Left Behind in the Smoke

How Exemptions in California's Smokefree Workplace Act Affect Health Inequities

ChangeLab Solutions

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Note to readers: The percentages throughout this guide have been rounded to increase readability. For the precise percentages, please refer to the source material.

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Summary

These key points highlight the unfairness and injustice of the California Smokefree Workplace Act's exemptions and the resulting health inequities.

› Although widely perceived as a comprehensive smokefree air law, the California Smokefree Workplace Act* still does not completely prohibit smoking in places like hotels, cabs of trucks, private residences used for family day care, long-term health care facilities, outdoor places of employment, and tobacco shops and private smokers lounges.[1]

› As a result, 1 in 7 Californians faces secondhand smoke exposure at work.[2]

› The industries most affected by the exemptions in the California Smokefree Workplace Act primarily pay low wages and employ people of color.

› The exemptions in the law contribute to tobacco-related health inequities among the working poor and communities of color.

› These exemptions have become part of a system that makes it easier for some of California's most affected populations† to start smoking, makes it more difficult for them to quit smoking, and makes them more likely to die from diseases associated with tobacco use.

› Local governments should look for ways to close the gaps in California's Smokefree Workplace Act in order to minimize these sources of health inequities and ensure that all employees can work safely in a smokefree environment.

* *Smokefree Workplace Act*, a common synonym for Section 6404.5 of the California Labor Code, is used throughout this publication.

† We use the term *affected populations* instead of *vulnerable populations* because it is a more precise term. *Affected populations* refers specifically to the populations that have the highest health inequities because they are the most affected by a specific system (such as the California Smokefree Workplace Act) that creates the circumstances in which they live, work, and play.

California Labor Code, Section 6404.5: Exemptions

The law states that no employer shall permit smoking in an enclosed space at a place of employment. "Enclosed space" includes lobbies, lounges, waiting areas, elevators, stairwells, and restrooms that are a structural part of the building. For purposes of the law, "place of employment" DOES NOT INCLUDE any of the following:

20% of the GUEST ROOM accommodations in HOTELS, motels, or similar transient lodging establishments

Retail or wholesale TOBACCO SHOPS and PRIVATE SMOKERS LOUNGES

CABS OF TRUCKS OR TRACTORS, if no nonsmoking employees are present

THEATRICAL PRODUCTION SITES, if smoking is an integral part of the story in the theatrical production

MEDICAL RESEARCH OR TREATMENT SITES, if smoking is integral to the research and treatment being conducted

PRIVATE RESIDENCES, except for private residences licensed as FAMILY DAY CARE HOMES

Patient smoking areas in LONG-TERM HEALTH CARE FACILITIES

WORKPLACES THAT ARE LOCATED OUTDOORS

Introduction

1 in 7

workers in California continues to be needlessly exposed to secondhand smoke at work.

Once a leader in protecting workers from secondhand smoke, California has fallen behind. When California passed the Smokefree Workplace Act in 1994, it led the nation by becoming the first state to amend its Labor Code to require employers to prohibit smoking in enclosed places of employment.[3] However, California left holes in the Labor Code by not completely prohibiting smoking in places like hotels, cabs of trucks, family day cares in private residences, long-term health care facilities, and outdoor places of employment.[1] Since 1994, 28 states and the District of Columbia[3] have adopted comprehensive smokefree laws* — and California finally joined this group in 2016 by enacting legislative updates that closed several important loopholes. Still, other exemptions persist. As a result, 1 in 7 workers in California continues to be needlessly exposed to secondhand smoke at work.[2]

Comprehensive smokefree workplace policies have the power to reduce secondhand smoke exposure, decrease the number of people who smoke, and improve health outcomes.[4] Unfortunately, the California Smokefree Workplace Act's exemptions mean that people who work as cleaners, truck drivers, home health aides, orderlies, and child care assistants continue to be exposed to secondhand smoke at work. The exemptions in the law and the confusion these exemptions create for enforcement agencies exacerbate tobacco-related health inequities among low-wage workers and communities of color.[5]

These exemptions have become part of a system that makes it easier for some of California's most affected populations† to start smoking, makes it more difficult for them to quit smoking, and makes them more likely to die from diseases associated with tobacco use. Closing these exemptions is critical in order to eliminate a significant source of health inequities in California.†

* The Centers for Disease Control and Prevention use the term *comprehensive smokefree* laws to denote "state smoking restrictions for private-sector worksites, restaurants, and bars." However, to be truly comprehensive, localities may want to include other locations like outdoor areas, hotel guest rooms, and worksites located in private residences.

† This report focuses on the impact of exemptions that local governments have the authority to eliminate. Other populations may be exposed to secondhand smoke at work — for example, casino workers on tribal lands. These populations are not discussed because local governments do not have the authority to prohibit smoking in workplaces on tribal land.

An estimated 8% of secondhand smoke exposure at work is due to insufficient enforcement.

Unequal Enforcement of the California Smokefree Workplace Act

In passing California's Smokefree Workplace Act, the legislature intended to eliminate any confusion that might result from inconsistent enforcement of smokefree air laws.[1] Unfortunately, because the law has so many exemptions, there is still considerable confusion about enforcement of smokefree workplace requirements.

In addition, enforcement has not always been consistently applied to all worksites, including worksites that are clearly covered by the California Smokefree Workplace Act. The California Tobacco Control Program estimates that "there is likely poor enforcement or lack of implementation of the work ban policy for about 8% of those [workers] that reported exposure to secondhand smoke."[2]

Unequal enforcement of the existing law means that certain groups of people are less likely to be protected from exposure to secondhand smoke. Statewide polls suggest that the people most likely to be left out are from low-income communities and communities of color.[2] It is important that jurisdictions make sure that the California Smokefree Workplace Act is being enforced correctly, to reduce inequities in exposure to secondhand smoke at work.

What Do We Mean by *Health Inequities*?

The California Health and Safety Code defines *health equity*, *health disparities*, and *health inequities* in the following ways:[6]

> **"HEALTH EQUITY" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.[6]**
>
> **"HEALTH AND MENTAL HEALTH DISPARITIES" means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.[6]**
>
> **"HEALTH AND MENTAL HEALTH INEQUITIES" means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.[6]**

Throughout this report, we use the term *health inequities* as defined by the California Health and Safety Code because it is how the state legally defines health inequities and because it is very similar to definitions used by public health organizations like the Centers for Disease Control and Prevention.[5] More important, though, we use the term *health inequities* because it underscores the unjust and unfair nature of the exemptions in California's Smokefree Workplace Act and emphasizes that these exemptions negatively affect people's health in a systemic way that is entirely avoidable.

Impact of Local & State Closing of Loopholes

When California closed 6 of the 19 loopholes in its Smokefree Workplace Act, the average number of loopholes closed per jurisdiction increased from 6 to 10.

In 2016, Stanford University and ChangeLab Solutions conducted a legal epidemiological study that linked California's jurisdiction-level policy data, 2012–2016 census data, and county smoking prevalence from 2014 to 2016. The team identified 539 jurisdictions* in the state of California and systematically coded all city and county laws to quantify the degree of closure of loopholes in the Smokefree Workplace Act.

Researchers hypothesized that jurisdictions that closed more loopholes in California's 1994 Smokefree Workplace Act would tend to have the following characteristics:

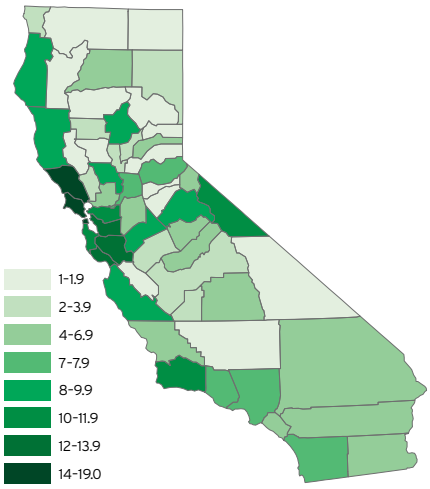
- larger, nonrural populations
- higher median household income
- higher percentage of non-Hispanic white residents

The team also hypothesized that loophole closure at the county level would be associated with a lower prevalence of smoking.

› Findings

FIGURE 1

Closed Loopholes in Smokefree Air Laws as of 2018



Initial hypotheses were confirmed. Cities and counties that closed more loopholes in California's Smokefree Workplace Act tended to have larger, nonrural populations, higher median household income, and a higher percentage of non-Hispanic white residents. Jurisdictions with higher loophole closure scores (ie, a larger number of loopholes closed in the jurisdiction) had lower smoking prevalence.

From 2015 to 2016, the state of California closed 6 loopholes, helping to reduce inequities and narrow the gap between jurisdictions. With the changes to state law, loophole closure scores improved more in jurisdictions that were less populated, with less-affluent residents and fewer non-Hispanic white residents.

Closing loopholes in local and state laws directly affects residents of the jurisdiction where the loophole is closed. Moving forward, researchers and lawmakers should consider which populations and what percentage of the population are protected by strong smokefree workplace laws.

* 539 jurisdictions (482 cities and 58 counties, including the City & County of San Francisco, which share a municipal code) were identified. Three cities (Loyalton, Needles, Westmorland) were excluded from the sample because their municipal code or relevant ordinances could not be obtained. County ordinances apply to unincorporated areas only, except in the City & County of San Francisco.

Tobacco's Impact on Health at Work

Almost half a million people die prematurely in the United States from tobacco-related diseases every year, making tobacco use the nation's leading cause of preventable death.[7] Tobacco use can cause disease in nearly all organ systems and is responsible for "87% of lung cancer deaths, 32% of coronary heart disease deaths, and 79% of chronic obstructive pulmonary disease."[7] It also causes a third of all cancer deaths. Tobacco smoke contains thousands of chemicals, including at least 250 harmful chemicals and at least 70 known carcinogens.[7]

The fact that the California Smokefree Workplace Act continues to exempt some worksites increases the likelihood that workers will:

Nonsmokers who are exposed to secondhand smoke at work are

20 to 30%

more likely to die from smoking-related diseases.

› Smoke

Workplace smoking bans reduce the number of people who start smoking, increase the number of people who quit smoking, and decrease the number of cigarettes consumed by people who continue to smoke.[8,9]

› Suffer from secondhand smoke exposure

According to the CDC, "comprehensive smokefree policies are the most effective means to protect all workers from secondhand smoke."[5] Secondhand smoke is responsible for as many as 41,300 deaths among nonsmokers each year in the United States.[10] The US Surgeon General has concluded that there is no risk-free level of exposure to secondhand smoke.[11]

In California, those who work in smokefree workplaces are substantially less likely to be exposed to secondhand smoke (11% versus 51%).[12] More than one-third (35.5%) of the civilian employed young adult population (more than 1 million young workers) in California works in the occupations with the greatest risk of secondhand smoke exposure in the workplace.[13] Research suggests that nonsmokers who are exposed to secondhand smoke at work are 20% to 30% more likely to die from smoking-related diseases.[11] Exposure to secondhand smoke in the workplace has also been linked to increased mortality rates, higher rates of heart disease, and severe exacerbation of asthma.[14,15]

Nonsmokers who are exposed to thirdhand smoke have significantly higher nicotine and cotinine levels in their blood than those who have not been exposed to thirdhand smoke.

› Inhale, ingest, or absorb dangerous contaminants found in thirdhand smoke

When tobacco is burned, the smoke forms a residue, often called *thirdhand smoke*. This residue is absorbed by porous surfaces like carpeting, drapes, and upholstery. It also creates a sticky film on non-porous surfaces like walls, countertops, appliances, and fixtures.[16] Thirdhand smoke has been found to contain carcinogenic materials that accumulate over time, presenting a health hazard long after the initial smoke is gone.[17] These materials are slowly re-released from carpeting and drapes into the air, where they can be inhaled or absorbed through the skin.[18] Nonsmokers who are exposed to thirdhand smoke have significantly higher nicotine and cotinine levels in their blood19 than those who have not been exposed to thirdhand smoke.[18] (Cotinine is the best available biomarker for measuring people's exposure to tobacco.) In addition, research has shown that thirdhand smoke damages human cellular DNA.[20]

› Experience the effects of adverse interactions between tobacco and other environmental toxins

Workers that the California Smokefree Workplace Act currently does not protect from workplace exposure to secondhand and thirdhand smoke are often likely to be exposed to other non-tobacco-related toxins and carcinogens at work.[21,22] For example, volatile organic compounds (VOCs), exposure to which may cause everything from headaches to cancer, are commonly found in cleaning agents, fuel and combustion products, and air fresheners[23] — substances that employees are likely to encounter if they work in hotels or as a tractor or truck driver. There are significant concerns that environmental contaminants interact in ways that increase people's risks for a wide range of health problems from inflammation of the lungs to cancer.[22]

› Be hurt or die in a fire

Nationally, smoking causes 2,130 fires each year in non-residential buildings.[24] Individuals from African American, Native American, and low-income populations are at highest risk for fire-related injury and death.[25]

California's Smoking-Related Health Inequities

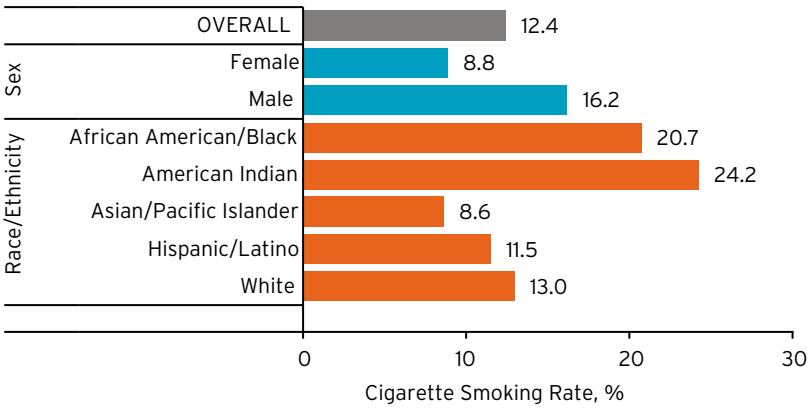
The California Smokefree Workplace Act's exemptions affect health inequities by creating disparities among communities of color and low-income populations. Many of these populations are the most likely to use tobacco and are also the most likely to work in industries that are not required to be smokefree under the Smokefree Workplace Act.

› Smoking is highest among men, American Indian (both male and female), and African American (both male and female) individuals

About 1 in 8 Californians over the age of 18 smoke or vape. American Indian and African American communities have the highest overall smoking rates (see Figure 2).[26]

FIGURE 2

Adult Cigarette Smoking Rate in California, by Gender and Race/Ethnicity, 2015–2016



Note: Restricted to respondents aged 18 or older. Respondents were asked to report cigarette smoking behavior. The race or ethnicity categories are non-Hispanic/Latino unless otherwise noted. The American Indian population includes Alaska Native. The Asian/Pacific Islander population includes Native Hawaiian.
Source: California Health Interview Survey 2015–2016. (Los Angeles, CA: UCLA Center for Policy Research; December 2017). Information provided by California Department of Public Health, California Tobacco Control Program.

Men (of all races) and individuals from Hispanic communities are most likely to be exposed to secondhand smoke at work.[12] In a 2013 survey, nearly 1 in 4 Hispanic nonsmokers and 1 in 6 African American nonsmokers reported being exposed to secondhand smoke in the last 2 weeks.[27]

Substantial costs are associated with smoking among African American and Hispanic communities.* For example, smoking-attributable health care expenditures and lost productivity was $1.9 billion for the Californian Hispanic community in 2010[28] and $1.8 billion for the African American community in 2008.[29]

In 2018, the average annual income in California was

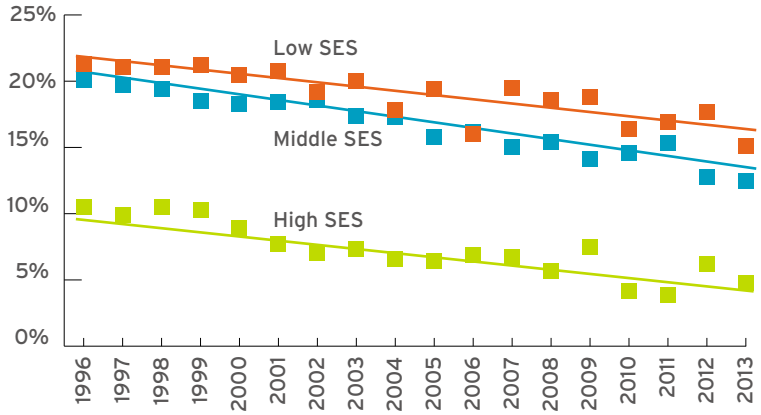
$59,150.[30]

› Smoking is highest among low-income populations

The smoking prevalence rates among low- and middle-income populations are significantly higher than smoking prevalence rates among high-income populations (see Figure 3).[31]

FIGURE 3

Smoking Prevalence Among California Adults, by Socioeconomic Status (SES)



Source: Behavioral Risk Factor Surveillance System, 1996–2013. Published 2014. Information provided by California Department of Public Health, California Tobacco Control Program.

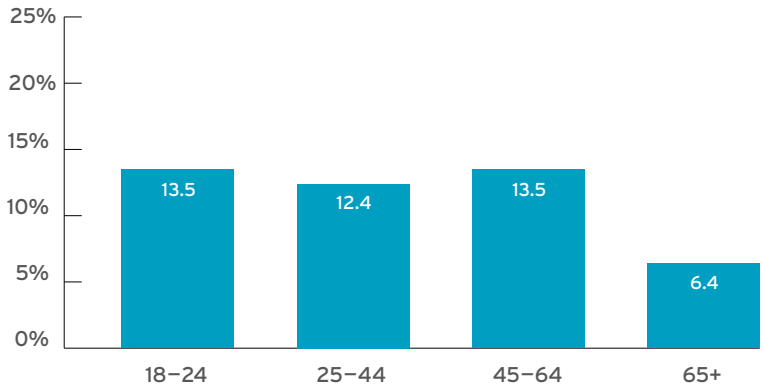
* Many of the populations that are disproportionately affected by the California Smokefree Workplace Act's exemptions are also specifically targeted by the tobacco industry and disproportionately affected by gaps in other tobacco-related laws. The confluence of these factors heightens their risk of smoking and suffering from tobacco-related diseases. For example, the tobacco industry specifically markets mentholated cigarettes to African Americans, to increase their use of these products. Another example is higher density of tobacco retailers in neighborhoods with a high concentration of poverty, which contributes to higher smoking rates among low-income populations. No single policy change like closing the gaps in the California Smokefree Workplace Act will eliminate health inequities; rather, a collection of strategies is needed to prevent tobacco use and exposure to secondhand smoke. A discussion of strategies that can be used to restrict tobacco use in addition to closing gaps in the California Smokefree Workplace Act can be found on our website at www.changelabsolutions.org/tobacco-prevention

› Tobacco use is highest among adults of working age

According to statewide surveys in California, working age adults are the most likely to smoke (see Figure 4).[32]

FIGURE 4

Smoking Prevalence in California, by Age, 2013



Source: Behavioral Risk Factor Surveillance System, 2013. Published 2014. Data are weighted to the 2010 California population. Information provided by California Department of Public Health, California Tobacco Control Program.

Other Populations Affected by Tobacco Exposure at Work

While the focus of this report is on low-income workers and communities of color, there may be many other affected populations. For example, lesbian, gay, bisexual, and transgender (LGBT) individuals may be disproportionately affected by the California Smokefree Workplace Act. However, because government employment figures do not systematically track people's sexual orientation or transgender status by industry or profession, it is difficult to determine the extent to which these populations may be affected.

Surveys and published research do suggest that LGBT populations have higher rates of smoking and secondhand smoke exposure. For instance, a recent California survey of lesbian, gay, and bisexual (LGB) populations* found that LGB populations are more likely to smoke and are more likely to report being exposed to secondhand smoke.[26] Considering the needs of other affected populations is important in health equity work, especially when addressing smoking-related health inequities. For this reason, jurisdictions should consider what other specific populations in their communities might be affected, in order to appropriately target education and enforcement activities.

* According to the California Tobacco Control Program, "The California Adult Tobacco Survey does not collect information about individual's transgender status."

Smoking-Related Health Inequities by Occupational Location

Among California workers who are employed in locations where smoking is not prohibited,

51%

reported being exposed to secondhand smoke in the last 2 weeks.

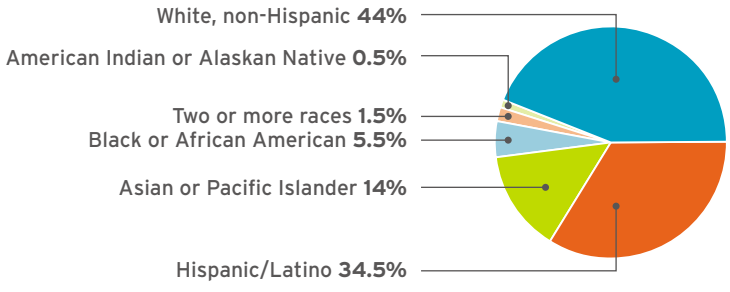
Comprehensive smokefree policies in the workplace are the most effective means of protecting all workers from secondhand smoke.[5] In California, people in many professions and industries may be legally exposed to secondhand smoke at work because of exemptions in the California Smokefree Workplace Act. Among California workers who are employed in locations where smoking is not prohibited, 51% reported being exposed to secondhand smoke in the last 2 weeks.[12]

Further, certain exemptions in the California Smokefree Workplace Act unfairly and disproportionately affect communities of color and low-income workers. This report finds that many of the industries that are exempted by state law — such as the hotel and accommodation, trucking, child care, and long-term health care industries — often pay low wages and employ persons of color at much higher rates than the state average. Additionally, those who work in restaurants, bars, and vehicles are some of the most likely to report being exposed to secondhand smoke.[2,12] Figure 5 illustrates the demographic composition of California's workforce as a whole — a markedly different distribution than the sectors explored in this report.

If one looks closely at the impact of some of the exemptions in the law, it becomes even more evident that this law unfairly targets the working poor and communities of color. Closing these exemptions will help reduce these health inequities.

FIGURE 5

California's Workforce, by Race/Ethnicity



Source: U.S. Census 2010

The following sections describe exemptions in the California Smokefree Workplace Act that directly contribute to health inequities. These sections are designed to be read both as sections within this larger report and as stand-alone fact sheets that can be used when working with community members to educate people about the impact of individual exemptions in the California Smokefree Workplace Act.

Hotels

Many people — including cleaners, bellhops, desk clerks, and doormen — help to ensure that a hotel or motel visit is comfortable, safe, and clean. Unfortunately, being exposed to secondhand and thirdhand smoke is a reality for many of these individuals because the California Smokefree Workplace Act still allows smoking in up to 20% of hotel guest rooms.

Some communities and hotel chains have decided to implement 100% smokefree hotel policies. In 2011, about a third of California hotels with 26 or more rooms (1,575 hotels) had gone 100% smokefree.[33,34]

Nineteen California cities have adopted local laws prohibiting smoking in all guest rooms.[35] However, the impact of this exemption on the California workforce remains quite large. In 2016, California hotels and motels (other than casino hotels) employed 214,745 people, many of whom worked in hotels where smoking was not completely prohibited.[36]

Who is most affected?

Nationally, 72% of people who work in the hotel industry are people who work in cleaning, food preparation, food service, and administrative support (eg, desk clerk) occupations.[37]

Housekeeping Staff
90% female[38]
80% Hispanic/Latino[38]
Annual income: $28,870[30]

Desk Clerks
57% female[38]
54% from communities of color[38]
Annual income: $28,890[30]

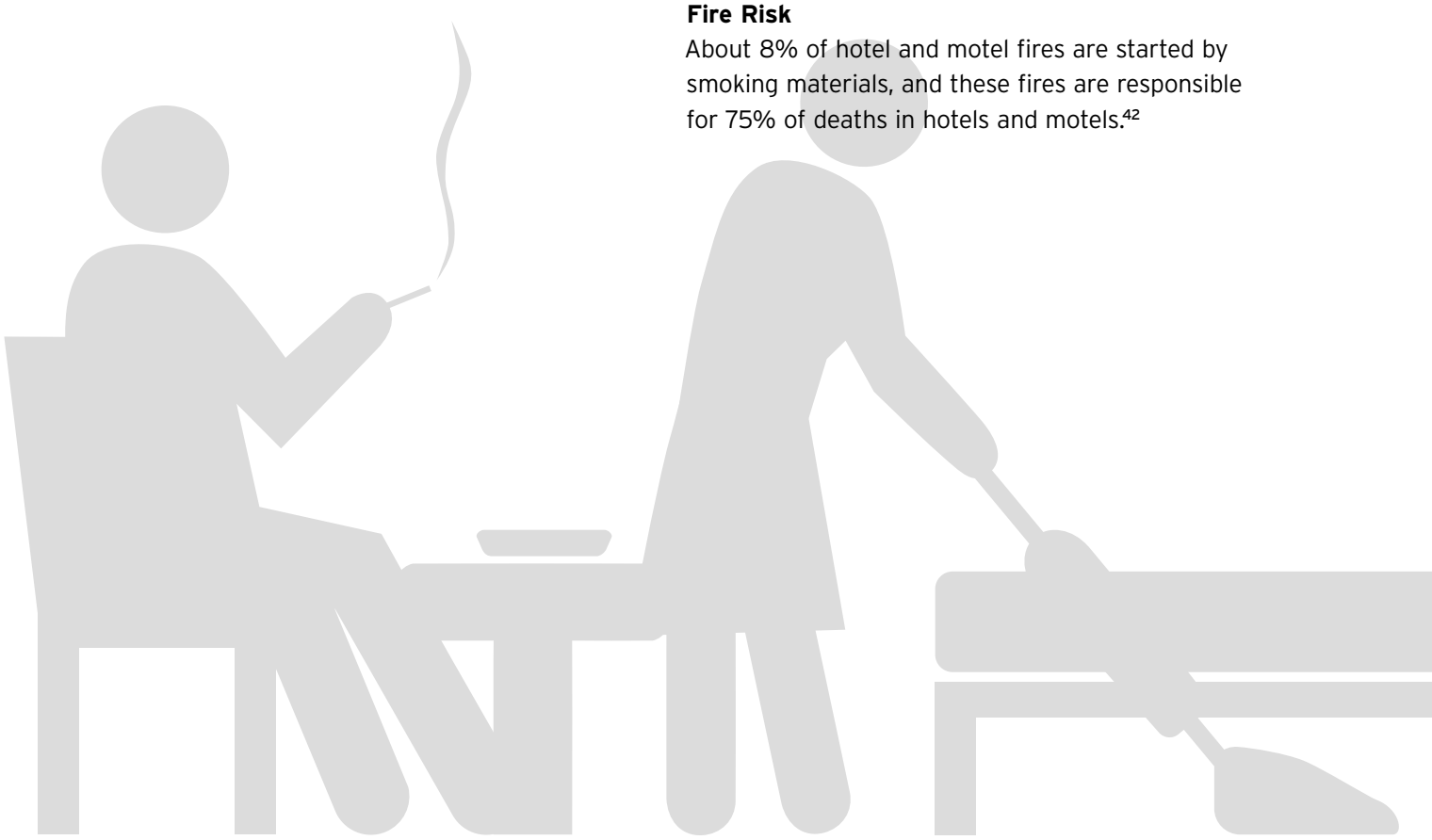
Waiters & Waitresses
65% female[38]
55% from communities of color[38]
Annual income: $31,160[30]

How does this exemption affect hotel workers?

Thirdhand Smoke
In California hotels that are not 100% smokefree, even rooms designated as nonsmoking have elevated nicotine levels in the air and on the surfaces of furniture and walls when compared with rooms in 100% smokefree hotels.[39,40]

Secondhand Smoke
After only 14 hours in a hotel, a hotel guest in a nonsmoking room of a hotel where smoking is allowed in other areas has 4 to 5 times the level of cotinine (a biomarker for nicotine) in their blood compared with guests who stay in a completely nonsmoking hotel.[39] Given that hotel employees spend about 26 hours a week in hotels,[41] their risk for elevated levels of nicotine and cotinine is substantially higher.

Fire Risk
About 8% of hotel and motel fires are started by smoking materials, and these fires are responsible for 75% of deaths in hotels and motels.[42]



Cabs of Trucks or Tractors

Truck drivers travel an estimated 23.6 billion miles on public roads annually in California.[43] They make sure that packages and goods arrive safely and on time. They work with dock workers, mechanics, and auto detailers to load and unload shipments, plan and drive the best routes, and maintain clean, running vehicles. Unfortunately, under the California Smokefree Workplace Act, smoking is not prohibited in cabs of trucks or tractors[44,45] if nonsmoking employees are not present.[1] Consequently, under state law, over 135,000 truck drivers in California may be involuntarily exposed to secondhand and thirdhand smoke.[30]

Truck drivers may share trucks, and cleaning crews, mechanics, or others may work on their trucks. When someone smokes in the cab, that smoke will linger, contaminating the air and lining the surfaces of the truck with toxins that the next person will breathe in and absorb into their bodies.

Who is most affected?

Drivers are obviously the most common positions likely to be affected by this exemption.

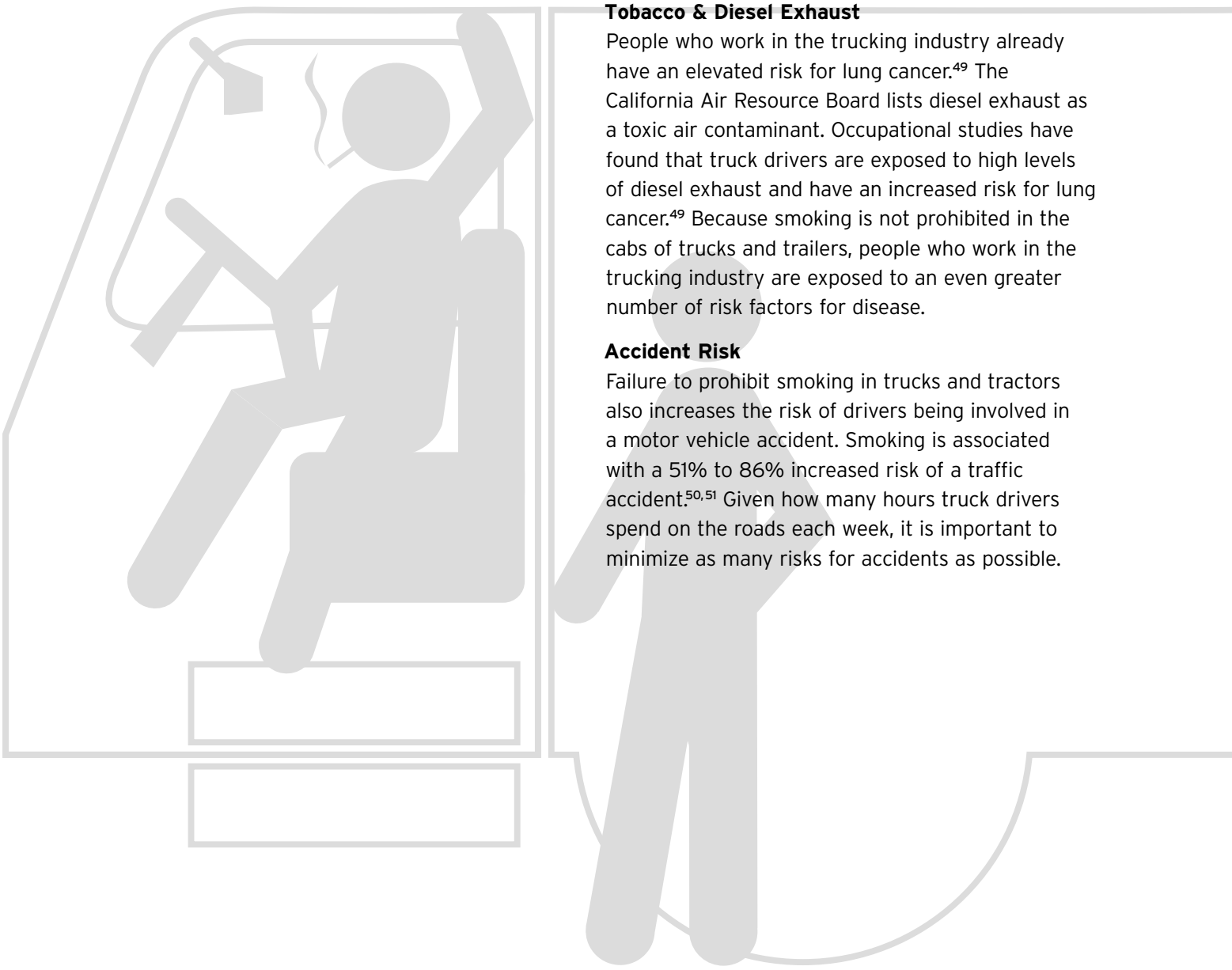
Heavy Haul & Tractor-Trailer Drivers
for example, cement truck drivers or moving van drivers[46]
Annual income: $47,300[30]

How does this exemption affect truck drivers?

Secondhand & Thirdhand Smoke
People who work in trucks can be exposed to secondhand smoke that may linger after a smoker has left the vehicle. Research has also found that thirdhand smoke contaminants are highest in vehicles where smoking is not prohibited.[40,47] Because drivers are allowed to drive as many as 60–70 hours in a week, truck drivers are likely exposed to high levels of tobacco contaminants in vehicles where smoking has occurred.[48]

Tobacco & Diesel Exhaust
People who work in the trucking industry already have an elevated risk for lung cancer.[49] The California Air Resource Board lists diesel exhaust as a toxic air contaminant. Occupational studies have found that truck drivers are exposed to high levels of diesel exhaust and have an increased risk for lung cancer.[49] Because smoking is not prohibited in the cabs of trucks and trailers, people who work in the trucking industry are exposed to an even greater number of risk factors for disease.

Accident Risk
Failure to prohibit smoking in trucks and tractors also increases the risk of drivers being involved in a motor vehicle accident. Smoking is associated with a 51% to 86% increased risk of a traffic accident.[50,51] Given how many hours truck drivers spend on the roads each week, it is important to minimize as many risks for accidents as possible.



Family Day Cares at Private Residences

Day care assistants who work in private residences for a day care provider play an invaluable role in watching over young children. Yet despite their efforts to provide safe and healthy environments for young children, they are potentially at risk for secondhand and thirdhand smoke exposure. Although the California Smokefree Workplace Act prohibits smoking in all indoor areas of day care centers and family day cares at all times, smoking is still permitted in outdoor areas like play yards.[1]

Who is most affected?

This loophole hurts primarily women of color and low-income day care workers. In 2005, according to estimates, 51.5% of licensed child care providers in California who cared for children in their home had at least one paid assistant,[52] and between 16,184 and 20,735 paid assistants worked in private residences licensed for day care.[52]

Paid Child Care Assistants
93% female[53]
67.5% from communities of color[53]
Annual income: $28,630[30]

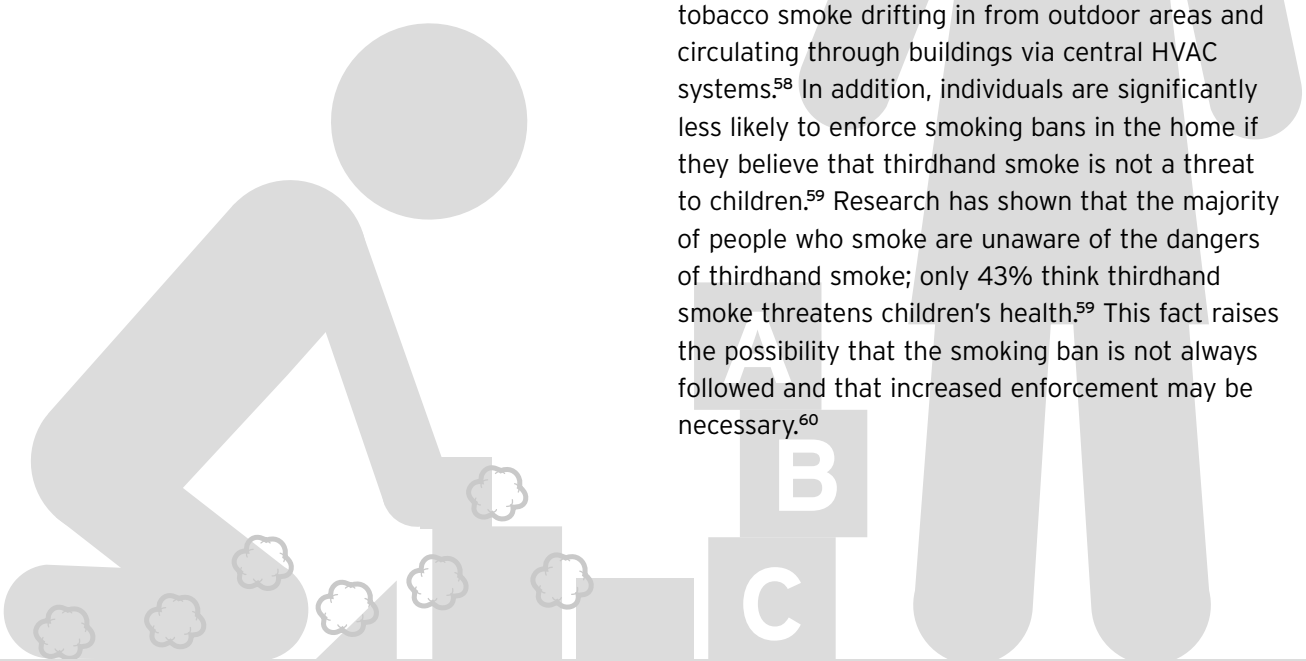
How does this exemption affect day care workers?

Outdoor Secondhand Smoke

The California Smokefree Workplace Act does not prohibit smoking outside in the yard, allowing smoke to drift indoors through windows and doors. Levels of secondhand smoke exposure outdoors can reach levels attained indoors, depending on wind direction and speed and the number and proximity of people smoking.[54] Smoking cigarettes near building entryways can double the level of air pollution, with maximum levels reaching the "hazardous" range of the US Environmental Protection Agency's Air Quality Index.[55] To be completely free from exposure to secondhand smoke on a backyard patio, a person might have to move more than 23 feet away from the source of the smoke (about the width of a two-lane road).[56,57]

Indoor Secondhand & Thirdhand Smoke

Thirdhand smoke may be deposited indoors by tobacco smoke drifting in from outdoor areas and circulating through buildings via central HVAC systems.[58] In addition, individuals are significantly less likely to enforce smoking bans in the home if they believe that thirdhand smoke is not a threat to children.[59] Research has shown that the majority of people who smoke are unaware of the dangers of thirdhand smoke; only 43% think thirdhand smoke threatens children's health.[59] This fact raises the possibility that the smoking ban is not always followed and that increased enforcement may be necessary.[60]



Closing the Loophole

For jurisdictions that wish to address secondhand smoke in private residences licensed as family day cares, it is important to ensure that smoking is prohibited in the outdoor areas immediately surrounding the residence. It is also important that jurisdictions make sure the law is being followed by educating providers about the dangers of secondhand smoke outdoors and thirdhand smoke. In these ways, jurisdictions can protect both child care workers and children who attend day care in licensed private residences.

Children Being Cared for in Licensed Home Day Cares

Providing 100% tobacco-free environments for children is an integral component of safe, healthy, high-quality child care, especially given the wide-ranging health implications for infants and children exposed to secondhand and thirdhand smoke.[11]

Even though smoking is never allowed in a day care center at any time, smoking is not prohibited in outdoor areas of licensed in-home day cares. Child care trends suggest that this private residence exemption in the California Smokefree Workplace Act affects tobacco-related health inequities because home day cares tend to be less expensive than day care centers, making them more affordable for low-income families. Home day cares are also more likely than day care centers to offer care before and after normal business hours, making home day cares more appealing to people who work non-traditional hours.

Nationally, licensed in-home day care represents about 10% of child care.[61] As of June 2016, California had 29,348 licensed family child care providers[62] caring for up to 302,970 children.[62] When children attend day care in private residences where smoking may occur either after hours or in outdoor play areas, they may face the following risks:

Secondhand Smoke

By merely prohibiting smoking within indoor areas of family day care homes, this exemption fails to protect children from secondhand smoke exposure in the backyard and from smoke that may drift indoors from the outside. As mentioned earlier, levels of secondhand smoke exposure outdoors can reach levels attained indoors, depending on wind direction and speed and the number and proximity of people smoking.[54,56]

Thirdhand Smoke

Given that 80% of children receiving care in private residences are not yet in kindergarten and nearly half of them are 2 years old or younger,[52] children of these ages are the most vulnerable to thirdhand smoke exposure. Thirdhand smoke may be deposited indoors by tobacco smoke drifting in from outdoor areas and circulating through buildings via central HVAC systems.[58] Children younger than age 2 are the most likely to inhale, ingest, and absorb thirdhand smoke contaminants as they crawl, put toys in their mouth, and kick up dust and other thirdhand smoke particles in the environment through their play.[63,64] They are the most vulnerable to thirdhand smoke because their immune and respiratory systems are not yet fully developed.

Prolonged Exposure

Children who receive subsidized care in a private home typically spend more hours in day care than children who receive care from day care centers, thus substantially raising their risk of exposure to secondhand and thirdhand smoke.[65] Prolonged exposure to thirdhand smoke could increase risk of cognitive and neurological disorders — such as learning disabilities and attention deficit — and decreased muscle and bone growth.[66]

Who relies on licensed child care provided in private homes?

Low-Income Families

The annual cost of home-based day care for children who are not yet in school is typically $1,404–$2,251 less than the annual cost of a day care center,[67] making it more affordable for families with low to moderate income.

Families Who Are Required to Work Evenings, Nights, or Other Types of Work Shifts

Licensed family child care homes are more likely to offer care in the evenings, on weekends, or overnight. Only 3% of day care centers offer these types of care, in contrast to 41% of providers who offer care in their homes.[68] Those employed in office jobs are significantly less likely to require care outside of regular business hours compared with those who work jobs that require shift work, such as hotel workers, food service workers, and security guards.[69] Thus, it is possible that this exemption disproportionately affects children of shift work employees.

Families Receiving Subsidized Care

Subsidized child care is critical for many California families. California provides funding for child care for 489,200 children statewide.[70] An estimated 22.5% of these children receive child care in a private home licensed for day care.[65]

Families of Color

California's family day care loophole likely disproportionately affects children who are Hispanic or African American. For example, 62% of children who receive subsidies for child care are Hispanic and 14% are African American.[65] Additionally, workers who are African American, Hispanic, and Asian are all significantly more likely to work evening and night shifts.[69] It is possible that their children are more likely to be receiving care in private residences licensed for day care.

What does this all mean?

Some of California's most vulnerable children are the most likely to receive care in private residences and spend significantly more time there. As a result, it is possible that their risk of exposure to secondhand smoke and thirdhand smoke is higher than that of children from families with higher incomes.

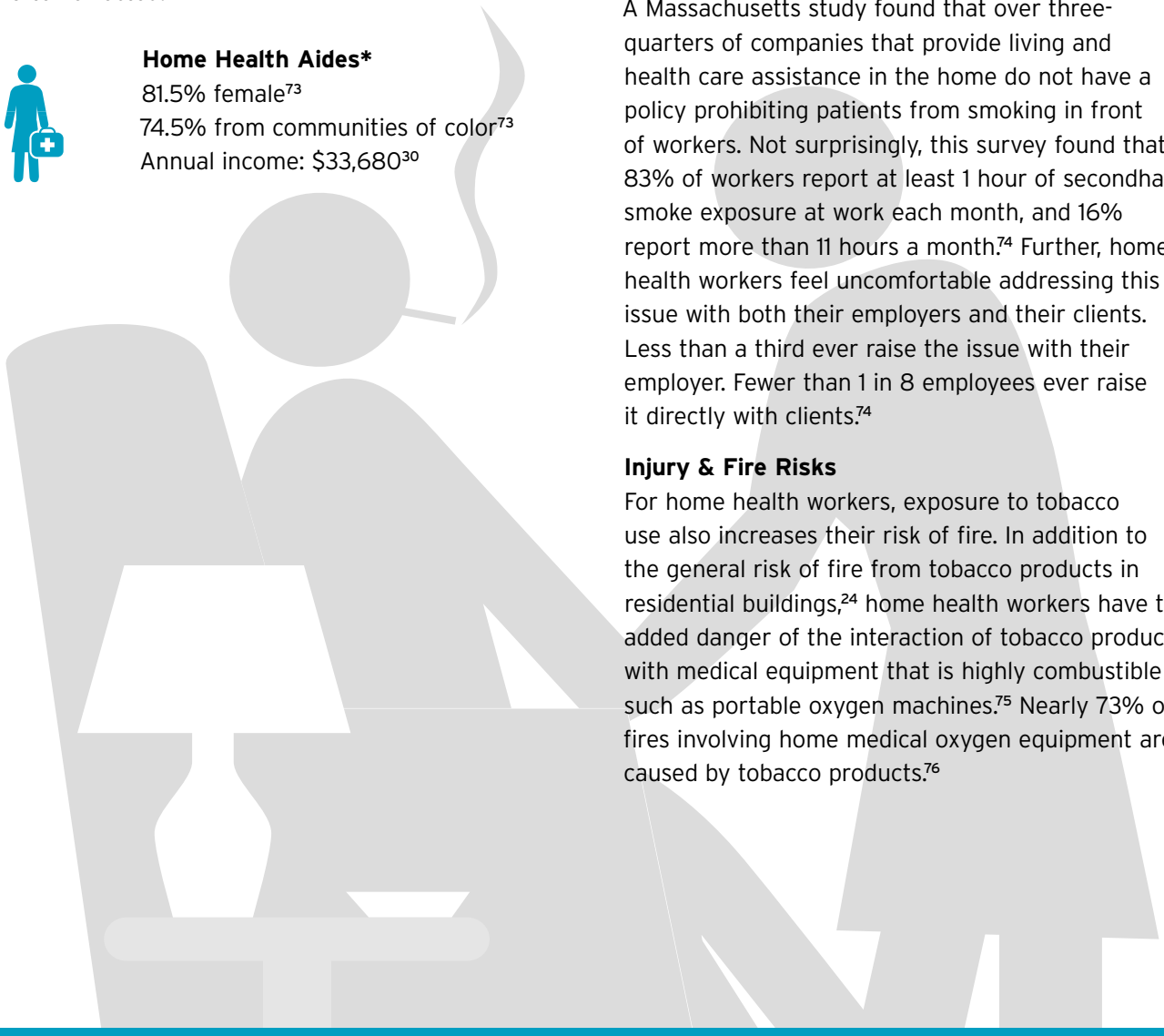
Private Residences & Home Health Workers

Many people work in private residences – for example, cooks, house cleaners, babysitters, caretakers, home health care workers, and maintenance workers.[71] Some of these workers take care of people's homes, and some care for children, aged or sick people, or people with disabilities. Unfortunately, workers in private residences have no legal protection from secondhand and thirdhand smoke. Even though one person's private residence may often be another person's place of employment, the California Smokefree Workplace Act does not include private residences in its definition of a place of employment. Because data on home health care workers are the most readily available, this section focuses on the nearly 90,000 Californians[72] who provide health care services in homes.

Who is most affected?

This exemption adversely impacts women of color and the working poor. Home health aides are often affected.

Home Health Aides*
81.5% female[73]
74.5% from communities of color[73]
Annual income: $33,680[30]



How does this exemption affect home health aides?

Secondhand Smoke

A Massachusetts study found that over three-quarters of companies that provide living and health care assistance in the home do not have a policy prohibiting patients from smoking in front of workers. Not surprisingly, this survey found that 83% of workers report at least 1 hour of secondhand smoke exposure at work each month, and 16% report more than 11 hours a month.[74] Further, home health workers feel uncomfortable addressing this issue with both their employers and their clients. Less than a third ever raise the issue with their employer. Fewer than 1 in 8 employees ever raise it directly with clients.[74]

Injury & Fire Risks

For home health workers, exposure to tobacco use also increases their risk of fire. In addition to the general risk of fire from tobacco products in residential buildings,[24] home health workers have the added danger of the interaction of tobacco products with medical equipment that is highly combustible such as portable oxygen machines.[75] Nearly 73% of fires involving home medical oxygen equipment are caused by tobacco products.[76]

Closing the Loophole

One way to reduce secondhand smoke exposure among home health workers is to provide training to home health workers and their clients about the dangers of secondhand smoke. Another way is to establish voluntary smokefree agreements between clients and home health workers.[75]

A stronger option would be to pursue a policy that would require private residences to be smokefree when any employees — such as home health aides, housekeepers, and cooks — are present. However, this policy option would not protect workers from thirdhand smoke, and it would be difficult to enforce. Jurisdictions would need to explore options on how to effectively implement this kind of requirement.[78]

* Because the US Census aggregates data on home health aides with data on nursing and psychiatric assistants, the race and gender demographics of home health aides may vary from the statistics shown.

Long-Term Health Care Facilities

Workers in long-term health care facilities include nurses, nursing assistants, and orderlies. They take care of some of the most underserved populations: people with disabilities, people with debilitating injuries, and people with terminal illnesses. Medical professionals in long-term health care facilities dedicate their lives to the health and safety of their patients. In doing so, they are often subject to secondhand smoke because under state law, smoking is not prohibited in patient smoking areas of long-term health care facilities.

Long-term health care facilities include the following types of workplaces:

- Skilled nursing facilities[77]
- Intermediate care facilities for patients with developmental disabilities[77]
- Small residential living health facilities for patients with physical disabilities or terminal illnesses[77]
- Pediatric day health and respite care facilities[77]

According to the California Health Facilities Consumer Information System, there are 2,618 long-term health care facilities in California.[78] These facilities include 18 pediatric day health and respite care facilities, which serve up to 390 children.[78]

Who is most affected?

Psychiatric assistants, nursing assistants, and orderlies are some of the workers most likely to be affected by this exemption.

Psychiatric & Nursing Assistants*
81.5% female[73]
74.5% from communities of color[73]
Annual incomes: $32,660 to $35,220[30]

Orderlies
Annual income: $39,410[30]

How does this exemption affect workers in long-term health care facilities?

Secondhand Smoke
Surveys of nursing facility administrators in the 1990s found that smoking prevalence in long-term health care facilities was as high as 80%.[79] Given that up-to-date data is sparse, additional research needs to be conducted to determine the current extent of negative health impact on employees in these settings.

Closing the Loophole
A complete ban of smoking in long-term health care facilities may pose challenges. For example, patients who smoke who cannot safely walk by themselves to designated smoking areas will require staff assistance even if smoking is prohibited indoors.

Communities interested in eliminating the long-term health care facility exemption will want to explore implementation strategies that anticipate the challenges that long-term health care providers face in providing safe and high-quality care for populations with high medical needs.

For example, communities might want to consider working with providers to offer cessation services, designate appropriate smoking areas, and reduce access to tobacco products.[90] However, these strategies will not entirely solve the problem of employees being exposed to secondhand and thirdhand smoke at work if they are required to transport patients to designated smoking areas or attend to patients in those areas.

For a full list of long-term health care facilities in your community that are eligible for this exemption, visit the California Health Facility Information Database (Cal Health Find) at cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/pages/home.aspx.

* Because the US Census aggregates data on nursing and psychiatric assistants with data on home health aides, the race and gender demographics of nursing and psychiatric assistants may vary from the statistics shown.

Workplaces Located Outdoors

People who work outdoors often have high rates of work-related injuries and fatalities.[80] Unfortunately, because people who work outdoors are not protected by the California Smokefree Workplace Act,[1] they are also at risk for secondhand smoke exposure.

As of March 2018, at least 56 jurisdictions in California have prohibited smoking at outdoor worksites and 151 have restricted smoking in outdoor dining areas.[81] However, most people who work outside remain unprotected from secondhand smoke.

Who is most affected?

Many industries that involve outdoor work, such as those listed here, often rely heavily on individuals from low-income communities or communities of color.

Farming, Fishing, and Forestry
75.5% male[82]
79% from communities of color[82]
Annual income: $27,520[30]

Restaurant Industry
69% from communities of color[83]
Annual income: $28,930[30]

Amusement Park Industry
Outdoor attendants who make up 27% of the industry[84]
Annual income: $26,660[30]

Construction Industry
for example, brick masons, cement masons, laborers, painters, and roofers
96.5%–99% male[87]
70%–81.5% from communities of color[87]
Annual income: $46,860–$59,880[30]

How are outdoor workers affected?

High Smoking Rates
Nationally, the Centers for Disease Control and Prevention find that those who work in food services, construction, transportation, and mining have some of the highest smoking rates.[85] Smoking prevalence ranges from 17.5% of those who work in mining to as high as 24% for those who work in the food service industries.[85]

Secondhand Smoke
Levels of secondhand smoke exposure outdoors can reach levels attained indoors.[54,56] To be completely free from exposure to secondhand smoke, a person might have to move more than 23 feet away from the source of the smoke.[56,57]

Secondhand Smoke Exposure & Smoking Rates
This gap in the law helps to support a vicious cycle in which workers who are exposed to higher rates of secondhand smoke see others smoke, so are more likely to smoke themselves.[86]

Tobacco Shops & Private Smokers Lounges

The California Smokefree Workplace Act does not prohibit smoking in retail tobacco shops and private smokers lounges if the retailer's main purpose is the sale of tobacco products. Tobacco shops and private smokers lounges include places like smoke shops, tobacconists, cigar bars, and hookah lounges. This exemption affects occupation-related health inequities.

According to the US Census, California has 1,289 tobacco shops with employees,[72] a count that excludes both mail order and online tobacco retailers.[72] These stores employ 3,237 individuals, although it is likely that more individuals are affected.[88]

This exemption contributes to inequities in the following ways:

Makes enforcement more difficult

Enforcement for this exemption is a major issue; many tobacco shops and private smokers lounges have tried to use these exemptions while serving food and beverages. Opinions from the attorney general and legislative counsel of California have both concluded that tobacco shops and private smokers lounges no longer qualify for these exemptions if they serve alcoholic beverages[89] or prepared food.[90] Despite these legal opinions,* confusion persists, deterring enforcement.

Fails to protect low-income workers from secondhand smoke

Even though some may argue that people who work in private smokers lounges and tobacco shops know the risks of working in these kinds of establishments, this exemption results in substantial income-related health inequities. For example, the average income for those working in tobacco shops is $20,151,[72] which is well below the state average of $59,150 per year.[30]

* California's attorney general, as the state's chief law enforcement officer, issues formal legal opinions on questions related to the enforcement of particular laws. Although these opinions are not legally binding like a court decision, they carry a great deal of weight with courts that are considering a legal question for the first time. Therefore, the attorney general's formal legal opinions serve as guidance for law enforcement or how a law should be interpreted.

Conclusion

Exemptions in California's state law against workplace smoking have become part of the system of forces that bring about smoking-related health inequities in the state. These exemptions unfairly impact communities of color and low-income workers. Closing these exemptions will reduce an important source of health inequities and reduce the disproportionate impact of tobacco-related illnesses among some of California's most affected populations. Local communities should also make sure that the California Smokefree Workplace Act is being properly enforced.

Resources

The following resources may help communities interested in building momentum for comprehensive smokefree laws in workplaces.

- **California Tobacco Control Program**
  Smoke-free Protections in the Workplace and Electronic Smoking Devices: A Summary for Employers and Owner-Operated Businesses (2016)
  cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/CDPH%20Document%20Library/Policy/ElectronicSmokingDevices/SmokefreeProtectioninCaliforniaWorkplaces.pdf

- **Centers for Disease Control and Prevention**
  A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease
  cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf

- **ChangeLab Solutions**
  Model Ordinance: Comprehensive Smokefree Places
  changelabsolutions.org/product/comprehensive-smokefree-places

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