



postnote

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SMOKING IN PUBLIC PLACES

The Chief Medical Officer has called on government to consider introducing legislation to ban smoking in all enclosed public places. Several other countries have already introduced such laws. This briefing considers the evidence that passive smoking causes disease; describes government policy on passive smoking; and discusses options for reducing exposure of staff and customers in public places to tobacco smoke.

Background

Changes in public attitudes both to the health and comfort aspects of exposure to tobacco smoke mean that it is now common practice for smoking to be banned in workplaces such as offices and in other enclosed public places such as cinemas, buses and trains. This trend has not been widely followed by pubs and restaurants. The current debate around smoking in public places is thus focused on these premises.

Health effects of passive smoking

Evidence on the health effects of passive smoking comes from population studies. As outlined in the box on page 2, when such studies are taken individually they are generally inconclusive, tending to show a positive, but not statistically significant, relation between passive smoking and coronary heart disease/lung cancer.

However, when the results from such studies are pooled and re-analysed (a method known as meta-analysis), they show statistically significant links between passive smoking and both lung cancer and coronary heart disease, increasing the risk for each by around 25%. In addition, it is well established that passive smoking exacerbates asthma and can cause various respiratory disorders.

National and international public health bodies along with many in the scientific community have interpreted such results as clear evidence that passive smoking can seriously harm health (see box on page 2).¹ For instance, the British Medical Association (BMA) recently concluded that there is no safe level of exposure to tobacco smoke and the International Agency for Research on Cancer has classified environmental tobacco smoke as a cancer-causing agent.²

However, some scientists have questioned the process used to derive these results,³ suggesting that meta analysis may over-estimate the risks of passive smoking.⁴ The Tobacco Manufacturers Association (TMA), suggests that the evidence base is too weak to draw the conclusions above and that there is thus room for debate over the extent to which passive smoking affects health.

Government policy

The Department of Health (DH) works on the assumption that smoke-free is the ideal.⁵ It wants to make rapid progress towards increasing the number of smoke-free pubs and restaurants because: it believes there would be significant health gains because of the reduction in passive smoking (see box); and smokers may stop smoking, leading to greater health gains.

Regional tobacco alliances

A network of 42 regional tobacco alliances across England was established by DH in 2000. Each alliance brings health services, local authorities and others together to implement DH tobacco policy at a local level. Reducing passive smoking was set by DH as the priority area for 2002/03 and a number of alliances have called on local councils to work towards smoke-free policies for public places in their areas.

Health effects of passive smoking

Lung cancer and coronary heart disease – research in this area investigates the health of people who have never smoked. Studies usually compare the health of those with low exposure to environmental tobacco smoke with that of those who live or work in a smoky environment. Taken individually, the results of such studies are equivocal:

- For lung cancer, of 37 studies reviewed, 31 reported an increase in risk. This was found to be statistically significant in 7 of the studies.⁶
- For coronary heart disease, 18 studies have been reviewed.⁷ All reported an increase in risk; this was also found to be statistically significant in 7 studies.

Pooling the results of the individual studies and reanalysing them provides a potentially powerful tool for identifying links between passive smoking and disease. Applying this technique to the studies above suggests that passive smoking significantly increases the risk of lung cancer and coronary heart disease, each by around 25%.^{7,8} For lung cancer this represents an increase in cases from a typical 10 per 100,000 non-smokers to 12.5 per 100,000.

However, there is still some scientific debate over the method used to derive these figures. One potential source of error is misclassification; the possibility that some of those classified as never having smoked in a study may actually once have smoked.^{3,4} Given the strong link between smoking and lung cancer (over 80% of cases are attributed to smoking), this could have a significant effect on the results. Another is publication bias; the possibility that studies yielding positive results are more likely to be published. A recent study concluded that a modest degree of publication bias leads to a substantial reduction in risk.⁹

Other health effects -passive smoking has been found to cause a range of respiratory disorders, including reducing lung function and increasing respiratory symptoms such as coughing. Passive smoking can also exacerbate asthma. Exposure to tobacco smoke in the home has been found to be harmful to children, being linked with low birthweight, sudden infant death syndrome, and middle ear disease.

Smoking in pubs and restaurants

A Public Places Charter was launched by the hospitality industry in 1999 with support from DH. It is promoted by 14 industry associations, representing sectors such as pubs, restaurants and casinos. Venues are expected to have a written smoking policy and to display signs showing which of the five levels of policy they apply:

- no smoking;
- separate smoking and non-smoking areas;
- ventilated premises with separate areas;
- ventilated premises with smoking allowed throughout;
- smoking allowed throughout.

DH hoped that this partnership with industry would lead to increased provision for non-smoking customers in pubs and restaurants. Targets were agreed that 50% of all such premises should have a formal smoking policy and carry an external sign and that 35% of these should restrict smoking to designated and enforced areas and/or have adequate ventilation. To date, 43% have met the first standard (below target) and 53% the second (above target). DH notes that few pubs are entirely smoke-free and that around half of those complying with the Charter do so by allowing smoking throughout.

Smoking in workplaces

Bars and restaurants are workplaces as well as public places and, in 1998, government proposed an Approved Code of Practice on smoking. This would have given guidance to employers on how to apply general health and safety legislation to passive smoking – for example, by introducing a workplace smoking ban or installing ventilation, and would have applied to the hospitality industry. However, no progress has been made since 2000 when a draft code was put to government by the Health and Safety Commission.

International agreements

A Framework Convention on Tobacco Control was unanimously adopted at the World Health Assembly in May 2003. The convention requires signatories firstly to recognise the dangers of passive smoking, and secondly to implement 'effective' policies to protect people from passive smoking in indoor workplaces and public places.⁹ The UK was among the first countries to sign. The government hopes to ratify the convention in 2004 but has not yet established if this will require any changes in policy.

Restrictions on smoking in other countries

Bans or restrictions on smoking in public places have been introduced in other countries through legislation aimed either at workplaces or directly at public places. In California (see box on page 3), legislation introduced to protect the health of employees in all workplaces means that smoking in enclosed public places is effectively banned. New York and Boston introduced similar legislation in 2003 and Ireland plans to follow suit in 2004. In order to gain public support for such legislation, the California Department of Health Services advises that:

- public education about the dangers of passive smoking should be the first step;
- change should be incremental;
- a focus on protecting workers, rather than customers, is likely to gain most support.¹⁰

Hong Kong has focused on restricting smoking in public places. Restaurants that seat more than 200 people have had to designate one-third as non-smoking since 1997. There are now proposals to phase in a complete ban on smoking in restaurants and bars. In New South Wales, Australia, the state government introduced legislation in 2000 banning smoking in all enclosed public places, including restaurants and the dining areas of pubs and clubs, but giving exemption to bars. Compliance is reported to be high and largely enforced by staff. Legislation restricting smoking in France was introduced in 1992 without support from staff or customers and has thus largely been ignored.

Public attitudes in the UK

Public awareness of passive smoking has increased in recent decades. Today, 55% of non-smokers say that they mind if other people smoke near them. As the figure on page 3 shows, this can be for a variety of reasons relating to both health and comfort.

Smoking policies in California

In 1988 Californians voted to increase cigarette tax by 25 cents per packet, with 20% ring-fenced for public health education. This funded a Tobacco Control Programme that aimed to increase awareness of the harmful effects of passive smoking through local initiatives and the media. Smoking was presented not just as a personal risk decision but one that threatened the health of others too. During the early 1990s, several cities and counties within California introduced local bans on smoking in workplaces. Building on these local developments, the state-wide California Smoke-free Workplace Act was passed in 1994. This effectively banned smoking in any enclosed public place. It came into effect in 1995 but most entertainment venues were given a three year exemption until 1998.

88% of on-site alcohol consumption in California is in bars attached to restaurants. In 2001, it was reported that there was 90% compliance with the 1994 Act in these venues. At the same time, sales of alcohol at these establishments had increased. A study looking at the respiratory health and lung capacity of bar workers reported measurable improvements following the introduction of the ban.

Source: See endnote 10

The Office for National Statistics reports that, in 2002, 54% of the public were in favour of restrictions on smoking in pubs; 88% in restaurants and 87% in other public places.¹¹ A 2003 MORI poll looked in more detail at attitudes to different types of restrictions in restaurants.¹² 40% said that smoking should not be allowed at all in restaurants; 54% that separate smoking and non-smoking areas should be provided; and only 4% that smoking should be allowed anywhere.

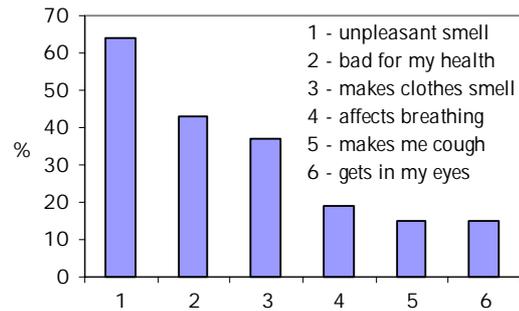
Reducing exposure to smoke

Banning smoking in public places

Action for Smoking and Health (ASH), a campaigning public health charity, believes that a ban on smoking in public places is the only way that the health of staff and customers can be adequately protected. Others are concerned that this would damage the hospitality industry and infringe smokers' personal freedoms. It is estimated that some 20 pubs and hundreds of restaurants in England have chosen to ban smoking. This has been driven primarily by commercial considerations. For example, earlier this year smoking was banned in all 350 Pizza Hut restaurants – these are family restaurants and many parents prefer not to expose their children to tobacco smoke. Pubs that have banned smoking are reported to be doing brisk business and have the added benefits of lower cleaning and insurance costs.

The UK hospitality industry is concerned that a ban on smoking would seriously damage it by reducing custom and causing remaining customers to spend less time and money at a venue. However, a review of studies on the effect of smoking bans concluded that, where studies controlled for changes in economic conditions and used objective measures (e.g. sales receipts), there was no evidence for a negative economic impact on bars and restaurants.¹³ Studies reporting a negative impact were generally based on predictions or impressions of the effect of bans rather than on quantitative data.

Why non-smokers mind if people smoke near them



Source: Office for National Statistics, 2003.

The TMA and FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco), a campaigning organisation that defends the interests of smokers, believe that a ban would discriminate against smokers. FOREST supports policies that accommodate smokers and non-smokers, such as providing separate areas or using ventilation, as discussed below.

Separate areas for smokers and non-smokers

Many restaurants and pubs provide separate smoking and non-smoking areas. This ranges from offering separate rooms to allocating areas as smoking or non-smoking. Larger venues, and those that have more than one room, have more flexibility over how they provide smoking and non-smoking areas. Some venues vary their policies with the time of day. For example, non-smoking areas may be extended when food is served at lunch times. Others focus on reducing staff exposure to tobacco smoke by banning smoking at the bar.

With separate areas, customers and staff are still exposed to tobacco smoke, but at a reduced level. While this may mean that customers are more comfortable, ASH, drawing on evidence from the BMA and others, believes that there is still an unacceptable risk to health. The hospitality industry suggests that it would not be practical for all venues to offer separate areas, particularly for smaller pubs and bars.

Providing ventilation

Installation of ventilation can improve air quality and provide a more comfortable environment for customers and staff. Some venues use ventilation in tandem with separate smoking and non-smoking areas, supplying outside air to non-smoking areas and bar staff, and removing stale air from smoking areas. Ventilation systems can cost ~£2,000 to £50,000, and require regular maintenance for optimal performance.

There is concern among public health campaigners internationally that tobacco manufacturers are promoting ventilation as a substitute for non-smoking policies. ASH points out that ventilation standards are based on creating a more comfortable atmosphere, rather than a safer one. Indeed, the BMA has concluded that ventilation does not provide effective protection against the health hazards of passive smoking. The TMA argues that indoor air may be contaminated anyway, so that proper ventilation is preferable to a smoking ban as contaminants from all sources are removed.

Policy options

Voluntary agreements

The hospitality industry has a strong preference for voluntary agreements on smoking in public places, such as the Public Places Charter. They argue that this is the only way that a diverse sector can be brought together without damaging economic consequences and that customer demand for smoking restrictions should be the driving force behind change. The TMA supports this view. Since 1997 it has funded the AIR (Atmosphere Improves Results) initiative, which provides advice to venues on implementing smoking restrictions and improving air quality. AIR was instrumental in raising the idea of establishing a hospitality industry funded Public Places Charter in 1998.

The industry feels that it has made good progress with introducing the Charter. It is disappointed not to have received greater recognition from DH and is concerned that, without commitment from government, the Charter will lose momentum. In particular, venues may be unwilling to invest in ventilation systems while the government's position on a smoking ban is unclear.

DH is in the process reconsidering its policies on passive smoking. A key issue is whether the Charter can be used as a way to generate change or whether it simply provides venues with a way to communicate existing policies. While the industry remains committed to the Charter, there appears to be no strategy in place for moving it forward and there are no targets for future levels of compliance. Suggestions have included extending the Charter to recognise good practice on protecting staff from tobacco smoke, and requiring all venues to have non-smoking areas within 12 months of joining. It has also been suggested that the Charter will only retain credibility if there is 100% membership.¹⁴

Regulation

The Chief Medical Officer does not believe that a voluntary agreement such as the Charter can tackle the health risks from passive smoking rapidly. He has therefore called on government to consider passing legislation to ban smoking in public places.¹⁵

The Approved Code of Practice proposed by government in 1998 would have required employers to control employees' exposure to tobacco smoke and been legally enforceable. The hospitality industry had a number of concerns about the Code: that it treated entertainment venues in the same way as other workplaces; that it would lead to a backdoor ban on smoking; and that it would have been too expensive for small businesses. They believe that it is the last of these points that has held up implementation of the Code. Government says that it is still considering further consultation on the Code but there is no expectation from either the hospitality industry or ASH that it will ever be implemented.

In the United States and Australia smoking restrictions have been introduced at a local rather than national level. It is not clear whether this is an option in the UK

as there is uncertainty over whether local authorities have the power to introduce bylaws on smoking in private properties. Any new legislation, local or national, would have to consider whether:

- specific restrictions or a total ban would be best;
- to treat the hospitality industry differently from other work places or public places;
- to treat the various sectors of the industry (pubs, restaurants, casinos, nightclubs etc.) differently;
- implementation could be phased to give venues time to adapt;
- measures to support enforcement would be needed.

Overview

There appears to be public support for measures to reduce exposure to tobacco smoke in public places such as restaurants both for health and comfort reasons. Reductions in exposure can be achieved by providing separate smoking and non-smoking areas, installing ventilation or banning smoking. A question is whether such measures are best encouraged through industry led voluntary agreements or through statutory requirements.

Endnotes

- 1 A summary of international position statements on passive smoking is given in *Report on the health effects of environmental tobacco smoke in the workplace*. Health and Safety Authority (Ireland), 2002. Available via www.hsa.ie
- 2 *Towards smoke-free public places*, BMA, November 2002.
- 3 J Bailar, *New England Journal of Medicine*, 340, 958-59, 1999.
- 4 see J Enstrom & G Kabat *British Medical Journal*, 326, 1057-61, 2003 and *British Medical Journal*, 327, 501-503 for a debate on the use of meta-analysis.
- 5 DH policy on smoking is set out in two key documents, available via www.doh.gov.uk. *Smoking kills – a white paper on tobacco*. DH, 1998. *NHS cancer plan*. DH, 2000.
- 6 A Hackshaw et al, *British Medical Journal*, 315, 980-88, 1997
- 7 J He et al, *New England Journal of Medicine*, 340, 92-26, 1999
- 8 J Copas and J Shi, *British Medical Journal*, 320, 417-18, 2000
- 9 *Article 8: WHO Framework Convention on Tobacco Control*. 2003. Available via www.who.int
- 10 *Eliminating smoking in bars, taverns and gaming clubs*. California Department of Health Services, 2001. Available via www.dhs.ca.gov
- 11 *Smoking related behaviour and attitudes, 2002*. Office for National Statistics, 2003. Available via www.statistics.gov.uk
- 12 Commissioned by SmokeFree London. Available via www.mori.com/polls
- 13 M Scollo et al. Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry. *Tobacco Control*, vol 12 (2003), pp 13-20.
- 14 *Scrutiny of smoking in public places in London*. Smoking in public places investigative committee, London Assembly, 2002. Available via www.london.gov.uk
- 15 *Annual report of the Chief Medical Officer, 2002*. DH, 2003.

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