



**Chartered
Institute of
Environmental
Health**

**Submission to National Assembly for Wales
on consultation on smoking in public
places**

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September 2004

THE CHARTERED INSTITUTE OF ENVIRONMENTAL HEALTH

Founded in 1883, the Chartered Institute of Environmental Health (CIEH) is a professional and educational body, dedicated to the promotion of environmental health and to encouraging the highest possible standards in the training and the work of environmental health professionals.

The Chartered Institute has approximately 9,500 members, most of whom work for local authorities in England, Wales and Northern Ireland. As well as providing services and information for its members the Chartered Institute provides information to government departments and evidence to them on proposed legislation relevant to environmental health.

In 1993 the Chartered Institute became the World Health Organisation Collaborating Centre for Environmental Health in Europe.

In 2002 the Chartered Institute established a regional office in Wales in order to facilitate direct liaison with the National Assembly for Wales, local authorities and non-governmental organisations within Wales, promoting and representing Chartered Institute of Environmental Health policies in a Welsh context.

The Chartered Institute of Environmental Health welcomes this opportunity to comment on this very important issue.

This consultation response will begin by answering the specific questions raised in the letter from the Clerk to the Committee dated 23rd July 2004, and there after we will make specific comment on the issue of smoking in public places. The questions will be addressed in the order of raising.

Q1 The health risks of environmental tobacco smoke.

1. The scientific evidence that environmental tobacco smoke damages the health of third parties is incontrovertible. It has been confirmed by the Government's Chief Medical Officer for England (CMO) Sir Liam Donaldson (July 2003) as well as by the heads of all Britain's thirteen Royal Colleges of Medicine 9 November 2003) and by the CMO for Scotland, Dr Mac Armstrong (in April 2004).
2. The non-smoker breathes environmental tobacco smoke from two sources, 'sidestream smoke' from the burning tip of the cigarette and 'mainstream' smoke that has been inhaled and then exhaled by the smoker. Tobacco smoke contains over 4000 chemicals, some of which have marked irritant properties and over 60 of which are known or suspected carcinogens. Carcinogens in environmental tobacco smoke include benzene, 1,3-butadiene, benzo[a]pyrene, 4-(methylnitrosamine)-1-(3-pyridyl)-1-butanone and others.^{1 2}
3. A report by the California Environmental protection Agency (EPA)³ identifies environmental tobacco smoke as a risk factor for the following :
 - Childbirth and infancy
 - Low birth weight
 - Cot Death (SIDS)
 - Illnesses in children
 - Middle ear infection
 - Asthma(induction and exacerbation)
 - Bronchitis (induction and exacerbation)
 - Pneumonia (induction and exacerbation)
 - Illnesses in adults
 - Heart disease
 - Stroke
 - Lung cancer
 - Nasal cancer
4. The California EPA report also identified a link between passive inhalation of environmental tobacco smoke and the following:

¹ Passive Smoking, ASH Fact sheet No. 8 2004

² Tobacco Smoke and Involuntary smoking. International Agency for Research on Cancer (IARC) Monographs on the evaluation of carcinogenic risks to humans,2002:Vol 83

³ Health Effects of exposure to environmental tobacco smoke, California Environmental Protection Agency, 1997

- Spontaneous abortion (miscarriage);
 - Adverse impact on learning and behavioural development in children;
 - Meningococcal infections in children;
 - Asthma exacerbation in adults;
 - Exacerbation of cystic fibrosis;
 - Decreased lung function;
 - Cervical cancer.
5. Short term exposure to environmental tobacco smoke has a measurable effect on the heart in non-smokers – 30 minutes exposure is enough to reduce coronary blood flow.⁴ The IARC review concluded that ‘the evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in never smokers’.³
 6. More than 5 million people in the UK now have asthma.⁵ A recent Department of Health survey for England shows that people who are exposed to other people’s tobacco smoke for 6 or more hours a week were 50% more likely to develop asthma symptoms and breathless ness, coughing and wheezing, than those who were not.⁶
 7. Children are particularly at risk from environmental tobacco smoke. Second hand smoke increases the risk of lower respiratory tract infections such as bronchitis, pneumonia and bronchiolitis in children. It also causes reduced lung function and increased severity in the symptoms of asthma in children, and is a risk factor for new cases of asthma in children.^{7 8}
 8. New research suggests that exposure to second hand smoke can increase the risk of contracting coronary heart disease (CHD) by 50-60%- twice previous estimates.⁹ The difference may be due to previous studies concentrating on exposure to second hand smoke in the home, rather than all exposure. including that in work and in public places. Researches at St. Georges Hospital Medical School and the Royal Free UCL Medical School examined the links between the blood cotinine levels and risk of coronary heart disease (CHD) and stroke in 4,729 men in 18 British towns. The men were monitored for 20 years. Higher concentration so f blood cotinine levels amongst non-smokers were associated with a 50-60% greater risk of CHD. In earlier partner smoking studies, second hand smoke is associated with 25-30% increased risk.

⁴ Acute effects of passive smoking on the coronary circulation of young adults. Otsuka R, Watanabe H, Hirata K, Toakai K, Muro T, Yoashiyama M, Takeuchi K and Yoshikaw J. JAMA 2001; 286:436-441

⁵ UK tops asthma table , Asthma UK Press release, December 2003

⁶ Health Survey for England, Department of Health, 2001

⁷ Respiratory effects of passive smoking, United States Environmental Protection Agency, 1992 EPA/600/6-90/006F

⁸ As 3 above

⁹ Passive smoking and the risk of coronary heart disease and stroke ; prospective study with cotinine measurement. Whinchip P, Gilg J, Jarvis M, Feyerabend C and Bryant A. *bmj* DOI:10.1136/BMJ.38146.427188.55 (published 30 June 2004)

2 The economic impact of restrictions on smoking in public places

1. A number of countries and local jurisdictions have acted to ban smoking in workplaces and enclosed public places. They include Ireland, Norway, California, Massachusetts and the city of New York. Small business and tobacco lobbyists often claim that smoking bans may damage businesses, particularly in eating and entertainment venues. There is no good objective evidence for this assertion. The most authoritative review, by Scollos et al found that (from 97 studies world wide) all independent studies found no negative impact on takings, and negative studies had tobacco industry backing and most subjective measures.¹⁰
2. Recently, New York city Finance Commissioner Martha Stark revealed that the business tax take from the city's hospitality venues had risen by 12% in the first nine months since the city's tobacco ban took effect.¹¹ Whilst any individual pub or restaurant choosing to go smoke-free may run a business risk, since consumers have readily available alternatives (the impact may be positive or negative) a smoking ban over a wide geographic area – city, region or country – presents much less of a risk, since it ensures a 'level playing field'.

3 The impact of a ban in reducing prevalence of smoking i.e whether a ban would encourage people to give up smoking, or not to take it up.

1. It is known that ending smoking in workplaces is a simple and cost effective way to encourage smokers to quit. The Wanless Report stated that ' the voluntary approach to smoking in the workplace has had limited success' and that ' a number of other countries have now implemented a work place smoking ban via legislation'. Some of this experience has been shown to be successful in reducing the prevalence of smoking. Public support for smoking restrictions has also been found, in surveys , to be high...' (para 4.21) ' Some studies estimate that a workplace smoking ban in England might reduce the smoking prevalence by around 4 percentage points – equivalent to a reduction from the present 27 per cent rate to 23 per cent if a comprehensive workplace ban were to be introduced in this country' ¹²
2. Most smokers want to quit; this is true for all socioeconomic classifications. A 2002 survey by the Office for National Statistics gave the following results for smokers who want to quit : ¹³

¹⁰ Review of the qualities of studies on the economic effects of smoke-free policies on the hospitality industry. Scollo M, Lay A, Hyland A and Glantz S. Tobacco Control 2002;12: 13-20.

¹¹ New York Times 01.04 2004

¹² Securing good health for the Whole Population, D Wanless H.M. Treasury 2004

¹³ Smoking related behaviour and attitudes. Lader D and Meltzer H. 2002. ONS 2003

	Professional and Managerial	Intermediate	Routine and Manual	Never worked and Unemployed
Very much indeed	25	26	25	30
Quite a lot	28	18	18	21
A fair amount	12	13	13	10
A little	8	6	6	14
TOTAL	71	73	68	76

3. Those people who indicated that they would like to give up smoking are likely to be assisted in doing so by smoking bans in work places and in public enclosed spaces, which ban would have the effect of assisting by prevention.

4 The effectiveness of extractor fans and other ventilation equipment to remove tobacco fumes from the atmosphere

1. It is important to note that there is no safe level of environmental tobacco smoke. Ventilation and similar equipment cannot eliminate all smoke and therefore can reduce but not remove risk. Ventilation standards are voluntary and are designed for comfort, not safety. Studies show that ventilation systems are usually not well maintained, reducing their effectiveness. It would require much higher ventilation rates than most commercial systems offer to reduce health risks significantly (although even these would not be fully effective). Such systems would be very expensive, noisy and would cause discomfort and are therefore unlikely to be installed in commercial premises. Air filtration or air ionising equipment can only remove visible particles; they are not effective in removing invisible and highly toxic gases. This equipment clogs up quickly and requires a high level of maintenance which is rarely given. Separate smoking areas are generally ineffective, as smoke drifts. The tobacco industry and its funded lobby groups (e.g. Forest) are keen to promote ventilation as an alternative to ending smoking in workplaces and enclosed public places, but this is an expensive, ineffective and unnecessarily complicated option.¹⁴
2. Philip Morris, the largest tobacco company in the world admits on its web site that ventilation systems have *'not been shown to address the health effects of second hand smoke'*¹⁵

5 Human Rights arguments in respect of smokers and non-smokers

1. The issue to be address would be whether a ban on smoking in workplaces and /or public enclosed places could be successfully challenged using Article 14 of the Human Rights Act 1998 – the prohibition on discrimination. On its

¹⁴ Example : Designated 'No Smoking Areas' provide from partial to no protection from environmental tobacco smoke. Cains T, Cannata S, Poulos R, Ferson M and Stewart B. Tobacco Control 2004 13:17-22.

¹⁵ Policies, Practices and Positions: Public Place Smoking.

www.philipmorrisusa.com/policies_practices/public_place_smoking.asp.2004

face Article 14 suggests that the prohibition on discrimination, direct or indirect, is absolute, that is to say, any act of discrimination, however minor or justified in the circumstances would constitute a breach. This inflexible approach was rejected however in the case of *Marckx –v- Belgium*¹⁶. It held that the principle of equality of treatment, enshrined in Article 14 is breached only if the distinction has no ‘objective and reasonable justification’. The court went on to elaborate on what was required to show a reasonable and objective justification. It said:

‘A difference in treatment in the exercise of a right laid down in the Convention must not only pursue a legitimate aim: Article 14 is likewise violated where it is clearly established that there are no reasonable relationship of proportionality between the means employed and the aim sought to be realised’

The test of justification is therefore two fold. The treatment must pursue a legitimate aim, and it must be proportionate to that aim.

2. For tobacco users to be successful in a challenge to a ban on the use of tobacco in the workplace and /or in enclosed public places they would have to demonstrate that such a ban discriminated against them, which it clearly would, did not pursue a legitimate aim, and was disproportionate.
3. It is an entirely legitimate and appropriate for the National Assembly for Wales to pursue a smoking ban in the workplace and in enclosed public places across Wales, as the evidence, as noted clearly shows that there are potent health risks to non-smokers from environmental tobacco smoke. The National Assembly for Wales is charged with protecting and improving the health of the population of Wales and in reducing health inequalities, therefore the legitimacy of such action would not be in doubt.
4. It is the view of the Chartered Institute of Environmental Health that a challenge based upon the disproportional nature of such a ban must also fail, since the ban does not seek to prevent those who use tobacco from doing so *in toto*, but rather to restrict the number of places in which they may do so. The restriction would be partial rather than complete, and is therefore likely to be seen as a proportionate response.
5. It is our view that a challenge brought by a smoker to any ban on his or her using tobacco in the workplace or in an enclosed public place is likely to fail under both limbs of the legitimate aim and proportionate test, and to be successful it would have to succeed under both. We also note that the Republic of Ireland, a state subject to the provisions of the European Convention on Human Rights has successfully introduced a ban on smoking in public places, which has not been the subject of a successful challenge to date.

¹⁶ *Marckx – V- Belgium* A/31(1979) 2 EHRR 330

6 Enforcement

1. It is clear that smoking bans do not require intensive or costly enforcement. This has been the experience in Ireland and in New York, and on the London Underground, other UK metro systems, buses and elsewhere. The reason for this is that such restrictions are usually observed by popular consensus.

General comments on this consultation

1. The Chartered Institute of Environmental Health acknowledges the rights of employees not to have to work in smokey environments and it supports the adoption of smoke free workplaces and public places.

The General Council of the Chartered Institute of Environmental Health adopted the following policy in 1999:

The Chartered Institute of Environmental Health believes that :

- There is a significant risk to health from exposure to second hand tobacco pollution;
- Unless by their own choice, no-one should be exposed to second hand tobacco pollution;
- All places where people work should be free from second hand tobacco pollution;

and that ventilation is not a suitable alternative to a no-smoking policy.

2. Whilst recognising that action based on co-operation and consensus is always preferable, on the issue of smoking in enclosed public places and workplaces the Chartered Institute of Environmental Health believes that only a complete prohibition will result in the level of health protection required. The Chartered Institute of Environmental Health will therefore support our members working to ensure high levels of workplace health and safety performance using existing risk reduction strategies, but we will also press for a national ban on smoking in enclosed public places and workplaces.
3. The Chartered Institute of Environmental Health has agreed the following joint statement with ASH:

The CIEH and ASH believe that the current 'voluntary approach' to smoking restrictions in workplaces and enclosed public spaces is wholly ineffective in tackling the significant public health impacts of involuntary exposure of employees and members of the public to second hand tobacco pollution. We want to see Government leadership in the form of national legislation to end smoking in workplaces and enclosed public places. CIEH and ASH call for the introduction of simple, enforceable national legal requirements, as now exist in Ireland, operated and enforced at a local level by Councils and their partners'

4. We have also, in association with ASH produced a toolkit for use by local authorities and their partners entitled 'Achieving Smoke Freedom – A guide for local decision makers' which has been distributed to all local authorities in England, Wales and Northern Ireland,. The tool kit outlines ways in which local authorities can act, either alone or in partnership to bring about local environmental smoke reduction or removal schemes, using the power to promote wellbeing and to promote health and reduce health inequalities.

5. The position of the Chartered Institute of Environmental Health in respect of environmental tobacco smoke is as stated in paragraph 3 immediately above. We would be happy to expand upon the information contained in this submission, if required and would be willing to give oral evidence to the Committee if required.