A new opportunity to eliminate policy incoherence in tobacco control in New Zealand

The Māori Affairs Select Committee is undertaking an inquiry into “the tobacco industry in Aotearoa (New Zealand) and the consequences of tobacco use for Māori”.¹ Our submission to this Committee emphasised the primacy of tobacco endgame policies—e.g. to have a sinking lid on tobacco imports so as to achieve a negligible level of smoking (<1% prevalence) by 2020. Nevertheless, we also argued that supplementary incremental steps might be needed if political leaders do not adopt endgame strategies. So with this in mind we briefly reviewed current key tobacco control policy interventions supported by central government.

The interventions we considered are those largely described on the Ministry of Health website and in other documents.² We particularly aimed to identify those central government interventions which could be strengthened by reducing the extent to which they were being constrained or countered by other government policies. That is, we classified these interventions as “coherent” where there was no such constraint or conflict, and “incoherent” where a policy was subject to such constraints and conflicts.

From the generated list of 12 intervention areas, we identified at least 4 where some level of policy incoherence appeared to exist (Table 1). Three of these interventions involving incoherence were within the most important four areas of tobacco control (as per current incremental approaches). Besides the specific intervention areas, there is the strategic contradiction of government encouraging and requiring tobacco companies in New Zealand to profit from selling an addictive and highly hazardous product (through the provisions of the Companies Act), while also having the reduction of tobacco use as a government health aim.

Making these current policies more coherent would support tobacco endgame policies. Such endgame policies could include a sinking lid of quotas on tobacco imports, and/or large regular (6-monthly) tax hikes, with both approaches aiming to achieve negligible levels of smoking prevalence within a decade (albeit with home-grown tobacco for personal use still being permitted).

Failing such endgame approaches being supported by the Select Committee, the Committee should at least recommend rapid resolution of these areas of policy incoherence and increase the intensity of all effective tobacco control interventions. This would mean that at least the incremental approaches for ending the tobacco epidemic could proceed more effectively.
Table 1. Tobacco control interventions supported by central government and classification in terms of policy incoherence

<table>
<thead>
<tr>
<th>Tobacco control intervention</th>
<th>Evidence of policy incoherence</th>
<th>Description of the coherence / incoherence</th>
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<tr>
<td><strong>Top 4 interventions</strong></td>
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<tr>
<td>Tobacco taxation to raise tobacco prices (to reduce youth uptake and promote quitting)</td>
<td>Yes</td>
<td>Tax/price policy has been inadequately implemented with no real increase in levels of tax since 2001.6 7 Tax/price policy is also partly undermined by government policy to permit duty free sales of tobacco and to allow for personal supplies of tobacco to be carried into NZ from overseas. This also results in substantial loss of government revenue that could be used for tobacco control.8 Allowing roll-your-own tobacco to be sold at essentially cheaper prices also undermines the price policy.7 Using all tobacco tax revenue for general purposes with no dedicated fraction for tobacco control may also partly undermine government arguments that the tax is a health protecting measure. Furthermore, the lack of any dedicated component of tobacco tax used to help smokers quit can be considered ethically problematic.6</td>
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<tr>
<td>Complete restrictions on tobacco sponsorship and nearly complete restrictions on tobacco marketing</td>
<td>Yes</td>
<td>The important marketing measures of point-of-sale displays, branding and use of positive imagery and wording on the tobacco packaging itself, continues to be permitted.</td>
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<td>Smokefree environments (especially indoor public settings and school premises)</td>
<td>Yes</td>
<td>Allowing smoking in cars with young children present – despite this setting potentially having extremely high levels of second-hand smoke.6 10 There is also a stark contrast with other in-vehicle laws designed for public safety purposes: seat-belts, child safety restraints and a ban on the use of cell phones when driving. New Zealand is becoming out-of-step with other jurisdictions in this area.11</td>
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<td>Mass media campaigns</td>
<td>No</td>
<td>There is a coherent policy that links cessation promotion campaigns well with the Quitline service. Nevertheless, these mass media campaigns are still under-funded and do not adequately exploit the synergies of co-interventions (e.g., smokefree law changes3), nor use more innovative approaches such as targeting the tobacco industry itself.</td>
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<td><strong>Other interventions</strong></td>
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<tr>
<td>Commerce Commission warning in 2008 on the misleading nature of &quot;light and mild&quot; descriptors</td>
<td>Yes</td>
<td>The government allows the tobacco companies to use other misleading descriptor words (e.g., &quot;smooth&quot;) and allows the colour-coding of packs.12 There is good evidence that many NZ smokers are being mislead by these messages on packaging, and misperceptions that these tobacco products are less harmful to health are common.13</td>
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<tr>
<td>Age restrictions on tobacco sales</td>
<td>Possibly</td>
<td>This policy is possibly being undermined by not having a more controlled system around tobacco retailing. For example, if retailer licenses were required to sell tobacco, then these could be withdrawn when there was evidence of illegal sales to youth. Similarly, there could be minimum ages for shop attendants and no sales could be permitted by retailers in close proximity to schools. Permitting point-of-sale tobacco displays and permitting additives to tobacco (eg, sweeteners and flavours) also partly undermines this policy.</td>
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<tr>
<td>Widely available and heavily subsidised pharmacotherapies (eg, NRT)</td>
<td>Possibly</td>
<td>This policy appears fairly coherent and the link with the Quitline provides a distribution system for nicotine replacement therapy (NRT). Nevertheless, the uneven retail availability (compared to tobacco) is possibly problematic (ie, there is no requirement for retailers to sell NRT products if they sell tobacco). Also, a possible form of policy incoherence is the lack of public education to reduce substantial confusion among smokers about nicotine being the major cause of cancer from cigarettes.14</td>
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</table>
Tobacco control intervention | Evidence of policy incoherence | Description of the coherence / incoherence
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Requirements for graphic health warnings on tobacco packaging | No | This appears to be a coherent policy but the failure to fully utilise this intervention (which costs taxpayers nothing once the policy is developed) might mean that more tax payer funds need to be spent on mass media campaigns to compensate. For example various design problems with the current NZ warnings exist, and in particular they are small compared to those used in some other countries (up to 80% of the front of the packet in Uruguay). Some other countries also use stronger “fear arousal” and “loss-framed” themes in their graphic warnings (eg, Brazil) which are probably more effective.
Funding the Quitline service | No | Policy appears coherent and there is relatively high use of the Quitline by international standards and linkage with information on cigarette packets.
Vending machine controls | No | Policy appears coherent.
Developing “New Zealand Smoking Cessation Guidelines” | No | Policy appears coherent.
ABC approach for smoking cessation (framework and work programme) | No | This Ministry of Health (MoH) policy appears coherent.

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Competing interests: Although we do not consider it a competing interest, for the sake of full transparency we note that some of the authors have undertaken work for health sector agencies working in tobacco control.

References:


