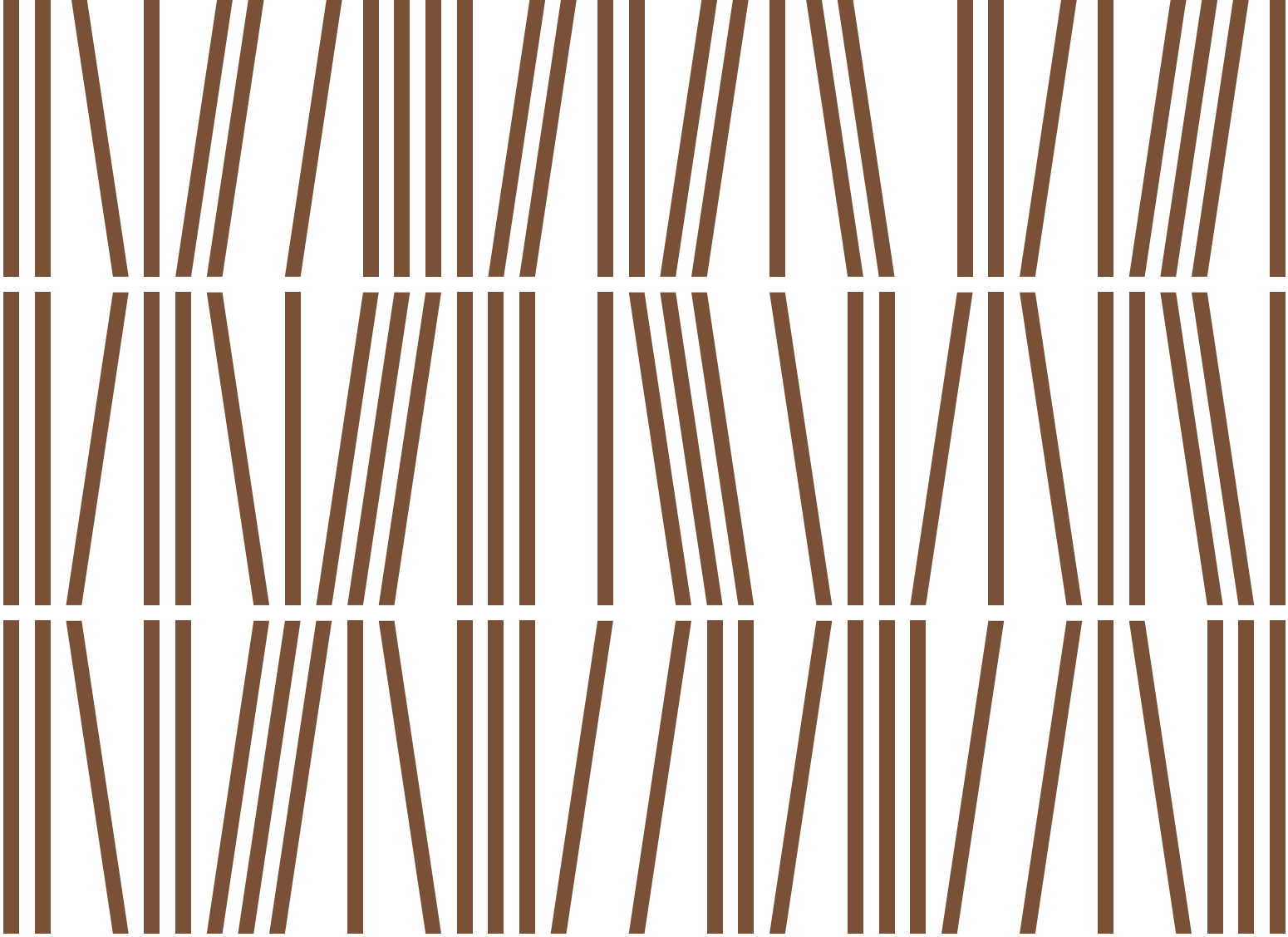

Submission on Proposals for a Smokefree Aotearoa 2025 Action Plan Discussion Document

Submission by Marewa Glover, PhD

31 MAY 2021

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Introduction

1. This submission on the 'Proposals for a Smokefree Aotearoa 2025 action plan discussion document' is made by Professor Marewa Glover, Director of the Centre of Research Excellence: Indigenous Sovereignty & Smoking (the Centre), Auckland, New Zealand (NZ). The Centre is a NZ-registered limited liability company. We are an independent research company with a mission to build knowledge and research skills to support Indigenous people around the world to reduce the harms associated with tobacco smoking.

2. Disclosure of Funding: I have never received funding from any tobacco or vaping industry company. Over 10 years ago I did receive payment from some pharmaceutical companies for advice on stop-smoking medications. I prepared this submission in my role as Director of the Centre of Research Excellence: Indigenous Sovereignty & Smoking. The Centre of Research Excellence: Indigenous Sovereignty & Smoking was established, and the work of the Centre continues to be funded with a grant from the Foundation for a Smoke-Free World, a US nonprofit 501(c)(3) private foundation with a mission to end smoking in this generation. The Foundation accepts charitable gifts from PMI Global Services Inc. (PMI); under the Foundation's **Bylaws** and **Pledge Agreement** with PMI, the Foundation is independent from PMI and the tobacco industry. The contents, selection, and presentation of facts, as well as any opinions expressed herein are the sole responsibility of the authors and under no circumstances shall be regarded as reflecting the positions of the Foundation for a Smoke-Free World, Inc. The funder had no role in my decision to make this submission, nor did they have any role in determining the content, preparing, reviewing or approving of the content.

3. I have worked to reduce the morbidity and mortality of tobacco smoking – which was the original intention of the Smoke-Free Environments Act (1990) – since 1992, when I joined the Public Health Commission. I have dedicated my career to reducing smoking among Māori and all New Zealanders. I am the longest-standing NZ tobacco-control expert still dedicated and working fulltime to deliver on the intent of that Act. I was the first person in NZ to obtain a PhD in the topic. I remain the most senior and most qualified indigenous expert on this topic in the world. I have over 120 scientific journal

articles, and over 50 technical reports on studies I have led or been involved with. It is this depth of experience and the knowledge that I have accumulated, combined with my Indigenous perspective, that sets my advice apart. My recommendations contained in this submission are shaped by my years of research with Māori and non-Māori people who smoke. A particular focus of mine has been how to reduce smoking while pregnant.

4. This submission seeks to highlight the importance of supporting evidence-informed methods that can more rapidly assist people to stop smoking.

Background

5. Ever since the 1964 US Surgeon General report confirmed that smoking tobacco was associated with a raft of diseases and premature mortality, the NZ Government has increased its efforts decade upon decade to discourage the uptake and consumption of tobacco smoking, and to reduce smoking prevalence (Glover, 2019).

6. In response, smoking prevalence among Pākehā men and women has declined. Smoking prevalence for them at 2019/20 is now 11.8% for men and 11.5% for women.

7. Whilst smoking prevalence rates have declined among Māori as well, the inequity in rates was large when tobacco control efforts began and the focus has not been on reducing that inequity. Rather, the focus was a utilitarian one of reducing smoking prevalence for as many people as possible, regardless of ethnicity. This approach favoured the majority ethnic group – Pākehā.

8. Declines in smoking prevalence have been slower among people in lower socioeconomic groups, among which Māori are over-represented.

9. Smoking prevalence among Māori as at 2019/20 remains disproportionately high at 24.7% for men and 35.0% for women.

10. Globally, it is unusual for a higher proportion of women than men to smoke in any population (Houghton et al. 2019). The higher smoking among Māori women is due to the introduction of tobacco to Māori women at the time of colonisation. Conversely, women in the colonising countries did not smoke at that time and did not take up smoking en masse until the post-World War I 1920-30s. This

outcome of colonisation is shared with some other similarly colonised Indigenous peoples, such as the Aboriginal and Torres Strait Island peoples, and several of the Pacific nations.

11. Other minority sub-groups have been left behind by the utilitarian justification to focus on the majority. For example, people with disabilities also have a disproportionately high smoking rate, and a higher rate in women (16.9% and 20.8% in men and women respectively)[1].

12. The discussion document draws attention to the disproportionally higher rate of smoking among those living in the most deprived areas, and among teenage girls, particularly Māori girls. But the use of Māori is exploitative. There is no kaupapa Māori analysis in the document. The proposed plan promotes strategies first promoted by overseas Western anti-smoking academics. The proposed strategies have been debated before in NZ, and failed to find support among the sector. One strategy that has been used to shift opinion is to rid the sector of people who object to the regressive policies that will deliver disproportionate harm to Māori, Pacific and lower socioeconomic groups. It is clear that the appointment of a new Associate Minister of Health has provided an opportunity for the NZ members of the small international tobacco temperance movement to once again lobby for their ideology to be tested in NZ.

13. There is no evidence to inform the likely positive or negative effects of several of the policies being proposed upon the NZ people and NZ society. I object to NZ being used as the testing ground for their social experiments. Controlled studies conducted under ethics guidelines for human participants in research is the more appropriate testing ground for the prohibitionist policies being proposed. NZ is a unique environment with a unique tobacco ecology and a diverse population. Overseas studies, where they do exist (although still only small indicative experiments have been done, for example on taking the nicotine out of tobacco) can only be considered as background, not evidence for implementing policies in NZ.

14. The new Associate Minister of Health, Dr Ayesha Verrall is to be commended for recognising that, "much work still needs to be done, particularly to reduce smoking rates among Māori, Pacific people and those living in our most disadvantaged communities." For that work to be effective, Māori and Pacific people need to be involved in designing Indigenous and Pasifika solutions. That involvement needs to go beyond the Māori and Pacific people who are currently employed by, or are in a subordinate or dependent position in relation to the non-Māori, non-Pacific proponents of the extreme prohibitions being proposed (that is, they are students of them, work for them or receive funding and favours via them). It is, after all, Māori, Pasifika and Asian sub-groups who will suffer disproportionately the negative unintended effects of the policies.

15. In addition to the financially deprived and Indigenous people, the World Health Organisation (WHO) acknowledges that those with mental health conditions and the LGBTQI community are two other groups that have been 'left behind' by Framework Convention on Tobacco Control directed smoking-prevention programmes (Glover et al., 2020).

16. The proposed action plan fails to address the inequities in public health addressed above. In particular, the discussion document pays no attention to possible unintended consequences of the proposed policies. Many of these unintended consequences will hit hardest those who the proposals need to help the most.

[1] *All data from the Ministry of Health website.*

17. The proposal appears to consider that the best approach to improving health outcomes is total prohibition. There is perhaps a realisation that total prohibition might still not receive majority political support at present, so 'prohibition by stealth' is promoted. Prohibition by stealth would gradually make it harder to access tobacco products. This approach is favoured by people who have never smoked themselves, and who don't have any understanding of dependency on tobacco smoking – or if they do, they clearly believe that a 'tough love' approach is called for. It is the utilitarian focus, or majoritarianism, that is contrary to the intended relationship that Māori and non-Māori would have as set down in Te Tiriti o Waitangi. The proposed prohibition-by-stealth policies will do little to address the health inequities currently being experienced in NZ. They could even increase inequity.

18. A harm-reduction approach is a legitimate strategy of the WHO Framework Convention on Tobacco Control.

19. As a founding document of NZ, Te Tiriti o Waitangi can be looked to for guidance on how to reduce smoking-related disease and premature deaths. A first step of tobacco control in NZ should have always been to reduce the inequity in the smoking-prevalence rates between Māori and non-Māori. That should be the priority now. First, reduce the inequity. Once that has been achieved, then consider policies that, if applied, would then be expected to have equal effects across the different groups in society. This is simply to ensure equity and fairness.

20. The Government has adopted a harm-reduction approach with its progressive (relative to most other countries except the UK) Smokefree Environments and Regulated Products (Vaping) Amendment Act. The regulatory detail of that legislation has not yet been released. Thus, asking for comment on the policies in the proposed plan is premature. To give a fully informed opinion on them, we need to know what barriers to switching to low-risk alternatives, if any, are going to be introduced.

21. Regulation and restrictions of the alternative vaping and smokeless products will need to retain financial and experiential advantages for consumers if they are to continue to attract people away from smoking tobacco (Bates et al. 2019).

22. The Government, via its Health Promotion Agency, has only just begun its Vape2Quit Strong campaign in March this year. That campaign needs to be given a chance to begin having an effect. It was good to see some funding in the budget allocated, hopefully, for this campaign to be optimised. Our Voices of the 5% Study with a diverse range of people who had no intent to quit, is suggesting that there are still widely dispersed sub-groups that are not seeing any Vape2Quit Strong campaign content.

23. Through our Voices of the 5% Study, we interviewed 61 diverse people who had no intention of giving up smoking or who believed they couldn't do so, in order to identify barriers that prevent them from switching to vaping[2]. The main barriers were Doubts about the safety of vaping, that vaping provided a Diluted experience, Difficulties due to a lack of information on where to find vaping and product support, and that it was just too Distanced from smoking for them. These are all barriers that the HPA campaign and improved cessation support can address.

24. Shifting thinking from prohibition to harm reduction, that is to see alternative means of delivering nicotine as a valid and relatively harmless alternative to combustible tobacco products, is one way to ensure a decline in the quantity of combustible tobacco products used (Wilson et al. 2018; Bates et al.

[2] *Video presented at the Global Forum on Nicotine, Liverpool 2021. https://gfn.events/videos/45/voices-of-the-5-barriers-to-vaping*

The need to consider unintended consequences.

Figure 1.

Inspired by Greene's (2018) legal immobility theory of poverty, the fences in this picture signify laws and regulations. Persistent changes and tightening of laws and regulations ensures the ongoing existence of a population who are kept on the wrong side of the law. By this strategy, upward social mobility remains difficult to achieve, especially for people on low incomes who lack resources and support. Some proposed tobacco-control law or regulatory changes can overnight change a person's status from law-abiding citizen to criminal. People with disproportionately high smoking rates, such as, lower socioeconomic groups, Indigenous peoples, LGBTQI and people with mental health conditions, are more likely to suffer the negative consequences of these shifts.

2019). This approach needs to be supported with messages and training for relevant health workers to counter the popular misinformation that nicotine is the harmful product in tobacco (Abrams 2020).

25. Laws, regulations and legal instruments generally impact more greatly on the less financially advantaged sectors of society. As Greene (2018) states:

"Poverty creates an abrasive interface with society; poor people are always bumping into sharp legal things."

(Greene quoting a poverty lawyer from the 70s, 2018).

26. Greene (2018) identified three ways that laws can impact on poor people. The first is through 'calculated exploitation,' where the poor are used for revenue grabs. Regressive taxation laws are the example she gives. The second is through 'gratuitous management', a form of micromanaging that infantilises the poor by assuming they are less responsible than the general population at managing their own lives. Child welfare laws that preferentially punish poor parents are an example. The third is through 'routine neglect'. High financial barriers to entry for occupations that require licensing are examples of this type of 'sharp legal thing'.

27. Greene's (2018) study was written in the United States, but there are parallels with New Zealand law. All three forms of legal instruments that can disadvantage the poor can be seen in present tobacco policy and proposals in this discussion document.

28. 'Calculated exploitation' can be seen in the way in which taxation of tobacco products disadvantages those who can afford them the least. Tobacco tax, unlike the levies on gambling and alcohol, is not ring-fenced to help those with addiction problems, but goes into general treasury coffers. Using more of this money to fund other initiatives to encourage smoking cessation could speed up the reduction of the inequity in smoking prevalence rates in society. For example, financial incentives have been found to be effective at enhancing quit rates (Glover 2018; Notley et al., 2019).

29. 'Gratuitous management' can be found in some of the proposed policies to punish and stigmatise the poor by, for example, removing filters from cigarettes.

30. 'Routine neglect' can be seen in the proposed policy to reduce the numbers of retailers available for tobacco products. This would disproportionately affect the poor, who are less mobile and have fewer cash reserves. This means they will have to spend more to travel to outlets further from their home. For those that can scrape together enough cash, they will be forced to stock up on products when they do get to a retailer. Of course, the existing black market would expand to meet demand for tobacco in areas with poor access.

31. In my answers below, I have proposed strategies for achieving reduced smoking-related morbidity and premature mortality using a harm reduction approach, such as community-based initiatives, instead of prohibition strategies. Tobacco harm reduction encourages people who smoke and who cannot stop smoking, to switch from the product associated with a high risk of harm (e.g. smoked tobacco), to a relatively low risk product (e.g. vaping).

Answers to specific questions

What would effective Māori governance of the tobacco control programme look like?

32. For tobacco control or harm reduction policies to be effective for Māori, Māori cultural, hauora, Whānau Ora and kaupapa Māori experts need to be involved in policy analysis, intervention design and evaluation, and implementation. One example of where health policies initially failed Māori but then started to reduce inequities as they were adapted to Māori concerns, was in the reduction of infant mortality rates, such as SIDS and later SUDI. These are relevant to tobacco harm-reduction policies since smoking during pregnancy is a risk factor.

33. Early education campaigns to reduce infant mortality were successful in the general population, but infant mortality rates for Māori remained high until strategies of relevance to Māori were implemented. These included providing wahakura (flax woven bassinet) to provide infants with a defined space close to the mother while they slept, and the creation of smokefree rules. Leaders from within the Māori community were appointed to lead these outreach and educational activities (Rutter and Walker, 2021).

34. This demonstrates the importance of funding Māori-led programmes that centre on Māori knowledge, culture and tikanga. One-size-fits-all policies, such as the ones being proposed, are inappropriate for the NZ context.

35. Another example of programmes that Māori leaders might develop to reduce smoking-related morbidity and premature death, is the study recently funded by the Health Research Council. Dr Sue Crengle and colleagues will be inviting participants to undergo early screening for lung cancer

through their GP or a central hub, to test how to improve health outcomes by enabling early diagnosis of lung cancer. Survival rates from lung cancer are poor, but can be improved with early diagnosis and intervention (Health Research Council 2021). This type of programme could help to reduce inequities in lung cancer rates between Māori and non-Māori.

36. The excise tax on tobacco in NZ is the highest in the world relative to income. The disproportionately high smoking rates among Māori results in a massive economic loss to the Māori nation amounting to a total expenditure on tobacco including the tax and GST of $1,023,000,000 per annum! Considered in the context of the over-representation of Māori among the unemployed, and lower income deciles, this loss of money to tobacco smoking is a seriously negative economic determinant of ill-health for Māori (Siddharth, 2018).

What is needed to strengthen community action for a Smokefree 2025?

37. A promising community action for Indigenous communities is the use of mentors working within the community in a culturally appropriate way to encourage pregnant women to quit. One of my feasibility studies showed that such a programme could help – 33% of participants stopped smoking while pregnant, and 57% were able to cut down their smoking (Glover et al., 2015). Other successful strategies that have been rolled out in NZ are financial incentives to quit smoking (Notley et al., 2019). Retail vouchers, prize draws and gift packs could all be used to incentivise quitting or switching to less harmful alternatives (Glover et al., 2014).

38. For community actions to be effective, they need to be smaller stand-alone programmes, motivated by community spirit and aroha (e.g. Glover et al. 2016). This is in keeping with the views of the Associate Minister of Health Ayesha Verrall, who stated in an interview:

"I don't think everything should be centralised, but I'd much rather we had a pragmatic approach and thought, 'What do we need to solve this problem?' – whether it's cancer, covid, tuberculosis, diabetes – rather than putting the health system structure first and using that as a justification for why it can't improve."

39. Such a view is also in keeping with effective altruism strategy. The marginal benefit of increased funding to less well funded charities is higher than continually providing funds to the already well-resourced (MacAskill 2015).

What do you think the priorities are for research, evaluation, monitoring and reporting?

40. As there are only about 580,000 smokers in New Zealand, one cost-efficient intervention could be to establish a register of smokers and use computer-assisted dialling and an interactive voice-response system to identify and support people who want to stop smoking with quit-or-switch support. One such highly innovative intervention was used in Ottawa hospitals to follow-up people who smoked

who had been supported to quit while in hospital. Having identified a patient wanting quit support, the automated system then sent a follow-up referral to a live nurse. This programme has supported 500,000 people with quitting smoking. Patients who had previously been supported but had not reported for 6 months were followed up. Of those reached, 44% were smoke-free. Of those not ready to quit, 45% were supported in reducing the amount they smoked (Coja et al., 2019).

Do you support the establishment of a licensing system for all retailers of tobacco and vaping products (in addition to specialist vape retailers)?

41. I have never, and still do not, support a licensing system. A licensing system would add extra compliance costs. If central government pays these, then this means valuable funds are being diverted from more urgent priorities, such as the intervention, monitoring and outreach programmes detailed above. If compliance costs are passed on to the retailer, then the retailer will in turn pass these on to the consumer. This represents yet another burden on those who can least afford it. In the case of vaping products, any cost to the consumer would be counterproductive in terms of presenting vaping as a valid, cheap alternative to smoking (Bates et al. 2019).

Do you support reducing the retail availability of smoked tobacco products by significantly reducing the number of retailers based on population size and density?

Do you support reducing the retail availability of tobacco products by restricting sales to a limited number of specific store types (eg specialist R18 stores and/or pharmacies).

42. I do not support either of these proposals to reduce retail availability. The necessity to travel longer distances and stock up on product would impose another disproportionate burden on the poor, who have fewer cash reserves and are less mobile (Greene 2018).

43. Restricting retail availability of tobacco products would essentially mean an import quota, since there is no domestic supply. It is possible that this could constitute market access restrictions under GATT or WHO regulations, and could lead to a legal challenge (Kelsey 2012).

44. Trading regulations would allow a quota management on harmful constituents of cigarettes, but not the cigarettes themselves. This strategy has been applied in the past for sodium added to foods, and for the carbon trading system. In these cases, however, the objective was to allow sales of products to continue, but just restrict the additive or the harmful by-products. In the case of tobacco, the objective is to reduce consumption of the product totally, which makes such a policy questionable (Tait et al., 2013).

Do you support introducing a smokefree generation policy?

45. I do not support this ideology. This is one of the "prohibition by stealth" policies mentioned in the introduction. It is effectively prohibiting tobacco sales to an increasing number of adults, while allowing access to an older age group. This would put people who smoke tobacco at higher risk of harm from having to find and purchase tobacco on the black market. People who are normally law-abiding citizens would be entreated to sell product to others, which would put them on the wrong side of the law. This would increase the tobacco black market. I oppose this policy on the basis that this graduated prohibition has unintended negative consequences.

46. Prohibition of a readily available product in 1920s America as a way of reducing alcohol use is generally regarded to have been a mistake. It led to bootlegging and an increase in organised crime. Similar consequences can be seen when smoked tobacco is banned. When South Africa banned tobacco last year as part of their COVID-19 lockdown provisions, this resulted in an increase in illicit trade (Harris-Cik, 2020).

Do you support reducing the nicotine in smoked tobacco products to very low levels?

47. Like the proposed policy above, this is thinly disguised prohibition. If the only cigarettes available have very low nicotine content (VLNC), then this is effectively forcing all smokers to go 'cold turkey'. Like all prohibition policies, it has unintended consequences.

48. Reduced-nicotine cigarettes can be used as a cessation tool and I support them being available on the market as a cessation option. But they still deliver carbon monoxide, tar and the harmful smoke. Effort should go into encouraging people to quit altogether or, if they cannot, then to switch to vaping or smokeless products.

49. The South African experience (Harris-Cik 2020) shows what the consequences are of a total ban where black market contraband is available. During the COVID-19 lockdown in South Africa, the smoking ban failed in its intent to curb smoking, and led to an increase in black market tobacco supply and an increase in the price people paid for tobacco.

50. The increase in aggravated robberies to obtain cigarettes from shops in NZ (Glover et al 2021) shows what scarcity of an addictive product can lead to. An impending ban on smoking nicotine from combustible tobacco, which is what low-nicotine cigarettes amount to, could lead to panic buying, stockpiling, robberies and a thriving black market within the country.

51. There is little research available on the consequences of a ban where no black market products can be found, but there is some anecdotal evidence from prisons, which are increasingly becoming places where no tobacco products are allowed at all, by inmates or staff. In NZ, prisons have been totally smoke-free since 2011. Some prisons in countries like the UK, Australia and the USA are also smoke-free, though there is no country-wide ban.

52. A systematic review on both positive and negative consequences of a tobacco ban in prisons (de

Andrade and Kinner 2017) found success in smoking cessation, but in one study they noted a short-term increase in prisoner-on-prisoner assaults without injury. Awofeso et al., (2004, cited by Muir 2012) report prison rebellions in the form of riots and fires when smoking privileges were stopped.

53. There have also been some anecdotal news reports. The BBC (2018) reports how a prisoner being accused of a prison mutiny testified that a ban on smoking was a contributing factor. Corrections officers in an Australian prison blame a prison riot on an impending smoking ban (McInerney 2015).

54. In NZ, an investigation of the effectiveness of New Zealand's smoking ban in prisons (Collinson et al. 2012) describes an increase in violence in the month following the ban. It cites a report on stand-over tactics and violence in a Whanganui prison due to black market contraband and prisoners suffering from withdrawal.

Do you support prohibiting filters in smoked tobacco products?

55. Filters have been widely reported to lead to more tobacco use and a greater risk because of compensatory smoking (eg Evans-Reeves 2021), but there is also a great deal of misinformation. For an example of this, it is instructive to read the regulatory statement on this discussion document, which cites a study supposedly showing that adding filters to cigarettes leads to more 'aggressive' peripheral adenocarcinoma. In fact, the original study found no significant difference in cancer types between smokers who used filtered and unfiltered cigarettes (Brooks et al., 2005).

56. The authors of the other study used in the impact statement as an argument for banning filters (Ito et al., 2011) did find that as filtered cigarettes became more popular, one type of lung cancer (squamous cell carcinoma) declined, as another (adenocarcinoma) increased. However, the authors made no comment on which type of cancer is more 'aggressive', or on the relative risks of mortality or morbidity. Their closing conclusion is instructive.

These findings emphasize the importance of tobacco control programs, namely programs that prevent the initiation of smoking, hasten the rate of smoking cessation or limit exposure to ETS, have been associated with a decrease in both cigarette consumption and smoking rates, and subsequently with a decrease in lung cancer incidence.

57. I agree with this conclusion, and therefore I oppose the policy to prohibit filters. It is a distraction from the real aim of a tobacco control programme, which is to reduce smoking.

58. A filter ban sends a message that smokers need to be punished by making smoking a less pleasurable experience, which will not help the left behind groups. It is a further example of how the legal system is using "gratuitous management" (Greene 2018) to infantilise smokers.

59. Anecdotal evidence suggests that smokers will make their own filters from cardboard when commercial filters are unavailable. These may or may not be more harmful than the commercially available ones,

[3] *The environmental message espoused by the Regulatory statement is another distraction at best, and a cynical ploy to pander to the environmental lobby at worst. Most plastic waste, as shown by analysis of the Texas-sized gyre in the Pacific Ocean, is discarded fishing gear (Lebreton et al., 2018). This is also a conclusion of the Royal Society (2019) report on plastic waste in NZ, which also cited the packaging sector as a major contributor. Cigarette filters hardly rate in comparison.*

making a ban pointless. There are better ways to reduce or prevent smoking, which I have outlined in answers to previous questions, and these are more respectful to Māori and other vulnerable sectors.

Do you support allowing the government to prohibit tobacco product innovations through regulations?

60. I oppose these regulations. The reason for prohibiting tobacco-product innovations such as packaging or flavourings is to reduce the incidence of smoking by making it less attractive. But there are often unintended consequences. For example, the removal of all branding and promotions from tobacco products in Australia ('plain packaging' legislation) actually caused an increase in overall tobacco consumption. This is because the collapse of brand loyalty caused smokers to switch to cheaper brands, and increase their consumption (Underwood et al., 2020).

61. Tinkering around with making tobacco products less attractive is another way of using 'gratuitous management' (Greene 2018) to stigmatise smokers. It may also open us to legal challenges as a technical barrier to trade under WTO and GATT agreements (Kelsey, 2012). There are kinder and easier ways to reduce smoking.

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

62. I oppose minimum pricing. Focus groups organised by the Ministry of Health have provided good anecdotal evidence that price increases encourage quitting smoking or not starting, particularly among those on low incomes (Ministry of Health 2018). However, the same focus groups also emphasised the inequity of a tax that disproportionately affects those on low incomes. There is also evidence that the price is now so high that tobacco has become a sought-after commodity for criminals, leading to an increase in violent robberies of stores selling tobacco (Glover et al., 2021). Further increasing the price of tobacco would increase the crime rate and disproportionally affect the poor and other left behind groups.

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

Do you have any other comments on this discussion document?

63. My priority groups have always been, and remain in this order:

- All pregnant women who smoke
- Parents of young children (aged 0-7 years)
- People with smoking-related disease, or illnesses exacerbated by smoking.

64. The inequity in smoking prevalence between Māori and Pākehā should be the first objective. Ways of achieving this objective are provided in my answers to the earlier questions.

65. My aim is to focus most attention on the more vulnerable sectors of the population who still have a high prevalence of smoking and suffer the most harm from smoking. The aim should be for the smoking rate for these sectors to be reduced to the same level as the rest of the population. Only then can we start to look at strategies that might benefit all sectors equally. Given that resources are limited, resources need to be targeted towards interventions that will help Māori, such as culturally based community programmes, as well as people living with mental health conditions, those with financial difficulties and the LGBTQI community.

66. This is best achieved through community groups that understand the sector concerned. As Associate Minister Ayesha Verrall has stated, we need to concentrate on what works.

67. Resources channelled in this direction through several small-scale initiatives run by dedicated people would be a more cost-effective use of funds than the blunt instrument of regulation and prohibition by stealth advocated by the Ministry of Health. Such initiatives need to be supported by scientifically supported research, including systematic reviews, so that we can concentrate resources on initiatives that work.

Setting a punitive precedent

68. Banning a product often has unintended consequences, as can be seen with the ban on alcohol in 1920s America. It also creates a dangerous precedent. Tobacco may well not be the first product that prohibitionists are planning to ban, without regard for the consequences.

69. Regulation and control of tobacco products has progressed since the 1960s when the US Surgeon General published their historical and ground-breaking report. Attitudes towards smoking have changed to such an extent that market forces have created a viable and relatively safe alternative in the form of smokeless nicotine devices. Instead of overly regulating this emerging market, it would make more sense to encourage it and perhaps even shape it to some extent, as recommended by the ASH strategy (Bates et al. 2019). Market shaping has been a successful strategy in switching consumer preferences. Market shaping strategies from activists for example, have successfully increased market share of free-range over battery eggs. Industry group campaigns have instituted a science-based change in the wine industry from cork to screw-top caps, and an increase of the incidence of wooden over concrete buildings (Ruis et al. 2020). The Ministry of Health could play a role in reducing or eliminating some of these barriers. They could, for example, provide scientifically informed information on safety, allow vaping suppliers to provide product information and advice, and allow vaping product innovations that will enhance the experience.

70. The 2021 budget shows me that the current Government understands that to reduce smoking prevalence among the low income and marginalised, they must do something to reduce the drivers of smoking – the economic and social determinants. Their focus is on alleviating poverty, on alleviating accommodation insecurity and on supporting reparative programmes that enable Māori to trial and implement more Māori-for-Māori health programmes. This is what Māori have been calling for instead of oppressive taxes on tobacco and moving the fence posts so that too many Māori end up on the wrong side of the law (see graphic), just as they were starting to feel some improvement in their situation.

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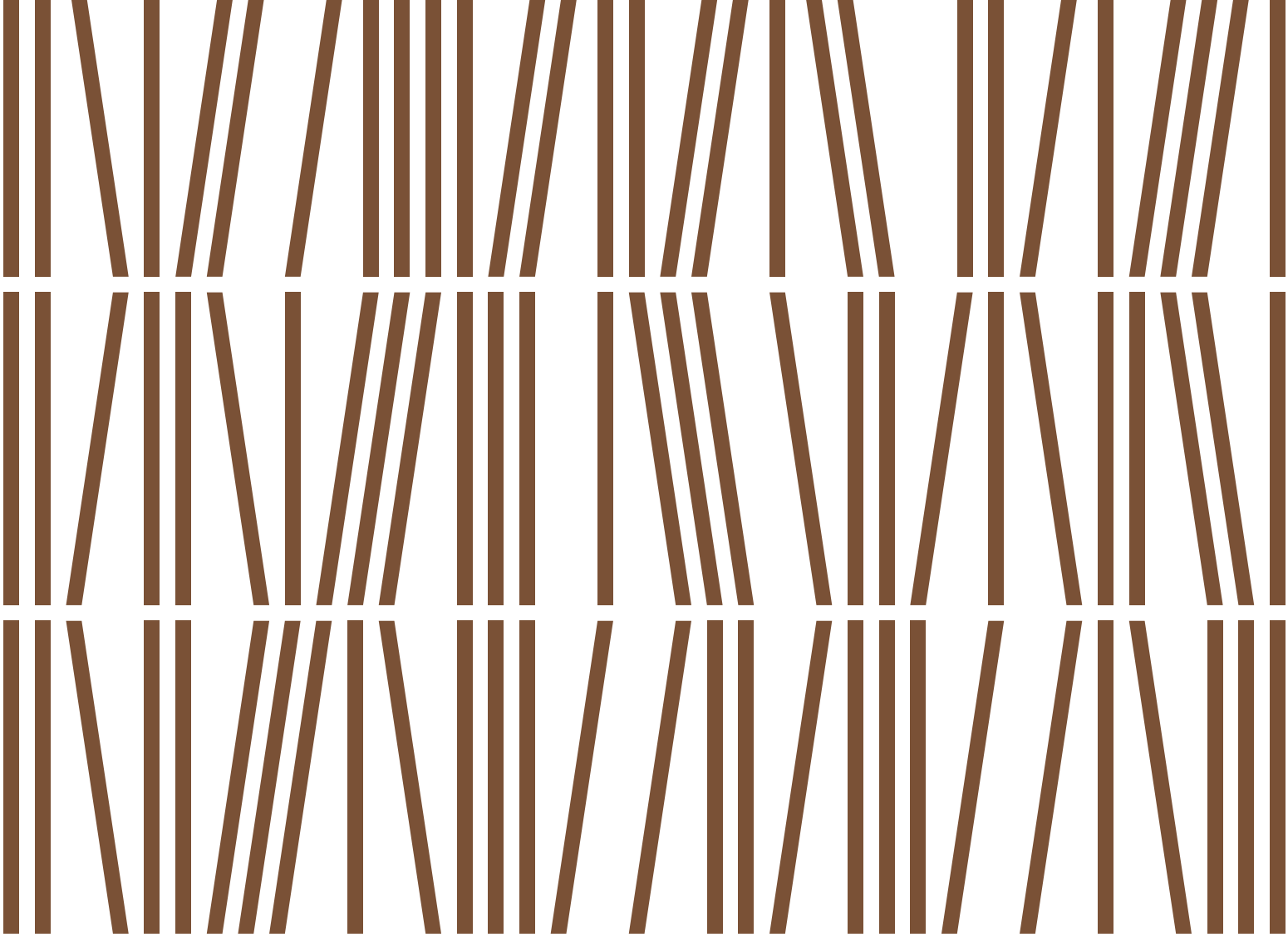

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