

Are we there yet? Aotearoa's Smokefree 2025 goal and what comes next

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In 2011, the National-led Government set the bold ambition of “*reducing smoking prevalence and tobacco availability to minimal levels, thereby making New Zealand essentially a smoke-free nation by 2025.*”¹ As 2025 comes to an end, we reflect on the Smokefree 2025 goal, assess whether it has been achieved and propose next steps.

Smokefree Aotearoa 2025

In the mid-2000s, Māori leaders pioneered the Tupeka Kore (Tobacco Free) vision, which would see Aotearoa return to a nation without tobacco.^{2,3} The Māori Affairs Select Committee (MASC) inquiry into the impact of tobacco on Māori developed this vision and recommended the Government adopt a goal of becoming a smoke-free nation by 2025.⁴ Importantly, the inquiry emphasised that tobacco control must target the tobacco industry and addictive products that sustain the tobacco epidemic.⁴

The inquiry highlighted the devastating, inequitable and preventable burden tobacco use imposes on Māori whānau and communities, and on society, undermining all pillars of wellbeing. At the time, nearly half of Māori adults (45%) smoked, along with one in five non-Māori (21%).⁴

To address these gross inequities, the health sector and successive governments interpreted the prevalence component of the Smokefree goal as requiring daily smoking to fall below 5% for all population groups.^{5,6} The goal's second component—reducing tobacco *availability* to minimal levels—has received less attention but is crucial to creating a context in which non-smoking is the default.

Progress towards the Smokefree 2025 goal

So, has Aotearoa achieved the Smokefree 2025 goal? The answer is clearly “no”.

There has been no progress in reducing tobacco availability to minimal levels. Deadly and addictive tobacco products are still sold in almost every dairy, service station and supermarket—around 6,000 outlets—with clustering in low socio-economic areas.⁷

Although the prevalence of daily smoking has decreased markedly since the Smokefree goal was set in 2011, it remains at 15% among Māori and 10% among Pacific peoples—three and two times higher than the 5% threshold, respectively (Figure 1). Only Asian peoples are below the threshold at 4.5%, although, concerningly, smoking appears to be rising in this group.

Among adults overall, daily smoking declined to 6.8% in 2022/2023, but progress has since stalled (Figure 2). A plateau across three annual surveys is unprecedented in the history of the New Zealand Health Survey.

Disappointing, but not surprising

While immensely disappointing, the failure to achieve the Smokefree 2025 goal and singular lack of progress since 2023 is not surprising.

The coalition Government elected in 2023 dashed hopes of achieving the Smokefree 2025 goal and shocked the nation by repealing world-leading tobacco control policies.⁸ The repealed measures would have greatly reduced the availability, addictiveness and appeal of smoked tobacco products, making it much easier for people who smoke—most of whom want to quit⁹—to do so. The measures were evidence based,^{10,11} equity focussed,¹² had strong public support^{13,14} and were predicted to bring rapid, profound and equitable reductions in smoking prevalence.¹²

The coalition Government pledged ongoing support for the Smokefree goal and promised that “*decisions will be based on data and evidence.*”¹⁵ Yet several measures it introduced lacked robust evidence, aligned with tobacco industry interests and went against official advice. Analyses concluded

Figure 1: Prevalence of daily smoking by ethnic group, 2011–2025, New Zealand Health Survey.

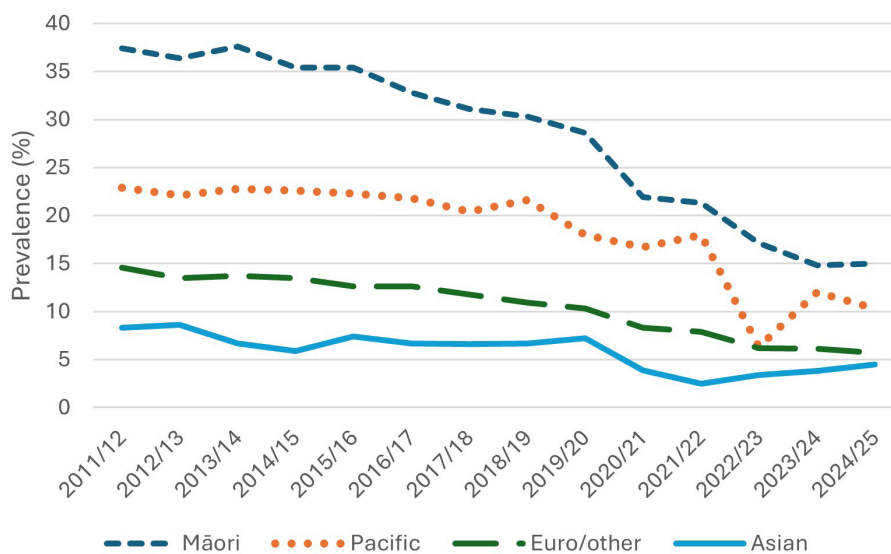
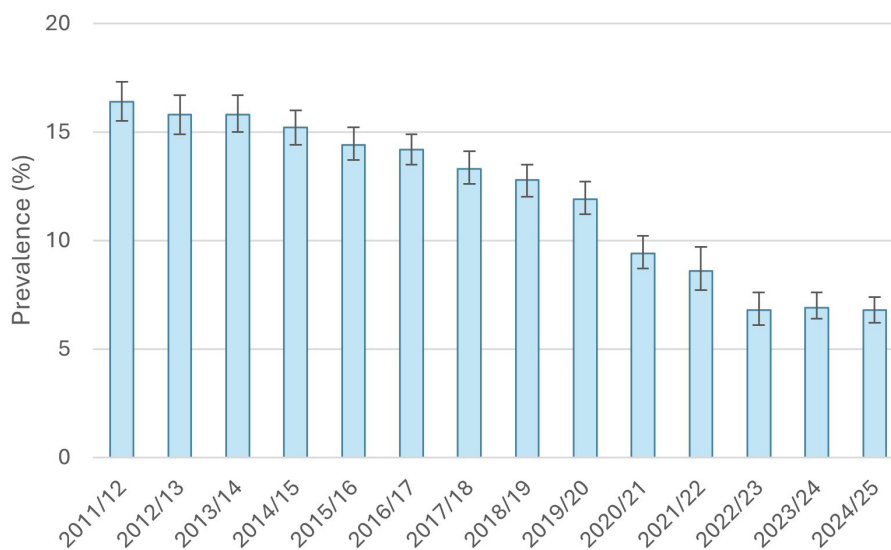


Figure 2: Prevalence of daily smoking, 2011–2025, New Zealand Health Survey.



that halving the excise tax on heated tobacco products and distributing free vaping kits would deliver minimal public health benefit.^{16,17} Unsurprisingly, they have failed to sustain the decline in smoking.

The Government’s approach places the onus squarely on individuals to stop smoking, while ignoring the most important known barriers to quitting: tobacco’s extraordinary addictiveness and widespread availability. Behavioural science

shows individual-focussed interventions produce “disappointingly modest” results¹⁸ and deflect attention away from systemic interventions (e.g., regulation, taxation), which have strong evidence of effectiveness.¹⁸

Getting tobacco control back on track

The results of the current approach are now

clear: smoking rates have flatlined since the new Government took office 2 years ago. The coalition Government must acknowledge that its strategy is not working.

The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), an international treaty Aotearoa ratified in 2005, sets out legally binding obligations designed to protect population health. Importantly, the FCTC preamble recognises the disproportionate harm experienced by Indigenous peoples, and Article 4 calls on parties to promote Indigenous communities' participation in developing, implementing and evaluating tobacco control measures that are culturally relevant and appropriate.¹⁹

Grounded in Aotearoa's obligations under the FCTC, we outline three key areas for action.

1. Restore evidence-based, pro-equity policymaking

FCTC Article 5.2(b) requires parties to “*Adopt and implement effective legislative, executive, administrative and/or other measures ... for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.*”¹⁹ This legally binding obligation aligns with the Government's stated commitment to evidence-based policy and rigorous evaluation.¹⁵

The Government has many evidence-based, pro-equity and cost-effective measures available to it, with several repeatedly recommended by expert groups, the MASC review and international evidence reviews.^{4,10,11,20–22} These include well-established approaches Aotearoa has yet to implement, such as retailer licensing, increasing the minimum legal age for tobacco sales and routinely refreshing pictorial health warnings and mass media campaigns. They also include innovative measures to manage the industry and create an environment that cues and supports cessation, such as retailer reduction, mandating non-addictive nicotine content levels, disallowing or phasing out commercial tobacco sales and placing a moratorium on the market entry of new commercial tobacco or nicotine products. International interest is also growing in “producer pays” policies that hold the tobacco industry financially responsible for the harms it causes.¹¹

Re-centring policy on this strong evidence base would prevent further backsliding and support equitable progress towards Aotearoa's Smokefree goal.

2. Protect public policy from tobacco industry interference

FCTC Article 5.3 requires parties to protect policy development from tobacco industry influence. Aotearoa's Global Tobacco Industry Interference Index ranking plummeted from second to 53rd in 2025,²³ and the Cancer Society's 2025 country report provides convincing evidence of industry interference in policymaking.²⁴

WHO issued Article 5.3 implementation guidelines in 2013,²⁵ and both the MASC report⁴ and past Cancer Society country reports²⁶ urged stronger protections against tobacco industry interference. These recommendations were ignored, and the consequences are now evident. The latest Global Index²³ and a recent *The Lancet* paper²⁷ highlight escalating industry interference worldwide, noting that strong safeguards are more important than ever.

To restore trust and prevent future tobacco industry influence, the Government must embed Article 5.3 obligations across the whole of government, following WHO guidance and the Cancer Society's recommendations.

3. Protect the next generation from nicotine addiction

Under FCTC Article 5.2(b), quoted above, Aotearoa is obligated to reduce *nicotine addiction*, as well as tobacco consumption, an obligation consistent with the Tupeka Kore vision. Current policy settings have failed young people in this regard.

The New Zealand Health Survey shows daily nicotine use (cigarettes or vapes) among 18–24-year-olds has risen from 17% in 2019/2020 to 26% in 2024/2025, and from under 15% to 17% in adults overall. Aotearoa has among the highest youth vaping rates globally.²⁸

While “lower harm” products may help some people stop smoking, regulators must recognise that tobacco and nicotine companies aim to maximise profit rather than population health.²⁹ After the aggressive marketing of vaping to young people rather than people who smoke, it is essential to protect young people from the tobacco industry's latest attempt to hook them: oral nicotine products.^{30–32}

Smoked tobacco should remain the central focus of tobacco control, but measures to end industry exploitation and addiction of the next generation are also vital.

Conclusion

Aotearoa has come a long way, but progress has stalled under current policy settings. Nearly 300,000 people still smoke daily; this figure has not fallen in recent years. Two-thirds of these people will die prematurely unless they stop, and many will be from Māori, Pacific and low-income communities, which continue to face gross inequities. Tobacco caused an estimated 3,660 deaths in 2023³³—more than 10 times the road toll—and imposes huge costs on whānau, the

health system and society.³⁴ Yet allowing tobacco companies to profit while the public pays is not inevitable. Restoring evidence-based policy can yet see Aotearoa achieve its smokefree vision.

Kua tawhiti kē tō haerenga mai, kia kore e haere tonu. He nui rawa ō mahi kia kore e mahi tonu.

We have come too far to not go further.

We have done too much to not do more.

– Sir James Hēnare

COMPETING INTERESTS

J Ball has received consulting fees from: the Ministry of Social Development (paid to institution); The University of Auckland; and the Government of South Australia. JB has been/is the secretary of the Public Health Association, Wellington branch, and a member of the Smokefree Expert Advisory Group, Health Coalition Aotearoa.

J Hoek has received: ITC programme advisory fees; funding from the Japan Tobacco Society to present to the 2022 conference; and small gifts for speaking at conferences. JH has received: travel and accommodation paid to attend the IASLC meeting in Singapore 2023; funding from the Thoracic Society of Australia and New Zealand to present to a conference in 2023 (Singapore) and 2025 (Adelaide); funding from La Fondation Contre le Cancer to present in Brussels in 2025; and funding from UniSante to present in Lausanne in 2025. JH is: the co-director of ASPIRE Aotearoa; part of the Health Coalition Aotearoa Smokefree Expert Advisory Group; part of various Australian health advisory groups; a senior editor, *Tobacco Control* journal; a co-opted member of the Public Health Advisory Committee, Health Research Council; and a member of the Ministry of Health Smokefree Advisory Committee. R Edwards has received: consultancy payments for contributing to an International Tobacco control project (from NIH grant), annually 2022–2024; payment for membership of the CENIC study advisory board (from NIH grant), 2003; occasional fees for external PhD marking; occasional honoraria for invited presentations at international scientific meetings; payment for deputy editor services to the Society of Research on Nicotine and Tobacco (*Nicotine & Tobacco Research* journal); honorarium for a paper published in *Tobacco Control* anniversary edition 2022; honorarium for an editorial published in *The Lancet* in 2022; travel costs covered by Hāpai te Hauora for attendance at the national SUDI conference in Rotorua, New Zealand in May 2022; and travel costs covered by an NHMRC grant at University of Queensland for attendance at SRNT-O meeting/NHMRC Research Centre meeting in Brisbane, May 2024. RE has been/is: a member of Expert Advisory Group, Asthma and Respiratory Foundation (2013–2022); a member of the Smokefree Expert Advisory Group, Health Coalition Aotearoa (2019–2024); a member of the National Tobacco Control Advocacy Service Advisory Group, Hāpai te Hauora Māori Public Health (2016–2024); a member of the New Zealand Cancer Society's National Scientific Advisory Committee (2020–2023); chair, Public Health Communication Centre Expert Advisory Board (2021–2024); president, Society for Research on Nicotine and Tobacco (SRNT) Oceania branch (2025–2026), and board member (president elect) (2024–2025).

L Teddy received registration costs covered by conferences hosts (cancer councils NSW, WA and Queensland) for the Oceania 2024 conference, and travel and accommodation costs covered by Hāpai te Hauora for the national tobacco and SUDI conference in 2024. LT is a board member of the Society for Research on Nicotine and Tobacco (SRNT) Oceania branch. A Waa has had travel and accommodation costs covered by Hāpai te Hauora for the national tobacco and SUDI conference 2024, and travel, accommodation and registration costs covered by conference organisers for the World Tobacco Control Conference, Dublin, 2025. AW is a board member for the Society for Research on Nicotine and Tobacco (SRNT) Oceania branch and a deputy editor for *Nicotine & Tobacco Research*.

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