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Global policy scan of commercial combustible tobacco product retailing regulations by WHO region

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ABSTRACT

Background/aims Regulatory schemes for tobacco retailing help restrict the supply and availability of smoked tobacco products. Tobacco retailer density and the proximity of tobacco outlets to youth spaces, such as schools, are greater in more disadvantaged areas. Exposure to tobacco retailing normalises smoking and increases ease of access, thus increasing smoking uptake and undermining quitting. To inform future policy, we conducted a global scan of combustible tobacco retail regulatory schemes (We use the term schemes to refer to any kind of relevant initiative, policy, regulations or legislation that we found).

Methods All types of English language records concerning the regulation of commercial tobacco product availability were considered, including peer-reviewed journal articles, key reports and policy documents. The key features of regulatory schemes were documented. In addition, we contacted key informants in different countries and regions for advice on additional sources and undertook targeted searching in regions where we initially found little data.

Results/findings Although many countries have well-established and comprehensive tobacco control programmes, tobacco retail policy that actively addresses the availability of tobacco is underutilised. Many jurisdictions have implemented a minimum purchase age and restricted point-of-sale advertising and marketing. Other tobacco retailing regulations also included licensing systems with licence fees, caps on licences and restrictions on store location, type and retailer density/proximity. A very small number of jurisdictions have ended tobacco retailing altogether.

Conclusions At a minimum, policy-makers should implement licensing schemes, licence caps and proximity limits and invest in robust monitoring systems and compliance enforcement. Tobacco products' ubiquity is incompatible with its status as a dangerous addictive substance and does not align with tobacco endgame goals.

INTRODUCTION

As more countries adopt tobacco endgame goals, the anomalous widespread availability of tobacco products has gained greater attention. Reducing tobacco availability could improve health equity.¹ Several studies have found more tobacco retail outlets in low-income areas than affluent neighbourhoods.²⁻⁴ Smoking prevalence is typically associated with greater tobacco retailer density,⁵⁻⁷ and people living in more disadvantaged areas have more difficulty maintaining quit attempts than those living in areas with fewer tobacco retailers.⁸⁻¹⁰ Despite this evidence, many tobacco control strategies do not

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Smoking prevalence is typically associated with greater tobacco retailer density; several studies report that low-income areas have more tobacco retail outlets than affluent neighbourhoods.
- ⇒ Regulation of the tobacco retail space is an important tobacco control policy that can address inequitable tobacco supply distribution.

WHAT THIS STUDY ADDS

- ⇒ This study provides an overview of the global tobacco retail regulation landscape.
- ⇒ We identify opportunities to contribute to stronger policies that will limit tobacco availability.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Retail regulation to decrease tobacco availability could contribute to tobacco endgame goals and is neglected in many countries' tobacco control policies.
- ⇒ To maximise the impact of retail regulatory measures, policy-makers should introduce measures to actively reduce tobacco retailer numbers such as licence caps and restrictions on tobacco retailer density and location.

address tobacco product availability¹¹⁻¹³; reviewing existing approaches to regulating tobacco sales could identify opportunities to improve the use of this policy lever.

Numerous studies have reported higher smoking prevalence and heavier tobacco consumption among people experiencing socioeconomic disadvantage; recent work suggests differences in outlet concentration may increase these health and social inequities.¹⁴ For example, people in lower-income neighbourhoods have lower life expectancy, higher age-adjusted mortality and more deaths from chronic respiratory disease.¹⁵ Modelling studies show the potential impacts of proequity policies such as price increases and targeted cessation services.¹⁶⁻¹⁸ Research from the USA,^{19 20} Scotland,¹⁷ Australia²¹ and Aotearoa/New Zealand^{16 22} suggests retail reduction policies could also improve health equity.

Recent systematic reviews and meta-analyses have examined associations between tobacco retailer density and smoking behaviours. Higher outlet density and proximity to people's homes and schools are associated with an increased risk of smoking initiation among young people^{23 24}

and higher smoking prevalence among both young people and adults.^{25–27} Positive associations between smoking prevalence among adults and adolescents and tobacco retailer density, and a negative association between smoking cessation and outlet density have been reported, although findings regarding retailer proximity and smoking prevalence were mixed among young people.²⁸ Other studies concluded that, despite evidence of positive associations, challenges in study designs and exposure measurements warrant further research using improved methods such as assessing trends in smoking behaviour following substantial changes in retailer density using quasi-experimental studies with longitudinal designs and investigating mechanisms of association between retailer density and smoking behaviour in qualitative studies.²⁹ Nonetheless, evidence linking tobacco outlet density with adverse health outcomes, increased smoking prevalence among adults and adolescents, and larger health inequities^{30–32} suggest that reducing outlet numbers and density could bring important health, social and economic benefits.

Recent work has summarised tobacco retail licensing schemes in Europe in 2021,³³ the USA³⁴ and more widely.³⁵ Yet despite documenting approaches taken in high-income countries, fewer studies have examined policies from low-income and middle-income countries.³⁶ This review attempts to contribute to filling this gap by providing a global overview of different retail policies from each world region. We examined published and grey literature to identify international examples of advanced tobacco retail regulation policies addressing the availability of tobacco products and identify opportunities for further policy measures.

METHODS

We undertook a policy scan of commercial combustible tobacco product retail regulatory approaches implemented in countries, according to their WHO region. Although not a systematic review, we approached the search in a systematic way, using specific search terms, combinations of search terms and databases. To identify as many regulations as possible, we also conducted purposive searches of grey literature, interviewed key informants from different regions and discussed findings within the team throughout the search. We identified relevant literature by conducting a systematic search of electronic databases (PubMed, CINAHL, Science Direct and Google Scholar), hand-searching the reference lists of relevant peer-reviewed publications and undertaking targeted searches of grey literature and online resources. The latter included news sources, government websites and the web resource Tobacco Control Laws, which is maintained by Campaign for Tobacco Free Kids.³⁷ We also used general internet searching via Google to retrieve information that may not have been indexed in a bibliographic database. Search terms are listed in online supplemental data.

Our study focused on supply control measures to regulate combustible tobacco products, given that these are the most harmful and frequently retailed nicotine products sold in most countries. We did not examine age restrictions, flavour bans or point-of-sale advertising and marketing restrictions.

We included all English language records concerning the regulation of commercial tobacco sales, including peer-reviewed journal articles, key reports or policy documents from national and international governments and other peak bodies such as the WHO. English language records were available for some countries in which English is not the main or official language. In addition, we contacted key informants in South America, South East Asia and Africa to seek advice on additional data sources and identify initiatives that may not have already been captured

in our document searches. These interviews provided detail and clarification around regulations that had already been identified. We undertook these searches between April and November 2022 and stopped searching when we found no new relevant information. We examined data from 53 countries, 5 of which also included subnational regulations. Updates were added in June 2023 and March 2024 for Australia and Aotearoa/New Zealand and a final rapid search was conducted in October 2023 to check for updates.

RESULTS

We categorised our results by WHO region (see online supplemental file for a full list of results). The terminology varies across jurisdictions (ie, retailer permits or licences); we consider these terms to be largely synonymous. It should be noted that in many places, there is an absence of retail regulation restricting outlet numbers, density and location. We have only included countries for which regulations were found.

African Region

African countries did not typically have legislation requiring tobacco retailers to obtain licences or permits. However, many countries (Chad,³⁸ Republic of Congo,³⁹ Cote d'Ivoire,⁴⁰ Ethiopia,⁴¹ Gambia,⁴² Mauritius,⁴³ Senegal⁴⁴ and Uganda⁴⁵) restricted sales within a certain radius (eg, 100 m–300 m) of educational and/or healthcare facilities. Some countries (Cote d'Ivoire,⁴⁰ Gambia,⁴² Mauritius,⁴³ Senegal,⁴⁴ Uganda⁴⁵) included government offices, places of worship, cultural facilities and transport terminals within this radius. Although Gambia had some of the most extensive restrictions^{42 46} (including a sales ban within 100 m of educational facilities and childcare facilities, sports arenas, cinemas and theatres, healthcare facilities and clinics, public places of worship and public transport terminals), news articles from several years postlegislation indicated that delays in setting regulations had hindered implementation.⁴⁷ South Africa implemented a temporary tobacco sales ban for 4.5 months in 2020 as part of the country's COVID-19 response.⁴⁸ Botswana also implemented a 6-month ban on sales during the country's 6-month state of public emergency.⁴⁹

Region of the Americas

In Canada, tobacco retail licensing is typically managed at the provincial level rather than nationally, and licences are either free or incur a minimal fee (eg, maximum of US\$91 in Nova Scotia⁵⁰). Three provinces (Saskatchewan,⁵¹ Alberta⁵² and Quebec⁵³) required no licence to sell tobacco. We did not identify any subprovincial regulations. Countries for which data could be found in South and Central America tended to have either licensing measures (Argentina,⁵⁴ El Salvador,⁵⁵ Panama⁵⁶) or proximity measures (Chile,⁵⁷ Paraguay⁵⁸), but not both.

The USA has no overarching national legislation; regulations thus differ at state, county and local levels. Many subnational jurisdictions already have or are moving towards, a permitting or licensing system, and some restrict the sale of tobacco near schools and other youth and health facilities, including pharmacies. The US Centers for Disease Control and Prevention tracks licensing at a state level,⁵⁹ here, we highlight some key examples. Some of the longest standing schemes included Santa Clara County⁶⁰ and San Francisco⁶¹ in California. In 2017, the cities of New York^{62 63} and Philadelphia⁶⁴ introduced several tobacco retail regulatory measures. New York City^{62 63} included a pharmacy sales ban and predicted a 40% reduction in retailer numbers within 10 years of the measure's introduction. The state

of New York also mandated tobacco-free pharmacies in 2020. Philadelphia⁶⁴ specifically focused on reducing the numbers of tobacco retailers in low-income and high-minority areas to reduce tobacco-related inequities. More recently in 2021, the cities of Beverly Hills⁶⁵ and Manhattan Beach⁶⁷ in California introduced near comprehensive sales bans. In 2022, Brookline, Massachusetts⁶⁸ implemented a tobacco-free generation law that bans tobacco product sales to anyone born after 1999. Stoneham and Wakefield (also in Massachusetts) passed nicotine-free generation laws in March 2024.⁶⁹

South-East Asian Region

There is no national licensing scheme in India although there is a restriction on tobacco sales within 100 yards of any educational institution.⁷⁰ Attempts at the states level in India and Bangladesh to implement licensing schemes have been unevenly implemented and slow to progress.^{71–73} The sales ban introduced in Bhutan in 2004⁷⁴ was suspended as part of the country's COVID-19 measures.⁷⁵ Thailand has introduced overarching legislation to govern licensing and implement proximity restrictions, although, like Gambia, regulations have not been promulgated.⁷⁶

European Region

Many countries in Europe operate either a licensing or registration scheme for retailers. Hungary introduced one of the strictest licensing schemes in 2013, reducing the number of tobacco outlets from around 40 000 to 70 00.⁷⁷ Spain, Italy and France have long-standing licensing systems that restrict the locations where tobacco sellers may operate; however, these state-governed monopolies remain driven by profit maximisation objectives rather than public health goals.³³ France restricts tobacco sales to specialist tobacconists ('bureaux de tabac').⁷⁸ Russia does not operate a licensing scheme but does not allow tobacco sales within 100 m of educational facilities, or in bus and train stations, airports and other transport hubs.⁷⁹ Norway,⁸⁰ Ireland⁸¹ and Scotland⁸² only require retailers to register their business as a tobacco retailer. Attempts to introduce a licensing scheme in Scotland in 2007 and Norway in 2017 were stymied by tobacco industry interference and retailer opposition, respectively.³³ There is no tobacco retailer licensing scheme in the Netherlands, however, from 1 July 2024, Dutch supermarkets will not be permitted to sell tobacco.⁸³

Eastern Mediterranean Region

In the Eastern Mediterranean region, Jordan, Pakistan, Qatar and the United Arab Emirates ban tobacco sales near schools and healthcare facilities ranging from 50 m in Pakistan⁸⁴ to 1000 m in Qatar,⁸⁵ but in Pakistan, there is no specific licensing requirement. Only Islamabad, Pakistan, has a licensing requirement where licensees must renew their licence annually and submit an affidavit stating they will comply with sections 5, 7, 8, 9 and 10 of the Prohibition of Smoking and Protection of Non-smokers Health Ordinance 2002 (relating to smoke-free shops, advertising packaging of cigarettes, underage sales, proximity to schools and signage in the shop). This condition is intended to raise awareness of tobacco control laws.⁸⁶

Western Pacific Region

Most tobacco retailing policy activity in the Western Pacific region is in Aotearoa/New Zealand and the Philippines. The Smokefree Aotearoa 2025 Action Plan was launched in December 2021 and legislation introducing a retailer reduction strategy (from around 6000 retailers to no more than 600) commenced on 1 January

2023, with implementation scheduled for 2025.⁸⁷ Prior to its repeal in March 2024, this law was one of the most comprehensive and ambitious national plans underway, that also included mandated very low nicotine cigarettes and a smoke-free generation policy.⁸⁸

In the Philippines, an ordinance passed in 2008 in Balanga City prohibited the sale, distribution, use, advertising and promotion of tobacco products within km of the city's university.⁶⁶ Two further ordinances in March and September 2016 extended the initial measure by a further 3 km, thus covering a much broader geographical area, added e-cigarettes to the restricted products⁶⁶ and introduced a tobacco-free generation law, although this was overturned following intense opposition from the tobacco industry.⁸⁹

Tobacco sales are not regulated nationally in Australia, but all states and territories except Victoria⁹⁰ and Queensland⁹¹ had either a licensing or notification (New South Wales⁹²) requirement. The Queensland Parliament has passed an amendment bill that will introduce a tobacco retail licensing scheme requiring all retailers to be licensed by 1 September 2024.⁹³ There are no restrictions on tobacco retailer density or location in Australia.

A licensing scheme is in place in Brunei⁹⁴ and, following the introduction of high taxes, advertising restrictions and mandatory large graphic health warnings for tobacco packaging in 2014, the tobacco industry ceased sales in Brunei, citing excessive regulations (reported by a local informant). In practice, there are now no tobacco retailers in Brunei.

In China, the production, sale and regulation of tobacco is controlled by the government. The China National Tobacco Corporation controls the business side, and the State Tobacco Monopoly Administration is the regulatory arm of the industry.⁹⁵ A licence is required to sell tobacco, and sales of tobacco products are not permitted around kindergartens or primary or secondary schools.⁹⁶

DISCUSSION

We found that licensing schemes are the most commonly implemented tobacco retail regulation measure globally and report examples of tobacco retailer restrictions implemented at all levels of government (national, state/county/province and local). While national regulation is likely to be most effective in countering cross-border purchasing and providing a consistent approach to tobacco supply regulation, retail laws implemented subnationally may be more feasible in countries where policy-making primarily occurs at the state or provincial level (eg, USA, Canada, Australia and India). These countries may find model laws developed by tobacco control organisations support local and state/provincial governments to introduce policies that will reduce tobacco retailer density, proximity to educational/youth or healthcare facilities or to phase out tobacco sales.

As reported by others,^{34 97} we found that some jurisdictions use tobacco retailing to reduce retailer numbers by capping the number of licences issued, exempting existing retailers and relying on natural attrition. Some jurisdictions enforce licensing caps and actively reduce retailer numbers as soon as a policy commences. For example, Hungary enforced a strict cap at the introduction of a new licensing scheme in 2013; this measure reduced retailer numbers, although tobacco company interference allegedly disrupted implementation.^{98–100} Transparent processes for allocating tobacco licences are paramount to maintaining public confidence in and support for tobacco control regulations as a health measure. Licence caps may also be driven

by historical factors, monopoly and profit protection rather than public health aims, as in France, Italy and Spain.³³

Rather than mandating a reduction in tobacco retailer numbers, governments may prefer to incentivise retailers so they voluntarily discontinue tobacco sales; for example, by introducing or increasing retail licence fees. Research in the Australian state of South Australia,¹⁰¹ the state of California^{60 102} and the city of Philadelphia⁶⁴ in the USA showed tobacco retailer numbers decreased following a licence fee increase. However, voluntary measures did not appear to bring substantial reductions in tobacco retailer numbers, suggesting mandated reductions in retailer numbers may be required to achieve large supply reductions.

Other jurisdictions have sought to restrict tobacco sales locations. Several low-income and middle-income countries such as Bangladesh,¹⁰³ Mauritius,⁴³ Paraguay⁵⁸ and the Philippines¹⁰⁴ have restricted the proximity of tobacco vendors to educational and healthcare facilities. Balanga City in the Philippines was the first jurisdiction to introduce a tobacco-free generation ordinance and ended tobacco sales in proximity to the city's university.⁶⁶ Regulations in California also restricted the proximity of tobacco retailers to schools, to not within 500 ft of a school in San Francisco,⁶¹ and not within 1000 ft of a school in (unincorporated) Santa Clara County,⁶⁰ regulations in the city of Philadelphia restricted tobacco retailers to not within 500 ft of a school in Philadelphia.⁶⁴ However, other high-income countries with advanced tobacco control programmes, such as Canada, Ireland, Scotland and Australia, have limited registration or licensing requirements, and have no restrictions on vendor location. In the Netherlands, bans on vending machine and supermarket sales should reduce outlet numbers by 43%.⁸³ In a country described in 2011 as 'a Nirvana for the tobacco industry',¹⁰⁵ framing retail reduction policies as a youth protection measure and collaboration between civil society organisations has helped the Netherlands develop stronger policy measures.⁶⁶ New Zealand would have been at the vanguard of policy internationally with legislation to restrict tobacco sales to no more than 599 retailers nationally,⁸⁵ however, this was repealed by the new government in February 2024.¹⁰⁶

While the public health community strongly supports tobacco retail restrictions, stronger legislation offers an opportunity that is not currently well used, with the tobacco industry, retailers and retailing organisations regularly opposing new measures, such as licence caps. They describe these as unfair¹⁰⁷ and argue these policies would reduce their business profitability and sometimes commercial viability.¹⁰⁸ However, research has found that tobacco is not a major source of foot traffic for mixed business retailers and most purchases do not include tobacco.^{109–112} Furthermore, many retailers are amenable to stricter regulations,^{72 107 113 114} and some voluntarily stop selling tobacco products for either business or moral reasons.^{115–117} While policy-makers should consider how to support retailers' transition out of tobacco sales,¹³ commercial opposition to a measure should not deter its implementation. The strength of industry opposition may even indicate a measure's likely effectiveness.¹¹⁸ Advocates of tobacco retail restrictions should prepare evidence and arguments to support retailing reduction measures and counteract industry arguments.

Careful consideration is needed to ensure that gains in reducing retailer density are equitable. Evaluations from San Francisco⁶¹ and New York⁶³ found these cities' policy impacts were not evenly distributed. In San Francisco, land use (ie, commercial vs residential) was strongly associated with inequitable retailer density. The new ordinance had a more significant impact in

commercial areas and a weaker impact in residential and mixed-residential areas. In New York City, neighbourhoods that benefited most from the pharmacy sales ban typically already had lower smoking prevalence.⁶³ These findings illustrate how the equity impact of policies must be a primary consideration. In Philadelphia, where equity was a primary policy consideration, the decrease in retailer density in low-income areas was modestly, but significantly, greater than in 'not-low-income areas'.⁶⁴

Elsewhere, we observed the conflict governments face when measures threaten the potential economic benefits tobacco product sales may deliver. For example, in June 2022, the Spanish government announced that 203 new licences would be added to the existing 13 000, with 30 to be allocated to the border area with France, a move that dramatically increased retailer concentration in this region.¹¹⁹ Furthermore, proximity to another retailer or school in the border region was reduced from 150 m to 23 m. Tobacco control researchers suggested this measure takes advantage of recent price increases for tobacco products in France, providing cheaper tobacco products to nearby French residents.¹¹⁹ This move does not align with public health messaging and governments should not reduce regulation; nonetheless, having promoted specialist tobacco retailers, governments may need to consider supporting them as they transition to new business options. We saw another recent example of this when the Smokefree Environments and Regulated Products Amendment Act in Aotearoa/New Zealand was repealed. The government admitted that tobacco excise tax revenue was needed to fund other tax cuts promised during the election cycle.¹²⁰

In addition to a relatively low smoking prevalence, successful implementation of intensive retail policies will likely require good control over the illicit market, adequate lead time to prepare the population and retailers, an increase in smoking cessation support, and (possibly) access to lower risk substitute nicotine products.^{12 121 122} We found several examples of sales bans, however, we agree with Filby *et al* about the preconditions required in many jurisdictions before a sales ban could be considered.⁴⁸ Research with small retailers in Manhattan Beach and Beverly Hills following sales bans also highlights the necessity for comprehensive policies that minimise exceptions and cover a wide geographical area.¹²³

Licensing schemes, on their own, may not result in tobacco retailer reductions or may bring only minimal changes, particularly in settings where licences are free or inexpensive. However, policies need to be considered as part of a broad, strategic package, rather than as standalone measures. The cumulative effect of policy packages may be key to achieving endgame goals,^{20 124–126} particularly as endgame goals aim to reframe smoking as a practice that has lost social acceptability¹²⁷ and present tobacco as a lethal product. Sales regulations help define tobacco as toxic and assert consumers' rights to protection from products that invariably harm long-term users.^{12 128} Licensing can thus facilitate enforcement and monitoring of other sales restrictions, such as a minimum legal sales age and flavour bans.

Strengths and limitations

Despite searching globally for relevant data, our search may have missed some relevant examples because we limited our search to English language sources due to limited capacity to translate materials into other languages. We addressed difficulties locating information from low-income and middle-income countries by contacting local informants where possible in South America, South-East Asia and Africa and using translated

resources. However, we acknowledge that this process may have overlooked some data and warrants closer investigations by local researchers. Strengths included the use of all data source types to capture as much retail regulation information as possible. Opportunities for future research include examining the impact of regulations on tobacco sales and smoking prevalence, probing the origin, introduction and framing of regulations, assessing how policies are enforced, reviewing policy used to manage non-combustible tobacco products, novel and emerging nicotine products, and further investigation of regulations in non-English-speaking countries.

CONCLUSION

Tobacco products' ubiquity is incompatible with its status as a dangerous consumer product that creates health inequities; nor does it align with tobacco endgame goals, which aim to bring about rapid (and equitable) reductions in smoking prevalence. While many jurisdictions have introduced tobacco retailer licensing requirements or restricted where tobacco may be sold, few have actively reduced retailer numbers, relying instead on natural attrition. Furthermore, retail regulations have done little to address inequitable tobacco retailer distributions, and enforcement and monitoring activities remain unclear or inconsistent. We recommend policy-makers in all countries implement stronger regulations for the retail of tobacco that significantly decrease the number and density of tobacco retail outlets, including at a minimum, implementing licensing schemes, licence caps and proximity limits, and investing in robust monitoring systems and enforce compliance.

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