

In Confidence

Office of the Associate Minister of Health

Chair, Cabinet Social Policy Committee

Report back on New Zealand's Tobacco Control Programme

Proposal

- 1 This paper provides a report back on the review of the tobacco control programme and discusses both the effectiveness of the tobacco control programme and value for money evidence.

Executive Summary

- 2 Smoking causes a significant amount of preventable disease and premature death in New Zealand and contributes to health disparities due to the difference in smoking rates between Māori, Pacific and the rest of the population.
- 3 There has been a significant impact on smoking rates and tobacco consumption over the last decade. The rate of daily smoking has decreased from 18.3 percent in 2006/07 to 15 percent in 2014/15. The total amount of tobacco consumed per capita has fallen by nearly 23 percent from 2010 to 2014 and importantly the rate of daily smoking by Year 10 students (14 and 15 years of age) has decreased from over 15 percent in 2000 to under 3 percent in 2014.
- 4 Approximately \$61.7 million was spent on the national tobacco control programme in 2014/15.
- 5 The tobacco control programme includes a range of interventions which are designed to achieve two goals - stopping people (particularly children and young people) from starting to smoke and getting those that are smoking to quit.
- 6 The combined effect of all the tobacco control programme interventions has resulted in a downward trend in smoking rates. It is difficult to quantify or isolate the cost effectiveness of each individual intervention in a comprehensive tobacco control programme.
- 7 The break-even amount for a tobacco intervention is estimated to be \$29,344.70 for each individual smoker who quits and \$13,338.50 for each young person who does not start smoking. For every \$1 million spent on stop smoking services 34 people need to quit for the service to break-even.
- 8 The evidence associated with the majority of interventions is strong and the programme is based on international best practice and global and domestic research.
- 9 The tobacco control programme continues to evolve to ensure best value for money. Two recent reviews carried out by the Ministry of Health have resulted in approximately \$21 million worth of contracts being retendered in order to improve value for money.

Projects financed through innovation funding over the past two years are being evaluated for effectiveness and impact on tobacco control.

Background

- 10 At the Social Policy Committee (SOC) meeting on 11 November 2015 (SOC-15-MIN-0041 refers) the Committee “noted that a review of the tobacco control programme is being undertaken by the Ministry of Health and invited the Associate Minister of Health to report to the Social Policy Committee on the outcome of the above review, by 1 April 2016”.
- 11 This Cabinet paper provides that report back and I have also asked the Ministry of Health to report on value for money evidence across the wider tobacco control programme budget. This paper also has an appendix that provides more detailed background information on the tobacco control programme.
- 12 The Ministry of Health has undertaken two recent reviews of the tobacco control programme (see paragraphs 30-36). These reviews did not cover the entire programme but focused on the components that are directly funded by the Ministry of Health (excluding contracts with Public Health Units for compliance and enforcement work related to the Smoke-free Environments Act 1990).

Key figures relating to the tobacco control programme

- 13 Smoking causes a significant amount of preventable early death in New Zealand. Between 4500 – 5000 New Zealanders die prematurely each year from a smoking related illness.
- 14 Current smoking¹ by adults (15 years and over) has steadily declined from 33 percent in 1983 to 18.3 percent in 2006/07 and 16.6 percent in 2014. The New Zealand Health Survey 2014/15 shows that 15 percent of the adult population (15 years and over) or 550,000 New Zealanders are daily smokers. Māori (35.5 percent smoke daily) are more likely to smoke than the rest of the population. Pacific people also have high rates of smoking with 22.4 percent of the population smoking daily.
- 15 Consistent reductions in the rates of smoking amongst Year 10 (14 and 15 year olds) students is a success story. The data shows that total rates for Year 10 students are coming down and the gap between the Māori (7.17 percent) and non-Māori (2.81 percent) rates of smoking is closing.
- 16 Adult per capita consumption of tobacco has dropped by approximately 23 percent between 2010 and 2014.
- 17 The tangible costs² of smoking have been estimated to be \$2.5 billion in 2014 dollars. The intangible costs have been estimated to be between \$3.11 billion (using Treasury’s

¹ A current smoker is someone who has smoked more than 100 cigarettes in their lifetime and are smoking at least once a month.

² **Intangible Costs include (from O’Dea, Thompson G et al – footnote 2):**

- Lost life-years due to tobacco-induced premature mortality
- Lost health-related quality of life due to tobacco-induced morbidity

Tangible or Economic Costs include:

- Lost work-force production due to smoking-induced premature mortality
- Lost work-force production due to smoking-induced illness, absenteeism, reduced productivity
- Lost resources to addictive consumption, ie those resources consumed in smoking solely because of the addictive properties of nicotine
- Costs in treating smoking induced diseases and their consequences

recommended \$38,110 per QALY) and \$11.2 billion (using \$137,500 per QALY³) with 81,650 QALYs lost.

- 18 In 2014/15 approximately \$61.7 million was spent on the programme and approximately \$1.5 billion (gross) was received in tobacco excise.

New Zealand's tobacco control programme is comprehensive and evidence based

- 19 New Zealand's tobacco control programme is comprehensive and evidence based and designed on international best practice⁴. Being a Party to the global tobacco treaty, WHO Framework Convention on Tobacco Control (FCTC), has assisted New Zealand to develop an evidence based programme through obligatory (large health warnings on tobacco products, prohibiting tobacco advertising) and voluntary (including graphic pictures in the health warnings) measures. The FCTC which came into force in 2005 now has 180 parties (as of 4 April 2016).
- 20 The international literature⁵ reports evidence for most of the population-level tobacco control interventions used in New Zealand. In many cases there is supportive New Zealand-specific evidence showing interventions being effective.
- 21 Australia, Canada, the UK and Ireland (and many other higher income countries) have implemented tobacco control programmes that are similar in nature to New Zealand's. For example, they all aim to prevent children and young people from starting to smoke, offer help to smokers to quit, warn about the dangers of smoking, enforce bans on tobacco advertising and sales to minors and other legislative provisions, and prevent people from being exposed to second-hand smoke. Smoking rates are declining in all of these countries. Each of the countries tobacco surveys use different methodologies and are not directly comparable, for example the age ranges in the surveys differ - New Zealand (15 years and over), Australia (14 years and over) and Canada (12 years and over).

Tobacco control interventions are cost effective and provide value for money

The cost effectiveness of tobacco control interventions in New Zealand

- 22 There is clear evidence⁶ that the combined effect of New Zealand's comprehensive programme has seen a significant downward trend in smoking rates over time but it is difficult to quantify the cost effectiveness of each individual intervention. It can also take some time for the additional impact of a new measure, for example standardised tobacco packaging, to become apparent.
- 23 To assess the cost-effectiveness of an intervention the Ministry has worked with New Zealand public health modellers to estimate the net benefit per each additional smoker who quits, or potential new smoker who does not start, as a result of the measure.

• Property damage from smoking-caused fires.

³ O'Dea D, Thompson G et al. 2007. *Report on Tobacco Taxation in New Zealand*. Smokefree Coalition.ASH

⁴ WHO Framework Convention on Tobacco Control

⁵ WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER package Geneva, World Health Organization, 2008

⁶ Smoking Prevalance in New Zealand 1983-2014, Ministry of Health

- 24 Combining the QALY gained per quitter result (of 0.77 QALYs discounted at 3%⁷) with Treasury's suggested valuation of \$38,110 per QALY yields a preliminary figure of \$29,344.70 per individual ex-smoker as the "break-even" point for a tobacco control initiative. The same calculation for avoided initiators yields a break-even point of \$13,338.50. These figures increase to over \$35,000 and \$16,000 per person when health care savings and productivity gains are factored in.
- 25 A targeted stop smoking support intervention that costs \$100,000 a year needs to cause an additional four individual smokers to quit to break even (on average). Similarly, a \$2 million media campaign would need to create either 68 additional successful quits or prevent 150 people from ever starting, to be considered cost-effective and good value for money.
- 26 Between the 2006 and 2013 census the number of regular smokers in the 15-19 age bracket reduced by over 25,500. If we apply the break-even point of \$13,338.50 to each of these people and spread this figure over the seven years between the two censuses, there is a potential accrued benefit of up to approximately \$48 million per year for this age group alone.

International evidence

- 27 The World Health Organization states 'that the cost-effectiveness of tobacco treatment is well established and has one of the best cost-effectiveness ratios for any preventive or healthcare intervention'⁸. Tobacco treatment in this context refers to stop smoking services that have scientific evidence to support them and are based on WHO FCTC guidelines⁹.
- 28 The cost effectiveness guide commonly used by NICE (National Institute for Health care Excellence, UK) to judge whether a treatment can be provided by the National Health Service in the United Kingdom on economic criteria alone is £20,000 per QALY¹⁰ (approximately \$42,500 at today's exchange rate). Many health care interventions, including treatments for smoking-related diseases such as cancer and heart disease exceed this guidance. In contrast, all smoking cessation interventions fall below this figure (cessation interventions of the type offered by stop smoking services cost up to £985 per QALY - 2005-06 prices or about \$2650 in today's NZ dollar amount).

Evidence of effectiveness of funded tobacco control interventions

- 29 The tobacco control programme budget (approximately \$61.7 million) funds a range of activities including stop smoking services, stop smoking medicines, education, social media campaigns (and associated mass media) and compliance and enforcement activities.
- 30 The Ministry continues to review the effectiveness of the programme budget. In 2013 the Shore & Whariki Research Centre based in the College of Health at Massey University were selected by the Ministry of Health to undertake a Review of Tobacco Control

⁷ The tobacco excise scenarios modelling forms part of a bigger Health Research Council funded research programme on health intervention cost effectiveness (BODEEE) and a 3% discount factor has been consistently applied to all health interventions modelled.

⁸ http://www.who.int/tobacco/publications/smoking_cessation/benefits_and_rationale_est_who_tobacco_quit_line_services.pdf

⁹ http://www.who.int/fctc/treaty_instruments/adopted/Guidelines_Article_14_English.pdf?ua=1

¹⁰ NICE. Public Health Guidance Methods Manual. London, National Institute for Health and Clinical Excellence, 2006

Services. The review focused on the components and services funded by the Ministry of Health.

- 31 The review reported in July 2014 that ‘in general the Ministry of Health funded services in the tobacco control area were assessed as in line with evidence. Important initiatives are being funded and evaluated allowing for innovative developments where evidence is lacking and to further develop tobacco control efforts’.
- 32 The review also found that with respect to cost effectiveness virtually all treatments that are effective are also cost effective because the health benefits from cessation are so large. All estimates of cost expressed in terms of life years saved, DALYs or QALYs, are well below the levels of other health interventions. Brief advice was found to be the most cost effective because of the limited time involved. The review identified some areas for further development including increasing successful quit rates.
- 33 As a result of the Massey review the Ministry has begun a process to retender and realign all face-to-face stop smoking services (including Māori, Pacific and pregnancy stop smoking services) and all health promotion and advocacy services for tobacco control purchased by the Ministry of Health. These contracts have a combined budget of \$12.133 million. New services will be in place by 1 July 2016.
- 34 The purpose of the retendering and realignment process is to ensure better integration of services across health and the wider social sector and to lift quality and performance.
- 35 In addition, in 2013 the Quitline service was subject to a contestable service re-tender. On 1 November 2015 Quitline became part of the new national tele-health service operated by Homecare Medical (incorporating Healthline, Poisonline, Quitline, Gambling Helpline, Alcohol and Drug Helpline, National Depression Initiative (the Lowdown, Journal) and immunisation advice for the public). The service now operates 24 hours a day, 7 days a week.

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Funded interventions with strong evidence

- 37 There is strong evidence available for the effectiveness of the following interventions:
- 37.1 Stop smoking medicines
 - 37.2 Quitline
 - 37.3 Community based stop smoking services
 - 37.4 Ministry of Health non departmental expenditure.

Stop smoking medicines (\$14.96 million spent in the 2014/15 financial year)

- 38 New Zealand funds a range of evidence-based stop smoking medications including nicotine replacement therapy (patches, gum and lozenges) to assist current smokers to stop. PHARMAC manages the budget associated with subsidised stop smoking medications (as part of the wider community pharmaceutical budget). PHARMAC also make the decisions on which stop smoking medications are publicly funded.

- 39 Stop smoking medicines have been shown to significantly improve quit rates as opposed to quitting without any support and they are most effective when combined with behavioural support¹¹.

Quitline (\$9.42 million spent in the 2014/15 financial year)

- 40 Quitline is the national stop smoking service that provides a range of evidence based stop smoking support to consumers via telephone, text and on-line support. Quitline can also supply subsidised nicotine replacement therapy via a Quitcard redeemed at a pharmacy. The Quitline service utilises multiple channels (telephone, online, text) access to subsidised NRT, mass media advertising, proactive calling and 24-hour access to maximise utility and effectiveness.
- 41 There is strong evidence for telephone counselling. After pooling multiple clinical randomized trials, the 2006 Cochrane Review¹² found an odds ratio of 1.4 (people calling the quit line and receiving counselling were 40 percent more likely to quit successfully when compared with people receiving less assistance). The United States Public Health Service¹³ conducted a similar analysis, finding an even higher odds ratio of 1.6. There was a wide range of effectiveness between different quitline studies. Proactive telephone support and automated text messaging are also effective means of promoting tobacco cessation¹⁴.
- 42 In 2012/13 New Zealand's Quitline supported 50,297 quit attempts. Quitline achieved a 24.2 percent self-reported quit rate at 3 months and 20.9 percent at 12 months. Māori rates and Pacific rates were lower at 16.4 percent and 18.9 percent respectively at 12 months. A cost effectiveness study¹⁵ of Quitline calculated that it cost \$187 per supported quit attempt and \$743 per 4-week quit.
- 43 In 2012 an environmental scan was undertaken on behalf of the Quit Group (who ran the Quitline prior to November 2015) by Allen & Clarke to inform its future strategic direction. The environmental scan outlined that the cost for Quitline per successful quit at 12 months was \$2,000 (based on research which was completed in 2007).
- 44 An economic evaluation¹⁶ of the Quitline assessed the cost effectiveness of nicotine replacement therapy when added to the Quitline and showed that the cost per QALY ranged from \$2,449 to \$6,794 depending on assumptions about the quit rate. This demonstrates the intervention is cost effective when compared to other health care interventions.

¹¹ West, R., Raw, M., McNeill, A., Stead, L., Aveyard, P., Bitton, J., Stapleton, J., McRobbie, H., Pokhrel, S., Lester-George, A., and Borland, R. (2015) Health-care interventions to promote and assist tobacco cessation: a review of efficacy, effectiveness and affordability for use in national guideline development. *Addiction*, 110: 1388–1403. doi: [10.1111/add.12998](https://doi.org/10.1111/add.12998).

¹² Stead LF, Perera R, Lancaster T. Telephone counselling for smoking cessation. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD002850. DOI: [10.1002/14651858.CD002850.pub2](https://doi.org/10.1002/14651858.CD002850.pub2).

¹³ Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

¹⁴ West et al (2015)

¹⁵ O'Dea D. 2004. An Economic Evaluation of the Quitline Nicotine Replacement Therapy (NRT) Service. Unpublished report to the Ministry of Health. For the report summary see <http://www.quit.org.nz/research.html>

¹⁶ *ibid*

Community based stop smoking services - funded by the Ministry of Health (\$8.49 million spent in the 2014/15 financial year)

- 45 This budget provides for 42 community based smoking cessation services in New Zealand including 32 Aukati Kaipapa (Māori), 4 Pacific and 6 pregnancy focused services.
- 46 Interventions that promote and assist smoking cessation are highly cost-effective in high-income countries¹⁷. Community-based stop smoking services are an effective means of promoting tobacco cessation¹⁸. Effectiveness depends upon having in place appropriate procedures for selection, training, assessment and professional development of practitioners as well as evidence-based treatment protocols. Its effect appears to be broadly additive to medication if that is being used.
- 47 Data from evaluation of long-term outcomes in the UK¹⁹ show that:
- Clients who received specialist one-to-one behavioural support were twice as likely to have remained abstinent than those who were seen by a general practitioner (GP) practice and pharmacy providers
 - Clients who received group behavioural support (either closed or rolling groups) were three times more likely to stop smoking than those who were seen by a GP practice or pharmacy providers
- 48 Community based stop smoking services provide the best chance of quitting for an individual. They also make significant contributions to reducing health inequalities, particularly when delivered to populations in which smoking prevalence is high. Studies have demonstrated that stop smoking services are effective in reversing the inverse care law (that states that healthcare is more readily available to affluent than deprived groups). They do this by reaching and treating proportionally more smokers in disadvantaged areas (Chesterman et al 2005, Hiscock et al 2013).
- 49 All community based stop smoking services were reviewed by Massey University in 2014 for effectiveness. The Massey review noted a wide variation in effectiveness of services. The Aukati Kaipapa services had validated (via a carbon monoxide breath measurement) quit rates at three months ranging from 4 percent to 71 percent with annual enrolments in these services ranging from 90 to 560 people. The Pacific services had four week validated quit rates of between 7 percent and 32 percent. Each service enrolled between 200 and 400 people. Pregnancy services had validated quit rates of between 0 and 33 percent (though the self reported rates were between 30 percent and 77 percent) at four weeks.
- 50 As a result of the review these services are currently being retendered with new services commencing 1 July 2016. The Ministry will be monitoring the impact of the new services and associated value for money. New national clinical standards to ensure quality, effectiveness and efficient delivery and monitoring are also being implemented.

¹⁷ West, R. (2007), The clinical significance of 'small' effects of smoking cessation treatments. *Addiction*, 102: 506–509. doi: 10.1111/j.1360-0443.2007.01750.x

¹⁸ West et al (2015)

¹⁹ Dobbie F, Hiscock R, Leonardi-Bee J, et al. Evaluating Long-term Outcomes of NHS Stop Smoking Services (ELONS): a prospective cohort study. Southampton (UK): NIHR Journals Library; 2015 Nov. (Health Technology Assessment, No. 19.95.) Available from: <http://www.ncbi.nlm.nih.gov/books/NBK327140/> doi: 10.3310/hta19950

- 51 To demonstrate value for money the new services will aim to reach around 5 percent of the local population of smokers annually. It will also aim to achieve quit rates that are higher than those that can be achieved with smokers receiving medication and minimal behavioural support (for example a prescription and GP advice).

Ministry of Health miscellaneous non departmental expenditure (\$2.68 million spent in the 2014/15 financial year)

- 52 This Budget funds a range of contracts including the tobacco health target champions, collation of health target data, smoking cessation clinical leadership, provision of clinical guidance and support, research projects, health promotion resource development and workforce development and data (including a New Zealand Qualification Authority qualification for cessation practitioners and the development of a national client management system that will enable Ministry funded stop smoking services and Quitline.
- 53 Effectiveness of stop smoking services depends upon appropriate procedures in place for training, assessment and professional development of practitioners as well as evidence-based treatment protocols. Brief advice to stop smoking from healthcare professionals is effective and highly affordable²⁰. The latest evidence suggests that brief advice from a doctor increases long-term quit rates by 2 to 4 percent, compared with receiving no advice²¹.
- 54 Systematic delivery of brief advice requires change in clinician behaviour. The key drivers of behaviour change are: clinical leadership, systems and tools to prompt and assist clinicians, audit and feedback, guidelines and training and incentives²².

Funded interventions with moderate evidence

- 55 There is moderate evidence available for the effectiveness of the following interventions:
- 55.1 District health board (DHB) tobacco control funding
 - 55.2 Public health units
 - 55.3 Mass media campaigns
 - 55.4 Health promotion, leadership, advocacy.

District health board (DHB) tobacco control funding (\$9.14 million spent in the 2014/15 financial year)

- 56 This funding provides for a range of activities including the development of Smokefree 2025 plans, six community based cessation services, work with local government and actions relating to meeting the Government's 'Better Help for Smokers to Quit' health target.
- 57 The six community based cessation services were recently reviewed for effectiveness and are also being retendered with new services commencing 1 July 2016. The Ministry will be monitoring the impact of the new services including value for money as well as

²⁰ West et al (2015)

²¹ Stead LF, Buitrago D, Preciado N, et al. 2013. Physician advice for smoking cessation. *Cochrane Database of Systematic Reviews* (5): CD000165.

²² Myers et al Smoking cessation interventions in acute and maternity services: review of barriers and facilitators NICE 2012.

the adoption of national clinical standards for quality, effective and efficient delivery and monitoring.

- 58 DHBs report their progress against the Government's health target including that 95 percent of patients in secondary care, 90 percent in primary care and 90 percent of pregnant women are given brief advice about stopping smoking. The majority of DHBs consistently meet the hospital and maternity target. The primary care target is close to being achieved. From 1 July 2015 the primary care target broadened to include the entire primary healthcare organisation (PHO) enrolled population rather than just those that are seen. DHBs do not routinely report quit rates but consideration of a new target which is more outcome focused is underway.

Public health units – (\$5.84 million spent in the 2014/15 financial year)

- 59 Public health units provide regulation and compliance activities relating to the Smoke-free Environments Act 1990 and Smoke-free Environments Regulations 2007 and employ both enforcement officers and health promoters. Public health units undertake a range of health promotion activities and work alongside other groups (for example local Government) to achieve common goals.
- 60 Public health units are contracted to enforce the Smokefree Environments Act and are required to dedicate at least 40 percent of the work in tobacco control to this area. Key regulatory activities undertaken in 2014/15 involved undertaking controlled purchase operations, where volunteers under the age of 18 attempt to purchase tobacco from sellers (1483 visits were made with 104 positive sales), retailer education (2460 premises visited) and working licensed premises. Health promotion work has recently focused on working to improve and increase the number of smoke free environments.
- 61 These services are output rather than outcome focused. For example, it is not possible to accurately determine the specific impact controlled purchase operations have on youth smoking rates.

Mass media campaigns (\$3.87 million spent in the 2014/15 financial year)

- 62 New Zealand's mass media campaigns for tobacco control are designed to encourage smokers to quit or prevent children and young people from starting and include the use of a variety of media including television, radio, print and online (Facebook, Instagram and websites such as Trade Me).
- 63 Evidence from international studies shows that mass media campaigns are effective in reducing smoking prevalence through increasing cessation and reducing initiation. These studies include two Cochrane reviews on the impact on cessation and initiation. Evidence from a systematic review of economic evaluations of mass media campaigns for tobacco control²³ concluded that all studies showed that mass media campaigns are a cost effective public health intervention. The authors also noted that the intervention offered good value for money.
- 64 Effectiveness of mass media in reducing smoking prevalence (through increasing cessation and reducing initiation) has been informed by research conducted both

²³ Atusingwize, Edwinah and Lewis, Sarah and Langley, Tessa (2015) Economic evaluations of tobacco control mass media campaigns: a systematic review. Tobacco Control, 24 (4). pp. 320-327. ISSN 1468-3318

internationally (Cochrane Review 2012; Wakefield et al 2010) and domestically (Wilson 2007; Wilson et al 2004). This includes research directly focusing on priority populations.

- 65 Buying of mass media is done through the All of Government (AOG) scheme which guarantees some of the best rates in the market. The combined value of three New Zealand campaigns in 2014/15 was \$8.76 million against a spend of \$3.87 million. The campaigns undertaken were Stop Before You Start (\$1.71 million), Quitline (\$1.82 million) and Smokefree Cars and Homes (\$0.34 million). This level of value was delivered through purchasing on the AOG advertising rates compared to the media provider's full ratecard. Savings above the AOG rates were achieved by strategic media buying and negotiation.

Health promotion, leadership, advocacy (\$2.30 million spent in the 2014/15 financial year)

- 66 This budget provides for information and advocacy services at a national level from four non-government organisations who provide leadership and coordination of the tobacco control sector including ASH, Smokefree Coalition, Te Ara Hā Ora (the National Māori tobacco control leadership service) and the National Heart Foundation.
- 67 These services were reviewed by Massey University in 2014 for effectiveness and are being retendered with new contracts to commence from 1 July 2016.
- 68 Policy recommendations launched during the 12th World Conference on Tobacco or Health (2003) were that alongside an individual approach (behavioural and/or pharmacological interventions) to treatment of tobacco dependence a supportive environment is needed to encourage tobacco consumers in their attempts to quit. The 2003 recommendations included a mix of three main strategies:
- a public health approach that seeks to change the social climate and promote a supportive environment
 - a health systems approach that focuses on promoting and integrating clinical best practices (behavioural and pharmacological) which help tobacco-dependent consumers increase their chance of quitting successfully
 - a surveillance, research and information approach that promotes the exchange of information and knowledge to increase awareness of the need to change social norms.
- 69 Between 1997 and 2003 New Zealand went from having almost no publicly funded smoking cessation services and minimal broader tobacco control measures to having one of the most advanced mixes of population-level tobacco control initiatives in the world. A significant driver for this change has been increased public awareness and support for reducing tobacco-related harm.
- 70 These services are also output rather than outcome focused and the specific impact on smoking rates cannot be measured.

Funded interventions with weak evidence

Pathway to Smokefree New Zealand Innovation Fund (\$5 million spent in the 2014/15 financial year)

- 71 The Pathway to Smokefree New Zealand 2025 Innovation Fund was established in 2012 to support the achievement of Smokefree New Zealand by 2025. The budget for this initiative was \$5 million per year for four years. Twenty four projects have received

funding in the two rounds administered to date. The Innovation Fund supports the implementation and evaluation of innovative approaches to reduce the smoking prevalence among Māori, Pacific people, pregnant women and young people across New Zealand.

- 72 The effectiveness of each project is being evaluated and reported at the project's completion (final projects being completed late 2016). The Ministry of Health is also completing an overall assessment of the innovation fund. Early indications are that the majority of projects have had a low impact on smoking cessation rates. A small number of the innovation fund projects have had positive evaluations and these initiatives are beginning to spread across some DHBs (for example, the use of incentives (vouchers) to encourage and support pregnant women to quit smoking).

Wider impacts of tobacco control measures

- 73 The impact of tobacco control measures are likely to produce positive economic productivity gains. This is due to non-smokers and ex-smokers having higher life expectancy than smokers and being more productive mainly due to reduced absenteeism. Non-smokers enjoy better health than smokers and have reduced health care costs.
- 74 A recent UK tobacco excise cost-benefit study estimated these productivity gains added together totalled about 20 percent greater than the health cost saving.²⁴
- 75 Having fewer smokers will also have an impact on national superannuation (ex-smokers living longer will mean more people drawing superannuation for longer) and ACC costs (smoking complicates and extends rehabilitation so this cost is likely to reduce).

Consultation

- 76 The Treasury has been consulted on this paper and the Department of Prime Minister and Cabinet has been informed.

Publicity

- 77 No publicity is proposed around this report back.

²⁴ Reed, H, The Effects of Increasing Tobacco Taxation: A Cost Benefit and Public Finances Analysis, Report prepared for ASH UK by Landman Economics, 2010

Recommendations

The Associate Minister of Health recommends that the Committee:

- 1 note that good progress is being made in reducing smoking prevalence and consumption with daily smoking prevalence falling from 18.3 percent in 2006/07 to 15 percent in 2014/15 while the volume of tobacco consumed has fallen by nearly 23 percent between 2010 and 2014
- 2 note that in 2014/15 approximately \$61.7 million was spent on the tobacco control programme
- 3 note that the break-even point for a tobacco control intervention is estimated to be \$29,344.70 per each individual smoker who quits and \$13,338.50 for each young person who does not start
- 4 note that evidence associated with the majority of interventions is strong and the programme is based on international best practice
- 5 note that two recent reviews have resulted in approximately \$21 million worth of contracts within the tobacco control programme being retendered in order to improve cost effectiveness.

Authorised for lodgement

Hon Peseta Sam Lotu-liga

Associate Minister of Health