Going smoke-free: the medical case for clean air in the home, at work and in public places

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Numerous authoritative reports on passive smoking have concluded that environmental tobacco smoke (ETS) causes or exacerbates a range of important health conditions among adults and children.[1-3] There is broad consensus that protection from ETS exposure is an important public health concern. So why has the Tobacco Advisory Group of the Royal College of Physicians (RCP) published yet another report on passive smoking?

Going smoke-free: the medical case for clean air in the home, at work and in public places[4] is the latest in a series of RCP reports addressing the biggest single cause of preventable death and ill-health in most developed and, increasingly, most developing countries. In 1962, the first report, *Smoking and health,*[5] recommended government action to ensure wider restrictions on smoking in public places, a recommendation repeated subsequently.[6,7] For many years there was only limited progress within the UK, and most other countries, on this aspect of tobacco control. However, recently several US states such as New York and California, and countries including New Zealand, Norway, and Ireland, have introduced comprehensive legislation to make enclosed public places and workplaces smoke-free.

This new document does not simply cover the well-trodden ground of previous reports which largely outlined the health effects of ETS exposure. Instead *Going smoke-free* provides a succinct and comprehensible summary of the evidence, arguments and issues concerning the introduction of smoke-free policies and legislation (ie banning smoking from all enclosed public places and workplaces).

The report is particularly timely for the UK where Scotland, and (probably) Wales will soon introduce smoke-free legislation, whereas in England the situation is uncertain. The English Public Health White Paper, *Choosing health,*[8] proposed a partial ban on smoking in public places, with exemptions for private members' clubs and pubs or bars which do not prepare and serve food. The UK government recently completed a consultation exercise[9] on the *Choosing health* proposals, the outcome of which is awaited. The decision on policy is therefore in the balance and informed advocacy in favour of comprehensive smoke-free legislation is crucial. However, since ETS exposure is a global problem and few countries have comprehensive smoke-free legislation, the issues outlined in *Going smoke-free* are of wider relevance.

The problem of passive smoking

Clear evidence that ETS exposure harms individual and public health is crucial to support the case for the introduction of smoke-free policies. The report describes the composition of ETS, how exposure is measured, and summarises the evidence for the many adverse health effects of ETS on adults, children and the unborn child. Evidence cited is strong, and although the increased risks from ETS exposure at an individual level are modest compared to active smoking, they are important in public health terms because of the ubiquity of exposure. Thus, ETS exposure is estimated to cause 12,200 deaths annually in the UK, including 500 from occupational exposures, with 50 in the hospitality industry alone. These are conservative estimates due to the assumptions of the model. Also morbidity attributable to ETS exposure, which will undoubtedly be substantial, was not estimated.

The considerable burden of ill health attributable to ETS contrasts markedly with the far lower and often unsubstantiated risks which have been evident in many recent, well-publicised, but transient health scares. The clarity about the magnitude of harm caused by ETS documented in *Going smoke-free* contrasts sharply with the language used by the UK government in *Choosing health,*[8] suggesting that strong advocacy is still required. For example, the latter states weakly that: 'The evidence of risk to health from exposure to second-hand smoke points towards an excess number of deaths, although the debate on the precise scale of the impact continues'.[8]

Solutions and non-solutions

The two main proposed solutions to the problem of ETS in public places and workplaces discussed are partial and comprehensive smoke-free policies. Whilst comprehensive smoke-free policies prevent smoking throughout enclosed workplaces and public places, partial policies seek to minimise harm from ETS by using designated smoke-free or smoking areas with or without additional atmospheric ventilation/filtration.

Evidence cited demonstrates that workers in the hospitality sector, particularly in bars, pubs and clubs, are the most heavily exposed occupational groups. Perversely these venues are often excluded wholly or partially from smoke-free policies, as is the case with the *Choosing health* proposals. The report cites international evidence showing that smoke-free areas with or without additional ventilation offer, at best, limited improvements in air quality for workers in the hospitality trade and elsewhere. There is absolutely no evidence that these minimal changes in air quality will improve health outcomes and protect the health of exposed staff. In contrast, there is unequivocal evidence that comprehensive smoke-free policies massively improve air quality, and there is some evidence of direct improvements in workers' health following their introduction. Therefore, proposals to introduce partial smoke-free measures (including the 'smoke-free zones' around the bar area proposed for pubs in England) will be wholly ineffective for protecting workers' health. The case for excluding these workplaces from complete smoking bans is impossible to justify, particularly as hospitality workers are the most heavily ETS-exposed occupational group. *Going smoke-free* illustrates that such proposed exemptions are illogical, unethical and unreasonable.

Ethical and economic arguments

Not only do comprehensive smoke-free policies offer the greatest potential for health gain amongst the population, but there are strong ethical and economic arguments for their adoption.

Choosing health describes the ethical issues as 'hotly debated ... involving as [they do] a conflict between individual rights, and between rights and responsibilities in society'.[8] It argues, with little attempt at justification, that the partial smoke-free proposals represent the 'right balance between freedoms and responsibilities'. The rigorous exploration of the ethical case for smoke-free policies in *Going smoke-free*, however, clearly demonstrates that this view is impossible to sustain. Ethically, the argument for comprehensive smoke-free policies is an almost wholly one-sided debate with the ethical balance being clearly tipped in favour of the individual rights of non-smokers. Put simply, non-smokers deserve protection from the harm caused by ETS released wittingly or unwittingly by smokers. These and a range of other ethical arguments presented in *Going smoke-free* in favour of smoke-free legislation far outweigh the relatively minor restriction that such legislation imposes on smokers as to where, not whether, they can smoke.

The economic arguments presented for introducing comprehensive smoke-free policies are compelling. The report indicates that from the societal perspective, smoke-free legislation is highly cost effective, providing substantial benefits to countries' economies. These are estimated at £4,000 million per year in the UK.

However, arguments about the economic effects of smoke-free policies tend to focus on the hospitality sector. Experience from around the world is that in debates about the introduction of restrictions on smoking the hospitality industry usually sides with the tobacco industry, aiming to prevent or delay smoke-free legislation, by arguing that implementation would be economically ruinous. The chapter on the potential economic impact of legislation dispels the myth that smoke-free policies would harm the hospitality industry. Hard economic data from many countries show that after adjustment for trends and other key factors, the overall effect of comprehensive smoke-free policies on the hospitality industry is broadly neutral or weakly positive. Judging by the following quote from a tobacco company marketing and sales director in 1994, the tobacco industry has long been aware of this:

> *Economic arguments often used by the industry to scare off smoking ban activity were no longer working, if indeed they ever did. These arguments simply had no credibility with the public, which isn't surprising when you consider our dire predictions in the past rarely came true.*[10]

Public opinion

The remaining argument advanced in *Choosing health* and subsequently by UK Government Ministers against comprehensive smoke-free legislation is that public opinion does not support legislation for all pubs and bars to be smoke-free. This is based on the findings from a single national survey.[11]

Politicians often seem to delight in ignoring manifest public opinion, generally with brazen declarations of the need to take 'difficult' or 'unpopular' decisions. Introducing comprehensive smoke-free legislation would demand just such political machismo, if public opinion were indeed strongly against it. The evidence suggests this is not the case.

Going smoke-free reviews rigorously the evidence about public opinion on smoke-free areas. This reveals that public opinion is more complex than the simplistic analysis suggested by the UK government, and is not a substantial barrier to implementing comprehensive smoke-free policies. A review of a range of independent surveys and polls from the UK in the report demonstrates that there is overwhelming support for the principle of the right to work in a smoke-free environment. There is also majority support for legislation to make public places and workplaces smoke-free, and for smoke-free legislation for most specified public places and workplaces. The exception to the latter are bars, pubs and nightclubs, although there is majority support among non-smokers for these venues to be smoke-free.

These somewhat contradictory findings suggest that pubs and bars are not always perceived as workplaces, and that once this is explained support will increase further. This is supported by the finding that where smoke-free legislation has been introduced, public support increased steadily during the run up to implementation as the issues were debated, and increased further after its introduction.

Smoke-free legislation and ETS exposure in homes

The main source of ETS exposure in the UK, particularly for children, is in the home. The former UK Health Secretary claimed that making all pubs and bars smoke-free would

increase smoking in the home and children's exposure to ETS. [12] *Going smoke-free* demonstrates clearly that this assertion was based on belief not evidence, and that introducing smoke-free legislation is likely to reduce domestic ETS exposure.

The report firstly summarises the overwhelming evidence that smoke-free policies discourage people from starting smoking and encourage smokers to quit or cut down, thereby reducing smoking prevalence and tobacco consumption. This is an extremely welcome side-effect of such policies, though not as the report makes clear the mainstay of the ethical case for introducing smoke-free legislation. Reducing smoking prevalence and consumption should by itself reduce ETS exposure in the home. This is supported by evidence that declines in children's ETS exposure in the UK (as indicated by their cotinine levels) have mirrored declines in population smoking prevalence.

Furthermore, after restrictions on workplace and public place smoking were introduced in the USA, Australia and Ireland, the proportion of smoke-free homes among homes with one or more smokers increased. This suggests that introducing comprehensive smoke-free policies, often with supporting health education campaigns, resulted in smokers implementing their own voluntary, domestic smoke-free policies. Presumably the new legislation helped to change social norms, a possibility that was suggested in justifying the recommendations within the first RCP tobacco report.[5]

Tackling domestic ETS exposure raises complex issues of ethics and civil liberties. However, the evidence suggests that comprehensive smoke-free legislation is likely to be an effective intervention to reduce ETS exposure in the home. This is an important finding given evidence that behaviour-change interventions to promote smoke-free homes have only a limited impact.[13]

The tobacco industry

Finally, doctors who are unfamiliar with the strategies of the tobacco industry simply must read about the shoddy, self-interested tactics of this discredited industry in relation to passive smoking and smoke-free policies. A key point is that the tactics are repeated in every setting and hence are entirely predictable. These tactics include: disputing and attempting to undermine the scientific evidence; championing coexistence of smokers and non-smokers in the same environment through smoke-free areas and ventilation; predicting economic meltdown for the hospitality industry; and portraying smoke-free legislation as 'nanny statism' advocated by health fanatics. The report indicates the motivations of the tobacco industry's stance, revealing that it has long understood the threat which smoke-free legislation poses to its sales and profits – another good reason to support it.

Summing up

Going smoke-free details exhaustively how ETS exposure contributes to the enormous burden of ill health and premature death caused by tobacco smoking. This alone makes it compelling reading and a formidable reference text for all physicians. By detailing the issues and arguments for comprehensive smoke-free legislation it is invaluable to those who want greater involvement in tobacco control advocacy. We urge that all doctors and other health professionals stand up and are counted on this issue.

What the UK and other non-smoke-free countries urgently need is to repeat the Irish experience of going smoke-free as described in the final chapter of the report. This relates how Micheál Martin, the Irish Health Minister, demonstrated principled political leadership to achieve a key public health measure in the face of determined resistance from the tobacco and hospitality industries. This section of the report should be compulsory reading for health ministers globally. Introducing comprehensive smoke-free legislation as advocated in *Going smoke-free* requires similar bold political action. Physicians need to play their part to ensure that this happens.

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