The Effects of Environmental Tobacco Smoke on the Insurance Industry

An Honors Thesis (ID 499)

by

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I would also like to thank Ange Cooksey for her contagious enthusiasm. She helped me stay motivated and finish the Honors program. She also pointed me in the right direction concerning my major.
Section I

Introduction

It is a well-known fact that smoking causes cancer. The question that remains unanswered is whether a smoker affects those who inhale his secondhand smoke. Although one might argue that the air inhaled by a passive smoker (sidestream smoke), is dilute compared to that inhaled by a smoker (mainstream smoke), it is similar chemically [17, p. 1.2]. It contains many of the same carcinogenic and toxic agents, for instance, nicotine and cotinine. Section II of this paper will address the hazards associated with environmental tobacco smoke (ETS).

The insurance industry adjusted its mortality tables to reflect the effects of smoking. Section III will address the action an insurance company can take to reduce ETS in the workplaces of its clients. The effects of ETS is a hot, current topic. There are many articles written on legal cases pending. But because this is such a new issue, there is not an enormous amount of documentation proving financial loss. For this reason, many of the ideas in Section III are just opinions of the author of this paper. The most likely candidate for legal action would be an insurance company.

I chose this topic because as a nonsmoker, I am fed up with smokers' empty arguments. Smokers often adopt the attitude that it is their right to damage their own health. They claim that it shouldn't matter to anyone else since the only harm is to themselves. They use such civil rights statements as these to back up their arguments, but now there is proof they are harming others. Here I quote from an editorial in The New York Times, "[s]moking does involve the violation of rights, and it is the smokers who are the violators. . . . No one would grant his neighbor the right to blow tiny amounts
of asbestos into a room or sprinkle traces of pesticide onto food. By the same logic, smokers have no right to spew even more noxious clouds into the air around them" [14].

Not only is ETS harmful, it is the innocent bystanders that are the ones affected. Unfortunately, I think the ones who suffer the most are the children. They do not have a choice whether or not their parents smoke. They cannot get up and leave their home, like I can leave a restaurant. I hope that more parents soon realize that they are subjecting their children to these deadly carcinogens. I think it is a pity that parents would knowingly subject their children to a hazard such as ETS.
Section II
The Hazards of ETS

A. Background

The United States Environmental Protection Agency's (EPA) report on passive smoking, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, will be used to show that passive smoking is hazardous. Because of the extensive amount of data published in this report, I have chosen to concentrate on three sections: 1. Summary and Conclusions, 6. Population Risk of Lung Cancer from Passive Smoking, and 8. Assessment of Increased Risk for Respiratory Illnesses in Children from Environmental Tobacco Smoke. This report will be the basis for all ideas presented and quotes stated in Section II unless otherwise indicated.

ETS is best defined by the Surgeon General. In *The Health Consequences of Involuntary Smoking*, ETS is the "combination of smoke emitted from a burning tobacco product between puffs (sidestream smoke) and the smoke exhaled by the smoker" [16, p. ix]. In this 1986 report, the Surgeon General conducted research into the effects of inhaling such secondhand smoke. They concluded that ETS can cause lung cancer in adult nonsmokers and that children of parents who smoke have an "increased frequency of respiratory symptoms and acute lower respiratory tract infections" [16, p. 7].

The most recent study, 1992, uses a database double the size used in 1986. The information gathered shows that there are chemical similarities between mainstream smoke and ETS. From these observations, secondhand smoke is classified as a Class A carcinogen which puts it in the same category with asbestos and benzene [4, p. 76].
The effects were measured on children of smokers and, for adults, on spouses of smokers. All conclusions drawn were made where there was an association with ETS that could not be explained by bias or chance. Because all data were collected from human participants, no inferences needed to be drawn and the degree of confidence was high. In addition to this, the large number of studies and the consistent results increased the level of credibility in the estimates. Altogether, there were 30 studies taken from eight different countries. Some studies were carried out by testing air samples in both the home and the workplace. Measurements were then taken to determine the level of nicotine (See Appendix B). These numbers indicate a definite increase in the level of nicotine in the air in a household with smokers as opposed to one with nonsmokers. In other studies, cotinine concentrations in urinary bioassays were determined. Cummings et al. (1990), with data on 663 nonsmokers, found that over 90% had detectable levels of cotinine [17, p. 6.1]. No matter what the level of cotinine measured, this figure indicates that a large majority of nonsmokers come into contact with ETS. Therefore, ETS exposure is a health problem of national concern.

B. Primary Findings

1. ETS and Lung Cancer

Lung cancer is the primary health hazard associated with smoking. It is natural then to wonder how ETS affects one's risk for lung cancer. As seen in Appendix D, there are approximately 3,000 deaths per year caused by lung cancer that is attributable to ETS. This table is a combination of never-smokers and former smokers. Former smokers were included in the study because as is seen in Appendix C after years of quitting the risk for lung cancer drops dramatically.
There are two methods for estimating the risk of lung cancer from exposure to ETS. One approach uses a dose-response relationship based on cigarette equivalents. It assumes the dose-response curve for active smoking applies to passive smoking. The curve is lowered and converted to an equivalent level for passive smoking [17, p. 6.5].

The other approach analyzes epidemiologic evidence from case-control and cohort studies. This is the approach followed by the EPA report. The EPA chose this method because it uses the vast amounts of human data available and because no assumptions need to be made about passive smoking's relation to active smoking [17, p. 6.8].

The EPA's report differs in many ways from other epidemiologic studies. A few of the important ones follow:

- The EPA estimated the risk of lung cancer solely on data collected in the United States. Whereas, prior reports combined data from other countries to arrive at an estimate. The exclusion of the extraneous data by the EPA is for the following reasons: differences in lifestyles, exposures to other air pollutants, and differences in the history of risk for lung cancer.

- The EPA uses the estimates for females and applies them to males to arrive at a total estimate for the population. Prior reports attempted to use data on males which is often not large enough and the misclassification error is too large.

- The misclassification error mentioned above is another difference. The EPA adjusts for this error prior to calculations. Whereas, other reports adjust the results by lowering the estimates[17, p. 6.5].

It is quite interesting to note that ETS causes "30 times as many lung cancer deaths as all regulated air pollutants combined" [15, p.1]
2. **ETS and Noncancer Respiratory Diseases**

ETS can also cause nonrespiratory diseases just as smoking does. In children, exposure to ETS causes an increased risk of lower respiratory infections (LRIs). These include pneumonia, bronchitis and bronchiolitis. The exposure can be either during pregnancy, maternal smoking, or postnatal due to smoking of either parent. The EPA says,

"This report estimates that exposure to ETS contributes 150,000 to 300,000 LRIs annually in infants and children less than 18 months of age, resulting in 7,500 to 15,000 hospitalizations. The confidence in the estimates of LRIs is high. Increased risks for LRIs continue, but are lower in magnitude for children until about age 3; however, no estimates are derived for children over 18 months" [17, p. 1.5].

ETS is also the cause for an estimated 8,000 to 26,000 new cases of asthma in children who were previously asymptomatic and whose mothers smoke at least 10 cigarettes per day. ETS also causes increases in asthma attacks in children who already have asthma. The EPA estimates the number of children this affects is approximately 400,000 to 1,000,000. Of half of these, ETS is a major aggravating factor [17, p.1.5].

The effects on non-smoking adults are subtle. Nonetheless, there are certain symptoms that occur due to passive smoking in adults. These include phlegm production, coughing, chest discomfort, and reduced lung function [17, p. 1.6].

Sudden Infant Death Syndrome (SIDS) is another child related tragedy associated with smoking. An infant is three times more likely to die from SIDS if his/her mother smoked during pregnancy [15, p. 2]. According to the definition of ETS given above, maternal smoking is not considered an
exposure to ETS. For this reason, the EPA did not attempt to tackle the impossibility of separating exposure to maternal smoke and exposure to ETS after birth. SIDS is included here because whether or not it is ETS or maternal smoke that causes SIDS, the infant is involuntarily exposed to someone else's tobacco smoke.
Section III
Insurance Concerns

A. Relevant Cases

The EPA report summarized in the preceding section was published over a year ago. This section will first detail cases where ETS has been the prime motive in legal action. Then suggestions will be made about the ways the insurance industry can handle this new problem.

Once the public was informed about the effects of ETS, they started taking action in the court system. John Banzhaf, a George Washington law professor and the executive director of Action on Smoking and Health, is a prime example. He is responsible for setting in motion the disappearance of cigarette ads from television and the ban of smoking on domestic airlines. Next on his agenda are restaurants. He has begun this process by notifying fast-food chains of the possibility of a lawsuit if a child should have an asthma attack in their restaurant [4, p. 76].

Banzhaf and others warn restaurants that this type of litigation will be supported by the Americans with Disabilities Act (ADA). The ADA requires restaurants to remove physical barriers to the handicapped. With asthma attacks, it is easy to pinpoint the aggravating cause. "Cigarette smoke can trigger an asthma attack" [4, p.84], says attorney David Steed. He is defending Lynn Hayes and Margaret Ann Keathley in a suit for their right to eat in a restaurant that is free of smoke. Both women are asthmatics and unable to eat in a restaurant where they can be exposed to ETS. This includes restaurants that have non-smoking areas designated, unless they are separate rooms. Most restaurants do not completely ventilate the non-
smoking areas. This can best be shown by the cartoon used in Steve Brooks' article, "The Heat Is On" reproduced below [4, p. 76].

![Cartoon](image)

The restaurants most vulnerable to litigation from asthma sufferers are the fast-food chains. This is evident in a suit filed against Burger King, McDonald's, and Wendy's. The plaintiffs claim that allowing smoking in these restaurants denies access to people with asthma and other respiratory problems. These plaintiffs are three children with asthma. One parent tells Mr. Hansen that if her two children go to a restaurant where smoke is prevalent, they have to hurry home, wash their clothes, and take showers. Her children beg to go to these restaurants. Matthew Staron who is ten years old is one of the other plaintiffs. He says that when he is exposed to ETS in a restaurant he gets severely congested. These incidents cause him to miss school. One parent says that her children "recognized the golden arches before they could even talk" [8]. Situations like these are difficult for parents to explain to their children. Why shouldn't they be able to enjoy McDonald's like all the other children?

Their suit also references the ADA as the backbone of their argument. The ADA "defines the disabled as people with physical impairments that substantially affect one or more major life functions, including breathing" [8]. Asthma attacks would be considered a disability according to this
definition. And as stated above, cigarette smoke can be a cause of an asthma attack.

In a precedent setting 1990 California case, Avatar Uhbi was awarded $10,000 plus $85,000 for medical expenses. Uhbi, a nonsmoker, suffered a heart attack after working five years in a smoke-filled nightclub. There was no family history of heart disease [4, p.84]. This decision sparked other victims of ETS to take action.

Rosita Garcia filed suit against Mariott Corporation at the San Francisco International Airport where she was a waitress for eleven years. She is a 37-year-old nonsmoker who is battling terminal lung cancer [4, p.84].

In 1990, a non-smoking employee received workers' compensation for a heart attack he blamed on ETS from the restaurant where he worked. Several other cases are pending and five have received workers' compensation due to problems they have encountered due to their exposure to ETS [4, p.76].

Veronica Bland won £15,000 ($22,000) in an out-of-court settlement filed against the Stockport Metropolitan Borough Council in England. She worked there fourteen years with seven colleagues who smoke heavily. She developed chronic bronchitis which was determined to be the result of her exposure to ETS [2].

The above cases are just a small sampling of the numerous suits from which to choose. There are many other cases decided and pending, but I chose these to show the wide range of people ETS exposure affects. The EPA report's findings will affect large businesses, small businesses, employees, employers, adults, parents, and children.
B. Solution

The restrictions put on one's rights to smoke are a controversial current issue, but if one just looks at the financial loss caused by litigation based on ETS exposure, the problem becomes more objective. This is supported by Jeffrey C. Kauffman who says, "Workplace smoking can be dangerous to your company's financial health. On-the-job smoking may increase legal liability, as well as absenteeism rates and healthcare premiums" [9, p. 22]. There have been no data published yet on the actual effects of ETS on the financial aspects of a business; therefore, the following comments support just one suggestion for avoiding this extra expense.

The first concern to be addressed is whether or not there will be a flood of cases that warrants attention to be drawn to this issue. Anti-smoking activists believe that the publishing of the EPA's report will be the "start of a new and promising litigation trend" [8]. Whether it is viewed as positive or negative, the trend seems to be continuing and will cost money. In Best's Review, Joseph F. Mangan, CPCU, says that "the defense costs borne by general liability and workers' compensation insurers will increase" [13, p.72].

The next step in the litigation process is to follow through to a decision. The biggest expense would then be the settlement. What is the likelihood of a judge deciding in the plaintiff's favor? Carol Browner, EPA administrator, says that the "scientific evidence is sufficient to warrant actions to protect non-smokers from involuntary exposure to secondhand smoke" [5]. Because ETS was classified as a Class A carcinogen, Glantz says, "If a restaurant had an open vat of benzene sitting out and people got sick, a jury wouldn't have a hard time determining the cause" [4, p.84]. With the support of the EPA report, the victims of ETS have a very sound case.
In a legal brief in *Small Business Reports*, attorney Jeffrey C. Kauffman lists the possible arguments that will be used by the plaintiffs. They are as follows:

- **Workers' compensation.** Nonsmokers may claim they're entitled to worker's comp benefits because they became ill due to a smoke-filled workplace. Many states have already recognized that this is a viable claim.

- **Unemployment compensation.** Nonsmokers may claim they were forced to quit because of allergic reactions to smoke and apply for unemployment benefits. These claims have been upheld in various states.

- **Failure to accommodate disabled employees.** Nonsmokers may claim that an allergy to tobacco smoke constitutes a disability that should be protected under state and federal handicap protection laws including the Americans with Disabilities Act.

- **Failure to provide a 'safe and healthful' workplace.** The courts have recognized an employer's general responsibility to provide a safe workplace. In theory an employee who develops lung cancer may be able to sue an employer for punitive damages if harmed by a failure to provide a safe workplace" [9, pp. 22-23].

As Kauffman has stated above, many of the states have already upheld the EPA's findings and decided in favor of the nonsmoker.

Now that it has been shown that nonsmokers exposed to ETS have sufficient support in the courts and that this will cause a financial strain on the company who must pay the settlement, what can be done to alleviate this burden? This paper makes the assumption that insurance companies will be the entity that will be responsible for such payouts.
Because of the difficulty of determining ETS rates to charge similar to the rates charged to smokers, this paper suggests premium discounts. This method is followed by King County Medical Blue Shield, Washington state's largest health insurer. Discounts are given on premiums charged for group medical plans for companies with a smoke-free workplace. Discounts are also given to companies who offer a stop-smoking program for its employees. Dr. Robert Hoffman, medical director for King County Medical Blue Shield, says, "Better life styles do lead to lower health costs" [1, p. 68].

The idea behind this sort of discount is that by eliminating the cause of the problem, smoking, health costs will go down. If a company makes the effort to help its employees to stop smoking, it would reduce the amount of ETS the other employees are exposed to. Another possibility is banning smoking from the workplace, including restaurants referred to so often above. This would definitely take care of the possibilities of workers' comp claims, unemployment compensation, ADA claims, and failure to provide a safe and healthy work environment. The above are ways a company would qualify for the discount.

The amount of the discount is a more complex issue. King County Medical Blue Shield did not detail its method of discount. The actuaries of the company would need to analyze the numbers in more detail to determine an adequate percentage deduction. For a while, this would have to be a more subjective procedure than in the future when there will be more data to follow.

As stated before, this is just one option to handle the complex problem of ETS. The point made by King County Medical Blue Shield is that it is a definite problem that needs to be handled by insurance companies in a way that encourages healthy lifestyles.
Section IV
Conclusion

Whether it is called secondhand smoke, passive smoke, or environmental tobacco smoke, it is dangerous. The EPA has shown that ETS does cause approximately 3,000 lung cancer deaths per year. The report also showed that this is a nationwide problem and cannot be ignored. The worst part of this problem is that it affects innocent people.

There have been cases decided that have set a precedent in favor of the victims of ETS. There are many cases pending that will show how these victims will be protected in the future. Many restaurants are taking a step in the right direction. For instance, Taco Bell and McDonald's in Muncie have posted no smoking signs in their restaurants.

Such smoking bans are one way to prevent litigation. Another is by encouraging employees to stop-smoking in order to cut down the ETS. Discounts on the premiums insurers charge a business is another incentive for employers to cut down the ETS in the workplace.
Section V
Works Cited


Appendix A. Statistical Formulae [7 D1-D2].

1. CELL FREQUENCIES: The observed outcome of a case-control study or a cohort study may be depicted in a 2x2 table, where a, b, c, and d are cell frequencies.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>a</td>
<td>b</td>
</tr>
<tr>
<td>No</td>
<td>c</td>
<td>d</td>
</tr>
</tbody>
</table>

ETS Exposed

2. CASE-CONTROL STUDIES: The true (but unknown) odds ratio is estimated by the observed odds ratio (OR),

\[ \text{OR} = \frac{ad}{bc} \]

A confidence interval on the (true) odds ratio may be calculated from the normal approximation to the distribution of \( \log(\text{OR}) \), the natural logarithm of OR (Woolf, 1955). The variance of \( \log(\text{OR}) \) is estimated by

\[ \text{Var}(\log(\text{OR})) = \frac{1}{a} + \frac{1}{b} + \frac{1}{c} + \frac{1}{d} \]

and the standard error by its square root,

\[ \text{SE}(\log(\text{OR})) = (\text{Var}(\log(\text{OR})))^{1/2} \]

Approximate 90% confidence limits are given by

\[ \log(\text{OR}) + 1.645 \times \text{SE}(\log(\text{OR})) \]
The value 1.645 is replaced by 1.96 for 95% confidence limits and, in
general, by $Z_{\alpha/2}$ for 100(1 - $\alpha$)% confidence limits. Significance level (p-
value) of a test for effect, i.e., $H_0$: (true) odds ratio = 1 against the alternative
$H_a$: (true) odds ratio > 1, is the area under the standard normal curve to the
right of the value of the test statistic, given by $\log(OR)/SE(\log(OR))$. If the
(true) odds ratios are assumed to be equal in k studies, then a pooled estimate
is calculated from

$$\log(OR(P)) = \sum w_i \log(OR)_i / \sum w_i$$

where the summations are on i, from 1 to k; OR(P) is the pooled estimate;
$\log(OR)_i$ is the logarithm of OR from the ith study; and
$w_i = (\text{Var}(\log(OR)_i))^{-1}$ is the weight of the ith study (Breslow and Day,
1980).

3. COHORT STUDIES: The true (but unknown) relative risk is
estimated by the observed relative risk (RR),

$$RR = \frac{a/(a+c)}{(b/(b+d))}.$$  

A confidence interval on the (true) relative risk may be calculated from the
normal approximation to the distribution of $\log(RR)$, using the analogue of
Woolf's method referred to above (Katz et al., 1978). The variance of
$\log(RR)$ is estimated by,

$$\text{Var}(\log(RR)) = \frac{c}{(a^2 + ac)} + \frac{d}{(b^2 + bd)}$$

and the standard error by its square root,

$$\text{SE}(\log(RR)) = (\text{Var}(\log(RR)))^{1/2}.$$  

The remaining calculations follow the description for case-control studies in
A. 2. with "odds ratio" and "OR" replaced by "relative risk" and "RR,"
respectively. The pooled estimate of relative risk from both case-control and
cohort studies is calculated by the same methodology for pooling estimates
from case-control studies or from cohort studies separately, i.e., the logarithm of each individual estimate is weighted inversely proportional to its estimated variance (Kleinbaum et al., 1982).
Appendix B.

Weekly average concentrations of each measure of exposure by parental smoking status in the cross-sectional study, Minnesota, 1989 [7, 3.36].

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>Non-smokers</th>
<th>Light smokers only</th>
<th>Father only</th>
<th>Mother only</th>
<th>Both parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of subjects</td>
<td>23</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Total cigarettes (no./week)</td>
<td>0.9</td>
<td>28.8</td>
<td>68.6</td>
<td>58.8</td>
<td>227.6</td>
</tr>
<tr>
<td>Activity room nicotine (m/m)</td>
<td>0.15</td>
<td>0.32</td>
<td>2.45</td>
<td>5.50</td>
<td>12.11</td>
</tr>
<tr>
<td>Bedroom nicotine (m/m)</td>
<td>---</td>
<td>0.30</td>
<td>1.21</td>
<td>2.66</td>
<td>5.32</td>
</tr>
</tbody>
</table>
Appendix C.

Relative risk of lung cancer in ex-smokers, by number of years quit, women, Cancer Prevention Study II (Garfinkel and Silverberg, 1991) [7, 4.14].

**Smoked 1-20 Cigarettes a Day**

<table>
<thead>
<tr>
<th>Years of Cessation</th>
<th>Never Smoked</th>
<th>1-2</th>
<th>3-5</th>
<th>6-10</th>
<th>11-15</th>
<th>16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=2</td>
<td>1.0</td>
<td>10.3</td>
<td>13.6</td>
<td>8.4</td>
<td>3.3</td>
<td>3.0</td>
</tr>
<tr>
<td>3-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.6</td>
</tr>
</tbody>
</table>

**Smoked 21 or More Cigarettes a Day**

<table>
<thead>
<tr>
<th>Years of Cessation</th>
<th>Never Smoked</th>
<th>1-2</th>
<th>3-5</th>
<th>6-10</th>
<th>11-15</th>
<th>16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=2</td>
<td>1.0</td>
<td>21.2</td>
<td>32.4</td>
<td>20.3</td>
<td>11.4</td>
<td>4.1</td>
</tr>
<tr>
<td>3-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.0</td>
</tr>
</tbody>
</table>
Appendix D.

Female and male lung cancer mortality estimates by attributable ETS sources for United States, 1985, using 11 U.S. studies (NS and FS\(^1\) who have quit 5+ years)\(^2\)

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>Sex</th>
<th>Exposed to spousal ETS</th>
<th>No. at risk (in millions)</th>
<th>Lung cancer mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Background ETS</td>
</tr>
<tr>
<td>NS F</td>
<td>No</td>
<td>12.92</td>
<td>410</td>
<td>410</td>
</tr>
<tr>
<td>NS F</td>
<td>Yes</td>
<td>19.38</td>
<td>620</td>
<td>470</td>
</tr>
<tr>
<td>NS M</td>
<td>No</td>
<td>9.93</td>
<td>320</td>
<td>320</td>
</tr>
<tr>
<td>NS M</td>
<td>Yes</td>
<td>3.13</td>
<td>100</td>
<td>80</td>
</tr>
<tr>
<td>FS F</td>
<td>No</td>
<td>2.0</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>FS F</td>
<td>Yes</td>
<td>6.7</td>
<td>210</td>
<td>160</td>
</tr>
<tr>
<td>FS M</td>
<td>No</td>
<td>8.8</td>
<td>280</td>
<td>280</td>
</tr>
<tr>
<td>FS M</td>
<td>Yes</td>
<td>6.2</td>
<td>200</td>
<td>150</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>69.06</td>
<td>2,200</td>
<td>860</td>
</tr>
</tbody>
</table>

\(^1\)NS = never-smokers; FS = former smokers who have quit 5+ years ago.

\(^2\)Percentage of total ETS-attributable lung cancer deaths (3,060) in parentheses.