



29 January 2010

Committee Secretariat
Māori Affairs Select Committee
Parliament Buildings
Wellington 6160

Tēnā koe, e te rangatira

Inquiry on the tobacco industry and Māori tobacco use

Thank you for your invitation to make a submission to the Māori Affairs Select Committee on this important kaupapa.

Attached is our submission.

We would like to appear before the Select Committee hearings.

Yours sincerely

G.M. Keating
National Executive Officer

Who we are

The Public Health Association of New Zealand (PHA) is a voluntary association which provides a major forum for the exchange of information and stimulation of debate about public health in New Zealand. Membership of PHA is open to individuals interested in public health. Members belong to the public, private and voluntary sectors. In addition to membership fees, donations and other earnings, the PHA has had a contract with the Ministry of Health to encourage and facilitate informed debate on key public health issues, and to enhance development of the public health workforce. The PHA is a member of the World Federation of Public Health Associations.

Public health is defined as actions to improve, promote and protect the health of the whole population ‘*through the organised efforts of society*’ⁱ.

The PHA operates in accordance with the Treaty of Waitangi. We partner with Māori in our decision making, and recognise the rights Te Tiriti affords Māori as the indigenous people of Aotearoa/New Zealand. Our vision is “Good health for all - health equity in Aotearoa”, or “Hauora mō te katoa – oranga mō te Ao”.

The impact of tobacco use on the health, economic, social and cultural well-being of Māori

As a long-term supporter of smokefree action, the Public Health Association welcomes the Select Committee’s commitment to investigating the damaging impact tobacco has had on Māori health, as well as on the health of all New Zealanders.

Rates of tobacco use among Māori

45.8% percent of Māori adults identify themselves as current smokers, more than double the smoking rate of non-Māori. Of particular concern to the PHA is the high smoking rate of Māori women - over 50%.ⁱⁱ Thirty-nine percent of Māori women in New Zealand smoke during pregnancy.

The uptake of smoking by rangatahi remains high. The prevalence of regular smoking by Māori boys decreased by 1.7% from 2006 to 19% in 2007, and daily smoking by Māori girls decreased from 25% to 22% in the same period. By international standards, having nearly a quarter of young women regularly smoking tobacco is extraordinarily high.

We are concerned that with smoking rates declining among other New Zealandersⁱⁱⁱ, the tobacco industry needs to retain existing Māori smokers, and is likely to be targeting Māori to recruit new smokers. The industry has no incentive to support smoking reduction efforts among Māori.

Impacts of tobacco use on Māori health

Tobacco smoking is a leading cause of preventable, premature death and injury for Māori. Between 600-800 Māori die each year from smoking-related diseases.^{iv} Up to 30% of Māori deaths are attributable to tobacco smoking.^v Of adult Māori cigarette-attributable deaths, 78% were in middle age (35-69 years) and only 22 per cent in old age (70 years and over), compared to 41% of cigarette deaths in middle age for non-Māori.

A 1998 report for Te Puni Kōkiri estimated that total Māori deaths from smoking are expected to double within 30 years, mainly due to aging of the population. Although cigarette death rates are falling in men, the Māori population aged 35 years and over (the age group in which tobacco-related deaths occur) is projected to increase two and a half times in the next 30 years.^{vi}

As well as the impacts on smokers, the effects of secondhand smoke are well recognised. Smoking by mothers contributes to low birth-weight, and also to the high SIDS rate among Māori babies. There are costs for the child, as well as for their whānau, and in turn for New Zealand's health system.

Historical context of Māori tobacco use

The problems Māori face with tobacco in the 21st century have their origins in the colonisation of New Zealand. The use of tobacco as a trade good, including its use as part of the signing of the Treaty of Waitangi, has set the stage for the current situation.^{vii} We note that as far back as the beginning of the 20th century, Dr Maui Pomare, the first Māori doctor, expressed concern about the effects of tobacco on Māori health. However, such concerns were marginalised or ignored until recently.

We support the view that the Treaty of Waitangi recognises the status of iwi and hapū, and reinforces the rights of Māori to taonga, including wellbeing in its broadest sense. This is supported by the Crown's duty of 'active protection' and 'participation' confirmed by New Zealand's Courts. These duties relate to hapū and iwi (Article 2 of the Treaty of Waitangi), and to Māori as citizens of New Zealand (Article 3). Those commitments in turn are linked to the international commitments made by New Zealand in the Framework Convention on Tobacco Control.

In addition, the use of Māori images in tobacco packaging and advertising have not only exploited Māori culture for tobacco company profit, but have contributed to normalising tobacco as part of Māori society.

Tobacco use as a contributor to Māori inequality

Tobacco use has been a significant contributor to Māori health disparities. Smoking is responsible for around 10% percent of the gap in health between Māori and non-Māori.^{viii} Tobacco use is an indicator of inequality, and helps perpetuate inequality in

health, as well as having economic costs. PHA believes that these inequalities negatively affect not only Māori, but all New Zealanders.

Stopping smoking has been called the most important thing a person can do to improve their health. Smokers who quit before the age of 35 have a normal life expectancy, and even those who quit smoking in their seventies reduce their risk of developing lung cancer, cardiovascular disease, and chronic obstructive pulmonary disease (COPD).^{ix} People who quit experience fewer days of illness and are absent from work less.^x

Smoking also has economic consequences for Māori smokers and their whānau. Even buying one packet of 20 cigarettes per day costs at least \$3600 per year for each smoker.^{xi} Smokers are sick more often, which adds to the already significant financial costs of tobacco to that person, and those they support. The level of this burden can be shown by the fact that Māori contribute over \$260 million in tobacco taxes each year.^{xii}

As noted above, the impacts are not only on the person who smokes, but on their whānau and community. The commitment and time needed to support people who are ill, people with disabilities, and people dying from tobacco-related illness, affects the physical and mental health of caregivers and their ability to care for children and other whānau members, and can also reduce their own personal and economic development. Many costs are not borne by the health sector but directly by whānau.

However, it should be noted that the loss of a person's potential contribution to society, and the emotional, spiritual and social costs of tobacco use, cannot fully be measured by conventional tools.

While smoking rates in New Zealand have declined, this decline has been almost exclusively among non-Māori. Between 1996 and 2008, smoking prevalence among Māori only fell from 50% to 45%, a decline slower than any other nation with comparable tobacco control policies. Unless immediate action is taken by Government this trend will continue, and inequalities caused by smoking will increase. However, we believe the problem should not be seen as insoluble. What has been achieved in reducing smoking rates in New Zealand as a whole shows what can be done if government makes a real commitment to reducing smoking by Māori, and provides the resources to support its commitment.

Effects of tobacco use on Māori development

As yet, little research has been done on the effects of tobacco on whānau, hapū and iwi Māori. However, the statistics presented above show that tobacco use has caused the loss of many Māori kaumātua and pakeke, as well as their continuing illness and disability. In Māori society elders play a critical part as leaders, as guides and as role models to younger generations.^{xiii} The loss of pakeke before they can become elders, and the premature loss of kaumātua, is likely to affect the ability of hapū and iwi to achieve their aspirations for social wellbeing, economic development and cultural affirmation.^{xiv}

Taking action to reduce tobacco-related harm to Māori

Develop and resource a national Māori smokefree plan

We urge the Government not only to continue support for national and international smokefree policies, but to take stronger action to reduce tobacco use and its harms. We support the vision of an Aotearoa New Zealand in which future generations of children are free from exposure to tobacco and enjoy smokefree lives.

Aotearoa New Zealand has been an international leader in treating tobacco as a drug, and including tobacco in its National Drug Policy. By doing so, this country is recognising the fact that tobacco is an addictive substance, considered by many researchers to be the most addictive drug available. Emphasising tobacco as an addictive substance is helpful in breaking down the belief (shared by smokers as well as non-smokers) that difficulty quitting is a sign of weakness. The National Drug Policy's framework of supply control, demand reduction and problem limitation is a useful way to consider the actions needed.

We believe a specific national Māori smokefree strategy is needed, including a coordinated national Māori public health service tobacco control purchasing plan. It should be developed in conjunction with Māori iwi and hapū, Māori health providers, and Māori communities. Key elements of a plan would include:

- Taking intersectoral action
- Dedicating resources to a plan
- Using taxation to control demand and support reduction services
- Monitoring tobacco users, and tobacco producers and retailers
- Providing cessation promotion and cessation services
- Protecting children from tobacco
- Controlling tobacco promotion

Taking intersectoral action

Any strategy needs to be comprehensive and intersectoral. As well as the health sector, agencies involved in family and community development are critical to success, and local government has a role to play (for instance, promoting smokefree public places) as well as central government.

Dedicating resources

Resources need to be dedicated to eliminating Māori tobacco use, and that resource should come from tobacco tax rather than general taxation.

Using taxation to control demand and support reduction services

The PHA supports increases in tobacco taxation on the basis that a significant amount of the funding should be directed into cessation services, anti-smoking campaigns and smokefree enforcement.

A recent WHO report^{xv} shows that price of pack of cigarettes in Aotearoa New Zealand is not high compared to other countries. Tobacco excise tax increases should be regular and substantial to deter new smokers and to encourage smokers to quit. However, price increases can be seen as unfairly disadvantaging the low income smoker, and such moves may disproportionately affect Māori. Tax increases should ideally be preceded by increased funding for tobacco control, including improved support, for people to quit.

Taxation of roll-your-own and loose tobacco should be harmonised with cigarette taxation immediately. A 2008 Ministry of Health report showed that, contrary to common belief, loose tobacco products are no safer than the most commonly sold tailor-mades, and some brands actually produce more cancer-causing substances. As the report also found that RYO use was common among Māori smokers, this change should be given priority.

Monitoring tobacco users, and tobacco producers and retailers

We also believe there should be adequate funding for research to provide quality monitoring of the tobacco industry. Tobacco companies are well funded, and as private organisations are able to keep their policies and marketing plans from scrutiny. International researchers have been able to access material from companies (some of them parent companies of New Zealand branches) which indicate that tobacco companies are still looking to recruit young smokers.

Providing targeted cessation promotion and cessation services for Māori

We urge the Select Committee to recommend that government commit more effort and resources be into targeted cessation services for Māori smokers. We strongly support the commitment that government has made to growing cessation services,

New Zealand research shows that contrary to the story presented by the tobacco industry, few tobacco users are happy with their habit. A 2008 Ministry of Health review concluded that “most smokers [including Māori] show regret at becoming a smoker”, and most Māori smokers have tried to quit smoking, whether for health reasons, economic reasons or both.^{xvi}

However, cessation services are not yet reaching Māori as well as they could. In particular, Māori seem to be accessing NRT at much lower rates than needed, or than possible. Studies in South Auckland found that Māori receiving NRT from health services are not being given prescriptions for the eight to eleven weeks needed to get maximum benefit (as indicated by New Zealand national guidelines).^{xvii} Community

campaigns are needed to make sure that Māori fully understand the benefits of NRT, and are also aware of what they are entitled to. At the same time, high numbers of Māori smokers report using help from whānau and friends when quitting, which suggests that providing 'quit support kits' to help those support people would be valuable.

We support the government's target for cessation advice being provided to people in hospital, and the similar target for primary care being introduced from this year. Given the high numbers of Māori hospitalised for cancers, heart disease and stroke, and diabetes, we are concerned at the 2009 performance report showing that many health providers are not meeting the targets, and more emphasis needs to be given to this. However, for long-term Māori tobacco users, especially people with serious health problems, more than brief intervention is needed. There are indications that even areas such as cardiovascular services are not consistently offering intensive cessation interventions. All high-risk people should be offered intensive cessation, and government should ensure that such cessation services are funded. Primary health care practitioners will also need to be trained and resourced to provide more cessation support.

Government needs to improve cessation support targeted at young Māori. Health promotion campaigns, such as the current series of posters at bus stops and other public places, are beginning to normalise the idea that young people can and should quit. This health promotion campaign needs to be backed up by appropriate and accessible services. Some rangatahi are accessing Quitline and other services, but numbers are low. In the past youth-focused cessation services have not been highly ineffective, but New Zealand trends show increasing demand which should be met.

We also urge government to increase cessation support for Māori women before, during and after pregnancy. Community-based programmes such that at Kōkiri marae have reached young Māori women who do not necessarily use ordinary primary and maternity care. However, such programmes are not available in all parts of the country, and we would like to see this changed.

Protecting children from tobacco

To improve the health of tamariki Māori, legislation to ban smoking in cars carrying children should be introduced. Even if this legislation was not passed, the public attention it would bring would increase understanding of the damage that exposure to cigarette smoke causes.

Bans on cigarette sales to young people should be strictly enforced. This, and other measures, could be funded through tobacco taxation. More effort also needs to be put into understanding and counteracting marketing through the internet (for instance, viral marketing on YouTube) movies, TV, and international sports events. Given the high proportion of young people in the Māori population, such action would be of special benefit to Māori.

Controlling tobacco promotion

Banning tobacco retail displays, especially in dairies and convenience stores where they are highly visible to tamariki and rangatahi, would be a step in denormalising tobacco use. It would also address the concern of many people who quit tobacco use that displays make it harder for them to continue staying smokefree. Stores in those in Te Taitokerau which are refusing to sell tobacco, or which put it out of sight, should be supported and recognised at a national level.

We also support further limiting tobacco product branding to generic plain text and graphic picture warnings, as well as regulation on the use of terms, packaging (eg colours) and marketing tools including 'light' and 'mild'. These are highly misleading to tobacco users.

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- ⁱ Acheson D. (1998). Independent inquiry into inequalities in health. London: HM Stationery Office.
- ⁱⁱ Ministry of Health, (2007). New Zealand Tobacco Use Survey 2006.
- ⁱⁱⁱ Ministry of Health. (2007). New Zealand Tobacco Use Survey 2006.
- ^{iv} ASH. (2009).
- ^v Laugesen, M. (1998).
- ^{vi} Laugesen, M & Clements, M (1998). Cigarette smoking mortality amongst Māori, 1954-2028.
- ^{vii} Reid, P & Pouwhare, R. (1991) Te-taonga-mai-tāwhiti.
- ^{viii} Laugesen and Clements (1998).
- ^{ix} Ministry of Health (2007).
- ^x Easton, B.H. (1997). The Social Costs of Tobacco Use and Alcohol Misuse.
- ^{xi} Easton (1997); Thomson, G et al. (2000). The financial effects of tobacco tax increases on Maori and low-income households
- ^{xii} Thomson, G et al. (2000). The financial effects of tobacco tax increases on Maori and low-income households.
- ^{xiii} Durie, M. (2001). Mauri Ora: the dynamics of Māori health; Mead, H.M (2007). Tikanga Māori: living by Māori values; Barlow, C. (1991). Tikanga Whakaaro
- ^{xiv} Durie, M. (2001). The Parameters of Māori Development.
- ^{xv} WHO. (2010). Report on the Global Tobacco Epidemic, 2009: Implementing smoke-free environments;
- ^{xvi} Ministry of Health. (2008). New Zealand Tobacco Use Survey 2008: Quitting results.
- ^{xvii} Thornley, G. et al (2010). Few smokers in South Auckland access subsidised nicotine replacement therapy. NZMJ; Glover, M. & Cowie, N. (2010). Increasing delivery of smoking cessation treatments to Māori and Pacific smokers. NZMJ.