Submission by ASH (UK); the Royal College of Physicians and SPECTRUM To the consultation on: Proposals for a Smokefree Aotearoa 2025 Action Plan: Discussion document.

Published in April 2021 by the Ministry of Health closes on 31 May 2021.

Respondents

This consultation response is on behalf of ASH (UK); the Royal College of Physicians (RCP); and the Shaping Public Health Policies to Reduce Inequalities and Harm (SPECTRUM) Consortium.

Action on Smoking and Health, ASH (UK), is a public health charity set up by the Royal College of Physicians in 1971 to advocate for evidence-based policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK.

The Royal College of Physicians is an independent patient centred and clinically led organisation, that drives improvement in the diagnosis of disease, the care of individual patients and the health of the whole population both in the UK and across the globe. The RCP has played a leading role in the development of tobacco policy since its first seminal report, Smoking and Health, in 1962 and has just published its latest report, *Smoking and Health 2021: a coming of age for tobacco control.*

SPECTRUM is a public health research consortium of academics from 10 UK universities and partner organisations funded by the UK Prevention Research Partnership. The key focus of its research is unhealthy commodities which include tobacco.

None of the organisations, or their members, have any direct or indirect links to, or receive funding from, the tobacco industry, except for nominal shareholdings in Imperial Brands and BAT for research purposes.

Introduction

We welcome the opportunity to respond to this consultation and to the recognition that, “much work still needs to be done, particularly to reduce smoking rates among Māori, Pacific Peoples and those living in our most disadvantaged communities.”

Māori and pacific nation participation in the negotiations for the WHO Framework Convention on Tobacco Control (FCTC) played a key role in ensuring that the high levels of smoking and other tobacco consumption among indigenous peoples were acknowledged and that “the need to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate to their needs and perspectives;” was embedded in the guiding principles of the FCTC (WHO FCTC 2003)

Furthermore, the Māori Affairs Committee’s recommendation (Māori Affairs Committee 2010), that New Zealand’s long-term goal should be to make Aotearoa a smoke-free nation by 2025, which was endorsed by the New Zealand government in 2011 (New Zealand Government 2011), was

groundbreaking. Setting a date to be smokefree has subsequently been adopted by numerous other countries including, within the United Kingdom, both Scotland and England.

The respondents do not have insight into the specific needs of Māori and Pacific Peoples. The degree of disparity between smoking rates by ethnicity found in New Zealand between Māori and European/other populations is shocking. Such differences by ethnicity are not found in the UK; however, higher smoking rates in disadvantaged communities is a problem we share. The highest smoking rates in the UK are found among the most disadvantaged populations, those with diagnosed mental health conditions, on low incomes, living in social housing or homeless, with no qualifications. Tackling these inequalities is therefore a central focus for tobacco control in all the nations of the United Kingdom.

We share a Smokefree goal. However, it is defined differently. The Aotearoa New Zealand goal is to be Smokefree by 2025, meaning that less than 5 percent of New Zealanders of all ethnic and social groups aged 15+ will smoke daily by 2025.

There is not a UK-wide goal. The goal for England is that 5 percent or less of adults aged 18+ will be current smokers by 2030, and for Scotland the date is 2034 (Wales and Northern Ireland do not currently have a target date for being Smokefree).

NB Once the differences in the way smoking rates are measured are taken into account smoking rates in the UK and New Zealand are very similar. The key measure in the UK is current smoking in adults aged 18 and over. In New Zealand the measure is for daily smoking in those aged 15 and over. Daily smoking rates and smoking rates for 15-17 year olds are lower than current smoking rates and smoking rates for those aged 18+. Once these differences are taken account of, smoking rates in New Zealand and the nations of the United Kingdom are similar.

Focus area 1: Strengthen the tobacco control system

a). What would effective Māori governance of the tobacco control system look like?

b). What action are you aware of in your community that supports Smokefree 2025? What is needed to strengthen community action for a Smokefree 2025? Please give reasons.

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

d). What else do you think is needed to strengthen New Zealand's tobacco control system?

Please give reasons.
Our answers relate only to questions c) and d).

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

The consultation document includes a series of cutting-edge tobacco control policies, such asreducing the nicotine content in tobacco, the Smokefree generation policy and reducing the number of outlets. It is always important to carry to pre- and post-evaluation, but with novel policies like these, which have not been implemented previously in other jurisdictions, it is essential. Furthermore, careful consideration needs to be given on how to most effectively evaluate the individual impact of policies if they are introduced concurrently.

Examples of good practice include the comprehensive evaluation of the impact of standardised (plain) packaging in Australia and the Scottish evaluation of the implementation of its Smokefree policies. The Australian evaluation was particularly important as it played a key role in ensuring that legal challenges to the policy by the tobacco industry and those acting on its behalf, did not succeed. It also helped provide the necessary evidence for other jurisdictions, like New Zealand and the United Kingdom, to follow where Australia led.

d). What else do you think is needed to strengthen New Zealand's tobacco control system?

A key tactic used by the tobacco manufacturers to subvert tobacco control policies is to argue that these will be ineffective because they will increase the illicit trade. At the same time tobacco manufacturers have facilitated the growth of a parallel illicit market by allowing their products to be accessed by organised crime groups.

This was the situation in the UK in the 1990s, after the Government introduced an annual tobacco tax escalator that raised the price of tobacco year on year. There was rapid growth in the illicit market. The illicit market share of manufactured cigarettes rose from only 3 percent in 1996-97 to 18 percent and rising by 1999-2000. The market share for illicit roll-your-own tobacco rose even higher, to 80 per cent by 1999. The tobacco manufacturers argued that taxes should be lowered but the manufacturers were revealed to have fuelled the illicit market (Langley et al 2020). The evidence of the industry's behaviour was taken into consideration in the negotiations for the WHO FCTC and led to the inclusion of Article 15, requiring Parties to the Convention to implement tracking and tracing of tobacco products to control the illicit trade, and subsequently the first Protocol to the FCTC which further developed the requirements to control the supply chains of tobacco manufacturers (WHO 2012).

The tobacco manufacturers are under threat from New Zealand's cutting-edge policies, and it is in their interest to facilitate a parallel illicit market in the same way they did in the UK in the 1990s. We therefore recommend that New Zealand become a party to the Illicit Trade Protocol, which will support the imposition of much more stringent controls on the tobacco manufacturers' supply chains down to retail level, essential, for example, if nicotine reduction is to be introduced. This will also help underpin an effective retail licensing system and help limit the number of retail outlets. We therefore recommend that New Zealand seriously becoming a Party to the Illicit Trade Protocol. The FCTC Convention Secretariat and the UK's HM Revenue and Customs are experts on the operation of the protocol and would be able to advise.

Focus area 2: Make smoked tobacco products less available

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

☒ Yes ☐ No

Please give reasons:

A licensing scheme, backed up by the Illicit Trade Protocol which we recommend that New Zealand become a Party to, will enable a much more complete understanding, and facilitate the control, of the manufacturers' supply chains.

The consultation document estimates that there are between 5,000 and 8,000 retail outlets in New Zealand, demonstrating that currently the authorities don't know exactly how many tobacco retailers there are. Instituting a retail licensing scheme will enable the authorities to develop a full understanding of the retail environment, including the geographical distribution, which enables the development of a much better understanding of inequalities in availability, in particular by race ethnicity and socio-economic status. This is essential to any attempt to make smoked tobacco products less available as well as to ensure effective enforcement of tobacco regulations.

Lessons can also be drawn from licensing systems established for alcohol retailers, which demonstrate some of the practical implementation challenges in any attempt to reduce availability through licensing including differences in local interpretation and implementation of the law, and legal arguments/challenges undermining stated objectives of the licensing system. (Fitzgerald et al 2017, 2018; Wright 2019; Reynolds 2020). Good practices emerging from alcohol licensing including involvement of communities in the licensing system and restrictions on opening hours, not just density, of outlets are also worth considering (Reynolds et al 2020; Sherk et al 2018).

Lastly, given the relatively much higher risk of smoking than vaping it is clearly not proportionate to require specialist vaping retailers to be licenced, but not vendors of smoked tobacco products.

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

☒ **Yes** ☐ **No**

Please give reasons:

There is sufficient evidence that reducing the number of sales outlets would be likely to support reductions in smoking prevalence (through reducing initiation and supporting cessation), but it needs to be implemented carefully and with conditions (see below).

In New Zealand, as in the United Kingdom and many other countries, tobacco can be sold anywhere, and tobacco manufacturers have highly sophisticated distribution systems, marketing to retailers and ensuring that their products are widely available and highly visible at point of sale. As restrictions on bans on advertising were ramped up, the pack and its display at point of sale was increasingly used as a promotional tool. In response New Zealand, like the UK, legislated to put tobacco out of sight at point of retail and cigarettes in plain standardised packs.

However, although the prohibition of displays and introduction of standardised packaging has reduced, if not eliminated, tobacco manufacturers' ability to use the pack as a promotional tool, the distribution network remains a key marketing tool at point of sale. Indeed, point of sale provides a key remaining channel for promoting and marketing tobacco products. The normalisation of smoking is sustained by the widespread availability of the product. It is notable that the vast majority of tobacco gantries at point of sale in the UK are still paid for by tobacco manufacturers, demonstrating their importance to the industry's business model.

The evidence from numerous pieces of research on the geography of tobacco retailing carried out in New Zealand, Scotland, and elsewhere demonstrates that retail outlets are disproportionately concentrated in neighbourhoods with a high proportion of low income, disadvantaged ethnic minority residents. (Shortt et al 214, 2015, 2021; Pearce et al 2009, 2016; Tunstall 2018)

For example, Scottish children from low income households had six times the exposure to tobacco retailing as children from high income households, and longitudinal research showed that neighbourhood tobacco supply levels had a significant impact on maternal smoking during pregnancy. (Clemens et al 2020) Scottish research showing that reductions in density would be likely to have an impact, led Scotland in its most recent tobacco strategy (Scottish Government 2018) to decide to consider implementing such a strategy.

However, it must not be assumed that limiting the number of retailers will on its own be effective. France has strict controls on the number of retail outlets, all of which must be licensed "tabacs" and a comprehensive study of the impact of the French distribution system and how it compared to those in other European countries was carried out (CNCT 2014). In 2012 there were 27,000 tabacs for a population of around 65 million, while there were 95,700 sales outlets for the UK (including hospitality venues) for a population of 63.5 million. This equates to 1 retailer per 679 people in the UK, similar to New Zealand (between 1 per 1,000 and 1 per 625) while France had 1 per 2,407 people (the concentration for New Zealand is based on current population of around 5 million (Stats NZ 2020) and the estimated number of retail outlets of 5-8,000).

Despite the far more limited number of retail outlets, smoking rates in France were much higher than those in the UK, and have remained higher (Pasquereau et al 2020). In 2012 more than 28% of adults smoked in France compared to 19.6% in the UK, and in 2019 the comparable figures were 24% in France and 14.1% in the UK. In the UK the measure was all current smokers 18+ while in France the measure was 18-75 years daily smoking. However, the trend is the key and the UK has seen far more rapid declines in smoking during that time than France. The difference is that the UK has had comprehensive strategies to tackle smoking in place since the end of the 1990s, and has led Europe in the extent of its implementation of the key World Bank measures to tackle supply and demand for tobacco since 2007. (Feliu et al 2019) By comparison France has slowly risen up the rankings from 7th in 2007 to 2nd behind the UK in 2019.

What is clear is that limiting the number of retail outlets is not on its own a solution. The conclusion of the report on the French retailing system was that the relationship between tobacco industry and retailers was overly close and lacking in transparency, that the supervisory authorities failed to engage retailers in the public health rationale for tobacco control and that enforcement of the rules, in particular on sales to minors, was ineffective. Indeed, the retail distribution arrangements for tobacco products in France were considered to play a significant role in helping to maintain high levels of smoking especially among younger people. (CNCT 2014)

Therefore, any restriction in retail availability needs to be combined with a comprehensive approach including strict retail licensing and enforcement regime, a requirement for the tobacco manufacturers to be fully transparent about their marketing practices (e.g. number of visits to retailers by sales staff, communications shared with retailers, any incentives provided to retailers).

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

☐ **Yes** ☐ **No**

Please give reasons:

Neither support nor oppose.

How this is implemented and regulated will have substantial impact on a) overall provision and b) geographical inequalities. Work in Scotland examining a range of stakeholder defined policy scenarios for reducing availability demonstrated that that whilst all scenarios led to an overall reduction in availablity (to varying degrees) the most 'successful' options also led to a rise in inequalities in availability. Therefore it is essential that policy-makers carefully consider the methods by which tobacco retail density is reduced, and success measured, align with policy aims, and in particular the need to reduce inequalities. (Caryl et al 2020)

Limiting access to certain store types needs to be part of a comprehensive strategy including universal access to tobacco dependence treatment and alternative less harmful nicotine products for smokers. It is essential that smokers are given opportunity and support to switch or stop, particularly those in communities which are more likely to smoke, and to be heavily addicted, to avoid this being a punitive action against those who are already more disadvantaged in society.

d). Do you support introducing a smokefree generation policy?

☐ **Yes** ☐ **No**

Please give reasons:

Neither support nor oppose.

The policy being proposed would prohibit the sale, and the supply in a public place, of smoked tobacco products to new cohorts from a specified date. For example, if legislation commenced on 1 January 2022, then people younger than 18 years at that time or those born after 1 January 2004 would never be able to lawfully be sold smoked tobacco products.

Such a policy has never been tried anywhere before and needs careful consideration before being implemented as there are significant issues to be considered about its feasibility and enforceability. Research in New Zealand (Edwards et al 2013) and elsewhere demonstrates that the vast majority of smokers start before the age of 21 and it is rare after the age of 25, it may be easier to simply increase the age of sale.

The proposal currently under consideration in England is to increase the age of sale to 21 (T21). T21 has cross party political support, as well as majority support from the public, including children and young adults, and retailers. When T21 was implemented in the US and previously when the age of sale was increased in England from 16 to 18 in England, it had an immediate and sustained impact in reduced smoking prevalence in the relevant age group by at least 30% (Beard et al 2020, 2021; Fidler 2010). We recommend that New Zealand should increase the age of sale from 18 to 21 as a first step, while further work is carried out on the feasibility of the Smokefree generation policy.

As part of our consultation response we submit a brief on T21 prepared for the UK tobacco control community for more information:
Arnott D. Ashcroft R. Pike K. West R. Rationale for Increasing the Age for sale for tobacco in England from 18 to 21. ASH. London. 26th May 2021.

e). Are you a small business that sells smoked tobacco products?

☐ **Yes** ☒ **No**

Please explain any impacts that making tobacco less available would have on your business that other questions have not captured. Please be specific:

None of the respondents are small businesses that sell smoked tobacco products, however, we have carried out research into the impact of tobacco sales on small businesses. In particular by scrutinisng the difference between what tobacco manufacturers' and their front groups say, and the evidence on the ground.

Tobacco manufacturers direct influence on policy in countries like New Zealand and the UK has become constrained by Article 5.3 of the WHO FCTC, which requires Parties to protect the setting and implementation of public health policies with respect to tobacco control from the "commercial and other vested interests of the tobacco industry". Manufacturers therefore try to use front groups and what is called "astro-turfing", lobby groups purporting to be grass roots organisations which are developed and funded by the industry (Apollonio et al 2007).

That is why it is so important that in this consultation the New Zealand Ministry of Health, like its UK counterpart, has asked all respondents to disclose whether they have any direct or indirect links to, or receive funding from, the tobacco industry. It is also important to go further and rather than leave it to front groups and "astro-turf" organisations to be the standard bearer for retailers, it should pro-actively engage retailers to gather their views and communicate the benefits of tobacco control policies to them and their communities.

Tobacco manufacturers mis-represent the value of tobacco sales to retailers as playing an important role in driving footfall to their stores. Research commissioned by ASH(UK) analysing industry data found that the margin on tobacco products was only 6% compared to 24.1% for other products sold by independent tobacco retailers. It also demonstrated that only 21% of small retailer transactions included the purchase of tobacco products and that, while tobacco was a driver of footfall, it was by no means the most important one. The report was launched in parliament and its results were covered by the retail trade press (Anderson 2016). Research demonstrating similar results has also been carried out in New Zealand and elsewhere (Hitchman et al 2016; Robertson et al 2019; Marsh et al 2020) and has demonstrated that over time as smoking rates decline tobacco is becoming an increasingly less important driver of footfall (Wood 2021).

Qualitative research in New Zealand has already shown that retailers are ambivalent about tobacco control measures like standardised packaging; while they were concerned about short-term effects on their business, they recognised the harm smoking causes (Guthrie et al 2015). We recommend that the New Zealand government commission quantitative research in New Zealand to inform its consultation.

Quantitative research commissioned by ASH(UK) has been used to inform the UK Ministry of Health post-implementation reviews of a range of measures which impact on point of sale, including the display ban and standardised packaging. (ASH and SPECTRUM 2021) In 2019 a market research agency conducted a survey among retailers of small shops in England which sold tobacco. Interviewees were owners or managers of these small shops. 558 retailers were interviewed, around half were convenience stores or local supermarkets, but respondents also included off-licences, newsagents, petrol stations, and specialist tobacconists. (NEMS 2019)

The key findings of the survey in England were that the majority of small retailers supported the existing tobacco regulations as well as increasing the age of sale to 21:

- **61% support prohibition of tobacco displays** (26% oppose, 13% neither support/oppose or don't know)
- **52% support restrictions on display of tobacco prices** (35% oppose, 13% neither support/oppose or don't know)
- **51% support standardised "plain" packaging of tobacco packs** (36% oppose, 12% neither support/oppose or don't know)
- **64% support minimum pack sizes for cigarettes and rolling tobacco** (27% oppose, 8% neither support/oppose or don't know)
- **72% support regulation of e-cigarette content and packaging** (9% oppose, 18% neither support/oppose or don't know)
- **84% support age of sale for e-cigarettes of 18** (7% oppose, 8% neither support/oppose or don't know)
- **52% support increasing the age of sale for cigarettes to 21** (39% oppose, 9% neither support/oppose or don't know)

The majority of small retailers said the current regulations had no impact on their business, either positive or negative:

- **71% said prohibition of tobacco displays had no impact** (19% negative, 5% positive, 4% don't know)
- **72% said restrictions on display of tobacco prices at point of sale had no impact** (20% negative, 4% positive, 4% don't know)
- **67% said standardised "plain" packaging of tobacco packs had no impact (**24% negative, 5% positive, 3% don't know)
- **61% said minimum pack sizes for cigarettes and rolling tobacco had no impact** (24% negative, 12% positive, 3% don't know)
- **73% said regulation of e-cigarette content and packaging had no impact** (5% negative, 8% positive, 10% not applicable, 5% don't know).

The survey also found that the majority of retailers strongly agreed that the following enhanced enforcement measures could help ensure retailers don't sell illicit tobacco or sell to underage smokers:

- **71% strongly agreed on having a tobacco licence which could be removed if retailers break the law** (net agree 84%, net disagree 9%, neither agree/disagree or don't know 7%)
- **55% strongly agreed on removal of alcohol licences from retailers who break tobacco laws** (net agree 66%, net disagree 25%, neither agree/disagree or don't know 9%)
- **65% strongly agreed on larger fines for breaking tobacco laws** (net agree 77%, net disagree 16%, neither agree/disagree or don't know 7%)
- **67% strongly agreed on strengthening of Challenge 21 and Challenge 25 schemes** (net agree 78%, net disagree 14%, neither agree/disagree or don't know 7%)
- **66% strongly agreed on more regular checks by trading standards** (net agree 81%, net disagree 10%, neither agree/disagree or don't know 9%)
- **72% strongly agreed on quicker action when offences take place** (net agree 84%, net disagree 5%, neither agree/disagree or don't know 11%)

NB Challenge schemes require retailers to ask for identification from anyone who looks like they could be under that age. It is a legal requirement in Scotland (Scottish Government 2017)

Focus area 3: Make smoked tobacco products less addictive and less appealing

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

☐ **Yes** ☐ **No**

Please give reasons:

Neither support nor oppose.

The WHO FCTC Conference of the Parties decided that an expert working group should be set up to discuss "the potential positive and negative individual and societal consequences, the conditions to support successful implementation, and the barriers to implementation". (WHO FCTC COP 2016)

The Working Group met in 2018 and its report was presented to COP8. (WHO and the Secretariat of the WHO FCTC 2018) There was no consensus amongst the experts that a nicotine-reduction strategy would necessarily reduce smoking prevalence, due to a range of potential unintended consequences of such a policy, in particular that it would drive demand for illicit tobacco. The high level of noncompliance (60%) in studies where participants have been incentivised to use very low nicotine content (VLNC) cigarettes is an indicator this could be a problem. As is the evidence that addictiveness of cigarettes is not driven solely by nicotine, and that some smokers may sustain smoking in the absence of nicotine, particularly if there are misconceptions about the harm of reduced addictiveness products which could in addition contribute to renormalization of smoking, especially for those who have quit.

There is evidence that when participants are switched to low nicotine cigarettes but have medicinal and non-medicinal sources of nicotine available to them, use of other alternatives (especially e-cigarettes) increases and that increase is associated with smoking fewer cigarettes. (Smith et al 2018) However, it is also evident that it is essential to ensure the availability of alternative less harmful nicotine delivery systems. (Donny et al 2017; Hatsukami et al 2017; Benowitz et al 2017) This could also minimize demand for illicit cigarettes.

Further, the experts agreed that mandated reductions in nicotine to minimally addictive levels must be part of a comprehensive tobacco control approach, where key demand reduction measures are successfully implemented and a developed capacity for market surveillance and product testing exists. The experts agreed that it was a fundamental prerequisite that key demand reduction measures under the WHO FCTC were implemented, in particular Articles 6 (increasing tobacco taxation) 8 (implementing Smokefree legislation) 11 (packaging and labelling to include health warnings) 13 (banning advertising promotion and sponsorship) and 14 (smoking cessation) of the Convention and the implementation guidelines.

The conclusion reached by the working group was that "it was not opportune to develop international guidelines on the nicotine reduction policy at the current time, in advance of the necessary country experience that would be valuable in informing such guidelines."

New Zealand is a good candidate to be the first to try this policy as it is a country in the forefront of implementation of the key measures of the WHO FCTC, has a positive attitude to harm reduction and supports the use of alternative nicotine products such as e-cigarettes. It is also recognised as a country with strong democratic institutions and low levels of corruption (Transparency International 2021) and is an island nation whose closest neighbour is Australia, more than 1,600 kilometres away. However, this is a complex policy with serious risks of unintended consequences, and we therefore believe it is for New Zealand to decide whether to proceed or not.

b). Do you support prohibiting filters in smoked tobacco products?

☒ **Yes** ☐ **No**

Please give reasons:

We support this recommendation but believe that it should be taken forward through a staged process, which starts by prohibiting filter ventilation while more research is carried out on the health impact of unfiltered cigarettes. The evidence supporting a ban on filter ventilation is well established. However, there is some indicative evidence which raises concerns that a ban on filters could increase the harm from smoking for smokers who switch to unfiltered cigarettes rather than quit.

Banning filter ventilation was proposed nearly two decades ago, (Kozlowski and O'Connor 2002), but it has only gained significant traction as a policy option more recently. A systematic review of the evidence has concluded that the use of filter ventilation has failed to make cigarettes less harmful and has more than likely made them more harmful. (Song et al 2017) The weight of evidence showed that filter ventilation:
1) alters tobacco combustion, increasing smoke toxicants;
2) allows for elasticity of use so that smokers inhale more smoke to maintain their nicotine intake; and
3) causes a false perception of lower health risk from "lighter" smoke.

Prohibiting filter ventilation is already under examination by the FCTC Conference of the Parties (WHO FCTC COP, 2018) and implementation by an individual party like New Zealand will support the development of international Guidelines.

When it comes to banning filters altogether, the blog on the University of Otago website which sets out the rationale for going further and banning filters altogether is very persuasive, particularly about the benefits to the environment. (Hoek et al 2021).

We believe however, that this is a policy which requires further evaluation before implementation to help quantify any unintended as well as intended consequences of such a policy. Analysis of US data has demonstrated that mortality outcomes were the same whether smokers smoked regular, light or ultralight cigarettes, but were significantly higher for smokers of unfiltered cigarettes. Smokers of unfiltered cigarettes included in this study were 40% more likely to develop lung cancer and nearly twice as likely to die as those who smoked filtered cigarettes. However, only 11.4% of smokers in this one study used unfiltered cigarettes, and while the analysis controlled for sex, age, race and pack years it did not control for socio-economic status which is a key factor both for health outcomes and selection of unfiltered cigarettes. The authors concluded that the results were likely to reflect the totality of design features of filtered cigarettes including the amount density, and blends of tobacco in the column, additives and paper porosity. (Tanner et al 2019)

Furthermore an analysis of biomarkers in found that exposure to polycyclic aromatic hydrocarbons per day is 0.7 μg/day for those smoking unfiltered cigarettes compared to 0.4 μg/day for those smoking cigarettes with filters. (Sullivan et al 2001)

c). Do you support allowing the Government to prohibit tobacco product innovations through regulations?

☒ **Yes** ☐ **No**

Please give reasons:

The tobacco manufacturers have consistently over time demonstrated their ability to find loopholes in regulations, most recently in the UK with respect to the ban on menthol flavourings in cigarettes. (Branston et al 2020, Hiscock et al 2020)

We therefore strongly support the recommendation that a regulatory power should be added to the Smokefree Environments and Regulated Products Act 1990 to enable the Government to prohibit innovations aimed at increasing the appeal and addictiveness of smoked tobacco products. And that this should cover flavours, additives and design features. Using regulations means that faster changes could be made, because it would not be necessary to amend the Smokefree Environments and Regulated Products Act 1990 each time.

Focus area 4: Make tobacco products less affordable

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

☐ **Yes** ☐ **No**

Neither support nor oppose.

Please give reasons:

We support making tobacco products less affordable, as there is good evidence that it is effective in reducing smoking prevalence by reducing uptake and increasing smoking cessation and is particularly effective with those on low incomes and young smokers. Furthermore there is evidence that the tobacco manufacturers manipulate prices to segment the market so that lower price products remain available for the most price-sensitive smokers, while sustaining their profitability with higher priced premium brand products. (Partos 2020) However, we are not convinced that setting minimum unit price through the means described in the consultation the best way to achieve this, as it will serve to enhance the already extreme profitability of the tobacco manufacturers, (Branston and Gilmore 2015) with little benefit to government revenues.

A minimum price can be secured by other means, which benefit the public purse rather than increasing the profitability of the tobacco industry, and which will have wider health benefits too. We favour capping wholesale tobacco prices, with tobacco duty increasing to offset the lower wholesale prices so that retail prices do not change. This would not only control industry pricing tactics more broadly, but would also transfer the majority of industry profitability to the state with higher tax revenues. (Gilmore et al 2010; Branston and Gilmore 2014; Branston and Gilmore 2015; Branston 2021)

Final questions:

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

Set out below are what we believe are the priorities but it should be noted that we have not attempted to rank these.

1. Increasing the age of sale

We recommend increasing the age of sale to 21 as implemented in the US where it has smoking prevalence in young people aged 18-20 by 30%.

2. Enhance existing initiatives

Sustaining existing initiatives in particular mass and social media campaigns and stop smoking services, including the evolving New Zealand policy encouraging switching to reduced risk nicotine products for those who can't quit, will increase and sustain the impact of any new measures which are introduced. Standardised packaging requirements should also be strengthened, by the addition of warnings on cigarettes and pack inserts containing government-mandated quit advice.

3. Evaluation of all policy measures pre and post implementation

A lot of the measures being proposed are novel and have never been carried out before. It is therefore essential that their impact be properly evaluated both for New Zealand and to support their implementation by other jurisdictions.

4. Reducing retail availability of tobacco

This has potential to reduce inequalities and smoking uptake as well as prevalence. However, it needs to be carried out in conjunction with a strict retail licensing and enforcement regime, and a requirement for the tobacco manufacturers to be fully transparent about their marketing practices. New Zealand should also become a party to the Illicit Trade Protocol to the FCTC to enable better control of the illicit market in legally manufactured tobacco products.

b). Do you have any other comments on this discussion document?

Enhance existing initiatives

We strongly support proposals in the consultation document to scale up its investment on well-established mass and social media campaigns and stop smoking services. Their effectiveness and cost-effectiveness is well established, most recently by a comprehensive evaluation of the extensive US campaigns which have been running since 2012. (CDC)

Making tobacco less affordable is a highly effective tobacco control intervention which reduces smoking uptake and increases cessation. However, disadvantaged smokers who don't quit bear a disproportionate share of the tobacco tax burden, because of the greater concentration of smoking among these groups. In addition, due to their higher rates of smoking, these populations also bear a disproportionate share of the burden of disease caused by tobacco.

This poses a dilemma which can be resolved by ensuring that all efforts are made to motivate and support smokers in quitting, particularly the most disadvantaged. The evidence is clear that the positive health impact of taxes is greater when supported by comprehensive tobacco control strategies (Chaloupka et al 2012).

Strengthening of standardised packaging regulations

New Zealand standardised packaging regulations have removed some of the loopholes in the UK legislation. (Moodie et al 2019) However, they could still go further to require health warnings on

cigarette sticks and rolling papers; and government mandated pack inserts promoting quitting and switching to less harmful products.

'Dissuasive cigarettes'

There is evidence that smokers become inured to an extent to existing warnings and new techniques are needed to refresh their interest. Under consideration both in Canada, Australia and Scotland are what is known as 'dissuasive cigarettes' carrying health warnings. Requiring health warnings to be printed on cigarette sticks to encourage smokers to quit is supported by 68% of adults in England with only 8% opposing (Yougov 2020).

Adding health warnings to cigarettes would require a simple revision of the standardardised packaging regulations and there is a growing body of research evidence supporting their effectiveness (Drovandi et al 2019; Gallopel-Morvan 2019; Hoek et al 2016; Mitchell, Critchlow et al 2020, Mitchell, Moodie et al 2020; Moodie et al 2015, 2016, 2017, 2018, 2019,2020).

This would also provide the clearest warning possible to children, who are not necessarily exposed to the unappealing packaging and on-pack warnings when they experiment, not to start. This should also be required for smoking accessories such as cigarette papers, and filters, which are used with handrolling tobacco.

Pack inserts

The health harms warnings on the outside of the pack help motivate smokers to think about quitting. Pack inserts on the inside could be used to provide the best advice on how to succeed, providing complementary and cost-effective support to the smoking cessation services provided by local authorities and the NHS. This is a straightforward measure requiring a simple revision of the UK's standardised packaging legislation which currently prohibits pack inserts. Requiring the inclusion of government-mandated information about quitting in pack inserts is supported by 69% of adults in England with only 7% opposing. (YouGov 2020).

Pack inserts are:

- Easy and cheap to implement
- Targeted at current smokers
- Have already proved effective in Canada.

Canada has had a legal requirement for manufacturers to include educational material within cigarette packs since 2000. Canadian government mandated pack inserts highlight the benefits of quitting and provide tips on how to do so, and since 2012, the inserts have updated to include graphics rather than just text. Research into their impact has shown that while reading on-pack health warnings significantly decreased over time, reading inserts significantly increased, with more frequent reading of inserts associated with self-efficacy to quit, quit attempts and sustained quitting at follow-up. (Thrasher et al 2015 and 2016)

Focus group research by academics at the University of Stirling found that smokers, diverse in age, gender and social grade, supported the use of such inserts in the UK to encourage them to quit (Moodie 2018, Moodie et al 2018).

Regulating to restrict media exposure to smoking imagery

Any exposure to tobacco imagery, branded or unbranded, not just that included as a result of advertising, promotion or sponsorship by the industry, is a cause of smoking uptake and is thus by definition harmful. The most recent RCP report (RCP 2021) recommends that with limited exemptions to allow bona fide news reporting and use of tobacco imagery for health promotion purposes, the portrayal of tobacco imagery in any new media content likely to be seen by children should be prohibited, and where portrayal does occur, measures should be taken to ameliorate the effect through anti-tobacco messaging. We encourage the New Zealand government to consider implementing the following recommendations which are taken from the RCP report (RCP 2021):

- Film licensing laws and television broadcasting codes require amendment to ensure the exclusion of all tobacco imagery from new productions that might be seen by children.
- Health messaging is required on all tobacco imagery in existing content and when communicated in the media.
- All new films containing tobacco imagery are classified as unsuitable for viewing by persons aged under 18 years.
- Inclusion of tobacco imagery is prohibited in all programming (broadcast or ondemand) likely to be seen by children.
- Any film, television, video-on-demand, and other online content such as music videos and print media that contain tobacco imagery is required to display a health warning while such imagery is visible.
- In cinemas, anti-smoking health promotion messages are shown immediately before films containing smoking.
- All forms of tobacco industry sponsorship and advertising, including alibi marketing, for example use of social media influencers, are prohibited.
- All retail tobacco gantries and cabinets are removed from sight.
- Tobacco product imagery is not shown on online sales websites.

References:

All online links for references accessed May 2021.

Anderson W. Counter Arguments: How important is tobacco to small retailers? ASH. London. 2016.

APPG on Smoking and Health. Delivering the vision of a 'Smokefree Generation': The All Party Parliamentary Group on Smoking and Health response to 'Prevention is better than cure'. 2019

Apollonio DE, Bero LA. The creation of industry front groups: the tobacco industry and "get government off our back". Am J Public Health 2007;97:419

ASH and SPECTRUM Consultation response on behalf of ASH and SPECTRUM. Tobacco and related products legislation introduced between 2015 to 2016: reviewing effectiveness. 2021.

Beard, Emma, Jamie Brown, Sarah Jackson, Robert West, Will Anderson, Deborah Arnott, and Lion Shahab. Long-term evaluation of the rise in legal age-of-sale of cigarettes from 16 to 18 in England: a trend analysis. *BMC Med* **18,** 85 (2020). https://doi.org/10.1186/s12916-020-01541-w

Beard E, Brown J, Jackson SE, West R, Anderson W, Arnott D, Shahab L. Who would be targeted by increasing the legal age of sale of cigarettes from 18 to 21? A cross-sectional study exploring the number and characteristics of smokers in England. Addiction. 2021 Feb 10.

Benowitz NL, Donny EC, Hatsukami DK. Reduced nicotine content cigarettes, e-cigarettes and the cigarette end game. Addiction. 2017;112(1):6-7.

Benowitz NL, Nardone N, Hatsukami DK, Donny EC. Biochemical estimation of noncompliance with smoking of very low nicotine content cigarettes. Cancer Epidemiology and Prevention Biomarkers. 2015 Feb 1;24(2):331-5.

Branston JR, Hiscock R, Silver K, Arnott D, Gilmore AB. Cigarette-like cigarillo introduced to bypass taxation, standardised packaging, minimum pack sizes, and menthol ban in the UK. Tob Control. 2020;0:1–4. doi:10.1136/tobaccocontrol-2020-055700

Branston JR, Gilmore AB. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy. University of Bath. 2015 Feb. https://researchportal.bath.ac.uk/en/publications/the-extreme-profitability-of-the-uk-tobacco-market-and-the-ration

Branston JR. Industry profits continue to drive the tobacco epidemic: a new avenue for tobacco control? Tobacco Cessation and Prevention 2021 forthcoming.

Branston R, Gilmore A. The case for Ofsmoke: the potential for price cap regulation of tobacco to raise £500 million per year in the UK. Tob Control 2014;23:45–50. doi:10.1136/tobaccocontrol-2011-050385

Caryl F, Pearce J, Reid G, Mitchell R, Shortt N. Simulating the density reduction and equity impact of potential tobacco retail control policies. Tob Control 2020;0:1–6. oi:10.1136/ tobaccocontrol-2020-056002

Caryl F, Shortt N, Pearce J, Reid G, Mitchell R
Socioeconomic inequalities in children's exposure to tobacco retailing based on individual-level GPS data in Scotland. Tob Control. 2020;29:367–373.
https://tobaccocontrol.bmj.com/content/early/2019/07/05/tobaccocontrol-2018-054891

Centers for Disease Control and Prevention (CDC). Publications and Evaluation Results about the Tips Campaign By Topic. Accessed 24th May 2021.

Chaloupka F, Yurekli A, Fong G. Tobacco taxes as a tobacco control strategy. Tobacco Control 2012; 21:172-180.

Clemens T, Dibben C, Pearce J & Shortt NK (2018) Neighbourhood tobacco supply and individual maternal smoking during pregnancy: a fixed effects longitudinal analysis using routine data. Tob Control. 2020;29:7–14. doi:10.1136/tobaccocontrol-2018-054422

Comité National Contre le Tabagisme (CNCT). Etude comparée des modalitiés de distribution au détail des produits du tabac et de leur efficacité dans la mise en oeuvre de la Convention Cadre (FCTC). 2014

Donny EC, Walker N, Hatsukami D, Bullen C. Reducing the nicotine content of combusted tobacco products sold in New Zealand. Tobacco Control. 2017 Mar 1;26(e1):e37-42.

Drovandi A, Teague PA, Glass B, Malau-Aduli B. Do health warnings on cigarette sticks dissuade smokers and non-smokers? A focus group and interview study of Australian university students. Psychol Res Behav Manag. 2019;12:361–373.
doi:10.2147/PRBM.S193754.

Edwards R, Carter K, Peace J, Blakely T. An examination of smoking initiation rates by age: results from a large longitudinal study in New Zealand. Aust N Z J Public Health. 2013;37(6):516-19.

Feliu A, Filippidis FT, Joossens L, Fong GT, Vardavas CI, Baena A, Castellano Y, Martínez C, Fernández E. Impact of tobacco control policies on smoking prevalence and quit ratios in 27 European Union countries from 2006 to 2014. Tobacco Control. 2019 Jan 1;28(1):101-9.
Fidler JA, West R. Changes in smoking prevalence in 16-17-year-old versus older adults following a rise in legal age of sale: findings from an English population study. Addiction. 2010 Nov;105(11):1984-8. doi: 10.1111/j.1360-0443.2010.03039.x. Epub 2010 Aug 17. PMID: 20722633.

Fitzgerald N, Nicholls J, Winterbottom J, Katikireddi SV. Implementing a public health objective for alcohol premises licensing in Scotland: A qualitative study of strategies, values, and perceptions of evidence. Int J Environ Res Public Health. 2017;14(3).

Fitzgerald N, Winterbottom J, Nicholls J. Democracy and power in alcohol premises licensing: A qualitative interview study of the Scottish public health objective. Drug Alcohol Rev [Internet]. 2018 Jul;37(5):607–15. Available from: http://doi.wiley.com/10.1111/dar.12819

Gallopel-Morvan K, Moodie C, Guignard R, Eker F, Beguinot E. Consumer perceptions of cigarette design in France: A comparison of standard, innovative (slim, pink) and plain cigarettes. Nicotine Tob. Res. 2019; 21(7): 911-917. doi: 10.1093/ntr/nty105

Gilmore AB, Branston JR, Sweanor D. The case for OFSMOKE: how tobacco price regulation is needed to promote the health of markets, government revenue and the public. Tob Control. 2010;19:423e430. doi:10.1136/tc.2009.034470

Guthrie J, Hoek J, Darroch E, Wood Z. A qualitative analysis of New Zealand retailers' responses to standardised packaging legislation and tobacco industry opposition. BMJ Open. 2015;5:e009521. doi: 10.1136/bmjopen-2015-009521

Hatsukami DK, Luo X, Dick L, et al. Reduced nicotine content cigarettes and use of alternative nicotine products: exploratory trial. Addiction. 2017;112(1):156-167
Hiscock R, Silver K, Zatoński M & Gilmore AB. Tobacco industry tactics to circumvent and undermine the menthol cigarette ban in the UK. Tob Control 2020;29:e138-e142
https://doi.org/10.1371/journal.pone.0228069

Hitchman SC, Calder R, Rooke C, McNeill A. Small retailers' tobacco sales and profit margins in two disadvantaged areas of England. AIMS public health. 2016;3(1):110.

Hoek J, Gendall P, Eckert C, Louviere J. Dissuasive cigarette sticks: the next step in standardised ('plain') packaging? Tob Control. 2016:25;699-705.
doi: 10.1136/tobaccocontrol-2015-052533

Hoek J, Gendall P, Novotny T, Wilson N, Robertson L, Edwards R, Thrasher JF. The Case for Banning Cigarette Filters: Addressing a Consumer Fraud, Smoking Decoy and Environmental Hazard. 15 May 2021. Sciblogs. 2021 [Accessed xx] Available from: https://sciblogs.co.nz/public-health-expert/2021/05/17/the-case-for-banning-cigarette-filters-addressing-a-consumer-fraud-smoking-decoy-and-environmental-hazard/

Kozlowski LT, O'Connor RJ. Cigarette filter ventilation is a defective design because of misleading taste, bigger puffs, and blocked vents. Tob Control. 2002;11(Suppl I):i40–i50. doi: 10.1136/tc.11.suppl_1.i40. PMID: 11893814; PMCID: PMC1766061.

Langley T, Gilmore AB, Gallagher A & Arnott D. Confronting Illicit Tobacco Trade: A Global Review of Country Experiences [online]. World Bank Group; 2020 Available from:
https://pubdocs.worldbank.org/en/248361548435105081/WBG-Tobacco-IllicitTrade-UnitedKingdom.pdf

Māori Affairs Committee. Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori. Forty-ninth Parliament (Hon Tau Henare, Chairperson). November 2010.
Reynolds J, Wilkinson C. Accessibility of "essential" alcohol in the time of COVID-19: Casting light on the blind spots of licensing? 2020; Available from: http://www.euro.who.int/en/about-us/regional-director/news/

Marsh L, Cameron C, Quigg R, Wood S, Blank M-L, Venter N, et al "Is the tobacco 'footfall' argument justified for tobacco purchases in New Zealand convenience stores?." Tob Control. 2020;0:1–6. doi:10.1136/tobaccocontrol-2020-056032

Mitchell D, Critchlow N, Moodie C, Bauld L. Reactions to, and trial intentions for, three dissuasive cigarette designs: a cross-sectional survey of adolescents in Scotland. Tob Control. 2020;0:1–7. doi: 10.1136/tobaccocontrol-2020-055842

Mitchell D, Moodie C, Critchlow N, Bauld L. Adolescents' reactions to, and perceptions of, dissuasive cigarettes: A focus group study in Scotland. Drugs: Education, Prevention and Policy. 2020;27:462-9. doi: 10.1080/09687637.2020.1732300

Moodie C, O'Donnell R. 'I'm killing myself, but I'm saving the planet': rolling tobacco smokers' perceptions of rolling papers. Tob Control 2020;0:1–4. doi: 10.1136/tobaccocontrol-2020-056103

Moodie C. Adult smokers' perceptions of cigarette pack inserts promoting cessation: a focus group study. Tob Control. 2018;27(1):72-77. doi: 10.1136/tobaccocontrol-2016-053372

Moodie CS, Hiscock R, Thrasher J,Reid G. Perceptions of cigarette pack inserts promoting cessation and dissuasive cigarettes among young adult smokers in the UK: a cross-sectional online survey. BMJ Open 2018;8:e019662. doi: 10.1136/bmjopen-2017-019662

Moodie C, Hoek J, Scheffels J,Gallopel-Morvan K, Lindorff K. Plain packaging: legislative differences in Australia, France, the UK, New Zealand and Norway, and options for strengthening regulations. Tob Control. 2019;28(5):485-492. doi: 10.1136/tobaccocontrol-2018-054483

Moodie C, Purves R, McKell J, de Andrade M. Novel means of using cigarette packaging and cigarettes to communicate health risk and cessation messages: A qualitative study. Int J Ment Health Addict. 2015;13:333–344.
doi: 10.1007/s11469-014-9530-1

Moodie C. Novel ways of using tobacco packaging to communicate health messages: Interviews with packaging and marketing experts. Addict Res Theory. 2016;24(1):54-61.
doi: 10.3109/16066359.2015.1064905

Moodie C, Hiscock R, Reid G. Perceptions of cigarette pack inserts promoting cessation and dissuasive cigarettes among young adult smokers in the United Kingdom. Stirling, Scotland: Centre for Tobacco. BMJ Open. 2018;**8:**e019662
doi: 10.1136/bmjopen-2017-019662

Moodie C, O'Donnell R, Fleming J, Purves R, McKell J, Dobbie F. Extending health messaging to the consumption experience: Adult smokers' perceptions of health warnings on cigarettes. Addict Res Theory. 2020;28(4):328-334
doi: 10.1080/16066359.2019.1653861

Moodie C, Gendall P, Hoek J, Mackintosh AM, Best C, Murray S. The response of young adult smokers and non-smokers in the United Kingdom to dissuasive cigarettes: An online survey. Nicotine Tob Res. 2019;21(2):227–233.
doi: 10.1093/ntr/ntx261.

Moodie C, Mackintosh AM, Gallopel-Morvan K, Hastings G, Ford A. Adolescents' perceptions ofhealth warnings on cigarettes. Nicotine Tob Res. 2017;19(10):1232-1237.

doi: 10.1093/ntr/ntw165

NEMS survey for ASH. Telephone survey of 558 independent retailers across all English regions. Respondents included convenience stores, off-licences, newsagents, independent fuel services and specialist tobacconists. Fieldwork undertaken between 6th August and 21st August 2019.

New Zealand Government Response to the Report of the Māori Affairs Committee on its Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori. 2011

NHS Digital Smoking Drinking and Drug Use Survey, 2018 https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england

Office of National Statistics. Adult smoking habits in the UK: 2019 [online]. 2020 [Accessed 26 Nay 2021]

Partos TR, Hiscock R, Gilmore AB, Branston JR, Hitchman S, McNeill A. Tobacco industry pricing strategies and price segmentation of the UK tobacco market. In Impact of tobacco tax increases and industry pricing on smoking behaviours and inequalities: a mixed-methods study 2020 Apr. NIHR Journals Library.

Pasquereau A, Andler R, Arwidson P, Guignard R, Nguyen-Thanh V. Consommation de tabac parmi les adultes : bilan de cinq années de programme national contre le tabagisme, 2014-2019. Bull Epidémiol Hebd. 2020;(14):273-81.
Article - Bulletin épidémiologique hebdomadaire (santepubliquefrance.fr)

Pearce J, Cherrie M, Best C, et al. How has the introduction of point-of-sale legislation affected the presence and visibility of tobacco retailing in Scotland? A longitudinal study. Tobacco Control 2020;29:168-174.

Pearce J, Hiscock R, Moon G, et al. The neighbourhood effects of geographical access to tobacco retailers on individual smoking behaviour. Journal of Epidemiology & Community Health 2009;63:69-77

Pearce J, Rind E, Shortt NK and Mitchell R. Tobacco retail environments and social inequalities in individual-level smoking and cessation among Scottish adults. Nicotine and Tobacco Research. 2016; 18:138-146. (This paper shows adults more likely to smoke and less likely to sustain successful quit attempts in areas of high density).

Reynolds J, McGrath M, Halliday E, Ogden M, Hare S, Smolar M, et al. 'The opportunity to have their say'? Identifying mechanisms of community engagement in local alcohol decision-making. Int J Drug Policy. 2020 Nov 1;85:102909.

Robertson L, Cameron C, Hoek JA, Sullivan T, Marsh L, Peterson E et al. Prevalence and characteristics of tobacco purchases in convenience stores: results of a postpurchase intercept survey in Dunedin, New Zealand. Tob Control. 2019;28:696–700. doi:10.1136/tobaccocontrol-2018-054643

Royal College of Physicians. Smoking and health 2021: a coming of age for tobacco control? London: RCP, 2021.

Scottish Government. Age verification guidance. 2017. https://www.gov.scot/publications/age-verification-guidance/

Scottish Government. Raising Scotland's tobacco-free generation: our tobacco control action plan 2018. Available online.

Sherk A, Stockwell T, Chikritzhs T, Andréasson S, Angus C, Gripenberg J, et al. Alcohol Consumption and the Physical Availability of Take-Away Alcohol: Systematic Reviews and Meta-Analyses of the Days and Hours of Sale and Outlet Density. J Stud Alcohol Drugs [Internet]. 2018 Jan 13 [cited 2018 Apr 30];79(1):58–67. Available from: http://www.jsad.com/doi/10.15288/jsad.2018.79.58

Shortt, NK, Tisch C, Pearce J, Mitchell R, Richardson EA, Hill S and Collin, J. The association between tobacco and alcohol outlet density and deprivation in Scotland. BMC Public Health. *2015:*15:1014.

Shortt NK, Tisch C, Pearce J, Richardson EA and Mitchell R. The density of tobacco retailers in both home and school environments and relationship with adolescent smoking behaviours in Scotland. Tob Control. *2014:* 25; 75-82. (Showing that kids in areas or higher density are more likely to try smoking).

Shortt NK, Tisch C, Pearce J, Mitchell R, Richardson EA, Hill S, Collin J. A cross-sectional analysis of the relationship between tobacco and alcohol outlet density and neighbourhood deprivation. BMC public health. 2015 Dec;15(1):1-9.

Shortt N, Tunstall H, Mitchell R, Coombes E, Jones A, Reid G, Pearce J. Using point-of-sale data to examine tobacco pricing across neighbourhoods in Scotland. Tob Control. 2021;30:168–176. doi:10.1136/tobaccocontrol-2019-055484
https://ueaeprints.uea.ac.uk/view/research_group/RGEPI/2020.ispublished.html

Smith TT, Hatsukami DK, Benowitz NL, et al. Whether to push or pull? Nicotine reduction and non-combusted alternatives - Two strategies for reducing smoking and improving public health. Prev Med. 2018. 24.

Song MA, Benowitz NL, Berman M, Brasky TM, Cummings KM, Hatsukami DK, Marian C, O'Connor R, Rees VW, Woroszylo C, Shields PG. Cigarette Filter Ventilation and its Relationship to Increasing Rates of Lung Adenocarcinoma. J Natl Cancer Inst. 2017 Dec 1;109(12):djx075. doi: 10.1093/jnci/djx075. PMID: 28525914; PMCID: PMC6059254.

Stats NZ 2020. Population | Stats NZ

Sullivan JB, Krieger GR, eds. 2001. Clinical environmental health and toxic exposures. 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins. (exposure to polycyclic aromatic hydrocarbons per day is 0.7 µg/day (unfiltered) vs 0.4 µg/day (filtered)

Tanner NT, Thomas NA, Ward R, Rojewski A, Gebregziabher M, Toll B, Silvestri GA. Association of Cigarette Type With Lung Cancer Incidence and Mortality: Secondary Analysis of the National Lung Screening Trial. JAMA Intern Med. 2019;179(12):1710-1712. doi: 10.1001/jamainternmed.2019.3487. PMID: 31633739; PMCID: PMC6806424.

Tattan-Birch H, Brown J, Shahab L, Jackson SE. Association of the US Outbreak of Vaping-Associated Lung Injury With Perceived Harm of e-Cigarettes Compared With Cigarettes. JAMA Netw Open. 2020;3(6):e206981. doi:10.1001/jamanetworkopen.2020.6981

The Tobacco and Related Products Regulations 2016 (legislation.gov.uk) Rule 38(4) "The unit pack or container pack in which an electronic cigarette or refill container is, or is intended to be, presented for retail sale may not contain any element or feature which suggests economic advantage by including printed vouchers or offering discounts, free distribution, two-for-one or other similar offers."

The Tobacco and Related Products Regulations 2016 (legislation.gov.uk) Rule 43: "No person may in the course of a business include, or procure the inclusion of, an electronic cigarette advertisement in an information society service provided to a recipient in the United Kingdom."

Thrasher JT, Osman A, Abad EN, Hammond D, Bansal-Travers M, Cummings KM et al. The innovative use of cigarette package inserts to supplement pictorial health warnings: An evaluation of the Canadian policy. Nicotine Tob Res. 2015;17(7):870-875.
doi: 10.1093/ntr/ntu246

Thrasher JF, Swayampakala K, Cummings KM, et al. Cigarette package inserts can promote efficacy beliefs and sustained smoking cessation attempts: A longitudinal assessment of an innovative policy in Canada. Prev Med. 2016;88:59-68 doi: 10.1016/j.ypmed.2016.03.006

Transparency International. Corruption Perceptions Index 2020. 2021.

Tunstall H, Shortt NK, Mitchell R, & Pearce J. Tobacco outlet density and tobacco knowledge, beliefs, purchasing practices and price among adolescents in Scotland. Social Science and Medicine. 2018;206: 1-13
Wood L, Gazey A. Tobacco mythbusting—tobacco is not a major driver of foot traffic in low socio-economic small retail stores. Tob Control. 2021;0:1–4. doi:10.1136/tobaccocontrol-2020-056310

World Health Organisation. Report on meetings of expert committees and study groups. Report by the Director-General. Executive Board EB148/47. 148th session 23 December 2020 Provisional agenda item 22. 29 (i)

World Health Organisation. WHO Framework Convention on Tobacco Control. 2003

World Health Organisation. Protocol to Eliminate Illicit Trade in Tobacco Products. 2012

WHO and the Secretariat of the WHO Framework Convention on Tobacco Control. Report: Consultation on Tobacco Addictiveness Reduction Measures. Berlin, Germany, 15–16 May 2018

WHO FCTC COP 7. Further development of the partial guidelines for implementation of Articles 9 and 10 of the WHO FCTC (Regulation of the contents of tobacco products and Regulation of tobacco product disclosures). FCTC/COP7(14). 2016.

WHO FCTC COP 8. decision FCTC/COP8(21). Implementation of Articles 9 and 10 of the WHO FCTC (Regulation of contents and disclosure of tobacco products, including water pipe, smokeless tobacco and heated tobacco products). 2018.

Wright A. Local Alcohol Policy Implementation in Scotland : Understanding the Role of Accountability within Licensing. Int J Environ Res Public Health. 2019;1–21.

YouGov online survey for ASH. Total sample size was 10,749 adults. Fieldwork was undertaken between 17th February - 11th March 2020. The figures have been weighted and are representative of all English adults (aged 18+).