



The Royal Australasian
College of Physicians

New Zealand



THE CARDIAC SOCIETY OF AUSTRALIA AND NEW ZEALAND

Submission To The Select Committee

The inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori

Submitted by:

The Royal Australasian College of Physicians

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and

The Cardiac Society of Australia and New Zealand

The inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori

The Royal Australasian College of Physicians (the College) represents physicians practising across 35 medical specialities including adult medicine, paediatric and child health medicine. Fellows are employed primarily in hospitals and therefore routinely see the devastating impact of smoking on patients and their families/whānau. The College wishes to see tobacco denormalised and for New Zealand to be virtually tobacco free by 2020.

Tobacco smoking kills half its long-term users and reduces life expectancy by an average 10 years.¹ Smoking tobacco causes harm to the entire body and it is highly addictive. For these reasons the College strongly advocates changes to current tobacco policy in New Zealand.

The College's main concerns lie with the harm caused by smoking tobacco both directly and indirectly through second hand smoking. The College believes that substantial harm reduction can only occur by implementing legislative change regarding the supply of tobacco. Access to tobacco in New Zealand must be curtailed by limiting tobacco sale outlets and increasing the price of tobacco. Smoking cessation programmes need to be intensified. The funding of such programmes is cost-effective as they lead to long-term reduction in the health sector and prolong the life expectancy of people who quit smoking tobacco reduce the exposure of smoking to other individuals.

In the College's view there is no benefit to Māori or other New Zealanders by allowing tobacco companies to continue to sell tobacco. Tobacco supply and consumption must be reduced with a view to having tobacco use close to zero in New Zealand by 2020.

The tobacco industry must be held accountable for undermining the health of Māori by contributing to the health inequalities experienced by Māori smokers. More Māori (47%) are daily smokers compared to Pacific peoples (29%) and other New Zealanders (20%).² Smoking-attributable mortality rates are higher for Māori and may continue to grow as a contributor to health inequalities.³ For these reasons, the Select Committee investigation into the tobacco industry is warranted and timely.

SUMMARY OF RECOMMENDATIONS

The College makes the following recommendations:

1. Supply Issues

- a. That the tax on tobacco products is substantially and annually increased and that the revenue from this tax is used to fund cessation services which specifically address Māori needs.
- b. That research is undertaken to identify and adequately fund those effective Māori cessation programmes.
- c. That cessation programmes are devised to benefit pregnant women, particularly Māori women.

¹ The Royal Australasian College of Physicians & the Royal Australia and New Zealand College of Psychiatrists, 2005 *Tobacco facts for physicians*, Australia

² The Quit Group, *Fact Sheet 1, 2006, Maori smoking and tobacco use*, Ministry of Health, Wellington

³ Wilson, N et al, 2006, *What potential has tobacco control for reducing health inequalities? The New Zealand situation*. *International Journal for Equity in Health*, 5, 16.

- d. That all retail displays of tobacco are removed and smoking cessation information be made available at all points of sale.
- e. That tobacco packaging is reviewed and generic packing is implemented
- f. That the law banning underage tobacco sales to adolescents is strongly enforced.
- g. That the number of outlets selling tobacco are reduced over time.
- h. That parental influence on smoking habits and social supply is acknowledged and programmes are specifically designed to reduce this pressure within the Māori context.

2. Accountability

That a Ministerial Taskforce on Tobacco is established with the purpose to fully investigate the tobacco industry's practices in New Zealand. A growing concern is the marketing techniques used by tobacco companies to insidiously promote tobacco through new technologies such as Twitter, You Tube and other electronic communications.

3. Social Change

That support is given to Māori leadership to advocate for social change among Māori and reinforce messages that smoking is deadly and does not belong as part of the Māori cultural identity.

THE HARM

The level of tobacco-related harm in New Zealand is of serious concern to College members. In particular, the damage tobacco smoking does to Māori, individually, to the whānau and Māori culture as a whole, can not be under estimated.

Māori in all age groups have higher smoking rates than non-Māori⁴ and they also have been smoking for longer. For example, a higher proportion of Maori have been smoking for more than 20 years - 46% of Māori in this category compared with 40% of Pakeha⁵. These data illustrate how the smoking behaviour as the social norm has inveigled its way into the Māori culture.

1. Risks to Unborn Children

The College represents both Adult Medicine and Paediatric and Child Health physicians. In the course of their practice, Paediatricians have seen first-hand the negative impacts of tobacco consumption upon the unborn child.

Maternal smoking is linked to growth impairment, airway malformation, premature rupture of membranes, miscarriage and still birth.⁶ There is no safe level of cigarette smoking in pregnancy⁷. Furthermore children of maternal smokers are at risk of adverse health outcomes throughout their lives⁸. A recent article in the New Zealand Herald indicated that 45% of pregnant Māori women smoke.⁹ Pregnancy is an opportune time to encourage women to stop smoking as studies have shown that women are often motivated to stop smoking due to concerns for their child. Intensive quit programmes should be devised to assist pregnant women cease smoking.

⁴ The Quit Group ,*Fact Sheet 1, 2006 Maori smoking and tobacco use*, Ministry of Health, Wellington

⁵ Robson, B, 2004, *Economic determinants of Maori health and disparities: A review for the public health advisory Committee*, Wellington.

⁶ The British Medical Association, 2004, *Smoking and reproductive life: the impact of smoking on sexual, reproductive and child health*, London, United Kingdom

⁷ The Royal Australasian College of Physicians & the Royal Australia and New Zealand College of Psychiatrists, 2005 *Tobacco Policy: Using evidence for better outcomes*, Australia

⁸ The Royal Australasian College of Physicians & the Royal Australia and New Zealand College of Psychiatrists, 2005 *Tobacco Policy: Using evidence for better outcomes*, Australia

⁹ Johnston,M, 2010, *Maori women pay price for their high addiction rate*, New Zealand Herald 5 January 2010

2. Risks to Young Children

One of the College's key concerns is the impact that tobacco smoking has on young people. Whilst smoking amongst school-aged students has declined dramatically between 1999 and 2008¹⁰, it is still an issue with young Māori, especially Māori girls. Over half (56%) the young Māori women (aged between 14-24 years old) are smokers. Young Māori women are 4 times more likely to be smoke than non- Maoris females aged 14-15 years.¹¹ There is a need to explore why this group is continuing to take up smoking and to develop cessation programmes for this particular cohort.

In the family/whānau situation, the Māori child is exposed to a greater risk of second-hand smoke¹². The link to tobacco smoking and poor health outcomes for Māori children is well documented. Māori children have higher incidences of asthma, respiratory diseases (acute bronchitis, acute upper respiratory tract infections), and otitis media than non-Māori.¹³

New Zealand has one of the highest rates of Sudden Infant Death Syndrome (SIDS) in the world and maternal smoking is known to be a major risk factor.¹⁴ Māori women of child bearing age are often smokers¹⁵ and the incidence of SIDS amongst Māori is high¹⁶.

Maternal smoking also impacts on breast feeding practices¹⁷. Women who smoke have a lower rate of initiating breast feeding and, if they do breast feed, it is for a shorter period than non-smokers. There is evidence that smoking reduces milk production and infants may have slower weight gain¹⁸ and these facts may influence the mother's decision to cease breastfeeding. Breast feeding has a positive influence on the health status and social well being of the mother and improves life-long health outcomes for child.¹⁹

Exposure to second hand smoke contributes to a poor health status and may have long-term consequences for young Māori impacting on their educational aspirations i.e. absent from school due to respiratory complications of second hand exposure to tobacco smoke.

3. Physical Harm

Extensive research has documented the wide ranging and serious nature of injury and disease associated with tobacco dependency, particularly smoking tobacco.

Tobacco smoking contributes to cardiovascular diseases, strokes, chronic obstructive pulmonary disease and various cancers, predominately lung cancer,²⁰ but also cancer of the mouth, pharynx

¹⁰ Blakely, T, 2009, *Ethnic inequalities in mortality and the contribution of smoking. Learnings from Aotearoa/New Zealand*, Conference Proceeding Oceania Conference, October 2009

¹¹ The Quit Group, *Fact Sheet 1, 2006 Maori smoking and tobacco use*, Ministry of Health, Wellington

¹² Woodward, A & Laugesen, M, 2000, *Deaths in New Zealand attributable to second cigarette smoke*, Report to the Ministry of Health, Wellington

¹³ Robson, B & Harris R (eds), 2007, *Hauora Maori Standards of Health IV*, University of Otago, Wellington.

¹⁴ Woodward, A & Laugesen, M, 2000, *Deaths in New Zealand attributable to second cigarette smoke*, Report to the Ministry of Health, Wellington

¹⁵ The Quit Group, *Fact Sheet 1, 2006 Maori smoking and tobacco use*, Ministry of Health, Wellington. 56% of Māori women aged between 15-24 years smoke and the same proportion within the 25-44 age group.

¹⁶ Mitchell, EA, et al, 1991 *Results from the first year of the New Zealand cot death study*. The New Zealand Medical Journal, 27 February 1991, 104, 71-6.

¹⁷ www.kellymom.com/health/lifestyle/smoking.html accessed 22 01 2010

¹⁸ www.plunket.org.nz accessed 22 01 2010

¹⁹ Ministry of Health 2002. *Breastfeeding: A Guide to Action*. Ministry of Health, Wellington

²⁰ Harwood, M et al, 2005, *Lung cancer in Maori: a neglected priority*, The New Zealand Medical Journal, 15 April 2005, 118, no.1213

and oesophagus.

In New Zealand tobacco smoking by Māori continues to be one of the determinants of the health inequalities seen between Māori and non-Māori. For example, Māori, especially Māori women, experience exceptionally high rates of mortality for lung cancer²¹. Māori women also have high rates of respiratory disease. Māori in general have high incidences of cardiovascular disease.

Tobacco smoking impacts not only directly on an individual's health status but it also impedes treatment. Smokers use inpatient hospital services more than individuals who have never smoked and smokers are more likely to be admitted to intensive care after surgical procedures.²² These data illustrate the direct impact smoking has on the country's tertiary and secondary health services.

Smoking is also a contributor to house fires. Not only may a smoker start the fire unintentionally but young children playing with lighters and matches are also implicated in house fires. Māori are three times more likely to die in a house fire than members other ethnic groups²³.

4. Psycho-Social Harm to Māori

As noted above, the physical harm caused by tobacco smoking is well documented. However, tobacco use "has dramatically affected Māori cultural, social and economic development"²⁴. Smoking brings about the premature death of kāmātua and kuia resulting in loss of knowledge and tikanga. In essence Māori communities are being deprived of wisdom and guidance of their elders due the high prevalence of cardiovascular disease, chronic obstructive respiratory disease and lung cancer caused by tobacco smoking.

5. Economic Impact On Maori

Māori economic development is hindered as Māori continue to purchase tobacco. To put this in perspective the Crown receives at least \$200 million each year in tobacco tax from Māori. This tax is extracted from those at the lowest socio-economic levels where Māori are over represented²⁵. It has been noted that stopping smoking and remaining abstinent is most difficult for those at the lower end of the SES continuum²⁶. Quitline data indicates that quit rate for Māori (17.4%) is slightly lower than for non-Maori (21.7%)²⁷

SUPPLY CONTROLS

Analysis of relevant research makes it clear that the current ease of access and availability of tobacco encourages initiation and maintenance of smoking.

²¹ Harwood, M et al , 2005, *Lung cancer in Maori: a neglected priority*, The New Zealand Medical Journal, 15 April 2005, 118, no.1213

²² The Royal Australasian College of Physicians & the Royal Australia and New Zealand College of Psychiatrists, 2005 *Tobacco Policy: Using evidence for better outcomes*, Australia

²³ Duncanson, M et al, 200, *Unintentional house fire deaths in New Zealand 1991-1998*, New Zealand, Public Health Report, 7, 7-8 July-August 2000.

²⁴ Reid, P & Pouwhare, R 1991 cited in

²⁵ ²⁵ Robson, B 2004, *Economic determinants of Maori health and disparities : A review for the Public Health Advisory Committee*, Wellington

²⁶ Ibid

²⁷ The Quit Group ,*Fact Sheet 1, 2006 Maori smoking and tobacco use*, Ministry of Health, Wellington

1. Increase Tax on Tobacco

The College has reviewed the evidence relating to pricing and taxing of tobacco products²⁸. It is the view of the College that the most effective means of reducing tobacco smoking is to increase the price of tobacco substantially.

The cost of tobacco must increase substantially every year and more than keep pace with inflation. The short term goal should be \$20 for packet of 20 cigarettes. The tax increases should be well signalled and accompanied by public education campaigns and supported by clear messages about how to quit. Smokers themselves support an increased tax on tobacco if the revenue is used for health promotion and to help smokers to quit.²⁹

In the view of the College, it is imperative that the increased income tax is allocated to increasing cessation programmes and prevention programmes. There needs to be an extension of those cessation programmes that are effective for Māori. Cessation services such as Aukati Kai Paipa for Māori women have been found “to be acceptable and effective”³⁰ Further research needs to be undertaken to ascertain what types of programmes may reduce smoking prevalence rates amongst Māori and low-income groups.

2. Reduce Number of Outlets Selling Tobacco Products

Currently tobacco is widely available in a range of outlets in New Zealand. Sales are unregulated reinforcing the view that tobacco is an everyday commodity. As with alcohol, the wide availability of tobacco does little to reduce consumption³¹. The College supports the reduction of outlets selling tobacco and enforcing licenses to sell this harmful product.

3. Address Marketing/Advertising Policies

The College believes it is necessary to counteract the marketing and promotion of tobacco products so that smoking is denormalised. Māori radio and print media have supported campaigns to denormalise smoking within the Māori population.³² To this end the College encourages the government to implement legislation where tobacco products are placed out of sight and it is a requirement that quit messages are placed at all points of sale. It has been well documented that displaying tobacco results increased tobacco consumption.³³

The College would like to see generic packing introduced so there is no “opportunity to communicate misleading claims and so would afford the highest level of consumer protection”³⁴

According to a recent survey adult smokers support the vision of a smoke-free New Zealand if there are effective non-smoked nicotine products available. This research also indicated that Māori smokers are more likely to agree that the government has to do more to tackle the harm done by

²⁸ Wilson, N et al, 2006, *What potential has tobacco control for reducing health inequalities? The New Zealand situation*. International Journal for Equity in Health, 5, 16.

²⁹ Edwards, R et al, 2009 *Majority support by Maori and non-Maori for many aspects on increased tobacco control regulation: national survey data*, New Zealand Medical Journal, 11 December 2009, 122, 1307

³⁰ Wilson, N et al, 2006, *What potential has tobacco control for reducing health inequalities? The New Zealand situation*. International Journal for Equity in Health, 5, 16.

³¹ Chapman, S & Freeman, B, 2009, *Regulating the tobacco retail environment: beyond reducing sales to minors* Tobacco Control, 18:496-501 special communication

³² Gifford, H & Bradbook, S, 2009, *Recent actions by Maori politicians and health advocates for a tobacco-free Aotearoa/New Zealand*, A brief review Whakauae Research Services, Te Reo Marama, University of Otago, New Zealand.

³³ UMR Research Limited, 2009. *Cigarette displays omnibus results*, Cancer Society of New Zealand

³⁴ Peace, J et al, 2009, *Survey of descriptors on cigarette packets: misleading consumers?* New Zealand Medical Journal 25 September 2009, 122, 1303

smoking and that tobacco companies should be more tightly regulated³⁵.

4. Encourage Greater Parental Responsibility and Address Social Supply

Parental smoking is a key risk factor in commencing smoking. Research conducted in New Zealand³⁶ revealed that parental smoking patterns explained the increased smoking risk among young Māori. Parents who smoke are more likely to provide their children with cigarettes and normalise smoking behaviour. In this study Māori students were more likely to have both parents smoking, experience smoking in the house and be provided cigarettes by a family member. This research illustrates that any health promotion programmes aimed at reducing smoking among Māori children must include the parents and whānau. Parents smoking in cars whilst children are present is another issue which needs to be addressed within the gamut of parental responsibility.

5. Cessation Programmes

Physicians are committed to reducing smoking through their professional interactions with smokers. Research has shown that brief advice from a doctor during a routine consultation may reduce overall cigarette smoking by 2.5%.³⁷

However such activities need to be supported by smoking cessation programmes which consider the Māori cultural context. Gifford & Bradbrook (2009) state that there is “very little information is available on the effectiveness or reach of the initiatives. Much of the work being carried out by Māori tobacco control advocates is organic and often implemented with little funding³⁸”.

The College supports researching effective cessation programmes for Māori and ensuring they are adequately funded.

CONCLUSION

The College recognises that the government takes smoking cessation seriously and successful smoking cessation services have been included in the District Health Boards’ key performance indicators.

The College strongly advocates that the recommendations outlined in this submission are considered and acted upon. The high level of smoking among Māori continues to fuel health disparities in New Zealand. From our perspective, we cannot avoid being confronted by the substantial impact that tobacco has on Māori health outcomes and the health status of all New Zealand communities. We look forward to a tobacco free New Zealand in which the harm and health service impacts of tobacco products are substantially reduced.

³⁵ Edwards, R et al, 2009 , *Majority support by Maori and non-Maori smokers for many aspects of increased tobacco control regulation: national survey data*, New Zealand Medical Journal 11 December, 122, 1307

³⁶ Scragg, R et al, 2003 *Parental Smoking and related behaviours influence adolescent tobacco smoking: results from 2001 New Zealand national survey of 4th form students*, New Zealand Medical Journal, 12 December 2003, 116 ,1187

³⁷ The Royal Australasian College of Physicians & the Royal Australia and New Zealand College of Psychiatrists, 2005 *Tobacco Policy: Using evidence for better outcomes*, Australia

³⁸ Gifford, H & Bradbrook, S, 2009, *Recent actions by Maori politicians and health advocates for a tobacco-free Aotearoa/New Zealand, A brief review*, Whakauae Research Services, Te Reo Marama, University of Otago, New Zealand.

This submission is endorsed by the Cardiac Society of Australia and New Zealand (NZ).

The College would welcome the opportunity to discuss this report with the Select Committee.

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