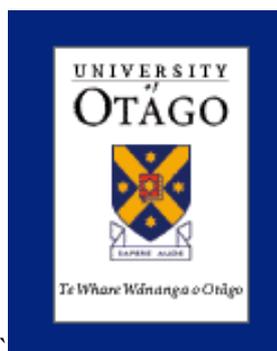


After the Smoke has Cleared: Evaluation of the Impact of a New Smokefree Law

Outstanding issues and recommendations for policy and research

Report Commissioned and Funded by the New Zealand
Ministry of Health



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Introduction

The smokefree provisions of the 2003 Smoke-free Environments Amendment Act (SEAA (2003)) evaluated in the report 'After the Smoke has Cleared: Evaluation of the Impact of a New Smokefree Law' were judged as broadly successful. However, the evaluation identified some key policy issues and areas of uncertainty which require further research. These are the focus of the recommendations that follow.

Outstanding issues and recommendations

1. The extent of non-compliance with the SEAA (2003)

As a result of the evidence of possible non-compliance and gaps in the evaluation data, we recommend specific research and more extensive and more active monitoring and enforcement of the SEAA (2003). This should include:

1. Further investigation to assess the extent and distribution of non-compliance in the non-office, non-hospitality sector. If this is confirmed as affecting 8% or more of the workforce, a more active system of monitoring and enforcement will be required to ensure that the SEAA (2003) is implemented effectively in all workplaces.
2. An investigation of compliance and air quality in a representative sample of remote rural pubs and bars outside of the major urban centres.
3. Repeated assessment of overall compliance in the hospitality sector at a minimum of every two years.
4. The requirements of the SEAA (2003) and the confidential compliance reporting telephone number should continue to be maintained and promoted. Promotion needs to be particularly targeted at those working in and managing small businesses.
5. To demonstrate the seriousness with which non-compliance is viewed, prosecutions should be undertaken wherever practicable in all cases of deliberate and sustained non-compliance.

2. Smoking in outdoor areas in the hospitality sector

The stakeholder interviews revealed that there are potential problems with outdoor smoking areas. These include: poor indoor air quality where smoke drift can occur from outdoor areas in communication with internal areas, or from smoking in

doorways; poor air quality in outdoor areas, particularly where they are semi-enclosed, and resultant second hand smoke (SHS) exposure for staff having to enter outdoor areas to work; and potential for negative role modeling to children of the association between drinking and smoking, due to its increased visibility in outdoor areas.

We therefore recommend the following:

6. An investigation of the air quality of semi-enclosed outdoor smoking areas in the hospitality sector (e.g. using measurements of fine particulate levels), and the effects of exposure in these settings on biomarkers of exposure in non-smoking customers and staff.
7. An investigation of the effects on indoor air quality and biomarkers of exposure in non-smoking customers and staff, of SHS from smoking in doorways and from outdoor smoking areas in communication with indoor areas.
8. The Ministry of Health to introduce further restrictions on the degree of enclosure allowed for outdoor smoking areas, and on the permitted proximity to non-smoking areas as appropriate, and as have been implemented in other jurisdictions.¹
9. An investigation of the extent of, and implications of, smoking on marae through Māori initiated and directed research, and exploration of appropriate solutions by Māori groups.

3. Second hand smoke exposure in exempted workplaces (prisons, residential homes, and residential care institutions)

There are currently no data available on the experience of implementation of the SEAA (2003) in settings where partial restrictions on smoking in indoor areas were introduced. These include prisons, residential homes, and residential hospital and disability institutions. It is unclear, for example, how practicable it has been to

¹ From July 2006, outdoor smoking areas in licensed premises in Queensland, Australia are limited to 50% of the total area, can only be visited by staff to clear glasses and empty ashtrays, are required to have a buffer zone around them, and food consumption and provision of entertainment such as TVs and pool tables within them is forbidden. (Queensland Health, 2006)

protect staff and non-smoking residents from SHS exposure and maintain air quality in institutions where smoking is allowed in designated rooms or areas. We recommend the following:

10. An investigation of the experience of implementing the SEAA (2003) in prisons, residential homes, and residential hospital and disability institutions should be commissioned. This should include: interviews with staff and non-smoking residents about changes in smoking policies resulting from the SEAA (2003); self-reported SHS exposure, and measurements of bio-markers of exposure and/or air quality; investigation for disparities in exposure between Māori and non-Māori in these settings.
11. The Ministry of Health to introduce tighter policies and regulations based on the findings of the investigations recommended above (and/or based on reviews of relevant international experience).

4. Second hand smoke exposure in other settings

The main source of SHS exposure, particularly for children, is now through exposure in private settings such as homes and cars. Although there is some evidence that the SEAA (2003) had positive impact on SHS exposure in the home at least, the extent of this SHS exposure remains unacceptably high from a public health perspective and requires further investigation and implementation of appropriate measures to reduce exposure. Internationally, there are recent precedents from Puerto Rico and the US States of Arkansas and Louisiana, which have passed legislation to ban smoking in cars, where children are passengers. We recommend the following:

12. Future investigations of SHS exposure in the other settings should include ongoing monitoring of smoking in the home and in cars, and should include regular measurement of objective measures of biomarkers of exposure in an adequately sized and representative sample of adults and children – in order to identify trends in overall SHS exposure over time, and by ethnicity and socio-economic status.
13. Investigation of the impact of different smoking restrictions on air quality within homes and cars. For example, the impact of smoking on air quality under different conditions of ventilation in cars, and the impact of different degrees of restrictions on smoking around the home on air quality in living

and sleeping areas.

14. The Ministry of Health to develop targets for the reduction or elimination of SHS exposure in homes and cars.
15. Drawing on findings of the above investigations and international experience, the Ministry of Health to consider the merits of introducing a ban on smoking in cars which are carrying children (as per the international laws described above).
16. The Ministry of Health to support the development, implementation and evaluation of additional mass media, community and household based methods to promote smokefree homes. These should particularly focus on communities with high smoking prevalences, such as low socio-economic and Māori communities.
17. Ensure that future strengthening of smokefree legislation and interventions to promote smokefree policies in private settings are evaluated using methods that include objective assessments of the impact on biomarkers of exposure and/or air quality.

5. Impact of the Smoke-free Environment Act Amendment on schools and early learning establishments

This report does not include an evaluation of the impact of the section of the SEAA (2003) that introduced a total ban on smoking in the buildings and grounds of all schools and early learning institutions. This should be investigated. We recommend the following:

18. An investigation of the experience of implementation of the SEAA (2003) policy banning smoking in the buildings and grounds of all schools and early learning institutions – to include lessons from the implementation process, and evidence for effects on attitudes and beliefs about SHS exposure and smoking, SHS exposure among staff and children, school policies on smoking among children, smoking prevalence among staff, and smoking experimentation and uptake among children.

6. Investigation of health impacts

The investigation of the impact of the SEAA (2003) on health using hospitalisation data did not find clear evidence of an effect. The opportunity to investigate for an effect on health on groups of workers such as bar workers who were heavily exposed to SHS prior to implementation of the SEAA (2003) was missed. We consider it important that efforts continue to investigate the effects on health of the SEAA (2003), or of subsequent further tightening of the restrictions on smoking in public places and workplaces. We recommend the following:

19. Commission innovative research to explore the possible impacts on health of the SEAA (2003).
20. Subsequent restrictions on smoking in workplaces should include support for research to investigate impacts on health among relevant key groups. Possible groups include prison officers, prisoners, and those working in residential and health care facilities with smoking rooms, and also on the differential impact among Māori and non-Maori.

7. Additional tobacco control efforts

The continued high level of smoking, particularly among deprived groups and Māori communities, is a continuing major source of avoidable morbidity and mortality, and cause of health inequalities in New Zealand. Tobacco control efforts must continue to be strengthened.

Experience from implementation of the SEAA (2003) shows that radical and innovative tobacco control policy measures can be implemented successfully, and attract strong public support. However, the decrease in promotion of smoking cessation through the Quitline at the time of implementation of the SEAA (2003) was unfortunate, and illustrates the need to co-ordinate tobacco control measures in order to maximize impact.

New Zealand has been a leader in tobacco control. There is an opportunity to continue that tradition. Successful implementation of the SEAA (2003) shows what is possible. If legislation for smokefree bars can be introduced, so can many other measures. The Smoke-free Environments Amendment Act should be seen as a necessary component of a co-ordinated strategy of substantive legislative and other

policy and health promotion measures that tackle the very serious but preventable problem of tobacco smoking in New Zealand.

We recommend the following:

21. To continue to pursue a co-ordinated strategy of tobacco control with a substantively enhanced legislative and other policy and health promotion measures to tackle the very serious but preventable problem of tobacco smoking in New Zealand. Banning all point-of-sale advertising, introducing generic packaging of tobacco products, tax and duty increases, major increases in cessation support, campaigns to denormalise the tobacco industry, and the removal of profit motivation from tobacco production and distribution should all be actively considered.
22. Additional funding to be made available for the promotion and delivery of smoking cessation support services such as the Quitline during and in the period after the introduction of new tobacco control policy measures which may result in increased motivation to quit and demand for such services.