BARRIERS TO INTRODUCTION OF SMOKE-FREE WORKPLACES IN CENTRAL EUROPE: EXAMPLE OF THE CZECH REPUBLIC

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SUMMARY

Objectives: Smoking at the workplace has a negative impact both on employers' economic interests and employees' health. The aim of this study is to describe the current situation, mainly barriers in implementation and resources in the Czech Republic as an example of a Central European country.

Methods: We synthesised relevant review papers with our knowledge of the local situation based upon professional experience of both authors.

Results: Despite smoke-free laws, some EU workers are still exposed to passive smoking during working hours. The main barriers towards smoke-free workplace implementation are the lack of resources, perception of smoking as a norm, and exceptions for leading personalities and their smoking. Social support increases smoking cessation effectiveness. Low availability of local smoking cessation services is an overall problem in Central Europe.

Conclusions: The working environment influences smoking habits. Smoking cessation support is cost-effective not only for the smoking employee but for employers as well. Smoking cessation resources should be available during the working day. No exceptions should be made as they serve as barriers to a smoke-free working environment.

Key words: smoking, employers, employees, economic, health, smoking cessation

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INTRODUCTION

Smoking seriously affects not only the health of active and passive smokers, but also has a large economic impact for both employees and employers (1, 2). Despite the fact that the EU has smoke-free laws, a substantial proportion of people are still exposed to passive smoking at the workplace (3). In the Czech Republic, where a smoke-free law was introduced on 31 May 2017 (4), 17% of smokers versus 12% of non-smokers were exposed to second-hand smoke (SHS) at the workplace during that year, with men almost twice as much exposed as women (5).

Health effects of long-term exposure to SHS can be well illustrated using mortality and morbidity changes after the implementation of smoke-free laws, when the SHS exposure is reduced. The Irish smoke-free law was introduced in 2004 and thus Ireland became the first country globally with all indoor public spaces smoke-free. It was followed by a 13% decrease in early all-cause mortality – 26% reduction in ischaemic heart disease (IHD), 32% reduction in stroke and 38% reduction in chronic obstructive pulmonary disease mortality (COPD). Post-ban risk differences did not change with a longer follow-up period. Mortality decreases were primarily due to reduced exposure to SHS (6). Furthermore, a significant reduction in small-for-gestational birth rates both immediately and sustained over the post-ban period were recorded in Ireland (7). Important factors in Ireland's pioneering action included a committed health minister backed by the entire Cabinet, and active support from labour unions representing hospitality industry workers, for whom indoor spaces such as bars are their workplaces. A German study by Fischer and Kraemer, where a software tool applying a Markov model for health impact assessment was used, estimated that overall 687,254 IHD cases, 231,973 COPD cases and 288,015 stroke cases yearly were attributable to SHS exposure in Germany in 2014 (8). SHS exposure at work is associated with increased COPD risk (9) and thus may be considered as a risk factor of occupational COPD. There was a positive court decision in the EU attributing a significant proportion of cancer disease to the SHS exposure of the employee, even though the worker was a smoker (10).

MATERIALS AND METHODS

Description of the current situation regarding smoke-free workplaces in the Czech Republic could serve as an example of problems with implementation typical for Central European

countries. Based on many review articles on this topic already available, we synthesise our experience with local conditions and point out barriers towards the implementation of smoke-free workplaces.

RESULTS

Smoke-free Workplaces: Barriers for Implementation

Basically all EU countries are covered by smoke-free laws, if not 100%, with very few exceptions which are hard to fulfil – e.g. in the Czech Republic, according to the act No. 67/2017 (4), all indoor public spaces are declared smoke-free: an exception is that smoking is allowed in restaurants in a room with a separate outside entrance with no service – but that is difficult to realize. Before such laws were adopted, some businesses introduced voluntary smoke-free policies in response to popular demand (11).

The first step should be mapping smoking habits among employees, and long-term preparation of a smoking ban (10). This is demonstrated in a case study of a large steel industry facility in Ostrava, ArcelorMittal, with approximately 7,500 employees. On 1 September 2015, the company went completely smoke-free. It happened after five years of step-by-step explanation, information, gradual restrictions of smoking possibilities, and smoking cessation support (specialist intervention and covering costs of medication). The smoking ban was respected also by visitors and truck drivers (12). Hopefully, the policy will continue.

As for overall health support at the workplace, barriers can include a competitive business environment, reorganizations, lack of resources (financial, personal, material), and inappropriate interventions. In a small organization (< 500 employees) it is challenging to assemble a critical mass of potential participants to take part in the intervention; in a large one, numerous competing priorities may be a barrier, or the existence of different company locations (13). A smoke-free workplace offers overall benefits, but some possible problems must also be considered, such as the concentration of smokers outside buildings, or more intensive smoking before and after working shifts (14). But, overall, there are no adverse effects of smoke-free workplace policies (15).

Based on our local knowledge, smoking areas should be carefully selected (places that are unsuitable or hard to reach or that disturb the local neighbourhood must be avoided).

Economic Impact of Smoking for Employers

The impact for the smoker is well known but less is known about that for the employer. Apart from costs such as fire damage, cleaning and ventilation, and lower work productivity (10), smoking employees mean a cost of **lost working time**. Even if the indoor workplace is declared as smoke-free, those who continue to smoke have to go outside to have their cigarettes. This means typically about 15 minutes per employee spent because of one cigarette. If a smoker smokes e.g. four cigarettes per working day, and if the smoking prevalence is at least 25% in Europe (24% of daily smokers) (16), the employer can easily count working hours lost due to smoking. E.g. in case of 1,000 employees, about 250 may be smokers, losing 250 hours daily, 250 × 5 = 1,250 hours weekly, or 1,250 × 52 = 65,000 hours yearly. The total of unproductive salary costs can be calculated. Smokers also have more **sick days** compared to non-smokers: between 3 to 7 more days per year (17, 18). This corresponds with the proven fact that the main cost of smoking to a nation's economy is the loss of productive working life.

Social Support

The social environment influences smoking habits, both in the general population and in smaller communities. Since we spend substantial time at work, the social environment is important in this sense, both in keeping it smoke-free and in successful quitting. Also, population subgroups should be considered (19). Of great importance is the attitude of leading personalities including their personal example. The effectiveness of smoking cessation incentives and competitions is uncertain (20).

Demands and Stress

Working demands may play both positive and negative roles in smoking cessation. They can stimulate people to stop smoking (personal image, bad smell, high demands, no time or possibility to smoke), but if the demands and stress are too high, they may lead to relapse (21, 22).

Resources for Smoking Cessation

Treatment of tobacco dependence should be available within existing healthcare systems, as the World Health Organization recommends in its Framework Convention on Tobacco Control, Article 14 (23). Unfortunately, there is a lack of such services in the Eastern part of Europe (3, 24). But still, employers could start cooperation with local physicians or specialists trained in smoking cessation. The list of trained medical doctors can be easily found at the webpage of the Society for Treatment of Tobacco Dependence*.

In some professions, high smoking prevalence, e.g., nurses or doctors and other professions across the health system, may be a barrier, as smokers cannot be credible counsellors (25–27). Among Czech nurses, about 40% smoke (24, 26, 27).

Smoking Prevalence in the Population

In restaurants, the smoke-free law mostly works – during 2018 in Prague there were 632 controls in restaurants, dining rooms, bars, pubs, and other catering businesses with only 48 faults – not only because of smoking, but also due to missing/wrongly placed signs "Smoking is not permitted on these premises", inappropriate placement of signs prohibiting the sale of alcoholic drinks and tobacco products to those younger than 18 years, or breach of the obligation of food service operators to alert a person who does not comply with the smoking ban to stop smoking or leave the area. For these 48 faults, total fines of 82,000 CZK were imposed (28).

However, more likely other workplaces may be a problem. The authors have personal experience from hospitals, where both

* https://www.slzt.cz

the staff and patients smoke in toilets despite the smoke-free law. These cases were rather random and there were attempts to solve them by personal discussion. Also in large, old facilities there might be some spaces difficult to control.

DISCUSSION

There are over 500 reviews about smoke-free workplaces available on PubMed, but only a few provide information about the real situation and barriers to implementation. The costs to employers of providing smoking-cessation pharmacotherapy to their employees is low and it may reduce the proportion of employees who smoke (29).

Employers should take social responsibility to support smoking cessation. There should be more robust leadership at the state level, as well as through advocacy, public health, and clinician organizations; there is little support from government, insufficient smoking cessation services, and incomplete reimbursement of pharmaceutical costs in Central Europe, especially in the Eastern part (30, 31).

The level of tobacco control, including laws and their application, depends on the level of political corruption in the given country – and this applies to compliance with legislation overall (32). Also, personal examples of leading politicians in the country as well as enterprise and company headquarters play important role.

CONCLUSIONS

Smoke-free workplace and smoking cessation support from the employer should be a standard part of the mosaic of tobacco control in the population. Employers should be concerned about smoking by their employees not limited to the working hours, but motivate them to stop smoking, support their treatment and consider the reality of conditions for 100% implementing smoke-free workplaces.

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Conflict of Interests

None declared

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