Cancer Society of New Zealand
National Office

Te Röpü Mate
Pukupuku o Aotearoa

Level 2
Red Cross House
69 Molesworth St.
PO Box 12700
Wellington

Telephone: 64 4 494-7270
Facsimile: 64 4 494-7271

Websites: www.cancernz.org.nz
Email: admin@cancer.org.nz

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Committee Secretariat
Māori Affairs
Parliament Buildings
Wellington
Phone: +64 4 817 9047
Fax: +64 4 499 0486

The Cancer Society of New Zealand; including all of its divisions and centres; congratulates the Māori Affairs Committee on launching such an important inquiry into the tobacco industry in Aotearoa; and the consequences of tobacco use for Māori. Tobacco has affected the lives of hundreds of thousands of New Zealanders and is continuing to do so. Among all New Zealanders, Māori have been the group most highly affected by tobacco smoking. Smoking not only has caused great pain, suffering and death among Māori but has also impacted negatively on economic, developmental and social aspirations of many Māori over the past century and beyond.

We acknowledge the progress which has been made in the past decade in relation to the reduction in smoking prevalence in New Zealand and legislation, including creation of smoke-free public places and the introduction of graphic health warnings; however, a disproportionately significant number of Māori in New Zealand continue to smoke. The Cancer Society believes that in order to make headway into reducing Maori smoking uptake and smoking rates, there must be a

significant tightening of the current environment for the retail of tobacco as well as policies to address the demand and supply of tobacco products.

As such the Cancer Society of New Zealand is recommending the following:

Recommendation 1: *That the Inquiry recommends that the NZ Parliament passes a law to require all tobacco companies operating in New Zealand to supply copies of all their marketing-related documentation (including plans and strategies), at six monthly intervals into the future (including all such materials produced since January 1960). This could be modelled on existing Canadian regulations.*

Recommendation 2: *That the Inquiry recommends that the NZ Parliament upgrades the out-of-date Fair Trading Act 1986 and strengthens the powers of the Commerce Commission, so that the very sub-optimal response by NZ agencies to misleading tobacco product descriptors (e.g., "light and mild" descriptors) is properly addressed and never repeated for other tobacco-related investigations or other hazardous products.*

Recommendation 3: *That the Inquiry recommend that the NZ Parliament legislates to ban all point-of-sale displays of tobacco, require plain packaging of tobacco products, require warnings be increased to at least 90 percent of all pack surfaces, and require a rigorous monitoring regime be established to identify any new methods of tobacco product marketing.*

Recommendation 4: *That sale to minors is strictly enforced with particularly emphasis placed in areas with educational facilities – Primary/Secondary Schools.*

Recommendation 5: *A sustainable industry denormalisation programme and counter marketing campaign communicating the smoke free Aoteroa 2020 messages to the public is developed and implemented in 2010.*

Recommendation 6: *That the Inquiry request that the Ministry of Health provide more detailed costing information on the health, social, economic*

and cultural impact tobacco use in Aotearoa, to better inform the deliberations of this Inquiry.

Recommendation 7: *That a dedicated tax, from the existing tobacco taxation revenue (over $1B), be established in 2010. The tax to be used to fund services/programmes ranging from health promotion programmes, enforcement, cessation/quit services, research and advocacy services. A substantive budget increase that truly reflects the disproportionate negative impact tobacco use has on Māori is required.*

Recommendation 8: *Increase tobacco tax substantially each year, from 2010 as recommended by the World Bank and the World Health Organization (WHO) along with the current annual CPI adjusted increases.*

Recommendation 9: *Harmonize tax on loose tobacco with manufactured cigarettes in 2010.*

Recommendation 10: *That a self-funding Tobacco Retailer Licensing Scheme (TLRS) which requires retailers to attend annual training be implemented. Breaches in relevant regulation should result in the loss of licenses and therein the ability to sell tobacco products.*

Recommendation 11: *That the Inquiry actively question people making oral submissions to the Inquiry on tobacco endgame solutions, and foster a public debate on "the time being right to have a clear endgame strategy to end tobacco sales in Aotearoa by 2020".*

We have attached a submission outlining our reasons for taking this position. Auckland branch of Cancer Society of New Zealand is also submitting on the inquiry.

We would appreciate the opportunity to make an oral submission and to provide additional material and references in support of the issues we have raised in this submission.

Yours Sincerely

Dalton Kelly
Chief Executive
Cancer Society of New Zealand

Navid Foroutan
Tobacco Control Advisor
Cancer Society of New Zealand

Cancer Society of New Zealand
National Office

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Email: admin@cancer.org.nz

Cancer Society of New Zealand

The Cancer Society of New Zealand is a non-profit organization which aims to minimize the incidence and impact of cancer on all those living in New Zealand. Tobacco smoking causes cancer of the lung, oral cavity, naso-, oro- and hypopharynx, nasal cavity and paranasal sinuses, larynx, oesophagus, stomach, pancreas, liver, kidney (body and pelvis), urethra, urinary bladder, uterine; cervix and bone marrow (myeloid leukaemia). Furthermore, passive smoking is a cause of lung cancer in non-smokers; the excess risk is of the order of 20 percent for women and 30 percent for men.[1]

As a result of the unequivocal link between smoking and cancer, the Society considers efforts to reduce smoking rates in this country to be one of the key strategic objectives of its cancer prevention programme and strongly supports efforts to reduce exposure to second-hand smoke, increase rates of smoking cessation and decrease uptake of smoking. Over the years the Society has provided important strategic leadership within Smoke-free, helping to establish key agencies which now play a major role in smoking cessation, health promotion and tobacco control policy development. We continue to strongly advocate for evidence-based regulation and other measures in order to reduce the impact of smoking in New Zealand.

[1] International Agency for Research on Cancer, 2004.
URL: http://monographs.iarc.fr/ENG/Monographs/vol83/volume83.pdf

Submission on the Māori Affairs Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Māori

Opening comments:

Tobacco is not a normal consumer product and must be regulated in line with the harm it causes;

- Tobacco products are not normal consumer products and should not be treated in that way. They are highly addictive and cause thousands of deaths in New Zealand each year.
- Smoking causes fatal and chronic diseases, leading to death in half of long term users.
- The nicotine in tobacco products is highly addictive [including to young people – and is the main reason that people continue to smoke.
- There is inadequate public understanding of the health effects of smoking and the addictiveness of nicotine, with few smokers fully appreciating the breadth of disease, both fatal and chronic, which smoking causes.
- Critically; this harmful and addictive product is almost always taken up when people are too young to make an informed decision.
- Most smokers – including young people [wish they'd never started to smoke and want to quit. Unfortunately smoking causes both physical and psychological addiction which makes quitting difficult especially when compounded by the impacts of poverty.
- The unique status of tobacco needs to be recognised when considering the type of regulation of tobacco products which is justified.

Summary: Tobacco is far from being a normal consumer product and therefore its legal status should in no way protect it from regulation aimed at increasing cessation rates and decreasing smoking initiation. Tobacco must be regulated in line with the harm it causes.

Health effects of smoking:

- Tobacco use is the leading cause of preventable death in New Zealand, accounting for around 4,300 to 4,700 deaths per year.[2] [3] [4] When second-hand smoke deaths are included, this estimate increases to around 5,000 deaths per year.[5] [6]

- Half of the people who smoke today and continue smoking will eventually be killed by tobacco.[7] They will die an average of 15 years early.[8] [9] [10]

- Globally, 1.3 billion people smoke. Each year tobacco causes 5 million premature deaths.[11]

- Tobacco use is currently responsible for the death of 1 in 10 adults worldwide. If current smoking patterns continue, it will cause some 10 million deaths each year by 2020.[12]

- Smoking increases the risk of developing diseases of the respiratory and circulatory systems, including cancers of the lung, oral cavity, pharynx, larynx, oesophagus and pancreas.[13] Smoking also increases the risk of developing diseases of the urinary tract, pelvis, bladder and digestive tract.[14]

- Smoking causes one in four of all cancer deaths in New Zealand.[15]

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[2] Peto, R., Lopez, A.D., Boreham, J., and Thun, M. (2006). *Mortality from smoking in developed countries 1950-2000*. Second edition. www.ctsu.ox.ac.uk/~tobacco/, retrieved 24 June 2009.
[3] Public Health Intelligence. 2002. *Tobacco Facts May 2002* (Public Health Intelligence Occasional Report No 2). Wellington: Ministry of Health.
[4] Peto, R. and Lopez, A. 1994. *Mortality from Smoking in Developed Countries 1950-2000: Indirect estimates from national vital statistics*. New York: Oxford University Press.
[5] Ministry of Health (2004). Looking upstream: Causes of death cross-classified by risk and condition, New Zealand 1997. Wellington: Ministry of Health.
[6] Tobias, M. and Turley, M. (2005). Causes of death classified by risk and condition, New Zealand 1997. Australian and New Zealand Journal of Public Health, 29, 5-12.
[7] Ministry of Health. 2008. *Tobacco control and smoking: Health effects of smoking*. www.moh.govt.nz/moh.nsf/indexmh/tobacco-effects, retrieved 19 June 2009).
[8] World Health Organization. 2006 *Why is tobacco a public health priority?* Tobacco Free Initiative. Retrieved on 23 January 2006 from www.who.int/tobacco/health_priority/en/print.html.
[9] World Health Organization. 2008. *The global tobacco crisis*. www.who.int/tobacco/mpower/en/, retrieved 24 June 2009.
[10] Peto, R. and Lopez, A. 1994. *Mortality from Smoking in Developed Countries 1950-2000: Indirect estimates from national vital statistics*. New York: Oxford University Press.
[11] World Health Organization. *Why is tobacco a public health priority?* Tobacco Free Initiative, www.who.int/tobacco/health_priority/en/print.html.
[12] *ibid*.
[13] Vineis, P., Alavanja, M., et al. 2004. Tobacco and cancer: recent epidemiological evidence. *Journal of National Cancer Institute* 96: 99-106.
[14] Ministry of Health. 2005. *Tobacco Facts 2005*. Wellington: Ministry of Health.
[15] Laugesen, M. 2000. *Tobacco Statistics 2000*. Wellington: Cancer Society of New Zealand.

- Tobacco is the only consumer product that kills half its users when used as the manufacturer intends.

- Inhaled smoke contains more than 4,000 chemicals including acetone (paint stripper), ammonia (toilet cleaner), cyanide (rat killer) and DDT (insecticide).[16] [17]

- About 1,300 people in New Zealand have untreatable blindness due to current and past smoking. [18]

Smoking in New Zealand

- Rates of smoking prevalence and of consumption of cigarettes per head have dropped substantially in New Zealand in recent decades.[19]

- More than 700,000 New Zealanders still smoke on a regular basis[20]and people generally begin smoking as teenagers (14.5 years is the average).[21]

- In 2008 the prevalence of daily smoking in adults aged 15 years and over was estimated at 20.7 percent. This was up from 18.7 percent in 2006/7.[22]

- Annual consumption is steady since 2006 at just over 1,000 cigarettes per adult including both factory-made and roll-your-own cigarettes. This compares with annual per adult consumption of about 3,200 in 1975, and 1,900 in 1990. [23]

Smoking and Māori

- Tobacco kills over 600 Māori prematurely every year.[24]Cigarette smoking accounted for 31 percent of all annual Māori deaths during 1989-93 as

[16] The Quit Group and the Health Sponsorship Council. 2000. *Break Free*. Wellington: Ministry of Health.
[17] Fowles J, Bates M, Noiton D. 2000. *The Chemical Constituents in Cigarettes and Cigarette Smoke: Priorities for Harm Reduction.* Ministry of Health. Retrieved on 4 January 2007 from www.ndp.govt.nz/moh.nsf/pagescm/1003/$File/chemicalconstituentscigarettespriorities.pdf
[18] Wilson G, et al. 2001. Smoke gets in your eyes: smoking and visual impairment in New Zealand. *NZ Med J*, 114, 471-4.
[19] The Quit Group. 2009. *Quitline Client Analysis Report January-December 2008* Wellington: The Quit Group.

[20] Ministry of Health. 2008. *Tobacco Trends 2007: A brief update on monitoring indicators.* Wellington: Ministry of Health.
[21] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health. Auckland, New Zealand. www.ash.org.nz/pdf/ASHYear10Report19992008.pdf, Retrieved on 19 June 2009.

[22] Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand.* Wellington: Ministry of Health.
[23] Ibid.
[24] Te Reo Mārama website: www.tereomarama.co.nz. Retrieved 9 November 2009.

compared to 17 percent of all deaths in the total population.[25]This is a significant loss of cultural knowledge and language.

- Life expectancy for Māori men is 70.4 years, compared to 78 years for non-Māori. For Māori women life expectancy is 75.1 years, compared to 82.2 years for non-Māori.[26]

- In 2008, the Year 10 female Māori who smoked daily was 22 percent compared to 13 percent for male Māori.[27]

- Of students aged 14 to 17 who smoked daily, 30 percent of Māori males reported first trying a cigarette at seven years old or younger, and 31 percent of Māori females first experimented at eight to nine years of age.[28]

- Māori women are more than twice more likely to be current smokers than women in the total population. Māori men are 1.5 times more likely to be current smokers than men in the total population.[29]

- In 2008, 45.4 percent of Māori adults smoked, compared to 21.3 percent of Europeans, 31.4 percent of Pacific Peoples and 12.4 percent of Asian People.[30]

- Tobacco plays a significant role in health inequalities within New Zealand for both youth[31]and adults. [32] Higher smoking prevalence is seen among low-income groups, Māori and Pacific peoples. [33] [34]

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[25] Te Puni Kōkiri. *Cigarette smoking mortality among Maori, 1954-2028*. Wellington: Te Puni Kōkiri. 1998.

[26] Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand*. Wellington: Ministry of Health..

[27] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999 - 2008: Trends in tobacco use by students 14 - 15 years*. Action on Smoking and Health NZ. www.ash.org.nz/pdf/ASHYear10Report19992008.pdf. Retrieved on 19 June 2009.

[28] Health Sponsorship Council. 2005. *Reducing smoking initiation literature review: A background discussion document to support the national framework for reducing smoking initiation in Aotearoa-New Zealand*. Wellington: Health Sponsorship Council.

[29] Ministry of Health. 2008. *A Portrait of Health: Key results of the 2006/2007 New Zealand Health Survey.* Wellington: Ministry of Health.

[30] Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand.* Wellington: Ministry of Health.

[31] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health. Auckland, New

[32] Blakely T, Tobias M, Atkinson J, Yeh, LC, Huang K. 2007. *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981 – 2004*. Wellington: Ministry of Health.

[33] Hill S, Blakely T, Howden-Chapman, P. 2003. *Smoking Inequalities: Policies and patterns of tobacco use in New Zealand. 1981 to 1996*. Wellington: Ministry of Health.

[34] Blakely T, Tobias M, Atkinson J, Yeh, LC, Huang K. 2007. *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981 – 2004*. Wellington: Ministry of Health.

Terms of reference and recommendations:

Terms of reference (ToR) 1: Historical actions of the tobacco industry to promote tobacco use amongst Māori.

The tobacco industry in New Zealand and worldwide has historically used a wide range of marketing methods that are likely to appeal to young people and adults from all ethnic groups, including Māori. Tobacco companies use highly advanced and specialized marketing strategies to sell their products even in face of ever increasing restrictions on tobacco advertising. Some examples are: price reductions, the packaging of products, point-of-sale displays, etc. Furthermore, smoking can be frequently seen in movies, music videos and television programmes (with some of this having resulted from past product placement by tobacco companies). Again, these practices reach a wide range of people – including Māori. A recent high profile example of smoking in movies with high young audience is the blockbuster movie "Avatar" where one of the main characters of the movie smokes in several scenes throughout the film.

Tobacco promotion has been exacerbated by chronic deception about tobacco risks, and the effects of tobacco-related policy interventions. Thus Māori and other smokers, and would-be smokers, have been deceived about the risks of addiction, and about second-hand smoke, smoke free policies, and many other areas[35] [36] [37].The industry has also concealed evidence of this deception, including destruction of documents, and has obstructed research into this deception.[38] [39] [40]

Of particular relevance to Māori is the likelihood that tobacco industry marketing has contributed to harmful misperceptions among Māori smokers. These include: misperceptions around "light and mild" cigarettes (currently marketed in colour-coded "blue" and "white" packs or with words such as "smooth"), misperceptions

[35] Stevenson T, Proctor RN. The secret and soul of Marlboro: Phillip Morris and the origins, spread, and denial of nicotine freebasing. *American Journal of Public Health* 2008;**98**:1184-94.
[36] 3. Proctor RN. The global smoking epidemic: a history and status report. *Clin Lung Cancer* 2004;**5**:371-6.
[37] Thomson G, Wilson N. The tobacco industry in New Zealand: A case study of the behaviour of multinational companies. *Public Health Monograph Series*. Wellington: Department of Public Health, Wellington School of Medicine, University of Otago, 2002.
[38] LeGresley EM, Muggli ME, Hurt RD. Playing hide-and-seek with the tobacco industry. *Nicotine & Tobacco Research* 2005;**7**:27-40.
[39] Muggli ME, LeGresley EM, Hurt RD. Big tobacco is watching: British American Tobacco's surveillance and information concealment at the Guildford depository. *Lancet* 2004;**363**:1812-9.
[40] Muggli M, Forster J, Hurt R, et al. The smoke you don't see: uncovering tobacco industry scientific strategies aimed against environmental tobacco smoke policies. *Am J Public Health* 2001;**91**:1419-23.

around the harm from menthol and roll-your-own tobacco, and misperceptions around the harm from second-hand smoke.

Recommendation 1: *That the Inquiry recommends that the NZ Parliament passes a law to require all tobacco companies operating in New Zealand to supply copies of all their marketing-related documentation (including plans and strategies), at six monthly intervals into the future (including all such materials produced since January 1960). This could be modelled on existing Canadian regulations*[41].

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Recommendation 3: *That the Inquiry recommends that the NZ Parliament legislates to ban all point-of-sale displays of tobacco; require plain packaging of tobacco products; require warnings be increased to at least 90 percent of all pack surfaces; and, require a rigorous monitoring regime be established to identify any new methods of tobacco product marketing.*

Recommendation 4: *That sale to minors is strictly enforced with particularly emphasis placed in areas with educational facilities especially Primary/Secondary Schools.*

Recommendation 5: *A sustainable industry denormalisation programme and counter marketing campaign communicating the Smoke Free Aoteroa 2020 messages to the public is developed and implemented in 2010.*

[41] Health Canada. Tobacco Reporting Regulations. Ottawa: Health Canada, 2009.
[42] Thomson G, Wilson N. Implementation failures in the use of two New Zealand laws to control the tobacco industry: 1989-2005. *Aust New Zealand Health Policy* 2005;**2**:32.

ToR 2: The impact of tobacco use on the health, economic, social and cultural wellbeing of Māori.

Health: Aside from the numerous health impacts of smoking which were mentioned earlier in this submission, tobacco use also contributes to the gap in health between Māori and non-Māori.[43] [44] In particular, the gap in cancer mortality between Māori and non-Māori is growing[45] and smoking contributes to this gap.

Economic: Nicotine addition means that most Māori smokers feel compelled to spend many millions of dollars a year buying tobacco (eg, expenditure on cigarettes by Māori in 2000 was estimated at $266 million per year[46]). Additional costs to Māori relate to treating tobacco-related illness; and lost income from premature death among workers and from sick leave. Low-income Māori particularly suffer from smoking-related costs.

Social and cultural: Physical impairment from smoking-related disease reduces the scope for participating in a wide range of family, social, community and cultural activities. Influential Māori from parents to community and iwi leaders have their contribution to whānau, iwi, communities and wider society restricted or cut short by tobacco related-disease and premature mortality. Furthermore, if there is not a major reduction in tobacco use in the next 10 years, in the next few decades smoking will have a larger *relative* impact on Māori life expectancy than it has now (ie, given the likely reduction in other risk factors for health, the harmful impact of tobacco will stand out even more). The lower life expectancy in Māori (partly due to tobacco) even results in fewer votes per life-time than for non-Māori.

> **Recommendation 6:** *That the Inquiry request that the Ministry of Health provide more detailed costing information on the health, social, economic and cultural impact tobacco use in Aotearoa, to better inform the deliberations of this Inquiry.*

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[43] . Blakely T, Fawcett J, Hunt D, et al. What is the contribution of smoking and socioeconomic position to ethnic inequalities in mortality in New Zealand? *Lancet* 2006;**368**:44-52.

[44] . Wilson N, Blakely T, Tobias M. What potential has tobacco control for reducing health inequalities? The New Zealand situation. *Int J Equity Health* 2006;**5**:14.

[45] Blakely T, Tobias M, Atkinson J, et al. Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981-2004. Wellington: Ministry of Health, 2007.

[46] Ministry of Health. Clearing the smoke. A five-year plan for tobacco control in New Zealand (2004-2009) Wellington Ministry of Health

ToR 3: The impact of tobacco use on Māori development aspirations and opportunities

Illness and premature death are completely counter to all human aspirations – including those of Māori (see response to ToR 2 above). Dependence on a highly addictive substance (nicotine/tobacco) is also counter to all notions of freedom and cultural identity. Māori smokers, in response to the question "If you had to do it over again, would you start smoking?" record high levels of regret at 85 percent.[47]

Given the scale of the tobacco problem for Māori, combined with the very slow rate of decline in smoking prevalence, exceptional measures are required to tackle the problem and so reduce the continuing uptake of smoking in young Maori.

ToR 4: What benefits may have accrued to Māori from tobacco use

It is likely that some smokers (including Māori smokers) may derive short-term psychological "benefits" from the pharmacological actions of nicotine on the brain (eg, improved visuospatial attention[48]). But such benefits come at an enormous price given the serious long-term harm to health from smoking. Even in the short-term smoking can degrade quality of life as: (i) smokers' can regularly experience withdrawal symptoms if they can not have a smoke in some circumstances (eg, on a long bus trip or when in a smokefree setting); (ii) brain function is impaired by carbon monoxide in the smoke; and (iii) smokers generally have poorer quality sleep. Some of these factors may explain why smokers are more likely to die from motor vehicle crash injuries and from a range of other injuries.[49]

The tobacco industry and the retail sector may argue that cigarette production and sales employs some New Zealanders (including Māori). But employment arguments are entirely spurious, since if people didn't smoke they would spend their money on other areas, or increase their savings rate, and will thus also

[47] Wilson N, Edwards R, Weerasekera D. High levels of smoker regret by ethnicity and socioeconomic status: national survey data. *N Z Med J* 2009;**122**:99-100.
[48] . Hahn B, Ross TJ, Yang Y, et al. Nicotine enhances visuospatial attention by deactivating areas of the resting brain default network. *J Neurosci* 2007;**27**:3477-89.
[49] Wen CP, Tsai SP, Cheng TY, et al. Excess injury mortality among smokers: a neglected tobacco hazard. *Tob Control* 2005;**14 Suppl 1**:i28-32.

maintain and generate jobs in this way (eg, in housing sector, education sector, food supply sector etc). Indeed, the productivity and size of a tobacco-free Aotearoa economy would be larger overall, as there would be less premature death of workers and less sick-leave from work.[50]

ToR 5: What policy and legislative measures would be necessary to address the findings of the Inquiry

Chipping away at the tobacco problem with a range of small incremental tobacco control steps is likely to work – eventually. But as the limited decline in smoking rates in Aotearoa over the last two decades (particularly among Māori) show, this process is far too slow to be ethically tolerable for our society. It also would allow the continuation of large Māori/non-Māori health inequalities. Continuing on this slow incremental path will result in tens of thousands of premature deaths among Māori and non-Māori before the last tobacco-related death occurs. Aotearoa needs a clear endgame strategy for tobacco use, as we can not wait for 70 or 80 more years before smoking is not a serious threat to public health anymore.

One of the most effective and proven ways to reduce the smoking rate is increasing taxation. The Cancer Society believes that the government should use the taxation tool strongly and effectively to work to reduce the smoking rate and a smoke free New Zealand.

Māori specific services/programmes receive approximately $8M from the $40M tobacco control budget and the majority of this money goes towards smoking cessation services. Considering that Māori contribute over $250M of the $1B collected in tobacco tax each year, the sector is under-funded for the task. Funding can be sourced by implementing a dedicated tax similar to three health-related dedicated taxes for alcohol, accident and gambling control.

Loose tobacco is taxed lower than ‘tailor-made’/manufactured cigarettes. This provides smokers with a cheaper tobacco product to buy. It also allows easier financial access by youth to loose tobacco.

[50] Easton B. The Social Costs of Tobacco Use and Alcohol Misuse. Wellington: Department of Public Health, Wellington School of Medicine, 1997.

Recommendation 7: *That a dedicated tax, from the existing tobacco taxation revenue (over $1B) be established in 2010. The tax to be used to fund services/programmes ranging from health promotion programmes, enforcement, cessation/quit services, research and advocacy services. A substantive budget increase that truly reflects the disproportionate negative impact tobacco use has on Māori is required.*

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[51] World Bank, *Curbing the Epidemic: Governments and the Economics of Tobacco Control. 1999.*
[52] World Health Organization. http://www.who.int/tobacco/mpower/facts_findings/en/index.html 2009.

For any correspondence in regard to this submission please contact:

Navid Foroutan – Health Promotion Advisor (Tobacco Control)

Level 2, 69 Molesworth street, Thorndon

PO Box 12700, Wellington 6144

Phone: 04 4947274

Fax: 04 494 7271

Email: navid.foroutan@cancer.org.nz

Web: www.cancernz.org.nz