Patterns of declining smoking in NZ – But more action needed by the New Government

19 November 2017

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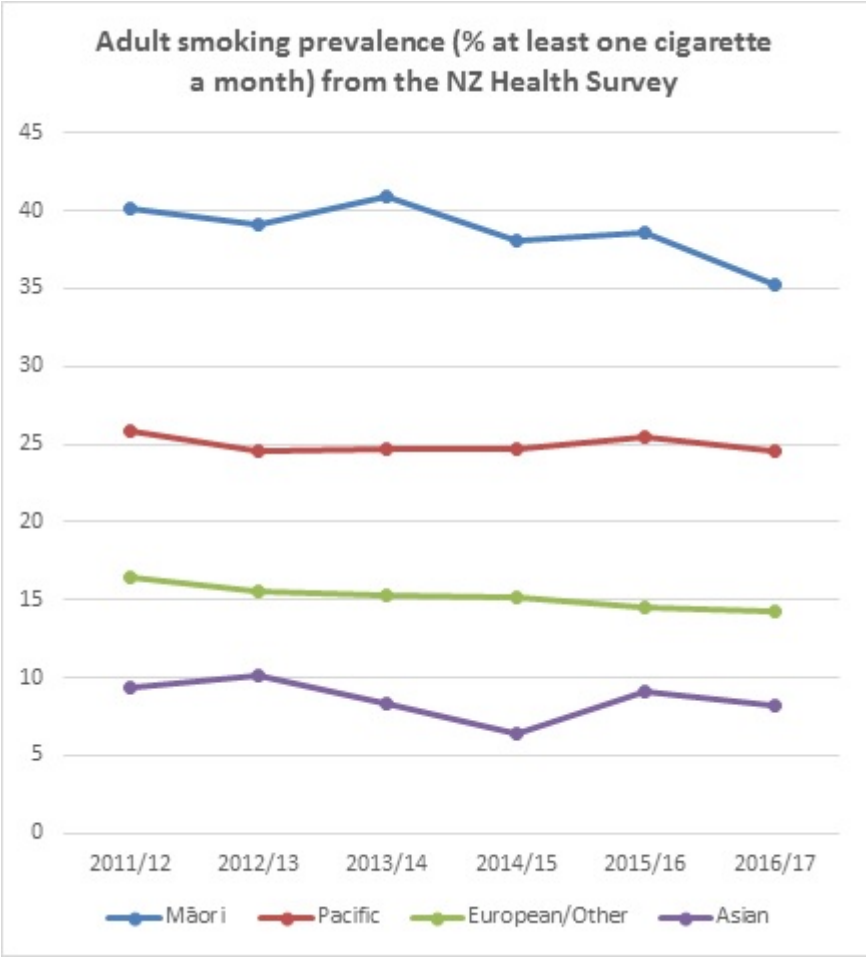
Just published results from the NZ Health Survey indicate ongoing declines in smoking for Māori and for European New Zealanders. In this blog we comment on the possible reasons for these trends and describe recent work on how progress could be accelerated.

Just published results from the NZ Health Survey indicate recent ongoing declines in smoking, with a graph below of the trends since 2012 (tabulated data in the Appendix). These downward patterns are consistent with long-term trend data from other sources such as the Census [1] and declining cigarette sales data.



We plan to do more detailed analyses of these trends and update our past work [1] when next year's Census results are available. But in the interim we note that the declining patterns are partly driven by the relatively stronger downward results for the most recent survey (and while the changes are generally statistically significant, not all are, e.g. not for: Pacific peoples, Asians, and some older age-groups). We also note (from the online data) that the largest declines have occurred amongst the 15-24 and 25-34 year age groups. This suggests that a relatively important part of the reduced smoking prevalence is due to reduced uptake (as opposed to quitting).

A range of factors including specific tobacco control activity, as well general social changes that are occurring among youth internationally, may account for reductions in prevalence. Of the tobacco control activities, the key ones probably include the following:

- Ongoing tobacco tax increases (e.g. see this NZ modelling work [2-4]). The stronger pattern of decline seen in the younger age-groups (as noted above) may partly reflect the role of tax increases since younger age-groups are typically more price sensitive.
- Ongoing de-normalisation of smoking with the growth of smokefree places around NZ – from local government and private sector activity (see this recent NZ review [5]). Other denormalisation may be arising from the removal of point-of-sale displays and media discourse on the topics of: e-cigarettes, plain packaging, the idea of pharmacy-only sales [6], and the Smokefree 2025 goal.
- Ongoing smoking cessation service provision – which includes health worker counselling and provision of pharmacotherapy; and dedicated services (e.g. see this recent study [7] which suggests how the NZ Quitline is helping to achieve health gain – while saving overall health costs).
- Ongoing media campaigns by agencies such as the Health Promotion Agency – even

though we consider the current investment by government in such campaigns is far from adequate [8].
- Possibly increased numbers of smokers switching to e-cigarettes or using e-cigarettes for quitting (e.g. see this US study [9] for some evidence that e-cigarettes are impacting at a population level). But this is an area where the evidence is not conclusive and we need more monitoring and research – as some people use e-cigarettes as well as continuing smoking tobacco (a dual use pattern that is unlikely to benefit health very much).

However, there is considerable published work that suggests that these downward trends arising from these business-as-usual activities are ***markedly insufficient*** to achieve the Government's Smokefree 2025 goal [3, 4, 10-13]. Furthermore, these trends are definitely not adequate to achieve <5% smoking prevalence by 2025 for Māori and Pacific peoples. This is why an evidence-based framework for making accelerated progress and addressing disparities in smoking was produced by researchers (with support from the tobacco control sector) earlier this year – as detailed in this report on "Achieving Smokefree Aotearoa by 2025" [13], and this blog on the topic.

We encourage the new government to consider this plan – and other recent publications relating to advancing tobacco control in New Zealand [4, 5, 14]. Also, given the new government's interest in poverty reduction – the role of tobacco use in generating both poor health and poverty should be given particular consideration. One aspect of this is that when tobacco tax is next increased, this action should be accompanied by a strong media campaign and enhanced quitting support services so as to maximise the impacts of price rises on smoking cessation rates and therefore reduce financial impacts of ongoing smoking. Furthermore, the extra tobacco tax revenue should be ploughed back into enhancing support for smokers to quit, as well as media campaigns and other tobacco control initiatives, so as to help create a supportive environment for quitting and staying quit. Alternatively, the extra tax revenue could go to contributing directly to poverty reduction initiatives, such as providing healthy lunches in schools in deprived areas.

So while the ongoing (but modest) decline in smoking is good for public health, now is a time for a new government to take a fresh look at potential interventions to greatly accelerate this progress.

Appendix: Tabulated data used in the figure (prevalence in % of adult current smokers from the NZ Health Survey [see elsewhere for details on statistically significant differences])

Years:	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**Absolute reduction since 2011/12**	**Mean annual reduction for the 5 year period**
Māori	40.2	39.1	40.9	38.1	38.6	35.3	4.9	1.0
Pacific	25.9	24.6	24.7	24.7	25.5	24.5	1.4	0.3
European/Other	16.5	15.5	15.3	15.1	14.5	14.2	2.3	0.5
Asian	9.4	10.2	8.3	6.4	9.1	8.2	1.2	0.2

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Public Health Expert Briefing (ISSN 2816-1203)
