Legislation and regulation: where to next, and how?

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ASPIRE2025

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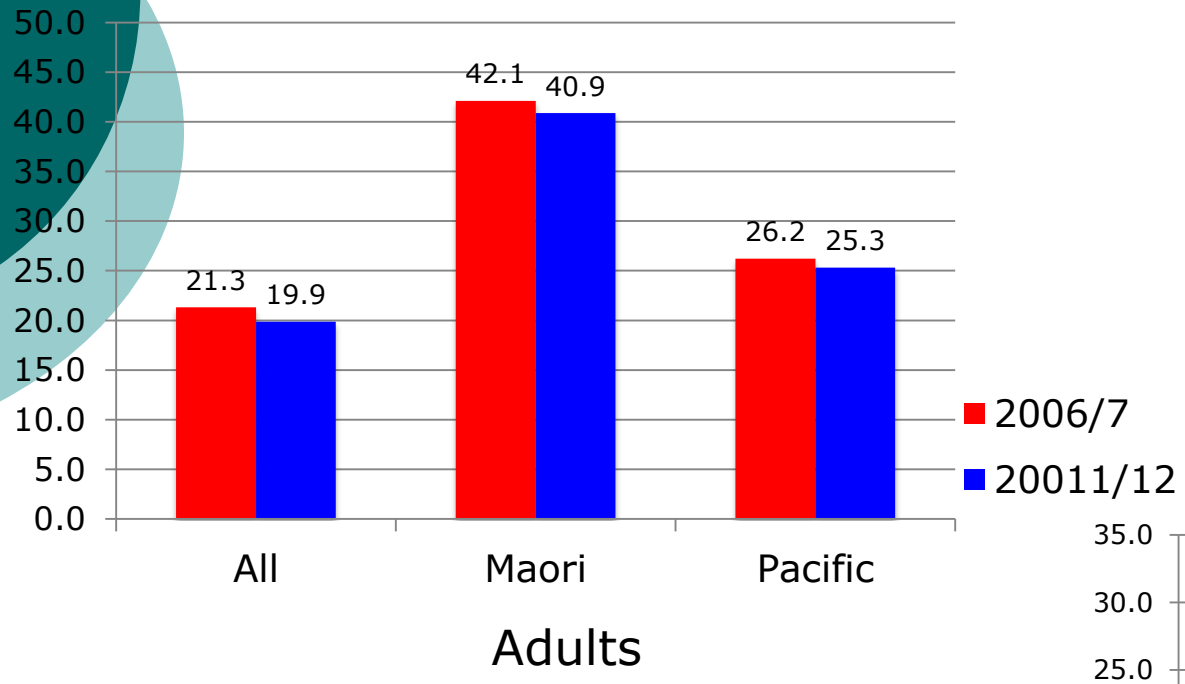
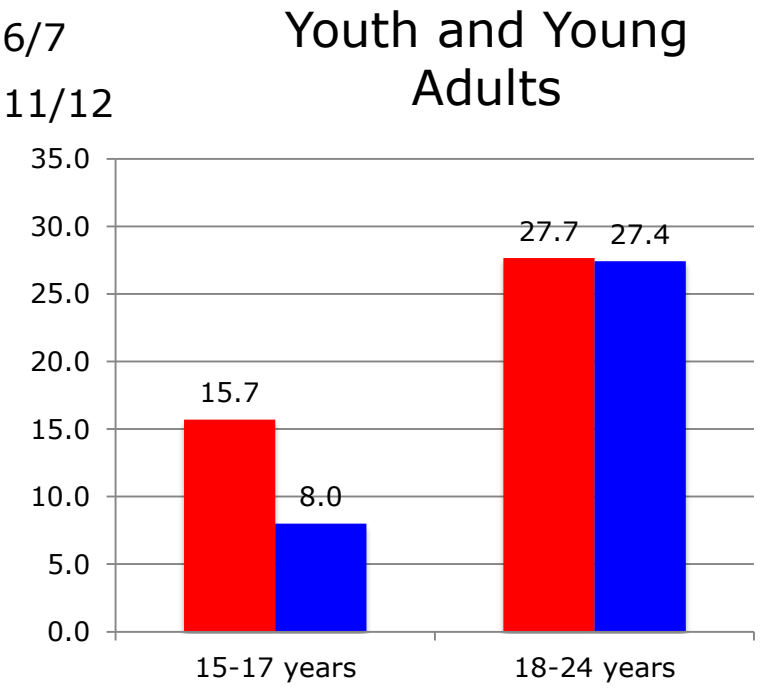
Overview

- Curent realities
- Smokefree 2025 – how do we get there?
- Current status in NZ –we need to go back to 1990 and we need a plan
- What's holding us back?
- Case study – party pills
- A way forward

Current smoking in 2006/7 and 2011/12 NZ Health Surveys





Interplay of cessation and uptake changes

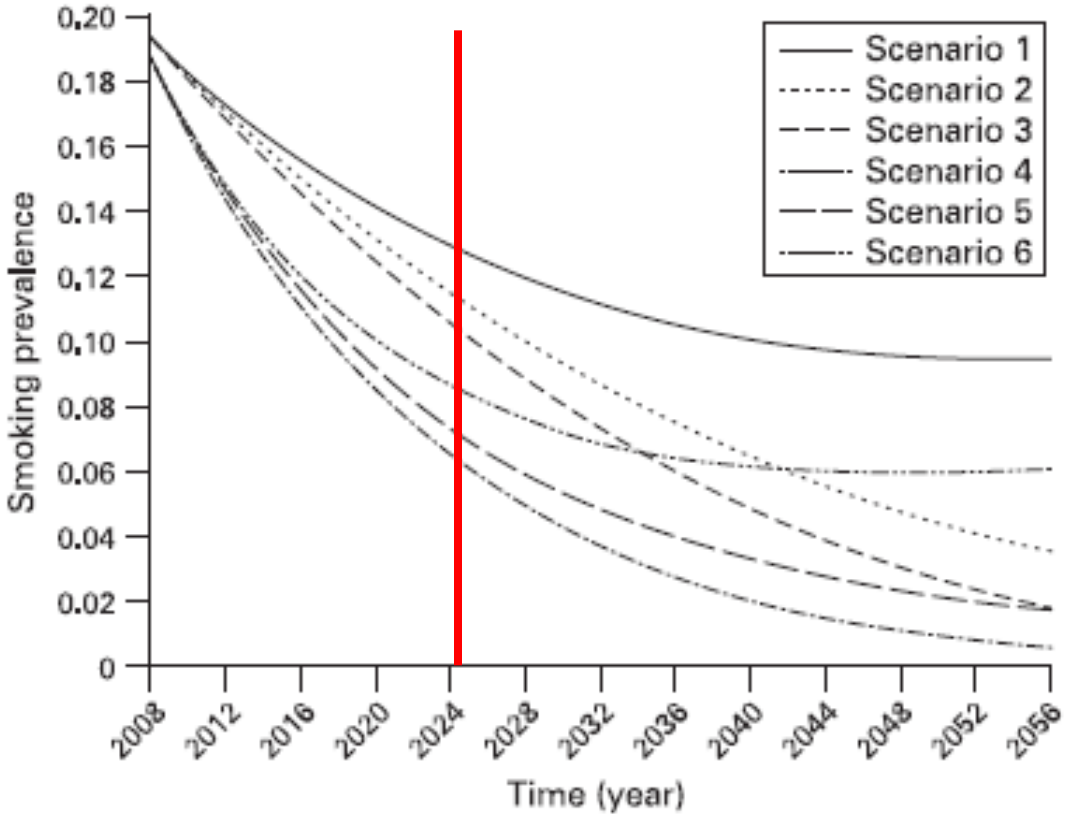
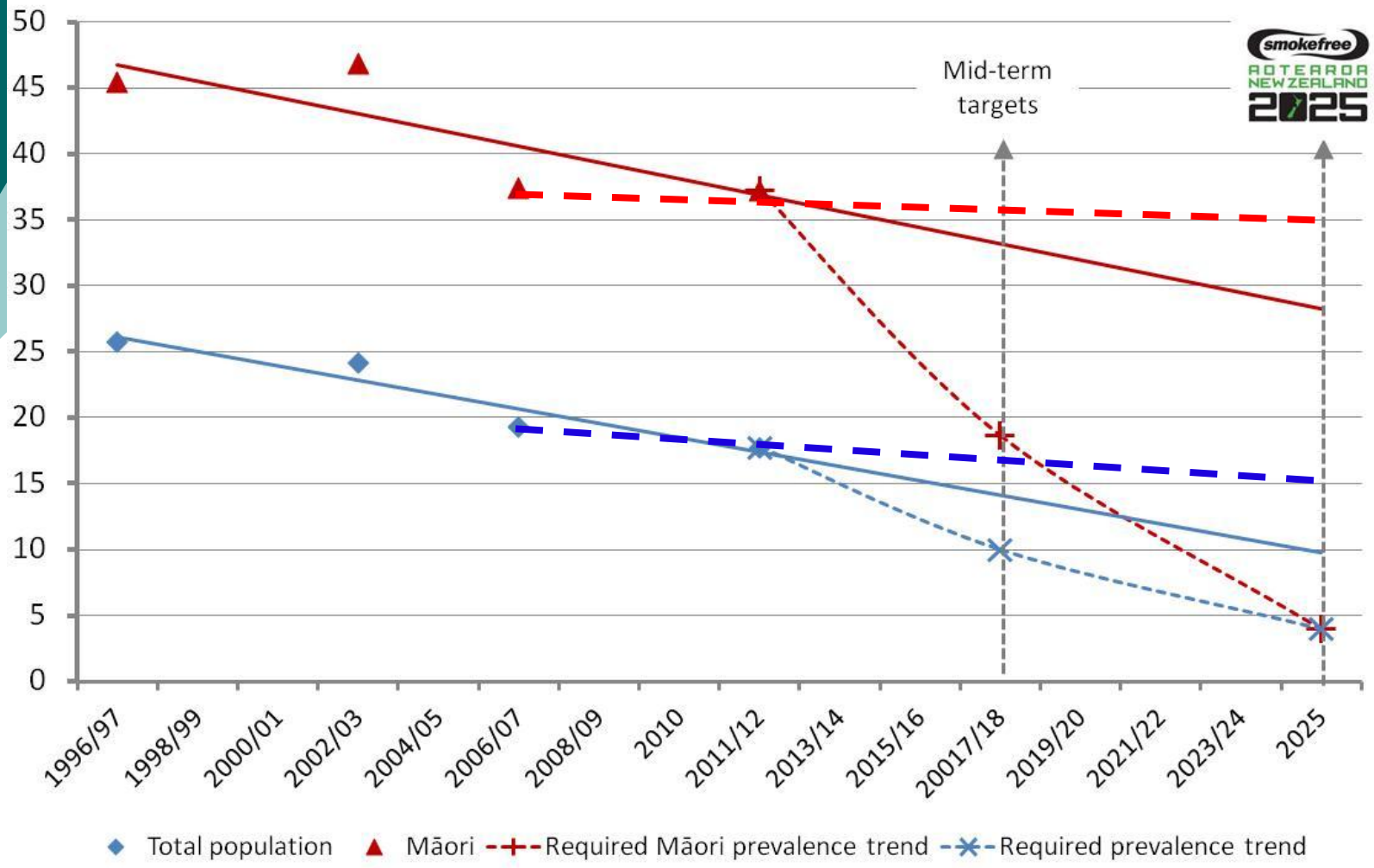


Figure 4 Projected future Australian smoking prevalence in the population aged 20+ under six scenario conditions.

Source: Gartner et al. Tobacco Control 2009; 18: 183-189.

MUCH more progress is needed



Why is 2025 important?

Philosophical - Paradigm shift

- Enough is enough – going beyond the status quo

- Stimulates new thinking
  - Radical solutions for unacceptable situation
- Signal to smokers and stimulus to quit
- Galvanises us, the public, the media and policy-makers
  - Clarity of purpose, noble goal, clear timeline

How do we get to 2025?

The Plan 2013-15

Smokefree Aotearoa 2025

Next Steps Action Plan

2013 -2015

auahi kore
AOTEAROA NEW ZEALAND 2025

Cancer Society
Te Kāhui Matepukupuku o Aotearoa

ASH
action on smoking and health

hpa health promotion agency

TALA PASIFIKA
PACIFIC VOICE ON TOBACCO ELIMINATION

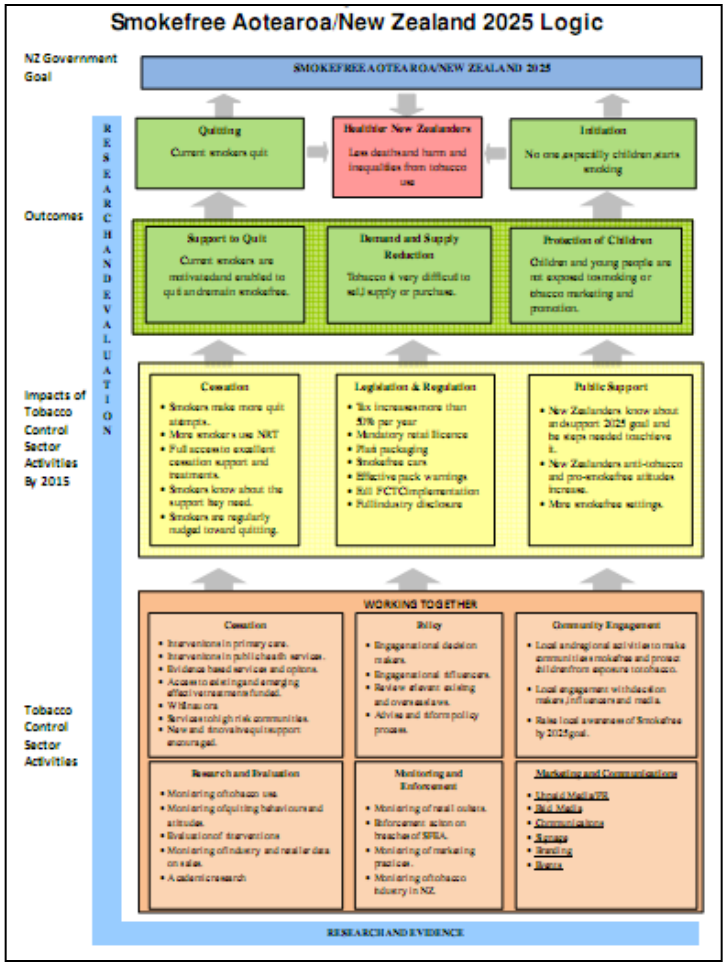
ASPIRE2025

The Quit Group
TE ROOPU ME MUTU

Smokefree Coalition
te ohu auahi kore

Te Reo Mārama
Māori Smokefree Coalition

Heart Foundation
The Heart of Our Nation



http://smokefree.org.nz/smokefree-2025

NSWG – actions and impacts by 2015

- Substantial increase in tobacco taxation
- Implement plain packaging and expand legislation to include:
  - Update product disclosure scheme
  - Implement control of harmful constituents
  - Introduce retail licensing
  - Smokefree cars with children legislation
  - Ban duty free sales
  - Increase mass media spend
  - E-cigarette regulation on MoH workplan
- Communicate goal to New Zealanders
- Establish monitoring and accountability framework for SF 2025 goal

Smoking - Can we stub it out by 2025? Yes, and here is how (IMHO)

Enhanced cessation promotion and support (within key populations)

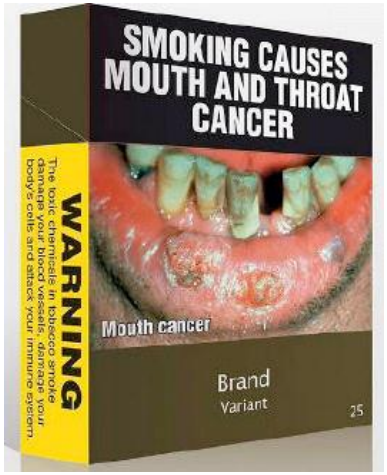
Substantial and sustained tax increases + co-interventions (duty free, integrated mass media and cessation support/promotion, hypothecation etc)

Greatly enhanced and sustained mass media interventions

(triggers to quit, denormalisation and SF 2025 social movement, social norms about social supply, cessation support, SHS exposure)

Other incremental measures

- Plain packaging, new health warnings
- Smoke-free cars and other smokefree policies
- Retail based interventions (licensing, proximity/density etc etc)



Smoking - Can we stub it out by 2025? Yes, and here is how

One or more radical measures

- Progressively increase age of purchase to 25 years
- Rapid and frequent tax increases
- Product modification – nicotine, additives
- Sinking lid or radical reductions in retailer supply

[Substitute nicotine delivery products (E-cigs, inhalers etc)]

Monitor progress – and be prepared to change course

Back to reality

- Tax – good, could be better
- Duty free - maybe
- PoS displays
- SF cars – no, other SF areas – local action
- Mass media – in reverse, may be about to change
- Plain packs – hopefully
- No strategy, piecemeal approach

Thinking big, acting small

A tentative estimate of tobacco excise increase options on smoking prevalence, tobacco consumption and annual deaths

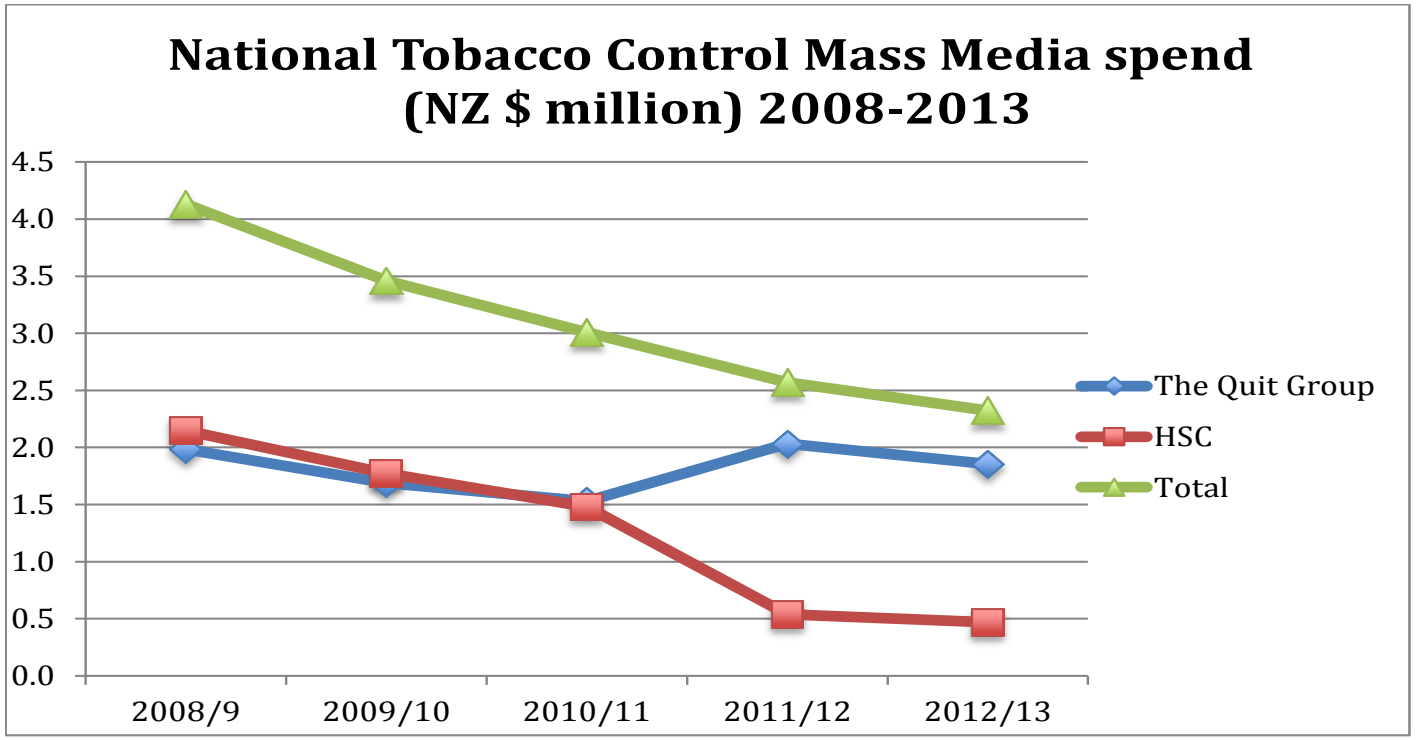
Excise Increase Options	Reduction in current smoking prevalence (%)*		Reduction in tobacco consumption (%)		Reduction in tobacco-related deaths per annum	
	2021	2031	2021	2031	2021	2031
10% each 1 Jan for 4 years	7	14	13	20	300-350	500-650
10% Budget night then 10% each 1 Jan for 4 years	9	16	16	24	350-425	600-750
30% Budget night then 10% each 1 Jan next 4 years	12	20	20	35	600-700	1000-1200

* A 1 percent drop in prevalence equates to approximately 30,000 fewer smokers.

- Treasury – favoured option 1 – as "likely to **contribute most** to a long term and sustainable strategy to reduce smoking rates"
- MoH – favoured option 3 as would provide greatest incentive to quit
- F&ESC report recommended option 1, probably on basis of concerns of economic impacts on continuing smokers and worries about illicit activity

Results - Expenditure

Figure 1: National Tobacco Control Mass Media Spend (NZ $ million) 2008-2013



Source: Expenditure information is for television and other mass media placement costs from The Quit Group and the Health Sponsorship Council. Data exclude development and production costs as these fluctuate greatly year on year.

Compare this to 1990 SEA Act

- **1990**: Smoke-free Environments Bill introduced to Parliament in May, and passed into law in August. The Smoke-free Environments Act 1990 (SFE) incorporated earlier bans and placed further restrictions on tobacco. These included:
  - ~ restrictions on smoking in many indoor workplaces
  - ~ a requirement for all workplaces to have a policy on smoking and to review that policy annually
  - ~ bans on smoking in public transport and certain other public places, and restricted smoking in cafes and restaurants
  - ~ regulation of the marketing, advertising and promotion of tobacco products and the phasing out of sponsorship by tobacco companies of products, services and events
  - ~ banning the sale of tobacco products to people under the age of 16 (raised to 18 in 1998)
  - ~ providing for the control, and disclosure, of the contents of tobacco products
  - ~ establishing the Health Sponsorship Council (HSC) to replace tobacco sponsorship and to "promote health and healthy lifestyles." The HSC introduced the Smoke-free brand.

Disclosure of ingredients SEA 1990

32. Labelling and health messages for tobacco products

(1) A manufacturer, importer, distributor, or retailer must not sell a tobacco product or offer a tobacco product for sale unless—

(a) the package containing it displays, in accordance with regulations under this Part, as many of the following things **as the regulations require**:

(ii) **a list of the harmful constituents of the product**:

(iii) if the tobacco product is intended for smoking, a list of the harmful constituents, and their respective quantities, present in the smoke:…

(b) if the regulations so require, there is placed inside the package with the product a leaflet containing—

(ii) if the tobacco product is intended for smoking, as much of the following information …as the regulations require:

(A) a list of the harmful constituents, and their respective quantities, present in the product:

(B) **a list of the additives, and their respective quantities, present in the prod**uct:

(C) a list of the harmful constituents, and their respective quantities, present in the smoke.

We need another 1990 Smokefree Environments Act

And then some!!

Can we get a comprehensive legislative and regulatory approach?

Yes ✔✔

- National and local political support
- Public support

Auckland Council approves new smoke-free policy

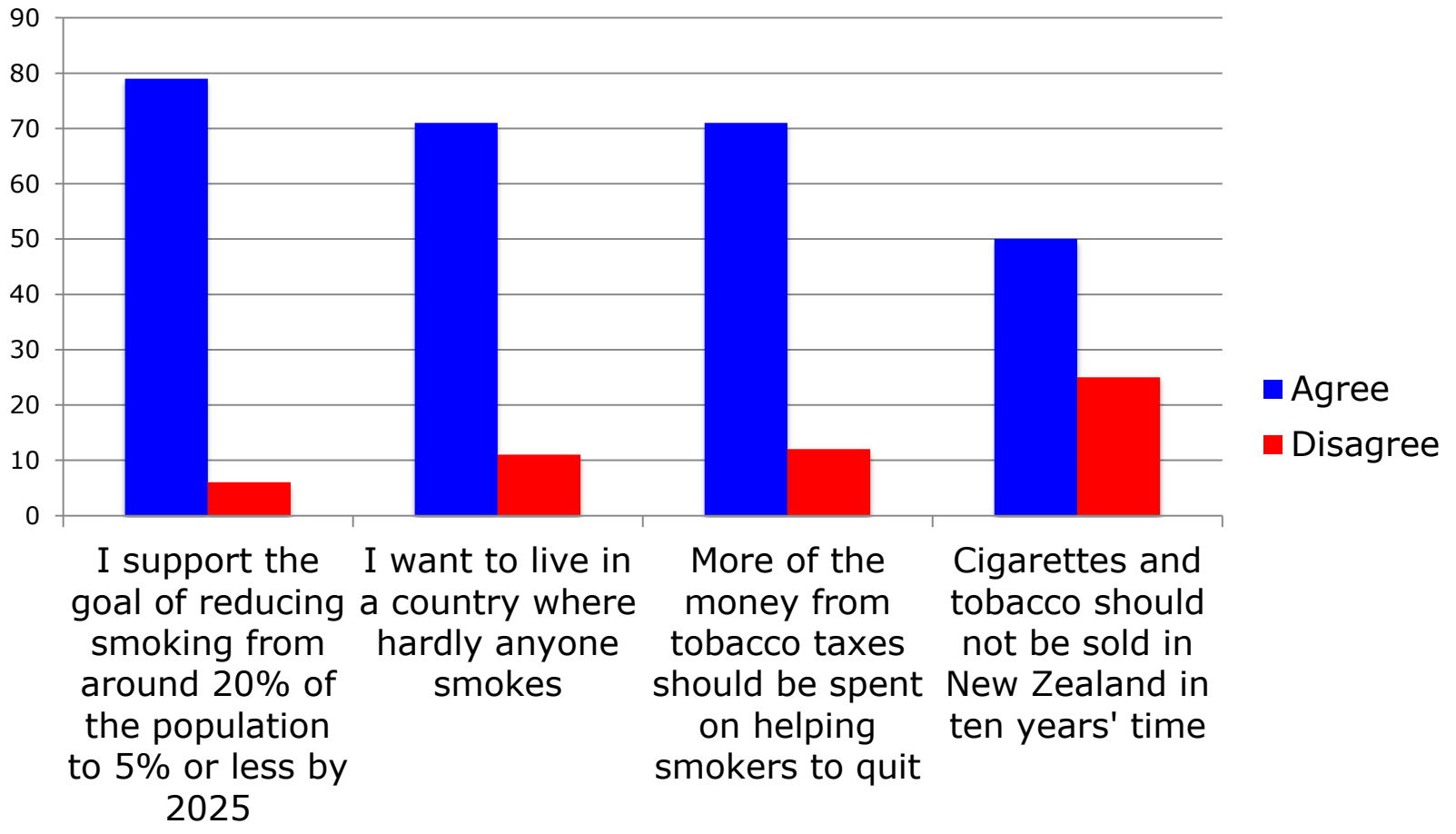
Wednesday, 24 July 2013, 12:27 pm
Press Release: Auckland City Council

Media release

24 July 2013

Auckland Council approves new smoke-free policy

Public support for Smokefree 2025



Gendall P et al. Public Support for More Action on Smoking. NZMJ 2013; 126:1375.

So what's holding us back?

- Industry/allies opposition and arguments
- Lack of coherence and framing of the case for action
- Lack of a political and social environment where political action becomes imperative
- Lukewarm political support, lack of political capital and political will/priority

Politicians and the 2025 smoke-free goal

~12,000 Releases and Speeches

Scoop INDEPENDENT NEWS

beehive.govt.nz
The official website of the New Zealand Government

Ben Healey, Richard Edwards, Janet Hoek, George Thompson

Lukewarm support: politicians (not) talking about SF 2025

	Items	Goal Ref.
Tariana Turia	59	28
Tony Ryall	26	1
Rahui Katene	14	1
Hone Harawira	13	1
Iain Lees-Galloway	13	3
Te Ururoa Flavell	12	1
Jim Anderton	8	0
Phil Goff	7	1
Bill English	7	1
John Key	7	0

NEW ZEALAND HAS A GOAL TO BE SMOKEFREE BY 2025 »

New Zealand has set a goal for a Smokefree Aotearoa by 2025. A big part of that goal is to discourage young people from starting to smoke. But another part is helping people to stop smoking. If you'd like to stop, this brochure provides information on how Champix® can help you.

The NZ Psychoactive Substances Act August 1st 2013

- Introduced Aug 2013
- All but one MP supported legislation in Parliament
- Definition of a psychoactive substance:

  " a substance, mixture, preparation, article, device or thing that is capable of inducing a psychoactive effect in an individual who uses the psychoactive substance"

http://www.legislation.govt.nz/act/public/2013/0053/20.0/DLM5042921.html

Key Facets of Act

Purpose:

"… to regulate the availability of psychoactive substances in NZ to protect the health of, and minimise the harm to, individuals who use psychoactive substances.."

- Introduces Expert Advisory Committee and Regulatory Authority
- Approved products:
  - Should pose no more than a "low risk" of harm to individuals using it
  - New products prohibited on **a precautionary basis** until regulatory authority (supported by an expert advisory committee evidence) review is satisfied that these pose no more than a low risk of harm

Key Facets of Act (2)

Retail restrictions

- Cannot be sold from dairies, convenience stores, supermarkets, garages
- Cannot be sold from temporary structures or any place alcohol is sold
- Are banned for sale and supply to minors <18 .
- Retailers are required to have a license
- Sellers are to be over 18 yrs
- Local authorities can restrict the location of retailers

Tobacco?

Subsection:

"this does not include any tobacco product unless they contain a psychoactive substance"

Key Facets of Act

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Tobacco?

- Subsection:

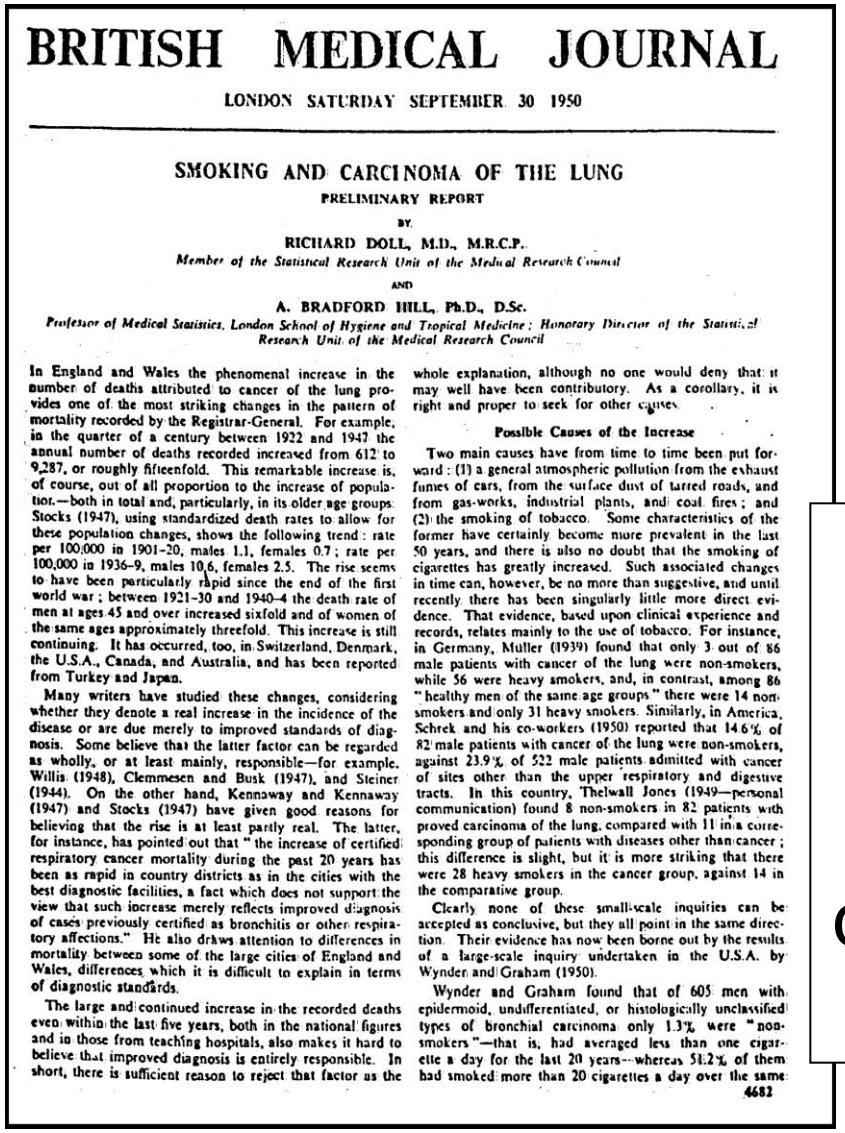
"*this does not include any tobacco product unless they contain a psychoactive substance*"

- Nicotine would meet most experts' definition of a psychoactive drug

- Tobacco poses serious risks of harm to users

SO WHY EXCLUDE TOBACCO FROM THE LEGISLATION?

1950 Epidemiologic Evidence



BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 30 1950

SMOKING AND CARCINOMA OF THE LUNG

PRELIMINARY REPORT

BY

RICHARD DOLL, M.D., M.R.C.P.

Member of the Statistical Research Unit of the Medical Research Council

AND

A. BRADFORD HILL, Ph.D., D.Sc.

Professor of Medical Statistics, London School of Hygiene and Tropical Medicine; Honorary Director of the Statistical Research Unit of the Medical Research Council

In England and Wales the phenomenal increase in the number of deaths attributed to cancer of the lung provides one of the most striking changes in the pattern of mortality recorded by the Registrar-General. For example, in the quarter of a century between 1922 and 1947 the annual number of deaths recorded increased from 612 to 9,287, or roughly fifteenfold. This remarkable increase is, of course, out of all proportion to the increase of population,—both in total and, particularly, in its older age groups. Stocks (1947), using standardized death rates to allow for these population changes, shows the following trend: rate per 100,000 in 1901–20, males 1.1, females 0.7; rate per 100,000 in 1936–9, males 10.6, females 2.5. The rise seems to have been particularly rapid since the end of the first world war; between 1921–30 and 1940–4 the death rate of men at ages 45 and over increased sixfold and of women of the same ages approximately threefold. This increase is still continuing. It has occurred, too, in Switzerland, Denmark, the U.S.A., Canada, and Australia, and has been reported from Turkey and Japan.

Many writers have studied these changes, considering whether they denote a real increase in the incidence of the disease or are due merely to improved standards of diagnosis. Some believe that the latter factor can be regarded as wholly, or at least mainly, responsible—for example, Willis (1948), Clemmesen and Busk (1947), and Steiner (1944). On the other hand, Kennaway and Kennaway (1947) and Stocks (1947) have given good reasons for believing that the rise is at least partly real. The latter, for instance, has pointed out that "the increase of certified respiratory cancer mortality during the past 20 years has been as rapid in country districts as in the cities with the best diagnostic facilities, a fact which does not support the view that such increase merely reflects improved diagnosis of cases previously certified as bronchitis or other respiratory affections." He also draws attention to differences in mortality between some of the large cities of England and Wales, differences which it is difficult to explain in terms of diagnostic standards.

The large and continued increase in the recorded deaths even within the last five years, both in the national figures and in those from teaching hospitals, also makes it hard to believe that improved diagnosis is entirely responsible. In short, there is sufficient reason to reject that factor as the whole explanation, although no one would deny that it may well have been contributory. As a corollary, it is right and proper to seek for other causes.

Possible Causes of the Increase

Two main causes have from time to time been put forward: (1) a general atmospheric pollution from the exhaust fumes of cars, from the surface dust of tarred roads, and from gas-works, industrial plants, and coal fires; and (2) the smoking of tobacco. Some characteristics of the former have certainly become more prevalent in the last 50 years, and there is also no doubt that the smoking of cigarettes has greatly increased. Such associated changes in time can, however, be no more than suggestive, and until recently there has been singularly little more direct evidence. That evidence, based upon clinical experience and records, relates mainly to the use of tobacco. For instance, in Germany, Müller (1939) found that only 3 out of 86 male patients with cancer of the lung were non-smokers, while 56 were heavy smokers, and, in contrast, among 86 "healthy men of the same age groups" there were 14 non-smokers and only 31 heavy smokers. Similarly, in America, Schrek and his co-workers (1950) reported that 14.6% of 82 male patients with cancer of the lung were non-smokers, against 23.9% of 522 male patients admitted with cancer of sites other than the upper respiratory and digestive tracts. In this country, Thelwall Jones (1949—personal communication) found 8 non-smokers in 82 patients with proved carcinoma of the lung, compared with 11 in a corresponding group of patients with diseases other than cancer; this difference is slight, but it is more striking that there were 28 heavy smokers in the cancer group, against 14 in the comparative group.

Clearly none of these small-scale inquiries can be accepted as conclusive, but they all point in the same direction. Their evidence has now been borne out by the results of a large-scale inquiry undertaken in the U.S.A. by Wynder and Graham (1950).

Wynder and Graham found that of 605 men with epidermoid, undifferentiated, or histologically unclassified types of bronchial carcinoma only 1.3% were "non-smokers"—that is, had averaged less than one cigarette a day for the last 20 years—whereas 51.2% of them had smoked more than 20 cigarettes a day over the same

4682

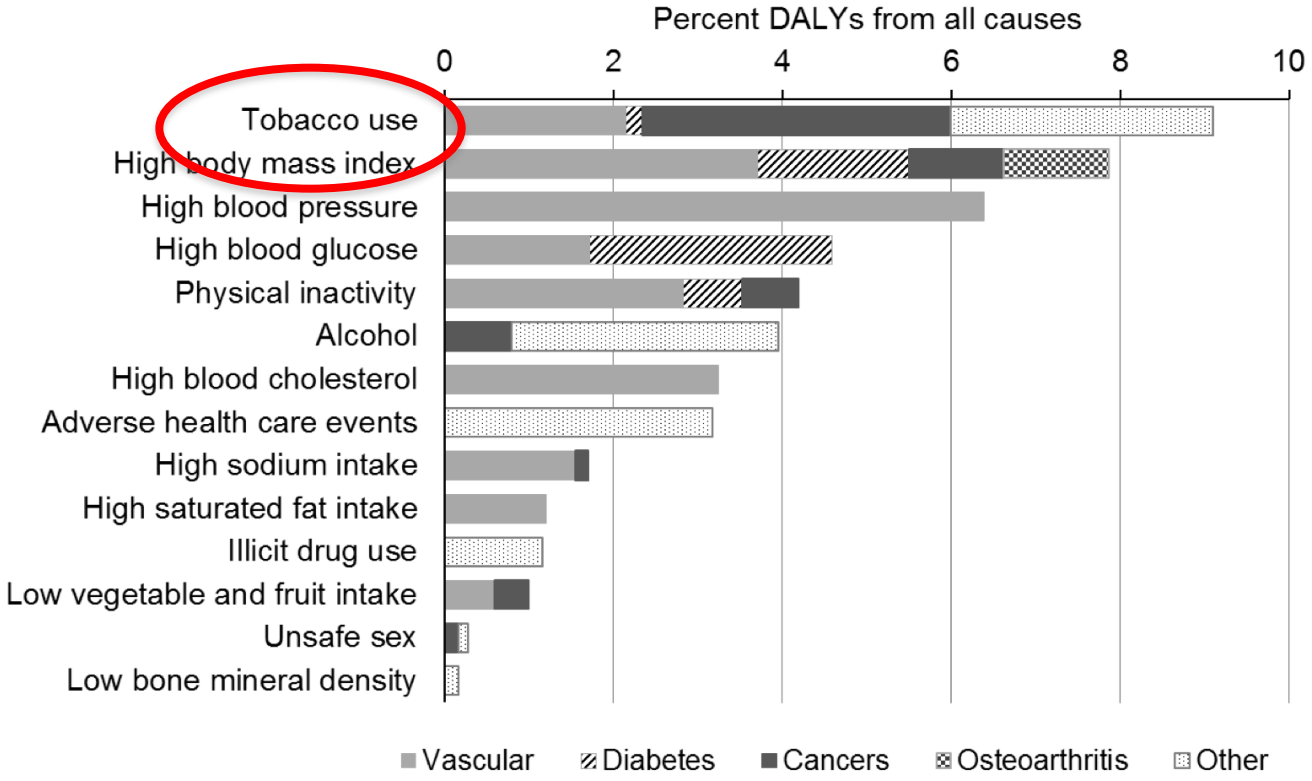
Richard Doll & A. Bradford Hill
(*British Medical Journal* UK)

Smoking and Carcinoma of the Lung; Preliminary Report

"We therefore conclude that smoking is a factor, and an **important factor**, in the production of carcinoma of the lung."

Burden of disease due to tobacco in NZ

Attributable burden (percentage of DALYs) for selected risk factors, 2006



Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Ministry of Health, 2013.

Dunedin man dies of BZP party pill overdose

By Thomas Mead
Online Reporter

Tuesday 05 Feb 2013 1:19p.m.

Join the discussion

The man died of a BZP party pill overdose (file)

Like 0 Tweet 1 +1 0

EMAIL PRINT

Related

A Dunedin man has been confirmed as the first New Zealander to die of an overdose of the illegal party pill benzylpiperazine (BZP).

Party pill protests continue

Home » Top Menu » Your Town » Oar

By Andrew Ashton on Sat, 19 Oct 201

The Regions: North Otago | Your Tow

Share 53

Renewed protests over the legal sale of party pills and other so-called legal highs have returned to Oamaru after it emerged psychoactive substances were being sold over the counter in the town.

The introduction of the Psychoactive Substances Act in July banned the sale of synthetic cannabis and legal highs in dairies and petrol stations, but allowed for tobacconists and R18 shops to apply for an interim retail licence.

The Ministry of Health has granted an interim licence to sell psy Tu (trading as Super Save) at 41 Th

Angry retailers are rising up

By Merania Karauria

6:35 AM Friday Jul 26, 2013

Save 0 0

The opening of a "pop-up" drug store in Dublin St has angered other retailers in the block and prompted community concern.

Iwi leader Ken Mair said yesterday that selling psychoactive pills was preying on the poor and vulnerable.

The Tupoho chairman has stepped into the fray and yesterday visited the YY Shop on the Dublin/Harrison St corner, and told the woman there she should shut the shop, which opened a week ago.

"We don't want their drug dens in our community," he said.

"They don't care about the health of our community, they are only interested in their profits.

"Families in the community have to be courageous and stand up against these vultures."

There's always a silver lining

- New Zealand has an incoherent approach to regulating harmful substances.

- The Psychoactive Substances Act **establishes a clear precedent** for the comprehensive supply measures, regulatory product oversight, adoption of a precautionary approach needed to achieve the smokefree Aotearoa goal by 2025.

https://blogs.otago.ac.nz/pubhealthexpert/2013/09/24/smart-party-pill-law-makes-tobacco-alcohol-regulation-look-pathetic/

Our most urgent next steps

- Develop and agree the plan
- Increase political support, will, and **expand** political capital
- Relentlessly promote the 2025 goal and develop the social movement
  - develop our framing and our case
  - communication to public, opinion leaders, politicians etc
  - all interventions framed within the 2025 context

Possible frames

- Health burden
- Inequalities – social justice
- Economic case
- Future generations
- Human rights approach
- Treaty obligations, identity and tikanga, Māori development

The Moral Case for Intervention

1. Smoking is a uniquely hazardous consumer product
2. Most smokers start young
3. Hardly anyone starts smoking as a mature adult
4. Most smokers want to quit
5. Smoking is highly addictive
6. Stopping smoking is very difficult (and the methods to help are not very effective)
7. Almost all smokers regret starting
8. Virtually all smokers don’t want their children to start smoking
9. Smoking causes and exacerbates health inequalities and poverty
10. Secondhand smoke harms non-smokers, including children

Importance of framing

How tobacco is framed dictates how it is treated by government, agencies of government, by law and in society and what is politically possible:

- Current framing mainly as a (risky) legal commodity and a tax source
  - governments reluctant to intervene in a legal commercial transaction
- Needs to be framed as an addictive poison by society and government, and as a threat to children and its widespread continued use as a societal failure, not just a health sector issue

Research and monitoring

- Scan: new evidence and innovations
- Intervention and policy oriented research (development, building the case)
- Advocacy, policy making – study and learn from other examples (party pills, social movements)
- Monitor progress
  - Ongoing evaluation of interventions, prevalence, smokers, priority groups
  - Hardening or snowballing?
- Be prepared to respond and change course

- What is the use of living, if it be not to strive for noble causes and to make this muddled world a better place for those who will live in it after we are gone? …. Humanity will not be cast down. We are going on swinging bravely forward along the grand high road and already behind the distant mountains is the promise of the sun.

No longer daring to dream ….

… deciding what's to be done, creating the conditions, and **realising the dream**

Kia ora

Thank you

richard.edwards@otago.ac.nz

smokefree AOTEAROA NEW ZEALAND 2025

ASPIRE2025

Exposure	Asbestos/dioxin	'Pro-smoking' influences e.g. PoS displays
Frame	Poison	**Risk factor**
Type	Environmental contaminant	**Potential influence on behaviour**
Public/policy-maker view	Any exposure = unacceptable	**Possible cause of uptake (what's the evidence?)**
Types of evidence	Toxicological, epidemiological (NB v. weak for low exposure)	**Epidemiological – exp/outcome (strong), intervention/outcome (probable but incomplete)**
Intervention	Remove	**Policy measures e.g. PoS regulations, PoS ban**
Evidence required for intervention	Presence of exposure	**Exp/outcome, intervention effectiveness, lack of adverse effects**
Evidence of success	Removal of exposure	**Reduced uptake, increased quitting, reduced prevalence, no/minimal adverse effects**
Paradigms	Protection, precautionary principle	**Cautionary principle, balanced, evidence-based**