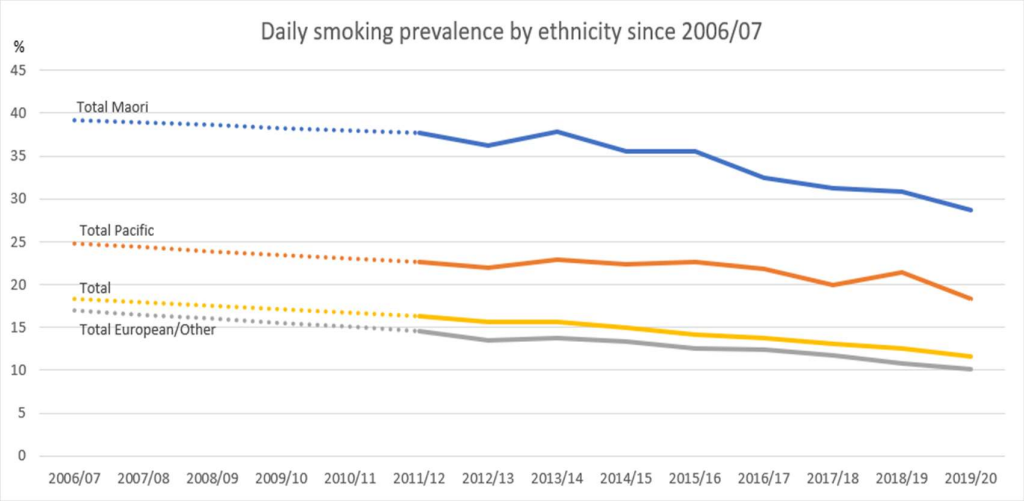
This wider network of organisations and advocates contributes by working to change norms about smoking and influencing the development of policy and legislation.

The Smokefree 2025 goal

In 2010, the Māori Affairs Select Committee led an inquiry into the tobacco industry in New Zealand and the consequences of tobacco use for Māori. In 2011, in response to this inquiry, the Government adopted the goal of reducing smoking prevalence and tobacco availability to minimal levels, which would essentially make New Zealand smokefree by 2025 (New Zealand Parliament 2011).

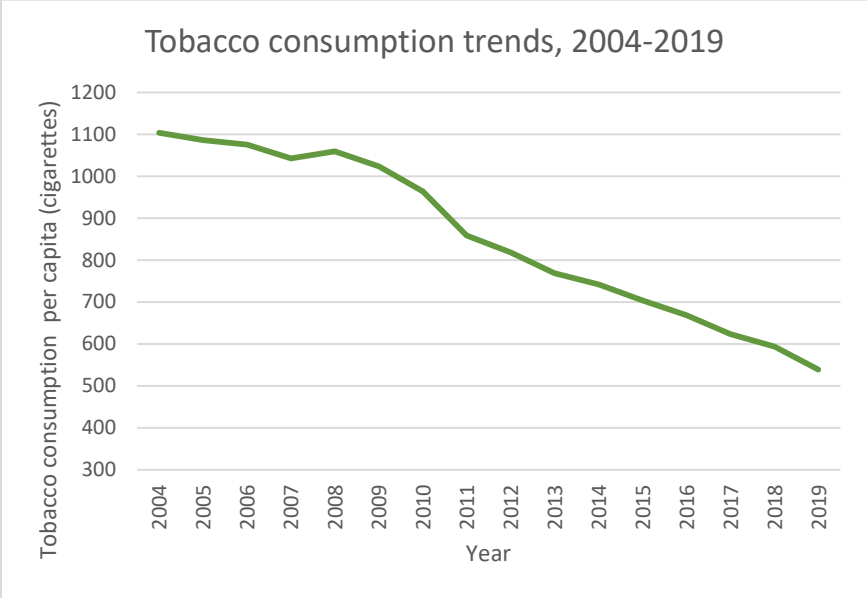
All ethnic groups in New Zealand have made progress towards this goal. From 2006/07 to 2019/20, smoking prevalence has reduced from 17 percent to 10.1 percent among European/Others, from 39.2 to 28.7 percent among Māori and from 24.8 to 18.3 percent among Pacific peoples (Table 6).

Table 6 Daily smoking prevalence by ethnicity, 2006/07–2019/20



The amount of tobacco New Zealanders consume is also decreasing. For example, cigarette consumption per person decreased by 40 percent between 2011, when the recent series of 10 percent increases on tobacco excise began, and 2019 (Table 7).

Table 7 Tobacco consumption trends, 2004–2019



However, modelling indicates that under a business-as-usual approach, smoking rates are projected to only reduce to 8.1 percent for non-Māori and 20 percent for Māori by 2025 (Table 8). The rates of daily smoking for Pacific peoples is projected to reach 11.7 percent by 2025. Māori are not projected to reach 5 percent until 2061.

Table 8 Projections of adult smoking prevalence (for daily smoking) for Māori and non-Māori to 2060