New Zealand community pharmacists' perspectives on supplying smoked tobacco as an endgame initiative: a qualitative analysis

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ABSTRACT

Introduction Tobacco endgame strategies often include measures to reduce tobacco availability by decreasing retailer numbers. Recently, some US pharmacies have delisted tobacco, though overall retailer numbers have not reduced markedly. Paradoxically, others have suggested limiting tobacco sales to pharmacies, to reduce supply and support cessation. We explored how pharmacists from Aotearoa New Zealand, a country planning to reduce tobacco supply, perceived supplying tobacco.

Methods We undertook in-depth interviews with 16 pharmacists from Ōtepoti Dunedin; most served more deprived communities with higher smoking prevalence. We probed participants' views on supplying tobacco, explored factors that could limit implementation of this policy, and analysed their ethical positions. We used qualitative description to analyse data on limiting factors and reflexive thematic analysis to interpret the ethical arguments adduced.

Results Most participants noted time, space and safety concerns, and some had strong moral objections to supplying tobacco. These included concerns that supplying tobacco would contradict their duty not to harm patients, reduce them to sales assistants, undermine their role as health experts, and tarnish their profession. A minority focused on the potential benefits of a pharmacy supply measure, which they thought would use and extend their skills, and improve community well-being.

Conclusions Policy-makers will likely encounter strongly expressed opposition if they attempt to introduce a pharmacy supply measure as an initial component of a retail reduction strategy. However, as smoking prevalence falls, adopting a health-promoting supply model, using pharmacies that chose to participate, would become more feasible and potentially enhance community outreach and cessation support.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Meta-analyses and systematic reviews have documented strong associations between tobacco retailer density and, to a lesser extent proximity, youth and adult smoking.
⇒ Pharmacists in some countries (eg, Aotearoa/New Zealand and Australia) do not supply tobacco products, in line with their professional practice standards.
⇒ Professional concerns and new policies have also seen some US pharmacists delist tobacco, though the actual reduction in outlet numbers remains small.
⇒ Modelling suggests limiting tobacco supply to pharmacies whose staff deliver brief cessation advice could reduce smoking prevalence.

WHAT THIS STUDY ADDS

⇒ In-depth interviews with pharmacists from Ōtepoti Dunedin (Aotearoa New Zealand) identified several factors, including time and space constraints, safety concerns, and resourcing, that could impede implementation of a pharmacy-only tobacco supply measure.
⇒ A majority viewed supplying tobacco as an ethically unsound measure that would threaten them, their patients and their profession.
⇒ A minority saw merits in the proposed measure and envisaged a role where supplying tobacco enabled them to support smoking cessation in their communities.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Strong opposition to supplying tobacco suggests implementing this measure as an initial component of a retail reduction strategy would not succeed.
⇒ As prevalence falls, moving from commercial sales of tobacco to an opt in, health-promoting supply model could become more feasible and enable greater smoking cessation support in communities where prevalence is highest.

INTRODUCTION

Cigarette smoking remains the leading modifiable cause of disease and death in Aotearoa New Zealand (A/NZ) and kills around 5000 people each year.[1] While smoking prevalence has declined, it has not done so quickly enough to achieve A/NZ's Smokefree (SF) 2025 goal; neither have these declines benefited all population groups equitably.[2 3] Inspired by Māori researchers, advocates and politicians,[4] recently enacted legislation set out three core measures to eliminate health inequities caused by smoking: greatly reducing the nicotine content of smoked tobacco products, introducing a smokefree generation, and decreasing the availability of tobacco products.[5]

Policies limiting tobacco retailer numbers recognise the irony of treating tobacco as a consumer product sold via the same channels as normal household items, an approach that leads to an oversupply

of tobacco.[6] Tobacco's widespread availability normalises tobacco use,[7] fosters uptake among young people,[8] and impedes quitting among people who want to become smokefree.[9 10] Systematic reviews and meta-analyses have reported associations between outlet density and greater youth smoking initiation and prevalence,[11–13] and between outlet density near schools and future smoking uptake.[12] Reviews have also reported associations between outlet density and more widespread and frequent tobacco use among adults,[11 14 15] lower rates of smoking cessation,[11] and higher risk of relapse.[16] Tobacco outlet density is greater in lower-income neighbourhoods, which risks further entrenching health inequities.[14 17–19]

Modelling studies have compared different retail reduction strategies, including the impact of limiting tobacco supply to pharmacies alongside offering brief cessation advice once a year, an approach predicted to accelerate reductions in smoking prevalence.[20–23] However, restricting tobacco supply to pharmacies may seem counter-intuitive, given recent moves by some US pharmacies and a large pharmacy chain to delist tobacco (either voluntarily or in response to new regulations).[24–29] Evaluations indicate this measure has supported cessation,[30] although the impact on reducing disparities in outlet density across higher and lower deprivation neighbourhoods requires further analysis.[31–34] In addition, modelling suggests substantial outlet reductions are required to reduce inequities in tobacco availability and smoking prevalence.[22] Studies assessing measures to decrease tobacco availability are revisiting the merits of restricting supply to pharmacies and reconsidering arguments made nearly a decade ago.[35] Potential benefits of a pharmacy supply model include fewer retailers, more limited opening hours, stronger adherence to regulations and new opportunities to offer cessation support.[17 35–37]

These analyses have particular salience in A/NZ, given recent legislation will reduce retailer numbers from around 6000 to no more than 600.[5] Unlike the US, A/NZ community pharmacies do not sell smoked tobacco products, presumably because they view offering these products as inconsistent with their code of ethics. Rather, these small owner-operated or franchised businesses dispense prescription and over-the-counter medicines, sell well-being and cosmetic products and, in some cases, stock gifts and sell lottery tickets. Pharmacists also provide free healthcare advice and have an expanding portfolio of healthcare services, such as supplying methadone to people with opiate dependence, offering influenza vaccinations and providing COVID-19 testing and vaccinations. International studies have found pharmacies provide effective nicotine replacement therapy (NRT) and behavioural support and improve abstinence rates relative to self-supported cessation attempts.[38 39] However, a Cochrane Review called for further research to test and strengthen this evidence base.[40]

Yet while modelling and intervention studies suggest implementing a pharmacy supply measure could reduce smoking prevalence and support A/NZ's SF 2025 goal, adopting this strategy would profoundly change how these businesses operate. For example, pharmacies may become more vulnerable to thefts, would require additional storage space, and the increased sales volume and requirement to provide cessation advice would place additional demands on staff. Further, pharmacists may find it difficult to rationalise supplying tobacco, given the known harms of smoking and their role as health professionals who support community well-being.[26]

Although ascertaining pharmacists' perceptions of a pharmacy supply measure is crucial, given this change could not succeed without their support, we have limited data on how pharmacists view proposals to supply tobacco alongside offering cessation advice. Only one survey (n=30) has explored A/NZ pharmacists' views on selling tobacco as part of a strategy to realise the SF 2025 goal, and it found low support for this idea.[41] Just 26% of respondents estimated they would be very or extremely likely to opt into selling tobacco and 56% stated they would be not at all or not very likely to do so (although support increased if there was evidence the policy had been successfully introduced elsewhere).[41] However, while the survey examined potential advantages and disadvantages of this approach, it did not probe participants' reasoning or the factors underpinning their responses. We therefore explored factors affecting the feasibility of implementing a pharmacy supply measure to support tobacco retail reduction goals.

METHODS

Setting, sample, and recruitment

We undertook this study in Ōtepoti Dunedin, a provincial city in A/NZ (population~135 000) where smoking prevalence in 2020/2021 was 10.2% (cf. national average of 10.9%).[42]

CM is a practising pharmacist and began recruitment by approaching nine professional contacts and sending those interested an information sheet and consent form, before contacting them by phone or email to confirm participation. This approach facilitated recruitment of participants from a busy professional population. CM and JH also purposively sampled from a list of registered pharmacists in Dunedin and contacted an additional four pharmacies serving neighbourhoods experiencing greater material deprivation, where smoking prevalence is higher than the national average.[43] Finally, we used snowball (participant referral) sampling. Inclusion criteria included holding a current annual practising certificate from the Pharmacy Council of New Zealand and working in a community pharmacy within the Dunedin city boundaries at least once a week. Of the 13 people initially approached, eight agreed to an interview; participants provided a further eight contacts who were interviewed, leading to a total sample of 16 participants. Online supplemental file 1 outlines the recruitment process.

Māori colleagues provided feedback on the study and we consulted with the Ngāi Tahu Consultative Committee; all advised the study had high relevance to Māori. All participants gave written or verbal consent (according to whether the interview was in-person or online) after having had any questions answered.

Interview guide and data collection

Our semistructured interview guide explored participants' work experience and current role, and their knowledge and perceptions of the SF 2025 goal. We explored functional factors associated with supplying tobacco before probing how participants viewed the ethics of supplying tobacco; we moved between topics following participants' lead. We offered participants an NZ$40 gift voucher (not redeemable for tobacco) to recognise any costs they incurred by participating in the study. Online supplemental file 2 contains the interview materials.

Interviews took place from November 2021 to January 2022; these lasted between 27 and 60 min and were conducted in meeting rooms within a university building, in pharmacies, or via Zoom (an online meeting room). In line with qualitative description, we ceased recruitment when two consecutive interviews did not elicit new ideas. Following each interview, we prepared summaries and analytic memos, and reviewed the interview guide to incorporate ideas elicited during earlier interviews; this

approach gave us confidence in the 'information power' of our data when interviewing concluded.[44]

Data analysis

With participants' permission, we audio recorded all interviews and used an online service (rev.com) to transcribe these verbatim; CM checked all transcripts for accuracy. We first examined participants' views of factors likely to affect pharmacies' ability to supply tobacco using qualitative description, an approach that stays close to participants' words.[45] Using headings from the interview guide (space, safety and time) as parent codes, we developed an initial coding framework by analysing three transcripts independently and identifying subcodes. We reviewed and agreed draft subcodes, coded two more transcripts and undertook a further review to reach consensus. CM began coding using this initial framework and met frequently with JH to review and nuance subcodes; we used Nvivo V.12 to manage the data.

Because participants' responses to the ethical questions were rich and complex, we used a social constructionist epistemology to align with our interest in how participants interpreted a potentially profound policy change. We identified recurring metaphors, and used these to develop common patterns, or 'organising constructs'.[46] Braun and Clarke's reflexive thematic analysis approach required us to recognise our roles as health researchers who supported the SF 2025 goal and CM's role as a practising pharmacist. We had much in common with our participants, who were well-educated health professionals, though JH lacked experience managing multiple community healthcare responsibilities. Our meetings reflected our shared interests in community well-being, and participants' frank and detailed responses suggest we created a safe space where they felt comfortable critiquing the proposed measure.

RESULTS

We first describe our sample before presenting their views on supplying tobacco and the challenges of implementing a pharmacy supply measure, which we outline using three themes: looming practical challenges, rejecting an existential threat and accommodating an existential threat. In line with qualitative description and to enhance transparency, online supplemental file 3 contains a codebook with supporting quotations; all participants were given pseudonyms. Our sample comprised 16 participants; table 1 contains details of their demographic characteristics.

Table 1 Participant characteristics

Gender	N
Male	5
Female	11
Non-binary	0
Age	
≤35	7
36–50	8
>50	1
New Zealand (NZ) Deprivation Index of pharmacy location*	
1–3 (low deprivation)	0
4–7	3
8–10 (high deprivation)	13
Years of community pharmacy experience	
≤5	5
6–10	3
>10	8
Role within pharmacy	
Owner or manager	2
Pharmacist or locum	15
Other role†	2

*The NZ Deprivation Index is based on measures including income, employment, qualifications, home ownership, family status, internet access, and living space and conditions.[43]
†Some participants managed more than one role (eg, locum and assisting with tertiary teaching).

Looming practical challenges

Most participants reported infrequent NRT sales and provided advice to patients depending on the time they had available. Supplying tobacco would increase time and staffing pressures, and several questioned how they could supply tobacco and support cessation alongside dispensing medicines and providing existing services to a high standard. James felt strongly about time pressures: "I don't believe that we've [got time] for pharmacy to do that… we're under the gun already… in every sense, in terms of time pressure, in terms of dispensing pressure, in terms of expectation… and in terms of…adequate reimbursement for our time". Time pressures risked compromising the quality of service they envisaged offering, as Mike explained: "I don't think that I'd be able to do a good job of it… unless it was funded well so that there was enough … good, trained staff to make sure that the service was being provided as it should be… unless it can be done properly, pharmacists shouldn't be putting a hand up to do it".

Most participants raised safety concerns, thought supplying tobacco would lead to increased crime, and worried about staff and patient well-being. Several believed supplying tobacco would undermine pharmacies' status as inviting spaces and worried about the connotations of providing tobacco. Angela commented: "a pharmacy is… often the gateway to health care. …And it's quite often also perceived as quite a safe space for patients to come in". She went on to argue: "… you're now putting your pharmacist and your wider pharmacy staff in a lot of danger… we see it in the media all the time… robberies happening in dairies [small convenience stores] and all of that". Others reported encountering aggressive responses to COVID-19 restrictions from customers and felt restricting tobacco supply to pharmacies could elicit similar reactions: "… we already… deal with customers who are quite aggravated… this might just increase… especially if they've had some drinks and now they wanna smoke" (Isabel). Several foresaw a need for greater security, including more robust storage arrangements and in-store cameras.

Some commented on spatial constraints; Harry noted: "a lot of pharmacies operate in kind of very limited space, like, physical space…. it's difficult to juggle quite a few different activities in- in that small area". Limited facilities could constrain opportunities to advise on cessation, thus reducing the service pharmacists could offer: "[as well as] the staff and the training, [you need] the space to do it… to store the product and to have conversations. If it was a busy dispensary… you'd need a separate place to be having these conversations alongside whatever other services are being provided in the pharmacy. … it's difficult [in his current pharmacy] to have … more intimate conversations with people, that are … required for that level of care" (Mike).

Participants also saw skill gaps and suggested training to address these and enhance the service they could offer, particularly when engaging with potentially resistant patients. Grace commented: "I guess to understand the condition a bit better, to understand why people smoke… the psychology behind that, how it affects them emotionally… then you have a little more… empathy… you'd be able to help".

Adjusting their store design to support consultations, store tobacco, and enhance security would require investment, as would increased staffing hours and training. Participants felt concerned that supplying tobacco would become another unfunded expectation they would have to meet and called for greater central investment, should the policy proceed. Harry explained: "Traditionally, I feel like pharmacy is overlooked resource-wise….. I would like to think none of it [additional resources] [will come] out of the goodness of pharmacists' hearts because I think the Ministry of Health relies far too heavily on that in the first place".

Beyond pragmatic concerns over stocking and supplying tobacco, maintaining a safe space for staff and customers, and funding a new service, participants held deeper anxieties, which we explored using reflexive thematic analysis, a more interpretive approach.

Rejecting an existential threat

Supplying tobacco could erase important differences between pharmacists and generic retailers, and some participants reacted strongly against this existential threat to their status as health professionals. Ella explained: "It's almost starting to make pharmacies … look like a shop or supermarket… Or a dairy…. it's kinda degrading, at some point". Some feared the reputational risk posed to pharmacies would transfer to pharmacists themselves. Belinda spoke bluntly: "I suppose [it depends on how] they [customers] view… the value that we bring as pharmacists… if their view is "You're just a glorified, um, checkout chick", then, then that would be different as well".

Others saw risks to their communities, practices and profession: "… If you take on this service… and it's not done properly, then it could be really negative for my experience as a pharmacist but also for the community because if you don't do it well, then all you're doing is, um, doing what the dairy does, but more expensive… for no gain" (Mike). Angela envisaged a "very, very, very slippery slope" where pharmacies, particularly those part of large franchises, could lose their health-promoting focus and simply become profit-oriented businesses. Belinda explained: "In an ideal world… the ideal patients that come in will be very happy to have a conversation… And in the real world… I think there's just that pressure to make another transaction…". If tobacco was simply another product with a profit margin (and potentially even sales targets and incentives), pharmacists' primary role of providing healthcare would diminish: "And then if you're dealing with the tobacco company and they're giving you more money… it's making you … want[ing] to sell more… I wouldn't be happy with that" (Ella). Tobacco companies' involvement as suppliers would threaten a health-promoting approach and participants favoured accessing tobacco from health agencies, to distance themselves from industry influence.

Several saw supplying tobacco as incompatible with their health-promoting responsibilities. Their deontological stance was simple; having undertaken to 'do no harm' and assumed the moral obligation of non-maleficence, they could not reconcile supplying a dangerous consumer product with their professional obligations. Some, like James, strongly opposed supplying tobacco: "I'm not gonna participate in supplying product that I know causes harm… I would be categorically and philosophically opposed to turning us into a supply vehicle for tobacco". Angela elaborated: "So, there are lots of different facets that feed into why I think this is not a good idea. First of all, if you look at what a pharmacy is, it's often the gateway to health care that [supplying tobacco] would go against the principle of not harming your patient. Because the moment a pharmacist was to supply that, that's the pharmacist saying, "I consent to this patient being in the possession of something that will harm them with my own knowledge that it will harm them".

All participants felt strongly committed to high personal and professional standards. However, while some felt that stance required them to reject supplying tobacco, others saw opportunities to use their skills to promote a greater good.

Accommodating an existential threat

Although a minority, other participants envisaged a role where supplying tobacco could align with their professional responsibilities. Narina explained: "For the moment, [I feel] neutral. 'Cause maybe… it will be good, and maybe we can start those conversations with smokers easily without having too much pushback". These participants felt open to supplying tobacco, so long as they could use their knowledge and skills to benefit their patients; anything less would reduce them to mere salespeople. Kelly commented: "… basically, if I'm just supplying, no questions asked, then I will be just [like] someone working at a supermarket checkout… I will feel like: 'am I making a difference in this transaction [if unable to counsel them]'". However, unlike those who rejected supplying tobacco as unethical, these participants envisaged sharing their skills to build relationships with their patients and moving from a 'transactional' to a 'elational' exchange. Belinda explained: "what would make that [supplying tobacco] any different from getting it from a supermarket? … [I hope] That moving tobacco into pharmacies, would create more relational interactions, rather than transactional interactions".

Participants saw supplying tobacco as an opportunity to use their skills more fully (provided they received appropriate resourcing), thus improving community well-being and increasing their own job satisfaction. Harry explained: "…I like the idea of the … widened scope of pharmacists… we're criminally under-utilised in New Zealand…So [many] skills and knowledge that are just not used or not recognized by the Ministry of Health".

Some even foresaw transformational benefits. Isabel explained: "… helping someone achieve their goal of stopping smoking is very rewarding… being able to provide those resources without stigma, without them feeling insecure or that there's no hope and nothing can be done…. that's what makes us, our job so wonderful… it gives people hope that there is an option and you're never … left stranded or alone. So, I guess that's what makes me willing [to supply tobacco], is seeing that positive side of the situation". So long as they could differentiate themselves from generic retailers and use their professional skills, these participants believed supplying tobacco could help people overcome potentially overwhelming challenges.

DISCUSSION

Overall, most participants opposed supplying tobacco, which some thought would violate their professional code of ethics. They framed tobacco as a uniquely harmful product that, as professionals committed to health, they could not supply without undermining their ethical standards and professional identity. A

minority adopted a more utilitarian perspective, looked beyond tobacco's inherently harmful properties, and felt willing to supply tobacco if doing so would reduce smoking prevalence. They anticipated increased job satisfaction from assisting patients gain better health, saw opportunities to support their local communities and expand their professional skills, and looked forward to developing therapeutic relationships with patients who smoke.

Participants' concerns about time, resourcing, safety, and the effect stocking tobacco would have on perceptions of pharmacies as well-being spaces reflect findings from earlier studies.[41 47] New responsibilities participants felt came without adequate resourcing (eg, providing COVID-19 testing and vaccinations) led several to feel that time pressures would leave insufficient time to provide cessation counselling and reduce the value they could offer patients. If they could not draw on their expertise, they felt they would not differ from other retailers making a transaction; this diminution in status presented a personal and professional threat.

Our findings extend van der Deen *et al*'s survey of pharmacists and build on earlier work by applying ethical concepts to interpret their responses.[41 48] Earlier studies found strong opposition to commercial tobacco sales[26 35]; yet despite presenting pharmacy supply as a short-term initiative to reduce smoking prevalence, most participants did not differentiate between 'selling' and 'supplying' tobacco. Introducing a pharmacy supply measure without clarifying this difference may lead to considerable resistance.

Nonetheless, we believe this measure merits further consideration in A/NZ for two reasons. First, pharmacists' high visibility and accessibility could enhance community cessation support and reach groups less likely to access other smoking cessation services. Second, mandatory denicotinisation will reduce the number of people using tobacco and requiring cessation support,[49] easing the time, workload, and space pressures participants outlined. Lower smoking prevalence should also reduce crime, given the illicit market will logically shrink,[50] thus ameliorating safety concerns participants raised.

Overall, these changes should make introducing a pharmacy supply measure more feasible. Current pharmacy numbers exceed the 600 outlets that will operate as commercial tobacco retailers once A/NZ's retailer reduction measure is implemented in 2024. Practices interested in supporting a cessation-oriented supply measure could thus opt in to the measure while those objecting could decline to participate.

Addressing participants' ethical concerns will need a policy (and clear communications) to present tobacco supply as a short-term, health-promoting initiative that incorporates cessation counselling and advice, thus utilising pharmacists' expertise. Without this clarification, pharmacists may view the strategy as a retrograde commercial initiative. Furthermore, the implementation process would need to shield pharmacists from interactions with commercial tobacco companies, which may attempt to undermine the measure.

Our study has limitations; we drew our sample from one city within A/NZ and began sampling using a convenience approach that may have reduced participants' diversity (although their varied views suggest high diversity). While most participants served communities experiencing higher deprivation, where smoking prevalence (and thus the policy impact) would be greater, we did not elicit views from pharmacists serving more affluent communities, whose perceptions may differ. Although some pharmacists rotated between different pharmacies (ie, located in higher or lower deprivation neighbourhoods), all worked in high deprivation communities. Our participants were based in urban or suburban pharmacies and pharmacists serving rural communities may hold different views, given they may see patients less frequently and face different supply and storage challenges. While interviews lasted around an hour, three participants completed the interview during a work break (~30 min), which limited opportunities for detailed probing. Nonetheless, we are confident we elicited varied views and gained a detailed appreciation of how pharmacists viewed a pharmacy-only tobacco supply measure. Strengths of our study include our detailed probing of most participants' responses, which elicited rich data not typically gleaned by surveys or used in modelling studies. CM's expertise as a practising pharmacist facilitated participant recruitment, enhanced reflexivity, and helped us create safe settings where participants provided frank assessments.

In summary, opposition to supplying tobacco reflects a strongly held ethical position that makes a pharmacy supply measure unlikely to succeed as an initial supply reduction intervention. However, policy-makers should explore this approach once smoking prevalence has decreased, when movement from a commercial to a health-promoting model may be more feasible.

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