Brief Report

Indoor smoking ordinances in workplaces and public places in Kansas


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Abstract

Introduction: The purpose of this study was to investigate the preferences of elected city officials regarding the need for a statewide clean indoor air law and to analyze the content of local smoking ordinances.

Methods: A survey of elected officials in 57 larger Kansas cities obtained information on the perceived need for statewide legislation, venues to be covered, and motivating factors. Clean indoor air ordinances from all Kansas cities were analyzed by venue.

Results: The survey response rate was 190 out of 377 (50.4%) for elected officials. Over 70% of the respondents favored or strongly favored greater restrictions on indoor smoking. Sixty percent favored statewide legislation. Among these, over 80% favored restrictions in health care facilities, theaters, indoor sports arenas (including bowling alleys), restaurants, shopping malls, lobbies, enclosed spaces in outdoor arenas, and hotel/motel rooms. Officials who had never smoked favored a more restrictive approach. Employee and public health concerns were cited as influential by 76%–79% of respondents. Thirty-eight ordinances, covering over half of the state’s population, were examined. They varied considerably in their exemptions.

Discussion: Official’s attitudes toward smoking regulations were associated with their smoking status. The examination of existing ordinances revealed a piecemeal approach to smoking regulations.

Introduction

Secondhand smoke (SHS) exposure has been found to cause numerous health problems, in both children and adults (Botello-Hardaum et al., 2009; Eriksen and Chaloupka, 2007; Juster et al., 2007; Meyers and Neuberger, 2008; Meyers et al., 2009; Muggli et al., 2008; U.S. Department of Health and Human services, 2006; Pearson et al., 2009). As of July 1, 2009, 22 U.S. States and 16 foreign countries have adopted 100% smoking bans in all workplaces, restaurants, and bars (American Nonsmoker’s Rights Foundation, 2009).

In Kansas, the primary regulation of indoor smoking has been left to local governments. State statutes prohibit smoking in public places but allow proprietors to designate smoking areas except for passenger elevators, school buses, and public means of mass transportation. In addition, proprietors may not allow smoking wherever the fire marshal or local ordinance or regulation has prohibited smoking. Many cities and counties have prohibited smoking in city and county buildings, as well as municipal vehicles, without allowing for an indoor designated smoking area. A legislative initiative has been underway to establish a uniform and strict statewide law.

A 2007 random telephone survey of 500 Kansas voters determined that 71% (error ± 4.4%) of the population favored a statewide ban in public places, including workplaces, restaurants, and bars. Fifty-nine percent strongly supported such a ban. When analyzed by smoking status, 31% of current smokers, 76% of former smokers, and 84% of never-smokers favored such a ban (20% of those in the survey were current smokers). Eighty-three percent of the surveyed population believed that SHS was a health hazard, with 59% believing that SHS was a serious health hazard (Public Opinion Strategies, 2007).

Andersen et al. (2006) surveyed 684 elected and appointed city and county public officials in Colorado by phone and mail. They found that the strongest predictor of support for indoor smoking bans was the belief that it was a serious problem for nonsmokers to breathe in other people’s cigarette smoke (odds ratio = 3.89, 95% CI = 2.08–7.26).

Because of the multiple health effects from SHS and the need for clean indoor air legislation at the state level in Kansas, this study was conducted. The purpose was (a) to identify the
attitudes of elected city officials toward restricting smoking in indoor workplaces and public places and (b) to identify the content of existing city clean indoor air regulations.

Methods

An opinion survey concerning regulation of indoor smoking was mailed in March 2008 to City Clerks of 57 Kansas cities exceeding a population of 5,000. The cities represented 67.9% of the state population of 2,681,983 (Kansas Secretary of State, July 1, 2007).

Mailings were sent under the auspices of the League of Kansas Municipalities. Surveys were distributed to all elected city officials (mayor, city council member, or commissioner), identified as Governing Board (GB) members. A follow-up phone call was made in the event of a city nonresponse. The confidential responses were completed by the end of April 2008.

The survey instrument included questions on the respondent’s age, gender, and smoking status, their attitude toward indoor smoke exposure in workplaces and public places, the need for statewide legislation, what venues should be covered, the importance of the legislation, and any health concerns. The instrument was pilot tested on five local city council members from small cities not eligible for the study. Statistical analysis included simple unweighted percentages and a chi-square test for differences by gender and smoking status. All statistical tests were two tailed and set at $p < .05$.

Clean indoor air ordinances from all Kansas cities (regardless of size) were collected from March 2008 to December 31, 2009, and analyzed for existing smoking regulations, the type of venues covered, and their exemptions. The findings were categorized into workplaces, public places, restaurants, bars, theaters, tobacco shops, hotel/motel rooms, bowling alleys, and other locations.

The project was approved by the Institutional Review Board of The University of Kansas Medical Center.

Results

Survey

Individual GB member response was 50.4% (190 out of 377 elected officials), representing an 89.5% response by cities (51 out of 57). Sixty-six percent of the 190 respondents were male, 26.3% female, and 6.8% did not report gender. The age distribution of respondents was 11.1%, age 19–39 years; 47.9%, age 40–59 years; 32.6%, age 60–79 years; and 8.4%, age unstated. Most respondents did not smoke; 3.7% were current smokers, 34.7% were former smokers, 54.7% were never-smokers, and 6.8% were unstated.

Sixty percent of respondents favored a comprehensive state mandated regulation with local enforcement. A strong association ($p < .05$) with smoking status was seen, with 59.1% of former smokers and 67.3% of never-smokers favoring a ban.

Both never-smokers and former smokers thought that city and state governments should be involved in restricting smoking while lower percentages believed that county government or federal government should be involved. The majority of smokers (57%) believed that no levels of government should restrict smoking. Never-smokers and former smokers overwhelmingly preferred city, county, or state regulation (Figure 1).

Overall, 71% of respondents either strongly favored or favored greater restrictions on smoking in indoor workplaces and public places. Most city officials (51%) were strongly in favor of further restrictions. One-in-five city officials were opposed to further restrictions. A higher percentage of female officials (60%) were strongly in favor of further restrictions than male officials (49%). More officials who had never smoked (61%) were strongly in favor of further restrictions than former smokers (47%) or smokers (0%). Indeed, 58% of smokers were opposed to further restrictions. However, some smokers did favor restrictions. Figure 2 indicates responses by smoking status.

Opinions about smoking restrictions varied considerably by smoking status. Between 60% and 78% of all respondents were in favor of further restrictions in health care facilities, restaurants, common areas in apartment complexes, hotel/motel rooms, theaters, shopping malls, indoor sports venues, and indoor areas of outdoor sports venues. A minority of respondents were in favor of further restrictions on smoking in bars (44%) or casinos (45%). This pattern held for both genders and for
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The majority of nonsmokers were in favor of further restrictions in all venues. The majority of smokers were in favor of further restrictions in all but the following venues: hotel/motel rooms (29%), restaurants (29%), bars (0%), and casinos (0%). For those favoring restrictions (135 out of 190), between 93% and 99% favored bans in shopping malls, restaurants, indoor sports facilities, motion picture theaters, and health care facilities. Between 82% and 88% favored bans in hotel/motel rooms, enclosed spaces in public areas, and common areas of apartments. Sixty-two percent of those favoring restrictions wanted bars and casinos included.

Among city officials favoring restrictions (135 out of 190), a variety of factors were cited as very or moderately important in influencing their opinions on restricting smoking. Health concerns dominated the reasons, including employee health at 79%, public health at 76%, and societal medical costs at 74%. Concerns about business impact and reduced tax revenue were cited by a lower percentage of officials (54% and 35%, respectively). The influence of adults in showing youth acceptable behavior (66%) was also cited by many respondents. There were few gender differences in the factors influencing official’s opinions. However, more males (51%) than females (44%) cited concern over business impact as an important influence. Influences on opinions about restricting smoking were also affected by smoking status. More never-smokers than smokers said that public health factors and medical costs were important opinion drivers (89% vs. 57% and 85% vs. 57%, respectively). More smokers said that reduced tax revenue (85%) was important in shaping their opinion than former (32%) or never-smokers (34%). All smokers said the influence of adults on youth was important in forming their opinions, compared with 56% of former smokers and 72% of never-smokers.

Ordinances

Existing smoking ordinances were identified in 35 cities and unincorporated areas of three counties at the end of December 2009. These ordinances covered 54.7% of the statewide population and the range in population covered was from 160 to 366,046 (Kansas Secretary of State, July 1, 2009). The cities with ordinances represent 5.6% of the cities in the state.

The analysis of the ordinances (Table 1) indicates considerable variability regarding where smoking was totally banned. Prohibitions per venue were highest for indoor restaurants (81.6%) and lowest for hotel/motel rooms (36.8%) and tobacco shops (34.2%).

“Distance requirements” separating outdoor smoking areas from doorways ranged from 10 to 50 feet. Sixteen of the ordinances (42.1%) did not specify any distance from a workplace or public place, 10 specified 10–15 feet, 9 specified 20–25 feet, and 1 specified 50 feet. In two cities, the smokers must be a “reasonable” distance from the public place.

Seventeen ordinances (44.7%) had a “non-retaliation clause,” making it a violation to retaliate against any employee who exercised his or her right to report a violation.

Many of the ordinances had separate “owner/operator penalties” or “individual penalties” for violations. In some cases, the violation was a misdemeanor and in others an

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<tr>
<th>Table 1. Smoking ordinance restrictions in 35 Kansas cities and unincorporated areas of three counties, by venue (%) (January 31, 2010)</th>
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<tbody>
<tr>
<td><strong>Venue</strong></td>
</tr>
<tr>
<td>Indoor restaurants</td>
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<tr>
<td>Indoor theaters and/or recreational facilities</td>
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<tr>
<td>Bowling alleys</td>
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<tr>
<td>Childcare and/or health care facilities</td>
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<tr>
<td>Enclosed public places</td>
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<tr>
<td>Gaming facilities, including Bingo halls</td>
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<tr>
<td>Bars and drinking establishments</td>
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<tr>
<td>Enclosed places of employment</td>
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<tr>
<td>Private clubs and fraternal organizations</td>
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<tr>
<td>Hotel and motel rooms</td>
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<td>Tobacco shops</td>
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<th>Table 2. Smoking Comparisons for Kansas in Three Data Sets (Three Different Surveys)</th>
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<td><strong>Sample</strong></td>
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<tr>
<td>2007 BRFSS (N = 8,474)</td>
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<td>2007 Telephone Survey (N = 500)</td>
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<td>GB 2008 Mail Survey (N = 190)</td>
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Note. BRFSS, Behavioral Risk Factor Surveillance System; GB, Governing Board.
administrative violation. Fines varied from a low of $25 to a high of $1000.

Discussion

Both the survey of Kansas voters in 2007 and this survey of GB members (2008) found that the majority of respondents favored statewide clean indoor air state legislation, with the GB members having a smaller percentage in favor than the general public (60% vs. 71%). The earlier survey of Kansas voters gave a slightly greater weight to health importance than did the elected city officials (83% vs. 76%–79%). Although the percentage of respondents was roughly equal in their health concerns, the voters had a much higher percentage of current smokers than did GB members (20% vs. 3.7%). Our findings of stronger support for a statewide ban among never-smokers and females align with previous studies (Cohen et al., 2002; Howard et al., 2000).

Limitations of the study include: (a) the survey was not representative of smaller cities and rural areas, (b) the response rate was only about 50%, and (c) very few current smokers were represented among the respondents.

While Andersen et al. (2006) reported a 61% response rate, their study surveyed individuals who were known to the researchers, whereas this study treated respondents in confidence.

The low percent of current smokers (3.7%, n = 7) likely represents a nonresponse sampling bias because smokers are undoubtedly underrepresented in this survey. Andersen et al. (2006) reported a 12.7% current smoking rate among all public officials surveyed, including GB members. The Kansas State Health Department’s 2004 Behavioral Risk Factor Surveillance System (BRFSS) survey indicated that the lowest weighted smoking percentages by occupation or industry were around 13% to 14.0%. (F. Ghouri, Kansas Department of Health and Environment, personal communication, July 2008).

The percentage of smokers from the state’s 2007 BRFSS smoking survey of the population (17.9%) were applied to the numbers of current, former, and never-smokers in the GB survey to calculate what the percentage responses would have been if the GB members had the same percentage of smokers as the general population. When normalized data were used, based on the most recent percentage of smokers in the total Kansas population the results of this survey were virtually unchanged (57.3% vs. 60.0% favoring a statewide ordinance).

By comparison, Table 2 indicates that the percent of current smokers was far smaller than that found in earlier surveys (BRFSS, 2007; Public Opinion Strategies, 2007). The surveyed GB members lag behind public opinion regarding the seriousness of the problem and the need for comprehensive state legislation.

Individuals in some low-income jobs or areas (e.g., waiters, bartenders, cleaning personnel in hotels/motels, or residents of certain cities) are not well protected. Given the various exemptions, thousands of employees, guests, and patients could be exposed to SHS. Exclusions for childcare and/or health care facilities (including psychiatric facilities) allow exposure of vulnerable populations to SHS (Centers for Disease Control and Prevention, 2007; Ellis et al., 2009; Mulcahy, Evans, Hammond, Repace, & Byrne, 2005; Samet, 1999; Scarinci et al., 2000; Max, Sung, & Shi, 2009; Nebot et al., 2009; Schober, Zhang, & Brody, 2008).

Minimum distance from entrances, operable windows, and air intakes for smokers outside of smoke-free facilities vary widely. Distances from doors and other openings frequently do not meet the minimum recommendations of a 20-foot minimum separation preferred by the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (2007). None of the ordinances include distances from operable windows and air intakes for ventilation systems.

In two of the larger cities, any of the facilities covered by the ordinance can pay a license fee and become exempt from any smoking restriction. Seventy-nine licenses have been issued to “smoker friendly” businesses, indicating that business interests override public health concerns.

Opponents of smoke-free laws frequently offer the following arguments in legislative and city council hearings: (a) the creation of an unlevel playing field, (b) business owner’s rights, (c) air handling systems as a solution to the problem, (d) economic impact on restaurants and bars, (e) gaming floors of casinos remaining unregulated, (f) government mandating personal choices, and (g) weaker laws being preempted. Many of these arguments cannot be substantiated (Cohen et al., 2000; Engelen, Farrelly, & Hyland 2006; Eriksen and Chaloupka, 2007; Morbidity and Mortality Weekly Report, 2005).

The policy implications of this study suggest that city officials are likely to make municipal decisions based on either their personal smoking habits, competing business interests, concern about voter backlash, or some combination of these, rather than what is in the best interests of the health of the public. Thus, awareness of a potential elected official’s smoking status should be taken into consideration at election time. The medical and public health professional community should also be actively involved throughout the legislative process to counter the influence of certain lobbyists and business owners.

In conclusion, there is support for a strict and more uniform statewide clean indoor air law in Kansas. While clean indoor air regulations have been established in some cities and counties, the various ordinances leave a number of loopholes and lack consistency. Lack of consensus on uniform and strict local ordinances leaves environmental and health disparities between cities, urban and rural areas, workers, and levels of socioeconomic status.

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Declaration of Interests

None declared.
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Acknowledgments
GB members and City Clerks in the 51 participating cities completed and forwarded the original surveys. City and County Clerks in 35 cities and three counties submitted copies of their clean indoor air ordinances. The Kansas Health Institute arranged a tobacco summit and provided feedback to the investigators. The Tobacco Free Kansas Coalition provided guidance in developing the questionnaire and historical information.

References


