

Resource Document: A Brief History of Tobacco Control in New Zealand

Commissioned by the AFPHM (NZ)

“We are dealing with a drug that has entered the common culture ... ”

Helen Clark (Hansard v.507, 1990, p.3232)

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Contents

1. INTRODUCTION	4
<i>1.1 The place of tobacco within public health and the economy</i>	4
<i>1.2 The place and aim of this work</i>	5
<i>1.3 Definition of terms</i>	5
2. METHODOLOGY	6
3.0 INDUSTRY DOMINANCE (BEFORE 1962)	7
<i>3.1 Introduction</i>	7
<i>3.2 The international scene</i>	7
<i>3.3 The developments in New Zealand</i>	9
<i>3.3.1 Before 1948</i>	9
<i>3.4 Discussion</i>	11
<i>3.5 Summary</i>	12
4. THE START OF AN EVIDENCE-BASED POLICY (1962 TO 1981)	13
<i>4.1 Introduction</i>	13
<i>4.2 The international scene</i>	13
<i>4.3 Research in New Zealand</i>	14
<i>4.4 The developments in New Zealand</i>	15
<i>4.5 Discussion</i>	19
<i>4.6 Summary</i>	20
5. ACCELERATING DEVELOPMENTS (1982 TO 1988)	22
<i>5.1 Introduction</i>	22
<i>5.2 The international scene</i>	22
<i>5.3 Research in New Zealand</i>	23
<i>5.4 The developments in New Zealand</i>	26
<i>5.5 Discussion</i>	33
<i>5.6 Summary</i>	35
6. THE PREPARATION AND PASSING OF THE SMOKE-FREE ENVIRONMENTS (SFE) ACT (1989 TO 1990)	36
<i>6.1 Introduction</i>	36
<i>6.2 The international scene</i>	36

<i>6.3 Research in New Zealand</i>	36
<i>6.4 The developments in New Zealand</i>	37
<i>6.4.3 Passing the SFE Act (May-August 1990)</i>	43
<i>6.5 Discussion</i>	45
<i>6.6 Summary</i>	50
7. GOVERNMENT INERTIA AND TINKERING (1991 TO 1996)	52
<i>7.1 Introduction</i>	52
<i>7.2 The international scene</i>	52
<i>7.3 Research in New Zealand</i>	54
<i>7.4 The developments in New Zealand</i>	59
<i>7.5 Discussion</i>	64
<i>7.6 Summary</i>	66
8. DISCUSSION OF THE HISTORY OF TOBACCO CONTROL IN NEW ZEALAND	68
<i>8.1 The overall trends</i>	68
<i>8.2 International context</i>	70
<i>8.3 Major influences in New Zealand</i>	71
<i>8.4 Differing strategic views</i>	72
<i>8.5 Continuing problems for tobacco control in New Zealand</i>	72
<i>8.6 How did government action occur?</i>	74
<i>8.7 Summary of interventions</i>	75
<i>8.8 Summary</i>	76
<i>8.9 Conclusions</i>	77
<i>8.10 End words</i>	77
<i>Acknowledgments</i>	78
<i>Glossary and Acronyms</i>	78
Sources	80

1. INTRODUCTION

1.1 The place of tobacco within public health and the economy

Health impact: Tobacco use has a major adverse impact on the health status of New Zealanders and this impact is preventable (Laugesen 1995a¹). Peto and colleagues² have estimated that there were approximately 4500 smoking-related deaths in New Zealand per year, out of the 26,500 total for 1990 (Dept. of Statistics 1993³). Smoking may rank with socioeconomic inequality as one of the major health issues of New Zealand in the 20th century. Furthermore, tobacco use is also an important cause of disparity in health status between Maori and non-Maori (PHC 1994a⁴; Reid and Pouwhare 1991⁵).

It is estimated that 56% of 18 year old smokers and 77% of adult smokers are clinically dependent on the nicotine in tobacco products (Laugesen 1995b⁶, p.420). There are probably well over 300,000 nicotine dependent individuals in New Zealand (TSB 1989⁷, p.105). The diseases which result from the use of tobacco are different from those of other pandemics, insofar as they have long latency, often several decades. The use of tobacco has therefore a particularly insidious danger. For youth in New Zealand:

“It is an activity without immediate negative consequences, ... it is a cheap and seemingly safe way of acting with panache and slightly outside the approval of authority” (Ritchie 1988⁸, p.14).

Young people, who naturally discount the distant future at a high rate, can become dependent in a small fraction of the time that the health damage takes to become manifest. As Helen Clark said in her introduction speech for the 1990 Smoke-free Environments Bill:

“Most of those who become addicted to tobacco do so as teenagers ... Most of them are already addicted by the time we would give them the right to vote or before we would allow them to fight for their country” (Hansard 1990⁹, p.1635).

¹ Laugesen M. Tobacco control: 10 000 deaths averted and greater gains possible. *NZ Pub Health Rep* 1995; 2: 89-91.

² Peto R, Lopez AD, Boreham J, et al. *Mortality from smoking in developed countries, 1950-2000*. Oxford: Oxford University Press, 1994.

³ Department of Statistics. *New Zealand official yearbook 1993*. Wellington, 1993.

⁴ PHC. *Our Health, Our Future. The state of the public health in New Zealand 1994*. Wellington: Public Health Commission, 1994.

⁵ Reid R, Pouwhare R. *Te Taonga Mai Tawhiti: The gift from a distant place*. Auckland: Niho Taniwha, 1991.

⁶ Laugesen M. Smokers run enormous risk: new evidence. *NZ Med J* 1995; 108: 419-20.

⁷ Toxic Substances Board. *Health or Tobacco: An End to Tobacco Advertising and Promotion*. Wellington: Department of Health, 1989.

⁸ Ritchie J. Commerce or con: young people and cigarette advertising. *Community Health Studies* 1988; 12: 9-14.

⁹ Hansard v.507. Wellington: NZ Government, 1990.

Financial impact: The present tobacco consumption of New Zealand is 2934 tonnes of all tobacco products (dry weight, Laugesen 1996a¹⁰, p.17). The immediate retail cost to smokers in 1991-1992 was \$1.1 thousand million. The measurable costs of tobacco use in New Zealand are calculated to be at least \$1.9 thousand million per year (PHC 1994b¹¹, p.35). Tobacco taxes were estimated to have brought in income of \$584 million in 1994-95 to the Government (PHC 1995a¹², p.4), with direct measurable costs to government of \$202 million in 1992 through hospital and primary health care expenses (Phillips et al 1992¹³, p.240; PHC 1994b, p.10).

To put the New Zealand tobacco manufacturing industry into context, in 1995 they had 494 full time equivalent employees, out of the New Zealand manufacturing industry total of 252,813 (Statistics NZ 1996¹⁴, p.437), or less than 0.2%. However, some additional employment is associated with distribution, retailing and marketing.

1.2 The place and aim of this work

There have been two analyses that have detailed aspects of the “tobacco wars” in New Zealand for select periods (Beaglehole 1991¹⁵; Carr-Gregg 1993¹⁶) and one general article on New Zealand tobacco use which covers a little of the history of tobacco control (Hay 1993¹⁷). However, there has been no long-term historical description that considers all the major developments. This document outlines the history of tobacco control and related health education in New Zealand up to 1996. Some indication is given of the roles of the various individuals and groups in the initiation and implementation of tobacco control activities. The role that international and New Zealand-based research played in supporting policy initiatives is also examined.

1.3 Definition of terms

Unless otherwise stated, the term “*industry*” is used to cover the whole tobacco related business, from the core of growing, importing and manufacturing, through marketing, advertising, and distribution, to the periphery of retailing. However, the manufacturers have generally taken the lead in tobacco related political activity.

¹⁰ Laugesen M. *Tobacco Statistics 1996*. Wellington: Ministry of Health and the Cancer Society of NZ, 1996.

¹¹ Public Health Commission. *Tobacco products: The Public Health Commissioner's advice to the Minister of Health*. Wellington: Public Health Commission, 1994.

¹² Public Health Commission. *Tobacco taxation as a health issue*. Wellington: Public Health Commission, 1995.

¹³ Phillips D, Kawachi I, Tilyard M. The costs of smoking revisited. *NZ Med J* 1992; 105: 240-2.

¹⁴ Statistics New Zealand. *New Zealand official yearbook 1996*. Wellington: Statistics New Zealand, 1996.

¹⁵ Beaglehole R. Science, advocacy and health policy: Lessons from the New Zealand tobacco wars. *J Public Health Policy* 1991; 12: 175-83.

¹⁶ Carr-Gregg M. Interaction of public policy advocacy and research in the passage of New Zealand's Smoke-free Environments Act 1990. *Addiction* 1993; 88(Suppl): 35S-41S.

¹⁷ Hay D. The rise and fall of smoking in New Zealand. *J Royal College of Physicians* 1993; 27: 315-319.

2. METHODOLOGY

Documentary sources: A Medline based literature review was undertaken for the period January 1966 to October 1996. Publications in the Ministry of Health and Statistics New Zealand libraries were also examined (including the print media clippings database held by the Ministry of Health that covers the period since 1990). A search of the World Wide Web using Lycos was conducted, along with a search of tobacco industry materials (the “Cigarette Papers”¹⁸).

Hansard was examined for the 1990 events and also the Appendices of the House of Representatives (AJHR) for selected periods between 1981 and 1992.

Interviews with key informants: These included Dr Murray Laugesen (public health physician) of Health New Zealand, and formerly of the Department of Health and Public Health Commission; Louise Delany, formerly of the Department of Health; and Helen Glasgow, of the Cancer Society of New Zealand and the Smokefree Coalition.

References: The first reference to a source is footnoted. All references can be seen in full in the bibliography.

Peer review: The report was reviewed by Dr Murray Laugesen.

¹⁸ The Cigarette Papers: Internet: <http://www.library.ucsf.edu/tobacco>.

3.0 INDUSTRY DOMINANCE (BEFORE 1962)

3.1 Introduction

This section covers the increase of tobacco smoking to near its peak in New Zealand, part of an explosive growth in cigarette use in the 20th century. It includes the early history of the research links between smoking and ill-health, leading eventually to the 1962 Royal College of Physicians' report. The change in New Zealand from a moral to a health based policy is traced, along with the slow and mixed reaction by the Department of Health (DoH) to the dangers of smoking.

3.2 The international scene

While the relationship between tobacco and cancer had been suggested by studies in the 1850s (Ravenholt 1993¹⁹, p.178; Diehl 1969²⁰, p.17), until well into the present century information transfer within the medical world was very inefficient. Despite the reservations of some doctors, and the moral disapproval of the temperance movement, in the early part of the 20th century smoking was generally considered by society in the “developed” world to relieve tensions and produce no ill effects.

Until the 20th century, smoking cigarettes appears to have been a minority activity worldwide (Diehl 1969, p.10). The beginning of the widespread use of cigarette making machines in the late 19th century (Pollock 1996²¹, p.174), and of “safety” matches, set the scene for a sharp worldwide rise in tobacco smoking in the last 100 years. Following this, the supply of cheap or free cigarettes to soldiers during World Wars I and II appears to have led to a large increase in smoking (Diehl 1969).

In Britain and the US, cigarette consumption per person appears to have doubled or trebled between the 1920s and 1950s (Royal College of Physicians 1962,²² p.3; US Surgeon General 1964²³, p.25). Indeed, during World War II physicians in the US endorsed sending soldiers cigarettes which were also included in ration kits (Encarta 1995²⁴). The combined effects of wartime military issues, and 20th century tobacco advertising and marketing, meant that annual cigarette use by adults in the US rose from 54 cigarettes per person in 1900 to 4345 per person in 1963 (Ravenholt 1993, p.179).

¹⁹ Ravenholt R. Tobaccosis. In: Kiple KF. (ed) *The Cambridge World History of Human Disease*. Cambridge: Cambridge University Press, 1993.

²⁰ Diehl H. *Tobacco and your health: The smoking controversy*. New York: McGraw Hill, 1969.

²¹ Pollock D. Forty years on: a war to recognise and win. In: Doll R, Crofton J, (eds.) *Tobacco and health*. London: Royal Society of Medicine Press, 1996: 174-182.

²² Royal College of Physicians. *Smoking and health*. Pitman Medical Publishing Co. Ltd.: London, 1962.

²³ US Surgeon General. *Smoking and health*. Rockville, Maryland: US Department of Health, Education and Welfare, Public Health Service: 1964.

²⁴ Microsoft Encarta. Smoking. Microsoft Corporation and Funk & Wagnall's Corporation, 1994.

In the first half of this century, medical texts hardly dealt with tobacco, with some even giving advice for “one who is learning to smoke” and on “the art of smoking” (Rosen 1948²⁵).

The rise of research information: In the 1930s there were at least three articles in mainstream American medical journals reporting links between smoking and cancer or poor blood circulation. These reports were followed by further medical journal articles in the early 1950s (Diehl 1969, pp.17-8, 22). A statistical study by Professor Raymond Pearl of John Hopkins University was published in 1938, and it concluded that smoking was related to shorter lifespan (Diehl 1969, pp.20-21). A report on lung cancer in smokers and non-smokers had been published by Muller in Germany in 1939 (Doll 1950²⁶, p.746).

The rising epidemic of lung cancer during the 1930s and 1940s in Britain and the US led to research there. Reports linking lung cancer to smoking were published in 1950 by Doll and Hill in Britain, and Wynder and Graham in the US (Doll 1950; Peto 1994²⁷, p.937). As a result of consequent prospective studies, the American Cancer Society and the British Medical Research Council in 1954 produced independent reports that death rates were higher for cigarette smokers (Peto 1994, p.937). A number of statistical and pathological studies on smoking and its effects were published in Britain and the US during the 1950s (e.g., Doll 1952²⁸, Doll 1956²⁹), but political considerations appear to have prevented government action in those countries at that period. Taylor states that by 1962 there had been 24 studies over nine countries linking smoking and lung cancer (Taylor 1984³⁰, p.3). In Britain, the advice on the need for tobacco control from a series of official committees was disregarded by the government. This apathy caused the Royal College of Physicians to decide in 1959 to start to prepare its own report which was to be published in 1962 (Taylor 1984, pp.5-7; Pollock 1996, p.176).

By the late 1950s there was evidence of reducing tobacco consumption was dropping amongst US doctors (Snegireff and Lombard 1959³¹) – partly at least because of concern about health risks such as lung cancer.

²⁵ Rosen G. *The Secret of Life. The human machine and how it works*. London: Odhams Press Ltd, 1948.

²⁶ Doll R, Hill AB. Smoking and carcinoma of the lung. *BMJ* 1950; 4682: 746-8.

²⁷ Peto R. Smoking and death: the past 40 years and the next 40. *BMJ* 1994; 309: 937-9.

²⁸ Doll R, Hill AB. A study of the aetiology of carcinoma of the lung. *BMJ* 1952; 4797: 1284-6.

²⁹ Doll R. Lung cancer and other causes of death in relation to smoking: A second report on the mortality of British doctors. *BMJ* 1956; 2: 1071.

³⁰ Taylor P. *The smoke ring*. London: The Bodley Head, 1984.

³¹ Snegireff LS, Lombard OM. Smoking habits of Massachusetts physicians. Five-year follow-up study (1954-59). *NEJM* 1959; 261: 603-4.

3.3 The developments in New Zealand

3.3.1 Before 1948

By the end of the 19th century the use of tobacco was widespread, with Dr Maui Pomare reporting on its common use by Maori (Reid and Pouwhare 1991). In 1883 the Anti-Nicotine Society was formed and it embarked on a moral crusade to prohibit tobacco (Thompson 1994³²).

The first tobacco control legislation in New Zealand was in 1903, outlawing the selling of cigarettes to minors, and of smoking by those aged under 16 years (Thompson 1994). This moral based government intervention seems to have declined in effect by the end of World War I, and until the late 1940s, the main government action on tobacco apart from taxes appears to have been *to assist* tobacco farmers. Nevertheless, the DoH produced posters in 1945 advising that smoking should only be done in moderation, and not before the age of 21 (Dow 1995³³, p.192).

The first history of public health in New Zealand had no discussion of tobacco or smoking – even in a section that dealt with air pollution (Maclean 1964³⁴, p.447). The word “smoking” appears to have been only mentioned in relation to the Maori Councils Act 1900. This legislation allowed Maori Councils to be set up in districts and to pass bylaws that dealt with such issues as sanitation, drunkenness and smoking (p.192).

3.3.2 From 1948

The formation in 1948 of the National Cancer Registry, by the DoH, marked a milestone in the development of medical statistical science in New Zealand. The Department appears to have been moving towards an anti-smoking attitude by 1948, with health education and public information against smoking (Toxic Substances Board {TSB} 1989, p.105), and by 1950, was noting the risk of lung cancer (Gardiner et al 1961³⁵, p.1). However, the emphasis for at least some within the Department was moderation rather than non-smoking. In 1953, Dr Turbott of the Department, was writing:

“Cut down your smoking. Heavy smokers have more coronary disease than light ones ... there is a growing body of opinion that the circulation and lungs may be affected ... and there is some connection between excessive smoking and cancer of the lungs. ... Tobacco has its uses. As a social habit it has become accepted by both sexes the world over. It is used to relieve tension and help relaxation. ... What is moderation? The latest American thought is – limit yourself to, say, six or eight cigarettes a day ...” (Turbott 1953³⁶, p.6-7).

³² Thompson S. Where there’s smoke there’s history. *Asthma New Zealand* 1994; 4(June): 6-7.

³³ Dow DA. *Safeguarding the public health - a history of the New Zealand Department of Health*. Wellington: Victoria University Press, 1995.

³⁴ Maclean FS. *Challenge For Health: A history of public health in New Zealand*. Wellington: Government Printer, 1964.

³⁵ Gardiner CE, Taylor CND, Roberts LD. *Smoking habits of school children: a survey of the smoking habits of New Zealand school children*. Wellington: Department of Health, 1961.

³⁶ Turbott HB. Live wisely and live longer! *Health* 1953; Sept. 1953: 6-7.

Later in a *Listener* article of 1955, he suggested to housewives that they could relax from work with a cigarette:

“Don’t overdo the cigarettes; chain smoking is a sure way to chronic tiredness.” (Dow 1995, p.192).

At this time the level of awareness of the health risks of tobacco, even in medically orientated youth, can be seen by the comment by Murray Laugesen of his experience as a medical student:

“About 1956, Sir Russell Brook, who was a chest surgeon, came out from England, from the Brompton Chest Hospital, speaking about lung cancer surgery. That was the first time that I had ever heard anything about smoking being a serious cause of disease ... the first time I had heard it articulated” (Laugesen interview, 1996).

By 1961, Dr Turbott was writing as Director General of Health:

“Habitual smoking is dangerous and far more so than was realised even a few years ago. ... It is a difficult situation if you are a parent or a teacher and you yourself smoke. You may explain nevertheless that our knowledge of the dangers of smoking is very recent and was not available when you were young.” (Gardiner et al 1961, foreword).

The example from within the Department was ambiguous. Director Generals during the 1950s, 1960s and 1970s such as John Cairney (1950-59), Harold Turbott (1960-1964), Doug Kennedy (1965-1972), and John Hiddlestone (1973-1983), were slow to give up smoking. Dr Cairney smoked at least until retirement, Dr Turbott until eventually convinced by evidence, Dr Kennedy until his first heart attack in 1969, and Dr Hiddlestone until confronted by a reporter about his own behaviour (Dow 1995, pp.228-9). To some degree they reflected the behaviour of medical practitioners in New Zealand. In 1964, two years after the Royal College report on smoking, almost 40% of doctors were still smoking. However, of those who had given up, many said that the new information 10 years earlier had been a factor (Dow 1995, p.193).

Besides the DoH information, little of the information from international research was available to the New Zealand public. The 39% jump in retail cigarette prices in 1958 (M. McLauchlan 1994³⁷, p.107), occurred in an near vacuum of public information, and with no planned health education follow-up. During the 1950s over 50% of men, and 35% of women smoked tobacco (Hay 1993, p.317).

In 1961 a survey on the smoking behaviour of New Zealand school children was published by the DoH (Gardiner et al 1961). Also in that year the statement “*Does not affect heart or lungs*” was voluntarily removed from cigarette packets by one company (Kent 1984³⁸, p.27).

³⁷ McLauchlan M. Up in smoke. *North and South* 1994; September: 104-9.

³⁸ Kent D. (ed). *Smoking control in New Zealand*. Auckland: Action on Smoking and Health New Zealand Inc, 1984.

By the early 1960s, 50% of the tobacco used in locally manufactured cigarettes and in cut tobacco was grown in New Zealand (NZ Encyclopaedia 1992³⁹, p.508). After the 1970s this percentage started to decline.

3.4 Discussion

A number of themes appear to pervade the history of tobacco in New Zealand during the period.

1. The dominance of the tobacco industry in comparison to any government action. Even when evidence of the danger from tobacco was produced, the government appeared to make no effort to restrict advertising, promotion, or the sales to young people. There was at that stage, however, both a low level of product safety intervention by government, and fairly limited restrictions on other social drugs such as alcohol.
2. The absent or minor role of tobacco within the disease prevention activities of the New Zealand Department of Health. The Department appears to have been highly focused on the control of communicable diseases – as shown in the history by Maclean (Maclean 1964).
3. The growing body of international health research findings relating to tobacco.
4. The relative absence of tobacco-related health research in New Zealand.
5. The decline during the 1950s in the use of tobacco by the medical profession in some countries. A model of the “maturity” of a country’s smoking epidemic, developed by Michael Kunze, suggests that smoking prevalence amongst doctors peaks before the general population. It further suggests that the peaking of the prevalence amongst the general population follows the point where the medical prevalence drops below the general rate (Davis 1993⁴⁰). This theory suggests that smoking by New Zealand doctors may have peaked before 1962.

A number of question arise:

- i) To what extent the did lack of New Zealand government action on tobacco reflect a general lack of public health intervention, outside the field of communicable diseases?
- ii) Was the experience in this period of British health advisers, with the ignoring of their recommendations on tobacco, also the experience of New Zealand public health advisers?

³⁹ “Tobacco” In: McLauchlan G. *New Zealand Encyclopaedia*. Auckland: David Bateman Ltd, 1992.

⁴⁰ Davis R. When doctors smoke. *Tobacco Control* 1993; 2: 187-8.

- iii) How much of the decline of smoking by doctors in other countries, *before* government intervention, was based on health information, and how much was based on social and other considerations? To what extent did that earlier decline of smoking by doctors occur in New Zealand?

3.5 Summary

The overall impression of this period is of a few anti-smoking voices crying in a smoky wilderness, with a New Zealand population for whom smoking had become a widespread norm by the 1950s. The end of the period is marked by a possible shift by some health professionals away from smoking tobacco.

4. THE START OF AN EVIDENCE-BASED POLICY (1962 TO 1981)

4.1 Introduction

This period covers the 1962 and 1964 Royal College and US Surgeon General's reports, the 1976 and 1981 New Zealand census questions, and the beginning of voluntary and legal controls on tobacco in New Zealand.

4.2 The international scene

The previous studies into smoking and health by a number of organisations around the world culminated in 1962 with one of the most authoritative reports to that date, that of the Royal College of Physicians in the UK. This was followed by three other reports by this organisation (in 1971⁴¹, 1977⁴², and 1983⁴³) all of which provided further evidence for the adverse health impact of smoking.

Studies in the US by the American Cancer Society and others also found increased mortality from cancer and other causes among smokers. Experimental studies in animals also demonstrated that many of the chemicals contained in cigarette smoke were carcinogens. This evidence was reviewed by a panel of scientists for the US Government, beginning in 1962. The work appears to have been the result of pressure by health lobby groups on US politicians. Half the panel were cigarette smokers, and all were approved by the tobacco industry (Diehl 1969, pp.154-55). The conclusions of the panel were included in the landmark 1964 Surgeon General's report on smoking and health (Arno 1996⁴⁴, p.1259). It concluded that cigarette smoking was a health hazard of sufficient importance to warrant appropriate remedial action.

The actions in the US that followed in the two decades after this report included the following (Encarta 1995):

- 1965 – A warning on cigarette packages. This was the first major US federal restriction on tobacco. However, the whole effect of the Federal Cigarette Labelling and Advertising Act may have been to help the industry more than consumers (Arno 1996, p.1259; Diehl 1969, pp.161-3).
- 1969 – A stronger warning that read “Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous to Your Health.”
- 1971- A ban on all cigarette advertising from radio and television.

⁴¹ Royal College of Physicians. *Smoking and health*. London: Pitman Medical, 1962.

⁴² Royal College of Physicians of London. *Smoking and health now*. London: Pitman, 1971.

⁴³ Royal College of Physicians of London. *Health or smoking*. London: Pitman, 1983.

⁴⁴ Arno P, Brandt A, Gostin L, Morgan J. Tobacco industry strategies to oppose federal regulation. *JAMA* 1996; 275: 1258-62.

- Also in the 1970s some US cities and states passed laws requiring nonsmoking sections in public places and work places.

Similar control activities occurred in a number of other developed countries. Singapore introduced strong limitations on tobacco advertising in 1971, and Iceland completely banned tobacco promotion in 1972 (TSB 1989, p.58). Other countries introduced partial and complete bans on tobacco promotion later in the 1970s (TSB 1989, p.58).

The formation in 1971 of Action on Smoking and Health (ASH) in Britain by the Royal College of Physicians, provided the model of a group that could co-ordinate anti-tobacco activity.

In 1976, the World Health Association asked all governments to take stronger action against smoking (NZ Hospital 1978a⁴⁵, p.8).

In 1979 the World Health Organization recommended that:

“non-smoking should be regarded as normal social behaviour, ... and that there should be a *total prohibition on all forms of tobacco promotion*” (our emphasis, quoted from TSB 1989, p.103).

In the United States, the US Surgeon General published a report on the health effects of smoking for women (DHHS 1980⁴⁶). Also in the US, businesses were beginning to realise the advantages of restricting workplace smoking, with reductions in maintenance, cleaning, fire and health insurance, and decreased job time loss, absenteeism and staff turnover (Weis 1981⁴⁷, p.39).

Towards the end of this period New Zealand gave some aid to the tobacco industry in Western Samoa (Kapoor 1980⁴⁸, pp.30-31).

4.3 Research in New Zealand

A survey of third form students in the North and South Islands conducted in the late 1960s was published in 1970 (Newman et al 1970⁴⁹).

A survey of doctors published in 1964 showed that 39.3% still smoked (Dow 1995, p.193).

⁴⁵ New Zealand Hospital. Restrictions on smoking. *NZ Hospital* 1978; August: 8-9.

⁴⁶ DHHS. *The health consequences of smoking for women: A report of the Surgeon General*. Rockville, Maryland: Department of Health and Human Services, (DHHS), Public Health Service, Office of the Assistant Secretary for Health, 1980.

⁴⁷ Weis WL. No ifs, ands or butts - why workplace smoking should be banned. *Management World* 1981; Sept: 39-44.

⁴⁸ Kapoor S. *Smoking and health: Policymaking structures and process*. MPP research paper. Wellington: NZ Institute of Public Administration, 1980.

⁴⁹ Newman IM, Ang J, Irwin RP, Smith JM. Adolescent cigarette smoking. *NZ Med J* 1970; 72: 161-6.

The 1972 article by David Hay (Hay 1972⁵⁰) was a major step in New Zealand writing on tobacco and health. He noted the finding by Doll that Maori women had, even then, the highest female lung cancer rate in the world.

In 1976, a question on smoking was included in the Census for the first time, and it was repeated in 1981. This seems to be the first time in the world that such a question had been given in a census, and it was perhaps the largest survey of smoking and smokers in the world to that date. It showed the (self reported) total population prevalence of smoking, and allowed analysis by any group. The Department of Statistics published some of the data three years later (DoS 1979⁵¹). This document had a complete absence of any interpretation or discussion of the findings. A more informative analysis using Census data was published by Hay (Hay 1978⁵²). A further publication using the 1976 Census data highlighted the importance of the ethnic dimension to smoking in New Zealand (Hay and Foster 1981⁵³), and the drop in smoking by male doctors from 37% in 1963 to 20% in 1976 (Hay 1980⁵⁴, p.285).

A study in 1977 found that 26% of mothers had smoked throughout pregnancy, with a further 8% having smoked at some time during pregnancy (Fergusson et al 1979⁵⁵).

Smoking in a small rural community (Wairoa county) amongst adolescents at school was investigated (Stanhope 1978⁵⁶).

A study found an increased risk for infants of contracting respiratory illness (pneumonia, bronchitis and bronchiolitis) with parental smoking (Fergusson et al 1980⁵⁷).

1980 – Eru Pomare produced a report on Maori health that related ill-health to smoking (Dow 1995, p.233).

4.4 The developments in New Zealand

Tobacco use: Total tobacco consumption per adult peaked in New Zealand in 1963 (TSB 1989, p.96), as part of a plateau between 1949 and 1975 (DoS/DoH 1991,⁵⁸

⁵⁰ Hay D. Smoking and health: The 1972 situation. *NZ Med J* 1972; 76: 4-12.

⁵¹ DoS. *1976 Census of Population and Dwellings: Cigarette smoking*. Bulletin No. 24. Wellington, Department of Statistics, 1979.

⁵² Hay DR. Cigarette smoking in New Zealand: Results from the 1976 Population Census. *NZ Med J* 1978; 88: 135-8.

⁵³ Hay D, Foster FH. The influence of race, religion, occupation and other social factors on cigarette smoking in New Zealand. *Int J Epidemiol* 1981; 10: 41-3.

⁵⁴ Hay D. Cigarette smoking by New Zealand doctors: Results from the 1976 population census. *NZ Med J* 1980; 91: 285-8.

⁵⁵ Fergusson DM, Horwood LJ, Shannon FT. Smoking during pregnancy. *NZ Med J* 1979; 89: 41-3.

⁵⁶ Stanhope JM. Social patterns of adolescent cigarette smoking in a rural community. *NZ Med J* 1978; 87: 343-8.

⁵⁷ Fergusson DM, Horwood LJ, Shannon FT. Parental smoking and respiratory illness in infancy. *Arch Dis Child* 1980; 55: 358-61.

p.12). It was notable that the death rate from coronary heart disease peaked five years after 1963 and has continued to decline ever since (along with tobacco consumption).

The prevalence of smoking in men over 14 years of age fell from over 50% at the start of the period to 35% in 1981, and the rate for women fell from 35% to 29% (Hay 1993, p.316-7; Laugesen 1996a, p.6).

Collection of international data: There were no New Zealand delegates to the First World Conference in 1967. However, in 1971 Dr David Hay provided a report on “The Second World Conference on Smoking and Health” (Hay 1971⁵⁹). He made a number of recommendations to the DoH, the National Heart Foundation, and the Cancer Society.

Voluntary agreements:

1962 – By the tobacco industry that they would not target youth by advertising (Kapoor 1980, p.6).

1973 – Warning notices and tar levels on packets, and restrictions on cinema and billboard advertising (Kapoor 1980, p.8; Hay 1993, p.315).

Legal controls: The Government established a number of regulatory and legal controls during this period (TSB 1989, p.104). These included:

- A ban on cigarette advertising on radio and television in 1963 . This was eight years before the TV advertising ban in the US.
- Restrictions on smoking in aircraft in 1974.

However, the (un-enforced) law on the sale of tobacco to children was repealed in 1981 (Wright 1985⁶⁰, p.18).

Health promotion:

1962 – An anti-smoking campaign was started by the DoH (Dow 1995, p.192).

1970 – DoH, Cancer Society, National Heart Foundation, and Tuberculosis and Chest Disease Society co-operate in a national anti-smoking campaign (Kapoor 1980, p.7).

1979 and 1980 – A mass media campaign was run by the DoH (PHC 1994b, Kapoor 1980, p.38). It focused on helping teenagers to stay nonsmokers.

1980 – Recognition by the DoH Advisory Committee on Smoking (ACSH) that current tobacco/health education might not be effective for Maori (Kapoor 1980, p.38).

Health bureaucracy:

1971 – DoH Annual Report gave an estimate of 8000 deaths per year, or 1 in 3 deaths, as resulting from smoking. There was a request by the DoH through the State

⁵⁸ DoS/DoH. *Tobacco Statistics 1991*. Wellington: Department of Statistics and Department of Health, 1992.

⁵⁹ Hay DR. *Smoking and health: A report to the Department of Health, Wellington, NZ*. The National Heart Foundation of NZ; The Cancer Society of New Zealand, 1971.

⁶⁰ Wright V. Citizens army in nicotine war. *Listener* 1985; July 20-26: 16-18.

Services Commission that all Departments and Hospital Boards adopt a non-smoking policy (Kapoor 1980, p.8).

1975 – A steering committee comprising people from the DoH, Cancer Society, and the National Heart Foundation was established to consider a World Health Organization report on smoking and health. This committee recommended that a Advisory Committee on Smoking and Health (ACSH) be established, and this was done in 1976 (Kapoor 1980, pp.8-9; Hay 1993, p.315). The committee membership by 1980 had become in essence seven doctors, a sociologist, and a representative from the Department of Maori Affairs.

1977 – A significant step was taken by the Director of the Social Services Division of Treasury, David Preston, who related the increases in health expenditure (as a percentage of GDP) to such problems as smoking and alcohol abuse (Preston 1977⁶¹, p.481). He wrote of his:

“doubts about the rationality of concentrating so many resources into critical care facilities rather than into preventative measures of a medical and non-medical nature” (p.483).

1978 – The Hospital Boards Association adopted a policy recommending the restricting of smoking in hospitals and board offices. This reflected the trend of restrictions in most hospitals already. The recommendation was significant in mentioning “*non-smokers rights*”. Professor O’Donnell of the Wellington Clinical School of Medicine, and a member of ACSH, also commented on the need for the protection of non-smokers rights (NZ Hospital 1978a, p.8).

1979 – ACSH recommended a fulltime DoH advisory officer for smoking and health. Kapoor states that the position was created, but the “sinking lid” policy at the time prevented an appointment (Kapoor 1980, p.42).

1979 – Tobacco was listed as a toxic substance in law (i.e., the Toxic Substances Act defined tobacco as a toxic substance), but the Act did not become law until 1983 (Kent 1984, p.27).

1981 – The Director General of Health, Frank Hiddlestone, wrote in his annual report:

“Smoking has been properly called the greatest medical evil of our day. ... The results of smoking cost an enormous sum of money to investigate and treat ... the total care of smoking-related disease costs far more than the revenue (that tobacco) taxes bring in” (AJHR 1981, E.10, p.3).

Taxation:

1978 – ACSH recommended that the tobacco tax be increased, and the extra income be used to substitute for tobacco sports sponsorship, and for health education. The NZ Planning Council recommended a tax to achieve a 25% retail price increase, in the context of the decreasing real cost of tobacco since 1961 (Kapoor 1980, p.26). The Government, in the annual Health Department report of March 1978, stated that a

⁶¹ Preston D. The health expenditure problem in New Zealand. *NZ Med J* 1977; 85: 480-483.

“duty on tobacco and alcohol (was) to be used for community health ...”
(AJHR 1978, E.10, p.44).

Later in 1978, the Minister of Health, Frank Gill, said that \$28.8 million of extra revenue from duties had gone into community health projects (NZ Hospital 1978b⁶², p.5). However, any direct relationship between tobacco duty and health funding does not appear to have lasted for long. In a retirement article, the Director General of the DoH at this time, John Hiddlestone, wrote of:

“the enlightened innovation of a dedicated levy on alcohol and tobacco – the so called ‘Beer and Baccy Tax’. A brilliant concept introduced with indecent haste, this nevertheless afforded a temporary financial spur to community programmes. .. The idea of financial penance seemed to appeal to the public, as this secular penance lacked the religious requirement of effort at subsequent abstinence. ... I fondly hoped that the initial one cent levy ... would gradually increase every second or third year .. Regrettably what had such allure to the health professional was fiscal nonsense to the economist. ... Possibly the variant embodied in the Alcoholic Liquor Advisory Council may act as a model for other similar endeavours.” (Hiddlestone 1983⁶³, p.8).

1979 – A 15% tobacco tax increase was imposed. However, the yearly rate of inflation was then 18% (Kapoor 1980, p.27).

Non-governmental organizations (NGOs):

1962 – The NZ Branch of the British Medical Association (NZBMA) supported the DoH anti-smoking campaign, and surveyed doctors’ smoking habits (Dow 1995, p.192).

It appears that as a consequence of going to a WHO conference, Dr David Hay came back and spoke to the NZBMA about the health risks of smoking. They in turn made a submission to the Minister of Health, and the 1963 TV tobacco advertising ban was made.

1972 – The tone of at least some current medical concern may be seen in a NZ Medical Journal editorial:

“... the government must ... lend its full weight to some of the measures which enlightened administrators are adopting in other parts of the world. Health warnings on packets, publication of tar and nicotine contents on cigarette packages, restriction of advertising and promotion, anti-smoking advertisements on television ... even certain taxation measures might discourage cigarette smoking ...” (NZMJ 1972⁶⁴, p.370).

⁶² New Zealand Hospital. Health projects benefit from beer and tobacco taxes. *NZ Hospital* 1978; Nov./Dec.: 5.

⁶³ Hiddlestone J. A decade of the Department of Health and health in New Zealand. *New Zealand Hospital* 1983; March: 4-5, 8-9.

⁶⁴ NZMJ editorial. Smoking and coronary heart disease. *NZ Med J* 1972; 75: 369-370.

However, the same year Hay noted that:

“It disturbs me ... that the Council of our (Medical) Association rejected a proposal to seek stronger government action regarding the limitation of cigarette advertising and promotion. Our hospital administrators are also rather lukewarm in their attitudes to more effective smoking control measures in hospitals.” (Hay 1972, p.11).

1975 – The Cancer Society of NZ and the National Heart Foundation are involved in the creation of ACSH (see above in *Health Bureaucracy*).

Tobacco industry:

1977 – The industry and the sports groups associated with them mobilised to fight a suggestion by the chairperson of ACSH that they were considering the role of tobacco sponsorship of sport. The Minister of Health, apparently without reference to the DoH or ACSH, declared that he would not stop sports sponsorship (Kapoor 1980, p.22).

1979 – A Dr Seltzer visits Australia and New Zealand publicising his research that showed no link between smoking and heart disease. The publicity material claimed that he was not connected with the tobacco industry but the industry appears to have closely followed his activities (The Cigarette Papers⁶⁵).

Other: By 1980 insurance companies in New Zealand were offering incentives to non-smokers (Kapoor 1980, p.31).

4.5 Discussion

In this period, the health effects of tobacco were clearly on the New Zealand health policy agenda. Among the causes of this change, the publicising of authoritative information on the effects of tobacco use appears to have been very important. The 59% drop in the prevalence of smoking by New Zealand male doctors between 1963 and 1981, from 37% to 15%, would be a health promotion worker’s dream if repeated in the whole population (Hay 1993, p.317).

However, the increasing social class differences in smoking prevalence (see section 5.3.1) may also indicate a strong social influence on smoking behaviour. The information and social effects together could have created a degree of synergy, with increasing publicity influencing opinion and social leaders, who in turn helped provide a social climate more open to health information and more accepting of non-smoking behaviour.

Whatever the cause, the period marks the end of the almost inviolate position of the tobacco industry with government. The period is also crucial in that overall tobacco consumption per person started to decline, showing that the industry was on the

⁶⁵ The Brown and Williamson Collection (The Cigarette Papers). Internet: <http://galen.library.ucsf.edu/tobacco/docs/html/2004.12/index.html>.

defensive with at least some of its customers. It should, however, be noted that the decline was strongest amongst Pakeha men (Hay 1993, p.316; Laugesen 1996a, p.6).

While NGO's became active, particularly the National Heart Foundation and the Cancer Society, the DoH appears to have been by far the dominant influence in policy making and legislation. It is noteworthy that despite the 1962 Royal College report and later ones, the medical professional bodies appear to have left the running in this period to other health lobby groups.

Kapoor attempted to sum up much of the DoH approach during the period to 1976:

“...a strong paternalistic approach can be identified in the selection of target groups, and in the educational focus of the hazards of smoking, with no evidence of the causes (e.g., stress factors) of the smoking habits or provision for assistance to cope with the cause.

These factors can be considered significant in limiting the effectiveness of eighteen years activity by the Department of Health officials, ...(there was) a climate of incrementalism where incomplete analysis failed to grasp what was critical in good policy ...”(1980, p.10).

However, Hay (1993, p.316), who was on the Department's Advisory Committee on Smoking and Health, noted that the establishment of such a committee in 1976:

“...helped ensure that smoking control issues remained on the political agenda ... A comprehensive smoking control policy was developed ... “ (but not until 1985 – TSB 1989, p.104).

The 1963 ban on tobacco ads on radio and TV could be largely circumvented by moves to other media, and by indirect advertising such as sponsorship. However, they were important in preventing the consolidation of a larger tobacco-media industry, and in providing a precedent for further action.

The movement of advertising helped to cause the 1979 restrictions on advertising in the print media (TSB 1989, p.98). Although cigarette print advertising fell 50% from 1977 to 1987 there was a major increase in televised tobacco industry related sponsorship (by about tenfold) over this same period (TSB 1989, p.98).

While the rationale of health expenditure and regulation for disease prevention was spelled out both inside (e.g., Preston) and outside government, there was a limited ability to convert this advice into action. Much of the action necessary was put in the politically “too hard” basket.

4.6 Summary

During this period, the conflict between the aims of the tobacco industry and government became significant. Even more importantly, the public attitude to smoking as a habit started a major change, with the consumption per person peaking. The extent of the New Zealand situation was shown by the census questions, which allowed accurate analysis of the epidemiology of tobacco consumption.

5. ACCELERATING DEVELOPMENTS (1982 TO 1988)

5.1 Introduction

This section includes the publication of evidence on passive smoking effects, the large increase in research within New Zealand, and the run-up to the major efforts of 1989-90. The research included census data analysis, other prevalence surveys, and advertising effects.

5.2 The international scene

Research: This period saw a number of major reports on the risks associated with smoking. These included the US Surgeon General's Report on passive smoking (DHHS 1986⁶⁶). Public concern over passive smoking appeared to greatly strengthen moves towards the restriction of workplace smoking throughout the developed world, and in the US in particular.

A review of 40 media health promotion and cessation programs in seven countries showed great differences in effectiveness, but little information on the causes of this (Flay 1987⁶⁷).

Regulation:

1986-87 – Tobacco advertising and sponsorship restrictions were introduced in Victoria and South Australia, and a dedicated 5% tobacco tax for health promotion was levied in Victoria (Palmer 1994⁶⁸, p.223).

1988 – The “Canadian Tobacco Products Control Act” was passed which enabled a total ban on tobacco promotion and sponsorship in Canada (TSB 1989, p.125).

In the US, stronger cigarette package labelling laws were passed in 1984, requiring four alternate warnings (Arno 1996, p. 1259). New York City passed controls on smoking in many indoor situations (Williams 1988).

Business:

1985 – The main domestic airline in Sweden, Linjeflyg, announced it would be the first airline in the world to keep a non-smoking ban in force (*The Dominion* 18.12.85).

1986 – The Compensation Court of New South Wales (NSW) awarded an ex-employee \$20,000 from her former employers, Ansett Airlines, who had refused to

⁶⁶ DHHS. *The health consequences of involuntary smoking: A report of the Surgeon General*. Maryland: Department of Health and Human Services, (DHHS), Public Health Service, Office of the Assistant Secretary for Health, 1986.

⁶⁷ Flay B. Mass media and smoking cessation: A critical review. *Am J Public Health* 1987; 77: 153-160.

⁶⁸ Palmer GR, Short SD. *Health care and public policy: an Australian analysis*. Melbourne: Macmillian Education Australia, 1994.

prevent her exposure to passive smoke while at work. The State Government refused to use the NSW Occupational Health Act against the company (Non-Smokers Movement of Australia 1986⁶⁹). Another court case, leading to a 1988 \$65,000 out of court award to a bus driver in Victoria, associated his lung cancer to the passive smoking at work (Palmer 1994, p.225).

Industry: In 1987 the Dutch Foundation on Smoking and Health was sued by the industry after stating the dangers of tobacco smoking. Although the industry lost and agreed to pay the legal costs, the long term legal action was used to harass the Foundation for nearly four years (Sweda 1996⁷⁰, p.191).

5.3 Research in New Zealand

5.3.1 Further Work From the 1976 Census Data

The role of socioeconomic status and smoking was explored in an analysis of the 1976 Census data (Pearce et al 1985⁷¹) that used the Registrar-General's social class classification developed in the UK. This work found a clear social class gradient for the percentage of current smoking (e.g., 47% in social class I rising to 69% in social class V (the social class with the lowest income)). Furthermore, it was considered that smoking patterns were likely to explain much of the increased risk for social classes III-IV but not the very high mortality for class V. A further paper suggested that 15% of the excess in Maori mortality that was not attributable to social class (at least as measured by occupation) was associated with smoking (Smith and Pearce 1984⁷²).

5.3.2 Analysis of the 1981 Census Data

Data from the 1981 Census were published by the Department of Statistics in 1983 (DoS 1983⁷³). The data were presented for statistical areas and divisions, local authority regions and urban areas. Trends between the 1976 and 1981 Census data on smoking were also published (Hay and Foster 1984a⁷⁴) and (Hay and Foster 1984b⁷⁵).

⁶⁹ Non-Smokers Movement of Australia. Record Tobacco Compensation Pay Out. Media release, 18.11.1986, Sydney.

⁷⁰ Sweda E, Daynard R. Tobacco industry tactics. In: Doll R, Crofton J, eds. *Tobacco and Health*. London: Royal Society of Medicine Press, 1996: 183-191.

⁷¹ Pearce NE, Davis PB, Smith AH, Foster FH. Social class, ethnic group, and male mortality in New Zealand, 1974-8. *J Epidemiol Community Health* 1985; 39: 9-14.

⁷² Smith AH, Pearce NE. Determinants of differences in mortality between New Zealand Maoris and non-Maoris aged 15-64. *NZ Med J* 1984; 97: 101-8.

⁷³ DoS. *New Zealand Census of Population and Dwellings 1981: Bulletin on Cigarette Smoking*. Wellington: Department of Statistics, 1983.

⁷⁴ Hay DR, Foster FH. Intercensal trends in cigarette smoking in New Zealand 1: age, sex and ethnic status. *NZ Med J* 1984; 97: 283-5.

⁷⁵ Hay DR, Foster FH. Intercensal trends in cigarette smoking in New Zealand 2: Social and occupational factors. *NZ Med J* 1984; 97: 395-8.

The 1981 Census data were also used in an influential 1988 study “The Big Kill” (DoH 1988a⁷⁶). Deaths attributable to smoking and smoking-related hospital admissions were calculated by an established method (Gray et al 1988⁷⁷) for electorates, local authority areas and hospital boards. The variation among local authority areas in the total deaths attributable to smoking ranged from 15.9% (Oamaru) to 23.4% (Mt Maunganui).

5.3.3 Other smoking prevalence surveys

An OTR Spectrum survey of over 10,000 persons was published in 1988. It found that 28.7% of adults smoked cigarettes (i.e., 730,000 adult New Zealanders) (TSB 1989, p.19).

From the Dunedin multidisciplinary study at the University of Otago (a cohort study) there were studies on the smoking prevalence of nine-year olds (Oei et al 1984⁷⁸) and 15-year-olds (Stanton et al 1989⁷⁹). The latter were found to have a smoking prevalence of 15% for daily smoking.

A study of adolescents by Mitchell (1983⁸⁰) found that when adjusted for sex and socioeconomic status, the higher rate of smoking in Maori was no longer significant. Yet there was still a significant association between a higher level of smoking and high cultural identity as Maori.

5.3.4 Research on tobacco advertising and its affects

1984 – The Cancer Society of New Zealand commissioned a poll in of 2200 people conducted by the National Research Bureau (NRB) (cited in TSB Report 1989, p.77).

1987 – The Cancer Society commissioned another NRB poll of 2000 adults. It found that 47% of cigarette smokers said they would find it very difficult to give up smoking for one week, and an additional 28% said it would be fairly difficult to give up. It also found that 65% of all those surveys supported a ban on cigarette advertising. A similar result was obtained (66%) in a DoH commissioned poll by AGB (TSB 1989, p.107).

For the period 1973 to 1986, the DoH purchased press and magazine cigarette advertising expenditures (TSB, 1989, p.24). These data were analysed along with cigarette consumption data with the finding that advertising did affect overall

⁷⁶ DoH. *The Big Kill, the Human Cost of Smoking in New Zealand*. Wellington: Department of Health, 1988.

⁷⁷ Gray AJ, Reinken JA, Laugesen M. The cost of cigarette smoking in New Zealand. *NZ Med J* 1988; 101: 204-7.

⁷⁸ Oei TPS, Brasch P, Silva PA. The prevalence of smoking among Dunedin nine-year olds. *NZ Med J* 1984; 97: 528-31.

⁷⁹ Stanton WR, Silva PA, Oei TPS. *The origins and development of an addictive behaviour: a longitudinal study of smoking*. Dunedin: University of Otago, 1989.

⁸⁰ Mitchell DR. A comparison of high school student’s smoking behaviour in 1968 and 1981. *NZ Med J* 1983; 96: 534-6.

consumption (with an elasticity of +0.07) (Chetwynd et al 1988⁸¹). Additional analyses suggested that this model and its conclusions were robust (while possibly underestimating the magnitude of the elasticity) (Harrison 1989⁸²).

Furthermore, in a DoH study it was found that the majority of smokers in Form 1 at school could name a preferred cigarette brand (McClellan 1987⁸³).

A majority of New Zealand adolescent non-smokers (70%) and 40% of adolescent smokers disapproved of cigarette advertising in a Hamilton study (Ritchie 1988, p.10).

5.3.5 Research for the tobacco industry on advertising

Research was conducted for the New Zealand tobacco industry by a market research group (“Children’s Research Unit”). It examined the responses of New Zealand children to advertising and considered that advertising was not a significant reason influencing children to try their first cigarette. The major methodological limitations of this work were detailed in the TSB’s Report (1989, p.45-6). Similar work funded by the industry has also been criticised by the World Health Organization (WHO 1988 cited in the TSB Report).

Surveys were taken for the industry concerning the question of sponsorship and its affect on smoking behaviour in 1978, 1982, and 1988 (MRL Research Group cited in the TSB Report (1989, p.49)). Of note was the finding in the 1988 survey where 17% of people disagreed with the question “Sponsorship of sport by cigarette companies will not encourage me to take up smoking”.

5.3.6 Research on the health impact of smoking

One of the first estimates of deaths in New Zealand attributable to tobacco use, (3693/year) was published in 1983 (King 1983⁸⁴, p.195).

A study of the impact of smoking on health care resource use showed significantly higher use by smokers (Chetwynd and Rayner 1986⁸⁵).

⁸¹ Chetwynd J, Coope P, Brodie RJ, Wells E. Impact of cigarette advertising on aggregate demand for cigarettes in New Zealand. *Br J Addict* 1988; 83: 409-14.

⁸² Harrison R, Chetwynd J, Brodie RJ. The impact of advertising on tobacco consumption: a reply to Jackson and Ekelund. *Br J Addict* 1989; 84: 1251-4.

⁸³ McClellan V. *A national survey of the smoking habits of form one students in New Zealand schools*. Health Services Research and Development Unit, Department of Health, 1987.

⁸⁴ King DR, Smith AH, Salter DM. Mortality attributable to smoking in New Zealand. *NZ Med J* 1983; 96:195-9.

⁸⁵ Chetwynd J, Rayner T. Impact of smoking on health care resource use. *NZ Med J* 1996; 99: 230-2.

5.4 The developments in New Zealand

Department of Health (DoH) activity:

1984-5 – A further voluntary agreement was made with the tobacco industry. The minimal improvement possible from this agreement provided a catalyst for the Department to find a more effective way to control tobacco. One of those approaches was to turn to the Toxic Substances Act and the Toxic Substances Board (Laugesen interview, 1996).

1984 – The appointment of a principal medical officer (Dr Murray Laugesen) at the DoH to work solely on tobacco monitoring and control (Laugesen 1995c⁸⁶, p.169). This appears to have been the first such New Zealand government position. One of the first activities was producing a paper to ACSH called “The promotion of non-smoking”:

“... it was presented to the Minister by the committee in May 1985. The chairman of the committee at the time was Geoff Holland, son of the former PM, ... he was a thoracic surgeon in Christchurch.” (Laugesen interview 1996).

1985 – The DoH published its advice on the promotion of non-smoking (DoH 1985⁸⁷). The goal of 80% of adults to be nonsmokers by 1990 was adopted (relative to 72% in 1987). The Advisory Committee on Smoking and Health (ACSH) recommended that advertising and promotion of tobacco be restricted and eventually eliminated.

The report of a government task force on asthma was also issued, advocating the banning of smoking in public places. The report appears not to have been explicit in stating that they referred to *confined* public places, and the recommendation was rejected by the Minister, Michael Bassett (*The Dominion* 22.6.85⁸⁸).

1986 – The Advisory Committee on Prevention of Cardiovascular Disease (New Zealand) reported to the Minister of Health and endorsed the goals of the ACSH (DoH 1986⁸⁹). This report led to funding for cardiovascular disease prevention, which meant the Department was able to put greater resources into creating tobacco control policy. In particular, it enabled the creation by 1988 of a small health promotion policy team.

⁸⁶ Laugesen M. New Zealand’s monitoring system for tobacco control 1984-92. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995.

⁸⁷ Department of Health. *Comprehensive policy for the promotion of nonsmoking*. Wellington: Advisory Committee on Smoking and Health, Department of Health, 1985.

⁸⁸ Pirie A. Bassett ‘no’ to ban on public smoking. Wellington, *The Dominion* 1985, 22.6.85.

⁸⁹ *Report of the Advisory Committee on Prevention of Cardiovascular Disease*. Wellington, Department of Health, 1986.

1986 – The Toxic Substances Board recommended the elimination of the advertising and promotion of tobacco (TSB 1986⁹⁰).

The chairman of the Board was Ian Prior, who was an epidemiologist. He had set up a subcommittee on the subject. The Board subsequently produced its recommendations for a ban on advertising in 1986, long before it actually happened. The recommendation went to Cabinet who sat on it. In February 1987 they decided that they would not ban advertising, but they would have a stronger voluntary agreement, stronger warnings, and reinstate the law against the sales to young people under the age of 16. ... Those were all recommendations of the Toxic Substances Board (Laugesen interview, 1996).

The Tobacco Institute of New Zealand made a submission in response to the TSB recommendations. A document appended to this submission was a study of 16 countries undertaken by the International Advertising Association (IAA). The quality of this work was critiqued in subsequent work by the TSB which found the IAA brochure to be “deficient and the conclusions simplistic, unjustified, erroneous and misleading” (TSB 1989, p.61). In 1987, however, the New Zealand tobacco industry agreed not to advertise in certain magazines which had a high percentage of their readership among adolescents (e.g., “Dolly” and “Charlie”) (TSB 1989). These were, however, low circulation publications and there was no change in advertising in major publications such as the *Listener*.

1986 – As a result of the ASH petition to Parliament for smokefree workplaces, and the consequent favourable recommendation from the Parliamentary Select Committee, the Department was asked to make recommendations on follow-up action. The outcome of this request was that:

“We asked Cabinet permission to consider the idea of smokefree indoor environments, and they agreed (in principle), – the decision didn’t commit anybody to anything. What it did was give us permission to start doing something ... the Cabinet approval did give us a mandate” (Delany interview, 1996).

1987- The offices of the DoH become smokefree (TSB 1989, p.104).

“At the end of 1986, I had been in Canberra at the Department of Health when it went smokefree. When I came back I told George Salmond about it, and during 1987 there was work in the Department towards going smokefree.” (Laugesen interview, 1996).

Until then, there had only been one floor of the Head Office of the Department which was smokefree:

“Our floor was smoke free, it was the only one – the Division of Health Promotion, it was the floor policy. But on all other floors at that stage, even

⁹⁰ *Recommended controls on tobacco for smoking under the Toxic Substances Act 1979: Report to the Minister of Health from the Toxic Substances Board.* Wellington: Department of Health, 1986.

the Director General's one, smoking was allowed. When I went to the Health Department there were ashtrays on many people's desks. I think our smoking rates were completely average, about 30% (at that time).

This was the first large organisation in New Zealand and the first public service type organisation to go smokefree. A project team was set up to ... tell people about it. It was a very traumatic process, but that was very useful for us with the SFE Act. I thought afterwards, comparing the two experiences, that getting the Department to go smokefree was harder. We had the unions involved, and smokers.

We had a six-to-seven month time frame for implementation as area health boards were about to be established, and we wanted district health offices, over which we had control, to go smokefree (before going into the boards). One district office mutinied over the issue, so they had to be visited by this great delegation. We offered people whatever assistance they wanted to help them through the painful period (e.g. hypnosis, stress counselling). We tried to get two people from each floor that would be responsible for informing and preparing people as well as implementing the policy.

The social pressure for non-smokers' rights built up fast, and so we not only had to fend off angry smokers, but we also had to fend off angry non-smokers who wanted to know why we were taking such a long time. We issued a smokefree news sheet once a week, interviewing, for example, smokers who were finding it hard, or smokers who had given up, or what had worked for some people. (Plus jokes, competitions, puzzles – everybody got one). Some smokers got so angry and annoyed about the whole process that they put in a special request to not be given one” (Delany interview, 1996).

“A typist at the Department was very grateful for the smokefree move as she said that she no longer had to stick her head out of a window to breath...Another staff member said that she had to take fewer days off work because of her asthma being aggravated by smoking. ... There had been an Advisory Officer who told me that she had learnt to smoke at the Department....” (Laugesen interview, 1996).

After the Health Department, other public service offices also went smokefree, e.g. the State Services Commission.

1987 – During the year, the Department was negotiating the last voluntary agreement with the tobacco companies. In September, the post election advice to the incoming Minister included recommendations for a total advertising and sponsorship ban (*NZ Herald*, 22.9.87, p.1).

1988 (September) – The Toxic Substances Board re-established its “Tobacco Subcommittee”. This Subcommittee was given the task of reviewing the issue of whether or not tobacco advertising and promotion should be eliminated.

“Professor Mathews had taken over from Ian Prior, and because he had been a heavy smoker himself, and he had seen (the responsibility for advice on tobacco) in the Act, he decided to do something about it. He picked that out and quite rightly too, because he had been plagued with it all his life ... he had found the addiction very difficult to give up. So he decided to reactivate the matter and set up the tobacco subcommittee again” (Laugesen interview, 1996).

1988 – “The Big Kill”, a breakdown of tobacco and health statistics by electorate and other areas, was published by the Department (DoH 1988a). Figures from this publication would be used in the arguments leading to the 1990 Smoke-free Environments Act, and in the parliamentary debate (Hansard v.507, 1990, p.1649).

1988 – Stronger warnings on cigarette packets were introduced (AJHR 1989, E.10, p.20) as a result of the 1987 voluntary agreement.

1988 – The DoH published a discussion paper on creating smokefree indoor environments (DoH 1988b⁹¹). Even before its publication, many local authorities were supporting the idea (*The Dominion*, 24.1.88⁹²). The discussion paper attracted over 3000 submissions (Hay 1993, p.316), of which 1838 supported the proposals, and 1073 were standard printed cards from industry sources (AJHR 1990-91, V.II, E.10, p.71).

1988 – The Department was now watching progress towards tobacco control in Canada and Australian states.

“In 1988 Canada had passed the Tobacco Products Control Act, and Caygill when he became minister had said “*keep us informed as to what is going on in Canada. As soon as they pass theirs, we will look at passing it here*” (Laugesen interview, 1996).

Fiscal control measures:

1986 – Tax induced price rises of 53% occurred (Laugesen 1996a, p.2).

1988 – Planned tobacco tax price increases spread through the year took place.

1988 – The Reserve Bank credit for tobacco growers was stopped (TSB 1989, p.104).

The tax changes in this period provided a major part of the doubling of real tobacco prices between 1986 and 1991 (Laugesen 1991⁹³).

Legal control measures:

1987 – Oral (chewing) tobacco was banned because of the risk of mouth cancer (PHC 1994b).

⁹¹ Department of Health. *Creating smokefree indoor environments: options for action, a discussion paper by the Department of Health*. Wellington: Department of Health, 1988b.

⁹² Williams C. Smoking ban move widely welcomed. Wellington: *The Dominion*: 24.1.88.

⁹³ Laugesen M. New Zealand’s monitoring system for tobacco control 1984-92. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995, p.170.

1988 – Restrictions on indoor smoking were introduced in three cities.

1988 – Smoking on aircraft banned by domestic airlines (TSB 1989, p.104).

1988 – The Toxic Substances Regulations Amendment of April 1988 made the sale to those under 16 years an offence (AJHR, 1989, E.10, p.20).

Health promotion:

1982 – Smoking intervention teacher kits were issued to schools (TSB 1989, p.105).

Anti-smoking education involved television campaigns in 1984, 1986 and 1988 (i.e. the *Kick it in the Butt* campaign) (PHC 1994b).

1985 – The first major community-involvement non-smoking events in New Zealand were organised, the Whangamata and Levin Smokefree weeks. The Levin week was a trial for the planned national event. In 1986, a national smokefree week was held to encourage smokers to quit.

Nicotine replacement therapy in the form of nicotine chewing gum became available in the mid-1980s and some pharmaceutical industry promotions of this product occurred on television and other media.

Other government action: The Statistics Department decided to not include a question about smoking in the 1986 Census. The level of accuracy in previous census was disputed by the Statistics Department and tobacco industry on one hand, and the former chief health statistician on the other. The response rate of answers to the smoking question in previous census had been over 98% (Hay 1985⁹⁴).

1986 – The State Services Commission adopted the idea that smokefree public service environments should be the norm (*Evening Post* 2.5.86).

During this period, the Government Life Insurance Company still held shares in the tobacco company Rothmans (Wright 1985, p.17).

NGO action:

1982 – The group Action on Smoking and Health (ASH) was formed. This allowed the employment of the first full time New Zealand health NGO lobbyist on tobacco. From this point on, there was a sharp rise in the New Zealand media mentions of the health risks of tobacco. The lobbyist from 1983, Dierdre Kent, was assiduous in visiting all the government departments concerned with tobacco in any way (Laugesen interview, 1996). The anti-smoking advocacy took a wide range of forms, including correspondence in medical journals.

November 1984 – A petition with 4271 signatures was presented to parliament, asking for a ban on all tobacco advertising. It followed a NRB opinion poll for the Cancer Society that showed that 53% of the public supported an ad ban compared to

⁹⁴ Hay D. The census and smoking [Letter]. *NZ Med J* 1985; 98: 656.

26% opposing the idea. Also 75% supported a ban on smoking in enclosed public places (Wright 1985, pp.17,18).

1985 – The Consumer Institute asked for a ban on all tobacco advertising and promotion (*The Dominion*, 16.7.85, p.12). The next year they would question the legal right of tobacco companies to advertise, on the grounds that the Toxic Substances Act stated that advertisements could not imply that a toxic substance was fit for human consumption (Sampson 1986⁹⁵, *The Dominion* 7.3.86).

1985 – Nine medical specialist groups, including the Royal Colleges submitted a statement to the Minister of Health on the need for a complete ban on advertising (including advertising through sponsorship) (TSB 1989, p.105; also RSMC 1985⁹⁶).

July 1985 – ASH, the Heart Foundation and the Cancer Society brought Michael Daube of the Western Australian Health Department, and Ruth Shean of the Australian Council on Smoking and Health, on a speaking tour to coincide with the ACSH report release. Compared to New Zealand, at that time, Western Australia spent over 40 times more on non-smoking promotion per person (*The Dominion* 26.7.85).

1986 – A number of lobby groups including ASH, the Cancer Society, the National Heart Foundation and the Consumer Institute, urged the Toxic Substances Board to recommend a complete ban on tobacco advertising (Consumer 1986⁹⁷, p.133). ASH was reported to be preparing a petition to parliament for smokefree enclosed public places, to close in October (*The Dominion* 22.8.86).

1986 – The Public Service Association agreed to the State Services Commission move to have smokefree office environments (*Evening Post* 2.5.86).

1987 – A petition to Parliament from the Tobacco Advisory Council (an anti-smoking lobby group) and over 4000 others, recommended that an advertising and promotion ban be placed on all tobacco products (TSB 1989, p.108). This petition was heard by the Social Services Select Committee. It recommended that the petition be referred to the Government for favourable consideration.

1988 – ASH sponsored a visit by Glenn Barr, who had been involved in the creation of the smokefree laws of Los Angeles (*The Dominion*, 24.1.88⁹⁸).

1988 – Heartbeat New Zealand was formed – a health promotion programme by the DoH and the National Heart Foundation, with non-smoking as one of its priorities (Beaglehole 1991, p.177). In December 1988 they imported Professor Stanton Glantz from California for a speaking tour (Hutchinson 1989⁹⁹, p.65).

⁹⁵ Sampson A. Tobacco adverts' legality questioned. Wellington: *The Dominion*; 7.3.86.

⁹⁶ Letter from the Royal Specialist Medical Colleges and Faculties to the Minister of Health (New Zealand), 1985.

⁹⁷ Consumer. Tobacco companies are morally corrupt. *Consumer* 1988; June:131-133.

⁹⁸ Williams C. Smoking ban move widely welcomed. Wellington: *The Dominion*; 24.1.88.

⁹⁹ Hutchinson P. Smoke-free workplaces: coping with the 'ifs' and 'butts'. *Management* 1989; Feb.: 65-72.

“Heartbeat New Zealand was the machinery recommended to implement the (1986 cardiovascular) report and Caygill was quite firm that this should not be within the Department, but it should be given to the Heart Foundation to implement. It was nested in the Heart Foundation and is still going ... the funding was seen as more secure if it was given to an outside organisation” (Laugesen interview, 1996).

For the 1988-89 year, \$700,000 went to Heartbeat NZ (AJHR 1989, E.10, p.21).

Local government: As examples of the reach of smokefree ideas into the community, the Hutt Valley Energy Board and the Hutt County Council banned smoking from meetings (*Evening Post* 16.8.85; 26.3.86). The Wellington Education Board banned smoking by school bus drivers (*The Dominion*, 15.8.85).

However, at the Hospital Board level, there were smokers on Boards who were still resisting both the request from the State Services Commission of 1971, and the Hospital Boards Association recommendation of 1978, for non-smoking policies. There were two smokers on the Wairarapa Hospital Board. The level of knowledge and thinking is shown by the reported comment of one Board member, the Mayor of Featherston:

“... that when a friend of his stopped smoking, he had more chest trouble than before and his doctor advised him to start smoking again” (*Evening Post*, 30.6.86, p.3).

From the report, it appeared that Returned Services Association visitors were still bringing cigarettes to patients, and that many hospital employees smoked while at work. The medical superintendent for the Wairarapa Board was reported as being concerned that a smoking ban might attract court cases. An article in late 1985 referred to recent moves by hospital boards on tobacco, and noted that:

“more than half of the New Zealand public hospitals now have no tobacco sold on their premises” (Morris 1985¹⁰⁰, p.8).

Media: Some examples of media opinion in this period included:

1985 – The *Dominion* editorialised that:

“smoking infringes twice as many rights as nonsmoking”, but had reservations about legislative bans. It also stated “The rights of companies to sell dangerous substances are rights of a very low order indeed. There is an overwhelming case for banning cigarette company sponsorship of sporting activities...” (25.6.85, p.10).

Television Telethon participants were asked not to smoke on camera, but the producer (a smoker):

¹⁰⁰ Morris L. A hundred year in the health business. *New Zealand Hospital* 1985; Nov./Dec: 5-16.

“said that the proposal was a qualified one. The organisers could not make hard and fast rules” (*NZ Herald* 27.6.86).

1986 – The Wanganui Chronicle said that the banning of all tobacco advertising in New Zealand was long overdue (29.7.86, p.6). However, these editorials appear to have been the exception, with most newspapers avoiding the issue.

Industry and business:

December 1988 – The Tobacco Institute of NZ published *Environmental Tobacco Smoke: A review of the literature* (Reinken 1990¹⁰¹, p.1).

A number of firms moved to smokefree policies, including the United Building Society (Hutchinson 1989, p.69).

5.5 Discussion

The increased rate of change: The speed-up of events in New Zealand can be ascribed to a range of factors which include:

- The rise in NGO activity, and in particular, the activity of ASH.
- The creation in the DoH of, first a specialist tobacco position, and then the Health Promotion Policy Group.
- The rapidly changing climate of social attitudes to smoking.
- New research information, particularly on passive smoking risks, and
- The Labour Government of 1984-90.

Rise of NGO activity: The development of ASH, an organisation focused entirely on tobacco control activities with full-time staff, provided professional lobbying and a focus for the coordination of NGO tobacco related activity. It also provided a change of style, to constant and vigorous advocacy. The period marks the emergence of the professional medical bodies into the tobacco politics arena. The importance at this stage of ASH is commented on by Murray Laugesen:

“... The main thing about ASH is that it took the route of advocacy rather than education. ... It realised that if we were going to take the education way, it would take another 40 years. ... They created an awareness in the media ...” (interview 1996).

DoH developments: Key developments included the appointment of a doctor (with skills in public health) for tobacco policy, and the formation of a specialist health promotion group, which enabled a concentration on tobacco control policy. The development by the Department of new techniques for New Zealand in health education and promotion was also significant.

¹⁰¹ Reinken J. *Through the Smokescreen: A critique of 'Environmental Tobacco Smoke: A review of the literature' by the Tobacco Institute of New Zealand*. Wellington: Department of Health, 1990.

“The Great New Zealand Smokefree week was quite important in helping smokers to understand that they were offending non-smokers by smoking, and non-smokers to understand that smokers had problems” (Laugesen interview, 1996).

By 1988 the DoH had much of the information, and the policy formation process in place for major new measures such as smokefree workplaces and advertisement bans. It was ready and waiting for a minister and government who would set the new policies in place.

The Labour government: The progress by the Department during 1984-88 was to a large degree made possible by supportive Ministers of Health. Some new funds were authorised, such as the \$300,000 for the 1986 National Smokefree week. Successive ministers profited by the increasing public support for tobacco control measures. The government, inadvertently or not, also made large health gains by having the political will to make big tobacco tax increases.

Social attitudes: An article in February 1989 in *Management* highlights some of the changes within the 1982-88 period:

“Less than a decade ago the idea of a smokefree working environment was distinctly remote. ... Smokers dominated the workplace with often flagrant disregard for others ... This, however, has changed within the space of only two or three years. ... Signs proclaiming smokefree zones have become commonplace in offices, factories, restaurants, and public buildings, and awareness of the health hazards of smoking has made it the second-most important health issue next to AIDS” (Hutchinson 1989, p.65).

However, the distance that even the DoH and the public health professional staff had to travel within the period can be seen in the comment:

(By 1984) “the Health Department had a rule that there was to be no smoking in meetings but lots of people used to smoke. About that time, Ken Newell, who was the Professor of Public Health at Wellington and was a chain smoker ... tended to smoke in meetings” (Laugesen interview, 1996).

New information: The release of information on the dangers of passive smoking appears to have changed much of the philosophical and political climate for tobacco control in New Zealand. The information provided a much stronger basis for non-smokers rights, and shifted the rationale for control to the protection of others such as non-smokers and children. It also reiterated in a new way the hazards of smoking. A fairly immediate result was the increased awareness within the medical community, leading to greater action on such matters as smokefree hospitals and some smokefree medical waiting rooms.

Missed opportunities: Except for the work of Hay and Foster, relatively little use was made of the census data on smoking. There were few efforts in this period to undertake detailed analyses of the relationship between smoking behaviour and age, sex, ethnicity, income, socio-economic status and occupation. The level of spatial

analysis was limited and few links were developed with other subsequent surveys. For example, the clustering of high smoking rates in the central North Island found subsequently in the 1981 Census data (Wilson and Clements 1996¹⁰²) may be associated with a similar pattern for mortality from diseases of the respiratory system described in a New Zealand mortality atlas (Borman and Leitaua 1984¹⁰³). Furthermore, a cancer mortality atlas covering the period 1974-1978 found particularly high rates for lung cancer in males in parts of the central North Island and Northland (Borman 1982¹⁰⁴).

Role of the Big Kill: By determining the numbers of deaths and “hospital beds filled unnecessarily” at the local level, this publication may have assisted in the campaign to tighten legal controls on smoking (M Laugesen, personal communication, March 1996). In addition, the calculation of deaths and hospitalisations per electorate was considered to be particularly helpful in the political aspects of this campaign (i.e., these data were used by some Members of Parliament). This type of publication on the impact of tobacco has been described as being part of the evidence that contributed to tobacco control legislation being adopted in New Zealand (Beaglehole 1991).

5.6 Summary

The moral and political basis of the smoking conflict moved appreciably with the new evidence on passive smoking. There was also a noticeable increase in the pace and scope of events within government and NGOs. The ACSH and TSB recommendations on tobacco advertising, and the DoH discussion paper on smokefree workplaces signalled that the health bureaucracy was preparing for major changes. The implementation of a smokefree policy at the DoH gave valuable experience.

¹⁰² Wilson N, Clements M. *Spatial analysis of smoking data in New Zealand* (Unpublished report). Wellington: Ministry of Health, 1996.

¹⁰³ Borman B, Leitaua S. *A General Mortality Atlas of New Zealand. Special Report 71*. Wellington: National Health Statistics Centre, 1984.

¹⁰⁴ Borman B. *A Cancer Mortality Atlas of New Zealand. Special Report 63*. Wellington: National Health Statistics Centre, 1982.

6. THE PREPARATION AND PASSING OF THE SMOKE-FREE ENVIRONMENTS (SFE) ACT (1989 TO 1990)

“ROTHMANS SHORTENS YOUR INNINGS!”(Banner towed by a plane over the final one day cricket match at Eden Park in early 1990.)

(*NZ Cricket*, April, 1990)

6.1 Introduction

This section covers the diversity of research information, and NGO, DoH, industry, and political activity that lead up to the passing of the Act. In particular it covers the Toxic Substances Board 1989 report, some of the lobbying activities, and discusses the factors that led to the successful passing of the Bill.

6.2 The international scene

A study of Australian smokers found that a workplace smoking ban reduced the smoking rate of heavy smokers by over 25% (Borland 1990¹⁰⁵).

1990 – The US Congress passed a smoking ban on domestic flights (Arno 1996, p.1259).

In April 1990, just before the introduction to parliament of the SFE Act, the Minister of Health, Helen Clark, gave an address to the World Conference on Tobacco and Health in Perth (Beaglehole 1991, p.178).

6.3 Research in New Zealand

The Toxic Substances Board Report: The research published between 1984 and 1988 on tobacco advertising was integrated and comprehensively discussed in the report by the Toxic Substances Board (1989). This report also involved research based on 14 econometric studies and it found that “advertising tends to increase tobacco consumption and market size, and not just market share” (p36). Stringent criteria were used to select the studies reviewed to maximise the validity of the analysis. Ideally, a meta-analysis could have been used, as has since been done by others.

The report also published information on tobacco advertising revenues of major New Zealand publications for 1988 and undertook a detailed study on the relationship between government tobacco promotion policies and tobacco consumption trends (TSB 1989). This study obtained data from 33 countries for the period 1976 to 1986. It found that the greater a government’s degree of control over tobacco promotion, the greater the annual average fall in tobacco use in adults and young people.

Particular advertising research information given in the report included :

¹⁰⁵ Borland R, Chapman S, Owen N, et al. Effects of workplace bans on cigarette consumption. *Am J Public Health* 1990; 80: 178-80.

- The ratio of 32 to 1 between cigarette ads and smoking /health articles in three weekly magazines during the 14 years from 1973 (p.51).
- The ratio of 43 to 1 between the expenditure on cigarette advertising and anti-smoking advertising between 1979 and 1988 (p.xxii).

Passive smoking: The first study to estimate the health impact of passive smoking in New Zealand was published in 1989. It estimated that the inhalation of environmental tobacco smoke (ETS) at work was responsible for 145 deaths per year in the 1980s in New Zealand (Kawachi et al 1989¹⁰⁶). Additional survey work identified that half of all adults are exposed to ETS on weekdays and weekends (DoS/DoH 1992).

Social class gradients: Trends in smoking as a cardiovascular risk factor in Auckland were examined (Jackson et al 1990¹⁰⁷). This work showed quite marked variation in smoking prevalence by socioeconomic status, and the social class gradient for men and women over age 54 years appeared to increase between 1982 and 1987.

Other: Data from the Dunedin Multidisciplinary Health and Developmental Study was published on smoking prevalence in children and adolescents (Stanton et al 1989¹⁰⁸).

Survey data also showed that two-thirds of teenage smokers aged 10 to 15 years were sold cigarettes by shops (DoS/DoH 1992).

The DoH published a review of a Tobacco Institute article on environmental smoke literature (Reinken 1990). The review showed the article was very selective, incomplete, and with poor quality sources that and mainly referred to unrefereed work.

The impact of smoking sickness absence from work in New Zealand was described by Batenburg and Reinken (1990¹⁰⁹).

6.4 The developments in New Zealand

6.4.1 The context of the actions

A little of the atmosphere of the period is captured in a 1990 article:

“The Stanley Street tennis courts in Auckland looked like a Benson and Hedges packet during the international tournament in January, which was the sponsoring tobacco company’s aim. ...”

¹⁰⁶ Kawachi I, Pearce NE, Jackson RT. Deaths from lung cancer and ischaemic heart disease due to passive smoking in New Zealand. *NZ Med J* 1989; 102: 337-40.

¹⁰⁷ Jackson R, Beaglehole R, Yee RL, et al. Trends in cardiovascular risk factors in Auckland, 1982 to 1987. *NZ Med J* 1990; 103: 363-5.

¹⁰⁸ Stanton WR, Silva PA, Oei TPS. Prevalence of smoking in a Dunedin sample followed from age 9 to 15 years. *NZ Med J* 1989; 102: 637-9.

¹⁰⁹ Batenburg M, Reinken JA. The relationship between sickness absence from work and pattern of cigarette smoking. *NZ Med J* 1990; 103: 11-3.

and again:

“The advertising for the New Zealand Grand Prix at Pukekohe in January looked as much like a Peter Jackson commercial, complete with raunchy jingle, as it did a promotion for the motor racing, which was doubtless the intention” (D. McLauchlan 1990¹¹⁰, p.41).

and by Hansard (recording John Banks, v.507, 1990, p.3753):

“The government will have an army of leather-vested, jackbooted officials sniffing out tobacco smells around the country...Little tin gods from the Department of Health will be going around the country in hobnail boots ...”

In November 1989, Rothmans was recruiting students to give free cigarettes out. It was reported as saying that it would only use students over 25 (Audiomonitor Ltd, transcript of TV3 News at Six, 29.11.89).

6.4.2 The build up to the SFE Act:

NGO activity 1989: In February 1989 the Coalition Against Tobacco Advertising and Promotion (CATAP) was formed, and become one of the biggest NZ health coalition groups ever (Carr-Gregg 1993, p.37-38S). CATAP in time contained 240 organisations from a wide spectrum (Carr-Gregg 1990a¹¹¹, p.5). The idea of the Coalition was partly from Canada – where there had been a purpose built coalition for the passing of their tobacco legislation (Carr-Gregg 1993, p.37S). Michael Carr-Gregg was employed as the coordinator.

At the same time ASH continued its role as the “radicals” of the anti-smoking movement. By 1990 they would have an annual budget of about \$140,000 (D. McLauchlan 1990, p.42), a fraction of the bigger players, but no longer a shoe-string scale operation.

The Coalition was based in Wellington and was set up to present research based information supporting stronger tobacco control legislation. It got seriously into the lobbying business, as publicist Helen Glasgow remembered:

“The groups that the coalition were interested in communicating with were politicians, the sporting groups who were lobbying to have sponsorship continued, the newspaper publishers association, and the general print media groups who were also quite vocal in support of the continued tobacco print advertising. Also groups like TVNZ, who were also very supportive of the tobacco industry, because a lot of their sports telecasts were actually funded from the tobacco industry, and they could see all this money going out of the

¹¹⁰ McLauchlan D. Behind the smokescreen. *North and South* 1990; March: 39-51.

¹¹¹ Carr-Gregg M. *A final report on the passage of the Smoke Free Environments Bill*. Unpublished report, Coalition Against Tobacco Advertising and Promotion, 1990.

window, and then the general public, and the general media working through the media to get to the general public”

Overseas speakers were also imported:

“We had Dr Nigel Gray from Victoria (Australia), in 1989, and quite a big meeting at the National Library, with a lot of media coverage, because we were looking at the Victorian model, where they had already done this (anti smoking legislation). Nigel was the director of the Anti-Cancer Council of Victoria, and had been very influential in getting the similar legislation passed there. That legislation had set up funded tobacco replacement sponsorship, through Vic Health, which was promoted as a model New Zealand could follow.

Also in 1989, Garfield Mahood, of the Non-smokers Rights Association from Canada toured, speaking about the Canadian legislation. He got a lot of media coverage, got on television and so on, and basically said “*you can do this, its OK, the sky won't fall on you*” (if you end tobacco advertising)” (Glasgow interview, 1996).

Government: Helen Clark was appointed as Minister of Health in February 1989.

“One of the first things she did, she took a trip to Canada and Europe, about April and when she was in Canada, she met with the officials from Health and Welfare, and people I think also from the Non-Smokers Rights Association of Canada, and they told her that there were votes in controlling tobacco” (Laugesen interview, 1996).

March 1989 – Helen Clark launched a national Smokefree media campaign, which included:

“a rap song, television, radio and cinema advertisements, and sponsorship of a netball team” (AJHR 1989, E.10, p.20).

May 1989 – The Toxic Substances Board’s report *Health or Tobacco* was published (TSB 1989).

“The TSB report was launched by Helen Clark at the Wellington Medical School, on world smokefree day, we had to get the smokers cleared out of the foyer to hold the meeting. So we had to get the Dean’s say so, to get the space cleared. I think it was the afternoon before that the Coalition to end Tobacco Advertising and Promotion had been launched with great fanfare in town” (Laugesen interview, 1996).

July 1989 – The Tobacco Institute published a review of the TSB report (Tobacco Institute 1989¹¹²).

¹¹² Tobacco Institute of NZ. *Independent Scientific Review of the Toxic Substances Board report* May 1989. Auckland, Tobacco Institute of NZ, 1989.

August 1989 – Smokefree NZ was formed to push for smokefree workplaces – with a Wellington lobbyist employed (Beaglehole 1991, pp.177-8).

“The Smokefree NZ lobbyist was Kevin Hackwell – but it never grabbed the media attention as much as the advertising issue. The smokefree issue was always more popular, it never had any problem getting public support, the ratings were very high on public opinion polls” (Laugesen interview, 1996).

December 1989 – Announcement of the first New Zealand health goals, with tobacco control the first priority. A Cabinet decision to ban tobacco advertisements was announced (Beaglehole 1991, p.178).

In the health goals, specific targets for tobacco control were set, e.g., for the percent of adults smoking by the year 2000 being reduced to 15% (referred to in PHC 1994b). The context of the announcement included the start of the (tobacco sponsored) summer sports season, and the imminent arrival of a (partly tobacco sponsored) around the world yacht race (Beaglehole 1991, p.180).

A Treasury report of December 1989 stated that: “At around \$6 million, the tobacco industry’s portion of the total (sports and cultural sponsorship) is less than 10%” (D. McLauchlan 1990, p.40). At the same time Treasury was reported to have stated:

“Measures to lower consumption (of tobacco) are argued to be beneficial, but in fact may lower welfare for many smokers. This is because many people gain pleasure from smoking” (D. McLauchlan 1990, p.50).

January 1990 – The Smoke-Free Environments draft bill was leaked, with publicity of a proposal for fines for workplace smoking, which was later dropped (Beaglehole 1991, p.180).

During this time the political temperature around the proposed Act was increasing sharply.

“We didn’t know for sure that Helen would get the Bill onto the legislative timetable in time, but she was by this time Deputy Prime Minister, and that was very important because she had so much political status and clout. Our perception was that she was quite important politically, and that Geoffrey Palmer, who was then Prime Minister would go along with it. He was certainly willing to do that for her. But it was also important that Caygill had been a Minister of Health, because he was Minister of Finance, another very senior, high status person. Also Michael Bassett, another senior government member, had been a previous Minister of Health.

Even given Helen Clark’s great clout, and commitment, it was still an amazingly hard political thing, because there were lots of bad publicity at this stage (in early 1990). I think the industry was doing a bit of road show, so there was a need for the cavalry. So we engaged a firm of public relations type people called Network, and we set up, partly at their suggestion, a much stronger set of relationships with smokefree people in the districts, and we

called them smokefree coordinators. Gradually the good news started happening, for example World Health smokefree day, media events, ensuring that enough Cabinet ministers were happy enough with our proposal to support its introduction to the House” (Delany interview, 1996).

Just before the Bill was introduced, there may have been a moment of high risk, when the Labour Caucus made their final decision. As Carr-Gregg saw it:

“The afternoon papers were awash with speculation that the government was going to kill the Bill. An ad was hastily put together and members (of the Coalition) went to work persuading MP’s to support the Bill (Carr-Gregg 1990, p.9).

In early April, Helen Clark commented on the Benson and Hedges fashion awards taking place in Wellington. The *Dominion*, relatively sympathetic to the smokefree movement, editorialised that:

“Health Minister Helen Clark is being a pedant when she rails against the Benson and Hedges fashion awards ... Political judgement and timing are not amongst this Government’s strengths. The awards were a glittering occasion, enjoyed ... by a massive (TV) audience. Ms Clark’s attack will have left a sour taste. ... the Government has chosen a devious and politically inept approach to the problem. It is devious because in trying to get at tobacco companies, the Government has chosen to penalise sports and fashion enthusiasts. It is inept because big events like the fashion show, cricket matches and motor racing are hugely popular”.

The industry counter-attack: The tobacco industry had been organising a lobby group called “*New Zealanders for the Right to Decide*”, fronted by former national soccer coach John Adshead. According to a *North and South* magazine article of March 1990, the group was actually run by a public relations firm, Burston-Marsteller, who had run a similar ploy in Canada, and was paid for by the industry (D. McLauchlan 1990, pp.40,47). An offshoot of their campaign in 1990 was the full page advertising from the “*Sports People for Freedom in Sport*” (Carr-Gregg 1993, p.36S), another front, run by Andy Haden’s public relations agency.

More seriously, most of the major team sport groups endorsed the statement:

“Government should not interfere in sports bodies seeking sponsorship from the manufacturers of legal products” (*Wanganui Chronicle* 14.4.86, p.9).

The groups included the Rugby Union, Rugby League, Softball Association, Cricket Council, Basketball Federation, Motorsport Association, and the horse racing groups. The Assembly for Sports, claiming 90 sports with 1.3 million athletes, argued that the existing voluntary code of practice for sponsorship was sufficient.

Rothmans brought a case against the government, on the basis that the voluntary agreement was still in place (*Evening Post*, 4.4.90). The opposition justice

spokesperson, Paul East, would find it “constitutionally offensive” that the legislation was introduced while legal proceedings were pending (Hansard v.507, 1990, p.1648).

NGOs 1990: To counter the support for the industry by sports groups, the Coalition supported the formation of a group called “Athletes For Tobacco-free Sport” headed by Gary Moller. That group were able to get the support of three-quarters of the 1990 New Zealand Commonwealth Games team for the Bill (Carr-Gregg 1990a, p.14).

The Coalition had also been in the front line of the discussion:

“We talked directly to (print, TV, radio) sports journalists, who on the whole were pretty hostile to our efforts, and very supportive of the tobacco industry, probably because there were benefits to them (from the tobacco sponsorship of sport), and they had had a long association working with the tobacco people.

There was vigorous debate of the issues via the media. When talking to tobacco related interest groups, in quite a lot of cases there was a reasonable amount of aggression from the other side. (Michael Carr-Gregg was the main front person) but I do remember attending a meeting of the Sports Assembly where there were about 50 or 60 people present, where a number of people got up and presented the tobacco sponsorship view in very strong terms, and quite aggressively. I remember one particular man from the Softball Association being a particularly aggressive antagonist at that meeting, and in releases to the media. Then six years later at the launch of the Health Sponsorship Council’s sponsorship of softball this year, there he was saying very nice things about the Health Sponsorship Council. It was quite ironical to see him getting along quite well with the health people now.

The proposed end to sports sponsorship and print advertising involved big, big dollars. Sports were getting big dollars from the industry, the newspapers were propping up their advertising with print ads from the tobacco industry, the magazines were getting good amounts of print ads, and television were getting dollars to support programmes, so we’re talking about plain self-interest and money” (Glasgow interview, 1996).

The media and tobacco: In 1990 the Auckland journalist’s club, The Fourth Estate, accepted \$30,000 from Rothmans. A club official, Warren Hastings, was reported as saying that:

“... the money has no strings attached, and does not leave the press industry open to criticism about its ability to remain unbiased on smoking issues”
(*Sunday Star* 1.4.90, p.A3).

Michael Horton, of *NZ Herald* publishers Wilson and Horton, was reported as opposing the proposed advertising ban, arguing on the grounds that if a product was legal to sell, it was legal to advertise. At the same forum, Michael Robson, managing director of Independent Newspapers Ltd, said:

“ ... we are seeing a product that is legal to sell totally banned from the advertising arena. It is the first step on the road to censorship and, in the interests of social engineering, New Zealanders are giving up an important freedom” (*Evening Post*, 4.4.90).

In 1988, the tobacco advertising revenues for 10 of the major New Zealand newspapers and magazines totaled \$2.7 million. Of this the *NZ Herald* got \$976,000, and the *NZ Listener* received \$402,000 (TSB 1989, p.52).

6.4.3 Passing the SFE Act (May-August 1990)

May 1990 – The SFE Bill was introduced to Parliament and to the select committee. The opposition health speaker, Don McKinnon, stated that sponsorship was a fundamental right, and that:

“A National government would repeal any legal ban on sponsorship as long as the product sponsored can be sold legally in New Zealand” (Hansard v.507 1990, p.1640-1).

The committee hearings were long and marked by emotion.

“There were a large number of select committee meetings, and a large number of overseas people brought in on both sides of the argument, and frequently there were meetings in the evenings. The committee was chaired by Judy Keall and she was criticised heavily by the industry for not being neutral. But it is very difficult to keep the thing neutral ... this particular issue of all issues it is very difficult for people to stay neutral” (Laugesen interview, 1996).

The other members of the committee for this Bill were Jenny Kirk and Russell Marshall (Labour); Don McKinnon, and Katherine O'Regan (National) with Jim Gerrard (National) attending apparently as a substitute for another National committee member. They were empowered to meet during sittings of Parliament, i.e. during debates in the main chamber (AJHR, Vol.VII, 1990, I.13, p.2). During the reporting back of the committee, the opposition described the running of the committee as unfair, disgraceful, and “gross and offensive” (Jim Gerrard and Merv Wellington, Hansard v.507, 1990, pp.3235, 3236).

A total of 5057 submissions were received by the committee, with 87% in favour of the Bill (Beaglehole 1991, p.178). Of these 1371 were form letters, 3462 shorter personal letters, and 524 were more substantive, including 150 from health professional groups. The committee heard 85 oral submissions (Hansard v.507, 1990, p.3228).

Judy Keall reported that many of the submissions called for plain packaging of tobacco, but said that:

“The committee, while impressed with the research on the issue, did not feel that such a change was feasible at this time” (p.3229).

August 1990 – The Bill was reported back to parliament, and its final reading was two weeks before the end of the parliamentary session (Beaglehole 1991, p.178).

The Act: The Smoke-free Environments Act 1990:

- Stopped print media advertising.
- Restricted shop advertising.
- Phased out sports and event tobacco sponsorship, and created a Health Sponsorship Council to provide smokefree sponsorship.
- Required employers to have a written policy on smoking.
- Prohibited smoking in buses, domestic aircraft, lifts, multi-person offices, and the public section of any workplace.

The Act did *not* require non-office areas to be smokefree. The Health Sponsorship Council (HSC) was formed and it began sponsoring its first events in late 1990.

Other events:

1989 – Tobacco taxation was linked with the consumer price index.

1990 – The Ministry of Women’s Affairs published a policy discussion paper on smoking (MWA 1990¹¹³).

Health promotion activities: Anti-smoking education continued with a television campaign in 1990 and other mass media campaigns (1989-90). The “Great Smokefree Workplace Week” was stated to have involved 800 businesses, and many schools took part in “World Smokefree Day” events (AJHR 1990-91 V.II, E.10, p.10).

The Health Sponsorship Council was set up under the new act passed in August 1990, and:

“They put on their first sponsorship, which was the cycle race from Wellington to Auckland on the Saturday before, or the Saturday of the election of 1990. Ken Gray was the (first) Chairman of the HSC and he got them into action pretty fast” (Laugesen interview, 1996).

¹¹³ Ministry of Women’s Affairs. *Women and Smoking. Policy Discussion Paper No. 2.* Wellington: Ministry of Women’s Affairs, 1990.

6.5 Discussion

In retrospect, there was a marked concentration of events and influences in 1988-1990, e.g., the DoH smokefree workplace discussion paper, the formation of Heartbeat NZ and CATAP, the TSB report, and the intense political activity around the SFE Bill.

6.5.1 The factors in the successful passing of the SFE Bill

Beaglehole (1991, p.179) lists the major factors as:

- international scientific evidence,
- DoH co-ordination, information, and energy,
- NGO lobbying, and
- a committed Minister of Health.

Michael Carr-Gregg (1990, p.2-3) attributed the factors of success in 1990 to most importantly:

- The weight of research evidence.
- The commitment by, and pressure on the government from Helen Clark.
- The influence and resolve of the Labour health caucus, led by Judy Keall.
- The focused and effective health lobby.

Other factors mentioned by him include the support of Health Department officials, some key newspapers, and public support. In his 1993 article (p.335), he specifically singled out the 1989 TSB report as being crucial to the passing of the Bill.

Another view of the factors for the campaign's success has been seen as:

“International examples of successful legislation, and very committed lobby people, in particular the Cancer Society, Heart Foundation and ASH, who had been in there a long time. Heart and Cancer had recommended banning tobacco advertising about 20 years ago.

The lobbies were essential, Murray (Laugesen the principal medical officer on tobacco from 1984) was essential. It would never have happened without Murray, that was an absolute certainty, and I don't think it would have happened without Helen Clark” (Delany interview, 1996).

The role of the TSB report: This report was a major achievement in providing high quality information to counter tobacco industry claims, summarising a wide range of relevant research (Carr-Gregg 1993, p.36S). The report managed to combine the roles of information and health advocacy. There was a mixture of input from DoH officials, and from other health professionals and researchers who provided information to the Board.

Concern about passive smoking: This development appears to have fundamentally expanded the tobacco debate in the developed world. It is considered to have moved

the ethical justification for smoking control policies from paternalism by the State towards both individual rights and “common good” ideas.

International: The enacting of anti-smoking laws in two Australian states, and in Canada the year before helped set the scene, both in providing models, and in showing the political possibilities. The TSB 1989 report led the back cover text with the words:

“In 1988, Canada banned the promotion and advertising of tobacco products. Should New Zealand follow Canada’s lead?”

NGO efforts:

At the beginning of 1989, the anti-tobacco lobby could be described as fragmented and uncoordinated, with a gap between ASH and the older, more cautious organisations. Until then there appears to have been no clear agreed set of goals. Many of the groups were centred on helping disease casualties rather than achieving political solutions (Carr-Gregg 1993, p.37S).

The period was a culmination of the shift of the voluntary and professional health groups towards political action. The NGOs were able to minimise their fear of losing business and community support, and overcome their “illness-based” stances. This was helped by the formation of the Coalition Against Tobacco Advertising and Promotion, which initially grouped all the main health groups, and many service organisations. From that base another 150 odd groups were recruited.

Within the Coalition, the more radical role of ASH allowed the other health groups to move into overt politics, yet still appear as moderates (Carr-Gregg 1993, p.38S). The groups were able to keep a strong pressure on the political process by very active lobbying, were able to focus widespread public concern, and helped in the public information process (Beaglehole 1991, p.179). They mobilised a large public support for the Bill, and provided a mass of expert evidence for select committee hearings, publicity and lobbying. While the tobacco industry produced a range of international “experts” to support its position, the health sector was able to counter this with its own international “super-experts” (Kill 1995¹¹⁴).

DoH efforts: The long term efforts of the Department, particularly of the Health Promotion Group, appear to have been crucial. They supplied workable policy options and authoritative information to the politicians, media and others, and kept strong and productive links to the NGOs (Beaglehole 1991, p.179). (See also section 8.6 on techniques used by health officials). In the short-term, the Department was able to mount a large promotion effort during 1990 to supply information in support of the Bill.

The Minister of Health: The appointment of Helen Clark as Minister of Health in February 1989 appears to have been critical to achieving the SFE Act. This was particularly so in (a) ensuring that the Act got on to and remained on the legislative timetable, (b) in making sure that the provisions were not diluted in cabinet, cabinet

¹¹⁴ Kill B. What civil servants can do to get tobacco legislation passed. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995.

committee or caucus, and (c) in forcing it through before the 1990 election. She has been quoted as saying that, in contrast to the MMP context now:

“It’s not like in 1989, when the health lobby got my ear on the smokefree legislation. I said, “Yep, I’m with you” and I sort of bulldozed aside the most appalling obstacles to get legislation through Parliament. ...” (Hubbard 1996¹¹⁵).

She appeared to have a strong personal interest in tobacco control and a thorough understanding of the issues. Her husband, Peter Davis, was a medical sociologist at Auckland Medical School, and a long term member of ASH. She has noted that:

“there were many who said it was political suicide to promote it (the SFE Act) in election year and certainly the tobacco industry spent millions of dollars trying to make that the case! Of the many trying episodes of my political life, the battle over that Bill was one of the nastiest” (Clark 1994¹¹⁶).

Carr-Gregg (1993, p.36S) stated:

“For the first time the health lobby had a committed and influential Minister, with the courage and political will to ... push through tough anti-tobacco legislation. The Minister also enjoyed unprecedented support in the bureaucracy ...”

The Political Environment: The passing of the SFE legislation was particularly significant in that there wasn’t bipartisan political support for it. It was also achieved by an administration that was not in a strong position in terms of electoral support. The last 15 months of the Labour Government had a number of events and features which indicated internal instability, including two new prime ministers and the sacking and reinstatement of a cabinet minister. In the light of this, the passing of controversial legislation demonstrates a committed caucus, cabinet and/or minister. Within the cabinet, Peter Tapsell at least was reported to be pro-industry (D. McLauchlan 1990, p.48). According to Beaglehole (1991, p.179), Helen Clark had to overcome:

“objections within the Government Cabinet and Caucus”.

Another view was that:

“There was a big fight in caucus I believe, to get the ban on point of sale advertising – that was given a sunset clause of Jan 1995. Shopkeepers picketed Geoff Palmer’s electorate office in Christchurch.

On sponsorship the opinion polls were between 45-55%, no better, and it was decided to go ahead all the same. All it meant (the instability in the Labour Party) was that it was a race against time to get the legislation through before the election. But by this time Helen Clark had become deputy PM ... and so

¹¹⁵ Hubbard A. Helen tries to talk for the people. *Sunday Star-Times*, 29.9.96, p.A5.

¹¹⁶ Clark H. The battle of the Bill. *Asthma New Zealand* 1994; 4(June): 5.

the Bill had the full backing of the government from the time that they announced they were going to legislate”.

“The sports (sponsorship) thing was the Achilles heel of the whole process ... the major difficulty. Lorraine Moller and other Commonwealth athletes ... came down to Parliament and decked out Helen with their medals. So you had this division between track athletes and people who were in receipt of money, tobacco dollars” (Laugesen interview, 1996).

The Labour MP Jack Elder was reported as advocating in April 1990 a delay for the legislation, on the grounds that the proposals had caused “resentment and offence”. In the same article, the NZPA also reported that:

“some MPs are known to be concerned that the proposals are seen as interference in legitimate business transactions” (Rotorua *Daily Post*, 19.4.90).

Labour MP’s were reported as fearing:

“... a backlash because they believe smokers were more likely to be Labour voters. Others argue that the policy can be sold to the electorate on the basis that smokers use up scarce hospital beds ...” (NZ *Herald* 26.4.90¹¹⁷).

After the Labour Caucus agreed in May 1990 to introduce the Bill, it was reported that this was:

“... in spite of opposition from some MPs worried the anti-smoking drive could have an adverse effect electorally”

In the same article, Mike Moore was reported as having questioned parts of the anti-tobacco proposals (NZ *Herald* 4.5.90¹¹⁸). One Labour MP, Geoff Braybrooke, actually disagreed with parts of the Bill when it was introduced, and stated that:

“A ban in newspapers or magazines will not have the slightest effect on people who may become smokers or who do smoke (Hansard v.507, 1990, p.1651).

He stated both that all smokers know that smoking might be injurious, and that smokefree education would be better than banning tobacco advertisements. He described Rothmans, who have a factory within his electorate, as:

“...a company of the highest integrity ... The company is very good in meeting its social obligations to members of the public” (pp.1651-2).

¹¹⁷ Armstrong J. Smoking bill may be trimmed. *NZ Herald* 26.4.90.

¹¹⁸ Armstrong J. Threats see Clark security tightened. *NZ Herald* 4.5.90.

6.5.2 The value of the SFE Act

This piece of legislation may prove to be the most important single long term tobacco control activity achieved in New Zealand to date. Only now is the international evidence showing that restrictions to workplace smoking have an important effect on consumption. Indeed, smoking bans in the workplace can lead to falls in daily consumption of up to 25% (Borland et al 1990; Woodruff et al 1993¹¹⁹) and also to cessation (Longo et al 1996¹²⁰). One of the key aspects of this legislation is the empowering of non-smokers to defend *their* rights, and their success in enforcing the act in offices.

6.5.3 The opposition

The major forces mobilised by the core tobacco industry included the media, commissioned public relations firms, sportspeople and groups, commissioned researchers and experts, industry lobbyists, and industry workers and investors. Much of the media industry was concerned with the potential loss of advertising revenue and sponsored events.

6.5.4 Significant omissions from the Act

One notable omission from the Act as passed was the tying of at least part of the tobacco tax to health promotion. This may not have been supported by Cabinet (Beaglehole 1991, p.180).

Michael Basset and Treasury had apparently disagreed over a tied tax in 1986, when he was quoted as saying:

“This is an attractive idea – even though the principle of tied tax does not appeal to Treasury” (*Dominion* 9.4.86¹²¹).

A Treasury report of December 1989 stated that a tied tax:

“...would create an unfortunate precedent for new indirect taxes to be imposed selectively in order to meet demands for approval of additional spending initiatives” (D. McLauchlan 1990, p.20).

Another significant omission was the requirement for the plain packaging of cigarettes. Seen from within the Department, the situation was that:

“There was a paper to the TSB, and they approved the principle of plain packs in about April 89, but we did not feel we had the time or the energy at that

¹¹⁹ Woodruff TJ, Robbrook B, Pierce J, Glantz SA. Lower levels of cigarette consumption found in smoke-free workplaces in California. *Arch Intern Med* 1993; 153: 1485-93.

¹²⁰ Longo DR, Brownson RC, Johnson JC, et al. Hospital smoking bans and employee smoking behaviour. *JAMA* 1996; 275: 1252-7.

¹²¹ *The Dominion*. Cigarette tax wins favour. 9.4.86.

point to get that properly straightened out (as the industry had raised trademark and other problems) and there was no international precedent. So we felt we had enough on our plate” (Laugesen interview, 1996).

6.5.5 The parliamentary debates

From a reading of Hansard, the debates appear to have been marked by opposition speakers with a limited grasp of the issues. They agreed that smoking was unhealthy, but showed little comprehension of the scale of its impact on health, or the effort needed for successful tobacco control.

The Deputy Leader of the Opposition, and opposition health spokesperson, Don McKinnon, described the Bill as giving a message of intellectual dishonesty and academic arrogance. The National Party speakers attempted to argue that education was more appropriate to control smoking (e.g. Hansard v.507, 1990, pp.1645, 1650, 1654), *but* that advertising and promotion was not a factor in smoking (pp.1639-41). They argued that a product should be banned if it could not be legally promoted (p.1641), that the Bill was an assault on freedoms (p.1644), anti-employer and anti-worker (p.1645), and that it might destroy jobs (p.3237).

Don McKinnon claimed that if tobacco advertising were banned, then intellectual honesty would require vehicles to not be capable of being driven at over 100 km per hour (Hansard 1990, p.1639). McKinnon and Katherine O’Regan both argued that as marijuana didn’t need legal advertising, banning tobacco advertising might *increase* tobacco smoking (pp. 1639, 1645).

The opposition also targeted the officials behind the Act. Bill Birch stated:

“The Minister (of Health) has got it all wrong because she has been captured by an overenthusiastic group from within her Department” (p.1650).

John Banks was a little more direct:

“The Minister and her Government cronies have been hoodwinked by a few departmental officials. I say to those officials that in 9 weeks and 2 days the grin will come off their faces. They had better start looking for other jobs, because the kind of advice they have been giving to the Government will not be acceptable to the next Government” (p.3753).

The National Party opposition appears to have been a reversal of their stand in the parliamentary Labour Select Committee. That committee unanimously agreed with a 1989 petition for legislated smokefree workplaces (Graham Kelly, Hansard v.507, 1990, p.1649).

6.6 Summary

The Smoke-free Environments Act was passed in 1990, after considerable political and industry opposition, and as the result of several years of policy and research

work, lobbying, and public hearings. It banned nearly all advertising of New Zealand origin, tobacco promotion, and some workplace smoking. It also created the Health Sponsorship Council to replace tobacco sponsorship and promote smokefree lifestyles. Significant omissions from the Act include tied health funding from tobacco levies, and factory smoking bans.

7. GOVERNMENT INERTIA AND TINKERING (1991 TO 1996)

7.1 Introduction

This section covers over 40 items of research published in the period, traces the activities of the Health Research Council, and other developments including the 1991 and proposed 1995 amendments to the SFE Act.

7.2 The international scene

7.2.1 Events

A major feature of international tobacco control in the 1990s has been the development of legal action against the tobacco industry. In the US particularly, there has been legal action initiated by States, private class actions, and personal injury lawsuits. To date, this has resulted in one company, in March 1996, agreeing to pay seven US states a percentage of its pretax income for the recovery of health care Medicaid costs in treating tobacco-caused diseases (Chapman 1996¹²², p.99). Supporting these developments have been various acts of “whistleblowing” and “leaks” from the industry. The leaks have covered the US tobacco industry’s knowledge of and tactics relating to health issues. Furthermore, the US Food and Drug Administration has taken a number of steps towards regulating tobacco as a “drug delivery device”.

Other relatively new strategies include greater emphasis on monitoring tobacco sales to minors and then prosecuting any sellers (Jason et al 1991¹²³; Chapman et al 1994¹²⁴).

¹²² Chapman S. Tobacco control. *BMJ* 1996; 313: 97-100.

¹²³ Jason LA, Ji PY, Anes MD, et al. Active enforcement of cigarette control laws in the prevention of cigarette sales to minors. *JAMA* 1991; 266: 3159-61.

¹²⁴ Chapman S, King M, Markham P, Woodward S. Effects of publicity and warning letters on illegal cigarette sales to minors following purchase attempts by 12-17 year old children. *Aust J Public Health* 1994; 18: 39-42.

Some of the more notable events in the US:

- 1993 – Smoking banned in the White House (Davis 1994¹²⁵, p.889).
- March 1994 – Phillip Morris sue ABC (TV) regarding the nicotine “spiking” report. In the second half of 1994, TV news coverage of tobacco in the US dropped to a quarter of the previous rate. ABC apologised in August 1995 (Arno 1996, p.1260-61).
- April 1995 – US Government proposal to ban workplace smoking.
- August 1995 – President Clinton announced the FDA proposal to regulate tobacco as a drug, the first time a US president has made a full-scale statement on tobacco (Davis 1996¹²⁶, p.1281).
- 1995 – Professor Stanton Glantz has National Cancer Institute research funds cut off by the US Congress, after helping publicise the Brown and Williamson papers (Arno 1996, p.1261).
- February 1996 – CBS TV broadcast an interview with Jeffrey Wigand – former tobacco executive, with allegations of research by Brown and Williamson showing nicotine addiction (Davis 1996, p.1283).

1990-92 – In Australia legislation was introduced in Western Australia and the Australian Capital Territory to prohibit nearly all tobacco advertising. The Federal Tobacco Advertising Prohibition Act of 1992 was passed to ban most forms of tobacco advertising. An Australian Federal test case produced a 1991 judgement of “compelling evidence that cigarette smoking causes lung cancer in non-smokers” (Palmer 1994, p.224-6).

7.2.2 Research

Two meta-analyses provide strong evidence that nicotine replacement therapy increases smoking cessation rates (Silagy et al 1994¹²⁷; Fiore et al 1994¹²⁸).

There was some evidence from several other developed nations that the decline in adult smoking has stalled (Chapman 1996, p.98). This evidence led to a debate on a shift in emphasis to harm reduction (an approach that is widely accepted in other areas of drug control).

¹²⁵ Davis RM. Slowing the march of the Marlboro man [Editorial]. *BMJ* 1994; 309: 889-90.

¹²⁶ Davis R. The ledger of tobacco control. *JAMA* 1996; 275: 1281-84.

¹²⁷ Silagy C, Mant D, Fowler G, Lodge M. Meta-analysis on efficacy of nicotine replacement therapies in smoking cessation. *Lancet* 1994; 343: 139-42.

¹²⁸ Fiore MC, Smith SS, Jorenby DE, Baker TB. The effectiveness of the nicotine patch for smoking cessation. A meta analysis. *JAMA* 1994; 271: 1940-7.

The tobacco industry continued to cast doubt on the link between passive smoking and health (Davey Smith and Phillips 1996¹²⁹).

The evidence for the adverse impact of smoking on health grew extensively during this time period. One key report documented mortality from smoking in developed countries (Peto et al 1994¹³⁰). Another reported on the 40-year follow-up of male British doctors and found that the original work had underestimated the hazards of long-term tobacco use (Doll et al 1994¹³¹).

A study in the US found that 83% of US Senators and 68% of US representatives received a total of \$US2.4 million from the tobacco industry in 1991 and 1992 (Arno 1996, p.1261).

Two studies of workplace smoking bans found higher quit rates over five years (Longo et al 1996), and lower smoking prevalence and lower consumption (Woodruff 1993).

7.3 Research in New Zealand

7.3.1 Smoking prevalence and distribution

The 1992-1993 Household Health Survey found that of people aged 15 years and over, 23% smoked regularly (SNZ/MoH 1993¹³²). Somewhat higher figures were reported in a survey conducted for the Public Health Commission in 1993, reported in *Our Health Our Future 1994* (p.41).

The socio-economic gradient for smoking prevalence (i.e., higher smoking prevalence by lower socio-economic groups) was considered to be one of the factors that may have accounted for the increase in the social class gradient for coronary mortality in New Zealand men from 1975-1977 to 1985-1987 (Kawachi et al 1991¹³³).

More work was published on the Dunedin cohort study of children and adolescents (Stanton 1995¹³⁴). This study has explored smoking behaviour at a very detailed level – including information about vulnerability to smoking, nicotine dependence and efforts to quit. The smoking in this cohort from between 1960 and 1993 was also

¹²⁹ Davey Smith G, Phillips AN. Passive Smoking and health: should we believe Philip Morris's "experts"? *BMJ* 1996; 313: 929-33.

¹³⁰ Peto R, Lopez A, Boreham J, et al. *Mortality from smoking in developed countries 1950-2000*. Oxford: Oxford University Press, 1994.

¹³¹ Doll R, Peto R, Wheatley K, et al. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994; 309: 901-11.

¹³² Statistics New Zealand and Ministry of Health. *A Picture of Health*. Wellington: Statistics New Zealand and Ministry of Health, 1993.

¹³³ Kawachi I, Marshall S, Pearce N. Social class inequalities in the decline of coronary heart disease among New Zealand men, 1975-1977 to 1985-1987. *Int J Epidemiol* 1991; 20: 393-8.

¹³⁴ Stanton WR. The Dunedin study of childhood and adolescent smoking. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995.

reviewed, with the conclusion that there had been significant declines (McGee et al 1995¹³⁵).

Smoking in a small rural community (Wairoa county) was investigated again (Shaw et al 1991¹³⁶).

Innovative analysis of previous smoking data was published (i.e., data from the 1976 and 1981 Censuses (Easton 1995¹³⁷). Such work highlighted the lack of use of this original data that were collected over a decade before. Consideration was given to including a smoking question again in the 1996 Census (SNZ 1993¹³⁸, p.94-5). As a result of strong submissions from the health sector, two linked questions on smoking were included in the 1996 Census.

Spatial analysis techniques were used to examine the relationship between smoking in Christchurch women and income (Nelson et al 1995¹³⁹). This particular study also examined trends in smoking prevalence across different income groups. It recommended that smokefree intervention programmes need to be targeted specifically at low income groups.

7.3.2 Smoking in Maori and Pacific Islands people

The 1992-1993 Household Health Survey found that 54% of Maori aged 15 years and over smoked regularly (SNZ/MoH 1993). In particular, 57% of Maori women over 15 smoke, and 68% of pregnant Maori women. The average smoking prevalence for Maori for the period 1990-95 was 52% (Laugesen 1996a, p.4). The tax-driven New Zealand tobacco consumption drop of 1984-92 appears to have occurred less for Maori, who have to some extent turned to smoking the cheaper “roll-your-owns” (Glover, 1995¹⁴⁰).

A prevalence study of smoking in fourth-form school children focused on cultural factors as the ones of central importance in determining smoking (i.e., peer and social pressures) (Ford et al 1995¹⁴¹). This study noted that while Pacific Islands people have very similar measures of socioeconomic status to Maori, these groups are culturally distinct and have different smoking rates.

¹³⁵ McGee R, Williams S, Stanton W. Smoking among New Zealand adolescents 1960-93. *NZ Med J* 1995; 108: 85-7.

¹³⁶ Shaw RA, Crane J, O'Donnell TV. The changes in smoking habits in a rural adolescent population, 1975-89. *NZ Med J* 1991; 104: 40-3.

¹³⁷ Easton B. Smoking in New Zealand: a census investigation. *Aust J Public Health* 1995; 19: 125-9.

¹³⁸ Statistics New Zealand. *1996 Census of Population and Dwellings: Preliminary views on content*. Wellington: Statistics New Zealand, 1993.

¹³⁹ Nelson KP, Ford RP, Wild CJ. Women in low income groups smoke more: Canterbury 1976-92. *NZ Med J* 1995; 108: 148-50.

¹⁴⁰ Glover M. Mobilising an indigenous population: Reducing Maori smoking. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995. pp.907-9.

¹⁴¹ Ford DJ, Scragg R, Weir J, Gaiser J. A national survey of cigarette smoking in fourth-form school children in New Zealand. *NZ Med J* 1995; 108: 454-7.

A qualitative study into Maori women's attitudes to and experience with tobacco was undertaken (Broughton et al 1993¹⁴²).

In 1993, the international comparison data on cancer showed that the lung cancer incidence rates in Maori men and women are the highest recorded in the world for men and women respectively (IARC 1993¹⁴³).

An article on reducing smoking by Maori was published (Glover 1995). In 1996 a survey of smoking among Maori was conducted by the Te Ropu Rangahau Hauora a Eru Pomare, at the Wellington School of Medicine (Rankine 1996¹⁴⁴).

The importance of smoking as a major health issue for Pacific Islands people was identified in an Auckland study (Bell et al 1994 cited in PHC 1994c¹⁴⁵). However, there is still little detailed prevalence data for this population, given the sample sizes of surveys commissioned by the Ministry of Health during the 1990s.

7.3.3 Smoking in pregnancy

A study conducted in 1991 found that one third of mothers had smoked during pregnancy (Alison et al 1993¹⁴⁶). For Maori mothers and single mothers the rates were 68% and 65% respectively. These results were similar to those from an earlier and smaller study (Mitchell et al 1991¹⁴⁷).

A regional study examined the patterns of smoking during pregnancy in Canterbury (Ford et al 1993¹⁴⁸). Others studies examined the adverse sequelae of smoking during pregnancy and maternal smoking (Robertson et al 1993¹⁴⁹; McGee and Stanton 1994¹⁵⁰).

Another study of smoking and pregnant women was published in 1996 (Tappin et al 1996¹⁵¹). It identified a wide range in smoking in pregnancy by area (from 11% to

¹⁴² Broughton J, Lawrence M. *Nga Wahine Maori Me Te Kai Paipa: Maori women and smoking*. Dunedin: Department of Preventive and Social Medicine, University of Otago, 1993.

¹⁴³ International Agency for Research on Cancer. *Cancer Incidence in Five Continents*. 6th ed. Lyon: IARC, 1993.

¹⁴⁴ Rankine J. Surveying Maori Smokers. *PHA News Insert (HRC Research News)* 1996; 5(1): 3.
¹⁴⁵ Public Health Commission. *The Health of Pacific Islands People in New Zealand*. Wellington: Public Health Commission, 1994.

¹⁴⁶ Alison LH, Counsell AM, Geddis DC et al. First report from the Plunket National Child Health Study: Smoking during pregnancy of a New Zealand cohort. *Paediatr Perinat Epidemiol* 1993; 7: 318-33.

¹⁴⁷ Mitchell E, Scragg R, Stewart AW et al. Results from the first year of the New Zealand cot death study. *NZ Med J* 1991; 104: 71-6.

¹⁴⁸ Ford RP, Wild CJ, Glen M, et al. Patterns of smoking during pregnancy in Canterbury. *NZ Med J* 1993; 106: 426-9.

¹⁴⁹ Robertson J, Pattemore PK, Ford RP. The effect of maternal smoking on admission to hospital in infancy. *NZ Med J* 1993; 106: 476-7.

¹⁵⁰ McGee R, Stanton WR. Smoking in pregnancy and child development to age 9 years. *J Paediatr Child Health* 1994; 30: 263-8.

¹⁵¹ Tappin DM, Ford RPK, Nelson KP, et al. Prevalence of smoking in early pregnancy by census area: measured by anonymous cotinine testing of residual antenatal blood samples. *NZ Med J* 1996; 109: 101-3.

57%). Geographical clustering of high smoking rates in pregnancy were identified, as were associations with socioeconomic indices such as average income.

7.3.4 Passive smoking

An investigation into possible respiratory effects of emissions from a fertiliser plant in Christchurch highlighted spatial variation in passive smoking exposure in New Zealand (Wilkie et al 1995¹⁵²). The exposure of children to passive smoking was 44% in the industrial suburb of Hornby compared with 29% for the rest of Christchurch. The full range for passive smoking exposure for “clusters of children” throughout Christchurch was 11-55%.

Survey work commissioned by the DoH identified a one-third reduction in the proportion of New Zealand workers exposed to ETS during actual working hours between 1989 and 1991. This reduction has been considered likely to be associated with the publicity and workplace smoking policies that are required by law (i.e. the Smoke-free Environments Act 1990) (PHC 1994b, p.13).

A report for the DoH evaluated the effect of the Smoke-free Environments Act (Brander 1992¹⁵³). It found that 60% of workplaces had complied with the requirement to have a policy on smoking, with a further 30% claiming smoke-free environments even without a written policy. The report concluded that the Act was effective in reducing workplace smoking, particularly in offices, and in moving much of smoking during work time to outside of enclosed workplaces.

A study on the relationship between respiratory symptoms and environmental factors (in the Bay of Plenty) identified that night cough and nasal symptoms were more common in school students exposed to smoking in the home (Moyes et al 1995¹⁵⁴).

Sudden Infant Death Syndrome (SIDS): A large number of studies in New Zealand have found that tobacco exposure is a major modifiable risk factor for SIDS (cot death) (e.g., Mitchell et al 1992¹⁵⁵).

7.3.5 The cost of smoking

The cost of tobacco use to publicly funded personal health care in New Zealand was estimated at \$202 million dollars (1992 dollars for the 1987 year)(Phillips et al 1992). This analysis excluded the costs of passive smoking. Nevertheless, the economic costs of tobacco use to society are thought to far exceed the health care costs to government. The annual measurable cost to New Zealand, based on Australian

¹⁵² Wilkie AT, Ford RP, Pattermore P, et al. Prevalence of childhood asthma symptoms in an industrial suburb of Christchurch. *NZ Med J* 1995; 108: 188-90.

¹⁵³ Brander P. *Evaluation of the smoke-free environments legislation affecting workplaces*. Wellington: Department of Health, 1992.

¹⁵⁴ Moyes CD, Waldon J, Ramadas D, et al. Respiratory symptoms and environmental factors in schoolchildren in the Bay of Plenty. *NZ Med J* 1995; 108: 358-61.

¹⁵⁵ Mitchell EA, Taylor BJ, Ford RPK et al. Four modifiable and other major risk factors for cot death: the New Zealand study. *J Paediatr Child Health* 1992; 28(Suppl 1): S3-8.

figures, is \$1.9 thousand million (PHC 1994b, p.35). This may be a major underestimate. The equivalent estimate in 1990 for overall tobacco-caused health and mortality costs in the US is \$67,958 thousand million (US Office of Technology Assessment, in Chollat-Traquet 1996¹⁵⁶, p.57) or US\$2.59 per pack of cigarettes. Brian Easton has calculated the tangible and intangible costs of tobacco for New Zealand in 1990 as \$20.5 thousand million (Easton 1996¹⁵⁷, p.4).

7.3.6 Tobacco advertising

Two brief reviews of the New Zealand experience with tobacco advertising have been published (Weir 1995a¹⁵⁸; Weir 1995b¹⁵⁹). These argued that in the early 1990s there was still extensive tobacco advertising in retail outlets and sponsorship advertising in all media including television.

A study was conducted on how newspaper advertising of “downmarket” cigarette brands in New Zealand was associated with increased total cigarette sales (Laugesen and Meads 1991¹⁶⁰).

7.3.7 Sales to minors

Survey data in 1991 confirmed previous findings that two-thirds of teenage smokers aged 10 to 15 years said that they were sold cigarettes by shops (NRB 1991 cited in PHC 1994b).

7.3.8 Education in schools

A survey of fourth form school children in Wellington in 1993 identified that only 48% said they had received education at school about smoking and health (McGee 1993¹⁶¹).

7.3.9 Policy development

A number of articles examined policy development issues in a major publication on tobacco control. These included a review of the impact of tobacco policies on

¹⁵⁶ Chollat-Traquet C. *Evaluating tobacco control activities*. Geneva: World Health Organization, 1996.

¹⁵⁷ Easton B. *The social costs of tobacco use and alcohol misuse: Report prepared for the Alcohol Advisory Council of New Zealand, the Health Research Council, and the Public Health Commission*. Wellington: Economic and Social Trust on New Zealand, 1996.

¹⁵⁸ Weir J. Tobacco Advertising: The NZ experience. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995.

¹⁵⁹ Weir J. Tobacco Advertising: The New Zealand experience. *Tobacco Control* 1995; 4: 90-1.

¹⁶⁰ Laugesen M, Meads C. Advertising, price, income and publicity effects on weekly cigarette sales in New Zealand supermarkets. *Brit J Addict* 1991; 86: 83-9.

¹⁶¹ McGee R. Smoking among New Zealand adolescents: 1960s to 1990s. *Proceedings of the Conference on Kicking the Adolescent Habit*, 1993; Wellington. Wellington: Cancer Society of New Zealand, 1993.

consumption (Laugesen 1995d¹⁶²), and the experience of civil servants in getting tobacco legislation passed (Kill 1995).

7.3.10 Other

A review of New Zealand's monitoring system for tobacco control for the period 1984 to 1992 was undertaken (Laugesen 1995c). Monitoring data on tobacco was published by the Departments of Statistics and Health (DoS/DoH 1992).

7.4 The developments in New Zealand

7.4.1 Activity by the Health Sponsorship Council

The Health Sponsorship Council (HSC) provided sponsorship services which were bought by the Central Regional Health Authority on behalf of all the RHAs (with funds provided under Vote: Health. The HSC expanded during this period, and in 1992 it sponsored more than 250 organisations or events (PHC 1994b¹⁶³, p.23). These included some national level sports and arts events. In 1994, the HSC spent around \$4 million on "smokefree" sponsorships of sport and arts (e.g., netball, rally driving, rugby league, school rock concerts) (PHC 1995b). This compares as follows to the reported \$7.5 million tobacco sponsorship in 1992, the estimated \$202 million in direct costs from tobacco to health services, and \$1.9 thousand million in total measurable costs in 1992 (Phillips et al 1992, p.241; PHC 1994b, p.10,35), and the \$584 million of tobacco excise tax in 1994-95 (PHC 1995a, p.4).

7.4.2 The 1991-93 amendments to the SFE Act

The new National government wanted to amend the SFE Act, and a first amendment was passed to allow tobacco sponsorship of international events, such as yachts in the Whitbread round-the-world race (Hay 1993, p.316). The government made a number of attempts at drafting amendments to repeal the whole sponsorship section, and:

"...they got it into select committee, and then they started having less and less frequent meetings, fewer and fewer meetings, and spun it out for a year and a half. Because the more they heard submissions the more obvious it was that they were going against very solid advice from the community. So that's what happened. It got stalled in committee for a year and a half, until the time came that they had to do something, because the Act said that sponsorship was going to be banned from 1st July 1993 So come early 1993, they got an all-party consensus that the sponsorship ban would be postponed for another 2 years." (Laugesen interview, 1996).

¹⁶² Laugesen M. The impact of tobacco policies on trends in tobacco consumption. In: Slama K (ed). *Tobacco and Health*. New York: Plenum Press, 1995.

¹⁶³ Public Health Commission. *Progress on Health Outcome Targets*. Wellington: Public Health Commission, 1995.

For this move, there was a “conscience” vote in Parliament, rather than on strict party lines (Hay 1993, p.319).

7.4.3 Health promotion

In 1992 the Cancer Society and the DoH produced teaching aids for tobacco education in schools, and in 1994 these two organisations produced a booklet on Smokefree Schools. In 1995 the PHC bought some “Smokefree” radio advertising in conjunction with the Cancer Society (PHC 1995b).

The public health units of Crown health enterprises were also engaged in smokefree promotion programmes (PHC 1995b). Various other public health programmes such as the one attempting to reduce SIDS also had a “smokefree” component.

In August 1996, the Ministry of Health began a multimedia smoking reduction campaign (MoH 1996¹⁶⁴). This was designed to reduce the uptake of smoking amongst young people, especially Maori and women.

Another development of relevance to Maori was a series of nationwide hui aimed at reducing smoking in Maori women, especially those that were pregnant. Te Hotu Manawa was contracted for 1994-97 to develop Maori smokefree initiatives, networks and a media plan (PHC 1995b, p.82).

Between 1991 and 1995, there were no major mass media anti-smoking campaigns (PHC 1995b, p.120).

7.4.4 Nicotine replacement therapy

Further advances in nicotine replacement therapy took place during this period, particularly with the nicotine patch. This product was considered to have wider acceptability than nicotine gum.

7.4.5 Industry initiatives continue

In 1992, the tobacco industry introduced new varieties of cigarette tobacco (menthol and mild varieties) (PHC 1994b). The industry also exploited loopholes in the SFE Act by producing new advertisements under the guise of these being “price-notices” (Weir 1995b). This has allowed for relatively extensive advertising of tobacco products to continue. Television programmes and cinema from overseas broadcast in New Zealand continue to show smoking by role models or in actual advertisements (e.g., in sporting events).

1995 – The US-based Trademark Association came out in support of the NZ tobacco industry (*Independent* 9.6.95).

¹⁶⁴ Ministry of Health. Smoking reduction campaign commences in August. *Prescriber Update* 1996; (12): 26.

The ban on tobacco product advertising in shops came into effect in December 1994 and the sponsorship of tobacco products ceased in 1995.

7.4.6 NGO Activity

1993 The Cancer Society launched a campaign that was repeated each February of the following two years (*Be Smart Don't Start*). This was supported by the Health Sponsorship Council and had a focus on Maori and young women (MWA 1990).

1993 – A conference on “Kicking the Adolescent Habit” was organised by the Cancer Society of New Zealand (CSNZ 1993¹⁶⁵).

1994 – The first prosecution against cigarette sales to those under 16 years of age was made (with the action being taken by ASH). ASH subsequently criticised the Ministry of Health for turning the case into a “fiasco” because of inadequate legal work (*NZ Herald* 16.2.95).

1995 – Two prominent Maori become patrons of ASH (Mason Durie from Massey University's Maori Studies Department and Areta Koopu, president of the Maori Women's Welfare League (*Dominion* 11.4.95). In the same year, however, the Speaker of the House, Hon Peter Tapsell criticised the anti-tobacco lobby. In turn his comments were criticised by the Maori Smokefree Trust (*NZ Herald* 6.7.95).

1995 – Initial plans for legal action against tobacco companies began by a group of people with smoking-related illnesses (*NZ Herald* 6.3.95). ASH supported this move.

1995 – The publication of a survey of NZ fourth form students (see section 7.3.2), was an example of NGO supported research.

1995 – A new lobby organisation of twenty groups was formed i.e., – the Smokefree Coalition. It was created specifically to influence the amendments to the Smoke-free Environments Act introduced to Parliament in October 1995.

1996 – The Cancer Society launched *The Big Kill Continues*¹⁶⁶ and a joint publication with the Ministry of Health on tobacco statistics (Laugesen 1996a). There was extensive television, radio and print media coverage of this work.

7.4.7 The Public Health Commission

Sandra Coney has written that in August 1993, National party cabinet minister Murray McCully found that the PHC's work was countering his intentions for alcohol and tobacco taxes. She reported that McCully wrote to his colleague Maurice Williamson and asked that the Commission be abolished, describing the PHC as:

¹⁶⁵ Cancer Society of New Zealand. *Kicking the adolescent habit*. Wellington: Cancer Society of New Zealand, 1993.

¹⁶⁶ Laugesen M. *The big kill continues*. Wellington: Cancer Society of New Zealand, 1996.

“... a bunch of cretins calling themselves the Public Health Commission”
“...pointed headed wasters”, “...play things for social engineers” (Coney 1994).

In 1994, the Public Health Commission (PHC) published data on tobacco use and its associated problems in publications on the state of the public health in 1993¹⁶⁷ and 1994¹⁶⁸. Also in 1994, it presented its advice on tobacco control to the Minister of Health (PHC 1994b). This document included the following objective:

“To reduce tobacco use, exposure to environmental tobacco smoke, and their adverse health consequences.”

In addition, recommendations were made for health status in relation to tobacco, risk reduction factors (with eight targets specified for the year 2000), public health policy, public health programmes, and surveillance. Progress towards meeting targets was reported on in 1994 (PHC 1994a) and then again in 1995 in a specific report on progress towards health outcome targets (PHC 1995b¹⁶⁹).

In 1994, the PHC contracted with Te Hotu Manawa Maori for a three year national Smokefree co-ordination service (PHC 1995c¹⁷⁰). This included the development, monitoring and evaluation of a national smokefree networking structure. The PHC also bought services from The Smokefree Trust for the establishment of regional rangatahi smokefree councils and to develop and promote rangatahi smokefree resources (PHC 1995b).

1995 – The PHC released a discussion document on the need for tobacco taxes to be substantially increased. One of the proposals was for a tobacco tax tied to the purchase of on-going and comprehensive media and local community programmes to reduce smoking (PHC 1995a).

June – 1995 – The PHC was disbanded with some of the staff moving to the Public Health Group of the Ministry of Health.

7.4.8 The 1994-96 proposed Amendments to the SFE Act

In response to the PHC recommendations, in 1994 the Government announced that it intended to amend the SFE Act and Regulations 1990, to make it more difficult for young people to take up smoking. This proposal also built on some of the recommendations arising from the 1994 Youth Summit on Tobacco and Health

¹⁶⁷ Public Health Commission. *Our Health, Our Future: The state of the public health in New Zealand*. Wellington: Public Health Commission, 1993.

¹⁶⁸ Public Health Commission. *Our Health, Our Future: The state of the public health in New Zealand*. Wellington: Public Health Commission, 1994.

¹⁶⁹ Public Health Commission. *Progress on Health Outcome Targets*. Wellington: Public Health Commission, 1995.

¹⁷⁰ Public Health Commission. *He Matariki: A Strategic Plan for Maori Public Health: The Public Health Commission's Advice to the Minister of Health*. Wellington: Public Health Commission, 1995.

organised by the Cancer Society. The proposed amendments covered the following (MoH 1995¹⁷¹):

- Raising the age for purchase of tobacco products to 18 years (up from 16).
- Banning the sale of single cigarettes.
- Restricting the size of packets to make it difficult for young people to obtain cigarettes.
- Restrictions on price notice “advertising”.
- Strengthening of health warnings on cigarette packets.
- Further restrictions on cigarette vending machines.

In March 1995, a discussion paper was released by the Ministry on the proposed amendments to the SFE Act (MoH 1995¹⁷²). It attracted 133 submissions (Barwick 1995¹⁷³). A large majority of submissions were in favour of the proposed amendments.

The Ministry commissioned a report on the key issues underpinning the proposed amendments (Barwick et al 1995¹⁷⁴).

There was significant NGO activity in response to the proposed amendments with the Smokefree Coalition being established at the end of 1995. The Coalition produced a widely circulated publication entitled “The (not very) Smoke-free Environments Amendment Bill” (Smokefree Coalition 1995¹⁷⁵).

The Bill was introduced to Parliament in October 1995, but did not get through before the end of the 1996 parliamentary term, and the election. This is in contrast to the passing of the SFE Act in 1990, where that Bill was introduced in May, and passed in August.

The 1995 select committee hearings appear to have been different in style from those in 1990:

“The (1995) select committee was extremely interested in the issues, addressed them seriously, and when they brought the Bill back to the House, it was considerably strengthened on the original Bill, and on many of the clauses there was complete (bipartisan) support. There was a very distinct difference in the attitude of the select committee from when we attended the hearings in 1990, where I can remember members of the select committee getting up and walking out, making sarcastic remarks, sitting there looking bored, and not really seriously addressing the whole issue, whereas with the select committee

¹⁷¹ Support shown for smokefree proposals. *Health Magazine*; 1995 6(July): 20.

¹⁷² Ministry of Health. *Proposed amendments to the smoke-free legislation - 1995*. Wellington:Ministry of Health, 1995.

¹⁷³ Barwick H. *An analysis of the submissions on proposed amendments to the smoke-free legislation - 1995*. Wellington: Ministry of Health, 1995.

¹⁷⁴ Barwick H, Berghan P, Burns J, Walzl T. *Smoke-free Issues: An analysis of key issues underpinning proposed amendments to the smoke-free environments legislation*. Wellington: 1995.

¹⁷⁵ Smokefree Coalition. *The (not very) Smoke-free Environments Amendment Bill 1995*. Auckland: Smokefree Coalition, 1995.

last year I attended hearings in Wellington and Auckland, and I thought that they were really addressing the issue seriously” (Glasgow interview, 1996).

7.4.9 Ministry of Health

The dilemma of the Ministry for at least part of the period is shown by the exchanges before the 1994 budget. Staff at the Ministry were reported as being unable to comment in case they upset associate-minister of health Maurice Williamson, who was in charge of tobacco issues. Williamson said that tobacco taxes were a matter for the finance ministry. The finance ministry said it was a health ministry matter (M. McLauchlan 1994, p.108).

Another account reports that a Ministry spokesperson said that:

“We would prefer to leave generic packaging until we know what has been decided in Canada. They are still debating the matter, and the tobacco industry is arguing it” (Patterson 1995¹⁷⁶, *The Dominion* 12.9.95, p.7).

In 1996 the Ministry released part one of the National Drug Policy “Tobacco and Alcohol” (MoH 1996¹⁷⁷). This document was in stark contrast to the work done previously by the PHC, in that it was extremely brief and did not appear to build on the vast research base that exists (i.e., it had no references). Of particular note was the focus on harm minimisation (applied to both alcohol and tobacco) and that there was no mention of one of the most powerful tobacco control measures – tobacco taxation.

7.4.10 Action by Local Health Authorities

1993 – Healthlink South took a successful prosecution against a retailer under the SFE Act for erecting a new tobacco advertisement (Thompson 1994).

1995 – Local media started reporting on moves by health authorities to undertake surveillance of tobacco retail advertising (for example in the Hutt Valley (*Western News* 17.2.95)).

7.4.11 Action by Local Authorities

1995 – The Porirua City Council made it a requirement of groups seeking Council funding (e.g., sports groups) to have a policy on smoking (*The Dominion*, 9.2.95).

7.5 Discussion

¹⁷⁶ Patterson C. Battling the tobacco demon. *The Dominion*, 12.9.95, p.7.

¹⁷⁷ Ministry of Health. *National Drug Policy, Part 1: Tobacco and alcohol*. Wellington: Ministry of Health, 1996.

Trends in tobacco consumption: The effects of the changes of 1984-1990 continued to show up in this period. By 1992 the proportion of 15 to 24 year olds who smoked had dropped to 30% compared to 38% in 1984 (PHC 1994b). This could be partly related to the tobacco tax increases that were instituted during this time period, as between 1986 and 1991 the real price of tobacco doubled (Laugesen 1995c, p.170). The decline in tobacco consumption per adult in the 1960-90 period was the fastest in the 24 OECD (Organisation for Economic Co-operation on Development) countries. Indeed, by 1992 New Zealand had the lowest tobacco consumption per adult in the OECD.

The role of the PHC: The PHC published a range of high quality information and advice during this time period. The demise of the PHC (that was operationally effective in mid-1995) was a blow for tobacco control. This was especially so since the PHC was focusing on the need for increases in tobacco excise tax:

“... tobacco excise taxation is the most effective policy instrument used by governments for discouraging the consumption of tobacco products” (PHC 1994b, p.17). “Collection of excise is efficient. Consumer responsiveness to the costliness of tobacco products has been exceptionally high since 1989, with marked gains in health” (p.35).

The role of the Department/Ministry of Health: The Ministry appears to have done relatively little on tobacco control during this period – partly because of the expanded role of the PHC. The organisational changes (along with the disestablishment of the PHC) also led to the loss of some of the personnel with the most experience in tobacco control from the central health bureaucracy.

The role of the NGOs: The establishment of a new Smokefree Coalition appears to have helped to strengthen the 1995 Bill on amendments to the SFE Act, as shown by the revisions when it was reported back from the parliamentary committee.

Role of educational strategies: The value of these activities is not entirely clear in the New Zealand or the international setting. A meta-analysis on smoking prevention programmes suggested the results are somewhat disappointing (Rooney and Murray 1996¹⁷⁸). Nevertheless, education messages may improve the environment for allowing legislative controls to be adopted.

The role of the Government: Generally the 1990-1996 National Government did not appear to be particularly sympathetic to major tobacco control initiatives. This may have been partly due to the inherent conservatism of this administration but also to its stronger association with the business sector. That is, the development of stronger controls on tobacco could have given politically adverse signals to other industries that produce products that can adversely effect public health (eg, the alcohol industry).

Whatever the mix of reasons, the amendments to the SFE that were initially proposed in 1995 were rather weak tobacco control measures. The Minister did, however,

¹⁷⁸ Rooney BL, Murray DM. A meta-analysis of smoking prevention programs after adjustment for errors in the unit of analysis. *Health Educ Q* 1996; 23: 48-64.

support further funding for the Health Sponsorship Council to cover a motor rally and fashion parade. There was a Ministerial exemption for rugby league tobacco sponsorship. In the view of Sir David Hay this:

“illustrates how readily some politicians are prepared to sacrifice health principles for expediency and votes” (Hay 1995¹⁷⁹, p.19).

The fact that the tobacco industry supported raising the age of legal purchase of tobacco products suggested that such a move did not pass the “litmus test” of relevancy (Chapman 1996, p.97). That is, “if the industry opposes a tobacco control initiative, this is diagnostic of a policy that promises to bite hard into tobacco sales”.

The changing role and style of parliamentary select committees in health matters:

“There are three things that are different this time (1995-6) compared to (the legislative process in) 1990. One is that the select committee process has been smartened up considerably. The chairmanship is tighter, more efficient ... the whole process is more efficient. Secondly, we are trying to improve a law, instead of design a new one that hadn't been there before.

The emphasis is now on evidence based lobbying. Before 1990, it was largely emotional, the issues were so emotional, you were either for or against it ... the audience was the whole general public of New Zealand. Now, in the Parliamentary committee the audience is more specialist, and the evidence has to be more factual. This time it was the Coalition that put forward the most factual lobbying.

The third thing is that there is a change now to MMP, which will accentuate the power of the select committee, in fact in the new parliament there will be a Health select committee, just for health – it will be a more specialist committee, there will be a higher standard of evidence required” (Laugesen interview, 1996).

Active Monitoring and Prosecutions for sales to minors: This new strategy may be a worthwhile one, given that there is some limited international evidence that selling rates can fall after monitoring exercises (Jason et al 1991). Whether or not this leads to reduced tobacco use by minors is, however, still not clear.

7.6 Summary

In contrast to the 1984-90 period, tobacco control in New Zealand during 1991-96 seems to have been marked by what didn't happen, rather than by what did. The 1990 Act was not repealed in any major way, and the 1995 amendments were not passed. Tobacco policy advice from a semi-independent body, the Public Health Commission,

¹⁷⁹ Hay D. Tobacco or Health: Action plans for the late 1990s. *Patient Management* 1995; (July): 15-20.

flowered briefly and then was extinguished. Purchasing by the PHC, of work by health promotion and other providers, was over far too short a period to achieve the visible long term delivery of tobacco results desired.

Positive developments included the continued flow of tobacco related research, the continued funding and performance of the Health Sponsorship Council, and the revival of the Smokefree Coalition in 1995.

8. DISCUSSION OF THE HISTORY OF TOBACCO CONTROL IN NEW ZEALAND

“If selling cigarettes was murder, surely Government would outlaw it” Jim Burns, corporate affairs manager for Wills (*Evening Post* 8.10.94¹⁸⁰).

(The tobacco industry) *“corporate child molesters, disease mongers”* and modern-day equivalents of opium warlords (Chapman 1995¹⁸¹, p.48).

8.1 The overall trends

Government action, social pressure, and individual rights: Within this century, smoking control in New Zealand has moved from a period of low level, moral-based government intervention, through a time where little government action except taxation occurred, to the decades of increasing research-informed policy since the early 1960s. However, moral and social pressures have continued to be important, particularly as smoking moves to be characteristic of women, Maori, and low income groups.

Tobacco control in New Zealand this century has made some moves from the moral and/or paternalistic approach, towards one where particular tobacco control consumer groups are involved in policy creation and implementation. However, there is danger that:

“... successful campaigning by middle-class health workers amongst middle-class people may inhibit appropriate action being taken where the need is now greatest” (Hay 1993, p.319).

In other words, as smoking victims come increasingly from less influential groups, those high-smoking groups may become further marginalised from real control of health policy and resources.

Ideology has been a policy influence in the wings. There has always been great tension in New Zealand between individualistic laissez-faire beliefs and the idea of community or government intervention for public health. In contrast to the relative disregard by government of poverty and inequality as risk factors for poor health, tobacco control has appeared to move against the individualistic tide of the last 12 years. While poverty was ignored in the 1989 DoH health goals, smoking was the number one priority. This may be partly due to the new passive smoking evidence since 1986 that provides much of the basis of the concern for non-smokers rights. It may also be much more difficult to show that the poverty and inequality in society impacts adversely on the lives, let alone on the rights, of those who are not poor.

¹⁸⁰ Dekker D. Ashes to ashes. Wellington, *Evening Post* 8.10.94:13-14.

¹⁸¹ Chapman S. Pecked to death by ducks. In: Slama K. ed. *Tobacco and health*. Plenum Press, 1995: 47-50.

There were, however, a number of other health measures that placed public health over individual rights in the last few decades including legal requirements for seat belts, motorcycle helmets, pedal cycle helmets, swimming pool fences and to some extent water supply fluoridation.

Research information: From the 1950s onwards, science based research has been one of the foundations on which New Zealand tobacco control action has taken place. Within New Zealand, the increasing flow of New Zealand-specific research (often building on international work) has bolstered control arguments.

Public acceptance: At the beginning of the 1962-1996 period, smoking was part of mainstream New Zealand life, at most levels, and in most places. The idea of a smokefree hotel public bar would have been almost a contradiction in terms. By the end of the period, smoking is automatically acceptable in a decreasing number of places. Indeed, the Hospitality Association was worried that tobacco smoke is putting people off bars and taverns (*The Dominion* 17.9.96).

The current attitude in New Zealand is now not so far from that which one American observer noted:

“By the 1990s the smoker was not only a foolish victim of his or her habit but also an obnoxious and uncivil source of danger, pollution, and illness to others.”(J. Gusfield quoted in Cook 1993¹⁸², p. 1750).

However, this attitude is that of blaming the nicotine-dependent victim and a more productive attitude may be to characterise the tobacco industry and its associated peripherals as the core problem. That is, this industry is the natural consequence of a market economy that lacks sufficient degree of regulation in this area. One of the market failures is an absence of information to consumers on the highly dependence producing characteristics of nicotine and the wide and complex array of adverse effects from tobacco consumption. Reducing this market failure would require further barriers on sales to minors and even better information to consumers. However, the adverse effects of tobacco are so complex and numerous (i.e., at least 25 different diseases) it is difficult to imagine how an adult can make a fully informed choice on the risks and benefits of using this product. There is also market failure due to such externalities as passive smoking related health damage, fire and litter costs.

Tobacco consumption per person and smoking prevalence: Consumption per person is the bottom line of “tobacco-or-health” work. Over the period from 1975 to 1995, the consumption of cigarette equivalents per person in New Zealand had fallen from over 3200 per year to 1426 (Laugesen 1996a, p.15). Between 1984 and 1991 there was a 42% decline per person (Laugesen 1995c, p.169). These figures give some optimism for the long term, and the latter figure indicates the effect of a proactive government policy.

Between 1976 and 1995, the prevalence of smoking by men fell from 40 to 27%, and by women from 32 to 26% (Laugesen 1996a, p.6).

¹⁸² Cook P. The matter of tobacco use [Book Review]. *Science* 1993: 262; 1750.

Age-specific and ethnic group-specific reductions in smoking prevalence: The prevalence of smoking for those aged 15-35 changed very little in the 1982 to 1994 period, with over 30% of this group still smoking (Laugesen 1995a, pp.18-19). Furthermore, smoking by Maori has changed less than that by Pakeha, and started from a much higher base. For Maori men aged 25-49, and Maori women of all ages, there was little change between 1981 and 1994-5. The main change has been in Maori men under 25 and over 50 (Laugesen 1996a, pp.6-7). Overall, the prevalence of smoking by Maori fell from 58% to 51% between 1976 and 1995 (p.4). Within that 1995 figure is the 68% of Maori women aged 35-40, and the 63% of Maori men aged 30-35, who still smoke (p.6).

The financial and mortality balance sheet: Over the 20 years 1975 – 1995, an estimated 10,000 deaths have been averted by decreased tobacco consumption, or 140,000 of years of life gained (at an average 14 years of life gained per person). The gross cost of government tobacco control, before considering tobacco tax or health service cost gains, was approximately \$42 million, or about \$300 per year of life. (Laugesen 1996a, p.20; Laugesen 1996b, personal communication). *However, as the rates of tobacco caused deaths have yet to fall in women and Maori, the gains in life at present are for non-Maori men as a group.*

Health and politics: Another major change over this century has been the gradual realisation by some in health NGOs and the health industry that long term and comprehensive solutions are often essentially political. In other words, that health solutions often depend on *who* has control of resources – money, people, information, and ideas. That:

“smoking is a political problem that needs a political solution” (Carr-Gregg 1993, p.37S).

Sometimes this realisation is shown in overt events, as with the run-up to the 1990 SFE Act. Virtually every health related group and part of the health industry took part in that campaign.

8.2 International context

Events in New Zealand have taken place in a world where a large stream of research information flows within the developed world, and some progress has been made in smoking reduction, but where other countries are increasingly and successfully targeted by multi-national tobacco companies (Davis 1994, p.889; 1996, p.1283). Evidence from the US, Europe, and elsewhere indicates that the industry uses heavyweight legal challenges, political payments, industry-friendly “research”, and the weight of their advertising revenue, on the stance of media (Davis 1996, pp.1282-3; Arno 1996, pp.1260-62; Davey Smith and Phillips 1996).

The tobacco industry in New Zealand is able to call on some of the political and other resources and expertise, of a worldwide industry with larger revenues than the New Zealand Government. That world industry needs to minimise any examples of successful anti-smoking activity in one country, in case the example and method is

spread. Except for China, the world tobacco trade is dominated by a small number of Anglo-American firms (Pollock 1996, p.175). They have a range of allies in the peripheral parts of the industry, such as Rupert Murdoch, who has a worldwide media empire while being a member of the board of Phillip Morris (Pollock 1996, p.188).

Industry challenges to tobacco control in New Zealand need to be seen in the context of a worldwide pattern of industry attempts to divert the resources of government and other anti-smoking bodies. Any delay in regulation or education, and any slowing of the decline in tobacco consumption, means profits that the industry would not otherwise make (Sweda 1996, p.191).

While some recent progress has been made in New Zealand, the question needs to be asked – why was New Zealand 17 years after Iceland in making a semi-total tobacco advertisement ban? Why 14 and 11 years respectively after Norway and Finland? If the answer lies in the nature of the political systems, in social attitudes, or other factors that anti-smoking strategies can take account of, we might be able to improve future strategies and policy making.

8.3 Major influences in New Zealand

The situation until the mid-1980s was summarised by Michael Carr-Gregg:

“Historically the tobacco industry was always able to win its battles. The health community lost out due to a combination of factors of varying importance: the raw magnitude of the industry; the high level of revenue collected by governments from tobacco products; tobacco industry financial contributions to political parties; the strength of the advertising industry, the close relationship between the media and the tobacco industry because of advertising revenues; politicians wanting friends in the media, not enemies, and finally the decision by many leading health and human service groups not to get involved” (Carr-Gregg 1990, p.2)

The positive features of the New Zealand health and tobacco environment have included:

- The lack of a strong indigenous tobacco growing industry and indeed its total demise by the 1990s.
- A health bureaucracy (particularly at the Department level) that at least for a time had individuals who were “product champions” of tobacco control, and a Department that during the late 1980s was able to assemble an effective policy team.
- A successful tobacco control dedicated NGO (ASH) and a number of other NGOs that could work successfully with the health bureaucracy and in coalitions with each other as required (particularly the Cancer Society and the National Heart Foundation).

- Politicians who for much of the 1980s were relatively accepting of the need for tobacco control and in particular, for a time, a Minister of Health who was highly supportive (Hon Helen Clark).

8.4 Differing strategic views

One view of the *overall* government tobacco control programme in New Zealand is that it does not appear to have had a clear strategic vision. While some individuals have been able to articulate strategies for periods or parts of the problem, government as a whole has not been able to provide a comprehensive and long term plan. ACSH provided a plan in 1985, but the government as a whole did not appear to grasp the overall vision. The PHC “Advice to the Minister” (PHC 1994b), has provided a start in the direction of a strategy, and the CRHA “Purchasing strategy for tobacco control” (Laugesen 1996c¹⁸³) has provided a partial follow-through. The critical view sees the need for a vision that would keep the New Zealand tobacco control focus on major issues such as taxation increases and not on relatively minor control adjustments (such as increasing the legal age for tobacco purchase from 16 to 18 years). This view is contrary to that expressed in the TSB report of 1989 (p.103) and elsewhere, which argued that effective tobacco control needs the parallel approaches of education, price rises, and promotion bans.

Another view sees tobacco as part of the wider problem of the class gradient of health, and the solutions as being partly in the empowerment of health consumers. Hay (1993, p.319) stated:

“Restricting the target to the issue of smoking is unlikely to succeed, nor will health promotion measures unless they are initiated by Maori health workers for Maori people”.

8.5 Continuing problems for tobacco control in New Zealand

These include a number of strategic and tactical problems:

Strategic problems:

- The low priority for the resourcing of government intervention on tobacco is part of the overall problem of the lack of priority for public health and preventative health investment. There appears to be a continued lack of sufficient multi-party political support to ensure that the thrust of tobacco control does not slow. The present base for public health funding is low. The budget percentage for public health depends on the definition of that category, but even with a wide definition, the 1992 amount for public health was only 3.2% of the total government health budget (McKendry 1993¹⁸⁴, pp.33-35).

¹⁸³ Laugesen M. Purchasing strategy for tobacco control. Wellington: Central Regional Health Authority, 1996c.

¹⁸⁴ McKendry C.G., Muthumala D. *Health expenditure trends in New Zealand 1980-1992*. Wellington: Ministry of Health, 1993.

“The percentage of Vote: Health spent on public health went down even when George Salmond was Director-General, during the 80s it went down until it is now about 1%. Even if that was increased by fivefold, that would still be only a twentieth of the health budget. So it’s not as though the public health people want to take over the world” (Laugesen interview, 1996).

- There is the long term problem of “soft” promotion, i.e. pro-smoking imagery in magazines, films and video.
- Tobacco promotion in offshore media also appears to present an ongoing and increasing problem, due in part to technological developments.
- There is a continuing major problem of a lack of resources for Maori to work on Maori smoking – a situation which has started to be addressed relatively late. *It is indicative of the scale of the issue of smoking by Maori, that the 1995 government target for the proportion of Maori women smoking during pregnancy by the year 2000, was 50% or less* (PHC 1995b, p.81).
- Any move to lower tobacco consumption must be made in the face of a New Zealand industry that had \$1.1 thousand million annual retail sales in 1991-92 (PHC 1994b, p.35). The core industry has allies in the public relations, distribution, and at least 12,000 retail areas (PHC 1994b, p.35), and in 1995, still employed 494 people in manufacturing (Statistics NZ 1996¹⁸⁵, p.437). That employment figure is, however, down from 1193 in 1975 (DoS 1975¹⁸⁶, p.462). It has long experience, and considerable expertise in lobbying government, producing “expert” evidence for its stance, withholding information, and evading voluntary and legal restrictions (Carr-Gregg 1993, p.37S; Weir 1995b; TSB 1989, p.31; Reinken 1990).

Possible tactical problems:

- There is a major difficulty for both those designing health policy and the politicians and advocates pushing for more effective options, in *getting control of tobacco tax decisions*. These taxes may be the most important tobacco control measure of all i.e., increasing taxation on tobacco products and/or nicotine and tar levels. The present New Zealand tobacco tax take is \$584 million in 1994-95 (PHC 1995a, p.4), or 2% of total government revenue (Laugesen 1996a, p.22).

The direct health services cost to government is \$578 per smoker in 1993 (PHC 1995a, p.15), but this does not include costs to the whole economy – loss of outputs and income, additional stress, loss of life, fires, etc. The average smoker paid an estimated \$815 of tobacco tax in 1993 (PHC 1995a, p.15).

- There has been resistance by Treasury and politicians to the tying of tobacco taxes to smokefree promotion and other tobacco control initiatives (see section 6.5.4

¹⁸⁵ Statistics New Zealand. *New Zealand official yearbook* 1996. Wellington, Statistics New Zealand, 1996.

¹⁸⁶ Department of Statistics. *New Zealand official yearbook* 1975. Wellington, Department of Statistics, 1975.

above, PHC 1995a, p.5; Beaglehole 1991, p.180; D. McLauchlan 1990, p.50). At present there are parts of the alcohol, petrol, and vehicle registration levies or charges tied to particular uses.

- There seems to be a lack of real recognition at the political and public level, that tobacco is *the only legal commodity which is commonly fatal when used as the industry intends* (Carr-Gregg 1990b¹⁸⁷, p.386). Such recognition could allow for stronger tobacco control efforts in general and specifically for the removal of all marketing by packaging, or the limitation of retail access.
- There has been a lack of movement in New Zealand on tar and nicotine reduction, assistance in managing nicotine dependence, and legal action on tobacco cost recovery.
- There appears to be a continued lack of effective government policy to ensure strong and consistent tobacco control investment by local and regional health authorities.

8.6 How did government action occur?

In looking at the overall trends, and the major influences and problems, the question occurs – how did government intervention emerge in particular forms? The question is largely answered from the civil servant’s viewpoint by Bette Kill (Kill 1995). She details much of the process, including:

- The need to maintain a specialist tobacco control team and budget over a number of years, which involves the selling of the issue within the bureaucracy, and continually producing new information and policy.
- The need to persuade politicians, including the briefing for incoming Ministers and providing regular updates, and by “designing a programme which progresses Ministerial involvement” (p.174).
- The selection of policy option packages likely to get approval. This involves the analysis of the public and political climate, and the accurate design of the presentation program for the packages.
- The use of the media, and the cooperation with other government spokespersons and NGOs to inform and persuade the public.
- The use of expert medical and scientific advice, and in particular, the use of “super-experts” with overwhelming international stature, to counter pro-tobacco experts.

From the point of view of those outside the civil service, there may be a greater stress on the influence by lobby groups and politicians. One view is that change has come

¹⁸⁷ Carr-Gregg M, Gray A. Generic packaging - a possible solution to the marketing of tobacco to young people. *Med J Aust* 1990; 153: 685-686.

about by the tobacco industry being “pecked to death by ducks” (Chapman 1995). This view highlights the role of the background of multiple minor blows to the industry. It also stresses the importance of even minor government or private interventions, as they commit the intervening body to the acceptance that action *is* necessary. Such multiple sources of attack diffuse any target for the industry counterattack, and create all the difficulties for them of a multi-front war.

8.7 Summary of interventions

The categories below are based on those in Chollat-Traquet (1996).

Over the last 93 years in New Zealand, the range of government and private intervention on tobacco has included:

- Financial – subsidies for the tobacco growing industry, tariff protection for local manufacturers, taxes on tobacco. The 1995 Porirua City Council funding requirement (see section 7.4.9) is a financial incentive for non-smoking. In March 1995, over 60% of the retail cost of cigarettes was tax (Laugesen 1996a, p.22).
- Age restrictions for tobacco purchase – partly enforced 1903-1916; age 16 from 1988 (TSB 1989, p.104), but rarely enforced.
- Smokefree or smoke reduced public and workplaces – domestic aircraft restrictions 1974, domestic aircraft ban 1988, local city restrictions 1988 (TSB 1989, p.104), partial workplace bans 1990.
- Tobacco advertising and sponsorship bans – radio and TV 1963, cinemas and billboards 1973, print 1990, sponsorship 1990-95 (except for some foreign based TV and events). The point of sale advertising restriction has, so-far, had limited success.
- Health warnings on packets – from 1974, with modifications since, e.g. 1988.
- Health education and promotion – from 1945 or before, more commonly from 1979 – including mass media campaigns, school teacher kits and aids, national smokefree weeks, the Health Sponsorship Council from 1990, the formation of Te Hotu Manawa Maori and its three year DoH contract in 1994, and smokefree hui.
- Commercial involvement – nicotine replacement therapy (gum and patches).
- Economic incentives by insurance companies.

Interventions that have not been used so far include:

- Dedicated tobacco taxes – e.g., for health promotion, smoking prevention and cessation programs. The exception was the tobacco levy briefly from 1978. The government now has a legal obligation to substitute sponsorship where tobacco

sponsorship has not been replaced, but this is not tied to the tobacco revenue base.

- Taxes based on nicotine or tar content.
- Wide scale subsidised or free specific smoking-cessation clinics (e.g., nicotine replacement therapy and expert help). To a limited extent cessation support provided by nurses and doctors is subsidised by general medical services payments and practice nurse subsidies. There may also be scope for commercial “selfhelp” groups, along the lines of Weight Watchers.
- Restrictions on the tar and nicotine content of cigarettes and tobacco.
- Full disclosure of cigarette contents and combustion products.
- The prevention of marketing by packaging – i.e. plain packaging regulations and/or package design by health authorities.
- Comprehensive and rigorously enforced restrictions on the point of sale – except for limits on vending machines and hospital shops, there has been no government effort to make tobacco less accessible, or to make point of sale age surveillance more workable. Ultimately tobacco could be as restricted in retail sales as are other dependence producing and dangerous drugs. The present 12,000 or more shops, supermarkets, pubs etc., could be cut to less than 500 licensed addictive substance outlets, with consequent increased age-of-buyer control, and a strengthening in social pressure against smoking.
- Litigation for cost recovery or punitive and exemplary damages. A claim by Maori against the Crown for a failure to act in accordance with the principles of the Treaty of Waitangi, might be a variation on this.
- Testing underage youth and other categories for tobacco residues as a means to discourage smoking. Robert DuPont suggested (in the US) testing drivers license applicants under 21 years of age for cotinine, the major metabolite of nicotine (DuPont 1996¹⁸⁸).

8.8 Summary

During this century, New Zealand government intervention on tobacco has moved from moral based laws or a relative absence of policy, to increasingly stronger and research based control efforts. These recent efforts have helped in the sharp decline of per person consumption from 1978 or before, and especially during 1984-1991. However, the decline has been mostly for non-Maori men over 35, and less so for the young, Maori and women. One consequence is that Maori and women, *as groups*, are not yet benefiting from a lowering of tobacco-caused deaths by smoking cessation.

¹⁸⁸

DuPont R. Review of *Tobacco* by Mark Gold. *JAMA* 1996; 275: 1285.

The last 20 years has seen the increased overt politicisation of the tobacco and health problem, with mainstream health and service groups joining in the political advocacy process.

Once the tobacco health problem was identified in the 1950s, progress to solutions has been slowed by the size and wealth of the industry, the media/advertising/industry links, and the lack of political concern with disease prevention. These factors have been countered by research information, dedicated and skilful work by NGOs and the DoH, and some supportive politicians, particularly in the mid and late 1980s.

The tobacco control measures tried in New Zealand have included taxes, age restrictions, smokefree-interior policies, advertising and promotion bans, and health education. Measures yet to be fully tried in New Zealand include tied taxes, tar and nicotine limitations and/or taxes, point of sale restrictions, and litigation for cost recovery.

8.9 Conclusions

In some ways, the continuation of smoking in such a large proportion (26%) of the population constitutes a failure of successful public health action (Peto 1994, p.938). Nevertheless, New Zealand has been described as one of the 12 countries that is deserving of special credit for its tobacco control programme (Davis 1994, p.889).

Ravenholt states the continuing problem for all public health workers. Tobacco created diseases have:

“an extraordinarily diffuse, subtle nature, and with lifetime latencies, tobaccosis poses the ultimate challenge to epidemiology and to world public health and political leadership” (Ravenholt 1993, p.185).

8.10 End words

“I invite the Deputy Leader of the Opposition to ... walk up to someone who is gasping through an oxygen mask and say: “We’ve stood up for your freedom, mate. We’ve really promoted your freedom; we’re not going to do anything that will stop somebody else having the freedom to die the way you are dying” (Michael Cullen, Hansard v.507, 1990, p.1644).

(To the perceived suggestion by the National party opposition that small businesses would be hurt by the SFE Act) *“Is he saying that that the promotion of addictive, poisonous and life threatening drugs should be encouraged in order that small businesses may flourish?” (Jim Anderton, Hansard v.507, 1990 p.3753).*

“The problem is so enormous, where do you start? The problem is so enormous: its so normal”, Dr Paparangi Reid (public health physician) on the “Frontline” TV programme, August 1990, quoted by Helen Clark (Hansard v.507, 1990, p.3232).

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Glossary and Acronyms

ACSH: Advisory Committee on Smoking and Health. A DoH advisory committee established in 1976.

ASH: Action on Smoking and Health is a lobby group focused on tobacco control (largely through introducing and supporting legislation). ASH also provides education on the benefits of not smoking and in supporting those who want to give up smoking.

Asthma Foundation of New Zealand: The voluntary sector organisation that is involved in promoting asthma prevention (including smoking control) and support for those with asthma.

Cancer Society of New Zealand: The voluntary sector organisation that is involved in promoting cancer prevention (including smoking control) and research into cancer. It also provides support for cancer patients.

CATAP: Coalition Against Tobacco Advertising and Promotion, a NGO that was set up in 1989 to achieve legislative change for tobacco control.

DoH: The New Zealand government's Department of Health

Excise (or selective) tax: A type of tax which is applied to a specific commodity (such as tobacco or alcohol). It therefore has a degree of discrimination in its intent.

ETS: Environmental tobacco smoke.

HSC – Health Sponsorship Council: The agency that promotes smokefree sports sponsorships, rock music and other contests through schools (it spends approximately \$4.5 million a year) (PHC 1994b). It was established under the Smoke-Free Environments Act 1990 to: “(a) promote health and to encourage healthy lifestyles, whether through the provision of sponsorship or otherwise; and (b) make sponsorship available to any person or organisation in accordance with section 56 of this Act.”

National Cancer Registry: The registry established to maintain a register of people who develop cancer (except basal and squamous cell skin cancers) treated in public and private hospitals, reported on death certificates and reports of incidental autopsy findings. It was established by the DoH in 1948.

National Heart Foundation of New Zealand: An organisation that aims to decrease suffering and premature death from diseases of the heart and circulation, including strokes. It promotes research and public and professional education as well as being involved in rehabilitation programmes.

NGO: Non governmental organization.

Price elasticity of demand: The percentage change in tobacco sales or consumption resulting from a 1% change in price. Tobacco products have a price elasticity in Western nations of approximately -0.5, i.e., a 10% rise in price causes a 5% fall in demand (Chapman 1996, p.97). (The term elasticity can also be applied to the effect of spending on tobacco advertising on sales or consumption).

Public Health Association of New Zealand: The non-governmental organisation composed of public health workers that is a lobby group and general advocacy group for improving public health in New Zealand. It has advocated for a range of smoking control measures and in 1996 established a new “Smokefree Group” to promote smokefree issues (PHA News 1996; 8(2): 3).

PHC – Public Health Commission: The governmental organisation established in the health reforms (1993) to protect public health (e.g., “to monitor the state of public health and to identify public health needs” along with purchasing non-regulatory public health services). In 1995 it ceased to be operational and its functions were largely transferred to the Public Health Group in the Ministry of Health.

Regressive: A tax is considered to be regressive if the tax burden (as a percentage of income) falls as income rises.

SFE: Smoke Free Environments Act 1990

Te Hotu Manawa Maori: The Maori Heartbeat organisation.

Te Puni Kokiri (TPK): Te Puni Kokiri (Ministry of Maori Development) is the government organisation concerned with all aspects of Maori development, including health.

TLA: Territorial local authority. City and district councils as defined under the Local Government Act 1974. There are 74 TLAs in New Zealand.

Tobacco Institute of New Zealand: The organisation that represents cigarette manufacturers in New Zealand. It tends to oppose tighter controls on tobacco such as restrictions on advertising and higher taxes.

*“The (smokefree) movement ... should be doing more to ridicule the tobacco companies ...otherwise it comes down to claim and counter-claim ... You shouldn't wrestle with the pig because the pig likes it”. Dr Alan Blum (reported by Rob Drent, *The Dominion* 29.3.90).*

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