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Submitted: 25 January 2024; Revision requested: 30 October 2024; Accepted: 7 November 2024

Key words: Smokefree legislation, public health policy, New Zealand, inequality

In a groundbreaking move, Aotearoa New Zealand (NZ) set a global precedent in 2022 by moving to implement a set of tobacco endgame measures for the next generation of its population [1]; protecting the population from a product that increases mortality threefold and leads to death 10 years earlier in those who smoke, compared with those who do not .[2] This pioneering law, amongst the first of its kind worldwide, has inspired international change.[3] The Smokefree legislation stated aims were to: i) significantly limit the number of retailers able to sell smoked tobacco products; ii) prevent young people from taking up smoking by prohibiting the sale of smoked tobacco products to anyone born on or after January 1st 2009; and iii) make smoked tobacco products less appealing and addictive .[1] This would have resulted in outcomes of reduced access, a smoke-free generation (SFG) who would never start smoking, as well as 'denicotinisation' or 'very low nicotine cigarettes' (VLNC). Additionally, the policy would have contributed to a reduction in inequities in smoking rates and smoking-related illnesses. However, the repeal of amendments to the Smokefree legislation outlined in a coalition agreement following a change in government during late 2023, has now been enacted. This casts uncertainty on NZ's world-leading trajectory towards a smokefree 2025 goal and more equitable future .[4,5]

This policy reversal will potentially elongate and perpetuate harm to Māori and Pasifika populations that have been historically disadvantaged politically, economically and socially in NZ .[5,6] It will exacerbate disparities, which include lower income, life expectancy, education, health outcomes and healthcare stigmatisation.[5] Indeed, a tobacco endgame vision was cast into the foreground following the 2010 Māori Affairs Select Committee inquiry into the tobacco industry and the effects of tobacco use on Māori .[7] It highlighted that while overall smoking rates were reducing the rates among Māori and Pacific peoples were higher; Māori women have among the highest lung cancer rates in the world. In 2022-23 smoking rates were 20.2% among Māori and 10.3% for Pacific peoples, compared to 7.7% for European/other and 3.7% for Asian ethnicities (**Figure 1**). A failure to address this regressive policy change risks further entrenching both poor health outcomes and ongoing health inequities in NZ.

In tandem with historical and socioeconomic disadvantages, there are geographic implications to the unravelling of the Smokefree legislation. Previous research has demonstrated that the distribution of both ameliorating and deleterious environmental exposures ,[8] such as the distribution of smoking outlets is non-uniform across NZ .[9] The Smokefree legislation proposed a reduction in the number of tobacco outlets by specific urban and rural areas. For example, reducing the number of outlets in Auckland to 25, Wellington to 8, and Christchurch to 13 as well as specifying that many rural areas would be served by a single outlet .[10] At a national level, this meant a reduction from over 6,000 to 599 tobacco outlets. Evidence has demonstrated the importance of geographical access as an important determinant of health behaviour and outcomes [8,11] including smoking cessation .[12] Turning to demographic considerations, the population structures of the Māori and Pacific populations are younger and growing in NZ, with median ages of 26 years and 24 years respectively, in comparison to European counterparts, who are older with a median age of 41 years. Māori or Pacific people were 3.3 or 1.3 times as likely to be current smokers after adjusting for age and gender compared with non-Māori, or non-Pacific peoples, respectively. A smokefree generation policy that reduced smoking at earlier ages would have a greater impact on reducing ethnic inequities in smoking and the associated adverse outcomes

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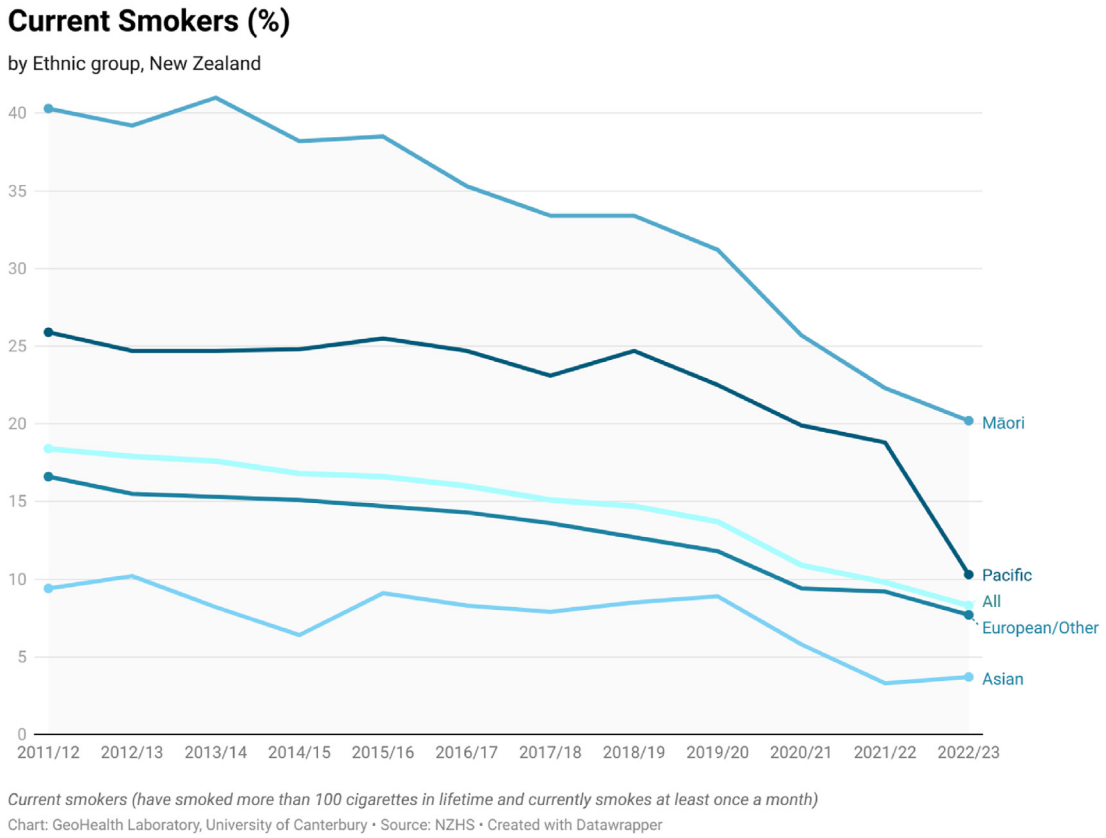
Aust NZ J Public Health. 2024; Online; https://doi.org/10.1016/j.anzjph.2024.100209

Figure 1: Current smokers by ethnic group, New Zealand, 2011/12 to 2022/23.



associated with such health behaviours over the longer term, given the younger age profiles of Māori and Pacific populations. Further, VLNCs would also have had significant impacts on inequity according to modelling [13]

We argue that the costs of this policy reversal to remove the Smokefree Environments and Regulated Products Amendment Act are of such a significant magnitude as to warrant reconsideration, whether immediate or for the next incoming government. Estimates of gains from a tobacco endgame are both immediately significant and accrue over a longer period to the tune of $US1.42 billion by 2040 .[14] However, as others observe, a balanced budget should not depend on revenue from continuing to sell addictive, lethal products to people in order to provide modest income tax reductions .[12] Moreover, the smokefree 2025 target, aiming for a 5% prevalence, would have been reached for non-Māori (2.7% in 2025), but not for Māori (7.3% in 2025), even under prior legislation. It would have taken until 2026 for Māori males and 2027 for Māori females for the smokefree 2025 target to be achieved .[13]

In summary, a government wishing to improve the lives of all New Zealanders, to improve health and wealth over the long term, should utilise robust evidence .[13] This change in approach may also increase Trans-Tasman inequalities in health .[15] Notwithstanding the large and ongoing estimated costs of a policy change, there will also be a slowing in reductions in inequity between ethnic groups. The costs of reversing robust evidence-backed policies are steep. Arguments in favour of the reversal have pointed to an increase in illicit sales, crime, and a need for enhanced revenue, but these arguments have been widely opposed and strongly criticised by public health researchers as lacking consistent and robust evidence, and perhaps most problematically, arguments in favour of repeal appear to mirror industry statements. It has been argued that no other health intervention would have reduced inequities in mortality by a similar magnitude as the Smokefree legislation.[13] NZ once championed a 'social-investment' approach, aiming to enhance citizens' lives through evidence-based investments. We urge a return to following the evidence to ensure the continued improvement of public health and reduction of avoidable inequities.

Author contributions

All authors made contributions to this manuscript.

Ethics committee

N/A.

Funding

None.

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Conflicts of interest

All authors have none to declare.

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