

Choosing Health?

Tobacco issues

The response of the
Tobacco Manufacturers' Association
to the consultation paper

June 2004

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Preface

Choosing Health? poses the question of what role individuals, central and local government, the NHS and the public sector more broadly, the voluntary and community sector and industry, the media and others, should have in helping people to be healthier. At section 4 of the consultation paper, and in the accompanying supplemental note on tobacco, specific questions are posed about possible future directions for tobacco policy.

The TMA is the body that represents the interests of UK tobacco manufacturers and this response is made on behalf of its principal members – British American Tobacco, Gallaher and Imperial Tobacco.

There may be some who claim that tobacco manufacturers have nothing worthwhile to contribute to the debate on tobacco policy. Such reactions do not serve the development of appropriate and effective policies that can only emerge from sensible and constructive debate and discussion.

This response addresses the tobacco issues and specific questions raised in the consultation paper, directly and constructively. It is keenly hoped that it will receive careful and open-minded analysis and consideration, in line with the Cabinet Office code of practice on written consultation.

June 2004

Executive Summary

Starting, continuing and quitting smoking

- ❑ Children should not smoke and they should not be allowed access to cigarettes, by family, friends, retailers or illicit traders.
- ❑ The effectiveness of the age threshold that applies to cigarette sales to children is substantially improved by the use of proof-of-age schemes that provide a reliable and secure means of identifying a person's age.
- ❑ There should be a crackdown at a local level on illicit traders in smuggled cigarettes, who have no concern about to whom they sell cigarettes.
- ❑ Everyone is already aware of the risks associated with smoking. There should be an assessment of the effectiveness of the current on-pack health warnings in terms of their role in encouraging and helping people to quit smoking. Pictorial health warnings, or other innovations, should not be introduced until such an assessment has been made and any changes have been justified.
- ❑ The development and bringing to the market of new, potentially reduced exposure tobacco products should be actively considered by the Government.
- ❑ Tobacco products should continue to be displayed at the point of sale.
- ❑ Tobacco tax policy no longer has significant potential to act as an instrument of health policy. Currently almost one third of UK consumption escapes or avoids UK duty, tax or product regulations.
- ❑ It is important that the Government takes further action and devotes more resources to tackling tobacco smuggling at the ports of entry to this country and throughout the illicit distribution chain.
- ❑ It must also carry out a fundamental review of tobacco tax policy.

Environmental tobacco smoke: the scientific evidence

- ❑ The hypothesis that environmental tobacco smoke (ETS) caused lung cancer and other serious diseases in non-smokers became the accepted view of the authorities without there being any convincing evidence to that effect.
- ❑ Subsequently that evidence was sought from epidemiological studies, but the findings of those studies are not conclusive. Even in those studies where a positive association is reported, it is generally of a low order of risk, well below that normally regarded as being significant in terms of public health policy.
- ❑ The scientific evidence has been deliberately misinterpreted and misused for other purposes.

Smoking in work and other places

- ❑ As the Health and Safety Commission and Executive confirmed in 1999/2000, there is already sufficient health, safety and welfare law that can be applied to the question of passive smoking in the work place and, given the uncertainty surrounding the magnitude and extent of the risk to the public from passive smoking in public places, the issue is better dealt with in ways other than by legislation.
- ❑ Voluntary self-regulation smoking in the work place is providing what employers, employees and the public want.
- ❑ Voluntary self-regulation is providing more smoke-free public places and the choice that the public wants.
- ❑ Legislation prohibiting and/or regulating smoking in work and other places is unnecessary, would be socially divisive, infringe certain human rights, and needlessly replace successful, voluntarily adopted policies with oppressive and costly bureaucracy.
- ❑ It is not appropriate that smoking or permitting smoking should be made criminal offences .

Local decisions

- ❑ ETS does not have a local dimension and it is not appropriate, nor sensible in practical terms, that it should be regulated on a local basis by local authorities.
- ❑ It would be particularly inappropriate for smoking in the work place to be regulated by local authorities.
- ❑ Bye-laws would not be an appropriate means for the prohibition or regulation of smoking in other places.
- ❑ Local authorities are in a position to be champions and exemplars of sensible, best practice smoking policies, and have the opportunity to work with local groups and businesses in promoting policies which provide more non-smoking facilities and accommodate both non-smokers and smokers.

What the public thinks and wants

- ❑ A substantial majority of people are opposed to a ban on smoking in restaurants, pubs, bars and clubs.
- ❑ They believe that it is better to have a choice of smoking or non-smoking facilities, and that there should be greater provision of non-smoking facilities.
- ❑ People want more progress to be made in that regard but believe that matters are best left to owners and managers, acting in their own commercial best interests.

Introduction

Although we now live in times when average life expectancy is higher than ever before, and when the ageing of the population is becoming increasingly challenging for both individuals and society as a whole, there is a desire for ever-greater longevity. The adoption of healthier lifestyles may contribute to the satisfaction of that wish - taking more physical exercise, eating healthier foods and eating less, drinking less alcohol and drinking more sensibly, not smoking.

However, when that does not happen by people exercising their own free choice about their lives, how far should government go in the name of 'the public good'?

In that context, tobacco and smoking is a test case in progress.

Not least is it so because:

- the health risks associated with smoking have long been known and publicised;
- for over 30 years, health warnings have been printed on packs of cigarettes - the current regime of health warnings was laid down by EC Directive 2001/37/EC and those warnings are now a prominent feature on a pack of cigarettes;
- consumer tobacco advertising and promotion was prohibited by the Tobacco Advertising and Promotion Act 2002, other than at the point of sale;
- price is well recognised as being the single most important determinant of tobacco consumption and tobacco products have long been highly taxed in the UK, both to raise revenue and to discourage consumption. Today tobacco taxation accounts for as much as almost £10 billion, and that figure would be some £3 billion higher but for revenue losses due to illicit sales of smuggled products; and,
- many other measures have been taken – including media advertising, education and quitting programmes – which have had the aim of reducing the prevalence of smoking and total tobacco consumption.

Yet today, in the UK around 15 million people over the age of 16 continue to smoke – a figure that has not significantly changed over the last 10 years

In Britain in 1948, 82% of men and 41% of women aged over 16 smoked¹. Over the succeeding years, the prevalence of smoking amongst men declined steadily, but amongst women erratically and more slowly. Around the mid-1970s, smokers ceased to be in the majority in the adult population. After 1982, the rate of decline slowed and then levelled out from 1992 onwards, at around 26 to 28%. In 2002, 26% of persons aged over 16 were reported to be cigarette smokers² (a finding on which the report advised caution). Independent research³ puts the total of smokers of all tobacco products (cigarettes, hand-rolling tobacco, pipe and cigars) somewhat higher at 30% (15 million people) and total cigarette consumption at around 100 billion (including hand rolling tobacco converted at a cigarette equivalent rate of 0.4g per cigarette).

It is therefore apparent that past and existing policies have not lived up to governments' intentions and expectations.

Whatever policies are introduced with the aim of reducing the prevalence of smoking and total tobacco consumption, they need to be fully researched, be based on reliable evidence, and devised and targeted to achieve specific policy objectives, with their outcomes being subjected to objective assessment. Otherwise they risk having unintended consequences, for those who continue to smoke, the retail and tobacco manufacturing sectors, and society as a whole.

¹ UK smoking statistics, Wald & Nicholaides-Bowman, *Wolfson Institute of Preventive Medicine*, 1991.

² Living in Britain: Results from the 2002 General Household Survey, *National Statistics*, March 2004.

³ BMRB, 2003

Starting, continuing and quitting smoking

The health risks associated with smoking are well known and publicised. People who smoke make an informed decision to do so, knowledgeable about the risks. People who are not capable of making an informed decision about their own welfare should not smoke; children should not smoke and should be strongly discouraged from doing so.

Why children smoke

The prevalence of "regular" smoking (defined as at least one cigarette a week) among young people aged 11-15 in 2003 was estimated to be 9% and has remained stable, at between 9% and 11%, since 1998. There was a sharp increase in prevalence of smoking with age – 1% of 11 year olds smoked regularly compared with 22% of 15 year olds; girls were more likely to be regular smokers than boys – 11% for this whole age group compared with 7%⁴.

One of the principal justifications claimed for the Tobacco Advertising and Promotion Act 2002 was that tobacco advertising caused young people to smoke. No evidence was provided in support of that claim and, in all the available research into why children smoke, advertising was not found to be a relevant factor. That young smokers were found to be more aware of the marketing of tobacco products was not a surprising finding, and it has been admitted that this did not and could not prove causal effects⁵.

Now that all tobacco advertising is prohibited (except at the point of sale in respect of which highly restrictive regulations have been made), anti-tobacco groups are no longer able to argue that tobacco advertising causes children to smoke.

It has long been known that tobacco advertising in the UK never did cause children to smoke. For generations, children have experimented with smoking not because of advertising but out of curiosity, wanting to appear grown-up, to keep up with friends, for bravado, or to rebel.

Denying access to cigarettes

Numerous surveys have shown that children who smoke have a wide range of sources of cigarettes. Friends, family and siblings are for many a ready source of cigarettes, particularly for the youngest. That should not be the case and a smoker should never give, allow or, as is known to be the case with family and friends, give or sell cigarettes to children; nor should children be sold cigarettes by retailers or illicit traders.

Surveys have also shown that regular smokers under 16 obtain cigarettes from a wider range of sources than occasional smokers; the older the person, the more likely they are to have bought their cigarettes from a retailer or someone else, and to have more than one regular source.

For almost a century it has been an offence to sell cigarettes to a person under 16. Under current legislation⁶, it is a defence for the person charged with such an offence to prove that they took all reasonable precautions and exercised due diligence to avoid commission of the offence. In that regard, it is therefore of importance for the retailer to be satisfied that the intending purchaser is over 16.

In December 2003, 96% of shopkeepers reported⁷ that they had been approached by people attempting to buy cigarettes whom they considered to be under

⁴ Drug use, smoking and drinking among young people in England in 2003, Headline figures, *National Centre for Social Research/National Foundation for Educational Research*, March 2004

⁵ MacFadyen, Hastings & MacKintosh Cross sectional study of young people's awareness of and involvement with tobacco marketing, *BMJ*;2001;322: 513-517

⁶ Children and Young Persons Act 1933 as amended by Children and Young Persons (Protection from Tobacco) Act 1991

⁷ Survey of Tobacco Alliance retailers, December 2003

16; 84% said that they were generally abused or threatened when they refused to sell. Given that sales to under 16s still take place, some retailers obviously find it safer to sell than to refuse to do so.

The fact is, of course, that the older a teenager becomes, the more difficult it is to assess age on appearances only and for a retailer to refuse a sale on those grounds. Thus, whatever the age government and Parliament might determine should be the threshold for sales of cigarettes, respect for the law depends greatly on retailers being able to fulfil their responsibilities without abuse, intimidation and risk to themselves.

Proof of age

Over the years, the TMA and its member companies have therefore supported a number of major efforts to make it plain to children under 16 that they must not be sold cigarettes and to assist retailers in overcoming the difficulties of refusing a sale.

In the absence of a government 'proof-of-age' scheme, the TMA has provided substantial financial support to CitizenCard, which was launched in 1999 with Home Office support.

The CitizenCard scheme is operated by an independent non-profit company limited by guarantee, sponsored by the Association of Convenience Stores, Camelot, Experian, Ladbrokes, the National Federation of Retail Newsagents, Somerfield and the TMA. CitizenCard was the first scheme to achieve PASS (Proof of Age Standards Scheme) accreditation developed by the British Retail Consortium with the Home Office. It is now the largest proof-of-age scheme in the UK, anticipated to approach 1 million cards in issue by the end of 2004.

CitizenCard provides a reliable and secure means of proof-of-age for the purchase of any goods or services for which an age threshold applies. It is recognised and accepted by many thousands of retailers, by a number of airlines and banks. It is the only proof of age scheme that is UK-wide with cards available on application to anyone legally resident, irrespective of their age. All cardholder details are held on a single secure database and are not available to any other party. It uses hologram-protected cards embedding a laser-etched colour photograph of the cardholder and shows the date of birth and the age of the cardholder in years.

In March 2004, CitizenCard launched its nationwide 'NO ID, NO SALE' promotion to retailers and potential cardholders, its most ambitious promotion to date which is reaching all known retailers of tobacco products. It has the object of substantially reducing the purchase of all products and services by the under-aged, by expanding the cardholder base, particularly amongst young teenagers, and providing retailers with appropriate in-store signage and promotional material, as well as assistance with

how best to protect their own position under the law. 'NO ID, NO SALE' is being extensively supported by retailers, their trade organisations, trading standards authorities, schools, colleges and community organisations, the Department of Health and the Home Office.

"These are very encouraging results [checks made by Trading Standards Officers during February 2004]. They show Trading Standards Service support for the new 'No ID- No Sale' initiative and their support for the distribution of CitizenCards in West Sussex schools over the last four years, as a method by which young people can establish their true age, is beginning to work. The total number of cards held by young people in West Sussex is now more than 12,500. The service has been encouraging all retailers to ask for established proof of age unless they are sure the young person is old enough to buy a particular product and warning them that failure to do so may result in conviction in court. I am particularly pleased to see the improvement in respect of the sale of alcohol to underage persons because of the clear links this has to anti-social behaviour within our community."⁸

CitizenCard will be undertaking research into the effectiveness of the 'NO ID, NO SALE' promotion that will be published. However, such a promotion can only go as far as the education of retailers and the creation of awareness of the law amongst them and the public.

ID card schemes themselves can only go so far in helping to prevent sales of tobacco and other products to children. Effective prevention requires wider action and co-operation. It is for this reason that the TMA is also currently sponsoring a study in an area of Swindon, Wiltshire, where there have been considerable difficulties surrounding young people and under-age sales. This study is being undertaken with the full co-operation and involvement of Trading Standards, the police, schools and community organisations and other representatives. The intention is that the study will provide an exemplar of best practice that can be promoted through the authorities countrywide.

As for ID schemes, there is no doubt that there would be great benefit in a single scheme applying nationwide. Thus the TMA is encouraged by the Government's proposals for a national ID card scheme to apply to every person over 16, as this could help to ensure that children would not have access to tobacco products. In the meantime, there would be advantage in a rationalisation of existing proof-of-age card schemes. Only a few operate nationally; some are purely local; and not all have PASS accreditation.

⁸ Councillor David Dewdney, CC Cabinet Member for Community Safety, *Mid-Sussex Times*, March 4, 2004

Illicit sales of smuggled cigarettes to children

“Maintaining the high price of cigarettes is a particular deterrent to young people.”⁹

The affordability of cigarettes is a major factor for children who smoke or might start to smoke. If they can buy them, just as many adults can and do, at around half the normal retail price from an illicit trader, children are more likely to smoke and keep smoking. Regrettably, illicit traders have no inhibitions about to whom they sell, or about the products they sell, that might well be counterfeit and not meet the regulatory requirements with which legitimate products comply.

Whilst it is not possible to know or estimate the level of such sales of cigarettes to children, it is reasonable to presume that they are a source as significant to them as to adults. According to official statistics, smuggling currently accounts for 18% of the cigarettes consumed in the UK. In addition, cross border shopping is estimated to account for 9%, a portion of which may be traded illicitly.

The interception and confiscation of the wholesale supplies of illicit traders is an obvious key target for the authorities. So, too, should the thousands of people who illicitly sell cigarettes at the ‘street level’ be targets for the authorities locally. The peddling of cheap, smuggled cigarettes and tobacco may be regarded as a petty crime, but it is the indispensable end link in the chain on which large-scale organised

crime depends. Illicit sales to children are working against health policy objectives, just as are such sales to adults. They also threaten to undermine the proof-of-age culture now being increasingly instilled by legitimate retailers.

Adults - Quitting smoking

“Health data are essential for monitoring the health of the population and for evaluating the effects of health interventions. However, despite their future influence on morbidity and mortality, the information collected on the important current behavioural factors such as smoking, drinking, diet and exercise is poor”¹⁰

The personal decision to smoke is one that a smoker may change at any time, as a very great many do. In 2002, 26% of persons over 16 smoked; 54% had never smoked; 21% reported that they were ex-smokers¹¹.

Of those smokers who give answers in surveys to the effect that they would like to give up smoking – 68%¹² - many will: that millions have done so already is testimony.

It is also the case, however, that an answer given by a smoker to the effect that they would ‘like to quit’ does not convey a commitment to quit. It is more likely to be an answer prompted by the context and nature of the questioning.

⁹ Miss Melanie Johnson MP, Minister for Public Health, House of Commons, Written Answer, *Official Report* March 17, 2004, Col.395W

¹⁰ Derek Wanless, *Securing Good Health for the Whole Population*, Final Report, *HM Treasury*, February 2004, p. 120

¹¹ General Household Survey: Living in Britain, 2002, *National Statistics*, Tables 8.2 and 8.3

¹² General Household Survey, Living in Britain, 2002, *National Statistics*

The fact is that any smoker who decides and is determined to quit smoking can do so. Some find it to be more difficult than others, but if smokers are constantly given to believe that it will be difficult and that they might not be able to cope without support, it becomes more likely that many will not even make the attempt.

On-pack health warnings

Health warnings have been printed on packs since 1971. For all packs manufactured from 1 January 2003, a new regime of on-pack health warnings that substantially increased their size and prominence, became mandatory on cigarettes sold in the UK, following implementation of Directive 2001/37/EC (commonly known as the Tobacco Product Directive). At the time, no research was undertaken as to the precise objectives and effectiveness of the warnings. It was nonetheless claimed in the Department of Health's consultation document that the larger warnings would lead to a fall in consumption of between 0.5 and 1%. There is no indication that this has happened or is happening.

If the object of health warnings is to help to inform smokers of the risks associated with smoking, it is reasonable to presume that they have been effective in that regard. Along with media coverage of smoking and health issues, and governments' public health awareness campaigns, amongst other things, the TMA believes that all smokers and non-smokers are aware of the health risks associated with smoking.

"To say that people don't understand the health risks associated with smoking when on every single pack there are enormous health warnings, I just find that unbelievable."¹³

The TMA supports the use of health warnings on packs and believes that it is for government to determine those warning messages. For their own part, UK tobacco manufacturers accept their responsibility by having a clear policy of placing a health warning on every tobacco product that they sell throughout the world.

Although the new health warning regime has only been in operation for a little over 6 months, it has been indicated that Ministers may be of a mind to take up the option, offered by the EC Directive from October 2004, for a Member State to introduce warnings combining coloured pictures and text, in place of the current back-of-pack text only warnings.

Pictorial warnings have been adopted in a number of countries outside the EC and, although various claims have been made as to their effectiveness, the evidence available amounts to no more than claims about their first appearance. For example, Canada introduced pictorial warnings in December 2000.

"...there is a lack of research that examines the effect of cigarette warning labels on smoking behaviour."¹⁴

Nonetheless, the justification given by Health Canada for moving to pictorial warnings was to

¹³ The Secretary of State for Health, Rt Hon Dr John Reid MP, reported in *The Observer*, 7 December 2003

¹⁴ Hammond D, Fong G T, McDonald P W, Cameron R & Brown K S, Impact of the graphic Canadian warning labels on adult smoking behaviour, *Tobacco Control* 2003;12:391-395

encourage smoking cessation and deter smoking initiation. However, the available findings and research do not provide any conclusive evidence that they have had that effect.

“To date, there is very little evidence available to policymakers on either the timeline or extent of this decrease.”¹⁵

It is not sufficient that the combined warnings may have refreshed the previous written-only warnings, particularly as the evidence to that effect demonstrates a tailing-off after the introduction of the pictorial warnings.

The TMA believes that - as should also be the case with all other tobacco policy measures –a full and detailed impact assessment should be made before any decision is made to change from existing text-only warnings. That assessment should not rely on unsubstantiated assertions and claims, but be founded on hard facts and evidence.

“Reasoning is not all that democracies do. They also provide the freedom to pay attention to what one chooses – including the right to be uninformed, and the right to say “I don’t care”. Without it, democracy dissolves into an agenda dreamt up by elites and merely submitted to the public for ratification. The erroneous belief in an information deficit persists, largely because it offers politicians and political activists an excuse for failure. They would rather be accused of not getting the message out – a diagnosis that often hides contempt for those too stupid to understand the message – than of having a dud programme. Take the anti-smoking campaign. Despite six decades of science indicating that cigarettes harm health, despite government declarations that nicotine is a veritable poison and despite the penetration of anti-smoking lessons into classrooms, politicians stubbornly contend that those who smoke do so because they do not know enough. So budgets for anti-smoking advertising rise, billboards in the US grow more macabre and in Europe warnings on individual cigarette packets have grown big enough to read across a football pitch.”¹⁶

New products

Given the health risks associated with smoking, it is understandable that the cornerstone of government policy will focus on encouraging smokers to quit, or not to start smoking in the first place. However, it does need to be recognised that, despite high public awareness of the risks associated with smoking, and the potential benefits of quitting, a very significant percentage

¹⁵ see footnote 14

¹⁶ Christopher Caldwell, senior editor The Weekly Standard , Tell us things we don’t know, *Financial Times* April 25 2004

of people will choose to continue to smoke what is a legal product. Indeed, the total number of smokers in the UK has not broadly changed over the past ten years.

However, current policy does nothing to encourage the development of potentially reduced-exposure products or their bringing to the market by tobacco manufacturers. The issues surrounding potentially-reduced exposure products are complex and the introduction of such products might face high scientific and regulatory hurdles. Nonetheless, these are not sufficient reasons for such products to be discounted by government, as is currently the case with its adherence to a 'step off' approach, to the exclusion of a 'step down' approach to risk reduction.

History shows that public health authority support for product modifications has been an essential element of the acceptance or rejection of new products by smokers: the relative success of low tar brands, and the total failure of tobacco substitute, demonstrates this. For this reason, the TMA believes that it is in the interest of smokers that public health authorities should be engaged on the issues surrounding the development of potentially-reduced exposure products.

This is especially relevant given that some researchers have suggested that 'nicotine replacement products', currently promoted as a means of helping the smoker to quit, should be developed into alternative products to cigarettes.

"steps should be taken to incentivise the production of clean recreational nicotine delivery systems"¹⁷.

That is to misunderstand the reasons why people smoke and the fact that smoking is for smokers an experience that is not simply related to nicotine.

The point of sale

When the Government took up the Tobacco Advertising and Promotion Bill, it claimed that the prohibition of advertising would reduce consumption, in the long term by 2.5%, and also reduce smoking by children. There is not evidence that the Act¹⁸ is having any such effects.

The Act prohibited all tobacco consumer advertising and promotion but permitted Ministers to make regulations to apply to advertising at the point of sale. Those regulations have been made and will come into force at the end of 2004. Essentially they permit only advertising not exceeding the equivalent area of an A5 sheet of paper, including a health warning taking up 30%. The UK manufacturers, along with other tobacco companies, have applied to the High Court for judicial review of the regulations and it is inappropriate here to lay out the grounds for that application.

Advertising at the point of sale does not cause and never has caused children to smoke, or cause non-smokers to take up smoking. Nor does it make smokers smoke more. Advertising at the point of sale is only of relevance to smokers who have made

¹⁷ McNeill A, Joossens L, Jarvis M, Review of the implementation of the Tobacco Regulation Directive EC 2001/37. *Commissioned by ASH*, March 2004

¹⁸ Tobacco Advertising and Promotion Act 2002

their decision to purchase and its purpose is only to influence their choice of brands.

However, anti-smoking activists have suggested that displays of tobacco products should be banned. They argue that “tobacco should become an ‘under-the-counter’ product”¹⁹, “that (is) are not displayed and must be requested by name”²⁰, on the ground that it is an “adults only” products. The TMA fundamentally disagrees with this argument and legal proceedings have been commenced in one country where such a law has been enacted. There are no grounds whatsoever for removing displays of tobacco products at the point of sale, or for limiting brand advertising there to a level which is disproportionate and tantamount to permitting no advertising at all, and also infringes the right to freedom of expression enshrined in the European Convention on Human Rights.

Tobacco taxation and smuggling

It is a common call of anti-smoking organisations that on health grounds tobacco tax should be substantially and progressively increased, over and above general retail price inflation, so as to make tobacco products even less affordable.

It is indeed a well recognised fact that price and affordability are the most significant determinants of consumption. However, the Chancellor is well aware that any increases in UK tobacco taxation have the effect of increasing the level of smuggling and the penetration of the UK market by illicit trading, as well as even further increases in the volume of cross border shopping. That is precisely what happened

during those years of the 1990s when tax increases well exceeded the level of general price inflation.

In the early 1990s, the smuggling of cigarettes and tobacco was almost non-existent. In 1997, cigarette smuggling stood at 3%. By 2000, however, 31% of the UK market for cigarettes and 78% of the market for hand-rolling tobacco was accounted for by non-UK duty paid products (cross-border shopping, smuggling of legitimate and counterfeit products, and fraud).

Converting hand-rolling tobacco into a cigarette equivalent, it means that no more than 62% of the cigarettes smoked in this country pay UK duty and VAT.

Whilst the level of smuggling is estimated to have fallen since 2000, the reduction has been more than countered by increases in cross-border shopping, particularly after the ‘indicative limits’ for imports for personal consumption were increased four-fold in October 2002.

In 2002/3, 18% of UK demand for cigarettes was met by smuggling and fraud²¹. A further 9% was accounted for by legitimate cross-border shopping. The resultant revenue loss (evaded and avoided) is estimated to have been £3.6 billion.

In 2002/03, 69% of UK consumption of hand-rolling tobacco was estimated to have avoided or evaded UK duty; smuggling and fraud accounting for 51%, cross-border shopping for 18%. The estimated revenue loss was £790 million.

¹⁹ Response to the consultation on the tobacco advertising and promotion draft regulations, *ASH* November 2002.

²⁰ Jamrozik K, ABC of smoking cessation: Policy priorities for tobacco control. *BMJ* 2004;328:1007-1009

²¹ Measuring and Tackling Indirect Tax Losses, an update on the Government’s Strategic Approach, *HM Customs & Excise*, December 2003

In other words, in 2002/03 the total loss of revenue as a result of smuggling and cross-border shopping was £4.4 billion. Since 1996, the total loss has amounted to around £20 billion, equivalent to more than two full, current years of tobacco tax receipts.

UK tobacco manufacturers have worked closely with HM Customs & Excise to ensure that smugglers are unable to source genuine brands and products. However, this has not deterred smugglers who have sought supplies from counterfeiters. Seizure data indicates that there has been an alarming increase in the volume of counterfeit products entering the UK illicit market. In 2002/03, 41% of HM Customs & Excise seizures of cigarettes were of counterfeit products. In the previous year, the percentage was 15%.

Apart from consequences for government revenue and law and order, there are most serious consequences for health policy. Smuggled products are sold at street prices which are virtually half those of premium brands – about £2.50 as opposed to a price close to £5.00 per pack of 20 cigarettes in the most popular price category. Retail tax-paid prices are therefore not acting as a disincentive in the case of 18% of the cigarettes sold in this country, and 51% of hand-rolling tobacco.

Illicit traders also do not discriminate as to whom they sell their cigarettes. They sell to children, as well as to adults. They sell counterfeit cigarettes and other brands that do not necessarily comply with the provisions of EC Directive 2001/37/EC.

As others have indicated, tobacco tax policy no longer has significant potential to act as a positive instrument of health policy.

“Although tobacco duty remains a powerful instrument for reducing demand for tobacco, the presence of tobacco smuggling places constraints upon the effectiveness of continuing increases. It is possible that, given the continuing existence of large volumes of smuggled and counterfeit cigarettes, the current rate of duty is somewhere near its optimum in terms of revenue raising and reducing consumption.”²²

Higher UK tobacco taxation since 1997 has not reduced total consumption or the prevalence of smoking. What it has done is to change from where and how products are purchased. All that higher UK tax will achieve is further substitution of UK sales by alternate, now well established sources.

The situation will not change until such time as smuggling and cross-border shopping are reduced to a very low level. The root causes of smuggling are: the UK's high tobacco prices, largely tax determined; the ease with which illicit imports can enter the country; and well organised distribution networks that extend to the street level.

However unappealing the options alternate to current tobacco tax policy may appear to be, it is becoming ever more important that there should be a comprehensive review of existing policy. There are both health and revenue imperatives for doing so. Such a review should consider all possible options, including that which would demand much political courage – in combination with other measures, reducing the level of UK tobacco duty, so as to bring the UK market under proper control.

²² Derek Wanless, *Securing Good Health for the Whole Population*, Final Report, *HM Treasury*, February 2004

The need for such a review is hastened by the enlargement of the Community which occurred on 1 May, 2004.

It is difficult to claim that tobacco policies – both revenue and health related – currently work when almost one third of UK consumption escapes or avoids UK duty, tax or product regulations.

Environmental tobacco smoke: the scientific evidence

The whole debate about smoking in work and public places revolves around and is founded on the assertion that environmental tobacco smoke (ETS, otherwise known as 'passive smoking', 'second-hand smoke' or 'involuntary smoking') is harmful to the health of the non-smoker.

"Because people do not have time to research complex issues themselves, they rely on those they trust: scientists and doctors. If television or newspapers pick up the experts' opinions and add colour or drama, they can turn them into full-blown scandals. It is not only that the public assumes the experts must be right. A consensus develops among the experts themselves. Once a large number believe something, it can be costly to argue the contrary. Academics who go against the grain can struggle to find posts or research funds. Europe's activists are particularly powerful. Many European campaigning organisations enjoy more credibility than scientists, and certainly more than governments. They can often win the public over even when science is not on their side..."²³

There could not be a more apt explanation than that which the above quotation provides that so well describes how the public have come to believe that ETS is a serious risk to the health of the non-smoker. It raises important questions about the role that science plays in informing public policy and the role of the media in covering scientific issues.

Over the years the public has been given an impression that there is conclusive proof that environmental tobacco smoke causes serious diseases in non-smokers, and that the risk is great. However, the reality is that:

- ❑ the scientific evidence, considered as a whole, does not demonstrate that ETS causes lung cancer, heart disease or any other chronic diseases in non-smokers, and attempts to attribute a number of deaths to ETS are not scientifically justified;
- ❑ in any event, the body of evidence, as weak and inconclusive as it is, relates for the most part to non-smokers living their lives with smokers and not to non-smokers (not living with a smoker) exposed to ETS outside the home;
- ❑ rather than the public being provided with the facts, sensationalist news headlines have distorted science and exaggerated risk.

"The main thing the science has done on the issue of ETS ... is it has legitimised the concerns that people have that they don't like cigarette smoke. We're on a roll, and the bastards on the run. And I urge you to keep chasing them."²⁴

²³ Michael Skapinker, management editor, Strategies to avoid being ambushed by public opinion., reporting on Corporate Political Strategies for Widely Salient Issues, Profs. Bonardi & Keim, Academy of Management Review 2004, *The Financial Times*, March 10 2004

²⁴ Glantz S, 7th World Conference on Tobacco and Health, 1990

The nature of ETS

Some studies, such as the Hackshaw *et al* study quoted here, use biochemical markers of tobacco as means of assessing ETS exposure. In this regard, it is important to understand the nature of ETS.

ETS is a mixture of the smoke released from the burning end of a cigarette (termed “sidestream” smoke) and the smoke exhaled by the smoker between puffs²⁵. This smoke quickly mixes with the ambient air and becomes highly diluted and, as a result, there are important differences between the level and the chemical and physical composition of the “mainstream” smoke inhaled by the smoker and ETS.

In all normal circumstances, ambient air contains a large number of substances, whether or not smoking has taken place²⁶. Such substances can include dust, pollen, bacteria, fungi, trace chemicals from vehicle emissions and other sources of pollutants, as well as, in certain circumstances, emissions from cooking and heating appliances. Research suggests that the types of substances found in indoor air are generally similar, with or without the presence of ETS²⁷.

It is extremely difficult to measure real-life ETS. The concentrations of the various substances that make up ETS are generally extremely low and many of the chemicals present in ETS are, irrespective of ETS, likely to be present in the air anyway, emanating from other sources. Moreover, ETS is a complex and constantly changing mixture, making it difficult to extrapolate total ETS exposure from the measurement of an individual chemical marker.

Nonetheless, the results of studies seeking to quantify exposure suggest that concentrations of chemicals in ETS are typically much lower than permissible exposure limits to these chemicals

approved by regulators²⁸. Studies have, not surprisingly, also reported that non-smoker exposure to ETS is a great deal lower than the smoker’s exposure to mainstream smoke. Generally such studies have looked at exposure to nicotine, not because airborne nicotine is widely thought to cause lung cancer, heart disease or respiratory disease, but because it is almost unique to tobacco smoke and can be measured even at low concentrations.

For example, one study²⁹ reported that, on average, in the course of a year, non-smokers had an exposure to airborne nicotine which was less than the amount delivered to a smoker by just five cigarettes with a yield of 1mg per cigarette. Another study³⁰ of British women exposed to ETS in various settings reported that on average a non-smoker would only be exposed to the equivalent nicotine of smoking a single cigarette over a period in excess of two years.

A variety of studies which have measured the biological metabolites of nicotine have suggested ETS exposures of an average of 0.2% to 0.4% of active smoking, while estimates of particulate exposure suggest a factor of around 0.05% to 0.1%.

Measuring uptake, as compared with exposure, of ETS by non-smokers presents its own problems. The most commonly used markers are nicotine and its metabolite cotinine, which can be analysed in body fluids. Subjects do vary, however, in the rate at which they metabolise nicotine. Nicotine and cotinine are also not quantitative markers for other components of ETS.

Most scientists also accept that there is a threshold for carcinogenesis and other disease processes³¹.

As a result, the findings on the nature of ETS suggests that no firm conclusions can be drawn on

²⁵ Baker R and Proctor C, The origins and properties of environmental tobacco smoke, *Environmental International* 1990;16: 231,245

²⁶Proctor C. The analysis of the contribution of ETS to indoor air. *Environmental Technology Letters*, 1998; 9: 553-562

²⁷ Guerin M *et al*, The chemistry of environmental tobacco smoke: composition and monitoring. *Chelsea, Michigan, Lewis Publishers*, 1992

²⁸ Gori G B and Mantel N, Mainstream and environmental tobacco smoke. *Regulatory Pharmacology and Toxicology* 1991;14: 88-105

²⁹ Jenkins R A *et al*. Determination of personal exposure of non-smokers to environmental tobacco smoke in the United States. *Lung Cancer* 1996;14;1: Supplement p195

³⁰ Proctor C *et al*. A comparison of methods of assessing exposure to environmental tobacco smoke in non-smoking British women. *Environmental International* 1991;17.4: 287-297

³¹ Kraus N, Malmfors T and Slovic P. Intuitive toxicology: expert and lay judgements of chemical risks. *Risk Analysis* 1992;12: 215-232

the possible health effects of ETS without adequate supporting evidence from clinical, experimental and epidemiological studies.

Criteria for causation

“Although there are methodological and statistical techniques to minimise confounding and other biases, the judgement as to whether the links observed are causal or not remains difficult. The criteria for causality proposed by Bradford Hill are usually used to guide the evaluation of a body of evidence (in this instance, ETS) is causal. The more criteria met, the more likely that the link is causal. But the judgement remains subjective and ‘proof’ is elusive.”³²

Even a brief review, such as has been provided here, of the epidemiological studies that have been undertaken into ETS would not be complete without mention of Bradford Hill’s³³ criteria of causation, the first statement proposing epidemiological criteria of causal association, although others enunciated several of them³⁴.

The criteria for causality proposed by Bradford Hill are used by some to guide the evaluation of a body of evidence as to whether or not an association between an outcome and a putative risk factor is causal.

³² Report on the health effects of environmental tobacco smoke in the workplace. *Commissioned by the Health and Safety Authority of Ireland and the Office of Tobacco Control from an independent scientific group*, January 2004.

³³ Hill A B. The environment and disease: Association or causation. *Proc.R S Doc. Med.* 1965;58: 295-300

³⁴ Susser M W . What is cause and how do we know one? A grammar for pragmatic epidemiology. *Am. J Epidemiology* 1991;133: 635-648

The Bradford Hill criteria of a causal association of a factor and a disease are:

Consistency – an association is consistent when results are replicated in studies in different settings using different methods.

Strength – defined by the size of the risk as measured by appropriate statistical tests.

Specificity – established when a single putative cause produces a specific effect.

Dose-response relationship – an increasing level of exposure (in amount and/or time) increases the risk.

Temporal relationship – exposure always precedes the outcome.

Biological plausibility – the association agrees with currently accepted understanding of patho-biological processes.

Coherence – the association should be compatible with existing theory and knowledge.

Experiment – the condition can be altered, prevented or ameliorated, by an appropriate experimental regimen.

The findings of ETS studies do not come close to meeting the Bradford Hill causality criteria. In particular, the results of the studies are not consistent, generally produce very weak or no excess risks, and rarely show dose-responses.

Scientific method and epidemiology

Scientific method and reasoning starts with systematic observations and/or experiments from which logical inferences are made and hypotheses are formulated and tested, in order to arrive at conclusions that can be generalised and expressed as testable laws and principles.

In the case of ETS, this was not the approach employed. Whilst it remained only speculation, the hypothesis that ETS caused serious diseases in non-smokers was virtually accepted at the outset by

the authorities. Inevitably, the subsequent investigations did not follow the conventions of scientific method and reasoning by starting with observations, then formulating and testing hypotheses; rather, their starting point was acceptance of the hypothesis for which they then sought affirmative findings.

The value of any scientific theory, no matter how theoretically elegant or plausible, is ultimately tested by experiment.

“In experimental animal research and in some situations in clinical medicine, for example testing the efficacy of a new drug, it is possible to carry out clinical ‘experiments’ comparing groups receiving different treatments. However, in epidemiological research requiring large populations for the evaluation of potentially harmful exposures, alternative approaches are needed. For example, to ‘prove’ that ETS causes cancer or heart disease would require the conduct of long term experiments (randomised controlled trials) involving hundreds of thousands of individuals half of whom would be randomly assigned to long term ETS exposure and the other half assigned to non exposure. But because it is not ethical to expose human subjects to a potentially harmful substance (in this case ETS), the only research approaches possible are those based on observational studies of non-smokers. Either disease rates in individuals exposed to ETS at home or at work are compared with rates in individuals not so exposed (cohort study); or past ETS exposures are compared in cases (those with the disease in question e.g. heart disease or lung cancer), and in those without these conditions (controls) (case control study). There is no certainty in either type of study that the two groups being compared are similar with respect to other relevant variables. Thus there is the possibility that any differences observed between the groups could be due to factors other than the ETS exposure. If such factors also affect the risk of disease, they are referred to as confounding variables. The consequence is that part or all of the observed association between ETS and the disease may be spurious.”³⁵

³⁵ Report on the health effects of environmental tobacco smoke in the workplace. *Commissioned by the Health and Safety Authority of Ireland and the Office of Tobacco Control from an independent scientific group*, January 2004.

Epidemiological studies into ETS present very considerable problems.

A 'cohort' study follows a population group through a lengthy time period. It tracks the disease incidence in the cohort, and can assess possible lifestyle factors and calculate their relationship to the disease incidence. Cohort studies are larger and lengthier than case control studies, and hence are more costly. However, they are thought to be somewhat more reliable than case control studies, especially when multiple risk factors are involved.

However, the vast majority of the investigations that have been undertaken into ETS have been case control studies. These have typically compared the incidence of certain diseases in non-smokers living with smoking spouses, as compared with non-smokers living with non-smokers.

For chronic diseases, such investigations need to assess exposure over a period of thirty to forty years. This is usually achieved through questionnaires - obviously relying on the personal recollections of people - of the intensity and duration of exposure to ETS over a lifetime. The uncertainty involved in this form of data collection makes such epidemiology a relatively imprecise tool.

Aside from the comparative unreliability of individuals' memories - known by epidemiologists as "recall" bias - the questionnaires were often administered not to the actual members of the populations being studied, but to surviving family members, so increasing recall unreliability and introducing other possible sources of bias.

The studies are also subject to many forms of bias that, in statistical terminology, relates to deviations from the facts arising from such factors as flaws in study design, data collection or analysis. For

example, smokers tend to marry smokers, and non-smokers tend to marry non-smokers and a proportion of people are known not to tell the full facts about their present or past smoking habits. Together, these represent a substantial misclassification bias.

Also there cannot be certainty about the precise cause of death, given both the difficulty of establishing that fact and also that

"inaccuracies in the registered cause of death are recognised, especially with multiple causes"³⁶.

In any event, death certificates do not record what caused the illness stated on the death certificate.

Diseases in smokers that are related to smoking are also multi-factorial. For example over 300 factors are known to be related to cardiovascular disease.

Publication bias is also possible - that is the likelihood that studies are published only if they produce positive results or results which conform to the accepted wisdom.

Studies are also subject to confounding - distortion because there may be an association of disease with factors other than ETS, such as diet, alcohol consumption, socio-economic circumstances, the level of exercise, the history of disease in the family, that happens to correlate with being in a household with a smoker. While many studies attempt to collect information on some confounding factors, there has been an inconsistency of approach.

³⁶ Derek Wanless, *Securing Good Health for the Whole Population*, Final Report, *HM Treasury*, February 2004, 5.49

There are methodological and statistical techniques to adjust for likely confounding and biases, but again they are not applied uniformly in each individual study, nor are they anything other than devices which may not reflect the true situation.

In reality, therefore, ETS epidemiological studies are statistical exercises, the measurements of which have limited credibility in terms of accuracy. That is not to say that they are irrelevant but to put them into a proper context.

Epidemiology is “a crude and inexact science”³⁷;

“...until we know exactly how cancer is caused and how some factors are able to modify the effects of others, the need to observe imaginatively what happens to various different categories of people will remain.”³⁸

In other words, epidemiological findings are not incontrovertible, objective conclusions; the judgements made about epidemiological data with a low level of risk, are inevitably subjective. And in the case of ETS:

“the judgement as to whether the links observed are causal or not remains difficult.”³⁹

Relative risk

Epidemiological studies express their findings in terms of relative risk (RR). This is the ratio of the incidence of the disease being studied in the group exposed, to the incidence of disease in the group not exposed.

RR has no direct bearing on the probability that an individual will acquire the disease in question. It provides only an index of the strength of any association between exposure and a disease, and is always a relative term to the incidence of disease in the non-exposed group.

In case control studies, relative risk (RR) is most often now expressed as an Odds Ratio (OR), as in this example:

1.26 (95% CI 1.06-1.47)

In that example, the RR of 1.26 is the estimated risk of the disease in non-smokers living with a smoker, relative to the risk in non-smokers living with non-smokers. Were the RR in that example to be less than 1.0, it would indicate that non-smokers living with smokers were less at risk of the disease than non-smokers living with non-smokers.

CI is the ‘Confidence Interval’ which is normally stated at the level of 95% to be statistically significant. It does not mean that there is 95% certainty that the figure, in this example, is 1.26. The 95% actually refers to the frequency with which the statistical test used will generate boundaries capturing the true figure. In other words, it relates to the reliability of the test, not to the parameter.

In interpreting what a RR figure means in terms of the population, it is necessary to know what the ratio or incidence of the disease in the population not exposed to ETS is: in other words what the rate of

³⁷ Dr Charles Hennekens, Harvard School of Public Health, New York Times, 1995

³⁸ Doll R & Peto R, The causes of cancer: Quantitative estimates of avoidable risks of concern in the US today. *Journal of the National Cancer Institute* 1981:66, 5-6: 1191-1308

³⁹ Report on the health effects of environmental tobacco smoke in the workplace. Commissioned by the Health and Safety Authority of Ireland and the Office of Tobacco Control from an independent scientific group, January 2003.

death or disease is in non-smokers living with non-smokers.

As explained in the 1988 report of the Independent Scientific Committee on Tobacco and Health, in the case of lung cancer in the UK population, the rate of death or disease amongst non-smokers living with non-smokers (the 'background risk') is generally taken to be 10 per 100,000 person-years of the population⁴⁰. Thus a RR of 1.26 would then mean that amongst non-smokers with smoking spouses, the incidence of the disease would be 12.6 persons in every 100,000 person-years of the population, as opposed to 10 per 100,000 in the case of non-smokers living with non-smokers.

The popularisation of scientific evidence

RR is sometimes expressed as a percentage. Most frequently is this the case when the purpose, either of researchers, publications or reporters, is to make the risk more easily comprehended by the public. The outcome is generally the reverse.

When a RR of 1.26 is expressed as an increased risk of 26%, the impression acquired by the ordinary person is that out of every 100 non-smokers 26 will suffer from the disease. What a relative risk of 26% indicates is that the incidence of the disease will be 26% greater amongst non-smokers exposed to ETS by their smoking spouses than it would be had they lived with a non-smoker. The percentage increase in risk is from 0.010% (amongst non-smokers not exposed to ETS) to 0.0126% a year (amongst non-smokers living with smoking spouses).

It is unfortunate that there is often a culture clash whenever the world of journalism comes into contact

with the world of science and statistics. Scientific and statistical studies are generally replete with 'ifs, buts and maybes', unfamiliar terminology and jargon, complex formulae and calculations. They do not generally make news that demands loud, clear and unequivocal headlines and sound bites. But if that kind of message is not provided by the research itself, or by the professional journals publishing their work and wanting to promote their own publications, the danger is that it can then be generated by reporting that lacks thoroughness and concern for detail and accuracy.

"Critics complain that policy is too often driven by public opinion that has been inflamed by sensationalist news headlines that distort science and exaggerate risk. Scientists themselves are sometimes assailed for manipulating science and the media to promote their own personal political agendas, and interest groups on all sides of these issues increasingly roll out battling experts who appear to agree on little, other than that their opponent's science is fundamentally flawed, misleading, biased or worse. These allegations raise serious questions about the role of science in informing public policy and the role of the media in covering scientific issues, particularly in contentious public policy areas. How the public learns about scientific news through the media, how public opinion is reflected and shaped by media coverage, and how pressure groups influence media coverage of science for their own political ends, are all important aspects of the policy-making process."⁴¹

⁴⁰ Fourth Report of the Independent Scientific Committee on Smoking and Health, 1988, para 69, citing IARC Monograph on the evaluation of the carcinogenic risk of chemicals to humans, *Tobacco Smoking*, 1985; 38: 214, 230-232

⁴¹ When media, science and public policy collide, *Proceedings of a workshop of the Kennedy School of Government at Harvard University*, November 2002 (Words written in the context of genetically modified foods)

"We must be interested in whether passive smoking kills, and the question has not been definitively answered. It's a hard question, and our methods are inadequate."⁴²

A recent example of the misuse of science, coupled with the drama of scare-raising reporting, was provided by an estimate⁴³ that claimed that ETS exposure caused the death of 49 workers in UK pubs and bars each year. This figure was arrived at by selecting from one review paper⁴⁴ relative risks for lung cancer, heart disease and stroke for home and workplace exposure; assuming a workforce in pubs and bars of 53,500 of which half were permanent staff; assuming that all of the workforce was exposed 100% of the time over a 6-hour shift to 3 times more smoke than would a non-smoker at home living with a smoker; and assuming that all the workers in those places were non-smokers. The review paper from which the relative risks were drawn did not claim precise predictions but only a guide dependent upon many assumptions and unknowns. The researcher's assumptions were highly speculative, but the estimate suffers from a much larger flaw - the assumption that a relative risk for a chronic disease, which is the result of prolonged exposure over forty or so years, can be applied to a population group which is much younger (as well as one which also changes jobs frequently), with a consequently much smaller duration of exposure. The incidence of lung cancer, heart disease and stroke, below the age of 40 is very low and the age distribution of working in the hospitality trade

on average is very different from those exposed to ETS at home.

Even though some may regard the public as being scientifically illiterate and mathematically innumerate, that is not a reason for the public to be misled, simply because of the perceived need to achieve headlines.

How the magnitude of a relative risk should be interpreted

In statistics, the words 'statistical significance', or 'statistically significant', have nothing to do with the magnitude of a measured difference. Statistical significance does not imply real life significance. It is a probability statement of the likelihood that the results did not occur by luck or chance if the groups were really alike; about how certain it is that they are not a fluke.

Traditionally, conventionally and historically, a RR is considered to be statistically significant when at a 95% CI it does not include 1.0, albeit that the choice of the value of 95% CI is arbitrary.

A RR finding of less than 2.0 is generally regarded as being weak. With a RR finding of that order, the estimated excess risk could well be accounted for by biases and confounding factors for which the study has not made full adjustment.

In the case of lung cancer, a 1997 meta-analysis⁴⁵ accepted by the UK authorities found a RR of 1.26 (95% CI 1.06 – 1.47) derived amongst non-smokers living and not living with smoking spouses. That has been claimed to be a "substantial" excess risk and one warranting bans on smoking in work and public places.

⁴² Richard Smith, editor BMJ, *BMJ* 2003;327:505

⁴³ Presented at the Royal College of Physicians' conference on 17th May 2004.

⁴⁴ Woodward A & Laugesen M, How many deaths are caused by second hand cigarette smoke, *Tobacco Control*, 2001;10: 383-388

⁴⁵ Hackshaw A K, Law M R, Wald N J. The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997; 315:980-988

A major study⁴⁶ of the supposed link between electric power lines and childhood leukaemias produced an Odds Ratio of 1.24, with a 95% Confidence Interval of 0.86 - 1.79. The researchers concluded in that case that such a small and non-significant effect provided "little evidence" of a link between power lines and leukaemia. The US National Cancer Institute went further, declaring that the study showed magnetic fields "do not raise children's leukaemia risk". The results were very similar to those obtained by the WHO (IARC) ETS study (see page 30), yet in that instance, the findings were promoted as "proving" a link between ETS and lung cancer.

Another study⁴⁷ of women with breast implants found an Odds Ratio for hospitalisation for connective tissue disorders of 1.3 with a non-significant 95% CI of (0.7 – 2.2), again close to the IARC passive smoking study. But whereas the IARC findings were claimed to prove a link between ETS and lung cancer, in the breast implant study they were found not to be associated "with a meaningful excess risk of connective tissue disorder"⁴⁸.

In 1992, the US EPA found a RR of 1.19 for lung cancer associated with ETS. However, that was only statistically significant at a 90% CI; it was not significant at 95% CI at which it included 1.0. Nonetheless, in 1998 that report was used as a basis for listing ETS as a known human carcinogen. In 1989, IARC found a RR in respect of diesel exhaust and lung cancer of 2.6. It was not listed as a human carcinogen.

What is needed is a clear explanation as to why the low RRs that have been reported in respect of lung cancer and ETS, with 95% CIs ranging very close to 1.0 (and sometimes including 1.0), where the excess risk found could easily be accounted for by modest degrees of bias and confounding, are considered to be large and proof of a causal link. And also why the interpretations of ETS RRs are not not more in line with the guide provided by the Government which stands in the Parliamentary record.

⁴⁶ Linet M, *et al.* Residential exposure to magnetic fields and acute lymphoblast leukaemia in children. *New England Journal of Medicine*;1997;337:1

⁴⁷ Nyren O *et al.* Risk of connective tissue disease and related disorders among women with breast implants: a nationwide retrospective cohort study in Sweden. *BMJ* 1998;316:417

⁴⁸ Cooper C, Dennison E. Do silicone breast implants cause connective tissue disorder? *BMJ*;1998;316:403

The Government's position on the interpretation of Relative Risk estimates

Baroness Jay of Paddington (Minister of State, Department of Health)

Relative risk provides a measure of the strength of association between a factor and an illness. It is an important way of measuring increases or decreases of risk over time or between different groups by comparing the incidence of an illness or hazard within a population to some baseline (for example, if drinkers are twice as likely to suffer from a particular disease as compared with the general population, a factor of 2 may be cited). A stronger association of greater than 2 is more likely to reflect causation than is a weaker association of less than 2 as this is more likely to result from methodological biases or to reflect indirect associations which are not causal. The significance of any such number does though need to be considered in context and from a number of viewpoints.

First, there is a statistical significance: in other words, what confidence is there in the number itself. This will depend on the quality and extent of the available data. Scientists usually express these by giving a confidence interval: rather than by saying that the relative risk factor is 2, they will say that (for example) one can be 95 per cent certain that it lies between 1.6 and 2.4.

Even when the strength of an association is precisely determined, it is insufficient in itself to confirm a direct causal link between possible cause and illness. The strength of an association is only one of several criteria which must be considered in the assessment of causation. Other criteria include:

the cause must precede the effect;

the biological plausibility of the association - is the association consistent with other knowledge e.g. experimental evidence?;

the consistency of the finding – is the same result obtained from different studies using different methodologies elsewhere?;

the presence of a “dose-response” relationship – an increased response to the possible cause being associated with an increased risk of developing the illness.

All these factors would be taken into account in trying to pinpoint cause.

The practical significance of risk factors, also needs to be considered and depends on how great is the underlying risk. Doubling a very small probability (risk), say 1 in 10,000,000, still results in only a very small risk of illness. Doubling a risk of, say, 1 in 100 could, depending on its nature, be more serious.

In practice, scientific judgments will be made and debated on a case-by-case basis. The Government can draw on the expertise of independent scientific advisory committees which are constituted to provide balanced judgment on the questions covered above.

House of Lords, Written Answer, 31 March 1988, Official Report Cols. 31-32

ETS studies and reviews

The chronology

In the US Surgeon General's reports of 1972 and 1975, initial speculations were raised about the possible consequences of exposure to ETS. The US Surgeon General's 1979 report noted several adverse outcomes that appeared to have an association with ETS; but also that there was only a limited amount of systematic information available regarding the health effects of ETS. The 1982 report raised the concern that ETS might cause lung cancer. Following that report a number of epidemiological investigations were published which claimed to show a relationship between ETS and lung cancer.

Then in 1986, the US Surgeon General's report, as well as reviews by the National Research Council National Academy of Science (sponsored by the US Environmental Protection Agency(EPA)), concluded that ETS caused lung cancer and claimed an increase in risk of 30%, with the latter two reviews also associating ETS exposure with adverse respiratory outcomes in young children.

However, a review published by IARC in 1986 came to different conclusions. It did not produce estimates of risk but concluded that: available studies:

“had to contend with substantial difficulties in determination of passive exposure to tobacco smoke and to other possible risk factors. The resulting errors could arguably have artefactually depressed or raised estimates of risk, and, as a consequence, each is compatible either with an increase or with an absence of risk.”⁴⁹

In June 1989, the US EPA issued a public notice that stated categorically that ETS was a cause of lung cancer. However, the EPA did not provide an analysis of the data on which it had based its conclusion. It did not produce its analysis and risk assessment until 1992.

The report was subsequently challenged in the courts⁵⁰ where the EPA was found to have knowingly, wilfully and aggressively disseminated false information with far reaching regulatory implications in the US and worldwide. Judge Osteen found that the EPA had:

“changed its methodology to find a statistically significant association . . . In conducting the ETS Risk Assessment, EPA disregarded information and made findings on selective information; did not disseminate significant epidemiologic information; deviated from its Risk Assessment Guidelines; failed to disclose important findings and reasoning; and left significant questions without answers . . . Gathering all relevant information, researching, and disseminating findings were subordinate to EPA's demonstrating ETS a Group A carcinogen.”

Yet to this day, despite that judgement which vacated the report after 'forensic' investigation of the EPA's review and process, its 1992 report is used as a 'gold standard' by the authorities. It is the ultimate foundation of the estimates made by UK authorities of UK deaths resulting from exposure to ETS. The report and its methods have subsequently been used as a model for other reports by the Californian

⁴⁹ IARC, 1986: p.308

⁵⁰ Flue-cured Tobacco Stabilization Corporation *et al v* United States Environmental Protection Agency and Carol Browner, District Court for the Middle District of North Carolina before District Judge Osteen, Order and Judgement, 17 July 1998

EPA⁵¹, the National Health & Medical Research Council of Australia⁵², and the UK's Scientific Committee on Tobacco and Health (SCOTH)⁵³. In 1998, the US National Toxicology Program accepted the EPA 1992 report and its twin from California as the basis for listing ETS as a known human carcinogen.

Publication

Over the past 25 years there have been numerous studies and reviews that have sought to determine risks associated with exposure to ETS. Many more studies and reviews have probably been undertaken but not published, perhaps because they have not found any association between ETS and disease or otherwise not appealed to publishers. In other words, published studies and reviews may reflect what is called publication bias. Quite different conclusions might be drawn from a review of all published and unpublished studies⁵⁴. The presence of even a modest degree of publication bias can lead to a substantial increase in the estimated risk⁵⁵.

An illustration of the reception that can be given to the publication of views which do not conform to the accepted wisdom was provided by the reaction to the publication by the British Medical Journal in May 2003 of a major new ETS study⁵⁶, in respect of which the BMJ carried the front-page headline, "Passive smoking may not kill".

The prospective study to measure the relationship between ETS, as estimated by smoking in spouses, and long-term mortality from tobacco related disease

was conducted on over 100,000 Californian adults between 1960 and 1998. The conclusions of the study stated:

"The results do not support a causal relation between environmental tobacco smoke and tobacco related mortality although they do not rule out a small effect. The association between exposure to environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed."

The publication of the study gave rise to a violent storm of criticism from the medical community. In responding, the editor of the BMJ was minded to comment:

"Of course the study we published has flaws – all papers do – but it also has considerable strengths: long follow-up, large sample size, and more complete follow up than many such studies. It's too easy to dismiss studies like this as fatally flawed with the implication that the study means nothing . . . I found it disturbing that so many people and organisations referred to flaws in the study without specifying what they were. Indeed, this debate was much more remarkable for its passion than its precision."

⁵¹ Californian EPA 1997

⁵² NHMRC 1998

⁵³ SCOTH 1998

⁵⁴ *The Lancet*, April 23, 2004 on the research commissioned by the National Institute for Clinical Excellence into the prescribing of anti-depressants drugs to children; and *The Independent*, April 23 2004

⁵⁵ Copas J, Shi J, *BMJ* 2000;320: 417-418

⁵⁶ Enstrom J E & Kabat G C, Environmental tobacco Smoke and tobacco related mortality in a prospective study of Californians 1960-1998, *BMJ* 2003;326: 1057-1061

ETS epidemiological studies

Over the past 25 years, hundreds of ETS studies have been published. An unknown number, unpublished, may have been undertaken. Their study design has varied greatly, as have their findings which have not been consistent. Even where a positive association between ETS and a disease has been reported, it has been of a low order of risk, well below that normally regarded as being significant.

Given the weak epidemiological results, it is really not appropriate to attempt to estimate mortality related to ETS exposure. Nonetheless, some public health and lobbying groups do use mortality estimates to promote their position that ETS is a serious risk to health.

Lung cancer

There have been over 60 epidemiological studies of lung cancer among life-long non-smokers. The overall evidence shows no statistically significant increased risk of lung cancer in relation to ETS exposure from parents in childhood, or in social situations or to non-spousal ETS exposure at home. The overall evidence shows that lung cancer risk among non-smoking women is associated with having a husband who smokes (and *vice versa* but an even weaker association). However, this excess risk of well below 2.0 may be accounted for by bias and failure to take account of confounding factors and misclassification. Those that reported stronger associations did not adjust for age, a standard procedure to avoid bias. 80% of the studies showed no statistically significant association with smoking by the spouse and lung cancer. The largest five studies (with over 400 lung cancer cases) produced inconsistent results; one reporting a small increase in risk, three no significant increase and one a statistically significant decrease in risk.

Of those studies, around 50 have examined the incidence of lung cancer in women who claim never to have smoked, but who are married to smokers ("spousal" studies), or the nearest equivalent index, such as living with a smoker. Many have reported a small increase in risk, but a significant majority have not reported overall statistically significant increases. Where a statistically significant association was reported, the magnitude of relative risk reported was so small (below 2.0) that it would generally be regarded as being too weak by normally accepted epidemiological standards to form a basis for public health policy⁵⁷.

The small increase in risk reported by various studies could be accounted for by a number of factors. For example, non-smokers living with smokers tend to have different lifestyles and diets from those living in non-smoking households. It is also not possible to be certain that all studies made appropriate adjustments for misclassification – such as when self-reporting non-smokers are in fact former or current smokers. This is especially problematic because former and current smokers not only have an increased risk of lung cancer, they are also more likely to have married smokers and thus be included among those exposed to ETS in these studies.

The data on ETS exposure at work is even less conclusive than the spousal data. Only a very small minority of the studies on ETS and lung cancer have reported an overall statistically significant increase in risk. Similarly, most studies which have looked at ETS exposure in social settings and during childhood do not report an overall statistically significant increase in risk of lung cancer.

⁵⁷ Dirty Water. US National Cancer Institute, *Reason* 1996;28:1.52

Coronary heart disease

There have been around 30 studies of heart disease and ETS among life-long non-smokers. The overall evidence does not indicate increased risk to ETS exposure in the work place, in respect of which only one study out of 18 reported a statistically significant association. Again the weak associations found between spousal smoking are generally not statistically significant and could be accounted for by lifestyle confounding factors – of which over three hundred have been reported – study design, absence of confirmation of diagnosis, and misclassification. Two of the most substantial pools of data on this subject are the databases of the American Cancer Society's Cancer Prevention Study and the database of the US National Mortality Followback Survey. Analyses of these data sets have reported no overall association between ETS and heart disease⁵⁸.

A further large study of ETS and heart disease was published in 2003⁵⁹ and also showed no increase in risk.

A report of the US Surgeon General⁶⁰ noted “because smoking is but one of the many risk factors in the aetiology of heart disease, quantifying the precise relationship between ETS and this disease is difficult”.

Respiratory diseases

Despite the large risk associated with active smoking and chronic obstructive pulmonary disease (COPD), relatively few published studies have investigated a

possible link between ETS and COPD. The studies that have been published, taken overall, do not demonstrate an increase in risk. Clinical studies of the reaction of adults highly sensitive to ETS have had difficulty in prompting a measurable response, though clearly some asthmatics will experience a non-specific exacerbation of symptoms in smoky environments.

Children

There is a large body of research on ETS exposure and respiratory disorders in children. These are difficult to analyse overall as there is great disparity in study design, age ranges and subjects, the symptoms measured and methods of diagnosis. There are quite a number of reports of statistically significantly increased risk of respiratory disorders in pre-school age children exposed to ETS. It is unclear to what extent this increase is influenced by other factors more statistically common in smoking households, such as poor diet, housing conditions and quality of pre-natal care. The pattern of increased risk is not consistently replicated for children of school age, suggesting that a real effect, if one exists, is short term.

Although smoking by parents has been associated in some studies with an increased risk of “cot death” (sudden infant death syndrome), a long list of other factors has also been reported⁶¹. Some recent studies have reported that incidence of ‘cot death’ has been reduced by up to 50% where parents have followed government advice not to put their children to sleep in a prone position. However, no one yet fully understands the reasons or mechanisms behind this syndrome. Some have suggested that there may be some residual effects of a mother's smoking

⁵⁸ LeVois M and Layard M. Publication bias in the environmental tobacco smoke/coronary heart disease epidemiologic literature, *Regulatory Toxicology and Pharmacology* 1995;21:184-191

⁵⁹ Enstrom J & Kabat G. Environmental Tobacco Smoke and tobacco related mortality in a prospective study in California, 1960-1998, *BMJ* 2003;326: 1057-1061

⁶⁰ Reducing tobacco use, a report of the US Surgeon General, *US Dept. of Health and Human Services, Public Health Service, Office of Smoking and Health*

⁶¹ Thornton A J & Lee P N . Parental smoking and sudden infant death syndrome: A review of the evidence. *Indoor Built Environment* 1998;7:87-97

during pregnancy, in respect of which there is strong public health advice to women not to smoke during pregnancy.

Meta-analysis

Given the great variability of individual studies, in major reviews, a weight of evidence approach has also been used. This involves considering the quality of individual studies, discarding some and including others in making an overall judgement. Inevitably, this approach involves a great many subjective judgements about the available studies.

Meta-analysis involves the statistical synthesis of the data from separate studies to provide a summary of the pooled results. For this to be a valid approach, the studies need to be similar and comparable in design and many other respects, otherwise the result is no better than mixing apples with oranges. Such inappropriate mixes may result from pooling studies from vastly different countries in respect of which there may be significant and varying confounding variables and differences in the time frames of the studies. In recent years, meta-analysis has been increasingly used to combine evidence from epidemiological studies of quite different design. This can result in a combined relative risk estimate that has narrow confidence limits (terms defined below); it may appear to be precise, but it is in fact a quite inaccurate estimate of the true association, if any.

For example, almost all of the ETS studies that have been undertaken have been of populations outside the UK, particularly in the United States and Asia. They are very different populations to the UK in a great many respects. They have been undertaken over a time period since 1981 and there is a marked difference in the findings between those studies conducted before 1989 and subsequently, the latter indicating a relative risk for lung cancer of a much

lower order – approximately 1.16 as opposed to 1.38 for pre 1989 studies.

The dangers of extrapolating data on one population and applying it to another on the basis that one group of people is broadly equivalent to another has been vividly illustrated by the study⁶² into the case of the extrapolation of risk scoring methods for coronary heart disease derived from the US Framingham heart study⁶³ and its application to the UK. The Framingham study played a key role in quantifying risks such as smoking and high cholesterol. The UK researchers compared the Framingham results with the British regional heart study. They found that using Framingham, there was an over-estimation of the risk of non-fatal coronary events of 57%, and also that 84% of British heart deaths occurred in the 93% of men classified as low risk by Framingham criteria. The fact is that substantial variations in coronary heart disease are found between different regions and different ethnic groups, socio-economic status and family history of coronary heart disease.

⁶² Brindle P *et al.* Predictive accuracy of the Framingham coronary risk score in British men: prospective cohort study, *BMJ* 2003; 327:1267-1270

⁶³ Dawber T R *et al.* An approach to longitudinal studies in a community: The Framingham Study, *Ann. NY Acad. Sci.* 1996; 107:539-556

Some noteworthy studies

Of all the epidemiological ETS reviews and studies that have been published, three warrant special comment:

- the review by the US Environmental Protection Agency, 1992⁶⁴, for two principal reasons, because:

it is regarded by the UK authorities as a gold standard on which UK estimates of the impact of ETS on the mortality and morbidity of the UK population are ultimately based; and,

it is nonetheless a report which has been thoroughly discredited in the courts.

- the study of the International Agency for Research on Cancer, 1998⁶⁵, because:

it is the largest study of ETS and lung cancer in western Europe and claimed to have provided the most precise estimates available;

- and the review by Hackshaw *et al*, 1997⁶⁶ because:

it also endeavoured to make ETS risk estimates extrapolated from the risks to smokers of smoking, using studies of biochemical markers of tobacco smoke.

⁶⁴ Respiratory Health Effects of Passive Smoking: Lung cancer and other disorders, *US EPA*, 1992

⁶⁵ Boffetta P *et al*, Multicentre case-control study of exposure to environmental tobacco smoke and lung cancer in Europe, *Journal of the National Cancer Institute*, 1998;90;1440-1450 and IARC Technical Report No.33

⁶⁶ Hackshaw *et al*, The accumulated evidence on lung cancer and environmental tobacco smoke, *BMJ* 1997;315: 980-988

The EPA review of 1992

In 1989, the EPA issued a public notice stating categorically that ETS “is a known cause of lung cancer” but without providing its analysis of published data. It was pressed to do so and the result was its report of 1992.

At the time the risk assessment was conducted, there were 30 published epidemiologic studies on ETS conducted in a number of countries.

Of the 30, 8 reported statistically significant associations between ETS and lung cancer. 22 reported either no association or no statistically significant association.

Of the 11 studies that examined US populations, only 1 reported a statistically significant association.

Using meta-analysis, EPA combined the 11 US ETS studies and came up with a RR of 1.19 that was significant at a 90% CI. It was not significant at 95% CI, at which it included 1.0 and thus did not confirm the EPA’s hypothesis that ETS caused an increased risk of lung cancer. The RR of 1.19 was also not one which in other circumstances would be judged sufficient to justify the classification of ETS as a Group A carcinogen, albeit that ETS was later declared as such on the basis of the report.

The report was subsequently challenged in the courts⁶⁷ where the EPA was found to have knowingly, wilfully and aggressively disseminated false information with far reaching regulatory implications in the US and worldwide. Judge Osteen found that the EPA had :

“changed its methodology to find a statistically significant association . . . In conducting the ETS Risk Assessment, EPA disregarded information and made findings on selective information; did not disseminate significant epidemiologic information; deviated from its Risk Assessment Guidelines; failed to disclose important findings and reasoning; and left significant questions without answers ... Gathering all relevant information, researching, and disseminating findings were subordinate to EPA’s demonstrating ETS a Group A carcinogen.”

Yet to this day, despite that judgement, which vacated the report after ‘forensic’ investigation of the EPA’s review and process, the report is used as a ‘gold standard’ by the authorities. It is the ultimate foundation of the estimates made by UK authorities of UK deaths resulting from exposure to ETS.

⁶⁷ Flue-cured Tobacco Stabilization Corporation *et al v* United States Environmental Protection Agency and Carol Browner, District Court for the Middle District of North Carolina before District Judge Osteen, Order and Judgement, 17 July 1998

International Agency for Research on Cancer (IARC)

IARC is affiliated to and funded by the World Health Organisation.

Its 1998 report⁶⁸ is a case-control study of lung cancer and exposure to ETS in 12 centres from 7 European countries that the researchers claimed provided “the most precise available estimate of the effect of ETS on lung cancer risk in Western European populations.” It reported no overall statistically significant increase in risk of lung cancer from ETS in any of the situations where people were exposed to ETS.

The conclusions of the study were:

“Our results indicate no association between childhood exposure to ETS and lung cancer risk (0.78 (95% CI 0.64-0.96)). We did find weak evidence of a dose-response relationship between risk of lung cancer and exposure to spousal (1.16 (95% CI 0.93-1.44)) and workplace ETS (1.17 (95% CI 0.94-1.45)). There was no detectable risk after cessation of exposure.”

In other words, not only were relative risks found to be low, but at the 95% Confidence Interval they included 1.0, indicating that they were not statistically significant.

The following observation was also made in the report:

“The available literature on ETS exposure from the spouse and lung cancer is large. However, only six studies are available from Europe; two of them, conducted in Greece, showed a twofold increase in risk for women ever married to a smoker. Of the other studies, one from Scotland provided very unstable risk estimates of the same magnitude as the Greek studies and two – one from the UK and the other from Sweden – provided little evidence of an association.”

The results were within the range at which the IARC itself concluded that unequivocal results may be forever unachievable.

Yet after negative reporting of the results by the media, IARC insisted that the finds “add substantially” to previous evidence of the risk between ETS and lung cancer. A WHO press release then implied that the results proved a link between ETS and lung cancer, a highly problematic conclusion given their own guidelines of epidemiological best practice⁶⁹.

It is hard to see how it could be claimed that the study adds substantially to the case against ETS and much less does it prove a link between ETS and lung cancer.

The interpretation of such weak evidence is not in line with the official interpretation of very similar findings of other supposed health risks.

⁶⁸ Boffetta P *et al.* Multi-centre case-control study of exposure to environmental tobacco smoke and lung cancer in Europe, *Journal of the National Cancer Institute* 1998;90: 1440-1450

⁶⁹ Isabel dos Santos Silva. *Cancer epidemiology: Principles and methods, IARC* 1999

Hackshaw *et al*, (1997)

This is a meta-analysis of 37 epidemiological studies (2 not published, out of a total of 60 published studies and probably many more unpublished) of the risk of lung cancer in non-smokers.

The findings were of a RR for lung cancer of 1.24 (95% CI 1.13 -1.36).

When adjusted for misclassification bias (classified as non-smokers when smokers) and dietary confounding, the figure fell to 1.16 (1.04 -1.27).

The increase to the overall finding of a rate of 1.26 (1.06 – 1.47) was as a result of adjustment for exposure to ETS in the reference group. The reference group was of non-smoking women living with non-smokers, who were taken to have no exposure and no increase in risk.

The risk estimate was then compared with that from extrapolation of the risk in smokers, using studies of biochemical markers of tobacco smoke, inappropriate as they are in assessing ETS exposure.

The indirect measures of the likely intake of ETS by non-smokers suggested that non-smokers had about 1% of the exposure to cigarettes of their smoking partners.

Assuming that smokers typically consume 25 cigarettes a day, face a relative risk of 20 and that there is a linear dose-risk relationship, the study reached an estimated relative risk of around 1.19 for non-smokers.

The study relied on markers of ETS exposure which are both indirect and not linked to carcinogenicity.

Direct studies of ETS exposure have consistently pointed to much lower levels of exposure – around 0.02 cigarettes a day for the most exposed to ETS.

Even adopting the same linear dose-risk relation as Hackshaw *et al*, this suggests a plausible relative risk for non-smokers exposed to ETS of around 1.02, on the very borderline of nil excess risk, and 10 times lower than Hackshaw *et al*.

Smoking in work and public places

As has been explained in the previous chapter, when considered as a whole, the scientific evidence does not demonstrate that ETS causes lung cancer, heart disease and other chronic diseases in non-smokers, and attempts to attribute a number of deaths to ETS are not scientifically justified. In any event, the body of evidence, as weak and inconclusive as it is, relates for the most part to non-smokers living their lives with smokers and not to non-smokers (not living with a smoker) exposed to ETS outside the home.

There are other substantial reasons why it is not either necessary or appropriate that there should be legislation – applying nationally or locally – prohibiting smoking in the work place or other places.

Work and other places are not two discrete places

Smoking in the work place and in public places are not two discrete issues, for the simple reason that some work places are also public places, in the sense that they are places where people work and which the public visit out of choice, or are places in respect of which the public have no choice in that regard. Even in its consultation document of 1999⁷⁰, although public places were outside the remit of the Health and Safety Commission, it found it impossible to consider all work places as being distinct from public places.

Inevitably, therefore, the debate largely centres around that sector in which the work place is most often also a public place -- the hospitality sector.

In 1988⁷¹, the Health & Safety Executive published guidance for employers explaining what they should do to comply with health, safety and welfare law as it applies to passive smoking (ETS). Many employers introduced policies, fairly and after consultation with employees or their representatives, on smoking as a result.

In 2002⁷², 50% of people reported their work place as being one in which smoking was banned (10% higher than in 1996); 36% worked in places where

smoking was permitted only in designated places. 5% worked alone. That left only 9% of employees, down from 13% in 1996, working in places where there were not formal restrictions on smoking - that represents around 2.5⁷³ million people, down from 3.4 million in 1996.

That data is a massive endorsement of the appropriateness of voluntary self-regulation of smoking in the work place, put in place by employers after consulting with employees and their representatives.

In 1999, when the Health & Safety Commission published its consultation paper it had much to say that remains relevant today, about work places generally and about work places that were also public places:

⁷⁰ Proposal for an Approved Code of Practice on passive smoking at work, *Health & Safety Commission, Health Directorate, Division A*, 1999

⁷¹ Passive smoking at work, *Health & Safety Executive*, November 1988

⁷² Smoking Related Behaviour and Attitudes, 2002, *Office for National Statistics*, July 2003

⁷³ Annual Abstract of Statistics, Labour Force Survey 2002, *Office for National Statistics*, 2003

The risk to health of ETS in the work place and public places

“Proving beyond reasonable doubt that passive smoking at a particular workplace was a risk to health is likely to be very difficult, given the state of the scientific evidence.” (para 17)

“[However]. we do not know how big the risk is of developing diseases such as cancer or ischaemic heart disease from passive smoking at work.” (para.26)

“...information about the magnitude and extent of the risk to the public from passive smoking in public places is even more uncertain . The issue is better dealt with in the other ways discussed in the White Paper⁷⁴.” (para. 29)

“Employers should not simply ignore their duty to ensure the welfare of employees who smoke .. but... where the welfare needs of employees who smoke and employees who do not smoke come into conflict, priority should be given to the needs of employees who do not smoke.” (para. 28)

The adequacy of existing law

“We believe there is already sufficient health, safety and welfare law that can be applied to the question of passive smoking”. (para.15)

“...tobacco smoke causes discomfort and irritation. These are matters of employee welfare, rather than their health. A provision in existing health, safety and welfare law⁷⁵ already requires employers to protect employees who do not smoke from the discomfort caused by tobacco smoke in rest areas and rest rooms.” (para.27)

“... regulation 6 of the Workplace (Health, Safety and Welfare) Regulations 1992 requires employers at enclosed workplaces to which those Regulations apply, to ventilate workplaces with a sufficient quantity of fresh or purified air. Similar provisions apply in other workplaces.” (para. 79)

The inappropriateness of prescriptive regulations

“We cannot be specific about what people should do to control passive smoking in every workplace, so prescriptive health and safety regulations about passive smoking could well be unreasonable and unenforceable. This would especially be the case in certain sectors where the workplace is also a public place (for example pubs and restaurants) or provides accommodation for off-shift workers (for example offshore installations).” (para.14)

Practicable solutions

“In our view, it is not currently reasonably practicable under health, safety and welfare law to ban smoking in all such [restaurants, pubs, residential care homes] workplaces: in some cases, because it would not be commercially viable, and in others because it would interfere with personal freedoms.” (para. 36)

“In some ways the charter [Public Places Charter] goes beyond what could be required under health, safety and welfare law for the protection of workers . . . So if an employer follows the charter’s principles, they should find it easy to comply with health, safety and welfare law.” (para. 25)

In March 2000, the Health and Safety Executive published a revised draft ACoP, which offered the following guidance:

“If your business is in the hospitality sector it might not be reasonably practicable to ban smoking completely in areas where employees need to work because you wish to cater for customers who choose to smoke. . . The hospitality industry’s Public Places Charter⁷⁶ aims to encourage better provision for non-smoking customers in places such as pubs, restaurants and hotels.” (para.58)

“Decisions on banning smoking by customers or clients will have to be made on a case-by-case basis. However, it will usually be reasonably practicable under health, safety and welfare law to ban completely customers or clients smoking for reasons of employee welfare in places where the public must visit, but where they normally remain only for a short time – for example, in: libraries, bus and railway station ticket offices and buffets, shops, supermarkets, Government (including Local Government) buildings, banks, building societies and post offices. This list is not exhaustive.” (para 60)

“Currently, it may not be reasonably practicable to ban completely customers or clients smoking where:

- a) the public must visit, but where they remain for some time – for example, airport departure lounges; or,
- b) the public visit out of choice – for example, restaurants, cafes, public houses, bars, clubs, hotels, casinos and betting shops; or
- c) people live – for example, the accommodation on an offshore installation, residential care homes, and prisons.” (para. 61)

⁷⁴ Smoking Kills: A White Paper on Tobacco, *Department of Health*, December 1998

⁷⁵ Workplace (Health, Safety and Welfare) Regulations 1992, Regulation 25(3).

⁷⁶ Smoking Kills: A White Paper on Tobacco, *Department of Health*, December 1998, p.69

Given these facts, in 1999 and 2000, the Health & Safety Commission and Executive suggested that one way of improving the situation might be for an Approved Code of Practice (ACoP) to be adopted as guidance for employers on smoking policies in the workplace. However, its consultation paper served to highlight the practical difficulties involved in providing such guidance and the need to make decisions on a case-by-case basis according to the circumstances. It estimated that there were then around 63,000 organisations and 223,000 units in the hospitality sector.

What has changed since 1999, if anything?

If that was the case in 1999, it is appropriate to ask what has since changed that might prompt a change in policy. As far as the Government is concerned, it has consistently stood firm in its belief in the voluntary partnership approach provided that it makes substantial progress:

“The Government have no plans to ban smoking in public places. We have consistently said that smoke-free public places are the ideal. We do not think that a universal ban on smoking in all public places is justified while we can make fast and substantial progress in partnership with industry...We look forward to faster and more substantial progress from employers and businesses.”⁷⁷

In 1998, the Government agreed with representative bodies within the hospitality sector a Public Places

Charter which seeks, by encouraging the adoption of formal smoking policies, best practice and the provision of more non-smoking areas, to provide customers with better choice. Virtually all the agreed targets for the five years ahead were met or well exceeded. In the Spring of 2004, with a view to achieving more rapid progress, Ministers discussed with the hospitality sector the possible directions for the way forward over the next few years. Progress has indeed quickened in pace over the past twelve months during which a significant number of businesses have reviewed their smoking policies, some introducing bans, others measures segregating smokers from non-smokers and/or improving air quality generally by ventilation etc. Such changes are best and most properly driven by what customers want, not what an arbitrary law determines.

The other most significant change that has occurred since 1999 has been the loudness of voice of the anti-smoking activists who, following the ban on tobacco advertising and promotion, have vigorously campaigned for the prohibition of smoking in work and other places, on the grounds that such bans would force smokers to stop smoking and help them to quit. If that were to be adopted as a justification for bans, it would represent an alarming denial of individual freedom, and set a most dangerous precedent.

⁷⁷ Lord Warner, Written Answer, House of Lords, *Official Report*, Col.WA177, March 10, 2004

“Considerations of rights, which are deemed by much of the population to be inalienable, unconditional and metaphysically unassailable, drive out considerations of kindness, decency, tolerance mutual obligation and so forth; all the considerations, in fact, that make civilised or dignified existence in a crowded society possible.”⁷⁸

Smoking is not illegal, but smokers do not have a right to smoke anywhere they please, and they do not do so. Most smokers are respectful of other peoples’ preferences and views, and respect smoking rules. There is no need or justification for intolerant, socially divisive prohibition. No freedoms or rights need be lost in a society that is tolerant and sensible.

Embedded deep in Britain’s history there is a classical liberal tradition that puts the importance of an individual’s autonomy and dignity front centre stage. Invasions of personal freedom, from whatever quarter they come, are generally tolerated and respected only when there are overriding justifications that have full public support. In the case of smoking, there are not overriding justifications for prohibition. Smokers and non-smokers can and do live together in society, without the need for invasive and divisive legislation, by respecting each others’ choices and preferences.

That is well demonstrated by the widespread coverage achieved by self-regulation of smoking in the workplace and in public places generally. The resolution of smoking issues in the hospitality sector are for the owners and operators of those businesses to resolve in a similar manner, having

regard for both the health, safety and welfare of their employees and the wishes and demands of their customers and clientele. In that regard, the further development of the Public Places Charter could obviously play an important part.

An example of legislation

The alternative is legislation imposing prohibitions and regulations. The Tobacco Smoking (Public Places and Workplaces) Bill [HL], a Private Member’s Bill⁷⁹ currently being considered in the House of Lords, provides an illustration.

The Bill abandons all voluntary self-regulation and, in its place, imposes a prohibition on smoking in all enclosed work and public places (other than a few exempt places). It enables certain enclosed spaces to be designated smoking spaces (but not the whole of any place), but that would be subject to each space complying with regulations to be made by Ministers. In other words, it would render void the current designation by employers of certain places as being designated smoking rooms, and replace them with the need to comply with Ministerial regulations, for no good, sensible or justifiable purpose.

Under the Bill “a suitable and sufficient proportion” of a place could be a “designated smoking area” provided that there was compliance with regulations made by Ministers. Those regulations could determine the maximum size as a proportion of the total capacity; require consultation with employees; set maximum permitted exposure levels to ETS or any of its constituent ingredients, for any employee or member of the public; make provisions for signs; regulate the design of ashtrays; and make

⁷⁸ Theodore Dalrymple, *Wronged by our rights*, *The Spectator*, April 24, 2004

⁷⁹ Tobacco Smoking (Public Places and Workplaces) Bill [HL] introduced in the House of Lords by Lord Faulkner on March 10, 2004

regulations governing the provision, design and operation of ventilation and air purification equipment.

The Bill creates two significant new criminal offences – smoking in an enclosed public place, other than in a designated smoking area complying with regulations, and failure of an occupier of any such place to take reasonable steps to ensure compliance, each offence being subject to a fine not exceeding level 5 on the standard scale (£2,500).

The Bill does not define a public place other than by way of listing in its Schedule places which are included within that term. But there are public places and public places.

For example, there are ‘public places’ such as Government and local Government premises, museums, libraries, etc. In those places smoking is generally prohibited.

There are places which are public in the sense that they ‘belong’ to everyone and no-one in particular, such as airport, rail and bus terminals. They are places which the public ‘must’ visit in the sense that they do not have a choice if, for example, they wish to travel. In those places, smoking is generally prohibited; but if permitted, it is confined to certain designated areas.

There are then places that the public visit out of choice – including shops, supermarkets, restaurants, cafes, hotels, pubs, bars, clubs. They are not public places in the same sense. They are places, privately owned and run, which the public can choose to visit or not, as they wish. If someone does not like the goods or services, or the environment of the place, or its other customers, they may and generally do take their business elsewhere. Smoking is generally not permitted in shops or

supermarkets. Amongst business in the hospitality sector, the public is provided with and demands a wide choice, and that is what market mechanisms are providing.

Most importantly, the Bill also makes significant provisions with regard to employment law. Amongst other things, it radically changes the law as it currently stands with regard to contracts of employment; extends the concept of “automatic unfair dismissal”; and makes provisions that are out of step with current law in that they extend rights on a quasi-public health basis, but to employees only, not to other workers or independent contractors. The latter provisions would be likely to result in services having to be provided in smoking environments through the use of non-employee workers and other contractors, presumably the opposite of what the Bill intends.

‘Private’ places and rights

The fact is, there is not sufficient evidence to justify a ban on smoking in work places on health grounds. Therefore, if an owner or occupier wishes to ban smoking, or permit smoking, either throughout his premises or only in part, provided that he ensures, so far as is reasonably practicable, the health, safety and welfare of his employees, he should be free to adopt such policies as he regards as best suiting his customers and clientele.

‘Private’ places which the public may enter if they choose, are characterised by property rights that clearly establish who is authorised to set the rules. Indeed, it is arguable that a prohibition of smoking in such places would not be compliant with the European Convention on Human Rights (ECHR) and might therefore be susceptible to challenge with regard to both Article 1 (infringing the right to respect for private life) and also Article 1 Protocol 1 (a

measure controlling the use of property). Prohibition would not be proportionate and not strike a fair balance between the rights of individual proprietors and operators and the general interest in protecting public health. The evidence on ETS does not demonstrate any adverse health effect for non-smokers and, as the Health & Safety Commission concluded in 1999, does not provide evidence adequate to justify a ban or prescriptive regulations.

Local decisions ?

Various city and other councils have made known their wish for their city, town or region to become smoke-free. The proposition that local authorities should be able to regulate or ban smoking in work and other places, by introducing laws to apply within their area, may have some political appeal at Westminster. It might, even if only in part, remove the issues from the desks of ministers. It would also enable the claim to be made that decisions were being delegated to local councils, communities and democracy. However, such a proposition implies that ETS issues have an overriding local dimension and there are grounds for the costly bureaucracy which would be involved, which is simply not the case. Indeed, as is shown here and in the following chapter, smoking bans are not even what the public wants.

Laws prohibiting and/or regulating smoking, whether on a national or local scale, are not justified on health or other grounds. They would needlessly be socially divisive and unnecessarily create criminal offences that would involve not insignificant costs of enforcement. The voluntary approach is not failing. It is producing what the public wants – both choice and more smoke free areas.

Smoking in the work place

It would be particularly problematic if local authorities were to be enabled to introduce laws, whether by way of bye-laws or other means, prohibiting or regulating smoking in the workplace. It would not assist the legal framework of health, safety and welfare and employment legislation, much of which is not devolved to the Scottish Parliament and National Assembly for Wales.

The probability would then also arise of there being different legal provisions applying from one local authority area to another. Businesses with more than one establishment and in different local authority areas could find that there were different provisions affecting their employees, according to where they worked. What would be an offence in one place might not be in another. The costs to local government and the private sector in managing such arrangements would be disproportionate and unnecessary, particularly when perfectly acceptable voluntarily adopted policies are already in place and working without any difficulties.

Bye-laws

If local authorities were to be afforded powers, other than by way of delegated powers to make bye-laws, it would be a major constitutional departure. Currently local authorities do not have the power to make laws without such power being delegated to

them by primary legislation at Westminster. Under s. 235 of the Local Government Act 1972, local councils may make bye-laws “for the good rule and government of the whole or any part of the district for which they are responsible.” Parliamentary legislation may give power or impose a duty to make bye-laws which are effectively delegated legislation. Generally, they are of limited scope and are of a negative character, in that they prohibit activities, unlike Local Acts that may permit them. Also, in every case a bye-law has to be confirmed or approved by the appropriate Secretary of State before it is valid and enforceable, not least because it creates a criminal offence.

In the case of a bye-law on smoking, different local authorities might make different decisions, some wishing to introduce a bye-law, others not. Then different smoking policies would apply in different areas. The local authority areas might adjoin one another, so creating a borderline on one side of which it would be a criminal offence to smoke in defined places, but not on the other.

Bye-laws, as they are generally provided for in legislation, and as they are promoted and brought into force, would also appear to be a most inappropriate means of regulating smoking. A council that wished to introduce a bye-law would

have to draft the bye-law (or adopt a model bye-law provided by the appropriate government department) and give notice of its intention to apply for confirmation of it in one or more local newspapers, at least one month before the application for confirmation by the Secretary of State is made.

As a general rule-of-thumb, it would appear that the considerations taken into account when examining a bye-law are: is it *intra vires*; have all the actions required by the legislation, such as consultation with named public bodies been taken; do they duplicate or conflict with general, existing bye-laws of any local Act or common law; does the nuisance that they address merit criminal sanctions; to a reasonable person, is the penalty available proportionate; do the bye-laws address a genuine and specific local problem, rather than attempt to deal in general terms with an essentially national issue; and do they conflict with government policy. There would currently appear to be some difficulty in providing a positive answer to the latter two questions.

Because it can be an immensely time-consuming process on the part of all concerned to draft, examine and eventually confirm each and every bye-law made by a local authority, it is common practice for Ministers to short-circuit the process by issuing 'model' bye-laws. The adoption of a model bye-law saves time and effort, in respect of drafting particularly on the part of local authorities, and in respect of the confirmation process so far as the Minister is concerned, as there is generally an expectation that councils consult with any interested parties and address their concerns as far as possible.

Not only, therefore, would it appear that it would first be necessary for primary legislation to be introduced at Westminster to enable local authorities to prohibit or regulate smoking/ETS but that it would also be

necessary for the Department to draw up one or more model bye-laws.

Enforcement

In the Private Member's Bill that is currently being considered in the House of Lords⁸⁰, a provision is included at clause 8 that makes it a duty of a local authority to enforce the Act and regulations made under it in respect of designated smoking areas. It then enables Orders to be made (subject to the negative procedure) "to make provision for powers to be granted to local authorities so as to enforce the Act and the regulations made under section 5 [regulations on designated smoking areas]."

With regard to that provision, the Select Committee on Delegated Powers and Regulatory Reform of the House of Lords has reported that::

it is "very open-ended and would cover giving authorised persons rights of entry and seizure for example. In view of the scope of this power, we recommend that its exercise (by the Secretary of State) should be subject to the affirmative procedure."

This indeed should be the case, but it also prompts the question why the Proposer did not included detailed provisions regarding enforcement in his Bill.

More fundamental still is whether local authorities would be in a position of being able, either under that Bill, another Bill, or under bye-laws, to enforce bans on smoking without undue cost to ratepayers. It would be extremely surprising also if people were to agree with the proposition – which they have not

⁸⁰ Tobacco Smoking (Public Places and Workplaces) Bill [HL]

seen in that light – that smoking in the work place or in a so-called ‘public place’, privately owned and run, should be a criminal offence, with the penalty on conviction perhaps being imprisonment and/or a significant fine.

Alternatives to legislation

Without having resort to legislation, there are a number of other ways by which local authorities, towns and cities, working with other public sector bodies and the private sector locally, could help to achieve more smoke-free public places. Legislation is not required, nor is it appropriate.

First, however, there should be efforts to establish what the local community wants both in terms of priorities for local action and in terms of the regulation of smoking. That should not be done simply by asking people whether they are for or against banning smoking in a particular place. True indications of people’s views can only be gained from questions which offer people choices in their response.

Having established what people locally want, a council can draw up its appropriate strategy and action plan, which should provide for both non-smokers and smokers.

Local councils are in a position of being able to set an example of best practice for the whole community by the way in which they manage smoking policy amongst their own employees and in their own premises, including those that are public places. That means developing an approach that is sustainable and firmly rooted in good practice: reviewing policies and the issues to which they may give rise, developing policy and engaging staff in consultation.

Best practice should also mean everyone being subject to the same policy in the same premises. For example, if the policy is one of smoking only in certain designated rooms, the same policy should apply to everyone, irrespective of their status.

Local councils can play a key role in engaging local businesses. There are numerous ways in which this can be done. It need not be costly. For example, the policy of the council can be promoted through environmental health officers who can make suggestions and give advice, particularly to businesses in the hospitality sector, when undertaking their inspections of premises.

Given the loud voice of those calling for legislation to ban smoking, the impression might be created that there are large numbers of people working in local businesses where smoking is not regulated, and that the non-smoker cannot avoid tobacco smoke in restaurants, cafes, pubs, bars and the like. Neither claim would be true. As data shows, 86% of employees work in places where smoking is either banned or permitted only in designated areas; and there is increasing provision of non-smoking facilities amongst restaurants, bars and pubs. The public is being provided with more non-smoking areas and with choice, rightly so to reflect the fact that, whilst smokers are in a minority in the population, there are still between 26% and 30% of adults who smoke.

These achievements – from a point where the vast majority of the population smoked, and where very few places were smoke free – have all been by way of voluntarily adopted self-regulation, and gradualism which has reflected changes in society. That, the TMA believes, should also be the approach of local councils and communities for the future.

What the public thinks and wants

There has been no shortage of claims as to what the public thinks and wants about smoking in the work place and public places.

Polling that canvasses votes or opinions – say, by telephone or the web – does not provide a true, representative snapshot of public opinion. The people most likely to respond are those who have the strongest opinions on the issue, and their views are not necessarily representative of the population as a whole. Such polls are also readily open to manipulation, by way of the encouragement and canvassing of mass responses of a particular view. They are frequently exploited in that way, albeit not by smokers who are not an organised group.

It also matters greatly how the questions asked of the public are framed and whether they require a simple Yes/No answer, or provide respondents with choices. For example, a recent BBC poll⁸¹, variously referred to as a consultation or survey, asked people to give a simple Yes/No answer to the question: “Should the Government ban smoking in all public places, in order to cut down on illnesses associated with smoking and passive smoking?” Given the loaded framing of the question, it was not surprising that the majority said Yes.

In contrast, opinion polls that use nationally representative survey and standard sampling techniques are able to provide reliable indications of public opinion, particularly when they do not use ‘loaded’ questions and when they offer people choices in their response.

⁸¹ ‘Consultation’ carried out for “Your NHS: For Better or Worse”, *BBC One*, March 24 2004

BMRB International – September 2003

This survey, commissioned by the TMA, used the BMRB weekend telephone omnibus survey ACCESS. 1,929 people over 18 were interviewed and the headline results were as follows:

Priorities for local action

People were asked to put quality of life issues on which they thought their local council should take action into an order of priorities. At the head of peoples' list were personal security issues: 37% thought that controlling yobbish behaviour was the greatest priority; 19% wanted increased security camera surveillance. Maintaining parks and open spaces and prohibiting litter and graffiti ranked at 18% and 12% respectively. Only 9% considered banning smoking to be a top priority.

Smoking in pubs, clubs and bars

30% of non-smokers and 55% of smokers said that they that they had no real concern about smoking in pubs, clubs and bars.

Less than a fifth (17%) of all adults agreed that smoking should be banned in those places.

The vast majority (86%) felt that the smoking situation in those places had improved in recent years, with almost 73% registering an increase in the number of non-smoking areas.

... and in restaurants

In restaurants, 32% thought that smoking should be banned, but only 14% that it should be banned in other places where food is served. Many preferred a more flexible approach, with the most popular options being more non-smoking areas (19%), offering a real choice of smoking policies (10%), or leaving it up to the management (8%)

Populus – April/May 2004

This research was commissioned by Forest⁸². 10,000 people over 18 were interviewed by telephone between April 20 and May 2; 1,000 interviews were conducted in each of eight cities – Birmingham, Brighton, Bristol, Cardiff, Leeds, Liverpool, Manchester and Sheffield – and two regions – North East England and Scotland. The results were weighted to be representative of all adults in those sampling areas. The data from each city or region are accurate to a margin of error of +/- 3% at a 95% confidence level. Further details of this research are available from Forest. The key findings were:

Priorities for local action

As reflected by the earlier BMRB International survey for the TMA, controlling yobbish behaviour (37%) and increased security camera surveillance (21%) were at the top of peoples' list in every area as being priorities for local government. The proportion of people regarding a ban on smoking in public places as the highest priority ranged from 11% in Brighton, to a high of 20% in Birmingham, and an average overall of 15%.

Frequency of visits to pubs, clubs and bars

Just over one-in-ten (11%) of those surveyed said that they went out to pubs, clubs or bars 'frequently' (defined as 'at least 3 times a week'). A further 21% said that they did so once or twice a week, and the same proportion 'once or twice a month'. Just under a quarter (23%) said that they did so only a 'few times a year'; 25% said that they almost never or never did so. There was little variation in the pattern of visits as between the individual surveys – around a third of people visited them frequently or often, except Manchester and Scotland, where a quarter of people did so.

⁸² Full results, including individual city and regional surveys, at www.forestonline.org

General attitudes to smoking in pubs, clubs and bars

The people surveyed were prompted with a range of six different propositions about smoking in pubs, clubs and bars and asked which best represented their view:

The smoking situation does not really bother me – 12%

Provided there is a real choice of smoking and non-smoking facilities, I am happy – 19%

I would like to see more non-smoking facilities – 9%

Smoking should be allowed in venues with good ventilation and non-smoking areas – 28%

Smoking should not be allowed at the bar in the interests of staff – 10%

I would like smoking banned altogether – 22%

Don't know – 1%

There was little variation in the range of responses in the various cities and regions surveyed, except on the last response – favouring a ban on smoking altogether. Bristol was the lowest at 18% and Birmingham the highest at 28% (that city survey included a higher number of people who had never smoked – 56% as opposed to 46% across the total sample).

Recent changes in the way smoking is dealt with in pubs, bars and clubs

People were asked whether they agreed with five statements:

Environments have significantly improved and are noticeably less smoky – 56%

The number of non-smoking areas/venues has increased – 67%

More venues have signs outside telling you if they are non-smoking or have non-smoking areas – 52%

There have been improvements over recent years, but more improvements are still required – 80%

There haven't been any real improvements in recent years – 43%

How smoking should be dealt with in pubs, clubs and bars

People were presented with four options:

Smoking should be allowed throughout all pubs, bars and clubs – 6%

All pubs, bars and clubs should be mainly smoking with separate non-smoking areas – 19%

All pubs, bars and clubs should be mainly non-smoking with separate areas for smoking – 49%

Smoking should be banned completely in all pubs, bars and clubs – 24%

Don't know 1%.

In other words, 74% prefer to retain some smoking facility, rather than ban smoking altogether (24%).

Just over two-thirds of non-smokers (67%) agreed with one of the options of how smoking should be dealt with in pubs, bars and clubs that would retain some smoking facility.

Amongst smokers, the percentage was higher (90%).

Reasons for not supporting a ban on smoking

Having established that 24% of adults think that there should be a ban on smoking in pubs, bars and clubs, the 74% agreeing with one of the other propositions were then asked *why* they did not support a complete ban. They were prompted with six reasons to which they were invited to agree or disagree:

It's better to have a choice of smoking or non-smoking facilities than banning it altogether -93%

A ban would harm the business prospects of pubs, bars and clubs – 77%

A ban infringes people's rights – 76%

Smoking is part of the atmosphere of pubs, bars and clubs – 73%

Smoking doesn't bother me – 71%

It would be divisive because you couldn't socialise with smokers – 62%

The 93% who agreed that it was better to have a choice of smoking or non-smoking facilities represented 69% of the overall sample of 10,000 people.

Among the non-smokers who did not support a ban, 91% agreed that it was better to have a choice of smoking or non-smoking facilities.

Amongst the smokers who did not support a ban, 94% agreed with choice being provided.

Who should take decisions about smoking in pubs, clubs and bars?

People were presented with four options:

The decision about smoking policy should be left to owners/managers – 63%

The Council should be given the power to ban smoking – 21%

Only central government should have the power to ban smoking- 14%

Don't know – 2%

The main findings of the BMRB and Populus surveys, whether considered individually as 11 separate polls or collectively, can be summarised as follows:

A substantial majority of people – including a majority of non-smokers - are opposed to a ban on smoking in restaurants, pubs, bars and clubs, whether such a ban were to be imposed by central government or local authorities. They believe that it is better to have a choice of smoking or non-smoking facilities and, reflecting the prevalence of smoking in the population generally, that there should be greater provision of non-smoking facilities. In that regard, they believe that more progress is required and that it should be the responsibility of owners and managers to satisfy this demand.

The TMA fully supports this approach and believes that individual businesses in the hospitality trade should investigate and, in their own commercial best interests, seek to satisfy the preferences of their customers, at the same time ensuring, so far as is reasonably practicable, the health, safety and welfare of their employees. The current public policy on smoking in work and public places is the most appropriate and its continuation is capable of providing what the public wants.