

Health Bill

Smoking in Workplaces and Enclosed Public Places

House of Lords Report Stage



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Executive Summary

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. Such legislation has proved effective, popular and easy to introduce and enforce in the Republic of Ireland, Scotland, New Zealand, New York, and elsewhere.
2. In its current form, the Health Bill (HL Bill 117) would end smoking in all workplaces and enclosed public places, with the exception of some residential premises, likely to include prisons, hotel bedrooms, halls of residence, long stay residential care facilities, offshore installations, and secure psychiatric units. The framework for exemptions is set out in Clause 3 of the Bill. Details of how any exemptions would apply will be contained in consequent Regulations.
3. The Smokefree Action Coalition, which includes many of Britain's leading medical and health organisations, strongly supports the smokefree provisions of the Health Bill. We consider it to be a public health reform of the first importance, and we greatly welcomed the overwhelming support for comprehensive legislation from MPs in a series of Free Votes at Commons Report Stage.

Key Points

4. The scientific evidence on the health effects of secondhand smoke is overwhelming:
 - The Government's scientific advisers on the Scientific Committee on Tobacco and Health have reported that exposure to secondhand smoke increases the risk of heart disease and lung cancer in non smokers, in both cases by about a quarter¹;
 - Four fifths of the country's five million asthma sufferers report that secondhand smoke makes their condition worse ² ;
 - Smoking at work in Great Britain is estimated to be responsible for up to three times the number of premature deaths each year as all industrial injuries and accidents (600 compared with 200+) ³;
 - Bar workers are currently routinely exposed to levels of smoke equivalent to a moderate smoker, but smokefree legislation dramatically reduces this exposure⁴.
5. The public now overwhelmingly backs comprehensive smokefree legislation. A major poll was conducted by polling firm You Gov in December 2005 (commissioned by Cancer Research UK and Action on Smoking and Health). Asked if they would support legislation

to make all workplaces smokefree, including pubs and restaurants, 71% across the UK said yes. The figure for England was 71%, the same as for Scotland. Given a list of

specific public places, 67% across the UK said that all pubs and bars should be smokefree by law. The figure for England was 66%, up from 51% in Spring 2004.

6. Comprehensive smokefree legislation is designed primarily to protect people from the health effects of other people's smoke. However, it has the enormous additional benefit of encouraging many smokers to quit. Indeed, the Government cannot achieve its targets for cutting overall smoking prevalence rates without such legislation. The Regulatory Impact Assessment published with the Health Bill estimates that comprehensive smokefree legislation would reduce smoking prevalence rates across the country by 1.7%. This is equivalent to around 600,000 smokers across England quitting their habit. Approximately half of those who smoke throughout their adult lives will die from a smoking-related disease.
7. Much of the detail of smokefree legislation will be in Regulations issued under the Health Bill. These are likely to follow the Scottish model quite closely, and likely key points are set out in this paper.
8. The Government originally proposed exemptions from smokefree legislation for pubs that do not serve prepared food and for membership clubs. Such exemptions would worsen health inequalities, fail to provide adequate health and safety for workers in exempt premises and undermine the benefits of the legislation on public health. The House of Commons voted overwhelmingly at Commons Report Stage (on a Free Vote) to remove such exemptions from the legislation. Moves to allow smoking areas in pubs would also fail to provide adequate health and safety protection for workers and members of the public.
9. There is good evidence that the overall economic effects of smokefree legislation would be overwhelmingly positive.
10. Claims that workplace bans displace smoking to the home are without foundation – extensive published and peer reviewed research shows the opposite effect.
11. England should not be the only part of the UK without comprehensive smokefree legislation:
 - Scotland has comprehensive smokefree legislation which came into effect this year
 - The National Assembly for Wales has voted overwhelmingly in favour of such legislation and will receive the powers to implement it when the Health Bill becomes law; and
 - The UK Government has announced that comprehensive smokefree legislation will be introduced in Northern Ireland.
12. There is extensive evidence of the success of smokefree legislation from other countries and jurisdictions.
13. Ventilation has been shown to have little effect in reducing the harmful effects of secondhand smoke, unless 'wind tunnel' conditions are produced.

Detailed Brief

Secondhand Smoke and Health

14. The scientific evidence that secondhand smoke (SHS) is a danger to health is now clear and overwhelming. It was summarised in the November 2004 report to the Department of Health from the Scientific Committee on Tobacco and Health (SCOTH)⁵. SCOTH concluded that

“knowledge of the hazardous nature of SHS has consolidated over the last five years, and this evidence strengthens earlier estimates of the size of the health risks. This is a controllable and preventable form of indoor air pollution. It is evident that no infant, child or adult should be exposed to SHS. This update confirms that SHS represents a substantial public health hazard.”

SCOTH estimated the increased risk of heart disease in non-smokers exposed to secondhand smoke at 25%, and the increased of lung cancer at 24%. SCOTH also noted that *“some groups, for example bar staff, are heavily exposed at their place of work”*.

15. Certain population groups are particularly vulnerable to the health effects of secondhand smoke: children, pregnant women, people with existing cardiovascular or cerebrovascular disease, and those with asthma and other respiratory disorders. Moreover, those in lower socioeconomic groups are at greater risk of exposure than those in better-off groups, because they are both more likely to live with a smoker and to work in a place where smoking is permitted. There is no safe level of exposure to secondhand smoke.⁶
16. Secondhand smoke worsens the symptoms of asthma and undermines the effectiveness of asthma medication. There is also growing evidence that smoking is a primary cause of asthma in adults and young people.

According to Asthma UK:

- There are 5.2 million people in the UK with asthma. In surveys, 82% (the equivalent of 4.3 million people) have reported that secondhand smoke makes their asthma worse.
 - Secondhand smoke is known to trigger asthma, and exposure to secondhand smoke at work doubles the chance of an adult developing asthma.
 - Secondhand smoke is the second most common asthma trigger in the workplace.
17. Smoking in public places reduces the choice available to people, particularly to many of the 8 million people in the UK with lung disease and the 5 million (including 1.5 million children) with asthma.

Results from Asthma UK's National Asthma Panel show that:

- 40% of adults with asthma are discouraged from accessing smoky pubs.
- 55% of parents of children with asthma avoid restaurants and places with smoky atmospheres
- 1 in 5 people with asthma feel excluded from parts of their workplace where people smoke.^{7 8}

18. Opponents of smokefree legislation, including some peers in Grand Committee, have claimed that secondhand smoke causes trivial atmospheric pollution compared with traffic fumes. In evidence to the House of Commons Health Select Committee on 20th October 2005, Dr. Richard Edwards, a senior lecturer in public health from Manchester, gave details of a study in the north-west that compared the level of particulate matter (PM2.5) found on heavy traffic roads with that found in smoky pubs.

(Particulate matter is the term used for a mixture of solid particles and liquid droplets found in the air. PM2.5 refers to particulate matter that is 2.5 micrometers or smaller in size, about 1/30 of the width of a human hair). Some 20 to 50 micrograms per cubic metre were found on heavy traffic roads, but 1,400 micrograms per cu m were found in some smoky pubs - 28 times the level. Dr Edwards concluded:

"So when you are talking about exposure from particles which are known to affect health, and there are plenty of studies to show that particulate matter affects health, some of the places where you get the very greatest exposure is in the indoor environment in smoky pubs".⁹

A study by Professor Colville of Imperial College London and colleagues of pollution levels on the Marylebone Road found that taking a cab exposed passengers to an average of 108,000 particles per cubic centimeter of air. The inside of a bus exposed them to 95,000 particles/cm³, but the inside of a private car exposed them to only 36,000 particles/cm³. Passing a cigarette smoker on the pavement exposed pedestrians to pollution levels as high as 300,000 particles/cm³.¹⁰

19. Opponents of smokefree legislation, again including some peers in Grand Committee, have quoted the late Professor Sir Richard Doll, who led the Doctors' study that first demonstrated conclusively that smoking causes lung cancer, as saying that secondhand smoke was not a serious health risk. For example, it was stated during debate in Grand Committee that:

"although Professor Sir Richard Doll certainly pointed out that active smoking was harmful, he is on record as having said that second-hand smoke did not worry him"¹¹

The comment referred to was made in passing on Radio 4's Desert Island Disks on 23rd February 2001. However, in the BMA booklet *"Smoke Free World: Doctors Notes on Smokefree Laws"*, published in February 2005, Sir Richard wrote:

"We first established the causal link between smoking and lung cancer in 1950, but the tobacco industry spent decades arguing that our results did not justify our conclusion ... Now tobacco companies are using the same technique to undermine the conclusion that passive smoking causes fatal disease. The evidence that it does is clear. As a responsible citizen, I believe that nobody should have to work in an atmosphere polluted by other people's smoke."¹²

20. Much of the tobacco industry continues to deny the scientific evidence on secondhand smoke. In a letter to peers on the Health Bill dated 27th April 2006, Frank Rogerson, Corporate Affairs Director of Imperial Tobacco Group, stated that:

"properly analysed and understood, the scientific and statistical evidence ... leads to the conclusion that a ban on smoking in public places cannot be justified on health grounds".¹³

However, more sophisticated tobacco lobbyists now take a different line. For example, the Philip Morris USA website states that:

“public health officials have concluded that secondhand smoke from cigarettes causes disease, including lung cancer and heart disease, in non-smoking adults, as well as causes conditions in children such as asthma, respiratory infections, cough, wheeze, otitis media (middle ear infection) and Sudden Infant Death Syndrome. In addition, public health officials have concluded that secondhand smoke can exacerbate adult asthma and cause eye, throat and nasal irritation. Philip Morris USA believes that the public should be guided by the conclusions of public health officials regarding the health effects of secondhand smoke.”¹⁴

Secondhand Smoke and the Workplace

21. Almost half of all workers in Great Britain are currently exposed to other people’s smoke at work. Many such workplaces are operated by small firms and employ relatively low - paid staff. Workplace smoking is of course also common in the hospitality trades - restaurants, pubs, casinos etc. Data produced for ASH by the Office for National Statistics shows that about 2.3 million people work in places where smoking is allowed throughout and a further 10.4 million in places where smoking is allowed somewhere on the premises. The figures also show a clear workplace health divide. Workers in routine and manual occupations are more likely to be exposed to other people’s smoke than managerial and professional workers. 900,000 people in routine and manual occupations work in places where there are no restrictions on smoking at all compared to 400,000 managers and professional people. 6.1 million people in professional and managerial positions work in places where smoking is not permitted at all, compared to 3.9 million people working in routine and manual occupations.¹⁵
22. Professor Konrad Jamrozik of the University of Queensland estimated in a paper published in the British Medical Journal that exposure to secondhand smoke in the workplace causes 54 premature deaths each year among hospitality industry employees - or more than one a week - and about 600 deaths each year across the UK in all occupations. This is more than three times the number killed each year in industrial injuries and accidents.¹⁶
23. Smokefree legislation has been shown to reduce dramatically the exposure of hospitality trade workers to secondhand smoke. In New York, a study of 104 workers in the hospitality industries one year after the City’s smokefree legislation came into force showed that hours of exposure to secondhand smoke in hospitality jobs decreased from 12.1 hours to 0.2 hours, and saliva cotinine concentration decreased from 3.6 ng/ml to 0.8 ng/ml. The prevalence of workers reporting sensory symptoms declined from 88% to 38%.¹⁷

Smokefree Legislation and Public Opinion

24. Recent polling evidence shows conclusively that the general public in all four countries of the United Kingdom now overwhelmingly back a new law to end smoking in all workplaces. They also back specific action to ensure that all pubs and bars are smokefree.
25. A major poll of 3,600 respondents was conducted in December 2005 by polling firm YouGov (commissioned by Cancer Research UK and Action on Smoking and Health). Asked if they would support legislation to make all workplaces smokefree, including pubs and restaurants, 72% said yes. The figure for England was 71%, the same as for Scotland. Given a list of specific public places, 67% across the UK said that all pubs and

bars should be smokefree by law. The figure for England was 66%, up from 51% in Spring 2004.

26. Detailed results were as follows:

Q1. The Government has announced plans to make most public places smokefree. Would you support a proposal to make ALL workplaces, including all pubs and all restaurants smokefree?

	England	Scotland	Wales	N Ireland	UK
	%	%	%	%	%
Would support such a proposal	71	71	70	78	71
Would not support such a proposal	24	25	27	18	24
Don't know	5	4	4	4	5

Q2. Looking at the following list of public places, please tell me how strongly, if at all, you would support or oppose a law to make it smokefree?

% who would support a law to make it smokefree

	England	Scotland	Wales	N Ireland	UK
	%	%	%	%	%
Hospitals	93	88	93	94	93
Offices	86	86	83	87	86
Taxis	86	86	85	83	85
Restaurants	85	85	87	84	86
Cafes	81	82	81	83	81

Shopping centres	79	80	73	74	79
Residential care homes	68	57	68	76	67
Bus and railway stations	65	68	63	71	65
Pubs and bars	66	70	67	74	67
Hotel rooms	65	61	65	66	69
Covered football stands	60	63	61	76	61
Prisons	41	41	38	45	41

Note: Interviews were conducted by YouGov using an internet panel survey with residents in England, Scotland, Wales and Northern Ireland aged 18 years and over. Sample sizes: England 1,995, Scotland 565, Wales 563, N Ireland 477: Total 3,600. Fieldwork conducted 2 - 7 December 2005.

27. Smokefree legislation, including pubs and restaurants, is already more popular across the UK than it was in the Republic of Ireland prior to its introduction there. And once the legislation comes in support will continue to grow. Research carried out by the Irish Department of Health three months after the legislation was implemented found that support had risen to 82%.¹⁸

Smokefree Legislation and Smoking Prevalence Rates

28. In the UK (2003/4), about 28% of men and 24% of women aged over 16 smoked cigarettes, with an overall prevalence rate of 26%. The decline in smoking rates over recent years has been heavily concentrated in older age groups: i.e., almost as many young people are taking up smoking but more established smokers are quitting. Smoking is highest among those aged 20-24: 38% of men and 34% women in this age group smoke.
29. Men and women in manual socio-economic groups are more likely to smoke than people in non-manual occupations. 20% of men and 17% of women in the professional and managerial groups smoke compared with 34% of men and 30% of women in routine and manual groups.¹⁹
30. The Government has set a target to reduce smoking prevalence rates to 21% or less by 2010; and to reduce smoking among routine and manual groups to 26% or less over the same time period.²⁰

31. Paragraph 14 of the Regulatory Impact Assessment published with the Health Bill estimates that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. (0.7% of this effect is estimated to result from the direct effect of ending smoking in employees' own place of work, and 1% from more places outside smokers' own place of work going smoke free). Using this estimate and data from the Office for National Statistics, Asthma UK and ASH have produced the following estimates of potential numbers of quitters for each English region.²¹

Region	Total Population	Adult population	Smokers (regional average percentage of adult population rounded down to nearest thousand)	Potential quitters (1.7% of total adult population, rounded down to nearest thousand)
East of England	5,463,000	4,386,789	1,140,000 (26%)	74,000
East Midlands	4,252,000	3,427,112	925,000 (27%)	58,000
London Region	7,388,000	5,947,340	1,784,000 (30%)	101,000
North East	2,539,000	2,051,512	635,000 (31%)	34,000
North West	6,805,000	5,444,000	1,524,000 (28%)	92,000
South West	4,999,000	4,064,187	1,056,000 (26%)	69,000
South East	8,080,000	6,488,240	1,686,000 (26%)	110,000
West Midlands	5,320,000	4,240,040	1,102,000 (26%)	72,000
Yorkshire & Humber	5,009,000	4,012,209	1,163,000 (29%)	68,000
England	50,093,000	40,575,330	10,955,339 (27%)	689,000

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Note: Prevalence rates for England in this table are slightly higher than those included in the UK figures in paragraph 23 because the ONS data on which the estimates are based relate to an earlier historic time series.

32. The tobacco industry has long recognised the potential effect of smokefree legislation on prevalence rates and hence sales of cigarettes. A Philip Morris internal memorandum from 1992 stated that:

*“total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing these restrictions consume 11% to 15% less than average and quit at a rate that is 84% higher than average ... these restrictions are rapidly becoming more common ... Milder workplace restrictions, such as smoking only in designated areas, have much less impact on quitting rates and very little effect on consumption”.*²²

Regulations

33. A great deal of the detail of smokefree legislation will be included in Regulations. The Department of Health has yet to publish a draft of these Regulations. However, they are likely closely to follow the Scottish model. Ministers are also known to want the lightest

possible regulatory touch consistent with ensuring that the legislation is effective and widely observed. On this basis, and given comments by Ministers during the Committee stage of the Bill, ASH have made the following forecasts for the likely contents of the

Regulations:

- The most likely implementation date (although this is far from certain) is 31st May 2007, World No Tobacco Day. Ministers have already stated that the legislation should come into effect by Summer 2007.
- The definition of an enclosed or substantially enclosed space will follow the Scottish law – which defines substantially enclosed as any premises where the opening makes up an area of less than half the area of the walls.
- Smoking is likely to be permitted in adult care homes, hotel rooms, hospices and prisons. This will be a decision for management, following the Scottish example. Special arrangements are likely to be made for mental health units.
- Smoking is likely to be permitted in laboratories for bona fide scientific research purposes
- Smoking will be permitted on stage and in television and film recording where it is integral to the story.
- Vehicles that are used for work will be smokefree, unless they are only ever used by one person. So, for example, refuse vehicles will be smokefree but company cars used by sales staff may not be.
- Signage requirements will be as flexible as possible, but will include the international no-smoking symbol.
- Smoking in a smokefree place (maximum fine £200) will be liable to a fixed penalty notice. Failing to display no-smoking signs (maximum fine £1000) will also be liable to a fixed penalty notice.
- Local authorities will decide which officers should be designated for enforcement work. In most cases this is likely to be Environmental Health Officers.

34. We support the Government’s general approach to these Regulations, which seem likely to provide the effective publicity and light regulatory and enforcement touch consistent with helping smokefree legislation to achieve maximum compliance rates through public consensus. However, we would wish to see the Government go further than it currently

intends to exercise its powers under Clause 4 of the Bill to designate some additional types of premise as smokefree, for example sports stadia that would not otherwise qualify as substantially enclosed. Currently, the Government intends to consider this when the legislation is reviewed after three years (i.e. in 2010). We would also wish to see a clear strategy and timeline for a smokefree policy in mental health facilities and a smokefree prison system (starting with institutions for young offenders).

Possible Exemptions for Some Pubs and Membership Clubs

35. Smoking prevalence rates are substantially higher in poorer communities; this is the biggest single contributing factor to differences in life expectancy between social classes. An exemption for pubs that do not serve prepared food, previously proposed by the Government but removed by the House of Commons by a large majority at Commons Report stage, would exacerbate health inequalities because those on lowest incomes would be most likely to remain exposed to secondhand smoke in pubs and clubs, and because the exemptions would make low-income smokers less likely to quit as a result of the new law.
36. ASH commissioned the research firm IFF Research Ltd to survey 1252 public houses and wine bars to establish: how many pubs currently do not serve prepared food; where such pubs are located; and what their likely future business decisions might be in relation to prepared food if the legislation includes the proposed exemptions. The survey showed that 29% of pubs and bars would currently be exempted from the legislation - at the top end of the estimate given in the November 2004 White Paper (10% to 30%). These premises would be concentrated in poorer communities. The IFF survey found that 45% of pubs and bars in the most deprived areas would be exempt, compared with 14% of pubs in the least deprived. The survey also showed that the proportion of pubs and bars not serving prepared food could rise to 40% if the final legislation includes the proposed exemptions.²³
37. The Government also originally proposed that membership clubs in possession of a club premises certificate, as defined by the Licensing Act 2003, could also be exempt from smokefree provisions, following a vote of members. Qualifying clubs are those run by and on behalf of the members, rather than for profit.²⁴ In mid-2004 there were about 20,000 such clubs in England and Wales.²⁵
38. It is unacceptable that members of clubs should have the right to vote to damage the health of their staff. The vulnerability of a bar worker to cancer or heart disease caused or made worse by secondhand smoke does not depend in any way on whether the bar in which they work is owned by members of a club or run as a profit-making business.
39. Private clubs with bars frequently compete with pubs in their local area. Exempting them from smokefree legislation will create unfair competition and is strongly opposed by the pub trade for this reason. The Morning Advertiser, newspaper of the pub industry, recommended in an editorial on Thursday 26th January that:

“the 20,000 members clubs in England and Wales must operate on the same lines as our pubs. If they do not, the Government will have created an explosive situation that could tear communities apart in many regions of the country. The trade must now switch its focus to persuading Government that only a total ban is fair...” (MA Opinion, Andrew Pring, Editor, 26.1.2006).

John Grogan MP, Chair of the All Party Beer Group, wrote in the same edition that:

“... the decision this week by a critical mass of the beer and pub industry to join with the

health lobby and local government to argue for comprehensive smokefree legislation is both historic and timely.”

40. The British Institute of Innkeeping

“strongly opposes the proposal that members clubs are exempt from the ban. If the basis for banning smoking is to protect staff working in licensed premises, those working in members’ clubs deserve the same protection. Allowing smoking in members’ clubs would lead to a migration of drinkers from local pubs into the members’ clubs, which could essentially become smoking clubs. This loss of custom to small licensed premises could drive them out of business.”²⁶

41. At Commons Report Stage, the Chair of the Health Select Committee, the Rt Hon Kevin Barron MP made the following key point:

“A member of a club in the Club and Institute Union can affiliate to the wider union for £3 a year, and can go to 2,600 clubs and buy a drink without anyone preventing them from doing so. Royal British Legion clubs, too, are not exclusive—a member of the British Legion can walk into any of its clubs and be served a drink.. Clubs differ marginally from public houses, because there are often many children inside them. They are family-oriented and many hold weekly discos for young children. They organise Easter bonnet parades, Christmas functions and so on for families and young children, so the proposal to exempt clubs from the smoking ban is ludicrous.”²⁷

42. **The House of Lords and House of Commons Joint Committee on Human Rights** has warned that the proposed exemptions from smokefree legislation for non-food pubs

and membership clubs may be subject to challenge under human rights legislation.

“In relation to the Article 8 ECHR rights of smokers, the Committee concludes that in view of the evidence adduced by the Government in its regulatory impact assessment on the health and financial benefits of the proposed ban, the fact that the prohibition does not extend to a person’s home and that provision is made to exempt places which are people’s de facto homes, the interference with the private life of smokers is likely to be upheld as being proportionate (paragraph 1.37).

In relation to the proposed exemptions from the prohibition on smoking for licensed premises not serving food and for membership clubs, the Committee notes that this gives rise to differential treatment of employees and members of the public which requires objective justification if it is to be compatible with Article 14 ECHR in conjunction with Articles 2 and 8. The Committee has written to the Minister pointing out the nature of this problem and asking what is the objective justification relied upon for these proposed exemptions (paragraph 1.41 and Appendix). The Committee may report again on this point on receipt of the Minister’s reply.”

43. Bill Callaghan, Chair of **the Health and Safety Commission**, wrote to Patricia Hewitt during the consultation on the Bill calling for exemptions for pubs and clubs to be dropped. A paper approved by the HSC at its meeting on 27th July 2005 ²⁸stated that:

“The arguments for a wider ban in all licensed premises are these:

- *The science: SCOTH [the Government’s Scientific Committee on Tobacco and Health] is clear that second hand smoke is harmful. The Government’s proposals appear to be at odds with equality in public health.*
- *Better regulation: for regulation to be effective it must be capable of ready application by those to whom it is addressed. Differing restrictions in the UK will lead to confusion*

and lessen benefits. A uniform approach to smoking will be easier for employers, employees and the public to understand and comply with...

- *Effective enforcement: a simpler regime, with fewer and less complex exemptions, will aid enforcement by the Local Authorities.”*

The letter to the Health Secretary stated:

“We are concerned that the proposals run the risk of creating health inequality and this we consider would be undesirable.”

44. Although national survey data are not available, it is clear from regional and local data that, as for pubs not serving food, licensed clubs in many areas are concentrated in poorer communities and areas of high smoking prevalence. The following map illustrates the point for the North East of England.

Clubs and Smoking Prevalence Rates in the North East



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45. At Commons Report Stage, the amendment to remove an exemption for private membership clubs from smokefree legislation was carried by 413 to 129 (on a Free Vote for all major parties). The New Clause removing an exemption for non-food pubs was carried by 453 votes to 125.
46. Liberal Democrat peer Lord Steel of Aikwood moved an amendment in Grand Committee that would allow smoking in pubs with separated and ventilated smoking areas. He also suggested that no worker would be required to work in such areas, although did not specify how this could be achieved. In fact, it is impractical to segregate smoking and non-smoking areas, since smoke inevitably drifts.

The liberal principle behind smokefree legislation is the one set out in Chapter 3 of JS Mill's "On Liberty":

"Acts of whatever kind, which, without justifiable cause, do harm to others, may be, and in

the more important cases absolutely require to be, controlled by the unfavourable sentiments, and, when needful, by the active interference of mankind. The liberty of the individual must be thus far limited; he must not make himself a nuisance to other people.”

Economic Impact of Smokefree Legislation

47. The 2003 Annual Report by the Government's Chief Medical Officer estimated that a comprehensive smokefree law could benefit the British economy by up to £2.7 billion. That's about £40 for every man, woman and child in the country. The total includes up to £680m from having healthier employees producing more goods and services, £140m saved through fewer sick days, £430m saved because less production would be lost to cigarette breaks and £100m saved by not having to clean up after smokers.²⁹

Displacement of Smoking from Work to Home

48. It is sometimes suggested that ending smoking in workplaces displaces smoking into homes – increasing domestic exposure to secondhand smoke. There is no good research evidence for this claim - no published peer reviewed study has ever demonstrated such an effect. In fact, the evidence shows the reverse – workplace bans lead to less smoking in the home as smokers quit and awareness of the dangers of secondhand smoke rises.
49. Giving evidence to the Health Select Committee, Public Health Minister Caroline Flint stated:
- “On the [...] point in terms of is there a displacement, in terms of the evidence we have got, in particular there have been two reports in the last six months [...] which had done some work looking at this issue about whether there was displacement to the home, which did not show that there was evidence that smoking restrictions did displace into the home [...] I am happy to say, as far as I am aware, there is no current evidence that would suggest there is a move to more smoking in the home as a result of restrictions or bans.”³⁰*
50. A written answer from the Health Minister on 28th November 2005 stated:

*“**Mr. Holloway:** To ask the Secretary of State for Health what research she has (a) commissioned and (b) evaluated on whether the proposed ban on smoking in public places will displace smoking from pubs to domestic environments. [28639]*

***Caroline Flint:** The evidence available from those countries with legislation for smokefree public places and bars is that there is no significant displacement to domestic environments. Smokefree legislation has been shown to result in reduced prevalence of smoking, which in turn means reduced prevalence of smoking in domestic environments as well as public places. Recent research on the ban in Ireland reported in the publication "Going Smokefree" by the Royal College of Physicians pointed to a "statistically significant increase in the percentage of smokers who banned smoking in their own homes after the smokefree law was introduced" (P.74).³¹*

51. The Observer newspaper on 18th December 2005 reported a discussion paper by Dr Jerome Adda, an economist at University College, London, which purported to show that smokefree ordinances in the US led to increased exposure for children from secondhand smoke in the home. Unlike the other published work in this area, this research has not been peer reviewed before publication. The author has made it clear that any effect observed in the US may not apply in other countries, and his handling of the data has

been criticised by other experts.

Scotland, Wales and Northern Ireland

52. On 30th of June 2005, the Scottish Parliament passed comprehensive smokefree legislation, which came into effect in all fully and substantially enclosed public places at 6am on March 26, 2006.
53. The National Assembly for Wales does not have primary legislative powers. However, on Tuesday 24th May 2005, the National Assembly voted in favour of calling for powers to introduce comprehensive smoking restrictions covering all workplaces. The Health Bill would give the Assembly the powers it is seeking.
54. The then Northern Ireland health minister Shaun Woodward announced on Monday 17th October that comprehensive smokefree legislation covering the province would come into effect in April 2007. Mr Woodward said:

"I am confident that, on top of the overwhelming health arguments for total control, the economy will not only not suffer, but that there will be opportunities for it to expand."

International Evidence

55. There is extensive evidence of the success of smokefree legislation in other countries and jurisdictions.
56. In the **Irish Republic**, the Vintners Federation of Ireland and other groups have frequently claimed that the smokefree law has reduced pub takings by "20-30%". This claim is demonstrably false. Indeed, Irish retail sales figures show that the volume of sales of beer, wine, spirits and food in pubs rose by in 5.3% in the year to October 2005, and the value of sales by 4.2% (seasonally adjusted). This in fact reverses a long decline in sales in the period before smokefree legislation came into effect.³²
57. It has also been suggested by the tobacco lobby that smoking rates in the Irish Republic have not fallen since smokefree legislation was introduced. The following comment is from the Irish Office of Tobacco Control:

"The article published in the Mail on Sunday on 26th March 2006 written by Jane Simpson, entitled 'Nicotine ban leads to rise in smoking' includes a number of inaccuracies and misleading claims.

The latest accurate research data show:

- *Smoking prevalence in Ireland has fallen to less than 24% in 2005, from 31% in 1998 and 27% in 2002;*
- *At December 2005 prevalence was 23.91% down from 25.51% in February 2004 (one month prior to the introduction of the ban);*
- *Health benefits are already accruing. A number of studies highlight this fact, including a study published by the British Medical Journal last October which indicated that the high rate of compliance with the smoke-free workplace law in Ireland has resulted in better air quality in bars and improved health for workers. Among non-smokers, cotinine concentrations (a marker for exposure to second hand smoke) in the saliva declined by 80%;*
- *The decline in smoking prevalence in the last 4 years is attributed to a range of factors including the smoke-free workplace law, together with the provision of Nicotine Replacement Therapies (NRT) to medical card holders, health promotion activities, prohibitions on tobacco advertising, and the raising of the legal age of sales from 16*

to 18 years of age.

We deduce that Ms Simpson based her claim that 'laws banning smoking lead to more people taking up the habit' on a very slight upward trend in cigarette smoking prevalence since August 2005. This is in the region of less than half a per cent. Clearly, marginal fluctuations in terms of fractions of a percentage regularly occur and these are not considered significant given the nature of tobacco addiction. The prevalence research is also available on the Office's website, www.otc.ie.

*Marie Killeen
Acting Chief Executive Officer
Office of Tobacco Control*

58. In **Scotland**, comprehensive smokefree legislation came into effect at 6am on 26th March 2006. Polling evidence already shows strong support for the legislation. For example, a major poll reported by The Publican website on 27th April 2006³³ showed that:

- 69% of pub-goers agree with the smoking ban in Scotland.
- 25% said they had gone to the pub more often since the ban, compared to 20% saying they had been less often.
- 61% said they were more likely to eat in a pub after the ban.

On 27th April 2006, ASH Scotland summarised the experience of the first month of smokefree legislation as follows³⁴:

- A fourfold increase in the number of calls to the NHS Smokeline was reported during the first 3 days after smokefree legislation came into force. Smokeline usually receives 100 calls a day, but during these 3 days 450 calls were received.
- Boots revealed that sales of NRT in Scotland had doubled since the ban came into force. The biggest increase was in Glasgow where sales were up 110% on the previous year.
- Figures from the national compliance line show (figures include both alleged breaches of smoking in no-smoking premises and signage breaches):

Week 1	26/03/06 – 01/04/06
	215 total calls 112 alleged breaches passed to EHOs
Week 2	02/04/06 – 08/04/06
	130 total calls 100 alleged breaches passed to EHOs
Week 3	09/04/06 – 15/04/06
	115 total calls 91 alleged breaches passed to EHOs.

59. In **New Zealand**, the Ministry of Health published a one year review of smokefree legislation in December 2005.³⁵

The review concluded that:

- The proportion of workers reporting smokefree workplaces increased from 80 percent to 91 percent in the first few months of the Amendment coming into effect.
- In the longer term, it is expected the reduction in workplace secondhand smoke exposure will be reflected in a reduction in health costs, work absenteeism, hospitalisations and tobacco-related deaths.
- Public approval for the right to smokefree work environments has built to over 90 percent overall, including an increase in support for smokefree restaurants and bars from 79 percent in 2003 to 91 percent in 2005.
- Smokers appear to have maintained their patronage levels of bars, while non-

smokers have markedly increased their patronage, from 33 percent to 49 percent.

- Economic data shows neutral to positive trends in the first eight months of revenue data for the main hospitality industries since the Amendment came into effect. Liquor retail and accommodation revenues in particular have continued to rise since December 2004, while bars, cafes and restaurants have maintained steady revenues overall.
- Enforcing the legislation has been straightforward, with only 400 reported complaints in the first nine months.

60. In **Norway**, evidence from the first year of smokefree legislation³⁶ shows that: People generally comply with the ban and inspection authorities and employees experience very few problems with compliance;
- A growing majority of people support the ban (76% in October 2005, up from 54% at the start of the ban in June 2004);
 - Guests state that air quality has improved;
 - There is little difference in the turnover index of bars and restaurants before/after;
 - There has been a distinct improvement in air quality in the workplace;
 - Fewer employees state that they have general medical problems;
 - Fewer employees state that they experience respiratory problems;
 - 1 of 10 employees has quit smoking.

61. In **New York**, where smokefree legislation came into effect in March 2003, the tobacco lobby and hospitality trade argued fiercely that smoking restrictions would be bad for business. The objective evidence does not support this. In March 2004, a report on the impact of the legislation in the City of New York was issued by the City's Department of Finance, the Department of Health and Mental Hygiene, the Department of Small Business Services, and the Economic Development Corporation. It concluded that:

*"One year later, the data are clear. . . Since the law went into effect, business receipts for restaurants and bars have increased, employment has risen, virtually all establishments are complying with the law, and the number of new liquor licenses issued has increased—all signs that New York City bars and restaurants are prospering."*³⁷

Ventilation

62. It is often claimed by the tobacco industry that ventilation will remove the effects of secondhand smoke in public places. There is no good scientific basis for this view. Tobacco smoke is a toxic mix of over 4,000 chemicals, including over 50 cancer-causing agents. Ventilation may remove the smell of tobacco smoke but it does not eliminate all the cancer-causing particles and gases from the air.
63. Research by D Kotzias and others at the European Commission Joint Research Centre's INDOORTRON facility concluded that:

"... changes in ventilation rates simulating conditions expected in many residential and commercial environments during smoking do not have a significant influence on the air concentration levels of ETS constituents, e.g. CO, NOx, aromatic compounds, nicotine. This suggests that efforts to reduce ETS originated indoor air pollution through higher ventilation rates in buildings, including residential areas and hospitality venues, would not lead to a meaningful improvement in indoor air quality. Moreover the results show that 'wind tunnel' like rates or other high rates of dilution ventilation would be expected to be required to achieve pollutant levels close to ambient air limit values".

In other words, for ventilation to have any significant effect, it would require tornado like

quantities of ventilation to produce an acceptable risk to those exposed to secondhand smoking.³⁸

64. The House of Commons Health Select Committee's 2005 report on smokefree legislation includes an excellent summary of the evidence on smoking and ventilation.³⁹

The Committee concluded that:

"We are not convinced that ventilation offers a practical means of reducing SHS to safe levels. The scientific evidence is clear that there is no safe level of SHS. The expert evidence we have heard suggests that at best ventilation can only dilute or partially displace contaminants. Ventilation offers cosmetic improvements but does not represent a sufficient response to the health and safety risks inherent in SHS."

65. A recent article in the British Medical Journal revealed how British American Tobacco promoted air filtration systems as a "solution" to secondhand smoke, despite knowing that they were largely ineffective. According to BAT scientist, Nigel Warren, the company's interest in air filtration was primarily "to negate the need for indoor smoking bans around the world".⁴⁰

Notes

- ¹ www.advisorybodies.doh.gov.uk/scoth/PDFS/scothnov2004.pdf
- ² www.asthma.org.uk/news_media/media_releases/689000_england.html
- ³ www.ash.org.uk/html/press/050302.html
- ⁴ tc.bmjournals.com/cgi/content/abstract/14/4/236
- ⁵ www.advisorybodies.doh.gov.uk/scoth/PDFS/scothnov2004.pdf
- ⁶ www.bma.org.uk/ap.nsf/Content/Smokefree
- ⁷ "Towards Smokefree Public Places": BMA November 2002
- ⁸ www.asthma.org.uk/news_media/media_releases/689000_england.html
- ⁹ www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/485/5102005.htm.
- ¹⁰ www.newscientist.com/article.ns?id=dn8563: Journal reference: *Atmospheric Environment* vol 40, p 386
- ¹¹ www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds06/text/60420-36.htm
- ¹² www.bma.org/ap.nsf/Content/SmokeFreeWorld
- ¹³ Letter to peers, copy available from ASH
- ¹⁴ www.philipmorrisusa.com/en/health_issues/secondhand_smoke.asp
- ¹⁵ www.ash.org.uk/html/workplace/html/workplacesmokingrestrictions2004.html
- ¹⁶ www.ash.org.uk/html/press/050302.html
- ¹⁷ tc.bmjournals.com/cgi/content/abstract/14/4/236
- ¹⁸ www.otc.ie/Uploads/1_Year_Report_FA.pdf
- ¹⁹ www.ash.org.uk/html/factsheets/html/fact01.html
- ²⁰ www.statistics.gov.uk/cci/nugget.asp?id=866
- ²¹ www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT_ID=4121917&chk=sUauD/
- ²² legacy.library.ucsf.edu/cgi/getdoc?tid=qhs55e00&fmt=pdf&ref=results
- ²³ www.ash.org.uk/html/press/050905.html
- ²⁴ www.culture.gov.uk/alcohol_and_entertainment/licensing_act_2003/qualifying_clubs.htm
- ²⁵ Department for Culture, Media and Sport Statistical Bulletin Liquor Licensing, England and Wales, July 2003-June 2004.
- ²⁶ www.bii.org/index.cfm/asset_id,673134/fuseaction,news/index.html
- ²⁷ www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060214/debtext/60214-16.htm
- ²⁸ 66.102.9.104/search?q=cache:9E-xfUnqE80J:smokefree.ash.positive-dedicated.net/consultation%2520submissions/HSCsubmission.doc+HSC+letter+hewitt+smokefree+legislation&hl=en&ct=clnk&cd=1
- ²⁹ www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/CMOAnnualReportsArticle/fs/en?CONTENT_ID=4086602&chk=hXW6k
- ³⁰ www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/485/485.pdf, page 42.
- ³¹ www.publications.parliament.uk/pa/cm200506/cmhansrd/cm051128/text/51128w77.htm
- ³² www.cso.ie/releasespublications/documents/services/current/rsi.pdf
- ³³ www.thepublican.com/cgi-bin/item.cgi?id=20608&d=32&h=24&f=23&dateformat=%25o%20%25B%20%25Y
- ³⁴ www.ashscotland.org.uk/ash/ash_display.jsp?pContentID=5044&p_applic=CCC&p_service=Content.show
- ³⁵ [www.moh.govt.nz/moh.nsf/0/7EC01E1971949178CC2570D20019E782/\\$File/SmokeClearing.pdf](http://www.moh.govt.nz/moh.nsf/0/7EC01E1971949178CC2570D20019E782/$File/SmokeClearing.pdf)
- ³⁶ www.shdir.no/vp/multimedia/archive/00003/Norways_ban_on_smokin_3413a.pdf
- ³⁷ www.health.state.ny.us/nysdoh/tobacco/reports/docs/nytcp_eval_report_final_11-19-04.pdf
- ³⁸ www.smokefreeeurope.com/assets/downloads/dimitrios_kotzias.doc
- ³⁹ www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/485/a1
- ⁴⁰ www.eurekalert.org/pub_releases/2006-01/bmj-tip012506.php

**See www.smokefreeaction.org.uk
for detailed evidence on the case for comprehensive smokefree
legislation**

Smokefree Action brings together leading UK health and medical organisations, professional bodies and other groups working towards smokefree workplaces and enclosed public places.

Members of the Smokefree Action coalition call for legislation to end smoking in all workplaces and enclosed public places. Such a law would protect all workers and the public from secondhand smoke and give many thousands of smokers the encouragement they need to give up. It's about health and it's about time.

The following organisations are members of the Smokefree Action Alliance. Please see the website for more information and contact details.

ASH	Horsham and Chantonbury PCT
ASH Scotland	Kent Alliance on Smoking and Health
ASH Wales	Leukaemia Research Fund
Asthma UK	Macmillan Cancer Relief
Barnsley PCT	Men's Health Forum
Beating Bowel Cancer	National Heart Forum
Breast Cancer Care	No Smoking Day
Bristol North PCT	Northern ASH
British Cardiac Society	Northwest ASH
British Heart Foundation	Peterborough Quit Smoking Service
British Lung Foundation	Pharmacy Health Link
British Medical Association	QUIT
British Thoracic Society	Roy Castle Lung Cancer Foundation
British Vascular Foundation	Royal College of Midwives
Cancer Black Care	Royal College of Nursing
Cancer Research UK	Royal College of Pathologists
Castleford Normanton District Hospital	Royal College of Physicians
Chartered Institute of Environmental Health	Smoke-Free Alliance for Shropshire County and Telford & Wrekin
Chelmsford PCT	Smokefree Devon Alliance
Diabetes UK	Smokefree Liverpool
East Kent Coastal Teaching PCT	Smokefree London
East Staffordshire PCT	Smoking Control Network
Eastbourne Downs PCT	Socialist Health Association
Eastern Cheshire PCT	South Tyneside PCT
Eastern Wakefield PCT	Stockport PCT
Faculty of Public Health	Stop Smoking Service Leicester
GASP	Teenage Cancer Trust
Gloucestershire Partnerships NHS Trust	The Roy Castle Lung Cancer Foundation
HALT (Humber Alliance on Tobacco)	World Cancer Research Fund (UK)
Health Challenge Pembrokeshire	Yorkshire ASH
Heart of Mersey	
Heartsave	

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