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**Submission to the Legislative Council
Bills Committee on Smoking (Public Health) (Amendment) Bill 2005**

*Comments by British-American Tobacco Co. (HK) Ltd. on
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Overview

Throughout the discussion on the Smoking (Public Health) (Amendment) Bill 2005, the Government and the Legislative Council Bills Committee both expressed concern on workers and non-smokers' unintended exposure to environmental tobacco smoke ("ETS"). In response, British-American Tobacco Company (Hong Kong) Limited ("BATHK") worked with the entertainment industry to establish showcase projects to demonstrate that ventilation could effectively reduce unintended ETS exposure and serve as an alternative to a blanket smoking ban. In one of these showcase projects, an independently-ventilated smoking room set up in a bar has been proven effective in preventing secondhand smoke drift to other areas of the venue while also creating a comfortable environment for smokers inside the room.

It has come to our attention that during a Bills Committee meeting on 23 May 2006, the Tobacco Control Research and Policy Unit ("tcrpu") of the University of Hong Kong has submitted a report which concluded our smoking room project showed such solution as unworkable and unsafe. This further submission seeks to respond to the report from tcrpu.

1. The Efficiency of the Smoking Room in Preventing Leakage of ETS

The measurements conducted in the smoking room and surrounding areas by an independent laboratory recommended by the Environmental Protection Department clearly demonstrate that the system in use prevents any leakage of smoke to the surrounding areas, a fact that the tcrpu report chose to ignore or misconstrue.

The tcrpu report misinterpreted the reason for the background level of respirable suspended particulates ("RSP") of $500\mu\text{g}/\text{m}^3$ in the dance floor as being caused by tobacco smoke when in fact it was caused by the poor outdoor air quality in Hong Kong on the test day. Background measurements, with no smoking activity, were taken outdoors, on the indoor dance floor and in the indoor smoking room. The smoking room was the location that showed the lowest level as a result of the filtration system used to filter the outdoor air. The background levels of RSP on the dance floor correlated strongly with the levels of RSP outdoors at all time. No increase in RSP in the



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dance floor was detected during any time when smoking was occurring in the smoking room, demonstrating that there was no leakage of smoke outside of the smoking room.

The smoking room has a totally independent ventilation system from the rest of the venue and no leakage or contamination was detected at any time during the tests.

2. Exposure to ETS

The tcrpu report somewhat surprisingly mixed up a very basic concept of air quality standard setting. Different levels of permitted exposure are used depending upon the length of exposure. The level permitted for one hour exposure is typically much greater than that for an 8-hour exposure period, which in turn is much higher than that for a 24-hour exposure period.

The World Health Organization ("WHO") guideline of $50\mu\text{g}/\text{m}^3$ for fine particles noted in the tcrpu report is for 24 hours average exposure and not for short periods of time. It is a useful standard for outdoor air measurements, where peaks in pollution during rush hour for example are averaged over a whole day and night. It is obviously the wrong standard to use to consider shorter time periods. Incidentally, the WHO guideline has not yet been adopted by any leading country nor any regulatory environmental agency.

A concern presented in the report about smokers being exposed to ETS in the smoking room is overestimated since any exposure would occur for very short periods of time. Smokers stay in the smoking room for short period of times of typically 15 minutes.

The indoor air quality standards adopted by leading countries in the region such as Singapore, Malaysia and Korea is $150\mu\text{g}/\text{m}^3$ of RSP averaged for 8 hours of exposure.

The tests clearly demonstrate that the ventilation creates a comfortable environment to smokers in spite of the concentration of smokers in the room.

The number of air changes in the smoking room is 50 per hour and the indoor air is kept in movement to guarantee continuous replacement by fresh air and efficient filtration. The air quality in the smoking room after smoking has ceased for one hour is better than the outdoor air according to the tests results on carbon dioxide (" CO_2 "), carbon monoxide (" CO ") and RSP.

There is no such near-universal recommended level for PM_{10} or $\text{PM}_{2.5}$ and this is an area for continuing study. There are limits established by different organisations which vary from $20\mu\text{g}/\text{m}^3$ (WHO for 1-year exposure) to $5,000\mu\text{g}/\text{m}^3$ (OSHA for 8-hour exposure). For CO_2 and CO the clear



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consensus among the agencies is typically around 1,000ppm and 10ppm respectively and is considered good markers for effective ventilation.

3. Risk of Exposure to ETS

We were surprised to see the authors of the tcrcu report called the International Agency for Research on Cancer ("IARC") study on ETS and lung cancer "flawed" as we do not think the WHO would agree with such assertion. The study was specifically designed to try and reduce some of the methodological difficulties in measuring very small increases in risk. It is a much larger study than virtually all others and was designed specifically by IARC to be better than studies that were published earlier. It reported relative risks of 1.16 for living with a smoker, 1.17 for working with a smoker and 1.14 for those who both lived and worked with a smoker. None of these were statistically significant. It also found no increase in risk for exposure in leisure settings.

The IARC study was consistent with many of the other, often smaller and less well-designed studies on ETS and lung cancer in that it found that if there were to be an increase in risk it is small and hard to measure.

Small increases in relative risk are sometimes reported in percentage terms. A relative risk of 1.2, for example is often popularised as a 20% increase in risk, giving an impression that if 100 people were exposed to the risk 20 of them would contract the disease. This is highly misleading. A 20% increase in a number which is small produces a number which is still small.

To put the matter simply, a relative risk of 1.2 for a disease for which the incidence is 10 per 100,000 per year in a non-exposed population implies that the probability is 12 per 100,000 in an exposed population. Thus among 100,000 individuals, only 2 cases would probably occur each year. Nevertheless, in the context of high degree of variability in data arising from the ETS studies, the majority being statistically insignificant, such relative risk figures cannot necessarily be credited with any scientifically accepted level of certainty.



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Conclusion

To conclude, BATHK maintained our stance that a total smoking ban is neither necessary nor desirable. There are other alternatives to address secondhand smoke that are more balanced and reasonable such as ventilated smoking room.

We urge members of the Bills Committee to seriously consider the fact and evidence that we presented in this document.

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