Protecting workers in licensed premises from the effects of secondhand smoke

Over the summer, the Department of Health has sought opinion regarding implementation of its proposed partial smoking ban for licensed premises. Since the General Election in May, Patricia Hewitt, the new Secretary of State is rumoured to be more sympathetic to a complete ban, so everybody is asking—is the lady for turning? And if so, what might encourage her to turn? The details of the ban are contained in the public health white paper Choosing Health: Making Healthy Choices Easier [1]. Many submissions will argue that the proposals are impractical and that a complete ban—as in other workplaces—would be preferable.

Woodall et al. [2] argue that a partial ban is likely to worsen socioeconomic inequalities in health and smoking prevalence, as most licensed establishments in the poorest areas would be exempt from the workplace ban on smoking, while most in the more affluent areas would be subject to the ban. Bar workers, who are usually locally recruited, will therefore be at greater risk in these poorer areas. In these largely non-unionized establishments, a variety of unproven and ineffectual measures (not smoking at the bar, smoking rooms, exhaust ventilation) are proposed to protect bar workers. Further, banning smoking completely only in establishments which serve food may encourage ‘dry’ pubs to give up serving food. Similarly, the exemption of private member clubs will result in an uneven playing field which may further increase health inequality.

The debate about the risks of environmental tobacco smoke (ETS) and the necessity for smoke-free workplaces has continued for many years, while many countries and cities, such as Eire, have banned smoking entirely in enclosed workplaces. Back in 1998, the Scientific Committee on Tobacco and Health (SCOTH) estimated the increased risk to non-smokers of lung cancer from ETS at 24%; the excess risk of heart disease in non-smokers exposed to ETS. This is especially relevant to the hospitality industry, where workers are exposed continuously to ETS and will continue to be despite attempts to reduce exposure by introducing no-smoking areas and ventilation.

Although commonly recommended by the tobacco industry, ventilation systems designed to extract carbon dioxide have not been proven to be effective at removing the hazardous smoke particles identified by SCOTH.

Replacing Associates calculated that they would have to create tornado-like levels of airflow to reduce exposure to the de minimis levels demanded of exposure used by the US Occupational Safety and Health Administration [5].

Some encouraging findings emerged in the first 12 months after the implementation of the Irish ban. Firstly, there has been a high level of compliance with the law. Secondly, the legislation enjoys very high support from the public. Of special interest to occupational health practitioners will be the finding that not only has a substantial improvement occurred in the air in Dublin pubs but also carbon monoxide levels in bar workers have reduced by 45% since the introduction of the ban [6].

The Irish review also found that although bar sales declined, this was only at the same rate as before the ban. The health and economic effect of the regulation of smoking in public places was also investigated jointly by the Irish and Scottish governments [7]. This could not demonstrate any statistically significant economic effect on the hospitality sector, against claims that sales would drop by 30%—which is perhaps to be expected when non-smokers already constitute a substantial majority of the population.

Additionally, estimated savings to the National Health Service of £5.7–15.7 million were quantified; fire damage savings were £4–5 million, and savings in cleaning costs were £11.7 million. The greatest possible gains (and the largest uncertainty) in the study, however, were attached to the savings due to improved staff attendance. This estimated savings of £3.8–6.4 million from reduced sickness absence and up to £73 million from a reduction in...
smoking breaks which is a finding that should tantalise human resource colleagues. Indeed, one large UK shipbuilder totalled the time lost to production through smoking 20 cigarettes a day which came to 1 day each week [8]. On this basis, the Board justified expenditure on a smoking cessation programme consisting of nurse counselling and the supply of nicotine substitutes prior to introducing a workplace ban. And there will be unexpected savings—such as those experienced by airlines related to filtration of air—for example, smoke-free hotels might expect a windfall from the improved utilisation of rooms.

So far the ETS battle has largely been fought in a public health setting, and this to some extent is its downfall for public health measures can always be set against a menu of choice. Interested parties, such as the tobacco industry, can easily present the demand for freedom from second-hand smoke to be a matter of choice and controlling it to be an arm of the nanny state. But as occupational health practitioners, we cannot allow involuntary workplace exposure to tobacco smoke to compromise the health of workers any more than we would knowingly expose them to any other hazard.

This July, the Tobacco Advisory Group of the Royal College of Physicians [9] estimated that in 2003 in the UK, 497 people of working age died from workplace exposure to ETS, which compares with 226 deaths from work-related accidents in 2002–03 and 1874 deaths from mesothelioma in the same year [10]. Ten percent of the deaths attributed to workplace exposure occur in the hospitality industry, or almost 50 a year [11]. Thus, the cumulative effects of ETS appear to be responsible for over twice as many worker deaths as accidents, but with a latency reminiscent of asbestos.

Earlier this year, the Faculty of Occupational Medicine issued a position paper [12] on Smoking and Work, which commits the faculty to 'continue to press for statutory regulation banning smoking in all pubs and clubs to protect the health of workers in the hospitality industry and to promote the benefits of smoke-free workplaces in general'. The Health Improvement and Protection Bill provides the obvious opportunity to deliver this objective, but there are others.

In a legal opinion obtained by ASH, J. Melville Williams QC suggests that not only has the date of guilty knowledge passed for employers, but also for the Health & Safety Executive and Commission. He further suggests that ETS should be formally recognized to be within the 1988 Control of Substances Hazardous to Health (COSHH) Regulations, not least because of the 4000 carcinogens that it is believed to contain; this would oblige employers to carry out a suitable and sufficient risk assessment.

So what should individual occupational health practitioners be doing about ETS? The weight of evidence against passive smoking now is such that:

We owe a duty to our employers and customers, especially those in the entertainment industry, to bring the hazards of ETS to their full attention, even though ETS is not yet formally recognized as an industrial hazard.

Because of the possibility of vicarious liability, we also need to emphasize to those larger employers (local authorities, blue chip companies, etc.) the advisability of taking action to ensure that all their tenants and contractors are fully compliant with their own smoke-free policies.

We also need to influence the statutory bodies responsible for health and safety to recognize the significance of the latent risks of ETS by including it in the formal requirements for risk assessments and workplace exposure limits.

Alongside these less welcome messages, we can also encourage employers and managers through the potential savings from introducing smoke-free workplaces, including:

Responding to the negative economic effects of smoking on attendance caused by smoking breaks and increased absenteeism.

Reducing the exacerbating effects of smoking on industrial conditions, such as chronic obstructive airways disease, asbestos- and vibration-induced disease, and the common causes of sickness absence, such as cardiovascular and respiratory disease.

Negotiating less expensive employers' liability compulsory insurance as well as reduced cleaning costs and fire insurance.

Workplace hazards do not come much bigger than ETS these days and with such incontrovertible evidence we have a unique opportunity as well as a duty to take action, whatever the outcome of the government's consultation.

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References