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The *Health Bill*: Part 1 Smokefree premises, places and vehicles

Bill 69 2005-06

The *Health Bill* (Bill 69 of 2005-06) was presented on 27 October 2005. It is due for second reading on 29 November 2005

This paper informs debate on Part One of the Bill, which seeks to make provision for the prohibition of smoking in certain premises, places and vehicles.

The measures will take effect from the summer of 2007 and will apply to England and Wales.

Part 2-7 of the Health Bill make provisions relating to: health care associated infections; the management and use of controlled drugs; medicinal products and pharmacy premises; the NHS in England and Wales and recovery of NHS costs; the establishment of an Appointments Commission; and social care training functions. These are discussed in a Research Paper 05/80.

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Summary of main points

Part One of the Health Bill makes provision for certain smokefree premises, places and vehicles. The measures will extend to England and Wales. Parts 2-7 of the Bill are discussed in a separate Research Paper.

Although a duty of care is owed to employees and others under health and safety legislation, there are no laws that ban smoking outright in workplaces and public places in England and Wales. The Government believes that passive smoking represents a danger to public and workers' health. Efforts to bring in a voluntary ban in public workplaces, including bars and restaurants proved unsuccessful. Public opinion and scientific evidence of the negative health effects of smoking on individuals and those passively exposed to second-hand smoke have increased pressure on the Government to act to bring forward smokefree legislation.

Following the publication of the Public Health White Paper, *Choosing Health* in November 2004 the Government announced its intention to introduce a partial ban on smoking in public places in England, with smoking to be banned in all places serving food from 2008. A consultation on smokefree legislation was launched in June 2005.

Intense lobbying during the consultation phase and mounting evidence of public support for a total ban, at first appeared to persuade the Government that a partial ban would be unacceptable and unworkable, especially in the hospitality industry. However, compromise moves to introduce sealed 'smoking carriages' in licensed premises not serving food and to include private clubs under the ban were later ruled out. The Bill as published is based on the promises set out in the Labour Party's 2005 Manifesto.

The Bill allows for the designation of enclosed or substantially enclosed public smokefree premises, and other additional smokefree places. Provision is made for the exemption of certain premises, including licensed premises not serving food, and private membership clubs. Some of the provisions relating to licensed premises will be conditional, including restrictions on the types of food served or prepared; proprietors will be able to designate smoking areas. Designated business and public transport vehicles will also become smokefree. New duties to display no-smoking signs will be brought in, along with offences and defences that may apply. There will also be new offences of smoking in a smokefree place, punishable by fixed penalty fines, and failing to prevent smoking in smokefree places. Enforcement is likely to be by local authority officials. It will be an offence to obstruct designated officials in these duties. Much of the detail of the Bill will be covered by Regulations, which will be issued in draft for consultation. The measures will come into force in April 2007 and there will be three-year review period.

The measures have received a mixed response, given the enthusiasm for a total ban generated during the 2005 consultation exercise. Arguably, the proposals will allow many more employees to be covered by a workplace ban than at present. Some of those most affected, particularly the hospitality industry, may not. In essence, the arguments centre on the ethical and human rights of individuals to smoke and the need to protect the health and safety of others.

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I Smoking in public places and workplaces

A. Legislative overview

Currently, there is no law in force that bans smoking outright in public places or workplaces in England, Wales, Scotland or Northern Ireland.

Action in other countries to control tobacco use, including bans on smoking in public places, has lent weight to the campaign for a statutory ban in the UK. In New York, smoking has been banned in restaurants for over ten years and in bars since 2003.

Closer to home, anti-smoking campaigners cite the success of implementing a ban on smoking in workplaces in the Republic of Ireland, including pubs and bars, brought in since May 2004 by the *Public Health (Tobacco) (Amendment) Act 2004*.

The **Scottish Parliament**, which has the power to introduce a legislative ban on smoking, has decided that smoking should be banned in public places to protect people from the health risks of passive smoking. The *Smoking, Health and Social Care (Scotland) Act 2005* was approved by the Scottish Parliament on 30 June 2005. The Draft *Smoking Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005* were published for consultation on 10 March 2005.¹ An updated version has been produced in the light of the responses.² Subject to being laid before, and formally approved by, the Scottish Parliament the regulations implementing the legislation are expected to come into force on 26 March 2006.

The Smoke Free Areas Implementation Group will steer the work of those responsible for delivering and enforcing the ban. A public information website - www.smokefreescotland.com - explains the detail of the proposed introduction of smoke free public places.

Northern Ireland Health Minister Shaun Woodward announced that a comprehensive ban on smoking in workplaces and all enclosed public places, including pubs and bars, in the Northern Ireland would take place by the summer of 2007.³

As the Northern Ireland Assembly is currently suspended, legislation to introduce a smoking ban would be implemented by means of an Order in Council by a UK Minister, in this case the Minister for Health.⁴ Background information can be found in Library Note SNSC-03783 *Smoking in Public Places: Northern Ireland*.

¹ <http://www.scotland.gov.uk/consultations/health/shsrc-00.asp>

² [http://www.clearingtheairscotland.com/The%20Prohibition%20of%20Smoking%20in%20Certain%20Premises%20\(Scotland\)%20Regulations%202006.doc](http://www.clearingtheairscotland.com/The%20Prohibition%20of%20Smoking%20in%20Certain%20Premises%20(Scotland)%20Regulations%202006.doc)

³ HC Deb 18 October 2005 c51WS

⁴ Orders in Council are United Kingdom Statutory Instruments made by Her Majesty, by and with the advice of Her Privy Council and with the endorsement of the UK Parliament, in exercise of powers conferred by Schedule 1 of the Northern Ireland Act 1974 and s.85 of the Northern Ireland Act 1998. An Order in Council to ban smoking would be introduced by a Direct Rule Minister.

The **National Assembly for Wales** (NAW) does not have powers to bring forward primary legislation, but does have powers to bring forward secondary legislation, in the form of regulations, which can be amended.⁵ In England secondary legislation can only be approved or rejected, through the affirmative or negative procedure process, but not amended. A Private Members' Bill earlier this year sought to gain powers for the NAW to bring forward legislation to ban smoking in public places through regulations, but ran out of parliamentary time. [See Section II A below]

In England and Wales, efforts to date to protect workers have centred on pursuing voluntary action by working closely with industries and businesses most affected, particularly the hospitality trade, to develop a Public Places Charter based on the Health and Safety Commission's Approved Code of Practice (ACOP). However, efforts to introduce an acceptable charter or ACOP have failed. Pressure for an outright ban has been growing in the light of public opinion and scientific evidence on the adverse effects of smoking and passive smoking.

The Public Health White Paper, *Choosing Health*, published in November 2004 announced the Government's intention to ban smoking in enclosed public places in England from 2007, with specific exemptions.

The Health Bill [Bill 69 2005/06]⁶, Explanatory Memorandum⁷ and overarching, partial Regulatory Impact Assessment⁸ are all available online.

The smokefree provisions contained in this Health Bill would extend to England and Wales.

1. The law on smoking in the workplace

The main piece of legislation controlling workplace conditions, including bars, clubs and restaurants, is the *Health and Safety at Work etc. Act 1974* (HSWA). This places general duties of care on employers to ensure the health, safety and welfare of their employees, and others.

Secondary legislation in the form of regulations made under the Act includes Regulation 25(3) of the *Workplace (Health, Safety and Welfare) Regulations* SI 1992/3004,⁹ which affords protection to non-smokers from tobacco smoke in rest areas. It requires that: "Rest rooms and rest areas shall include suitable arrangements to protect non-smokers from discomfort caused by tobacco smoke". The Regulations came into force for new workplaces on 1 January 1993 and for existing workplaces on 1 January 1996. Aimed primarily at protecting the health of workers, it covers places, such as restaurants and pubs, where workers and customers are often in close proximity.

⁵ Standing Orders of the National Assembly for Wales
<http://www.wales.gov.uk/keypubstandingorders/content/standingorders-untracked-e.rtf>

⁶ <http://www.publications.parliament.uk/pa/cm200506/cmbills/069/2006069.htm>

⁷ <http://www.publications.parliament.uk/pa/cm200506/cmbills/069/en/06069x--.htm>

⁸ Annex 1 Partial regulatory impact assessment – smokefree aspects of the Health Bill
<http://www.dh.gov.uk/assetRoot/04/12/19/31/04121931.pdf>

⁹ http://www.legislation.hmso.gov.uk/si/si1992/Uksi_19923004_en_1.htm

Fire precautions in workplaces also require that smoking be prohibited within and around confined spaces where flammable materials are stored, where there is risk of explosion or where high levels of property or personal loss may be incurred. Smoking may also be prohibited in less frequently accessed areas, where fires may go undetected.

Notices prohibiting smoking must comply with British Standard 5499 and the *Health and Safety (Safety Signs and Signals) Regulations* SI 1996/341.¹⁰

The health and safety regulations above will not be revoked by this Bill. For those workplaces exempted in the Bill HSWA and its regulations will continue to be the key legislation to protect workers. The new legislation will not change any employer's responsibilities as set out in health and safety and also employment legislation.

B. International tobacco control measures

Pressure to ban smoking in public spaces has met with varying measures of success, regionally, across Europe, and in other countries worldwide. The right of victims to sue tobacco companies for damage caused by inhaling tobacco related smoke is becoming a lever for change.

1. World Health Organisation

The World Health Organisation (WHO) has reviewed a number of tobacco control strategies, including Canada, Brazil, Poland, Norway, the Philippines, Thailand and South Africa. It suggests the following as key elements of a comprehensive tobacco control strategy.

Institutions and mechanisms. Legislation should create, empower and fund an authority to implement and direct legislation

Public education. Large public education campaigns are important parts of changing public attitudes and beliefs

Advertising, promotion and sponsorship. A comprehensive ban on tobacco advertising, promotion and sponsorship is a centrepiece of an effective tobacco control programme.

Taxes. Tax increases have been proven to be one of the most effective means of reducing tobacco consumption, especially among young people.

Second-hand smoke. Eliminating smoking in workplaces and public places protects non-smokers from the hazards of exposure to smoke; discouraged smoking initiation and promotes cessation.

Labelling and packaging. Large, clear health warnings and informational messages, using rotating messages developed by national authorities, should be required on tobacco packaging, and tobacco products should not be promoted using misleading terms.

¹⁰ http://www.legislation.hmso.gov.uk/si/si1996/Uksi_19960341_en_1.htm

Product regulation. Regulatory authority should be given to a specialised agency, to address such issues as ingredient disclosure, permissibility of harmful constituents, additive safety, and tar and nicotine yields.

Tobacco sales. Legislation should prohibit the sales of tobacco to minors.

Smuggling. To combat illicit trade, comprehensive legislation should include measures such as requirements for package markings or creation of a regime for tracing and tracing products through the distribution chain.

Other issues. Comprehensive legislation may also include provisions to address smoking cessation, create school-based programmes, modify agricultural policies or address issues of legal liability.¹¹

The WHO Framework Convention on Tobacco Control entered into force on 28 February 2005.¹² Article 8 states:

Each party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and / or other measures, providing for the protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

The provisions of the Treaty legally bind forty contracting parties. These provisions set international standards on tobacco price and tax increases, tobacco advertising and sponsorship, labelling, illicit trade and second-hand smoke. The UK is a signatory and ratified the treaty on 16 December 2004.¹³

2. United States

Smokefree workplace prohibitions are in place in over three hundred cities, and seven states, including California (1998); Delaware (2002); New York (2003); Connecticut (2003); Maine (2004); Massachusetts (2004) and Rhode Island (March 2005). In California, where smoking was banned in bars and restaurants in 1998, a significant improvement in the respiratory health of bartenders was reported.¹⁴ Following a six-month smokefree trial period in Montana, a forty per cent drop in hospital admissions for heart attacks was reported.¹⁵

Smoking has been banned in New York restaurants for over ten years. A ban on smoking in the bars of New York City, including cigar bars if they serve alcohol, came

¹¹ D. D. Blanke and V. de Costa e Silva (Eds) Tobacco control legislation: an introductory guide. Second edition. World Health Organisation. 2004

¹² <http://www.who.int/mediacentre/news/releases/2004/pr89/en/>

¹³ Updated status of the WHO Framework Convention on Tobacco Control <http://www.who.int/tobacco/framework/countrylist/en/>

¹⁴ Eisner M, Smith A, Blanc P, Bartenders respiratory health after establishment of smokefree bars and taverns, *JAMA* 1998(280) pp 1909-14

¹⁵ Sargent R, Reduced incidence of admissions for myocardial infarction associated with public smoking ban before and after study, *BMJ* 5 April 2004

into effect at the beginning of April 2003.¹⁶ This affects 13,000 establishments and extends the *Smoke Free Air Act* 1995, introduced by former Mayor of the City, Rudolph Giuliani to include restaurants with fewer than 35 seats. Cotinine¹⁷ levels in non-smoking bar staff are reported to have fallen by over eighty per cent after the ban.¹⁸

Other states are considering introducing smokefree workplace legislation in 2005, including Georgia, Minnesota, Maryland, Utah, Colorado, Washington, Oregon, New Jersey, Vermont, and possibly Pennsylvania.¹⁹

3. Europe and Asia

In 2004, smoking in all bars, restaurants, cafes, pubs and discos was banned in Norway to protect employees and guests from the effects of passive smoking. Measures to ban smoking in public places, such as railway stations, trains, toilets and offices were introduced in The Netherlands from 2004. Similar measures to ban smoking in restaurants and bars will be brought in if action by voluntary agreement fails.

Other countries which have introduced bans on smoking in public places include Finland, South Africa and Thailand. The Himalayan Kingdom of Bhutan, where the use of tobacco in Government buildings has been banned since the 17th century, has banned smoking altogether. Smoking has also been banned in indoor places in Pakistan and on the streets of Tokyo since October 2002; in many public places in South Korea since March 2003; in Government buildings in the United Arab Emirates since November 2002, and in public places in Romania, Italy (where smoking rooms are allowed) and Greece.²⁰

In January 1991, Belgium became the first country in Europe to require all restaurants, bars and cafes to set aside non-smoking areas. On January 1, 1993, the amount of space that must be reserved to non-smokers increased from the current 33 to 50 percent.

In November 1992 France followed Belgium's example and imposed non-smoking areas in restaurants. The decree, an amendment to the Evin Law (Loi Evin N° 91-32) passed in 1991 that banned cigarette advertising in all media, and outlawed smoking in many public places, required non-smoking sections in restaurants.

On 29 March 2004, Ireland implemented the provisions of the *Public Health (Tobacco) (Amendment) Act 2004*, becoming the first European country to create smoke free enclosed workplaces, including bars, restaurants and hotels.

¹⁶ Only one more day to light up in New York, *Financial Times*, 29 March 2003 p11

¹⁷ Cotinine, a by-product of nicotine, can be analysed in blood levels and is used as a measure of exposure to second hand smoke.

¹⁸ The state of smokefree New York City: a one year review, NYC Department of Finance March 2004

¹⁹ Scottish Executive Healthier Scotland: *What's happening elsewhere*
<http://www.clearingtheairscotland.com/background/beyond-scotland-t-z.html>

²⁰ Other examples can be found on the BBC News website:
<http://news.bbc.co.uk/1/hi/world/4016447.stm#australia>

Ireland has had regulations in place since 1995 that prohibit smoking in many public places, including where food is served. Tobacco control legislation was updated in the *Public Health (Tobacco) Act 2002*, which contained a number of key provisions, including the establishment of an independent statutory body, the Office of Tobacco Control, set up to advise the Government on the implementation of policies concerning the control and regulation of the manufacturing, sale, marketing and smoking of tobacco products.

Subject to approval of regulations, a total ban on smoking in public places in Scotland will come into force from March 2006 and in Northern Ireland from 2007.

4. Pressure for change in England and Wales

Despite the lack of statutory control, cases have been taken to court and compensation awarded to employees who have claimed that passive smoking at work has affected their health.²¹

Pressure for a ban on smoking in workplaces and public places in order to reduce the risks from passive smoking has been growing since the White Paper on Tobacco, *Smoking Kills*, was published in December 1998. It set out the Government's strategy for reducing tobacco smoking across the UK, including the aim to cut the number of people smoking in the UK by 1.5 million by 2010. More information on the Smoking Kills Strategy is given in Library Note SNSC-1576 *White Paper on Tobacco*

The White Paper announced that the Health and Safety Commission (HSC) would carry out a consultation exercise to find out whether people would support increased control of passive smoking at work. The consultation document, *Proposal for an Approved Code of Practice on passive smoking at work*, was issued on 29 July 1999.²² The document set out a range of options for action including a proposal to introduce an Approved Code of Practice (ACOP) designed to safeguard the health and safety of employees at work while recognising their rights and responsibilities.

Efforts to draw up and implement an effective ACOP have proved fruitless in the intervening years, mainly due to representations from the hospitality industry, including bars and restaurants, and tobacco manufacturers, fearing the impact it would have on jobs and revenue across these trades. Although some leading pub chains latterly agreed to introduce voluntary bans on smoking in their outlets, campaign groups have persistently called for more stringent measures to satisfy the swell of public opinion and scientific evidence against smoking in public. The background to the campaign is outlined in Library Note SNSC-01642 *Smoking in Public Places*.

²¹ See for example, Memorandum by Thompson's Solicitors (SP02) (Evidence 1) to Health Select Committee

²² <http://www.hse.gov.uk/consult/condocs/cd151.htm>

II Attempts to legislate for a smoking ban

A. Private Members Bills

The current Bill is not the first to seek to introduce a ban on smoking. In 1986 a Private Member's Bill sponsored by Joe Ashton MP was aimed at creating no-smoking areas in public houses.²³ In 1994 Tessa Jowell MP introduced a Bill to ban smoking in public places and the workplace.²⁴ In recent years a number of Private Members' and Ten Minute Rule Bills have been introduced,²⁵ none has reached the statute book.

1. Smoking in Public Places (Wales) Bill [HL] 2003-04

With pressure growing for a total ban on smoking in Wales, in the previous two parliamentary sessions, Private Members' Bills have sought that powers be given to the National Assembly for Wales to make provision for a ban on smoking in enclosed public spaces.

The *Smoking in Public Places (Wales) Bill [HL]* (Bill 12 2003-04)²⁶ was introduced by Baroness Finlay of Llandaff on 11 December 2003. The Bill had its second reading in the House of Lords on 16 January 2004.²⁷ The Government welcomed the Bill, which was reported with amendments on 23 April 2004 having completed its passage through the House of Lords. The Bill was passed from the Lords and presented for first reading in the House of Commons on 13 May 2004,²⁸ but subsequently dropped.

2. Smoking in Public Places (Wales) Bill 2004-05

A virtually identical Bill (*Smoking in Public Places (Wales) Bill*)²⁹ [Bill 23 2004-05] was presented for first reading by Julie Morgan MP on 12 January 2005. The question on the Bill receiving its second reading was not decided on 18 March 2005 and the Bill ran out of parliamentary time before the general election. A research paper prepared for the second reading debate explores the impact of smoking on health in Wales and the powers of the National Assembly of Wales to make regulations in greater detail.³⁰

On 25 May the National Assembly of Wales voted in favour of accepting the Committee on Smoking in Public Places' recommendations³¹ and to ask the Westminster Parliament

²³ No-Smoking Areas in Public Houses Bill [Bill 225 1985-86]

²⁴ Tobacco Smoking (Public Places) Bill 1994/95 [Bill 21 1994/95]

²⁵ See for example: Protection from Smoking (Employees and Young Persons) Bill 2001-02; Smoking (Restaurants) Bill 2002-03; Tobacco Smoking (Public Places and Workplaces) Bill [HL] 2003-04; Smoking in Public Places (Wales) Bill [HL] 2003-04

²⁶ <http://www.parliament.the-stationery-office.co.uk/pa/ld200304/ldbills/012/2004012.htm>

²⁷ HL Deb 16 January 2004 c769-97

²⁸ Bill 109 2003-04 <http://www.publications.parliament.uk/pa/cm200304/cmbills/109/2004109.htm>

²⁹ <http://www.publications.parliament.uk/pa/cm200405/cmbills/023/2005023.htm>

³⁰ Library Research Paper 05/22 *The Smoking in Public Places (Wales) Bill* [Bill No 23 2004-05] <http://www.parliament.uk/commons/lib/research/rp2005/rp05-022.pdf>

³¹ Committee Page: <http://www.wales.gov.uk/keypubassemoking/content/agendas-e.htm>;
May 2005 Report: <http://www.wales.gov.uk/keypubassemoking/content/report-e.pdf>

If they proceed through all their parliamentary stages the Liverpool Bill will require a confirmatory decision by Liverpool City Council to go ahead with the ban. In London, the measures would need separate decisions to be made in all 32 London boroughs.³⁸ Other cities and towns³⁹ have indicated that they are considering local bans on smoking in public places, either by a private petition to Westminster, or changing local by-laws, licensing laws or health and safety legislation.

The measures in these bills are more stringent than the current Bill, with respect to licensed premises. In comments supplied for this paper, the promoters of the Bills say:

"The Parliamentary Agent for the promoters of the Bills has indicated that Liverpool City Council and the Association of London Government are disappointed with the partial ban being proposed in the Health Bill and their current intention is to continue the promotion of their Bills, whilst at the same time joining in a wider campaign with other local authorities, health professionals and pressure groups to press for amendments to the Health Bill."⁴⁰

a. Local authority powers

Option 3 considered under the *Choosing Health* partial Regulatory Impact Assessment was to introduce legislation that would give local authorities new powers to control second-hand smoke in indoor places. As demonstrated, many cities in England have declared the intention to go smokefree if empowered to do so. Whilst this may have the advantage of allowing local people to influence policies that affect them at the local level through consultation, tailored to local needs, there is the obvious danger of ending up with slightly different policies across the country or even no policy at all. This would prove problematic for enforcement authorities. The hospitality industry chains would also face costs catering to multiple exceptions, unless a central policy decision was made. This will become a live issue as the home nations surrounding England move towards total bans, which may distort competition in the regions of these boundaries.

III Choosing Health White Paper 2004

The failure to find an acceptable voluntary ACOP on smoking in public places, or for the Public Places Charter to bring about voluntary change across the hospitality industry made the Government reconsider its position to pursue a voluntary route to smoking cessation in public spaces and workplaces. Evidence of a groundswell of public opinion in favour of a ban on smoking in public places, coupled with action already taken in the Republic of Ireland and latterly by Scotland and Northern Ireland, has added impetus to the case for a statutory ban.

In November 2004 the Government issued its Public Health White Paper, *Choosing Health*.⁴¹ This signalled that legislation would be brought forward to ban smoking in all workplaces by 2007 and in restaurants and public houses that serve food from 2008. It

³⁸ "plans for local smoking bans spread to more than 30 towns" *Guardian* 3 March 2005 p3

³⁹ Bradford, Canterbury, Milton Keynes, Poole, Brighton, Knowsley, Wirral, St Helens and Sheffield.

⁴⁰ Comments supplied by Parliamentary Agent for the Bills' promoters 15 November 2005

⁴¹ Cm 6374

was indicated that some exemptions would be permissible: in private clubs where the members make the rules and in bars where food is not served (an estimated 20 per cent of pubs or three per cent of all workplaces).⁴² It was proposed that staff would be protected by an exclusion zone around the bar.⁴³

In evidence to the Health Select Committee the Government stated that the legislation as proposed was designed to protect the majority who do not smoke rather than legislate against those that legally choose to.⁴⁴

The stance that the Government proposed was re-iterated in the Labour Party Manifesto 2005:

We recognise that many people want smokefree environments and need regulation to help them get this. We therefore intend to shift the balance significantly in their favour. We will legislate to ensure that all enclosed public places and workplaces other than licensed premises will be smokefree. The legislation will ensure that all restaurants will be smokefree; all pubs and bars preparing and serving food will be smokefree; and other pubs and bars will be free to choose whether to allow smoking or to be smokefree. In membership clubs the members will be free to choose whether to allow smoking or to be smokefree. However, whatever the general status, to protect employees, smoking in the bar area will be prohibited everywhere.⁴⁵

A. Health Committee enquiries

On 23 February 2005 the Health Select Committee took evidence on the Public Health White Paper from the Health Secretary at the time, Dr John Reid and Health Minister Melanie Johnson.⁴⁶

1. Displacement of smoking to the home

In the course of the session the Secretary of State explained that setting targets for a fall in smoking rates had to be compatible with “the sort of mature adult lifestyle and life choices people in this country want”. He also acknowledged that although many people make choices through their own free will, people in more deprived circumstances would find it difficult to change their lifestyle.

⁴² Oral evidence to the Health Select Committee on The Government's Public Health White Paper (Cm 6374) 23 February 2005 HC 358-i 2004-05 Q7
<http://pubs1.tso.parliament.uk/pa/cm200405/cmselect/cmhealth/uc358-i/uc35802.htm>

⁴³ Choosing Health White Paper Cm 6374 Department of Health November 2004
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4097491&MULTIPAGE_ID=4988869&chk=EPplxs

⁴⁴ Oral evidence to the Health Select Committee on The Government's Public Health White Paper (Cm 6374) 23 February 2005 HC 358-i 2004-05 Q54

⁴⁵ Chapter Four Britain forward not back. Labour Party Manifesto 2005
http://www.labour.org.uk/fileadmin/manifesto_13042005_a3/pdf/manifesto.pdf

⁴⁶ Oral evidence to the Health Select Committee on The Government's Public Health White Paper (Cm 6374) 23 February 2005 HC 358-i 2004-05

Dr Reid held the opinion that the ban in England should not extend to all public bars and restaurants, on the basis that smoking behaviour might be transferred to the home, where there is most evidence about the effects of passive smoking.⁴⁷ At the same time it was explained, national anti-smoking campaigns would continue to alert parents to the dangers of smoking to non-smoking family members, particularly children.

The home displacement argument is one supported by the tobacco industry. In the course of questioning, the Committee chairman reported that evidence from others suggested that social smokers would be unlikely to smoke at home if they could not smoke in the pub. The Secretary of State noted that, on the basis of anecdotal evidence and his own observations of smoking culture, he had formed the view that a percentage of people who previously went to the pub would get carry outs to consume at home with a cigarette. He asserted that in Ireland this accounted for approximately 15 per cent of social smokers.⁴⁸ However, he acknowledged that there was little hard evidence to support the view that smoking might be displaced to the home, because there are not many places that have had a long-term prohibition in place.

In a series of written questions, David Taylor MP asked the Government what research they had collated and what views they had received on the displacement of smoking in public places to the home in order to support formulation of Government policy. Under-Secretary of State, Melanie Johnson replied:

.....In preparation of the proposals, we took full account of the latest scientific and medical evidence of the risk to health from exposure to second hand smoke, as set out in the report from the Scientific Committee on Tobacco and Health, which was published alongside the White Paper.

Many of the studies covered look at the effects on non-smokers of living with smokers.....

We have made an assessment of the impact that smoking in public places would have in a reduction in smoking prevalence, which would thereby have a beneficial impact of reducing smoke at home. We will continue to act on the issue of second hand smoke in the home and have already taken action through the hard hitting campaign launched last year depicting the dangers of smoking around babies and children.⁴⁹

The Health Committee is currently embarked on a further enquiry into Smoking in Public Places. The Deputy Chief Medical Officer recently told the Committee that Dr Reid's earlier remarks on home displacement were made "on the best available evidence to him at that time."⁵⁰

⁴⁷ Oral evidence to Health Select Committee 23 February 2005 Q7

⁴⁸ *ibid* Q8

⁴⁹ HC Deb 24 January 2005 c191W

⁵⁰ Q. 36 Deputy Chief Medical Officer, Dr Sandra Adshead, Department of Health Uncorrected evidence before Health Committee Smoking in Public Places enquiry evidence session, 20 October 2005 <http://pubs1.tso.parliament.uk/pa/cm200506/cmselect/cmhealth/uc485-i/uc48502.htm>

Early responses to the June 2005 consultation exercise and written evidence to the Health Committee tend to support the view that net displacement is unlikely to take place, because workplace bans tend to reduce overall smoking prevalence rates and the quantity of cigarettes smoked. At the same time, such policies tend to increase public awareness of the dangers of secondhand smoke, with the view that few people wish to harm their children, even if they are prepared to risk their own health. A recent study reports a decrease in the percentage of smokers in Ireland allowing smoking in their homes following the implementation of smokefree legislation.⁵¹

Subsequently, information is starting to emerge on smoking trends and the positive effects of the ban in Ireland. (See pages 64-65).

However, industry reports suggest that predictions about smoking behaviours cannot be seen in isolation from other activities, particularly the consumption of alcohol. In April 2005 *Euromonitor* produced a report on the impact of the smoking ban on the tobacco and drinks industries in the Republic of Ireland since the ban. The executive summary states

Smoking and drinking in Ireland go hand in hand, and, as a result, pubs have reported dramatic sales losses in the few months following the ban. It seems that with customers now unable to enjoy a cigarette with their drink, many are choosing to drink at home instead.⁵²

The implication is that regular smokers, who like to drink, may drink more at home - along with smoking their cigarettes.

It should be noted that *Euromonitor's* conclusions have no firm statistical basis, but are drawn from discussions with pro-smoking industry groups to explain the fall in volume sales through pubs, as well as analysis of consumer lifestyle preferences and trends in other sectors, including the alcoholic drinks market.⁵³

Overall, there appears to be little long-range quantitative evidence from Ireland at this stage to support either case.

B. Smokefree legislation consultation 2005

A consultation document on the Smokefree elements of the proposed 'Health Protection and Improvement Bill'⁵⁴ was launched on 20 June 2005.⁵⁵

⁵¹ GT Fong, *The Impact of Smokefree Workplace Legislation on Smokers in Ireland: Findings from the ITC-Ireland/UK Survey* <http://www.smokefreeeurope.com/assets/downloads/geoffreytfong.pdf>

⁵² Tobacco in Ireland Executive Summary *Euromonitor* April 2005
http://www.euromonitor.com/Tobacco_in_Ireland

⁵³ Personal correspondence with *Euromonitor International* 27 October 2005

⁵⁴ Consultation on the Smokefree Elements of the Health Protection and Improvement Bill, Department of Health, June 2005
<http://www.dh.gov.uk/assetRoot/04/11/37/20/04113720.pdf>

⁵⁵ Department of Health Press release 2005/0213 *Consultation on smoking proposals launched today*, 20 June 2005

The main purpose of the consultation exercise on smokefree legislation was to test public opinion on the degree of acceptance of a total ban before enshrining such a measure in legislation. Responses to the spring 2004 *Choosing Health* consultation paper showed that the Government had not yet struck the right balance on smoking in workplaces and public places in the minds of the public, demanding that further action was required.

1. Views on the consultation

Since the proposals to ban smoking under public health legislation were announced in November 2004 there has been pressure from many interested parties for a total ban, with none of the exemptions proposed for licensed premises. Speculation increased that a total ban would be proposed after the recent general election when Patricia Hewitt was appointed Secretary of State for Health in place of Dr John Reid, who supported the partial ban.⁵⁶ Dr Reid did not favour an outright ban; preferring instead that the Government should provide balanced evidence but leave the final decision to the judgement of individuals. In the event, the consultation was based on the proposals set out in the Labour Manifesto.

Since then, many interested parties have speculated on how exemptions from a public smoking ban for licensed premises that do not serve food would operate in practice, or how exactly the measures will protect the health of bar staff. They have also queried how the measures fit in with the Government's national alcohol strategy; by promoting the sale of food in pubs, the Government hoped this would help reduce the effects of binge drinking on empty stomachs.

A wide range of opinions, backed up by surveys and evidence based research were publicised throughout the consultation period, the majority supporting the call for an outright ban in all public places. Essentially the views appear to centre on two main areas. The first is the straightforward view of uniform application of the law in all public places and clarity for the public on where smoking is not permitted. The second and arguably more important issue centres on evidence of the dangers of smoking and exposure to second hand smoke and the health and economic benefits to be gained from a ban. Some of the publicised comments are noted in Library Note SNSC-03700 *Smoking in Public Places: 2005 consultation*.

At the time of writing, analysis of some 57,000 responses is continuing, with an official summary expected in due course.⁵⁷

IV The Bill

The Health Bill [Bill 69 2005-06] was presented on 27th October 2005.⁵⁸ The Bill is in seven parts. Part one, the subject of this paper, makes provision for the prohibition of

⁵⁶ For example: "Hewitt's first test" *Guardian* 22 June 2005; "Hewitt's smokescreen", *Daily Telegraph* 22 June 2005

⁵⁷ HL Deb 9 November 2005 c85WA

⁵⁸ HC Deb 27 October 2005 c470

smoking in certain premises, places and vehicles. Parts 2-7 of the Bill make provision relating to: health care associated infections; the management and use of controlled drugs; medicinal products and pharmacy premises; the NHS in England and Wales and recovery of NHS costs; the establishment of an Appointments Commission; and social care training functions. These measures are covered in a separate Research Paper.

A. Overview of clauses

The Bill allows for the designation of enclosed or substantially enclosed public smokefree premises, and other additional smokefree places, along with exempted premises, including licensed premises not serving food, and private membership clubs. Some of the provisions relating to licensed premises will be conditional, including restrictions on the types of food served or prepared; proprietors will be able to designate smoking areas. Designated business and public transport vehicles will also become smokefree. New duties to display no-smoking signs will be brought in, along with offences and defences that may apply. There will also be new offences of smoking in a smokefree place, punishable by fixed penalty fines, and failing to prevent smoking in smokefree places. Enforcement is most likely to be by local authorities. It will be an offence to obstruct designated officials in these duties. Much of the detail of the Bill will be covered by Regulations that will be subject to the affirmative procedure. The measures will come into force in April 2007, one year earlier than proposed, and there will be a three-year review period.

Explanatory Notes⁵⁹ explain the provisions of the Bill in more detail.

B. Analysis of Clauses

1. Application

The provisions in Part One of the Bill extend to England and Wales. They also have effect in relation to the seas adjacent to England and Wales (Clause 12 (3)).

The provisions relating to smoking will come into force on a date appointed by the Secretary of State by means of an Order (Clause 79(6)). It is expected that the measures will be brought into force in the summer of 2007.⁶⁰

2. Scope

a. *The definition of smoking*

The Bill has set a wide definition of smoking. It includes smoking any tobacco or tobacco containing products, or the smoking of any other substance (Clause 1(2) (a)). This includes herbal cigarettes that at one time were considered to be outside the scope of the legislation. It will be an offence to be in possession of any lit tobacco or tobacco

⁵⁹ Health Bill Explanatory Notes [Bill 69-EN]
<http://www.publications.parliament.uk/pa/cm200506/cmbills/069/en/06069x--.htm>

⁶⁰ Department of Health Press release, *New health Bill will deliver commitment to ban smoking*, 27 October 2005

containing substance or any other lit substance in a form in which it could be smoked (Clause 1(2)(b)) in a designated smokefree place. This includes hubble bubble pipes, or hookahs which require tobacco to be lit before passing through liquid to the smoking pipe.

b. Smokefree premises

Smokefree premises will be designated dependant on satisfying a number of conditions that will be set out in regulations.

In essence, enclosed or substantially enclosed premises, which will be defined by regulations, are deemed to be smokefree if they are open to the public (Clause 2(1)). Premises are deemed to be open to the public if the public or a section of the public has access to them, either with or without invitation, and with or without payment of a fee (Clause 2(7)). Clause 12(1) of the Bill allows that the definition of premises also includes “a tent, moveable structure and an offshore installation”.⁶¹ Certain exemptions are set out in Clause 3 of the Bill.

All workplaces will be deemed to be smokefree at all times if more than one person works at a premise, or the public goes there to receive goods or services from the person working there (Clause 2(2)(a) and (b)). Work includes voluntary work (Clause 2(8)). A voluntary society fundraising fete held in a village hall would be deemed to be both a workplace and a public place and would therefore, have to be smokefree.

If only part of the premise is used for these purposes then only that part is deemed to be smokefree (Clause 2(3)). Private premises, such as stately homes, that are open to the public on a limited basis need only be smokefree at those times, provided they are not a workplace. If someone’s home is also their workplace, only those parts of the premises where the public come to receive goods or a service need be smokefree during times when the goods or service are offered.

c. Exempt premises

Clause 2(6) provides that some exemptions can be made by regulations to the requirements for smokefree premises, where a designated smoking room might be permitted. Clause 3 enables regulations to be made setting out what these exemptions might be. In general these include places that are a person’s home or living space, and licensed premises.

Premises where a person has his home, or is living permanently or temporarily (Clause 3(2) (a))

This might mean hotels, hostels, or bed and breakfast accommodation, and residential care homes, as designated for such purposes by the proprietor. In premises where a

⁶¹ Offshore Installation as defined in regulation 3 of the *Offshore Installations and Pipelines Works (management and Administration) Regulations* SI 1995/738). The provision is required because the definition of offshore installations refers to a set of regulations that might be amended or revoked.

person may be detained or is a person's full time home for an extended period, including prisons, detention centres, and psychiatric hospitals and units, it may be possible to designate smoking rooms, where it may be unsuitable to permit smoking to take place outside. The Government's intention is to phase out smoking completely in such places in due course.

A high proportion of prisoners smoke as do prison staff. HM Prison service has developed smoking policies covering prison staff and prisoners, taking into account the type of establishment, and the special needs of the prison population. Prisoners who smoke should do so only in their cells or in unenclosed spaces. Within the constraint of prison overcrowding, smokers and non-smokers do not usually share cells. Arrangements concerning smoking by prison staff are made at the local level ranging from complete bans to access to designated smoking rooms. Although smoking is not permitted in any office accommodation, some staff may be exposed to passive smoking from prisoners when checking their cells.

The Health Select Committee has heard that the Department of Health and the Home Office are working on strategies to promote smoking cessation in prisons. Evidence suggests that most prisoners who smoke are similar to the rest of the population in their attitudes to smoking and cessation.⁶²

Prison managers giving oral evidence to the Health Committee on 17 November 2005 noted that although there are practical issues to overcome, some prisons have already introduced successful no smoking policies. Wetherby Young Offenders Institute is one of two Young Offenders Institutions⁶³ in which no smoking is allowed within the perimeters. However, they acknowledged that there may be risks. In high security settings, smoking is one of the few privileges enjoyed by people incarcerated for extended periods; withdrawing tobacco may lead to control and order problems. Many prisoners have mental health, alcohol and drug abuse problems; in some cases, withdrawing smoking at the start of a sentence when a prisoner is particularly vulnerable or may attempt suicide may actually be harmful. Within the framework of the legislation proposed, prison managers will need to assess and manage the risks they perceive sensitively.

The Royal College of Physicians (RCP) believes that, in cases where smokers are detained against their will and are thus deprived of the option of smoking in their own private home, exemptions should be made, but in a context of provision of cessation support for the smoker to quit if he or she chooses, and of preventing exposure of other residents or staff to tobacco smoke. RCP also believes that, from a moral and ethical perspective, the rights of others to a clean and safe environment outweigh the human rights of the smoker in all of these circumstances.⁶⁴

⁶² Lester C, Hamilton Kirkwood L, Jones N. Health indicators in a prison population: asking prisoners. *Health Education Journal* 2003; 62(4): 341-9.

⁶³ The other is HMYOI Ashfield

⁶⁴ RCP Response to Consultation on the Smokefree Elements of the Health Improvement and Protection Bill http://www.rcplondon.ac.uk/college/statements/statements_smokefree.htm

The Government has said it recognises that although there is a commitment to end smoking in the NHS by the end of 2006, in some cases, this may not be achievable.⁶⁵ An exemption has been proposed for mental health establishments, including psychiatric units. However, the status of the premises for mental patients under this exemption is complex; while some patients suffering from mental illness are compulsorily detained in these establishments, and could be considered resident, others may enter on a temporary or voluntary basis. Many more are supported in their own homes by mental health staff working in the community.

Rethink, the campaigning mental health charity believes that people who experience severe mental illness and their carers, some of whom smoke, should be helped but not coerced into giving up smoking. However, they should be given fair access to suitable cessation programmes. At the same time, the charity points out that giving up smoking is difficult for such sufferers; many are driven by compulsion to smoke. Susceptibility to stress also makes it likely that smoking behaviour may be resumed.

In written evidence to the Health Committee,⁶⁶ the charity cites medical evidence that shows that smoking prevalence is higher amongst people with mental health problems, and highest amongst those with psychotic disorders. Daily consumption may be higher, and they often inhale deeply. However, many want to give up. At the same time, nicotine may help alleviate some of the positive and negative symptoms associated with psychiatric illnesses and may help to alleviate side effects of certain medications. In some cases the institutions may condone smoking, or use cigarettes as an incentive to behave well.

Given the difficulties associated with mental illness and smoking cessation *Rethink* supports the legislation for a workplace ban in order to protect staff, whilst urging recognition of the need to exempt certain people with a severe mental illness living in these accommodations. While smoking in a controlled outdoor area may be feasible for many mental patients, and manageable for staff required to enforce a ban, *Rethink* believes compulsorily detained patients unable to leave wards should retain the ability to smoke indoors.

Licensed premises

Licensed premises are those that hold a valid premises licence under the *Licensing Act 2003* authorising alcohol to be consumed on the premises. Under Clause 2 licensed premises, such as public houses would normally be deemed to be a public place and workplace and therefore smokefree. Clauses 3(3) and 3(4) of the Bill allow for regulations that may permit that premises or areas of premises are not smokefree in specified circumstances, at specified times or if certain conditions are followed.

Some of the conditions include, in the case of licensed premises, what else apart from alcoholic drinks, such as hot or cold food, is or is not sold for consumption there (Clause

⁶⁵ HC Deb 3 November 2005 c1348W

⁶⁶ Memorandum to Health Select Committee September 2005
<http://www.rethink.org/news+campaigns/consultation-documents/pdfs/smokefree-legislation.pdf>

3(4)(a)). The designation of types of foods that may be consumed in smokefree areas will be the subject of consultation and included in the conditional regulations.

A pub or venue serving food at any time, even just at the weekend or in a small room at lunchtimes, must be smokefree all the time. Smoking may be permitted outside in a pub garden, car park or the entrance to a pub, subject to any other company or local restrictions.

Clause 3(4)(b) allows the person in charge of the premises covered by Clause 3 to designate any rooms in which smoking is allowed. For example, this means that hotel bedrooms would be deemed to be smokefree unless designated otherwise. The regulations may specify that certain measures must be taken to protect those who do not wish to smoke but must enter the rooms for the purposes of servicing and cleaning, and to ensure that the smoking rooms are well ventilated by the best practicable means.

The provision does not extend to other smokefree premises as designated by Clause 2. Employers that continue to designate and offer smoking rooms in offices and workplaces may be fined by the Health and Safety Executive.

Smoking at the bar is already prohibited in many licensed establishments as a courtesy to bar staff. Discussion is continuing on whether to define bar areas and to introduce exclusion zones where smoking may not take place even in exempted licensed premises. A one-metre rule has been suggested. It is debatable if this will afford staff protection to the extent envisaged, given that tobacco smoke tends to drift.

The Smokefree Action Coalition argues that workers in exempted premises made ill by second hand smoke will be able to sue their employers for negligence under health and safety legislation. The Coalition contends that these workers may also have a case under human rights legislation, "because they will have been denied protection given to other workers and members of the public on the basis of scientific evidence about secondhand smoke and health."⁶⁷ The Coalition sees potential for the tobacco industry to target exempted premises with marketing campaigns for their brands, thereby reducing the impact of the legislation on smoking rates in areas where there are already health inequalities.

Private members' clubs where a valid club premises certificate is held

In the period July 2003-June 2004 (the latest period for which figures are readily available) there were 19,913 registered clubs - clubs owned by the members - in England and Wales.⁶⁸ A club premises certificate is defined in the Bill by the meaning under s.60 of the *Licensing Act 2003* (cap 17).

⁶⁷ Health Bill: Smoking in workplaces and enclosed public places, Briefing Note for MPs: Second Reading Debate Smokefree Action Coalition November 2005

⁶⁸ Department for Culture, Media and Sport Statistical Bulletin Liquor Licensing, England and Wales, July 2003-June 2004

These qualifying clubs (such as the British Legion, working men's or cricket and rugby clubs) are different from other venues or types of clubs because they must carry on activities from private premises (to which access is restricted by conditions) and must provide alcohol and other entertainments other than for profit. Further details are set out in the *Licensing Act 2003* and the explanatory notes to that Act.

The British Beer and Pub Association is concerned that the exemption for clubs may distort the hospitality market where clubs and pubs are located close to each other. Free houses may decide to become private clubs to circumvent the ban. The concerns are shared by the bingo industry; as proprietary clubs they would not qualify for an exemption in this respect, and fear that some working men's clubs that offer bingo as a social activity may attract customers in areas where they share smoking demographics.

There is also concern that, by having the right to vote on the smoking status of the club, club members may effectively be voting to injure their staff.

The Houses of Parliament are not covered by the Bill. Although the House authorities have introduced a number of no-smoking initiatives, smoking will be permitted in some areas.⁶⁹

d. Additional smokefree places

The provisions of the Bill are mainly designed to protect non-smokers from the harmful effects of passive smoking within enclosed or substantially enclosed spaces, where the dangers from the toxic products of smoking can do most harm. However, where people are likely to congregate and smoking may take place, there may still be dangers from passive smoking. Clause 4 allows for regulations to designate additional smokefree premises that are not covered by Clause 2. The types of places covered may include; sports stadia; bus stops; public entrances and exits to buildings; and grandstand areas.

e. Vehicles

Clause 5 of the Bill covers all types of vehicles, including trains, vessels, aircraft and other means of transport. Regulations will allow the designation of smokefree business and public transport and will set out all the descriptions of vehicles that are to be smokefree (Clause 5(2) (a)), and the circumstances (Clause 5(2) (b)) and areas under which these conditions will apply (Clause 5(2) (c)).

Under the regulations some classes of vehicles may be exempt (5(2) (d)), including private vehicles. A private car used in a car share scheme would have to be smokefree during those times that other passengers are carried.

⁶⁹ See House of Commons Staff Notice SN/03/2005
<http://dfaweb.parliament.uk/hocstaff/staffnotices/sn0305.pdf>

f. No smoking signs

Clause 6 places new duties upon designated persons to display no-smoking signs in smokefree premises, additional smokefree premises and vehicles, along with offences and defences that may apply. Regulations will set out in detail any special provisions that might be made, for example, in listed or heritage buildings (Clause 6(3)) and any requirements that signs must conform to, in terms of size, colour or language (Clause 6(4)).

The consultation document explains that, subject to approval, clear no-smoking signs will have to be at least A4⁷⁰ size, showing the international no-smoking sign and stating that it is illegal to smoke on the premises. They will have to be displayed prominently at all entrances to premises and on other areas such as toilets and rest rooms. Information on fines and a number to call when illegal smoking is detected may also be displayed. It will be down to the manager or owner to ensure that the smoking status of the premises is clearly highlighted.⁷¹

Listed buildings will not be exempt but there may be special arrangements when it is not possible to affix the sign to the building itself. Vehicles will also require signs, which will differ to those required on buildings.

The person who occupies or manages the premises is responsible for ensuring that the correct form of signage is displayed (Clause 6(1)). They will be guilty of an offence under Clause 6(5) if they fail to comply with their duties under Clause 6(1) (or Clause 6(2)), and be liable for a fine of £200 (Level 1 on the standard scale), unless they can provide evidence that they were not aware, or could not have been expected to be aware that the premises were smokefree (Clause 6(6)(a)). This might happen if there is any dispute over the extent of substantially enclosed premises.

They may also have a defence if they can show that they did not know, or could not have known that signs complying with the regulations that they believed had been displayed had not in fact been displayed; for example, where vandals have removed signs (Clause 6(6)(b)), or where it would be reasonable not to display the signs, for example in the time between knowing that a sign had been removed and actually replacing it (Clause 6(6)(c)).

g. Smoking in a smokefree place

There will also be new offences of smoking in a smokefree place, punishable by fixed penalty fines, and failing to prevent smoking in smokefree places.

Clause 7 makes it an offence to smoke in an enclosed or substantially enclosed smokefree place, an additional smokefree place or a vehicle (as designated under Clauses 2, 4 or 5). Those guilty of an offence (Clause 7(2)) may be liable on summary

⁷⁰ 280mm x 200mm

⁷¹ Consultation on the Smokefree Elements of the Health Protection and Improvement Bill, Department of Health, June 2005 Signage paras 27-9

conviction to a fine, to be specified in regulations (Clause 7(5)) but probably at Level 1 (£200) on the Standard Scale.

Clause 8 allows enforcement officers to give a fixed penalty ticket to those they have reason to believe have committed an offence. The provisions relating to the fixed penalty notices are set out in Schedule One of the Bill. The level of penalty fines and discounted penalties will be set out in regulations. It is intended that initially the regulations will prescribe a fine of £50 (fixed penalty notice) for an offence of smoking in no-smoking premises, but the Bill should contain the power to prescribe fines up to level 1. It is also intended that there will be an opportunity to have the case tried by a Court if there is a dispute.

A person must provide evidence that they did not know, or could not reasonably have been expected to know that it was a smokefree place if they are to use this as a defence in court (Clause 7(3)). If there is sufficient doubt on the issue the court must assume the defence is satisfied unless the prosecution can prove beyond all reasonable doubt that it is not so (Clause 7(4)).

h. Failing to prevent smoking in a smokefree place

Under Clause 9 of the Bill, any person whose job it is to control or manage smokefree premises, or additional smokefree premises (Clause 9(2)(a)) and vehicles (Clause 9(2)(b)), has a duty to prevent smoking in the premises. If they fail in their duty they may be guilty of an offence (Clause 9(3)) and liable to a fine of £200 (Level 1 on the standard scale).

In the Republic of Ireland proprietors face fines of up to 3,000 euros (£2,000) and those premises can be closed down for three months.⁷²

Sub section 4 makes provision for certain defences for a person charged under sub section 3. They must have taken reasonable action to cause the person to stop smoking, or attempt to evict them from the premises (9 (4) (a)). If they did not know or could not reasonably have known that smoking was taking place, such as on the basis of false information by an employee or witnesses, (9(4) (b)) or they had other grounds not to take compliance action because priority was given to some other legal duty, such as preventing disorderly conduct (9(4) (c)), then these might also be used as a defence.

As with the defences provided against smoking in a smokefree place, a defendant must provide the evidence to support it. Where there is sufficient doubt on the issue the court must assume the defence is satisfied unless the prosecution can prove beyond all reasonable doubt that it is not so (Clause 9(5)). A person guilty of the offence is liable to a fine on the standard scale, the level of which is to be specified in regulations (Clause 9(6)).

⁷² OTC http://www.otc.ie/smokefree_enforcement.asp

premises are smokefree, although individuals will be punished if cases against landlords are proved.

The Chartered Institute of Environmental Health Officers, representing English and Welsh counterparts, raised similar concerns over the safety of officials working late at night and in remote rural areas in its memorandum to the Health Select Committee.

14.3 Local authority staff in general, and environmental health practitioners in particular, are not familiar with imposing fixed penalties and such an activity will pose real risks to their safety and our members have expressed their unwillingness to undertake such a duty without the appropriate safeguards for their personal safety. Our members are also concerned that the inclusion of a power to spot-fine will raise unreasonable expectations about their ability to deal with offences, which will not be met.

14.4 In any case, we believe that the power to impose spot fines will be ineffective unless it is linked to police powers to require the production of identification, detain and if necessary arrest offenders. The risks to enforcement staff will be particularly great in open-air situations where such powers might be better exercised by the police service personnel themselves.⁷⁷

A recent survey, conducted with the co-operation of CIEH has revealed a national shortage of environmental health professionals, leading to potentially 700 unfilled posts across England, Wales and Scotland.⁷⁸

In Ireland, where there is a total ban, additional officers were recruited to enforce the ban there. They also enforce legislation prohibiting under age tobacco sales.

j. Obstruction of officials

An enforcement officer must not be obstructed in his duties. To do so would constitute an offence (Clause 11(1)). This might include failing to assist an officer (Clause 11(2)) or recklessly, or knowingly withholding information that might assist him in his duties (Clause 11(3)). Anyone found guilty will be liable to a fine not exceeding Level 3 on the Standard Scale (currently £1000) (Clause 11(4)). The same provisions apply if an enforcement officer is acting on behalf of the 'national authority' (Clause 11(5)).

V Smoking issues – the wider debate

A. Overview

Responses to the Health Bill are in similar vein to those expressed at the time of the *Choosing Health* consultation, clearly dividing along pro-smoking and anti-smoking lines. Interested parties have had many opportunities to re-state their position on the issue,

⁷⁷ CIEH Memorandum to Health Select Committee (SP44)

⁷⁸ CIEH Media Release 2005/029, *Future of Public Health at Risk with National Shortage of Environmental Health Professionals* November 2005 <http://www.cieh.org/news/press/cpr2005/cpr2005029.htm>

either in the context of this Bill; to the Health Select Committee;⁷⁹ to the Private Bills undergoing scrutiny in the Lords, or in response to the smokefree consultation exercises in Scotland and Wales.

The Government has drawn heavy criticism from many anti-smoking groups, who believe that the 2005 consultation exercise yielded significant medical and sociological evidence for a total ban, with opinion polls and surveys strongly suggesting that there is public, even industry acceptance that a total ban was the best way forward.

Pro-smoking campaigners and some industry representatives continue to oppose a total ban. They believe the Bill limits personal freedom of choice, and raises possible human rights issues. They also believe there are economic impacts that may affect large numbers of tobacco and hospitality workers. At the same time, other groups would prefer the restrictions on licensed premises to apply across the board to ensure there is a fair competition across the sector.

Appearing before the Health Committee on the day of publication of the Bill, the Secretary of State, Patricia Hewitt was asked about the perceived compromises that the Bill appeared to make with regard to workers' health. Acknowledging that each option considered presented its own disadvantages, particularly that some pubs may stop serving food to avoid the ban,⁸⁰ she stressed that the proposals offered the right balance between reducing the public health risk whilst allowing an element of choice for those who do want to smoke with a drink to do so in a way that has minimal impact on other people.⁸¹ She considered that the Bill was "a very significant step towards a complete ban," and that it was her opinion that, "it is only a matter of time before we do have a complete ban."⁸²

Pressed that the Bill would exacerbate health inequalities, she felt that this argument was in part countered by the fact that many more workers would now be covered by workplace bans. In the press notice announcing the Bill she argued, "99% of employees will be working in a smoke-free environment. Currently, only 51% of people report their workplace as being completely smokefree."⁸³

The objectives that the Government has set itself exemplify the difficulties it faces to satisfy all groups. The partial regulatory impact assessment presented with the *Choosing Health* White Paper explains:

The Government's objective is to:

- Reduce the risk to health from exposure to secondhand smoke

⁷⁹ Smoking in Public Places Written evidence to the Health Select Committee HC 845 II 2005-06

⁸⁰ Q.6 Secretary of State for Health Patricia Hewitt, Uncorrected evidence before Health Committee Responsibilities of the Secretary of State for Health, 27 October 2005.

⁸¹ Ibid Q.25

⁸² Q. 9 Secretary of State for Health Patricia Hewitt, Uncorrected evidence before Health Committee Responsibilities of the Secretary of State for Health, 27 October 2005
<http://pubs1.tso.parliament.uk/pa/cm200506/cmselect/cmhealth/uc623/uc62302.htm>

⁸³ Department of Health News Release 2005/0369, *New health bill will deliver commitment to ban smoking in majority of workplaces*, 27 October 2005.

- Recognise a person's right to be protected from harm and to enjoy smokefree air
- Increase the benefits of smokefree enclosed public places for people to give up smoking so that they can succeed in an environment where social pressures to smoke are reduced
- Save thousands of lives over the next decade by reducing overall smoking rates.⁸⁴

Quantifiable, objective tasks such as reducing risk from exposure to second-hand smoke and saving lives over a period of ten years sit alongside more subjective aims that perhaps embody the symbolism and mythology of smoking in the minds of the public. An ethical debate challenges liberal rights in society: setting the right of the individual to smoke against the right to peaceful enjoyment of an unpolluted environment.

The partial RIA notes the iconic status of the pub in this debate:

However, pubs stand apart from all other indoor places, even other parts of the hospitality sector, as being special in the mind of the public.⁸⁵

At the same time, there are other factors to consider; the addictive nature of nicotine impairs true freedom of choice for the smoker, whilst economic and social pressures may restrict the employment options of those allegedly free to choose to work in the smoky environments of the hospitality industry. Insufficient time has elapsed in places where a ban has been brought in to determine the true economic impact on the hospitality industry, and the economy as a whole. Most of the evidence surrounding the impact on smoking levels and displacement to the home is anecdotal; planning and environmental issues have yet to be adequately identified, let alone quantified.

B. Ethics and a smoking ban

1. Freedom of choice

Evidence given by the tobacco industry to the Health Select Committee Enquiry stressed that an individual's decision to smoke was an informed choice and that people should have 'the right to smoke a cigarette should they so choose'.⁸⁶

We support the Government in the aim of providing information for people to be able to make informed choices. As referred to, the advent of health warnings in 1971 certainly illustrates that, and we have worked with Government to safeguard their overall strategy. We are concerned with recognising that 12 million people still choose to smoke tobacco products, whilst we support the Government in its aim to seek a solution that talks about restriction rather than bans, and to work with them.⁸⁷

⁸⁴ Annex 3 Partial Regulatory Impact Assessment, Choosing Health White Paper Action on Second Hand Smoking

⁸⁵ *ibid*

⁸⁶ Barry Jenner, Gallaher Group plc, Uncorrected Evidence to be published as HC 485-I, Smoking in Public Places, Health Select Committee Report,

⁸⁷ Barry Jenner, Gallaher Group plc, Uncorrected Evidence to be published as HC 485-I, Smoking in Public Places, Health Select Committee Report,

The argument appears difficult to sustain when it is used in relation to an addiction. Many individuals continue to smoke because of a physiological or psychological addiction to nicotine (see section on smoking and addiction). For a decision or choice to be truly autonomous that decision must be competent, informed and voluntary. Voluntariness is diminished by defects in control, which would encompass addiction.

2. Moral rights

The traditional view of the rights of an individual comes from John Stuart Mills' essay, '*On Liberty*'

That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.⁸⁸

The aim of introducing legislation to create smokefree bars and workplaces is to prevent harm to individuals rather than curtailing people's freedom to smoke. It can be argued that a ban on smoking in public places is justifiable to prevent harm to others, especially as smokers are still free to smoke elsewhere.

However, a wider concept of moral rights would include positive claims to personal rights such as health. The Constitution of the World Health Organization states that health is a basic human right.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.⁸⁹

Therefore, any policy which is likely to worsen health inequalities could be seen as failing to promote health as a human right.

C. Smoking and addiction

In 2004, the Department of Health published a report entitled, *Smoking-related Behaviour and Attitudes, 2004*, produced as part of the Office of National Statistics Omnibus Survey. The report found that 73% of current smokers would like to give up, which is a similar finding to previous years. In addition the survey found that just under three-quarters of current smokers had tried to give up smoking in the past year, the majority unsuccessfully. These results show that for most people stopping smoking is extremely difficult. Part of the explanation for this difficulty is that nicotine is an addictive substance.

⁸⁸ John Stuart Mill, *On Liberty*, first published in 1859

⁸⁹ Constitution of the World Health Organization, http://w3.who.sea.org/LinkFiles/About_SEARO_const.pdf

1. Background

Over the past fifty years there has been a growing body of evidence that nicotine is an addictive substance. Tobacco industry documents from as far back as the 1960's demonstrate that the industry was aware that nicotine was addictive, and this accounted for why many people continued to smoke despite knowing about the potential detrimental health effects.⁹⁰ In 1979, a British America Tobacco (BAT) memo said:

We also think that consideration should be given to the hypothesis that the high profits additionally associated with the tobacco industry are directly related to the fact that the consumer is dependent on the product.⁹¹

In 2000, the Royal College of Physicians published a report on smoking, "*Nicotine Addiction in Britain*". The central message of the report was that smoking should be understood as primarily a 'manifestation of nicotine addiction'.⁹² The report summarised the research into the properties of nicotine.

Nicotine research expanded rapidly, in particular in the US after the earlier start in Britain in the 1960s and 1970s. Animal self-administration studies, together with many other types of study - neurochemical, absorption and dependence, craving and withdrawal, titration and effectiveness of nicotine replacement therapy (NRT) - all showed that nicotine was addictive. Behavioural studies in both Britain and the US finally confirmed that withdrawal symptoms were nicotine related.⁹³

Necessary criteria for substance misuse, under the World Health Organisation International Classification of Diseases, include:

- A strong desire to take the drug
- Difficulty controlling use
- Persisting in use despite harmful consequences
- Sometimes, a physical withdrawal state
- A higher priority given to drug use than to other activities and obligations.⁹⁴

It can be seen that smoking fulfils, to a greater or lesser extent, all of the above criteria so does meet the standard diagnostic criteria for addiction.

a. *Nicotine addiction*

The Royal College of Physicians report, "*Nicotine Addiction in Britain*", stated that nicotine was as addictive as other drugs traditionally associated with drug misuse such as heroin and cocaine.

⁹⁰ Nicotine and Addiction, factsheet no:9, Action on Smoking and Health, September 2004

⁹¹ Tobacco Institute, September 1980, Minnesota trial Exhibit 14,303, quoted in Nicotine and Addiction, factsheet no:9, Action on Smoking and Health, September 2004

⁹² Moxham J, "Nicotine addiction", *British Medical Journal*, 12 February 2000

⁹³ Nicotine Addiction in Britain, Chapter 4; Is Nicotine a drug of addiction?, A report of the Tobacco Advisory Group of the Royal College of Physicians, 2000

⁹⁴ Nicotine Addiction in Britain, Chapter 4; Is Nicotine a drug of addiction?, A report of the Tobacco Advisory Group of the Royal College of Physicians, 2000

Addiction to nicotine is far more common than addiction to cocaine, heroin or alcohol, and the rate of graduation from occasional use to addictive levels of intake is highest for nicotine in the form of cigarettes. Depending upon the definition used for occasional use, 33-90% of occasional users escalate to become daily smokers. In contrast, even when highly addictive dosage forms of cocaine (i.e. smokeable 'crack' cocaine) are readily available in the US, the risk of progression from any use to regular use is the exception, not the rule.⁹⁵

Absorption of cigarette smoke is quick and results in a rapid delivery of a high concentration of nicotine to the brain. This mode of administration allows a very fine regulation of nicotine intake. Studies have shown that smokers will smoke in a manner that enables them to achieve the desired blood nicotine level. A 'light' cigarette with lower nicotine content will be smoked in a way to allow greater nicotine absorption by taking deeper and longer inhalations.⁹⁶ Blood levels of nicotine fall rapidly and to maintain a raised steady blood nicotine cigarettes need to be smoked every one to two hours.⁹⁷ Withdrawal symptoms may be experienced within a few hours of smoking the last cigarette.

Nicotine withdrawal is characterised by irritability, restlessness, impaired concentration and increased appetite. However, it is difficult to determine whether all the symptoms produced by smoking cessation are due to nicotine withdrawal. It is likely that this is only one factor, although perhaps the major factor, in a more complex picture. Social and behavioural influences are also important in determining whether an individual continues to smoke. There may also be other constituents of cigarette smoke that contribute to the addictive effect of cigarettes.⁹⁸

Nicotine replacement therapy has an important role in smoking cessation treatments. There is strong evidence that nicotine replacement therapy reduces the severity of the cigarette withdrawal syndrome. The table below shows the symptoms commonly experienced on stopping smoking.⁹⁹

Effects of nicotine withdrawal

<i>Symptom</i>	<i>Duration</i>	<i>Incidence (%)</i>
Lightheadedness	< 48 hours	10
Sleep disturbance	< 1 week	25
Poor concentration	< 2 weeks	60

⁹⁵ Nicotine Addiction in Britain, Chapter 4; Is Nicotine a drug of addiction?, A report of the Tobacco Advisory Group of the Royal College of Physicians, 2000

⁹⁶ Moxham J, "Nicotine addiction", *British Medical Journal*, 12 February 2000

⁹⁷ Jarvis M, "ABC of smoking cessation: Why people smoke", *British Medical Journal*, 31 January 2004

⁹⁸ Nicotine Addiction in Britain, Chapter 4; Is Nicotine a drug of addiction?, A report of the Tobacco Advisory Group of the Royal College of Physicians, 2000

⁹⁹ Jarvis M, "ABC of smoking cessation: Why people smoke", *British Medical Journal*, 31 January 2004

Craving for nicotine	< 2 weeks	70
Irritability or aggression	< 4 weeks	50
Depression	< 4 weeks	60
Restlessness	< 4 weeks	60
Increased appetite	< 10 weeks	70

However, smoking arises from a complex interaction of environmental, social and genetic factors, and it is necessary to address all these aspects to attempt to reduce the incidence of smoking.

The link with nicotine addiction does not imply that pharmacological factors drive smoking behaviour in a simple way and to the exclusion of other influences. Social, economic, personal, and political influences all play an important part in determining patterns of smoking prevalence and cessation. Although drug effects underpin the behaviour, family and wider social influences are often critical in determining who starts smoking, who gives up, and who continues.¹⁰⁰

D. Economic cost of a ban on smoking on the hospitality and tobacco industries

There is a lack of consensus on the likely costs of implementing a smoking ban in enclosed public spaces to the hospitality and tobacco manufacturing industries.

Arguments put forward by the hospitality and tobacco trade focus on the adverse impacts on these sectors of the economy, should a ban be introduced. Much attention has focused on the impact of the ban in Ireland. Yet the exact cost to industry of the ban on smoking in public places in Ireland is unknown, and in countries where a ban has been introduced there is insufficient data to show any meaningful trends at this stage.

The Chartered Institute of Environmental Health (CIEH) represents local authority officers who are responsible for enforcing a ban. The existing powers and functions of local authorities are set out in Chapter 3 of CIEH's Toolkit '*Achieving Smoke Freedom*'.¹⁰¹ CIEH's earlier submission to NAW refers to evidence from a review by Scollos et al of 97 studies on the impact of the ban world wide.¹⁰² The study concluded that all independent studies found no negative impact on revenue, and negative studies had tobacco industry backing and mostly subjective measures.¹⁰³

¹⁰⁰ Jarvis M, "ABC of smoking cessation: Why people smoke", *British Medical Journal*, 31 January 2004

¹⁰¹ Achieving smoke freedom Toolkit, CIEH/ASH <http://www.cieh.org/research/smokefree/>

¹⁰² Committee on Smoking in Public Places Agenda Paper 2 13 January 2005 Chartered Institute of Environmental Health <http://www.wales.gov.uk/keypubassemssmoking/content/0105-paper2-e.htm>

¹⁰³ Review of the qualities of studies on the economic effects of smokefree policies on the hospitality industry. Scollo M, Lay A, Hyland A and Glantz S. *Tobacco Control* 2002; 12: 13-20.

The Tobacco Manufacturers Association asserts that it is not a straightforward matter to measure the costs and benefits of a ban in economic terms. It questions in particular the validity of models and studies supporting a ban that fail to specify their underlying assumptions, use subjective data or are not set in the UK context.¹⁰⁴

It is therefore unclear to what extent the impact of the ban on smoking in public places has had on tobacco manufacturers. Many believe the tobacco industry has been hard hit by the legislation. It is estimated that smokefree public places would cost the tobacco industry £310 million in lost sales every year in the UK.¹⁰⁵

It is difficult to say with any certainty, however, if the fall in cigarette volume sales experienced in Ireland is a direct result of the ban or if it is part of a wider trend towards greater health consciousness fuelled by mounting concerns over the adverse effects and the ever-rising cost of smoking. The ban may not be a direct cause of falling cigarette sales, but it may have served as a catalyst to an ongoing trend. As such it is possible that sales may stabilise in the long-term at a much lower level as the new patterns of permitted smoking are assimilated into Irish culture.

Evidence from other countries and cities that have introduced smoking bans (such as Los Angeles, Vancouver and most recently New York) indicate a short-term reaction followed by a period of normalisation as smokers become accustomed to the new regulations.

In regards to the hospitality industry, the Public Health White Paper¹⁰⁶ notes:

There have been reports of falling bars sales in Ireland following the ban. However, Irish retail sales data from the Central Statistics Office shows bar sales falls after the ban in line with the year on year falls since 2000. In general there is a lack of international evidence to support a prediction of a drop in sales in the hospitality industry.

Euromonitor International¹⁰⁷ states that because smoking and drinking in Ireland go hand in hand, pubs have reported dramatic sales losses in the few months following the ban. It seems that with customers now unable to enjoy a cigarette with their drink, many are choosing to drink at home instead.

A report from the Irish Central Statistics Office¹⁰⁸, however, revealed that in November 2004 (seven months after the ban was introduced) bar sales were down just 2.8 per cent compared with the previous year. The decrease in the year before was 7.1 per cent, and thus declining hospitality industry sales following the ban should be viewed in the context

¹⁰⁴ Misleading smoke signals. TMA *House Magazine* 11 October 2004

¹⁰⁵ Fichtenberg CM and Glantz SA. Effect of smokefree workplaces on smoking behaviour: systematic review. *BMJ* 2002; 325:188

¹⁰⁶ Partial regulatory impact assessment: Choosing Health white paper - Action on second-hand smoke <http://www.dh.gov.uk/assetRoot/04/09/48/41/04094841.pdf>

¹⁰⁷ http://www.euromonitor.com/Tobacco_in_Ireland

¹⁰⁸ Retail sales index. Dublin, Central Statistics Office Ireland, 2003 & 2004

of the long-term trend in Irish bar sales. Recent statistics, however, suggest retail sales in bars have increased for the first time in four years and there are 1,400 more people employed in that sector.¹⁰⁹ The Office of Tobacco Control¹¹⁰ in Ireland reports:

The 2004 Annual Report carried out an evaluation of the official hospitality sector data. It showed that there had been no adverse economic effect from the introduction of the Republic's smoking control measures. Bar retail sales in volume terms increased during the last three-month period (year-on-year) following a four-year decline. The numbers employed in this sector in the first quarter of this year increased to 23,200 - up 1,400 from the previous quarter. This represents the most significant quarterly increase in employment since the second quarter of 2002.¹¹¹

In Norway, the number of pubs, bars and restaurants that went bankrupt declined in the seven month period after the smoking ban was implemented in 2004. In 2003, 386 businesses in the sector went bankrupt and in 2004, this declined to 372, including the closure of 338 restaurants and 34 bars.¹¹²

A report commissioned by the Chief Medical Officer in England revealed that concern about falling profits is unfounded.¹¹³ In other parts of the world where legislation to create smokefree public places and workplaces has been introduced, profits in the hospitality and leisure industries have risen. Independent economic analyses carried out for the Irish Government and the Scottish Executive drew similar conclusions.¹¹⁴

Yet in Wales, Licensed Victuallers Wales (LVW) expressed its concern in a submission to the NAW consultative committee that many smaller pubs could be put out of business through a ban.¹¹⁵ LVW felt that larger pubs will more easily withstand a reduction in turnover caused by a ban. Full consideration of the economic impact of a smoking ban in pubs in Wales can be found in the Library's Research Paper 05/22 The Smoking in Public Places (Wales) Bill.

In regards to sales in pubs, results from attitudinal surveys in Great Britain suggest three quarters (76 percent) of people would visit pubs as often as they do now, but 20 percent say they would go more often. 30 percent of non-smokers say they would visit a pub more often if smoking was restricted. Even among smokers, the vast majority (85

¹⁰⁹ HL Deb 10 November 2005 c717-8

¹¹⁰ <http://www.otc.ie>

¹¹¹ Department of Health Social Services and Public Safety Press Release *Arguments against total smoking control don't add up* 17 October 2005 <http://www.nics.gov.uk/press/hss/051017g-hss.htm>

¹¹² Fewer businesses bust after smoking ban, 2005

¹¹³ On the state of the public health: Annual report of the Chief Medical Officer 2003. HMSO: London, UK Department of Health, 2004

¹¹⁴ Durkan J, Macdowell M. Smokefree Policies: Market Research and Literature Review on Economic Effects on the Hospitality Sector. Clane, Office of Tobacco Control, 2003. & Ludbrook A, Bird S, Van Teijlingen E. 2004. International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places

¹¹⁵ Committee on Smoking in Public Places Agenda Paper 5 Response from the Licensed Victuallers (Wales) Ltd 120 February 2005 <http://www.wales.gov.uk/keypubassemsmoking/content/0205-paper6-e.htm>

percent) say they would visit about as often as they do now, and only 12 percent would visit less often.¹¹⁶

In New York the City Finance Commissioner, Martha Stark, reported that the business tax revenue from the city's hospitality venues rose by 12% and 10,000 new jobs had been created in the first nine months since the tobacco ban took effect.¹¹⁷

However, evidence to the NAW Consultative Committee from the New York Nightlife Association, the Empire State Restaurant and Tavern Association and the United Restaurant and Tavern Owners, USA, suggest that reports that the total ban in New York has been an unqualified success are wrong; that the latest statistics from an independent report are 'damning' in terms of the economic effect the ban has had on the hospitality industry in New York.¹¹⁸ They note that economic statistics from bars and restaurants are not separated from other catering outlets. In addition, the ban was imposed post 9/11 during a recession; comparison with 2000 figures would present a different picture.

E. Costs and benefits to the Exchequer

A partial ban on smoking in public places would have costs and savings to the Exchequer, as detailed in the Partial Regulatory Impact Assessment – smokefree aspects of the Health Bill.

The main expected savings to the Exchequer from a partial ban on smoking in public places is the likely reduction in NHS expenditure through reduced smoking prevalence. It is estimated that a complete ban on smoking in public places would result in a fall in smoking prevalence of 1.7 percentage points. Overall smoking is estimated to cost the NHS around £1.5bn each year, and a reduction in smoking will reduce that burden (a 1.7 percentage point reduction in smoking rate from 25% would mean an estimated annual saving of £100m to the NHS. It is estimated that a partial ban would result in an estimated annual saving of £40-100m).

Other expected savings would result from greater productivity and efficiency at work, through reduced costs from sickness absence and time lost from smoking breaks.

The introduction of a partial ban on smoking is likely to lead to a number of costs to the Exchequer. There will be implementation and enforcement costs, including publicity and education campaigns about the legislation. The ban on smoking is likely to mean that some smokers will quit or smoke less, and there will be a loss to the Exchequer from taxes on cigarettes.

There may also be unintended consequences of the ban, such as costs to local authorities in cleaning up/providing disposal for cigarette butts in outdoor public places,

¹¹⁶ Achieving smoke freedom Toolkit, CIEH/ASH <http://www.cieh.org/research/smokefree/>

¹¹⁷ *New York Times* 1 April 2004

¹¹⁸ Committee on Smoking in Public Places Agenda Paper 3 9 December 2004 Written response 34 CIEH <http://www.wales.gov.uk/keypubassem smoking/content/0404-paper3-e.pdf>

and possible increases in antisocial behaviour from smokers drinking on the streets or at home, rather than in licensed premises.

The table below shows the likely costs and benefits of introducing the partial ban on smoking in public places.

Costs and Benefits of introducing a partial ban on smoking

Benefits

		<u>Annual Benefits (£m)</u>
Health Benefits		
Averted deaths from secondhand smoke	Employees	21
	Customers	150-250
Averted deaths from smokers giving up	Employees	1,600
	Customers	0-180
Averted deaths from reduced uptake of smoking		550
Economic and environmental benefits		
NHS expenditure saved through reduced smoking prevalence		40-100
Reduced sickness absence		28-140
Production gains		306-612
Safety Benefits		57-63
Reduced cleaning and maintenance costs		90-100
Total Benefits		2,842-3,616

Costs

		<u>Annual Costs (£m)</u>
Implementation		Minimal
Enforcement		7-20
Education/Communication		1
Revenue losses to the Exchequer	Employees	589
	Customers	0-113
Unintended consequences		-
Production losses		430
Consumers' surplus losses to continuing smokers		155
Total Costs		1,538-1,675
Net benefit		1,304-1,941

Source: DH, Partial Regulatory Impact Assessment - smokefree aspects of the Health Bill

Notes:

Employees are those benefiting from smokefree policies at their workplace

Customers are people making use of smokefree enclosed public places

F. Smoking and Litter

As smoking legislation leads to more cigarettes being smoked outside, one area of concern for environmental groups and local authorities is the rise in smoking related litter. Cigarette material is one of the most common types of litter around the world. Cellulose acetate filters may take up to 15 years to biodegrade and once disposed of will leach into their surroundings the toxic chemicals they absorbed during use.

The *Clean Neighbourhoods Act 2005* clarified the law on littering and cigarettes by expressly classifying discarded ends of cigarettes, cigars and similar products as litter.¹¹⁹ This means that under section 87 of the *Environmental Protection Act* fixed penalties can be issued to anyone dropping a cigarette end.

In February 2005 INCPEN, The Industry Council for Packaging and the Environment, released details of a study it commissioned from ENCAMS, the Environmental Campaigns group. The report found cigarette ends, along with chewing gum, to be the most prevalent form of litter in the UK. The report also suggests that a recent increase in smoking related litter is the result of more smokers being forced to smoke in the streets as more places ban smoking inside.¹²⁰

On 14 July 2005 the Government replied to a question by Caroline Spellman into the estimated affect of a smoking ban on litter and gave details of a forthcoming campaign to tackle the problem:

Smoking

Mrs. Spelman: To ask the Secretary of State for Environment, Food and Rural Affairs what estimate the Government have made of the effect of a public smoking ban on cigarette litter in the streets. [4298]

Mr. Bradshaw: Government have not made any estimate of the effect a ban on smoking in public would have on cigarette litter in the streets. However, restrictions on smoking in the workplace do appear to have increased the amount of such litter. The Local Environmental Quality Survey of England, conducted by ENCAMS on behalf of Defra, monitors the prevalence of smoking-related litter, including cigarette ends, cigarette packages, matches and lighters, based on an assessment of over 10,000 sample sites. Over the first three years of the survey, there has been an overall increase in the proportion of sites that have some form of smoking-related litter present:

	Percentage of sites
2001–02	63
2002–03	60
2003–04	79

Defra is already taking action to reduce smoking-related litter. Section 27 of the *Clean Neighbourhoods and Environment Act 2005*, which came into force on 7 June, provides clarification that smoking-related materials are litter for the purposes of part 4 of the *Environmental Protection Act 1990*. Therefore offenders can be prosecuted or issued with a fixed penalty notice. In February next year, ENCAMS will be launching a public awareness campaign aimed at reducing cigarette butt litter, encouraging smokers to take greater responsibility for the litter they create. In addition, the campaign will specifically look to employers who

¹¹⁹ *Clean Neighbourhoods and Environment Act 2005*, Section 27.

¹²⁰ INCPEN Press Release, *Litter set to increase due to public smoking bans*, 7 February 2005.

allow their staff to smoke outside their premises to provide practical means of disposing of cigarette ends responsibly.¹²¹

G. Ventilation

Mechanical ventilation and air filtration systems supplement natural ventilation through windows and doors. They are used in a wide range of settings, and serve two main purposes. Firstly, they can be used to extract, eliminate or disperse a significant proportion of harmful, toxic or carcinogenic substances from the surrounding air. Where it is not possible to reduce exposure to certain hazardous substances, such as asbestos, below known control limits, suitable respiratory protective equipment must be provided.

Secondly, ventilation systems are used to replace hot, stale or humid air with sufficient quantities of fresh air, free from impurities in order to improve the comfort and well being of employees. Minimum replenishment rates for fresh air are offered in guidance to the *Workplace (Health, Safety and Welfare) Regulations 1992*. The rate is dependant on factors including the floorspace available per occupant, the workplace activities, if there are airborne contaminants, and if smoking is permitted in the work area.¹²²

Employers must take steps to ensure that the equipment is regularly cleaned, tested and maintained, to ensure it is fully functioning. At the same time the velocity of ventilation might cause uncomfortable draughts and needs to be controlled. An employer who fails to ventilate his workplace effectively may be liable under common law if an employee becomes sensitised to a known respiratory sensitiser, even if the relevant occupational exposure levels (OELs) for known harmful substances are observed or exceeded.

Ventilation systems have been suggested as a way for the hospitality industry to minimise the risks to staff from passive smoking. A report on behalf of the Dutch Government reported that displacement ventilation can reduce environmental tobacco smoke (ETS) in enclosed areas by between 50 to 90 per cent.¹²³ Most evidence suggests that ventilation systems help condition the air and make it feel more pleasant around the bar. However, many anti-smoking campaigners believe that they do not provide a solution to ETS; they say such systems tend to be very inefficient at removing all the harmful, carcinogenic elements from the air. They cite research which has shown that to extract and re-circulate air through filters fine enough to remove micro particles that can do damage to the lungs and achieve near ambient air quality levels would require suction power almost the equivalent of a jet aircraft engine.¹²⁴ This would not only be extremely uncomfortable for those in the vicinity, it would also be expensive to run and maintain. Given the profit margins in such establishments, many clubs may simply opt not to switch the systems on.

¹²¹ HC Deb 14 Jul 2005 c1157-8W.

¹²² Ventilation V30/1-11 in *Tolley's Health and Safety at Work Handbook 2006* 18th edition.

¹²³ de Gids, W.F. and Opperhuizen, A. Reduction of Exposure to Environmental Tobacco Smoke in the Hospitality Industry by Ventilation and Air Cleaning, RIVM Report 340450001/2004

¹²⁴ D. Kotzias, O. Geiss, P. Leva, A. Bellintani, A. Arvanitis, S. Kefalopoulos, Ventilation as a means of controlling exposure of workers to environmental tobacco smoke (ETS); Commission of the European Union, Joint Research Centre Institute for Health and Consumer Protection http://www.smokefreeeurope.com/assets/downloads/dimitrios_kotzias.doc

VI Comments on the Bill

1. Political parties

a. *Conservative Party*

The Conservative Party's Action on Health manifesto states that a voluntary approach is preferred to a statutory ban on smoking in public places.

We do not believe that food producers are to blame if people eat unhealthily, or that pubs are to blame if people drink or smoke. Therefore we will seek voluntary, not statutory solutions to public health problems.

A Conservative Government will agree a code with the pub industry which will remove smoking from around 80 per cent of pub space. We will ensure the industry achieves a smokefree environment wherever children are present, and protect staff who wish to work in a smokefree environment.¹²⁵

In comments supplied for this paper, the party line remains thus:

"We want a workable solution which will severely restrict smoking in enclosed public places, but any solution must achieve three, clear aims. First, it must ensure that people are not exposed to second-hand smoke if they do not want to be. Second, it must ensure that children are not exposed to second-hand smoke. Third, it must protect staff who work in pubs and clubs.

"It is for Parliament to decide the best way through which these aims can be achieved. They could be achieved through self-regulation, or through legislation, but Conservative MPs will be given a free vote on the way forward."¹²⁶

b. *Liberal Democrats*

In comments supplied for this paper, the Liberal Democrat position is set out thus:

Liberal Democrats believe that everyone has the right to be protected from the harmful effects of second hand smoke in their working and social lives. That is why we support the introduction of national legislation to make all workplaces and enclosed public places smoke free.

There is now conclusive evidence that passive smoking causes lung cancer. Standing in the path of a smoker or being in a room where there are smokers brings people into contact with at least 50 agents known to cause cancer. The British Medical Association has estimated that as many as 1,000 people each year die as a result of passive smoking.

We are committed to tackling the causes of ill health, not just treating the symptoms. This aim is frustrated by passive smoking since the presence of

¹²⁵ *Action On Health* Conservative Manifesto 2005 Chapter 3, Feb 2005
<http://www.conservatives.com/tile.do?def=policy.topic.page&tabID=4>

¹²⁶ Conservative Party comments supplied 2 November 2005

2. Health and medical opinions

a. *Chief Medical Officer*

The Chief Medical Officer, Sir Liam Donaldson recommended “Very serious consideration should be given to introducing a ban on smoking in public places soon.” in his *State of the Nation* report 2002, published in July 2003.¹²⁹

In a letter of 7 November 2005 to the Chairman of Cancer Research UK, publicised by the Smokefree Action Coalition in their briefing on this Bill,¹³⁰ Sir Liam writes:

I have been pleased that the public opinion and the stakeholders are now supportive of its approach. When my 2002 Report was published, reaction was more mixed.

I should make it clear that, firstly, since the consultation closed, I have formally advised the Health Secretary that the evidence supports the approach on smoke free public places and workplaces and it is the action that should be implemented.

Finally, I have made clear that I am totally opposed to the various hybrid proposals that were discussed and my view was made known to members of the relevant Cabinet Sub-Committee.¹³¹

b. *Health charities and medical groups*

Health charities and medical bodies have expressed uniform dismay at the intention not to bring in a total ban on smoking in licensed premises. Many form part of the Smokefree Action Coalition (ASH, Cancer Research, Asthma UK, British Heart Foundation, BMA, Chartered Institute of Environmental Health, etc). The Coalition’s website contains detailed evidence on the case for comprehensive smokefree legislation.¹³²

The Executive Summary to its second reading brief on the Health Bill states:

1. An end to all smoking in workplaces and enclosed public places would protect non-smokers from the damaging effects of secondhand smoke, and would encourage many smokers to quit. The partial ban proposed in the Health Bill will protect many workers and members of the public but leave some of those at most risk still exposed to the health risks of secondhand smoke. It will also reduce the number of smokers quitting as a result of the legislation, worsen health inequalities and produce perverse and unfair competition between licensed premises.

¹²⁹ Annual Report of the Chief Medical Officer 2002, Department of Health 2003
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/CMOAnnualReportsArticle/fs/en?CONTENT_ID=4006432&chk=2qDtw4

¹³⁰ Health Bill: Smoking in workplaces and enclosed public places, Briefing Note for MPs: Second Reading Debate Smokefree Action Coalition November 2005

¹³¹ Letter 7 November 2005 from CMO Liam Donaldson to Professor Alex Markham Cancer Research UK

¹³² <http://www.smokefreeaction.org.uk>

2. Smokefree legislation is essentially a yes/no question. Once the health and safety case and public health benefits are conceded it is really not possible to find a compromise (whether exemptions for some premises, separate smoking areas, ventilation systems or whatever) that is both practical and logical.

3. There is still time for the Government to ensure that workplaces and enclosed public places in England will have the same protection from secondhand smoke as will soon be available in Scotland, Wales and Northern Ireland and already exists in the Irish Republic. The current Government proposals for England are a cumbersome and ineffective mess.¹³³

c. *British Medical Association*

The BMA, which represents many doctors, is dismayed at the Government's failure to implement a total ban on smoking. BMA Chairman, James Johnson, expressed 'utter disappointment' at the 'wasted opportunity to protect the public's health'.

"The Government has thrown away the opportunity of a lifetime to protect the public's health. It is astonishing.

"I cannot believe that, after consulting for three months, this Government has decided not to listen to the vast amount of conclusive evidence that secondhand smoke kills and what was needed was a total ban.

"They are letting down people all over the country leaving workers in England exposed to health dangers from which their colleagues in Scotland, Northern Ireland and potentially Wales, are protected.

"The BMA will continue to lobby at every opportunity while this legislation goes through parliament to try and change this situation."¹³⁴

d. *Royal College of Physicians*

The Royal College of Physicians (RCOP) recently appeared before the Health Select Committee to press its case for a total ban. Commenting on the publication of the Bill, Professor Dame Carol Black, President of the RCOP, said:

"When the Royal College of Physicians produced its first report on Smoking and Health in 1962 and began its campaign as the first medical organisation to lobby for a smoke free Britain, we could not have conceived that it would be over forty years before many of the recommendations became public policy. The publication of the Health Bill today, banning smoking in public places, covering 99% of the population, is a momentous leap for the UK. However, with the exemption for pubs that do not serve food, we are now one step behind more enlightened countries who have complete and publicly supported bans such as Australia and Ireland. In order to offer the same protection from death and disease to people who have to work in exempted places, we will continue our

¹³³ Health Bill: Smoking in workplaces and enclosed public places, Briefing Note for MPs: Second Reading Debate Smokefree Action Coalition November 2005

¹³⁴ BMA News Release *Doctors express utter disappointment at wasted opportunity on smoking ban* 26 October 2005 <http://www.bma.org.uk/pressrel.nsf/wlu/SGOY-6HJLDH?OpenDocument&vw=wfmms>

long-running campaign and pursue a complete ban. Until then, UK physicians remain disappointed in the Government's lack of leadership on fundamental public health issues."¹³⁵

e. Royal College of Nursing

Smoking is to be phased out in the health service by the end of 2006. Many staff, including mental nurses working with patients who are voluntarily or compulsorily detained in mental health settings, or supporting them in their own homes will not be covered by the Bill.

In comments supplied for this paper RCN states:

The RCN is deeply dismayed that the Government has failed to introduce a total ban on smoking in all enclosed public places. The Government has wasted an opportunity to protect workers and members of the public who have no choice but to breathe in the smoke of others.

...

The RCN continues to believe that only a complete ban on smoking in all enclosed public places will adequately protect the health of workers, encourage people to give up and help to achieve the Government's targets to reduce the health inequalities gap between the richest and poorest communities. This position was supported overwhelmingly by 86 per cent of members at the 2004 RCN Congress.¹³⁶

f. British Heart Foundation

Maura Gillespie, Head of Policy and Public Affairs at the British Heart Foundation criticised the Government's "reckless abandonment of its duty to protect all employees at work".

"It is really quite staggering that after months of consultation and an extraordinary week of bitter wrangling, we are left with a nonsensical legislative proposal that takes us back to where we were 12 months ago.

"This bill, if allowed to pass through parliament unchanged, will seriously harm the Government's attempts to reduce health inequalities.

"Pubs in the poorest areas will become smoking dens and it will be impossible for landlords to protect their staff from inhaling their customers' smoke. It may be inconvenient for the Government, but tobacco smoke will not obey invisible boundaries decreed by statute.

"We are surprised and disillusioned by this absurd fudge. It is extremely frustrating and saddening that the Government looks set to ignore the strongly held views of the medical community, with all its expertise and credibility, in

¹³⁵ RCOP News Release *RCP Comment on Health Bill* 27 October 2005
http://www.rcplondon.ac.uk/news/news.asp?PR_id=285

¹³⁶ Royal College of Nursing comments on Smoking Elements of the Health Bill, November 2005.

deference to some members of the cabinet, who clearly still fail to grasp the seriousness of this issue.

"Let us be absolutely clear: tobacco smoke is not just an irritation – it kills. Like asbestos, it has no place in any workplace, whether it serves food or not.

"Conclusive evidence of the danger of passive smoking has been laid before the Government and they have chosen to ignore it. This is nothing short of a reckless abandonment of its duty to protect employees at work."¹³⁷

g. Cancer Research UK

The Chief Executive of Cancer Research UK, Professor Alex Markham said:

"We are utterly dismayed that the Government has not listened to doctors, health charities and the public, all of whom have voiced overwhelming support for a smoke free law without exemptions.

"The compromised law will be unworkable. It also sends out a terrible message – that the Government is prepared to protect the health of some workers while leaving others exposed to the seriously damaging effects of secondhand smoke.

"Sadly, people will die as a consequence of this half-hearted decision. The scandalous fact is that the Government is fully aware of this, and is reneging on its fundamental duty to protect the people.

"It is disgraceful that the people of England will not enjoy the health benefits afforded to those in other parts of the UK, where total bans are planned.

"We will continue to do all that we can to get these exemptions dropped."¹³⁸

3. Tobacco and hospitality industries

a. Industry views

The Tobacco Manufacturers Association (TMA) represents the interests of UK tobacco manufacturers; its principal members are British American Tobacco, Gallagher and Imperial Tobacco. TMA is sceptical about the representative nature of opinion polls that show a substantial majority of the population in favour of a total ban on smoking. It also questions the scientific basis of a causal link between environmental tobacco smoke and ill health. Accepting the need for greater provision of non-smoking outlets, its main stance is to support individual freedom of choice, within a framework of voluntary self-regulation.¹³⁹

¹³⁷ British Heart Foundation News Release *BHF "surprised and disillusioned" by Cabinet smoking ban decision* 27 October 2005

<http://www.bhf.org.uk/news/index.asp?secID=16&secondlevel=241&thirdlevel=1728&artID=7710>

¹³⁸ Cancer Research UK News Release *Reaction to the Government's smokefree workplaces plans* 27 October 2005 http://www.cancerresearchuk.org/news/pressreleases/govt_smokefree_work

¹³⁹ Misleading smoke signals. TMA *House Magazine* 11 October 2004

In its response to this Bill TMA welcomes the fact that the Government has made at least some provision for smokers, but would have liked the Government to have gone further, and made more provision for smokers across the hospitality sector.

Commenting on the announcement Tim Lord, chief executive of the TMA, said,

"We applaud the Government's decision to make provision for smoking in pubs and clubs where no food is served. However we are disappointed that there has not been a provision for separate smoking rooms in all pubs, restaurants and clubs as well. What's important is that choice is maintained, unfortunately not enough for England's 10 million smokers."

The announcement that private clubs will be able to decide their own smoking policy was also welcomed. Tim Lord said, "Private clubs are just that - private places. It should be up to club members to decide their own smoking policy, with safeguards for employees." ¹⁴⁰

Gareth Davis, the chief executive of Imperial Tobacco, took a more defiant stance, saying he was "not happy at all" about the Government's smoking ban proposals but added that the effect would be minimal in the long run."

Mr Davis deplored government plans to introduce smoking bans in offices, restaurants and pubs serving food in England and Wales by the summer of 2007. Even so, he predicted confidently: "It is clear that smokers will continue to smoke. There may be an initial dip in consumption but this diminishes over time." Mr Davis pointed to Ireland, where cigarette consumption fell by 5 per cent after a ban was introduced but volumes are now perking up again, he said. Even so, he admitted that the long-term impact of the English smoking ban would probably be to reduce consumption by 1 to 2 per cent. Mr Davis, a keen smoker himself, said he understood that non-smokers might be irritated by smoke but added: "We don't believe there is sufficient scientific evidence to show that second-hand tobacco smoke causes disease. If there is a risk, then it's a very small one." ¹⁴¹

Although opinions vary across the hospitality sector, with some organisations proposing that the voluntary approach is the best way forwards, many companies and their representative bodies have reconciled themselves to statutory control. Many are concerned that the proposed exemptions in the licensed trade and in private membership clubs will lead to market distortion and unfair competition, and would prefer a full ban in such premises.¹⁴² Some would like a longer lead in time for a full ban than the Government proposes in order to give businesses and customers more time to prepare.

Although J.D. Wetherspoon has reported a fall in profits due to falling bar sales, which have not been offset by a slight rise in food sales, the company is committed to making

¹⁴⁰ News Release Wednesday 26 October 2005 *Tobacco Manufacturers' Association Response to Government Announcement on Smoking in Public Places*
<http://www.prnewswire.co.uk/cgi/news/release?id=156927>

¹⁴¹ The *Independent* (UK), 25 November 2005

¹⁴² "Leisure chiefs call for full smoking ban", *Financial Times*, 18 November 2005

all of its outlets smoke free by May 2006; thirty of its premises have already been opened or converted.

Some representatives, such as the Federation of Licensed Victuallers' Associations, support measures to make some provision for smokers. Prior to publication of the Bill endorsement was given to the 'smoking carriage' proposal – separate rooms where smokers would be sealed in, food and drink would not be served and staff would not go during business hours.¹⁴³ The British Beer and Pub Association, which favours this approach, recognises that there are practical difficulties, which need more time for discussion.¹⁴⁴ The Association of Licensed Multiple Retailers has proposed an exemption only for the smallest and most economically marginal businesses.¹⁴⁵

4. Trade Unions

The Tobacco Workers' Alliance (TWA) is a coalition of Amicus, Transport and General Workers Union (T&G) and GMB trade union members who work in the UK tobacco manufacturing industry and its major suppliers, currently representing 7,500 workers across the UK, supported by the Tobacco Manufacturers' Association.

TWA does not support a total ban on smoking in public places and has expressed its concern over the impact that a smoking ban could have on jobs in the hospitality, tobacco and related industries.

In its submission to the NAW Committee, TWA "fully recognises that there are health risks associated with tobacco products and fully supports reasonable and responsible regulation of tobacco products.....However tobacco products are legally manufactured, sold and consumed in the UK and while this remains the position adults should not be marginalised or vilified because they smoke."¹⁴⁶

Commenting on this Bill, Brenda Warrington, TWA's Chair, said:

"We welcome the Government's decision to honour its manifesto commitment and rule out a draconian ban on smoking in all public places. However, we are concerned the proposals will still have a serious impact on jobs. The TWA believes there are more practical solutions to the issue than just banning smoking everywhere but pubs that don't serve food."

"We also see no reason why smoking rooms, which have already helped ensure that 88% of workplaces have some form of smoking restriction, cannot continue to be used effectively in offices and factories across the UK."

The TWA has been calling for measures to tackle smoking in pubs, such as more non-smoking or separate smoking areas, bans on smoking at the bar and

¹⁴³ "New rumours on smoking spark fresh hope", *Publican* 13 October 2005

<http://www.thepublican.com/cgi-bin/item.cgi?id=18811>

¹⁴⁴ Memorandum (SP 36) to the Health Select Committee enquiry on Smoking in Public Places

¹⁴⁵ Memorandum (SP 24) to the Health Select Committee enquiry on Smoking in Public Places

¹⁴⁶ Committee on Smoking in Public Places Agenda Paper 4 Tobacco Workers Association 13 January 2005 <http://www.wales.gov.uk/keypubassemoking/content/0105-paper4-e.htm>

improved ventilation. It believes that these policies would serve to improve the welfare of hospitality employees without putting jobs at risk.¹⁴⁷

The Trades Union Congress on the other hand has called for smoking to be banned in all public places to defend workers against the effects of passive smoking. It believes that there should not be a blanket ban without due consultation with trade unions, and that employers should strive to achieve balance through effective smoking policies.¹⁴⁸

Reacting angrily to the Government's announcement on the Bill, TUC General Secretary Brendan Barber said:

'This is missed opportunity that is very disappointing. The government is now going ahead with proposals that were overwhelmingly rejected in a public consultation as unworkable. If ministers cannot agree among themselves, then they should give MPs a free vote.'¹⁴⁹

5. Enforcement bodies

The Chartered Institute of Environmental Health (CIEH), whose members will be responsible for enforcing smoking legislation, has described government proposals for a partial curb on smoking in public places as "contradictory, complex and unenforceable." Speaking on behalf of the CIEH director of policy Ian Foulkes said:

"Linking smoking to food consumption is itself illogical in public health terms – and in many pubs/clubs the law will not protect bar staff, unethically requiring our members to protect some workers while not others," Mr Foulkes continued.

It is feared that as many as one in five pubs will stop selling food in order to accommodate smokers. On-street consumption of fast food is expected to increase as burger vans proliferate, in contrast to government healthy eating messages

Mr Foulkes said: "By sticking to its bodged manifesto pledge, the government has pleased no one and shown itself to be completely lacking in direction or conviction.

"The only winners out of this will be the tobacco industry who will continue to make profit out of damaging the health of our nation – it begs the question as to what is government for, if not to protect health."

The CIEH, the professional body for environmental health practitioners tasked with enforcing the legislation, is calling for a comprehensive, unambiguous and positive legal measure that will protect all employees and members of the public from the significant risks associated with second-hand tobacco pollution.¹⁵⁰

¹⁴⁷ Tobacco Workers Alliance News Release *Tobacco Workers Concerned Smoking Ban Will Hit Jobs* 26 October 2005 <http://prnewswire.co.uk/newsindex.shtml?/cgi/news/release?id=156928>

¹⁴⁸ TUC News Release, *Wales TUC calls for a ban on smoking in public places* 1 November 2004

¹⁴⁹ TUC News Release, *Missed opportunity to make all workplaces smokefree* 26 October 2005

¹⁵⁰ CIEH News Release *Enforcing government smoking ban next to impossible, says CIEH* 28 October 2005 <http://www.cieh.org/news/press/cpr2005/cpr2005028.htm>

The Local Government Association and Local Authorities Co-ordinators of Regulatory Services (LACORS) provide guidance to help support councils' regulatory activity. Cllr David Rogers OBE, the LGA's public health spokesperson, said:

"These regulations leave a smoky haze that councils will have to wade through in order to police these proposals. It is absolutely imperative that any ban is clear in what it means for it to be properly enforced.

"If a new law is to be introduced on the grounds of public health, then we cannot have a situation where some workers are still exposed to second-hand smoke. Legislation not only has to be enforceable, but fair as well."¹⁵¹

6. Heads Up Forum

Students participating with MPs in the Hansard Society supported online *HeadsUp Forum* between 19th September – 7th October 2005 were split three ways (in favour, against and undecided) on whether there should be a partial ban on smoking in public places.¹⁵²

VII Smoking and health inequalities

A. Background

Measures to reduce health inequalities are central to the Government's health policy. In 2004, the Treasury published the latest set of Public Service Agreement targets, which were developed and refined from those agreed in the last Spending Review. For the Department of Health, the PSA included the following objectives:

Aim

Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

Objectives and performance targets

Objective I: Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

1. Substantially reduce mortality rates by 2010:

- from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;

¹⁵¹ LGA Press Release 149/05 *Partial ban leaves councils in a 'smoky haze'* 27 October 2005
<http://www.lga.gov.uk/PressRelease.asp?id=SXDCAD-A7834263>

¹⁵² <http://www.headsup.org.uk>

- from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
- from suicide and undetermined injury by at least 20%.

2. *Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.*

3. *Tackle the underlying determinants of ill health and health inequalities by:*

- reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
- halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. Joint with the Department for Education and Skills and the Department for Culture, Media and Sport; and
- reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health. Joint with the Department for Education and Skills.¹⁵³

The Secretary of State for Health is responsible for the delivery of the targets in this PSA.

In addition the UK is using its term as president of the European Union to urge the region to focus on reducing health inequalities. In October 2005, an EU summit was held in London focusing on the issue. At the summit the Secretary of State for Health stated:

"Almost all important health problems, and major causes of premature death across Europe such as heart disease and cancer, are more common among people with lower levels of education and income," said the UK secretary of state for health, Patricia Hewitt, who hosted an EU summit in London this week, called "Tackling health inequalities—governing for health"

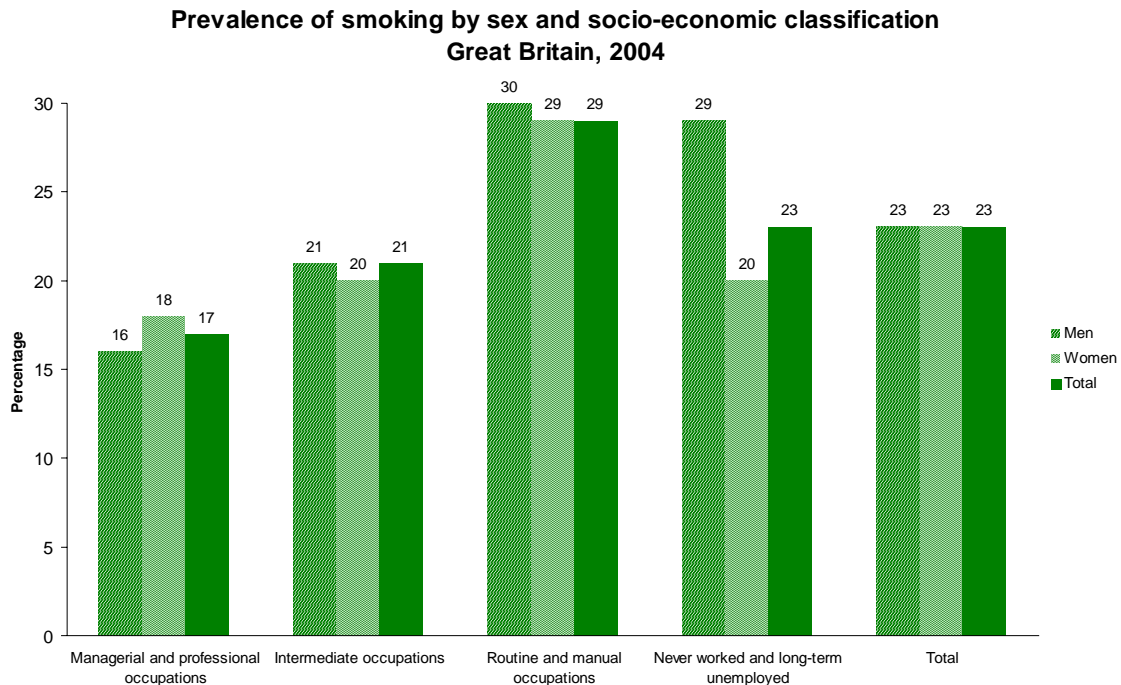
"Narrowing this health gap, and making good health a reality for everyone, is essential if we are to create a Europe of social justice as well as prosperity," she said.¹⁵⁴

Currently smoking has a strong association with social class. The chart below shows smoking prevalence by socio-economic classification in Great Britain, where prevalence is higher among people in routine and manual occupations. Although smoking in the UK has shown a general decline over the past fifty years, this trend has tended to hide the fact that smoking levels amongst socio-economically disadvantaged groups has remained relatively static, with a prevalence of more than 60% in the most

¹⁵³ Spending Review 2004: Public Service Agreements, HM Treasury, at: http://www.hm-treasury.gov.uk/media/4B9/FE/sr04_psa_ch3.pdf

¹⁵⁴ UK pushes EU to tackle health gap between rich and poor, *British Medical Journal*, Oct 2005;

disadvantaged groups.¹⁵⁵ This is mirrored by the figures on smoking cessation that demonstrate that there are lower success rates in the more deprived or disadvantaged groups.¹⁵⁶ Smoking prevalence rates also differ by region. Smoking rates are highest in the North East and North West of England (see page 58).



B. Potential effect of a partial ban

Concerns have been expressed by many health organisations that a partial smoking ban will have an adverse effect on health inequalities. It is likely that communities which already have higher than average smoking rates will be those most likely to be unaffected by legislation to introduce a partial smoking ban. This is because the proportion of pubs or bars not serving catered food tends to be higher in these areas. This exemption of pubs and clubs in the most deprived areas would undermine progress towards meeting the Government's targets of reducing health inequalities. The Government estimates that between 10 to 30 percent of pubs (between 5,000 and 16,000) will be exempt from smoke-free legislation. In addition, there are 19,913 registered clubs – clubs owned by the members – in England and Wales.¹⁵⁷

A number of surveys have looked at the potential effect of a partial ban on the poorer communities. Cancer Research UK and Action on Smoking and Health (ASH) commissioned a national survey, which looked at the likely effect on the pub trade of the proposed exemptions. The research found the potential detrimental health effects would

¹⁵⁵ Edwards R, "ABC of smoking cessation, The problem of tobacco smoking", *British Medical Journal*, 24 January 2004

¹⁵⁶ Chief Medical Officer, Update, Summer 2005

¹⁵⁷ Department for Culture, Media and Sport Statistical Bulletin Liquor Licensing, England and Wales, July 2003-June 2004)

be felt most in poorer areas of the country, where the proportion of pubs that do not serve food is higher than elsewhere. Additionally, the survey revealed that many pubs may stop serving food in order to become exempt from any smoking ban.

ASH believes a partial ban would threaten to undermine the Government's efforts to reduce public health inequalities through its range of healthier lifestyle strategies, including reducing the levels of smoking and states:

"the proportion of exempt pubs in England and Wales could rise by a third – from 29 per cent at present to 40 per cent – if the Government proceeds with a smoke free law that excludes pubs that do not serve prepared food. In the poorest areas, the proportion could be as high as 50 per cent."

Pub workers in deprived areas are already more likely to be exposed to secondhand smoke. Sixty-two per cent of surveyed pubs in the most deprived areas currently allow smoking throughout the premises – compared with 26 per cent in the most affluent areas.¹⁵⁸

Figures as at July 2005 from the British Beer and Pub Association (BBPA) confirm the figures above. The BBPA estimates that 19 percent of pubs do not prepare and serve food and an estimated 20% of the food pubs would discontinue food sales following the introduction of a ban on smoking.¹⁵⁹

The British Medical Association issued a press release commenting on further research looking at the likely geographical distribution of smoking and non-smoking pubs.

Research published by Biomedcentral today (Thursday 1 September, 2005) shows that 44% of pubs and bars across much of the Northwest of England do not serve food, and would therefore be exempt from smokefree legislation as currently proposed.

Commenting on the findings, Dr Vivienne Nathanson, head of science and ethics at the BMA, said:

"This is yet more evidence that a partial smoking ban will leave lives at risk, particularly in the poorest parts of the country. The research clearly indicates that pubs and bars will stop serving food in order to escape the ban. Unless it [the Government] shows leadership, and takes steps to make all public places in England smokefree, people's health will continue to be put at risk from passive smoking."¹⁶⁰

Written evidence to the enquiry by the Health Select Committee provides further support for the findings of these surveys on the probable impact of a partial ban. Southwark

¹⁵⁸ ASH Media Release "Health Inequalities Set to Worsen as Many Pubs Would Drop Food for Exemption from Smokefree Law" 5 September 2005

¹⁵⁹ http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT_ID=4121917&chk=sUauD/

¹⁶⁰ *Research adds to case for total public smoking ban, says BMA*, Press Release, British Medical Association, 1 September 2005; <http://www.bma.org.uk/pressrel.nsf/wlu/STRE-6FSKTP?OpenDocument&vw=wfmms>

Environmental Health undertook a Survey of Licensed Pubs and Bars in the London Borough of Southwark to establish proprietors' views on food and smoking policies. The conclusions of the survey were:

The proportion of pubs and bars that do not serve food was higher than the 10–30% suggested by the UK government. This proportion is likely to increase significantly given the indicated intentions of the business proprietors, if exemptions are permitted for non-food venues.

The proportion of pubs allowing unrestricted smoking and the proportion of non-food venues was higher in more disadvantaged areas, suggesting that the proposed UK government policy of exempting pubs that do not serve food from smoke free legislation, will exacerbate inequalities in smoking and health¹⁶¹

Smoke Free North East, a new body funded by each of the sixteen Primary Care Trusts in the North-East and Public Health Group North East, submitted written evidence to the enquiry stating that a partial ban would widen health inequalities.

Widening of inequalities—The North-East has one of the highest smoking rates in England (GHS 2003) and also the highest cancer and heart disease incidence. Smoking is the leading cause of health inequalities. (Ogilvie et al 2004). Smoke free environments encourage people to quit smoking, and so will help reduce inequalities currently seen between the poorest and the well off in our society (Chapman et al 1999).

[...]

Choosing Health estimated that 10–30% of pubs would be exempt from legislation. This was based on a survey of existing risk assessments for food safety carried out by Local Authorities. We have undertaken our own mapping in the North-East of the premises that would be exempt under the Government's preferred legislation and it is apparent that exempt premises are much higher than the predicted figures. An average 52% of premises would be exempt. The mapping exercise showed that these premises are also concentrated in our poorer communities, with the highest smoking rates, worst deprivation and highest Lung Cancer Standardised Mortality Rates.¹⁶²

1. Smokers in Great Britain

In the UK there are around 13 million smokers. The following table shows the percentage of smokers over 16 across Great Britain.

¹⁶¹ Written Evidence submitted by Southwark PCT

¹⁶² Memorandum by Smoke Free North East (SP28), written evidence to Health Select Committee

Self-reported prevalence of cigarette smoking by sex in Great Britain and constituent countries 1978 to 2003

Percentage smoking cigarettes (Persons aged 16 and over)

Country	Unweighted								Weighted				
	1978	1982	1986	1990	1992	1994	1996	1998	1998	2000	2001	2002	2003
Men													
Great Britain	45	38	35	31	29	28	29	28	30	29	28	27	28
England	44	37	34	31	29	28	28	28	29	29	28	27	27
Wales	44	36	33	30	32	28	28	28	29	25	27	27	29
Scotland	48	45	37	33	34	31	33	33	35	30	32	29	35
Women													
Great Britain	37	33	31	29	28	26	28	26	26	25	26	25	24
England	36	32	31	28	27	25	27	26	26	25	25	25	24
Wales	37	34	30	31	33	27	27	26	27	24	26	27	26
Scotland	42	39	35	35	34	29	31	29	29	30	30	28	28
All persons													
Great Britain	40	35	33	30	28	27	28	27	28	27	27	26	26
England	40	35	32	29	28	26	28	27	28	27	27	26	25
Wales	40	35	31	31	32	27	27	27	28	25	27	27	27
Scotland	45	42	36	34	34	30	32	30	31	30	31	28	31

Source: ONS, General Household Survey 2003

Note: Data prior to 1998 are unweighted. From 1998 data are weighted to compensate for under-representation of people in some groups. Trend tables show unweighted and weighted figures for 1998 to give an indication of the effect of the weighting.

Smoking rates are highest in the North East and North West of England.

Prevalence of cigarette smoking among adults, by sex and region England, 2003

	Men	Women	Persons
England	27	24	25
North East	30	27	28
North West	30	30	30
Yorkshire and The Humber	25	24	25
East Midlands	31	24	27
West Midlands	26	24	25
East of England	28	22	25
London	28	20	24
South East	25	22	24
South West	26	22	24

Source: ONS, General Household Survey 2003

C. Current research

In September 2005, the British Medical Journal published a modelling study on whether the proposed smoking ban, which can exempt pubs that do not serve catered food, would worsen health inequalities. The study, based on the borough of Telford and Wrekin, predicts that smoking could still be permitted in two thirds of the pubs in deprived

areas, and about a quarter in more affluent areas. If members' clubs are included in the model, four fifths of establishments in deprived areas and two fifths in more affluent areas could be exempt from the smoking ban. The study commented:

This is a small study in one borough, so care must be taken extrapolating the findings. However, Telford and Wrekin is similar to England in terms of demographics and socioeconomic profile. Higher exemption rates were also observed in a survey of 29 local authorities, but no data on deprivation were obtained. Our results show that people in deprived areas are more likely to live near licensed establishments exempt from legislation to protect them against smoking. It is possible that people from deprived neighbourhoods may visit establishments in affluent areas, whereas those living in affluent neighbourhoods make the reverse journey. It is more likely that the poorest people with the worst health and highest smoking prevalence would be those most likely to be harmed by passive smoking either working in pubs or as customers, and would be those most likely to have their attempt to stop smoking undermined.¹⁶³

D. Wider benefits of a total ban

Interventions to prevent smoking have been assessed to determine which measures are the most effective in reducing the incidence of smoking in the population. Policies that ban smoking in public places have been found not only to reduce passive smoking but to produce wider beneficial effects on reducing smoking. The overall smoking consumption is reduced; the usual quoted figure is a 4% drop in consumption, and also tends to reduce daily consumption amongst those who continue to smoke.¹⁶⁴ Smoke free policies also provide a role model to young people, indicating that non-smoking is the norm.

In 2004, 25% of Ireland's population were smokers, compared to 31% of the population in 1998. This is in part due to the intense legislative and educational efforts by the Irish government to curb the health and social costs of smoking, as well as the global trend towards declining smoker prevalence in developed countries. The fall in the total number of smokers is occurring simultaneously with new trends among those continuing to smoke; it is argued the ban on smoking in the workplace will erode the number of occasional or social smokers, while affecting those who already smoke regularly to a lesser degree.

The Royal College of Physicians published a report on passive smoking, '*Going Smokefree: The Medical Case for Clean Air in the home, at work and in public places*', on 12 July 2005. A key conclusion of the research that a ban would help reduce the amount of home smoking appears to dispel fears that the habit would be transferred to the home in the event of an outright ban.

By helping smokers to quit smoking, and by changing usual patterns of smoking behaviour, smokefree policies in public and workplaces increase the number of smokefree homes. Strong and sustained health promotion campaigns are required to enhance this process. These and other population and individual-level

¹⁶³Woodall A et al, "The partial smoking ban in licensed establishments and health inequalities in England: modelling study", *British Medical Journal*, 19 August 2005

¹⁶⁴Department of Health Oral evidence to Health Select Committee; Jamrozik J, "ABC of smoking cessation: Population strategies to prevent smoking", *British Medical Journal*, 27 March 2004

interventions to encourage smoking cessation are the most effective means of reducing ETS exposure at home.¹⁶⁵

VIII Smoking behaviours and health

A. Overview

Cigarette smoking is the largest avoidable cause of morbidity and mortality in developed countries. Smoking not only causes direct harm to individuals who smoke but also produces detrimental effects on the health of individuals who are indirectly exposed to tobacco smoke. According to the National Institute for Clinical Excellence (NICE), although nicotine has marked effects on the arteries, it is the tar from smoking products that is the main disease causing element. Tar contains at least 4,000 different chemicals, including over 50 known carcinogens and metabolic poisons. Tobacco smoke also contains carbon monoxide, oxides of nitrogen and hydrogen cyanide, all harmful to health¹⁶⁶

1. Smoking risks

Cigarette smoking is the single largest preventable cause of premature death and illness in the United Kingdom. Smoking related diseases cause about 120,000 deaths a year, which is around a fifth of the total annual deaths in the UK.¹⁶⁷ Recent research estimates that at least half of smokers will die prematurely from diseases caused by their smoking.

Smokers are at a greater risk of developing a number of diseases. The greatest associated adverse health effects are from lung cancer, chronic obstructive airways diseases and cardiovascular conditions. However, smoking also increases the risk of developing other conditions including, osteoporosis, periodontal disease, impotence, male infertility and cataracts. Women who smoke in pregnancy have an increased risk of spontaneous abortion, premature birth, low birth weight and stillbirth.¹⁶⁸

The longest prospective epidemiological study of smokers conducted in the UK, "*Mortality in relation to smoking: 50 years' observations on male British doctors*", published its most recent results in 2004. The research project, which began in 1951, has monitored the effects of smoking on a group of British doctors. Earlier results from the study, at 10, 20 and 40 years follow-up, demonstrated that smoking was associated with an increased mortality from a number of diseases. Although lung cancer accounted for about half of the excess deaths seen in smokers, the remaining deaths were from a

¹⁶⁵ Going Smokefree: The medical case for clean air in the home, at work and in public places Royal College of Physicians July 2005 <http://www.rcplondon.ac.uk/pubs/books/goingsmokefree/>

¹⁶⁶ National Institute For Clinical Excellence Technology Appraisal Guidance No. 38 Nicotine replacement therapy (NRT) and bupropion for smoking cessation Issue March 2002 <http://www.nice.org.uk/page.aspx?o=30631>

¹⁶⁷ Jochelson J, "Nanny or Steward? The role of government in public health", Kings Fund working paper, October 2005

¹⁶⁸ Nicotine Addiction in Britain, Chapter 1; Tobacco smoking in Britain: an overview, A report of the Tobacco Advisory Group of the Royal College of Physicians, 2000

variety of conditions including cancers especially of the mouth, pharynx and oesophagus, ischaemic¹⁶⁹ heart diseases and respiratory disorders.¹⁷⁰

The paper, detailing the finding of the fifty year survey, showed that about half of all smokers would die as a direct consequence of smoking. However, the study also found that there were health benefits from stopping smoking at any age, and these were related to the age at which a person stopped smoking. Individuals who stopped smoking at 60 years could gain about 3 years of life expectancy, whilst at the other end of the range those who stopped at 30 years had a pattern of survival almost the same as that of non-smokers.

The paper concluded:

What is already known on this topic?

- About half of all persistent cigarette smokers are killed by their habit—a quarter while still in middle age (35-69 years)
- After a large increase in cigarette smoking by young people, the full effects on national mortality rates can take more than 50 years to mature
- British men born in the first few decades of the 20th century could be the first population in the world in which the full long term hazards of cigarette smoking, and the corresponding benefits of stopping, can be assessed directly

What this study adds

- Among the particular generation of men born around 1920, cigarette smoking tripled the age specific mortality rates
- Among British men born 1900-1909, cigarette smoking approximately doubled the age specific mortality rates in both middle and old age
- Longevity has been improving rapidly for non-smokers, but not for men who continued smoking cigarettes
- Cessation at age 50 halved the hazard; cessation at 30 avoided almost all of it
- On average, cigarette smokers die about 10 years younger than non-smokers
- Stopping at age 60, 50, 40, or 30 gains, respectively, about 3, 6, 9, or 10 years of life expectancy.¹⁷¹

¹⁶⁹ Ischaemia – reduction of blood supply to part of the body

¹⁷⁰ “The problem of tobacco smoking”, *British Medical Journal*, 24 January 2004

¹⁷¹ Doll R et al, “Mortality in relation to smoking: 50 years’ observation on male British doctors”, *British Medical Journal*, 26 June 2004

a. The extent of harm

The adverse health effects of smoking are related to the number of cigarettes smoked, the duration of smoking and the age at which smoking started.

Many studies have shown a dose related effect between smoking and serious health consequences. However, a Norwegian study published in September 2005 found that even very low levels of smoking were associated with increased risk of premature death. The study included more than 40,000 individuals who were screened for cardiovascular disease risk factors in the mid 1970s. All the participants were required to state their daily cigarette consumption. A mortality follow up was conducted in 2002 by linking participant's records with the national register of causes of death, which established the number of deaths for specified conditions. The study found that even low levels of smoking were associated with a significantly higher relative risk of dying from ischaemic heart. For ischaemic heart disease, the steepest increase in risk of dying was smoking between 0 and 1–4 cigarettes per day. Above this level of smoking, the increase in risk was less pronounced.

In both sexes, smoking 1–4 cigarettes per day was associated with a significantly higher risk of dying from ischaemic heart disease and from all causes, and from lung cancer in women. Smoking control policymakers and health educators should emphasise more strongly that light smokers also endanger their health.¹⁷²

This study supported the findings from three other prospective studies which showed that light smoking significantly increased the risk of fatal and non-fatal myocardial infarction.¹⁷³

2. Second hand smoke

Tobacco smoke is made up of sidestream smoke from the burning tip of the cigarette and mainstream smoke from the filter or mouth end. Nearly 85% of the smoke in a room results from sidestream smoke.¹⁷⁴

Tobacco smoke contains thousands of different chemicals that are released into the air as particles and gases. The particulate constituents include nicotine, tar and benzene, whilst the gases include carbon monoxide, ammonia, formaldehyde, and hydrogen cyanide. Some of these chemicals are irritant whilst others are responsible for the longer-term adverse cardiovascular and respiratory health effects.

Awareness of the effects of passive smoking is widespread.¹⁷⁵ Over 80 percent of people in Great Britain agree that passive smoking increases a non-smoking adult's risk

¹⁷² K Bjartveit and A Tverdal, "Health consequences of smoking 1–4 cigarettes per day", *Tobacco Control*, August 2005

¹⁷³ K Bjartveit and A Tverdal, "Health consequences of smoking 1–4 cigarettes per day", *Tobacco Control*, August 2005

¹⁷⁴ What's in a cigarette, factsheet no: 12, Action on Smoking and Health, August 2001

¹⁷⁵ ONS, Smoking related behaviour and attitudes 2004
http://www.statistics.gov.uk/downloads/theme_health/Smoking2004_V2.pdf

of lung cancer, bronchitis and asthma. 60 percent of non-smokers (57 percent of men and 63 percent of women) mind if other people smoke near them. Most smokers are willing to modify their smoking in the presence of adult non-smokers; 45 percent would not smoke and 38 percent would smoke fewer cigarettes. Such opinions lend weight to the belief that there is no safe level of environmental tobacco smoke.

Figures on deaths from passive smoking can be found on page 64.

a. Adverse health effects

In November 2004, the Scientific Committee on Tobacco and Health published a review of the evidence relating to the health effects of exposure to second hand smoke (SHS). The review found that exposure to SHS was responsible for:

- An estimated overall 24% increased risk of lung cancer in non-smokers.
- A 23% excess risk of heart diseases in non-smokers.
- Children and babies exposed to SHS at home have an increased risk of pneumonia, bronchitis, asthma attacks, middle ear infections and sudden infant death syndrome.¹⁷⁶

An editorial on passive smoking in the *British Medical Journal* in February 2005 stated:

Existing evidence is already sufficient to implicate passive smoking as a cause of lung cancer and coronary heart disease. Moreover, smoke free workplace policies are effective in eliminating secondhand smoke and in encouraging active smokers to quit. Eliminating exposure to secondhand smoke is a public health priority not just for European countries but for the rest of the world as well.¹⁷⁷

b. Recent evidence

Recent research has strengthened the evidence that passive smoking has a causal link with a number of medical conditions. A study published in the *British Medical Journal* examined the association between home exposure to secondhand smoke and associations with specific causes of death, in Hong Kong. The study concluded:

We found significant dose dependent associations between passive smoking and mortality from lung cancer, chronic obstructive pulmonary disease, stroke, ischaemic heart disease, and from all cancers, all respiratory and circulatory diseases, and all causes (table). The association between mortality and passive smoking did not differ between males and females. Deaths due to injury or poisoning were not associated with passive smoking.¹⁷⁸

¹⁷⁶ "Secondhand Smoke: Review of Evidence since 1998", Scientific Committee on Tobacco and Health, Department of Health, 16 November 2004

¹⁷⁷ "More evidence on the risks of passive smoking", *British Medical Journal*, 5 February 2005

¹⁷⁸ McGhee S M et al, "Mortality associated with passive smoking in Hong Kong, *British Medical Journal*, 27 January 2005

3. Health benefits of a ban on smoking in public places

A study published in the *British Medical Journal* estimated deaths from passive smoking in the UK. It concluded that passive smoking at work was likely to be responsible for 617 deaths a year, including 54 in the hospitality industry. This would account for around a fifth of the estimated annual deaths from passive smoking in the 20-64 year age group; the others being linked to smoke exposure at home. However, it would account for around half the annual number of deaths from passive smoking in those working in the hospitality industry.¹⁷⁹ The study concluded:

Adoption of smoke free policies in all workplaces in the United Kingdom might prevent several hundred premature deaths each year, while the reduction of the prevalence of active smoking to that already achieved in other parts of the English speaking world might avoid several thousand more.¹⁸⁰

The Republic of Ireland's comprehensive ban on smoking in public places has now been in force for over a year and evidence is starting to emerge on the effects of the ban. One study measured the levels of salivary cotinine¹⁸¹ concentration in bar workers in Ireland before the legislation came into force and repeated one year after introduction of the ban. The results were compared to a similar group of bar workers in Northern Ireland who continued to be exposed to second hand smoke. The results found respiratory symptoms experienced by non-smoking bar workers declined significantly more in the Republic of Ireland than in Northern Ireland, and the decline in cotinine levels was twice as great.¹⁸² The study stated:

Implications of findings

The smokefree workplace law in the Republic of Ireland has provided protection for one of the most heavily exposed occupational groups by reducing their exposure to secondhand smoke both in and out of the workplace. The reduced exposure has led to a decline in respiratory and sensory symptoms in nonsmokers. The increase in support for the law in the Republic since its introduction, even among smokers, underpins its effectiveness. These findings have implications for policy makers and legislators in other countries currently considering the nature and extent of their smokefree workplace legislation.¹⁸³

Evidence is also emerging of other positive effects that have resulted from the total smokefree workplace law in Ireland. A research paper published in the journal *Tobacco Control* looked at the psychosocial and behavioural impact of the ban.

Key findings included:

¹⁷⁹ Jamrozik J, "Estimate of deaths attributable to passive smoking among UK adults: database analysis", *British Medical Journal*, 9 April 2005

¹⁸⁰ Jamrozik J, "Estimate of deaths attributable to passive smoking among UK adults: database analysis", *British Medical Journal*, 9 April 2005

¹⁸¹ Cotinine levels are used to measure exposure to tobacco smoke as they are a sensitive marker for nicotine uptake in the body.

¹⁸² Allwright S et al, "Legislation for smokefree workplaces and health of bar workers in Ireland: before and after study", *British Medical Journal*, published 31 October 2005

¹⁸³ Allwright S et al, "Legislation for smokefree workplaces and health of bar workers in Ireland: before and after study", *British Medical Journal*, published 31 October 2005

- There was a high level of compliance with the ban.
- There was a high level of public support for the ban.
- There was no evidence that the reduction in smoking in public venues was associated with increased smoking in private venues. There was an actual reduction in the numbers of smokers who smoked inside their homes.
- Nearly half (46%) of smokers reported that the smokefree law had made them more likely to quit smoking. Of those who had quit, 80% reported that the law helped them to quit and 88% said it helped them to stay as non-smokers.¹⁸⁴

B. Smoking cessation

It is estimated that in the UK about 4 million smokers a year attempt to quit but that only 3% to 6% of these (1% to 2% of all smokers) succeed.¹⁸⁵

Stopping smoking has both immediate and long-term benefits on health in relation to both prevention of disease and life expectancy. Smokers who quit before the age of about 35 years have a life expectancy only slightly less than those who have never smoked.¹⁸⁶ The excess risk of death starts to fall soon after stopping smoking and continues to decrease. The greatest effect is seen in those who stop at the youngest age. There is also a reduction in the indirect harm produced by passive smoking in public places.

The Government has set a target:

To reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.¹⁸⁷

The aim is to achieve this through a combination of policies comprising the tobacco control policy, of which these smokefree proposals form part.

A decrease in smoking would result in corresponding savings to the health service. At present, it is estimated that the treatment of smoking related disease costs the NHS around £1.5 billion per annum.¹⁸⁸ It is estimated that a reduction in the smoking prevalence rate of 1.7% as suggested would save the NHS around £100 million a year.¹⁸⁹

Smoking cessation has wider economic benefits on society. These include; reduced costs from sickness absence; safety benefits and reduced fire risks; and greater inclusiveness in the workplace for asthma sufferers. Although productivity gains are said

¹⁸⁴ Fong G et al, "Reductions in tobacco smoke pollution and increases in support for smokefree public places following the implementation of comprehensive smokefree workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK survey", *Tobacco Control*, October 2005

¹⁸⁵ Enhancing the Value of Health Statistics: Part 2 Section 2 - Statistics Covered in the Review. Statistics Commission 2004

¹⁸⁶ *ibid*

¹⁸⁷ Spending Review 2004 Public Service Agreement Chapter Three Department of Health
http://www.hm-treasury.gov.uk/media/70320/sr04_psa_ch3.pdf

¹⁸⁸ "Economics of smoking cessation", *British Medical Journal*, 17 April 2004

¹⁸⁹ *ibid*

to result through smokers taking less smoking breaks, there is some evidence that smokers' efficiency can drop significantly, especially during the smoking withdrawal phase due to the physical symptoms experienced.

Although many smokers attempt to stop smoking on their own, very few of these attempts are successful. In contrast the use of smoking cessation services can more than double the chances of success. The two main forms of intervention to support smoking cessation are:

- Interventions to support behavioural change including advice and motivation and support.
- Treatment with nicotine replacement therapy to reduce the symptoms produced by nicotine withdrawal.

These interventions are complementary and smokers benefit from using both methods

In 1998, the UK government announced the introduction of smoking cessation services throughout the NHS. In 2004, 240,000 people are thought to have given up smoking with the assistance of cessation initiatives.¹⁹⁰ Smoking cessation programmes are effective and appear to provide value for money, especially when compared to the cost of other healthcare interventions. Less resource-intensive interventions such as brief advice or self help were more cost-effective than the more resource-intensive specialist intervention services or the use of nicotine replacement therapy. As the intensity of smoking cessation interventions increases, both cost and effectiveness increase, but cost increases more rapidly. However, even the more intensive smoking cessation interventions are relatively cost-effective in terms of cost per life-year saved.¹⁹¹

The National Institute for Clinical Excellence (NICE) estimated the cost effectiveness of smoking cessation interventions. The study found that:

Costs to the NHS may be separated into short-term costs related to the smoking cessation interventions and long-term costs of health care for smokers who stop smoking. It is relatively straightforward to measure the direct costs of a programme but very complicated to measure its impact on long-term health care spending.

[...]

Results of studies of economic evaluations have consistently shown that smoking cessation interventions are cost-effective in saving lives, compared with many other accepted therapeutic and preventive health care interventions.

The estimated cost of the smoking cessation programme to the NHS in England and Wales would be about £67-202 million per year. Consequently, about 45,000-135,000 smokers will quit, and about 90,000-270,000 life-years may be saved. The average cost per life-year saved is about £750 (range £500 to £1,500).¹⁹²

¹⁹⁰ *ibid* Q11

¹⁹¹ "Economics of smoking cessation", *British Medical Journal*, 17 April 2004

¹⁹² A rapid and systematic review of the clinical and cost effectiveness of bupropion SR and nicotine replacement therapy (NRT) for smoking cessation, NICE Review, April 2002

The Department of Health funded an evaluation of smoking cessation services, which was published in April 2005.¹⁹³ The findings showed that services were effective at increasing the long term quit rate. Around 15% of people who accessed the service were still not smoking after one year compared to only 3-4% of those who used willpower alone.¹⁹⁴

Socio-economically disadvantaged groups and young adults show a relatively slow decline in the prevalence of smoking. Whilst smoking cessation initiatives should be targeted at all sections of the population these two social groups have particular needs that must be addressed if there is to be any real progress in achieving a significant reduction in the incidence of smoking.

In 2004 240,000 people are thought to have given up smoking with the assistance of cessation initiatives.¹⁹⁵ A PQ sets out the latest estimate of those who are no longer smoking after using the NHS Stop Smoking Service:

Smoking

Tim Loughton: To ask the Secretary of State for Health (1) what his latest estimate is of the percentage of people who have used the NHS Stop Smoking Services programme and who are no longer smoking after 12 months; [210136]

(2) how many people have used the NHS Stop Smoking Services in each of the last five years; and what the average cost to the NHS per person is of NHS recommended smoking cessation services. [210137]

Miss Melanie Johnson: The Department funded an evaluation of the national health service stop smoking services programme, which was led by a team at Glasgow university. The results will be published in due course.

The information is shown in the table.¹⁹⁶

¹⁹³ Addiction, volume 100, Supplement 2, April 2005

¹⁹⁴ Chief medical Officer Update, Department of Health, Summer 2005

¹⁹⁵ ibid Q11

¹⁹⁶ Results for 2004/05, since released by the Department of Health, are also shown in the table. Source: Statistics on NHS stop smoking services in England, April 2004 to March 2005 <http://www.dh.gov.uk/assetRoot/04/11/52/94/04115294.pdf>

Information about NHS stop smoking services in England, 1999/00 to 2004/05

	1999/00 ¹	2000/01	2001/02	2002/03	2003/04	2004/05
Number of people setting a quit date ²	14,600	132,500	227,300	234,900	361,200	529,520
Number of successful four week quitters (self report)	5,700	64,500	119,800	124,100	204,900	297,828
Cost of NHS stop smoking services (£ million) ³	5.0	21.5	24.7	24.5	36.2	46.8
Cost per person setting a quit date (£) ³	344	162	109	104	100	88
Cost per successful four week quitter (£) ³	872	334	206	197	177	157
Total net ingredient costs of prescriptions for NRT& bupropion (£million) ⁴	0.5 ⁵	16	29	30	37	46

Source: HC Deb 21 Feb 2005 c174w & Statistics on NHS stop smoking services in England, April 2004 to March 2005

Notes:

¹ In 1999/00, NHS smoking cessation services were set up in the 26 health action zones (HAZ) in England and services were rolled out across the NHS to the rest of England in 2000/01.

² Total number of people who have used the NHS stop smoking services is not collected centrally. However, information is collected on the number of people setting a 'quit date'; some people may use the services but not go onto set a quit date.

³ The cost of the NHS stop smoking services and the cost per successful quitter in 1999/00 and 2000/01 included the cost of giving clients free NRT (or vouchers); from 2001/02 onwards the cost of the service and the cost per quitter excluded the cost of NRT or Zyban on prescription. Only a few nicotine replacement therapy products were available on prescription until 17 April 2001, when all NRT products became available on NHS prescription. Bupropion (Zyban) became available on NHS prescription from June 2000. Therefore, the costs from 2001/02 onwards are not directly comparable with the costs in previous years.

⁴ Net ingredient cost is the basic cost of a drug and does not take account of discounts, dispensing fees or prescription charge income. Note that some prescriptions for NRT/Bupropion are dispensed to people not using the NHS stop smoking services.

⁵ This figure only includes the cost of NRT, as bupropion (Zyban) was not available until June 2000.

Sources:

1. Statistics on Smoking Cessation in the Health Action Zones in England, April 1999 to March 2000 <http://www.dh.gov.uk/assetRoot/04/02/24/22/04022422.pdf>.
2. Statistics on Smoking Cessation in England, April 2000 to March 2001—<http://www.dh.gov.uk/assetRoot/04/07/64/58/04076458.pdf>.
3. Statistics on NHS stop smoking services in England, April 2001 to March 2002—<http://www.publications.doh.gov.uk/public/sb0225.pdf>.
4. Statistics on NHS stop smoking services in England, April 2002 to March 2003—<http://www.dh.gov.uk/assetRoot/04/07/62/33/04076233.pdf>.
5. Statistics on NHS stop smoking services in England, April 2003 to March 2004—<http://www.dh.gov.uk/assetRoot/04/09/76/51/04097651.pdf>.

C. Deaths from smoking¹⁹⁷

Smoking is the greatest preventable cause of illness, disability and premature death in the United Kingdom. The Health Development Agency estimates that, in total, 106,100 persons die each year from smoking-attributable causes across the United Kingdom. It is estimated that 23 percent of male deaths from all causes are attributable to smoking. For women the equivalent figure is lower, at 12 percent.¹⁹⁸

¹⁹⁷ Smoking is not recorded on the death certificate as a cause of death. As a result, smoking-attributable mortality for Wales is estimated by applying a risk formula attributable to national estimates of age- and sex-specific rates of current and ex-smoking. The derived attributable proportions are then applied to national counts of cause-, sex- and age-specific mortality for Wales.

¹⁹⁸ Health Development Agency (2004), [The smoking epidemic in England](#)

Smoking-attributable mortality across the United Kingdom, annual averages 1998-2002

	Smoking-attributable mortality ¹			Percentage of all deaths attributable to smoking		
	Males	Females	Persons	Males	Females	Persons
United Kingdom	66,200	39,900	106,100	23	12	17
England	53,800	32,700	86,500	22	12	17
Wales	3,800	2,200	6,000	24	12	18
Scotland	7,100	4,200	11,300	26	14	19
Northern Ireland	1,500	800	2,300	21	10	15

Source: Health Development Agency (2004) *The smoking epidemic in England*

Notes: 1 These figures do not include an adjustment for deaths that may have been prevented by smoking (i.e. endometrial cancer and Parkinson's disease)

Although overall exposure to second hand smoke in the population has fallen slightly as the prevalence of smoking has declined, there are still particular groups, such as workers in the hospitality industry, that are exposed to high levels. A study published in the British Medical Journal states that passive exposure to tobacco smoke at work might cause more than 600 deaths each year in the United Kingdom, including over 50 people employed in the hospitality industry. This is more than double the number of fatalities (245) caused by workplace accidents in 2004/05. Exposure at home may account for 2,700 deaths in those aged 20-64 and 8,000 in those aged 65 and over.¹⁹⁹

D. Attitudes to restrictions on smoking in public places

Support for smoking restrictions in public places has been increasing in Great Britain.²⁰⁰ The vast majority of people in Great Britain agree that there should be restrictions on smoking in public places. In 2004, about four-fifths of people agreed that there should be restrictions: on smoking at work (88 percent), in restaurants (91 percent), in indoor shopping centres (87 percent), in indoor sports and leisure centres (93 percent), in indoor areas at railway and bus stations (82 percent) and in other public places such as banks and post offices (93 percent). The largest increase since 1996 is for support for restrictions in pubs, which rose from 48 percent to 56 percent in 2003 and then to 65 percent in 2004.

¹⁹⁹ Estimate of deaths attributable to passive smoking among UK adults: database analysis BMJ, doi:10.1136/bmj.38370.496632.8F (published 2 March 2005)

²⁰⁰ ONS, Smoking related behaviour and attitudes 2004
http://www.statistics.gov.uk/downloads/theme_health/Smoking2004_V2.pdf

Attitudes towards smoking restrictions in public places Great Britain, 1996 and 2004

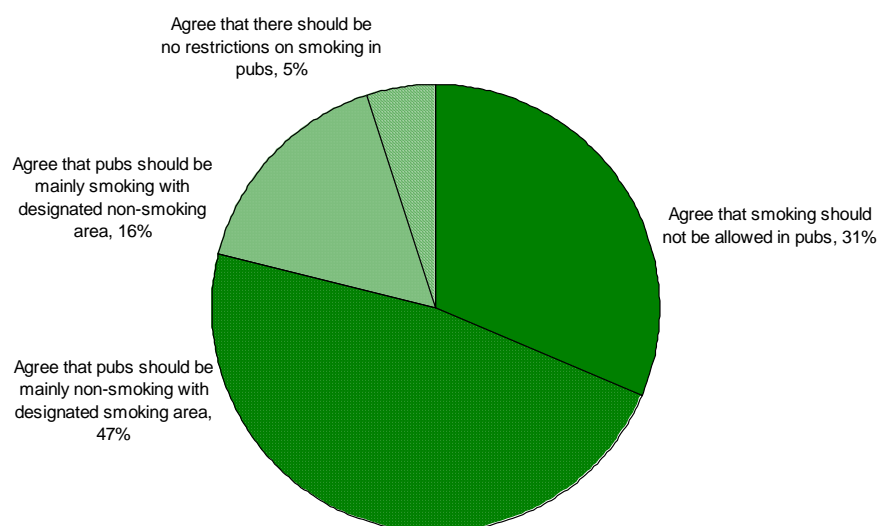
	percentage	
	1996	2004
Agree that there should be smoking restrictions:		
In pubs	48	65
In restaurants	85	91
In work	81	88
In indoor shopping centres	.	87
In indoor sports and leisure centres	.	93
In indoor areas at railways and bus stations	.	82
In other public places	82	93

Source: ONS, Smoking related behaviour and attitudes 2004

Note: . Data not available

The chart below shows people's attitudes towards smoking restrictions in pubs. Nearly a third (31 percent) agree that smoking should not be allowed anywhere, an increase since 2003 (20 percent). About half agree that pubs should be mainly non-smoking with smoking allowed in designated areas (47 percent), and 16 percent think the premises should be mainly smoking with a designated non-smoking area. Only 5 percent think there should be no restrictions on smoking at all. Smokers are more likely than non-smokers to want no restrictions at all in pubs, and less likely to favour no smoking anywhere in the pub. There is little difference in opinion between men and women and those in different age or socio-economic classification groups.

Attitudes towards smoking restrictions in pubs
Great Britain 2004



Source: ONS, Smoking related behaviour and attitudes 2004

30 percent of non-smokers say they would visit a pub more often if smoking was restricted. Even among smokers, the vast majority (85 percent) say they would visit about as often as they do now, and only 12 percent would visit less often.

51 percent of working adults aged 16 and over report that there is no smoking at all in their work place (compared to 40 percent in 1996), and a further 37 percent report that

smoking is permitted in designated areas only. Men, heavy smokers and those in routine and manual occupations are most likely to work at premises that do not restrict smoking.

Overall, the vast majority (94 percent) agree that there should be smoking restrictions in public places where there are, or are likely to be, children under the age of 16.