

Compilation of information briefs on forward-looking tobacco control measures developed by the experts

Expert Group on Forward-looking Tobacco Control Measures (in relation to Article 2.1 of the WHO FCTC)

Supplementary document

Purpose of the document

This document incorporates information briefs prepared by the experts of the Expert Group on Forward-looking Tobacco Control Measures (in relation to Article 2.1 of the WHO FCTC) established by the Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control (WHO FCTC) in decision FCTC/COP10(12), as part of its work conducted between the tenth and eleventh sessions of the COP.

Information briefs are provided for the 16 forward-looking tobacco control measures (FLMs) selected by the Expert Group, as outlined in document FCTC/COP/11/5. Short summaries (abstracts) for each FLM are provided in Annex 2 of document FCTC/COP/11/5.

This document informs and serves as a supplement to document FCTC/COP/11/5.

Details about the composition of the Expert Group and the three meetings held by the Expert Group are available as additional supplementary documents on the WHO FCTC website.¹

Please note that the Convention Secretariat is placing this report on its website for information purposes. The responsibility for the interpretation and use of the material lies with the reader. This publication contains the views of the experts comprising the Expert Group on Forward-looking Tobacco Control Measures (in relation to Article 2.1 of the WHO FCTC). Neither the Convention Secretariat nor the Expert Group guarantees the accuracy or completeness of information found in this document. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the Convention Secretariat or the Expert Group.

¹ [COP11 Documentation: Supplementary information](#) (accessed 29 August 2025).

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Abstract

Policy description and background. This policy permanently prohibits sales of some or all tobacco products to persons born on or after a set date, regardless of age. This would have the effect of increasing the age of legal purchase annually, while allowing sales to all current legal purchasers in perpetuity, gradually reducing tobacco uptake and use. The policy was passed in New Zealand (but later rescinded before implementation), the Maldives (in force from 1 November 2025) and in numerous cities in the state of Massachusetts (United States); has been introduced (but not yet implemented) in the United Kingdom; and is under consideration in the state of South Australia and several Canadian provinces. Variations on BSR policies have also been proposed elsewhere, including Australia, Malaysia, the Philippines, Tasmania and three American states.

This FLM aligns with advancing Article 4.2(b) of the WHO FCTC, in particular in respect of measures to prevent the initiation of tobacco products in any form; Article 12, in so far as the measure is accompanied by effective public education; and Article 16, as its focus is on lifelong prevention of tobacco initiation by young people through establishing policies that make it illegal ever to sell tobacco products to those born after the date selected.

Evidence of impact. Modelling studies suggest that the policy could reduce smoking and, if effectively enforced, would lead to a significant reduction in tobacco use. Modelling commissioned by the previous New Zealand Government found that, if well enforced, the policy could halve smoking rates within 15 years. A subsequent analysis projected that a combination of policies, including a BSR policy, would rapidly reduce adult smoking prevalence. However, as a stand-alone policy, a BSR policy would take several decades to affect population health. United Kingdom Government modelling studies estimated that under the policy smoking prevalence would fall from 13% in 2023 to nearly zero by 2050 among people aged 14–30 years, and from 12.7% in 2023 to 1.5% in 2056 among those aged 18 years and over.

Benefits and strengths. The policy is politically appealing as it does not call for immediate changes to the retail environment. It establishes the idea that tobacco is a product too harmful to permit sales to continue indefinitely.

Implementation considerations. Effective, systematic monitoring and enforcement are required, particularly as affected cohorts grow older. The risk of product shifting, particularly among young people, could be mitigated by ensuring that sales of all tobacco and nicotine products are subject to the policy.

Conclusion. A BSR policy, if successfully implemented and enforced – supplementary to other measures under the WHO FCTC – could have the potential to reduce the initiation of use of tobacco products significantly and could thereby eventually contribute to ending the tobacco epidemic. It would have a long-term (in around 30 years) impact on the whole population as the age for legal sales would rise annually. This could eventually close off the pipeline of tobacco users, as the tobacco industry would no longer be able to target younger potential users to become consumers for their business, “replacing” smokers lost to death and disease. However, the policy does not benefit older people who smoke as they are not subject to the policy.

Description of the intervention

“Tobacco-free generation” or “smoke-free generation” policies (henceforth birthdate-based sales restrictions or BSR) permanently prohibit sales of some or all tobacco products to all individuals born on or after a set date, even after they reach full majority age. This would have the effect of annually increasing the age of legal purchase in perpetuity, gradually reducing tobacco uptake and use.

This FLM aligns with advancing Article 4.2(b) of the WHO FCTC, in particular in respect of measures to prevent the initiation of tobacco products in any form; Article 12, in so far as the measure is accompanied by effective public education; and Article 16, as its focus is on lifelong prevention of tobacco initiation by young people through establishing policies that make it illegal ever to sell tobacco products to those born after the date selected.

Availability of information/research evidence on the potential impact of the FLM

The “tobacco-free generation” policy was first proposed by researchers from Singapore in 2010, with the idea of creating an expanding cohort that could never legally be sold tobacco (1). The policy’s rationale is that to end the cycle of young people initiation and addiction to tobacco products we must eliminate the notions associated with age-based restrictions that there is a “safe age” to begin using tobacco products, and that tobacco use is part of “coming of age” into adulthood. Proposed as an alternative to minimum-age laws, the policy is theoretically grounded in the mixed evidence on effectiveness of age restrictions, the tobacco industry’s longstanding enthusiasm for framing tobacco use as an “adult” activity, and findings suggesting that “young people control” measures may actually inspire reactive defiance among young people and make them more inclined to want to do whatever is age-prohibited (2).

To date, no comprehensive pre-post evaluations of BSR policy impact have been conducted. As with many other forward-looking policies, the evidence must be drawn inferentially from studies of other somewhat similar policies or modelled on the basis of inferential assumptions. Raising the age of purchase for tobacco products to 21 years, or Tobacco 21 (T21) – see evidence brief (v) “Increase in minimum legal age for sales of tobacco products” – while not fully equivalent, is the closest tobacco-related parallel, and research on its effectiveness is mixed. After statewide T21 policies were enacted in California and Hawaii in the United States, monthly cigarette sales volumes dropped when compared with states without such a law (3). An analysis of national survey data in the United States reported that living in an area covered by a T21 policy was associated with an approximately 3.1 percentage point reduction in likelihood of smoking among 18 to 20 year olds (4). A 2024 modelling study suggested that comprehensive enforcement of T21 federal, state and local policies could avert up to 52 ,000 premature deaths, but noted that enforcement varied widely (5).

Retailer noncompliance is a major barrier to successful implementation of T21 policies. A study of retailer compliance in New Jersey found that underage decoys had their identification checked only 65% of the time, and were able to successfully purchase products in more than 40% of visits (6), and a California study using pre- and post-T21 survey data found similar results regarding purchases by minors and little change in tobacco product use (7). A national study in the United States found that only 17% of grade students in grades 6 to 12 who attempted to buy cigarettes after the policy was in effect nationally were unsuccessful in doing so (8).

BSR, however, is different from T21 and may have potential for de-normalizing tobacco. Berrick (9) draws a parallel with evidence about a different type of policy: motorcycle helmets, which vary in that some jurisdictions mandate all motorcyclists to wear them and some require them only for minors. He notes the findings of a meta-analysis reporting that there is greater compliance with a universal law requiring helmets for all motorcyclists, and less young people defiance compared to age-restricted laws, suggesting that a BSR tobacco policy might have similar effects on young people. It is logical to assume that given strong ongoing enforcement and retailer penalties, such a policy would reduce tobacco use by limiting consumer access to product purchases.

The policy’s differential treatment of older tobacco users and those of succeeding cohorts is broadly consistent with other types of “grandfathering” provisions whereby some people or entities may

follow old rules instead of newly enacted ones. For example, many states in the United States changed the legal alcohol drinking age from 18 to 21 in the late 20th century, but those individuals who were already 18 to 20 at the time were “grandfathered” and permitted to continue (10).

There has been a surge of interest in BSR policies in recent years. A “tobacco-free generation” BSR has been enacted and successfully defended against court challenges in Brookline, Massachusetts, in the United States, and passed in at least 15 other Massachusetts communities; a statewide bill has been introduced (as of July 2025) (11). Legislation for a BSR policy was passed by Parliament in the Maldives on 13 May 2025, and will enter into force on 1 November 2025 (12). A BSR bill has been passed by one House of Parliament in the state of South Australia (13) and is currently being assessed by government staff.

New Zealand included a “Smoke-Free Generation” (SFG) BSR in its comprehensive Smokefree 2025 plan (14) (limited to smoked products). That policy, which was to have been accompanied by a comprehensive set of complementary FLMs aimed at achieving a goal of less than 5% daily smoking prevalence for all population groups by 2025, was subsequently repealed in full under a new government in 2024 and never implemented. Efforts continue to pressure the government to re-enact the policies, which are widely supported, including among young people (15, 16).

A BSR policy was introduced in the United Kingdom in 2023 but was not enacted prior to a change in government leadership (17). It has been reintroduced and appears to have public support, with 63% of respondents agreeing with the policy change (18). The United Kingdom policy plan includes smoked products, waterpipe tobacco, cigarette papers and herbal smoking products as subject to the new policy.

Two Canadian provinces also launched public consultations about BSR measures in 2024. Prince Edward Island proposes a BSR policy in conjunction with retail restrictions and expansion of cessation services (19). Newfoundland and Labrador have also launched a public consultation including a BSR policy, T21, and prohibiting vending machine sales (20). The province of British Columbia has started a campaign to promote adoption of the policy in combination with increased cessation support, denicotinization retail reduction, and banning flavoured vaping products (21).

This policy would, in the short term, affect only young people whose date of birth fell after the designated date. Longer term, it would grow to affect the whole population as it has the effect of raising the age for legal sales annually. Modelling commissioned by the New Zealand Government in 2021 found that a well-enforced BSR policy could halve smoking rates within 15 years, with greater health gains for Māori, New Zealand’s Indigenous peoples, among whom smoking rates are higher and the population younger (22). Subsequent peer-reviewed published analyses (23) projected that the combination of denicotinization, retail reduction and BSR would rapidly reduce adult smoking prevalence from 31.8% in 2022 to 7.3% in 2025 for Māori, and from 11.8% to 2.7% for non-Māori. Compared with denicotinization and retail reduction as separate policies; however, BSR alone would avert far fewer deaths during 2020–2040. As a stand-alone policy, the BSR would not achieve New Zealand’s goal of less than 5% smoking prevalence by 2025 for any portion of the population, and would take many decades to have an effect on health gains (23). This policy is likely to be most effective at the population level when enacted in combination with other policies, as in the New Zealand plan, particularly in countries where young people smoking rates are relatively low.

The Government of the United Kingdom modelling studies estimated that with a well-enforced BSR policy, smoking prevalence would fall from 13% in 2023 to nearly zero by 2050 among persons aged 14–30 years, and from 12.7% in 2023 to 1.5% in 2056 among those aged 18+ years. There are

relatively small projected short-term impacts on reducing disease cases and mortality, given the long trajectory for developing many tobacco-caused diseases. However, consistent with results of the New Zealand government modelling studies discussed in the preceding paragraph, under the modelled assumptions the number of premature deaths avoided would rise dramatically after 2044 in the United Kingdom. The United Kingdom's modelling study suggests that if the United Kingdom policy is successful, it will lead to public health benefits over 30 years, including improvements in the health outcomes of people who do not initiate smoking, reductions in healthcare costs, illness, and health inequalities, and increased spending in other sectors of the economy (18).

A recent paper (24) modelled a scenario in which sales were banned for individuals who were born between 2006 and 2010 in 185 countries to assess the impact on population lung cancer mortality through to 2095. *With perfect enforcement*, the study found that by 2095, the policy could prevent more than 1.1 million lung cancer deaths in people from this cohort.

BSR makes no immediate visible change to the tobacco retail environment; thus, even if fully implemented and enforced across several decades, it makes very gradual changes to the structural, political and social dynamics that sustain the epidemic. As the population to whom the products may be legally sold grows smaller and older, and the use of the products perhaps appears thereby less appealing to young adults, it may have a broader de-normalizing or signalling effect, contributing to reduced smoking prevalence (25). The policy is likely to be most effective in jurisdictions where smoking prevalence is low, other existing tobacco control measures in place, and where there is high capacity for ongoing effective monitoring and enforcement at the level of individual retailers. If well implemented, BSR could slowly close off the pipeline of "replacement smokers" (or other tobacco products users, if the BSR policy is extended beyond cigarettes) on which the industry depends.

Worldwide, over 93% of smoking-related deaths occur in those 50 and older. Even in low-income countries with larger proportions of younger people, 86% of smoking deaths occur among those aged 50+ years (26). Older smokers are less likely to benefit from the policy, which will initially have very modest effects but across several decades, will impact increasing numbers of people. Assuming projected estimates are correct, it will have high to significant population-level impact in 30 years. However, it is difficult to determine impact with much precision, given the very long trajectory of change.

As a stand-alone policy, BSR measures would take several decades to reduce smoking prevalence. Modelling conducted for the New Zealand government found that the smoke-free generation policy by itself would not achieve the smoke-free goal of prevalence at 5% or less for non-Māori until 2040 and for Māori until 2054 (22). The majority of the health-adjusted life years gained were after 2040.(23) A modelling study from Singapore found that a BSR type policy alone would achieve a smoking prevalence target of 5% or less only after 39 years, compared with combining nicotine reduction and a flavoured products ban, which were projected to achieve it within a decade (27). Another study examining the potential impact of such a policy in Solomon Islands found that BSR policy would take nearly 40 years to achieve a goal of prevalence less than 5% (28).

Awareness and profile of the FLM as a potentially promising intervention

In addition to the jurisdictions mentioned above, variations on BSR policies have also been proposed elsewhere, including Tasmania, Australia, the Philippines, Malaysia and three states in the United States, but have not yet been enacted (29–36). While some countries such as Denmark have used the “tobacco-free generation” language to describe their goals (37), we were unable to find others that had proposed or implemented a BSR policy.

Studies conducted in several countries have found substantial public support for BSR policies. A study from Tasmania, Australia found majority policy support among adults and students aged 12–17 years across all sociodemographic subgroups. Among adults, 75% supported the policy, including 72% of people who smoked. Among young people, there was 68% support, including 64% of those born after the proposed cut-off year (38).

Likewise, a study from New Zealand found strong support for “a law that prevents anyone who is currently 18 or younger from ever buying cigarettes or tobacco”, with more than 75% of people who smoke and those who have quit smoking supporting it (39). New Zealand young people interviewed about the proposed policy supported it as a social good and viewed it as liberating rather than restrictive (40). A study conducted in Ireland found 56% support for a “tobacco-free generation” policy (41).

Other studies have found moderate to low levels of support, and interpretation is hampered by differences in how the questions are asked. In Hong Kong SAR (China), a 2015 survey found 71% of adults supported a BSR type policy, although the question referred to a birthdate-based “smoking” ban rather than a sales ban (42). A recently published cross-sectional representative study from the United Kingdom, however, reported that just 34.5% supported the policy, while 41.3% were opposed (43). A recent meta-analysis of multiple endgame policies (44) included four studies measuring public support for BSR and estimated an overall 54% level of support for a “tobacco-free generation” policy.

Policy-makers may find the BSR approach appealing as it makes very small changes in the status quo, thus minimizing opposition. A qualitative study in the United States with California legislators, staff and tobacco control leaders (45) found that a TFG/BSR policy was regarded favourably as feasible due to its very gradual approach.

Implementation considerations specific to this FLM

Overall, the research literature suggests that retailer non-compliance is a significant limiting factor in the effectiveness of T21 policies (8, 46). BSR policies, which require retailers to make behaviour changes, including checking identification universally (not only for those who appear young, but for everyone, to verify birth year), and refusing sales based on birth year regardless of age, would require additional dedicated resources for much more rigorous enforcement and substantial penalties for retailer non-compliance. As the age of legal sale gradually increases under BSR, retailers may find universal identification checks and compliance more challenging as, for example, after many years someone aged 36 may be legally sold tobacco products but someone aged 35 cannot. However, it is also possible that as the policy takes effect some retailers may find that with additional compliance checks, declining tobacco sales, and relatively low retail-level profit margins, tobacco sales are no longer worth continuing. If this occurs, it could further enhance the effectiveness of a BSR policy through retail reduction by attrition.

Many young people obtain tobacco from social sources (47–49). These sources may be difficult to

identify and control. However, social supply of tobacco often comes from peers who are close in age, so social supply channels are also likely to shrink as the policy advances over time. As the cohorts still smoking grow older, young people may find that tobacco use (or smoking) becomes a practice regarded as less desirable to emulate.

Depending upon the way the BSR is structured and what products are included, it could allow or promote product shifting among young people; for example, if only cigarettes or combustibles are included, young people vaping or other nicotine product use could increase. Since there is no public health rationale for allowing people not already addicted to a product to purchase it, this risk could be mitigated by ensuring that sales of all tobacco and nicotine products are subject to the policy.

Another caution related to this FLM is that if policy-makers feel passage of BSR has “fixed” the tobacco problem, it could unnecessarily delay for decades more rapidly effective and definitive measures, such as retail reduction or other changes to the tobacco-promoting environment that reduce exposure to tobacco-promoting cues (50). Consideration of this measure should take into account the political appetite for additional, complementary measures. BSR should not be considered instead of established WHO FCTC measures, but as a supplementary option for jurisdictions that have already implemented required WHO FCTC policies.

While modelling from New Zealand suggests pro-equity effects, a BSR policy may also have the effect of “locking in” existing health disparities in several ways. As BSR has no direct effect on reducing the accessibility, availability, and attractiveness of tobacco products for consumers born before the birthdate cut-off, without additional concurrent interventions it may entrench (or at minimum do nothing to ameliorate) already-existing tobacco-caused health inequities among the population groups now most likely to be tobacco users, namely older people and disadvantaged groups. Communities traditionally preyed upon by the tobacco industry, evidenced through high retail density, targeted marketing exposure, and higher prevalence and disease burden (51–53) also often have weaker tobacco control infrastructure. They may be less able to successfully implement additional initiatives to address ongoing tobacco use among residents born before the birthdate cut-off, and BSR enforcement may be more challenging due to social conditions in deprived communities, thus further exacerbating disparities (50). Combining a BSR policy with other FLMs, particularly retail reduction, as in New Zealand’s previously-passed package of measures, would likely make enforcement easier and minimize the potential for negative consequences. A recent analysis suggests specific conditions that would maximize benefits and mitigate the potential for negative consequences of a BSR (50). These conditions include strong resources and authority for enforcement, education and monitoring of retail compliance, enacting the policy as part of a comprehensive package that includes measures that will also benefit the population not subject to the birthdate cut-off, and commitment of cessation resources, including direct assistance as well as ongoing motivating and supportive messaging through media and health systems to support people who use tobacco.

Summary

There has been a recent surge of interest in BSR policies, which have been implemented in numerous cities in Massachusetts in the United States, introduced but not implemented in the United Kingdom, passed and then rescinded in New Zealand, and are under consideration in the state of South Australia and several Canadian provinces. BSR-related policies have also been proposed in Tasmania, Australia, the Philippines, Malaysia and three states in the United States. While the policy would only have a short-term impact on people whose date of birth fell after the designated date, it would have a long-term impact on the whole population as the age for legal sales

rose annually. As the population to whom the products may be legally sold grows smaller and older and the use of the products perhaps appears thereby less appealing to young adults, it may have a broader de-normalizing or signalling effect. BSR makes no visible change to the tobacco retail environment, however, and thus would be expected to make only gradual changes to the social and structural dynamics that sustain the tobacco epidemic. BSR policies are politically appealing and, if rigorously implemented, could slowly close off the pipeline of “replacement smokers” (or other tobacco products users) on which the industry depends. Modelling studies suggest that if fully implemented and effectively enforced, the policy would have a dramatic positive impact on now-younger age groups, depending on their current smoking prevalence levels. Assuming projected estimates are correct, BSR could have high to significant population-level impact in 30 years.

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