

PostScript

LETTERS

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Are smoke-free policies good for business?

Studies of smoke-free policies in the hospitality trade using objective evidence have generally found no or a positive economic impact¹. Most studies are from North America and Australia. Published European studies are limited to a small study with a four month follow up period in which no adverse economic effects were demonstrated (six pubs) and popularity with customers was high (10 pubs).² However, UK proprietors from restaurants, pubs, and other hospitality trade businesses overwhelmingly predict negative economic effects.³⁻⁵

In a recent UK national survey, 88% of respondents agreed that smoking should be restricted in restaurants and 53% in pubs.⁶ Despite the existence of a Public Places Charter⁷ promoting smoke-free policies, progress in the UK has been slow. In a Scottish survey in 2000 over half of hotels, restaurants, and cafes, and 85% of pubs allowed smoking everywhere.⁵ We set out to assess if UK proprietors' negative perceptions were supported by the experience of businesses providing smoke-free facilities in the north of England.

In 2000-2001, pre-piloted questionnaires were sent to all 632 establishments from the hospitality trade included in the current Roy

Castle Good Air Award directory for Yorkshire and a smoke-free guide for Sunderland. After a mail-out and reminder, 389 (61%) owners and proprietors responded; 60 (45%) from pubs and bars, 195 (61%) from cafes or restaurants, 121 (75%) from hotels and guest houses, and 13 others.

Over half (57%) the businesses were totally smoke-free. A quarter provided one or more separate smoke-free rooms, 13% had smoke-free areas within larger rooms, and 5% had a combination of smoke-free rooms and areas. Pubs and bars generally provided smoke-free rooms (59%), or smoke-free areas (32%), often in eating or "family" areas.

A large majority (82%) reported no problems with their smoke-free policy. Of 64 respondents (18%) reporting problems, all but one described minor issues such as having to remind customers not to smoke or the occasional smoker complaining. The proportion reporting no problems was similar at pubs and bars (85%), at totally smoke-free establishments (79%), and among proprietors who thought over half their customers were smokers (85%).

Most respondents thought their no-smoking policies were "very" (55%) or "mostly" (32%) popular with customers. The remaining 13% thought the policy was neither popular nor unpopular, except for one respondent from a cafe who thought the policy was very unpopular. Policies were judged very or mostly popular at 81% of pubs and at 67% of establishments where over half of the customers were thought to smoke. When categorised by type of smoking policy, popularity was highest at totally smoke-free businesses, with 65% judged "very" popular, and 91% "very" or "mostly" popular.

The estimated effect of no-smoking policies on trade is shown in table 1. Most respondents reported an increase in trade, and only 7% a decrease as a result of the policy.

Nearly all (95%) respondents would recommend no-smoking policies to similar businesses, including respondents from 93% of pubs and bars and 93% of establishments where over half the customers smoked.

This survey provides strong evidence that no-smoking policies in the hospitality trade are popular with customers, and are much more likely to increase rather than decrease trade. Although the results from pubs and bars should be treated with caution because of the poorer response rate, the findings were just as strongly supportive of smoke-free policies as for other businesses. In the Scottish survey, 57% of food and entertainment sector businesses thought imposing smoking restrictions

would harm trade, and only 4% thought it would improve as a result.³ Our survey suggests that this belief is false. Correcting this mistaken perception should be a key objective of tobacco control advocates in the UK and other settings with slow progress in achieving smoke-free facilities in the hospitality trade.

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Intervention effects on youth tobacco use in the community intervention trial (COMMIT)

The Community Intervention Trial for Smoking Cessation (COMMIT) was an intervention trial funded by the National Cancer Institute to evaluate the effects of a multi-component, community based smoking control intervention on cessation in adult smokers.^{1,2} The primary (adult) outcomes of this trial have been

Table 1 Effect on trade of no-smoking policies by business type

Effect on trade	Pub/bar (%)	Café/ Restaurant (%)	Hotel/ B&B (%)	Other (%)	All (%)
Increased a lot	8 (14)	41 (22)	31 (26)	3 (38)	83 (22)
Increased a little	25 (44)	70 (37)	26 (22)	1 (13)	122 (33)
Neutral	20 (35)	59 (31)	43(36)	2 (25)	124 (33)
Decreased a little	2 (4)	11 (6)	8 (7)	0 (0)	21 (6)
Decreased a lot	0 (0)	1 (1)	1 (1)	0 (0)	2 (1)
Not known	2 (4)	9 (5)	10 (8)	2 (25)	23 (6)
Total	57	191	119	9	375

B&B, bed and breakfast.

Table 1 Percentage students by smoking status condition totals

	Current smoker*	Ex-smoker	Never smoker/intender	Never smoker/non-intender
Treatment: time 1	18.6	18.1	13.6	55.2
Treatment: time 2	21.3	18.8	15.8	44.0
Difference: T1 v T2	+2.7	+0.7	+2.2	-11.2
Comparison: time 1	19.6	18.2	13.7	48.5
Comparison: time 2	20.6	18.9	14.7	45.7
Difference: C1 v C2	+1.0	+0.7	+1.0	-2.8
Difference: C1 v T1	+1.0	+0.1	+0.1	-6.7
Difference: C2 v T2	-0.7	+0.1	-1.1	+1.7

No significant differences.

published elsewhere.^{3,4} In this letter we test the hypothesis that a comprehensive, community based intervention aimed at adult smokers would have an ancillary impact on the prevalence of youth smoking.

The COMMIT intervention⁵ included youth oriented activities directed toward four principle areas: school based education programmes, smoking policies in schools, legislative activities related to youth smoking, and participation by students and teachers in other COMMIT activities. The evaluation involved a two group, pre-test/post-test, quasi-experimental design with community as the unit of assignment and ninth grade classroom (ages 14–15 years) as the unit of assessment. Overall classroom participation rates were 90% (8235) at time 1 and 86% (8945) at time 2.

Table 1 shows percentages and change scores (increases or decreases) in mean per cents comparing time 1 to time 2 for each study condition. None of these differences were significant.

Rank correlations were calculated contrasting pair wise differences in adolescent seven day smoking prevalence with pair wise (that is, same pair) differences in adult cohort quit rates from the 1993 COMMIT Endpoint survey.⁶ These adult rate differences for each community pair were correlated with youth smoking differences in the same community pair using current weekly smoking rates from the 1992 Youth Survey. The correlation was 0.2 ($p < 0.001$), indicating that higher quit rates are associated with higher youth smoking.

The data reported here do not support the hypothesis that the adult focused COMMIT intervention was efficacious in reducing the prevalence of regular youth smoking. Among ninth graders living in treatment communities as well as among their counterparts living in comparison communities, the general trend was toward little or no difference over the time interval assessed (1990 to 1992)—a

levelling off in tobacco use rates that is consistent with national trends reported in other surveys conducted during this time period.

It is important to underscore that the COMMIT approach was without question and by design an adult focused intervention, and the design of the study was not set up to evaluate youth smoking changes. Other concerns that are relevant to the interpretation of these results include: implementation fidelity; the possibility that these activities may have been delivered inconsistently, or, at least, more effectively in some communities than in others; the age group selected for the evaluation (it is possible that the intervention had a greater effect on adolescents who were either older or younger than the ninth graders selected for our sample); and the time frame for the evaluation (that is, it is possible that the interim between 1990 and 1992 was not long enough for an intervention effect to have been demonstrated, especially given secular trends during that period).

It appears that the COMMIT intervention, which did target adult smokers, was not a cause of change in adolescent smoking behaviour. Changes in adolescent smoking rates are likely to come from other sources, such as exposure to tobacco product marketing, and broad based policies and programmes intended to discourage smoking such as cigarette taxes, limits on public smoking behaviour, and community based anti-tobacco education, and mass media messages about smoking. Targeting these influences certainly forms part of the national tobacco use reduction agenda for youth.^{7–10}

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