

## Key points

Successful attributes of the workplace smoking ban campaign

- › strong clear health message
- › strong political support and commitment
- › trade union support
- › unified approach of all tobacco-control agencies



# Ireland's workplace smoking ban

## Educational aims

- › To highlight the role of chest physicians in tobacco control.
- › To present the important elements in achieving the workplace ban.
- › To review some of the outcomes of the ban, including the impact on respiratory health.

## Summary

Tobacco control is arguably the most important health intervention of our time, and it is appropriate and important that chest physicians play an active role in this process. Smoking is the main cause of COPD and lung cancer, and is important in asthma. Its clear role in infections of both children and adults is such that there are very few respiratory physicians whose work is not affected by smoking. The workplace ban in Ireland is an example of a successful intervention with immediate beneficial respiratory health outcomes and, in all likelihood, enormous long-term benefits. This review examines the processes in the formation of a national tobacco control policy which supported the implementation of the ban and also reviews the effectiveness of the intervention, in particular with regard to acute respiratory health.

A number of elements came together to facilitate the introduction of the workplace ban on smoking in Ireland. One of the most important of these was an all-party parliamentary inquiry in 1999, which rejected the tobacco industry's insistence that environmental tobacco smoke (ETS) was not harmful to nonsmokers. The inquiry recommended a new national anti-smoking strategy, including restrictions on smoking in workplaces. Probably the most controversial recommendation was that restrictions be extended to include bars. The inquiry also proposed that it would be necessary to have a new government unit to deal exclusively with tobacco-control issues. This inquiry was followed by a government policy document called "Towards a Tobacco Free Society" [1], which proposed

the establishment of an Office for Tobacco Control (OTC) and accepted a recommendation from Action on Smoking and Health (ASH) Ireland that the Research Institute for a Tobacco Free Society (RIFTFS) be established. ASH Ireland campaigned throughout the 1990s for a ban on tobacco advertising and a ban on smoking in the workplace.

## The Health Alliance

When the government announced that workplaces – including bars and restaurants – were to go smoke-free, ASH Ireland was ready to form what became the Health Alliance. It did this in partnership with its funding agencies, the Irish Cancer Society and the Irish Heart

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Main image © Sharon Pominick  
iStock Photo.



ASH Monday: how one newspaper created the ban.

Foundation. While ASH Ireland took leadership in the alliance, it incorporated many other health organisations, including unions representing doctors, nurses and other healthcare workers through groups such as the Irish Municipal Public and Civil Trade Union (IMPACT). It also included Mandate, a small union representing mainly Dublin bar staff. These organisations entered into partnership with the Department of Health and Children (DOHC) and the statutory OTC.

Representatives of the alliance members met regularly to review progress with regard to all aspects of the introduction of the ban, including the media situation, planning for implementation (such as signage, warnings, education and educational materials) and training the environmental health officers (EHOs) who would be the main regulators of the ban.

## The opposition

It became clear that opposition to the workplace ban was coming largely from the hospitality industry, in particular the Licensed Vintners Association and the Vintners Federation of Ireland. In addition, there was the emergence of the Irish Hospitality Industry Alliance, an organisation that appeared suddenly, was highly resourced and went out of existence after the ban was introduced. The tobacco industry in its own name was scarcely seen, becoming publicly visible only when it challenged the OTC/Health and Safety Authority (HSA) "Report on The Effects of Environmental Tobacco Smoke (ETS) in the Workplace". This report confirmed the

consensus view that ETS has many adverse health effects, that workers should be protected from it and that high-risk groups require special consideration. It also conceded that more research was required into the levels and effects of ETS in the Irish workplace. The tobacco industry representatives latched onto these two latter points to emphasise that even this government-funded report conceded that more research was needed, and that the industry was willing to back special arrangements for vulnerable groups. Apart from this intervention, the tobacco industry's presence was never again overt. However, whether tobacco companies financed any of the extensive media campaign against the ban is unknown.

## The media campaign

The period between the announcement on January 30 2003 that there was to be a complete workplace smoking ban and the ban's implementation on March 30 2004 saw a very vigorous media campaign, in which the arguments for and against smoke-free workplaces were constantly rehearsed.

The main arguments presented by the Health Alliance were:

- > passive smoking is a serious cause of ill health;
- > all workers have a right to breathe clean air;
- > ventilation alone is unable to remove all the harmful constituents of smoke;
- > smoking and nonsmoking areas do not work;
- > most smokers do not want to harm their fellow man;
- > most smokers want to quit smoking;
- > cessation services are a requisite for the introduction of such legislation;
- > passive smoking is a health and safety issue with regards to employment law.

If these arguments are accepted as the realities surrounding passive smoking, then the legislation was necessary to protect workers from the harmful effects of ETS. It was important in the argument that, whatever desirable effects the legislation might have on smoking rates, initiation or cessation, these were not the essential elements of the law. The prime aim of the legislation was the protection of the health of workers in workplaces, not the prevention of smoking.

The industry representatives were intent on emphasising the possible negative effects of the ban, in particular economic effects on

employment, tourism and what they liked to call the "culture of Irish pubs". They also advanced "civil liberties" arguments. While it was necessary to refute these arguments, the health lobby by and large made certain that the health issues were kept to the fore.

An independent media analysis of the campaign showed that in the period between 2003 and March 2004, with the exception of August 2003, the Health Alliance "won" the argument. August 2003 was when the Irish Hospitality Industry Alliance entered into the campaign. That month was a "draw" according to media monitoring company Media Market.

On the government side, the Health Promotion Unit (HPU) and the OTC combined to deliver strategic leadership in terms of planning and education, including information and signage for employers and for the EHOs whose role it was to implement the legislation.

In the analysis of the media campaign, the success factors seem to be the consistency of the pro-legislation arguments and the unity between the government, HSA, OTC, trade unions and the Health Alliance.

The strength of the health message was such that fairly early on in the campaign it seemed to become accepted. The anti-ban representatives, while not conceding outright defeat on this issue, by and large engaged obliquely and reactively. This was not all good for the health lobby, because although the opposition may concede the health issues, it was very important that this message was kept to the fore. Health spokespeople therefore had to engage on other issues as they arose, so that they could reset the agenda in the health frame.

In debates on societal issues, such as democracy, the economy and politics, the health voice had to take part and ensure that the rationale for the ban was heard and understood. Crucial in winning these debates was the fact that the workplace smoking ban was not about getting people to stop smoking, but about protecting workers. In this regard, the fact that there were already bans in many white-collar jobs, while workers in service industries such as catering were not protected, attracted media interest when the health lobby pointed it out. These non-medical issues were very popular with the print media, which were reluctant to continue to write stories saying "smoking is bad for you" but were prepared to repeat the health messages when addressing the social issues.

One of the important roles played by the Health Alliance in the media campaign was

flexibility and availability to comment on all related issues at all times. This made for excellent relationships with the media, and worked particularly well when ASH Ireland was asked to respond to attacks on the proposed legislation or on health minister Michéal Martin from within his own political party and even from cabinet colleagues. Individual ministers, for various political reasons, spoke out for "moderation" or more often "compromise" with regard to exceptions and exemptions from the ban. The alliance was also entrusted with a leadership role as the main voice of the positive health aspects of the legislation.

The result was that when the legislation was introduced on March 29 2004 it was broadly welcomed and compliance approached 100%. There has been little or no slippage since its introduction.

## Key success factors

The key success factors in the campaign as a whole seem to have been the sustained, consistent, simple health message accompanied by ongoing political leadership and commitment. The political leadership was crucial. It was reflected in two all-party Dail reports in 1999 and again in 2001 recommending a workplace ban on smoking to protect workers. When the proposed legislation came before the Dail, not a single member voted against it [2]. But the most powerful political factor was the singular commitment of Michéal Martin, Ireland's health and children minister at the time the ban was introduced. When announcing the ban, he left himself no "wriggle room" when he declared that it was a moral issue.

*M. Martin and L. Clancy, Bewleys Cafe press conference March 29 2004.*





The ban was predictably unpopular with many publicans, who had been convinced that it meant ruin for them [3]. The opposition of the publicans had many politicians asking, or even demanding, compromise. Martin weathered all such approaches and made few exemptions (none with regard to pubs).

It was the OTC's role to make sure that the public was informed about the law and how it was going to be implemented and monitored. The OTC was also responsible for building confidence that the law was workable and enforceable, and importantly that it would be implemented. Information leaflets included counter-arguments to the tobacco industry, with evidence-based responses offered. The anti-legislation lobby was quick to claim that implementation would be impossible, claiming that the introduction of the law would see the police being called to every pub in Ireland practically every day. This was the Health Alliance's opportunity to point out to the public, most of whom were nonsmokers, that most smokers are reasonable people who respect the rights of others to breathe clean air. The fear of arrests and perhaps violence was completely allayed by the fact that the law would be enforced not by the police but by EHOs. This also made it clear that this law was being implemented as a health and safety at work issue.

The partnership between the Health Alliance, OTC, HSA and the DOHC was crucial in this aspect too, as each agency became familiar with the approach the others were taking and the agencies were able to influence each other and to be ready to support each new initiative as it was introduced. Cross-party political support was also important in this regard, as it meant that by and large politicians did not object on party political lines. The key and very active support of the Mandate and IMPACT trade unions supported by the Irish Congress of

Trade Unions (ICTU) was probably the most important element in the smooth implementation of the law. The early opposition and later inactivity of the employers' body, the Irish Business and Employers Confederation, was a disappointment.

## Implementation

The legislation was successfully implemented from March 29 2004, with a very positive response nationally and internationally. The media reaction bordered on the hysterical, with representatives from Ireland, the EU, the USA and Japan clamouring for attention. The Irish media had declared it a success from noon on its first day.

This was followed by a somewhat anxious time for the regulatory authorities while they waited to see how compliant everyone was going to be. In the event, most people's expectations were surpassed, with nearly 100% compliance throughout the country. Furthermore, the ban proved to be largely self-regulatory. There were some breaches, but they were dealt with effectively and by and large quietly by a small band of very knowledgeable and dedicated EHOs. Some very high-profile flaunting of the law by publicans resulted in court cases which (importantly and unusually) were dealt with speedily and resulted in maximum fines of €2,000 and substantial court costs being imposed. The popularity of the law was confirmed when the end-of-year poll carried out by the national broadcaster, RTE, found that the workplace ban on smoking was considered the most positive event of the year in Ireland in 2004.

## Scientific research evaluation

Once the ban was in force, it fell to the scientific community to show that the law was not only popular and feasible but brought the anticipated health benefits. The main early benefits that can be expected from a reduction in second-hand smoke exposure are likely to be seen in the non-life-threatening minor illness area of upper respiratory symptoms and in the life-threatening area of cardiovascular disease. The long-term benefits in respiratory diseases, such as in lung cancer and COPD incidence, will take time to develop and will need to be carefully studied.

All the right smoke signals: the Irish press react positively to the bans introduction.



Equally (if not more) importantly, morbidity and mortality from cardiovascular diseases, such as heart attacks and strokes, should be detectable earlier. This is less easy because of the more complex aetiology of these conditions. Data on these beneficial effects are scarce and tend to come from the USA, where smoke-free legislation is best developed, in states such as California, Massachusetts and New York [4].

In Ireland, the demand from regulators and particularly the public at large however was for instant results. They had accepted that second-hand smoke causes lung cancer, heart attacks, strokes, asthma and various infections, particularly in children, so now they wanted results. Some had accepted that some of the benefits may take a little time, but what of the benefits that were said to be acute changes?

See pages 242–243 for a full evaluation of the impact of the ban.

## Summary of campaign

The importance of strong, consistent, simple, medically led public health messages in convincing the general public of the benefits of legislation to ban smoking in the workplace was confirmed. The willingness of the public to accept such legislation when they understand and accept the harmful effects of second-hand smoke surprised many. But it was to be expected on the basis that most people, including smokers, are reasonable and have no desire to injure or eventually be responsible for the death of others. The fact that the legislative ban was essentially enforced by the people was very encouraging and was very important in proving that the assertion that the ban would be divisive and lead to violence and antisocial activity needing police intervention was entirely wrong. The enthusiasm with which the ban was accepted and the increased support for the ban among smokers after its introduction should encourage other countries to follow. Hopefully, smoke-free workplaces will become normality throughout the EU in the near future.

It is necessary to say, however, that a determined effort by health professionals to point out the need for comprehensive legislation, not accepting or relying on voluntary self-regulated efforts, is essential. Acceptance is grounded in the population being told and believing that second-hand smoke kills and that to be free to breathe fresh air at work is a right not only of the affluent but of all workers. It is important to remember as well that a workplace ban on smoking is only



one element of tobacco control and for it to contribute there must be a comprehensive policy in place. Indeed, one of the pitfalls of such a campaign is that advocates may concentrate too heavily on it and neglect more important aspects. Or, as happened in Ireland, the political will for further action can become temporarily dented. The main elements of tobacco-control policy are well known and include: price of cigarettes (particularly the tax element); bans on advertising and sponsorship; public information; labelling of products; cessation services; and restrictions on smoking areas. When these other interventions are properly employed, the possibilities for successful tobacco control are maximised and the case for restriction of areas for smoking can be made without undue influence from the tobacco industry. We have seen that when the public are allowed to look at all the arguments, they make a pro-health choice.

*During the ERS Glasgow conference 2004, a Special Award was given to Micheál Martin, the Irish Minister for Health and Children, in recognition of the legislation he introduced, which banned smoking in the workplace in Ireland.*



## Evaluation of the impact of the ban

The ban has been evaluated in a number of respects. The OTC has assessed public support for and compliance with the ban, and the prevalence of smoking. Attitudes to the ban among smokers have been assessed by the International Tobacco Control (ITC) Survey. The All Ireland Bar Study looked at self-reported changes in symptoms and exposure and in salivary cotinine in bar workers in Dublin, Cork, Galway and Northern Ireland before and after the ban. Changes in exposure to ETS in terms of exposure to particulates (particulate matter (PM)<sub>10</sub> and PM<sub>2.5</sub>) and benzene in Dublin pubs, as well as changes in respiratory function and breath carbon monoxide (CO) of bar workers were measured in the Dublin Bar Study. Changes in economic activity, including employment, tourism and sales of alcohol, continue to be reported from data routinely collected by the Central Statistics Office [5], and efforts to analyse the impact of the ban on these parameters also continue. A small study on attendances and employment in pubs in Dublin has also been published [6]. Changes in tobacco sales and the prevalence of smoking are regularly monitored by the OTC, which found a reduction in both in the short term.

### Study results

In each of the studies the results have been positive.

#### 1. Public support in the general population

Public support grew from 67% before the ban to 89% after its introduction. When canvassed about their opinions of the efficacy of the ban 2 years after its introduction, 98% of people said they believed that workplaces are healthier

(figure including 94% of smokers) and 96% considered the law a success (including 89% of smokers). Furthermore, 98% of all indoor workers reported that their workplace atmosphere was not smoky since the introduction of smoke-free workplace legislation.

#### 2. Support among smokers

Support among 2,000 surveyed smokers in Ireland for a total ban in the workplace increased from just over 40% before the ban to nearly 70% after its introduction (figure 1). When this was compared with equivalent results in the UK, it emerged that the increase in the proportion of smokers who supported the ban in Ireland, where they had experienced the ban, was much greater than in the UK, where the ban had not been introduced [7].

#### 3. Compliance

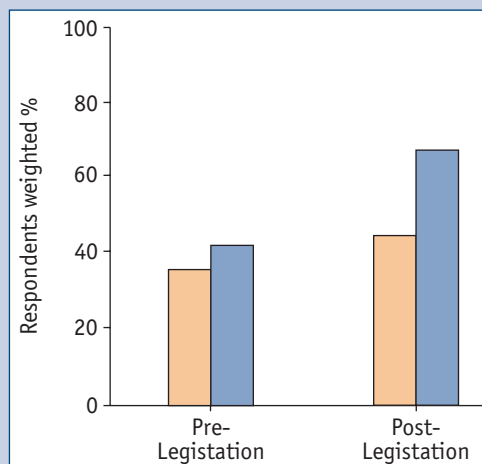
Compliance rates with the ban are very high and have been since the introduction of the ban. There are minor regional variations, but overall figures remain very high at 95% throughout the country. Breaches of the legislation have been few; the OTC recently reported that 35,000 inspections revealed 1,700 breaches, which resulted in only 38 prosecutions (37 of which were successful) [8].

#### 4. Particulate concentrations

Particulate concentrations (PM<sub>10</sub> and PM<sub>2.5</sub>) and benzene levels were measured in Dublin pubs before the ban and in the same pubs, at the same time of day, on the same day of the week, in the same month of the year, 1 year later, after the ban was introduced (table 1). Ambient particulate levels outside the pubs were also measured during the same visit. The most striking change in the concentration of particulates was the reduction in PM<sub>2.5</sub>, which is as expected

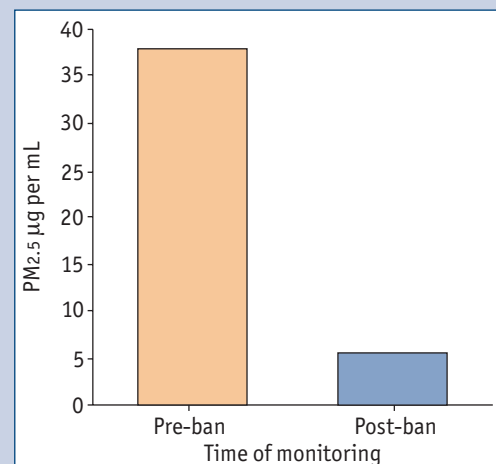
**Figure 1**

Support among smokers for total ban on smoking in the workplace in Ireland (blue) and the UK (orange). OR=1.87, p=0.002 (1.27 to 2.75).



**Figure 2**

Changes in PM<sub>2.5</sub> levels before and after the ban.



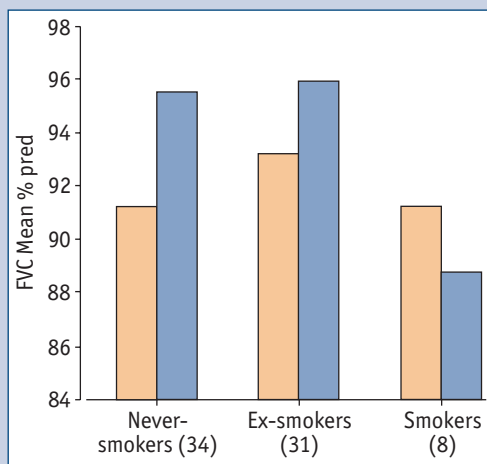
because it is believed that the particles generated by smoking are mainly  $<2.5 \mu\text{m}$  in size (figure 2). It is worth noting that the indoor level dropped to the same order as the external air. Benzene levels likewise dropped from a mean level of  $18.75 \mu\text{g per m}^3$  to  $3.72 \mu\text{g per m}^3$  – a similar level to that in ambient air in Dublin as seen in the PEOPLE Project report. Breath CO was reduced from a median of 4 ppm before the ban to 2 ppm after the ban in nonsmoking barmen [9].

### 5. Pulmonary function

Pulmonary function was measured in the pulmonary function laboratory of St James Hospital, Dublin, in 81 barmen before and after the ban's introduction with an interval of 1 year between measurements. Each subject completed a respiratory health questionnaire about upper respiratory symptoms and eye symptoms. They also performed spirometric tests as well as measurements of static lung volumes and CO diffusion. All these tests were performed using agreed European Respiratory Society (ERS) protocols. The results showed that the forced vital capacity (FVC) increased significantly in never-smokers and ex-smokers, while it declined in current smokers (figure 3). Peak flow also increased significantly in never-smokers, while the increase in ex-smokers was not significant and it declined in current smokers.

### 6. Respiratory questionnaire

There was a dramatic and statistically significant reduction in respiratory symptoms in terms of sneezing, coughing and runny nose and in eye symptoms such as redness, tearing and irritation in nonsmokers and ex-smokers when pre-ban scores were compared with post-ban responses. There were improvements in smokers, but these were not statistically significant [10].



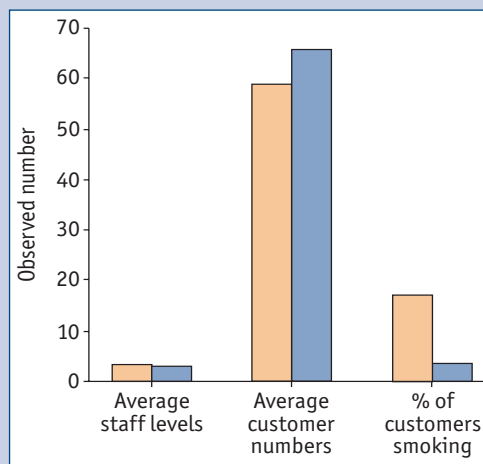
### 7. Pub activity in Dublin

A total of 38 pubs were visited for at least 3 hours before and after the ban, matching the visit for time of day, day of week and month of year. The number of staff and customers and the number smoking was counted. No-one was smoking in the pubs after the ban, but the number of people smoking outside the pub was counted. The results showed that there was an 8% drop in the number of staff working and an 11% increase in the number of customers present. Neither of these changes was significant. There was a highly statistically significant ( $p < 0.001$ ) 78% reduction in the number of customers smoking on a visit to the pub (figure 4).

### 8. Conclusions from research studies

These positive results indicate that the ban works and that it is accepted. Smokers come to accept and support it when they have experience of it. These are of course all early changes. The main improvements expected will be in mortality and morbidity in the long term, with an expected reduction in the social and economic costs of smoking. In this regard the effects of reduction in exposure to ETS can be surmised from the publication "Lifting the Smokescreen" [11]. These are of course estimates and it is important that this opportunity to verify the predictions by careful research is taken.

Experiences from countries that have introduced the ban after Ireland (Italy, Norway and Sweden) are similar to those in Ireland. Evidence from Scotland and Northern Ireland will soon be added to this database and should provide confidence in the estimates and lead to strengthening of the call for the introduction of such bans all over Europe.



**Figure 3**

FVC values of Dublin bar staff before (orange) and after (blue) the ban.

**Figure 4**

Pub activity before (orange) and after (blue) the workplace smoking ban.



**Suggested further reading**

*Curbing the Epidemic: Governments and the Economics of Tobacco Control.* Washington, The World Bank, 1999.

*This important report outlines effective policy interventions to reduce smoking. It provides an evidence-based review of policies to reduce demand for cigarettes, including taxation, the provision of information about the health consequences of smoking, comprehensive bans on advertising and promotion, and regulatory changes.*

*The ASPECT Consortium. Tobacco or Health in the European Union Past, Present and Future.*

Luxembourg, Office for Official Publications of the European Communities, 2004.

*This publication was financed and prepared for use by the European Commission. Extensive consultation and peer review was undertaken in its production. It covers the main tobacco control issues in the EU comprehensively and makes recommendations for appropriate interventions.*

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## Conclusions

The success of workplace bans on smoking everywhere they have been introduced is a clear invitation for their extension to all EU countries. The elements for progress are clear. What is needed is commitment and effort from healthcare professionals and politicians to which the general

public will respond. We hope that our efforts in this regard and the limited results of our observations will inspire a more comprehensive and concerted effort not only to introduce further restrictions on smoking areas but also a more comprehensive programme to measure and document the benefits to society in health as well as economic activity and indeed in the quality of life.

## Acknowledgements

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