DHB logo

Canterbury District Health Board's

SMOKEFREE / AUAHI KORE POSITION STATEMENT

November 2012

This position statement is consistent with those of Nelson Marlborough, West Coast, South Canterbury, and Southern District Health Boards (DHB). This position statement has been developed collaboratively by the South Island Public Health Units and represents the South Island DHBs working together to support the South Island to be a place where Smokefree lifestyles are the norm and harm from and exposure to tobacco smoke is minimised.

The purpose of this statement is to describe the commitment of the Canterbury DHB to the Government's goal of a Smokefree Aotearoa New Zealand by 2025 and the strategies to achieve this. This goal was determined at a national level in response to the 2011 Māori Affairs Select Committee Inquiry into the tobacco industry and the effects of tobacco on Māori. This position statement is informed by the Smokefree Aotearoa/New Zealand 2025 logic model (Appendix A) and aligns with the Canterbury DHB's Tobacco Control Plan.

The Canterbury DHB recognises the extensive harm from tobacco use that is experienced by people within the Canterbury district and that the burden of this harm is carried disproportionately by some population groups. Tobacco use is a major risk factor for numerous health conditions and is a significant cost to the health system.

CANTERBURY DHB POSITION

- Canterbury DHB supports the Government's goal of achieving a Smokefree Aotearoa New Zealand by 2025.

- Canterbury DHB aims to reduce the tobacco-related harm experienced by people within the Canterbury district by actively focussing on these outcomes:
    - Protect children from exposure to tobacco
    - Reduce the demand for and supply of tobacco, and
    - Increase successful quitting.

CANTERBURY DHB STRATEGIES

- Provide leadership and facilitate effective implementation of evidence-based strategies to support local populations to be Smokefree.
- Support and prioritise initiatives that address health inequalities by reducing smoking prevalence in Māori communities, and other priority populations including: Pacific People, pregnant women and their whānau, children, mental health consumers, rural populations and economically disadvantaged people.
- Work towards achieving the health target 'Better Help for Smokers to Quit' in primary and secondary care by implementing the ABC Strategy[1] for Smoking Cessation.
- Be a Smokefree role model in the community by reducing smoking initiation, supporting people to quit smoking and providing a Smokefree environment.
- Support the development of strong relationships with other community organisations to achieve the Smokefree Aotearoa 2025 goal.
- Develop and implement local solutions to achieve these strategies through its Tobacco Control Plan.

[1] The New Zealand Smoking Cessation Guidelines (Ministry of Health 2007) recommend that all health care workers use the three step ABC tool. The first step is to **A**sk about smoking status, then give **B**rief advice to stop smoking and finally to provide evidence-based **C**essation support or referral to a smoking cessation service.

SUPPORTING EVIDENCE

Preamble

The harmful effects of smoking on health are well documented. Smoking has been identified as a cause of a wide range of diseases and other adverse health effects. These include a range of cancers and cardiovascular diseases, respiratory diseases, fetal deaths and stillbirths, pregnancy complications and other reproductive effects, cataracts, peptic ulcer disease, low bone density and fractures and diminished health status and morbidity (Doll et al 2004; US Surgeon General 2004). In New Zealand smoking is a primary risk factor in one in four of all cancer deaths (Smoke Free Coalition/Te Ohu Auahi Kore undated). Quitting smoking has immediate and long term benefits, even for those who quit late in life (US National Cancer Institute 2011).

Environmental tobacco smoke (passive smoking or second hand smoke) is also well established as having adverse health effects. It increases the risk and frequency of serious respiratory problems in children, such as asthma attacks, lower respiratory tract infections, and increases middle ear infections. Inhaling second-hand smoke may cause lung cancer and coronary heart disease in non-smoking adults (US Surgeon General 2006). New Zealand studies of never smokers living with smokers showed that they had an excess risk of mortality from heart disease and cerebrovascular disease (Hill et al 2004). According to the Smokefree Coalition around 350 New Zealanders die from the effects of others' smoking each year (Smokefree Coalition/Te Ohu Auahi Kore undated). Exposure to second hand smoke is a public health hazard that can be prevented by making homes, workplaces, vehicles and public places completely Smoke free (US Surgeon General 2006).

Smoking in New Zealand

- In 2009 smoking data in New Zealand showed that one in five (21%) adults aged 15-64 years were current smokers, with 19.2% of adults smoking daily (Ministry of Health 2010). A current smoker is someone who has smoked more than 100 cigarettes in their lifetime and at the time of the survey was smoking at least once a month (World Health Organisation 1998).
- Smoking rates in New Zealand continue to decline. The age-standardised prevalence of current smoking in 15-64 year olds fell significantly between 2006 (24.4%) and 2009 (21.8%). There was no difference in the age-standardised prevalence of current smoking between males and females (Ministry of Health 2010).
- Table 1 shows that the prevalence of regular smokers in the South Island DHBs' area is highest in the West Coast DHB area and lowest in the Canterbury DHB area.[2]

[2] Anecdotal evidence suggests that smoking rates may have increased in Canterbury following the earthquakes.

Table 1. Smoking prevalence by South Island District Health Board area, 15+ years (Statistics New Zealand 2006)[3]

	Nelson Marlborough DHB area (%)	West Coast DHB area (%)	Canterbury DHB area (%)	South Canterbury DHB area (%)	Southern DHB area		NZ Total (%)
					Southern DHB - Otago (%)	Southern DHB - Southland (%)	
Prevalence of regular smokers	19.3	25.7	18.8	21.2	19.4	23.8	20.7

Smoking related disparity and health outcomes

- Māori in all age groups had higher smoking prevalence than non-Māori (Ministry of Health 2011a). Ethnicity data in Table 2 show that the prevalence of smoking amongst Māori is double that of the rest of the population (Ministry of Health 2010).

Table 2. Prevalence of current smokers by ethnicity and sex, 15-64 years, 2009 (Ministry of Health 2010)

	Male (%)	Female (%)
Māori	40.2	49.3
Pacific	32.3	28.5
European/other	20.6	18.9
Asian	16.3	4.4

- Smoking related disease is a major cause of health inequality. Health outcomes include a higher incidence of cancer, cardiovascular and respiratory disease and lower life expectancy for Māori compared to the rest of the population (Ministry of Health 2011b; Ministry of Health 2011c).
- The burden of tobacco related harm is experienced disproportionately by some population groups within the Canterbury district. Smoking prevalence is higher for Māori, Pacific and those living in more deprived areas (Ministry of Health 2010). These priority populations have higher rates of smoking during pregnancy, which poses various health risks to the develop foetus, infant and mother (Alliston 2005).

[3] These figures were taken from the last census (2006) at which time Otago and Southland DHB were separate entities.

Smoking cessation

- The Ministry of Health is committed to a Smokefree New Zealand and has developed the ABC strategy for smoking cessation which is being rolled out in all DHBs. This strategy is supported by the setting of a national health target, 'Better Help for Smokers to Quit'. The 2012/13 target is 95% of patients who smoke and are seen by a health practitioner in a public hospital and 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. Within the target a specialised identified group will include progress towards 90% of pregnant women who identify as smoking at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit (Ministry of Health 2011d).
- Evidence suggests that providing brief advice, particularly by a doctor, significantly increases the rate of quitting (Stead et al 2008) and long term quitting success (Ministry of Health 2011d). The proportion of successful quit attempts is increased by the provision of effective cessation support, such as medications, including Nicotine Replacement Therapy (NRT), and multi-session support including telephone or face-to-face support (Ministry of Health 2011d; Ministry of Health 2007).
- Research shows that one in every 40 smokers will make a quit attempt simply as a result of receiving brief advice (Ministry of Health 2011e).
- Table 3 shows South Island DHBs' secondary care results for the last quarter.

Table 3. Quarter Four (April-June 2012) results for 'Better help for smokers to quit' health target by DHB for secondary care (Ministry of Health 2012)

	South Canterbury DHB	Nelson Marlborough DHB	West Coast DHB	Southern DHB	Canterbury DHB
% of hospitalised smokers given advice to quit	96	96	90	96	90
Ranking (out of 20 DHBs)	9	8	18	7	16

Smokefree workplaces

- Workplace Smokefree policies reduce business costs associated with tobacco consumption. These include absenteeism, lost productivity, time spent on breaks, increased building, health and life insurance costs, potential legal costs and cleaning and maintenance costs (IARC 2009). Introducing workplace Smokefree polices reduces tobacco consumption and smoking prevalence within the affected workforce (Edwards et al undated). For instance, smokers have fewer opportunities to smoke, which reduces levels of consumption and encourages quit attempts (IARC 2009). Cessation support should be provided to support

employees who smoke to quit.

- Usually within a few months of implementing Smokefree policies compliance is high and in most places policies become self-enforcing (IARC 2009). Evidence suggests that compliance may be enhanced by media advocacy and public education campaigns that strengthen social norms before and during policy implementation (Ross 2006; US Surgeon General 2006).
- In 2005, the tangible costs of smoking to the New Zealand economy were NZ$1.7billion. Major components included lost production due to premature mortality or lost production due to smoking-caused morbidity (O'Dea et al 2007).
- A New Zealand cross-sectional survey conducted in 2006 found strong support for Smokefree workplaces. Of 2413 people surveyed 94.3% agreed that people have the right to work in a Smokefree environment and 93.9% agreed that people who work in a non-office environment also have the right to work in a Smokefree environment (Waa and McGough 2006, p.14).

Smokefree role modelling

- Role modelling is an important factor in smoking behaviour (Edwards et al 2012). For example, health professionals who don't smoke may be role models for patients in regards to healthy behaviour. However, medical professionals who smoke may increase public scepticism about the importance of quitting (Smith and Leggat 2007).

Smokefree environments

- The Smoke-free Environments Act 1990 is designed to protect non-smokers against the detrimental effects of other people's smoking. Other aims of the legislation include Smokefree role modelling and promoting a Smokefree lifestyle as the norm (Ministry of Health 2005a; Ministry of Health 2005b).
- There has been an increasing focus on Smokefree outdoor areas, with a large number (see Table 4 for South Island policies) of councils within New Zealand adopting Smokefree outdoor area policies.
- There is some evidence showing that second hand smoke in outdoor areas is harmful. A recent New Zealand study has found that smoking in outdoor areas does increase particulate levels to a level that could potentially cause health hazards (Wilson et al 2011). Evidence also suggests that smoking has a role modelling effect on teenagers: those who smoke are more likely to have been exposed to smoking than those who don't smoke (and exposure is likely to have been from outdoor places) (Alesci et al 2003). Therefore, the focus should be on "role modelling and making Smokefree normal" (Smokefree/Auhai Kore Tool Kit undated).
- The rationale for Smokefree outdoor areas is to reduce the visibility of smoking, especially to children, in order to reduce the uptake of smoking. It also has benefits of decreased litter (CanTobacco undated, Halkett and Thomson 2010).
- Table 4 shows how DHBs have engaged with local authorities to develop Smokefree policies within their communities.

Table 4. South Island councils and Smokefree Outdoor Area policies

Council	Description	Date adopted
Nelson Marlborough DHB		
West Coast DHB		
Buller District Council	All Council-owned parks, playgrounds and sports fields	2011
Grey District Council	All Council-owned parks, playgrounds and sports fields	2011
Westland District Council	All Council-owned parks, playgrounds and sports fields	2011
Canterbury DHB		
Christchurch City Council	All playgrounds, skate parks, stadiums and courts, sports fields and public events	2009
Hurunui District Council	All Council-owned reserves including playgrounds and sportsgrounds	2012
Waimakariri District Council	All Council-owned playgrounds	2012
Selwyn District Council	All playgrounds, parks, sports grounds and Council run or sponsored events	2011
Ashburton District Council	All playgrounds Sports fields in Council-owned parks Skate park	2007 2009 2011
South Canterbury DHB		
Waimate District Council	All playgrounds	2009
Timaru District Council	All playgrounds	2012
Mackenzie District Council	All playgrounds	To be adopted in 2012
Southern DHB		
Dunedin City Council	All playgrounds	To be adopted in 2012
Clutha District Council	All playgrounds, sports fields and council run family events	2012
Queenstown Lakes District Council	All playgrounds and swimming pools	2006
Invercargill City Council	All playgrounds All sports fields, Queens Park aviary and animal reserve	2008 2010
Gore District Council	All playgrounds and parks	Currently under development

- International evidence indicates that the public are generally in favour of restrictions on smoking in "various outdoor settings" and there has been a gradual increase in support for Smokefree public places over time (Thomson, Wilson and Edwards 2009; Klein et al 2007).
- Locally, the New Zealand public are supportive of Smokefree outdoor areas. For example, three quarters (76.4%) of New Zealand adults believed that it was 'not at all' acceptable to smoke at children's outdoor playgrounds (Cancer Society of New Zealand and Health Sponsorship Council 2008). In another study evaluating Upper Hutt's smokefree parks policy, 83% of adult park users thought having a Smokefree parks policy was a good idea (Stevenson et al 2008) and similarly an Dunedin study found that 73% of those surveyed were supportive of making playgrounds Smokefree (Harris et al 2009). People who smoke are generally supportive of Smokefree playgrounds (Thomson et al 2009).
- Community support for Smokefree outdoor areas is an important factor in getting councils to endorse outdoor policies (Halkett and Thomson 2010).

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Appendix A – Smokefree Aotearoa/ New Zealand Logic Model 2025

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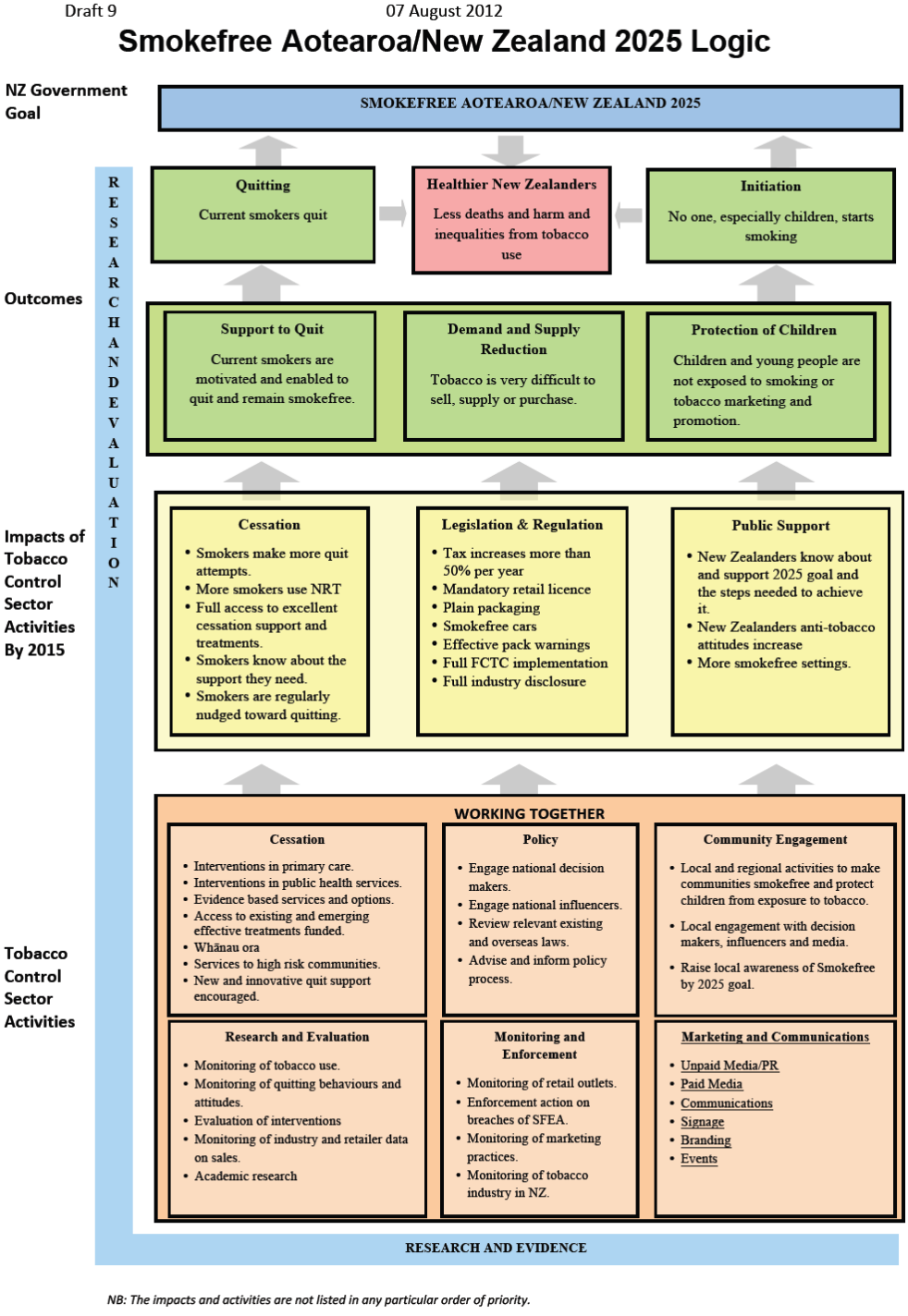

NB: The impacts and activities are not listed in any particular order of priority.

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