

Changing public attitudes about smoking

Health and Lifestyles Surveys 2008-2010

Background

Tobacco use has long been a health and social issue throughout the world. The New Zealand government has agreed to set specific mid-term targets as a means towards the longer term goal of making New Zealand essentially a smokefree nation by 2025. Towards this goal, it is important to understand what New Zealanders think about tobacco as a health and social issue. To help establish this information people were asked a series of questions in the Health Sponsorship Council's (HSC's) 2010 Health and Lifestyles Survey (HLS).

Overview of key findings

The majority of people thought that smoking is a real problem in New Zealand:

- In 2010, four in five respondents agreed that smoking is a real problem in New Zealand.
- People were more likely to agree with this statement in 2010 than in 2008.
- In 2010 average agreement with this statement did not differ by smoking status, ethnicity, neighbourhood deprivation status, age, gender, educational background, or parent/caregiver status.

The majority of respondents thought that society disapproves of smoking:

- In 2010, four in five respondents agreed that society disapproves of smoking.

- People appeared more polarised in their levels of agreement with this statement in 2010 than in 2008.
- In 2010, people who showed lower levels of agreement on average with this statement were current smokers, Māori and Pacific, and people living in neighbourhoods of high deprivation.

Methodology

In 2008 and 2010, all respondents were asked for their levels of agreement or disagreement ('strongly agree', 'agree', 'neither agree nor disagree', 'disagree', or 'strongly disagree') with the statements **smoking is a real problem in New Zealand** and **society disapproves of smoking**.

Mean (average) agreement scores (ranging from 1 = strongly disagree to 5 = strongly agree) from the 2010 HLS were calculated to compare responses by:

- Smoking status (current smokers: those who smoked at least monthly, and past smokers: those who had ever smoked but did not smoke at the time of the survey, compared with never smokers).
- Ethnicity (Maori, Pacific, and Asian people, compared with people of European/Other ethnicity).
- Neighbourhood deprivation status (high: NZDep2006 8-10 and medium: NZDep2006 4-7, compared with low: NZDep2006 1-3).

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- Age (25-34 years, 35-54 years, and 55 + years, compared with 15-24 years).
- Gender.
- Educational background (no formal qualifications, School Certificate/NCEA level 1, and UE/NCEA levels 2-3/trade certificates, compared with university qualifications).
- Parent/caregiver status (parents/caregivers of up to 16-year-olds, compared with those who were not parents/caregivers of up to 16-year-olds).

Differences in levels of agreement from the 2008 and 2010 HLS were also compared.

Statistically significant differences ($p < .05$) are reported.

Detailed Findings

Smoking is a real problem in New Zealand

In 2010, the majority of respondents thought that smoking was a real problem:

- Around four in five (79%) respondents either 'agreed' (42%) or 'strongly agreed' (37%) that **smoking is a real problem in New Zealand**.
- Fewer than one in 10 (7%) 'disagreed' (6%) or 'strongly disagreed' (1%) (see Figure 1 and Table 1).

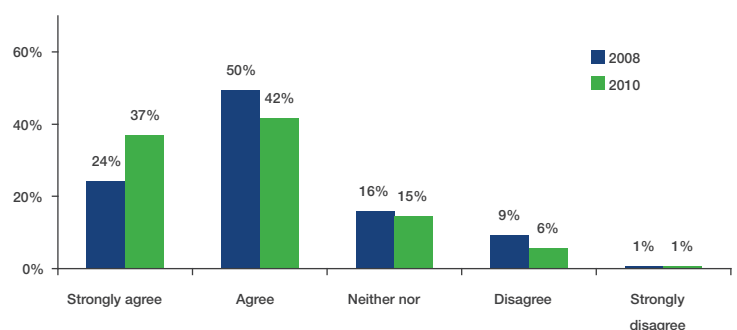
Respondents were more likely to see smoking as a real problem in 2010 than they were in 2008:

- Respondents were more likely to 'agree' or 'strongly agree' that **smoking is a real problem in New Zealand** in 2010 (79%) than in 2008 (74%).
- Respondents were less likely to 'disagree' or 'strongly disagree' in 2010 (7%) than in 2008 (10%).

Strength of agreement also increased from 2008 to 2010:

- Respondents were more likely to 'strongly agree' that **smoking is a real problem in New Zealand** in 2010 (37%) than in 2008 (24%).
- Respondents were less likely to 'agree' in 2010 (42%) than in 2008 (50%) (see Figure 1 and Table 1).

Figure 1. Agreement that smoking is a real problem in New Zealand, 2008 and 2010



*percentages may not add to 100 due to rounding

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In 2010, the overall mean agreement score (\bar{x}) was 4.08 (out of 5). Respondents who were less likely to agree with this statement were:

- Current smokers (\bar{x} =3.66), compared with never smokers (\bar{x} =4.22).
- There were no differences in mean agreement by ethnicity, neighbourhood deprivation status, age, gender, educational background, or parent/caregiver status.

Society disapproves of smoking

In 2010, the majority of respondents thought that society disapproves of smoking:

- Around four in five (79%) respondents either 'agreed' (56%) or 'strongly agreed' (23%) that **society disapproves of smoking**.

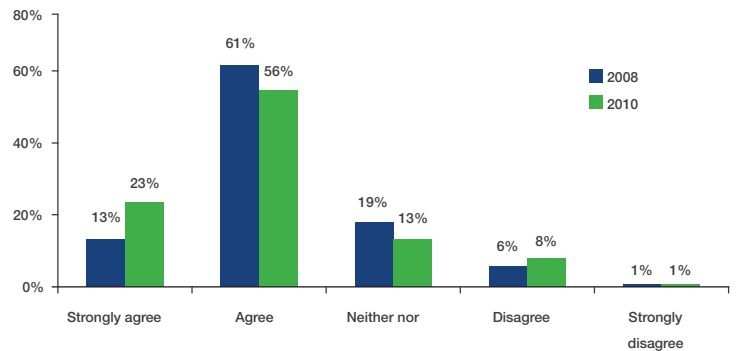
Respondents appeared more polarised in their views of whether **society disapproves of smoking** in 2010 than in 2008:

- Respondents were less likely to 'neither agree nor disagree' in 2010 (13%) than in 2008 (19%).
- Respondents were more likely to 'agree' or 'strongly agree' in 2010 (79%) than in 2008 (74%).
- Respondents were more likely to 'disagree' or 'strongly disagree' in 2010 (8%) than in 2008 (6%).

Within agreement, strength of agreement that **society disapproves of smoking** increased:

- Respondents were more likely to 'strongly agree' that **society disapproves of smoking** in 2010 (23%) than in 2008 (13%).
- Respondents were less likely to 'agree' in 2010 (56%) than in 2008 (61%) (see Figure 2 and Table 1).

Figure 2. Agreement that society disapproves of smoking, 2008 and 2010



*percentages may not add to 100 due to rounding

In 2010, the overall mean agreement score (\bar{x}) was 3.92 (out of 5). Respondents who were less likely to agree with this statement were :

- Māori (\bar{x} =3.73), and Pacific (\bar{x} =3.72), compared with people of European/Other ethnicity (\bar{x} =3.98).
- People living in neighbourhoods of high deprivation status (\bar{x} =3.77) and mid deprivation status (\bar{x} =3.90), compared with those living in neighbourhoods of low deprivation status (\bar{x} =4.07).
- There were no differences by smoking status, age, gender, or educational background, or parent/caregiver status.

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Table 1. Comparison of public attitudes about smoking, 2008 versus 2010 (odds ratios and confidence interval at 95% level)

	Strongly agree	Agree	Neither nor	Disagree	Strongly disagree
Smoking is a real problem in New Zealand	OR = 1.83* (1.57-2.13)	OR=.72* (.63-.83)	OR=.89 (.74-1.08)	OR=.58* (.44-.75)	OR=2.16 (.99-4.74)
Society disapproves of smoking	OR = 1.89* (1.57-2.26)	OR=.81* (.71-.93)	OR=.64* (.53-.77)	OR=.133* (1.01-1.75)	OR=1.13 (.47-2.73)

*denotes significant differences at .05 level

About the Survey

- The HLS is a nationwide in-home face-to-face survey conducted every two years, starting in 2008. The 2010 HLS consisted of a sample of 1,740 New Zealanders aged 15 years and over, who provided information about their health behaviours and attitudes relating to tobacco, sun safety, healthy eating, gambling, and alcohol.
- In 2010, the main sample, with a response rate of 57%, included 866 people of European/Other ethnicity, 460 Māori, 301 Pacific peoples and 113 Asian people (prioritised ethnicity).
- The data have been adjusted (weighted) to ensure they are representative of the New Zealand population.
- For this analysis, t-tests and analyses of variance (ANOVAs) were undertaken to compare mean agreement scores collected by the 2010 HLS. Response distribution from the 2008 and 2010 HLS were compared using chi-square tests, and differences between responses to statements in the two surveys were compared using odds ratios. The significance level used for statistical analyses was set to $\alpha = 0.05$.
- Data presented here from the 2008 HLS have been re-analysed to be comparable with the 2010 HLS. This may mean results differ slightly from those published previously.
- A full description of the 2008 and 2010 HLS survey methodology and further HLS publications can be found online at www.hsc.org.nz/researchpublications.html.

About the HSC

The HSC is a crown entity that uses health promotion initiatives to promote health and encourage healthy lifestyles, with a long-term focus on reducing the social, financial and health costs of a number of health behaviours.

Citation

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