Do Smoking Bans Reduce Heart Attacks?

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Introduction

Recent newspaper articles have heralded studies concluding that smoking bans lead to dramatic decreases in the annual incidence of acute myocardial infarction (AMI). Coupled with studies concluding that bans never harm businesses and that environmental tobacco smoke (ETS) significantly endangers health of nonsmokers, studies claiming AMI reduction have provided governments with additional evidence to support bans in the name of public health.

Some communities have expanded bans from workplaces to include parks, beaches, and other open areas, based on this growing body of evidence. This commentary argues that, as with distorted claims regarding economic harm and ETS, recent studies concluding that bans lower AMI incidence misrepresent public health benefits of bans.

Studies Reporting Dramatic AMI Reductions

Conclusions drawn in the recent Institute of Medicine (IOM) report commissioned by the Centers for Disease Control and Prevention (CDC) are often used as the rationale for expanding smoking ban coverage. The IOM report examined 11 studies and concluded that heart attack reduction caused by bans ranged from 6% to 47%, based on health outcomes measured by admission records of local hospitals. CDC argues that effects are explained by reduced ETS exposure among nonsmokers and reduced smoking, with the former making the larger contribution. Studies that link ETS exposure to increased rates of cardiovascular disease, respiratory illness, and lung cancer are cited to rationalize claims regarding economic harm and ETS, recent studies concluding that bans dramatically improve health outcomes of nonsmokers.

Most Studies Combine Smokers and Nonsmokers

Only two of 11 studies included in the IOM study—Monroe County, Indiana, and Scotland—examine AMI incidence in nonsmokers. This oversight apparently raised few concerns for writers of the IOM study, who also admitted that none of their studies had information on duration or pattern of ETS exposure, and thus also had no information on whether ETS exposure changed as a result of the ban. No information was collected on whether acute coronary events were triggered by acute and sporadic or by chronic exposure to ETS, or even whether bans induced some smokers to quit or reduce smoking. The stridency of the IOM’s conclusions is puzzling in light of the absence of information on previous ETS exposure and the paucity of information on nonsmokers. The IOM study appears to rationalize conclusions by the “precautionary principle”: resolve any doubt in the direction of measures that claim to protect public health.

Studies Ignore Other Health Factors

The IOM admits that, because no direct evidence shows that brief exposure to ETS can initiate heart attacks in nonsmokers, it relied on indirect evidence associated with particular matter from other pollution sources to validate their assessment on health effects from ETS. Selection bias is again apparent: The IOM study ignores the hypothesis that bans promote public health. This is clearly an inappropriate research methodology because of the “file drawer” or “publication” biases that arise when researchers selectively choose data or studies to publish, cite, or ignore, based on their personal judgments. “Cherry-picking” could explain how published studies “find” that bans reduce the incidence of AMI despite zero change in total AMI incidence.

Studies Contain No Direct Evidence of ETS Risk

IOM admits that, because no direct evidence shows that brief exposure to ETS can initiate heart attacks in nonsmokers, it relied on indirect evidence associated with particulate matter from other pollution sources to validate their assessment on health effects from ETS. Selection bias is again apparent: The IOM report ignores perhaps the most important study of the effects of ETS on nonsmokers, the large cohort study that followed, over a 40-year period from 1959 to 1998, the health histories of more than 35,000 never-smoking Californians who were married to smokers. This study found no causal link between ETS exposure and tobacco-related mortality, and included spouses who smoked 80 or more cigarettes per day. How can bans result in dramatic reductions in AMI incidence in nonsmokers when so far it has not been possible to show a causal link between ETS and poorer health in nonsmokers?

Studies Ignore Other Health Factors

Only one study, which is ignored in the IOM report, perhaps because it reported no effect from bans, has controlled for confounding factors that may affect health outcomes, such as smoking prevalence and improved prevention and treatment of cardiovascular disease.
Implausible Conclusions

Studies attribute AMI reductions of up to 47% to bans, even though CDC itself claims only a 25%-30% increased risk of developing heart disease from prolonged ETS exposure.28 Certainly ETS exposure is unlikely to be beneficial, but CDC estimates are not based on evidence from intermittent exposure associated with public places.

Although authors of the IOM study expressed confidence in the existence of an association between chronic ETS exposure and AMI incidence, they also admitted there is no convincing evidence of the magnitude of the association. It takes quite a leap of inference to believe that smoking bans would offer such immediate and dramatic health benefits of up to 47% fewer AMI admissions if risks are truly associated with prolonged ETS exposure, and there is no knowledge of the potential magnitude of effects on AMI incidence from reduced exposure.

Moreover, most studies examined bans implemented for less than 1 year, with the longest examining 3 years.9 Only two out of the 11 studies examined bans lasting 2 years or longer. For example, the Helena, Montana, study,17 which found a 40% reduction in AMI, based its conclusion on only 6 months of observation, during which AMI admissions decreased by 16 (from 40 to 24)—a very small sample size. During the baseline period, this hospital apparently admitted, on average, fewer than seven patients a month with AMI.

Discussion

Publicly led research on public health effects of smoking bans has overstated benefits by overreaching on conclusions, excluding studies that contradict predetermined conclusions, and relying on studies subject to biases outlined above. This pattern is lamentable for a number of reasons. One is that efforts claiming to improve public health appear to be driven more by social agendas than by science.24,27 The IOM released, and various media outlets promulgated overstated claims on the public benefits of smoking bans, apparently without even considering whether they met the simplest tests of believability.

Another problem is that overstating health benefits from bans may induce some individuals to alter behavior in ways that raise risk to themselves and others. For instance, research shows that drunk driving rises following bans in bars presumably because drinkers drive longer distances in search of places where they may drink and smoke.28 Research also shows that, if bans lead smokers to smoke cigarettes more intensely in anticipation of periods where they are subject to bans, their health suffers.29 Moreover, claims that bans significantly lower AMI incidence may lead some individuals to be less likely to make lifestyle changes that could lower their personal risk.

Conclusions

Claims that smoking bans in public places have led to dramatic reductions in AMI incidence are not supported by the evidence. Scientifically invalid claims, though promulgated in the name of protecting public health, have adverse consequences.

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REFERENCES