



House of Commons
Health Committee

Smoking in Public Places

First Report of Session 2005–06

Volume I



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Smoking in Public Places

First Report of Session 2005–06

Report, together with formal minutes

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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John Austin MP (*Labour, Erith and Thamesmead*)

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, which can be found in Volume III (HC 485-III). Written evidence is cited by reference in the form 'Ev' followed by the page number and the Volume Number, either Volume II (HC 485-II) or Volume III (HC 485-III).

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Summary

Smoking is bad for health, as is the inhalation of secondhand smoke (SHS) from other people's cigarettes. There is now an extensive body of medical evidence, established over the past 30 years, that SHS contributes significantly to the risk of a range of diseases, from cot death, glue ear and respiratory disorders in children to lung cancer and heart disease in adults. WHO, the US Surgeon General and SCOTH have concluded that SHS is a preventable cause of death and ill health. The Royal College of Physicians produced a report in July 2005, entitled *Going smoke-free: The medical case for clean air in the home, at work and in public places*, in which it summarised the evidence of the damage done by SHS. It is currently estimated that SHS causes at least 12,000 deaths each year in the United Kingdom. 500 of these deaths are due to smoke in the workplace.

There is no satisfactory way of allowing smoking in public and at the same time protecting non-smokers from the harmful effects of SHS. Ventilation, while technically feasible, is not a practical approach since the equipment necessary would be extremely expensive and would not be suitable for use in public places, such as licensed premises, where there are some of the highest levels of exposure to SHS. The only sensible way to afford protection from SHS exposure is to implement a comprehensive ban on smoking in public places and workplaces.

Many countries and states have taken the decision to legislate against smoking in public. The most prominent example is the Republic of Ireland, where there has been a popular and effective prohibition on smoking in public places and workplaces since March 2004, but similar restrictions are in place in (among other places), South Africa, Thailand, Australia, New Zealand, India, Norway, Italy, Vietnam, and parts of the United States of America including California, New York, Delaware and Florida. In addition, a comprehensive ban on smoking in public will be introduced in Scotland in March 2006, while the decision to implement a ban has been taken in principle in Northern Ireland.

The primary justification for a ban on smoking in public places and workplaces is that it protects workers and other vulnerable groups from the significant health risks which SHS poses. The Irish experience suggests that the consequences for smokers will be slight. Pubs will survive and smokers seem happy using outdoor smoking areas. Smoke-free legislation is also likely to have an impact on overall smoking prevalence, and it sends a powerful public health message about the dangers of smoking.

The Government, after consulting with the public, presented its plans for a ban on smoking in public places in the Health Bill, published in October 2005. It plans to treat public places which are also dwellings differently from other public places. While the consultation seems to have envisaged that prisons and military premises would be included in the legislation, they are not part of the Bill as published. We discovered with some difficulty that the provisions of the Bill do not extend to Crown property. We are disappointed that none of a host of Government witnesses to the inquiry informed us of this important fact. Although not covered by the ban, the MOD intends to keep within the spirit of the law. The Prison Service will move in the same direction but emphasised the huge difficulties it faced. We are concerned that this will be an excuse for inaction. We

recommend that target dates be set for penal institutions, MOD premises and psychiatric institutions to become smoke-free.

Under the proposed legislation, exemptions are also provided for licensed premises in which food is neither prepared nor served and membership clubs. The Government has sought to defend its proposals on the grounds that public opinion is not yet ready to accept a comprehensive ban and so there would be problems with compliance. The Minister for Public Health told us that bar workers would be protected by a one-metre exclusion zone round the bar, but under questioning admitted that would provide no health benefits. The previous Secretary of State for Health, Rt Hon John Reid MP, told our predecessor Committee that that under the Government's proposals few bar workers would die. He also argued that such a ban would lead to an increase in smoking in the home. The Government has now admitted that he was wrong.

The Government's contention that a ban on smoking in all pubs and clubs would be unpopular is disputed. The White Paper *Choosing Health* is confusing and possibly misleading on the subject. Moreover, since its publication opinion has been moving rapidly in favour of a comprehensive ban. The latest survey indicates that around 70% of the population support such a ban.

The evidence we have considered compels us to conclude that the only effective means of protecting all workers from the harmful effects SHS is a comprehensive ban on smoking in enclosed public places and work places. We therefore agree with the Chief Medical Officer that a failure to implement such a ban would put England "among the laggards of public health".¹

We recommend that the Government introduce a comprehensive ban on smoking in all public places and workplaces, which includes Crown property and which has very limited exemptions. This is primarily an issue of protecting workers in the workplace, and all employers have a duty of care in this regard. It is unacceptable for the Government to allow any worker to be excluded from protection from SHS on the grounds of public opinion, especially when these grounds are specious. Moreover, a comprehensive ban would be easier and more cost-effective to implement and enforce, and would be more intelligible to the public. The ban introduced in Ireland has been a popular model which the UK Government would do well to follow.

1 Introduction

1. Smoking is bad for health; so is inhaling other people's smoke. An extensive epidemiological literature over the past 30 years has established the risks, ranging from cot death, glue ear and respiratory disease in infants to lung cancer and heart disease in adults. Recent research estimates that at least 12,000 deaths per year in the UK can be attributed to secondhand smoke.² The author of the report considers this a conservative estimate. A series of reports in this country and elsewhere have reviewed the evidence and reached unambiguous conclusions. The World Health Organisation's International Agency for Research on Cancer (IARC) categorised secondhand smoke as a human carcinogen. In November 2004 the Scientific Committee on Tobacco and Health (SCOTH) concluded in its report on *Secondhand Smoke: Review of evidence since 1998*:

Knowledge of the hazardous nature of SHS (secondhand smoke) 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.

2. As a result of these and other findings, it is now widely recognised that non-smokers need to be protected from other people's smoke in the workplace.³ Some argue that this can be achieved by ventilation. However, according to most scientific opinion while ventilation can make the atmosphere seem more pleasant, it cannot in practice adequately remove the carcinogens. Many western governments have therefore begun to impose smoking bans in public places and the workplace. The most contentious aspects of such policies are bans where smoking is popular, particularly in pubs and bars. Nevertheless, an increasing number of governments have taken the view that bar workers, who suffer from some of the highest exposure levels, should be protected. In Ireland a comprehensive ban which included pubs was introduced in March 2004; the Scottish Executive has decided on a similar ban which will begin in March 2006.

3. In its Public Health White Paper, *Choosing Health*, the Government announced its intention to ban smoking in enclosed public places in England from 2008. However, there were to be a number of exemptions, most controversially for pubs and bars which do not prepare and serve food and for membership clubs. The White Paper claimed that in surveys and opinion polls only "20% of people chose 'no smoking allowed anywhere' and the majority tended to be opposed to a complete ban".⁴

2 Royal College of Physicians, *Going smoke-free: The medical case for clean air in the home, at work and in public places*, July 2005, ISBN 1 86016 246 0.

3 For example, World Health Organisation International Agency for Research on Cancer, *Tobacco Smoke and Involuntary Smoking*, IARC Monographs Volume 83, 2004; Report of the Scientific Committee on Tobacco and Health, *Secondhand Smoke: Review of evidence since 1998*, November 2004; US Office on Smoking and Health, *The health consequences of involuntary smoking: a report of the Surgeon General*, 1987; Australian National Health and Medical Research Council, *Effects of passive smoking on health*, Report of the NHMRC working party, 1987; United States Environmental Protection Agency, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, December 1992; California Environmental Protection Agency, *Exposure to Environmental Tobacco Smoke*, September 1997.

4 Department of Health, *Choosing Health: Making healthy choices easier*, Cm 6374, November 2004, pp 98-9.

4. In the Queen's Speech of May 2005, the Government announced its intention to introduce legislation to restrict smoking in enclosed public places and workplaces. In June 2005, the Department of Health issued a *Consultation on the Smokefree Elements of the Health Improvement and Protection Bill*. Following the General Election, the Health Committee was re-appointed in July 2005 and at its first meeting decided to hold an inquiry into smoking in public places in order to inform Parliamentary scrutiny of the legislation. We invited submissions but also announced that we would obtain copies of responses to the Department of Health's Consultation. The submissions were published on 24 November 2005.⁵

5. The Bill was published on 27 October and had its second reading on 29 November, when the Government indicated the general nature of the exemptions. However, their precise form is not known because they are to be specified in regulations. In October and November we took evidence from 40 witnesses, including the Chief Medical Officer, the Chairman of the Health and Safety Commission, the Royal College of Physicians, the Royal College of Nursing, tobacco companies, trade unions, several organisations representing the hospitality industry, the Director-General of the Prison Service, the Ministry of Defence, and Northern Ireland, Home Office and Health Ministers.

6. In November, the Chairman of the Committee appeared on *You and Yours* on BBC Radio 4. Many listeners sent their views on the subject to the programme team who compiled a submission to the inquiry based on an analysis of the contributions.⁶ Further detail of this analysis is provided in Annex 2.

7. During the inquiry we did not attempt to look at all the issues raised in the consultation referred to in paragraph 4, but decided to address the following key concerns:

- the health effects of secondhand smoke
- ways of dealing with such effects: ventilation or a ban?
- the justification for a ban
- the Government's proposals
- whether the proposed exemptions for institutions which are also dwellings are justified
- whether the proposed exemptions for non-food pubs and membership clubs are justified
- how to best ensure compliance
- conclusions: what the government should do.

8. In November 2005 we visited Dublin to examine the consequences of the total ban in Ireland. We are very grateful to the assistance provided by the staff of the British Embassy who facilitated this visit and to all the people we met there for providing us with crucial

5 www.dh.gov.uk/Consultations/ResponsesToConsultations/fs/en

6 Ev 119, Volume III

evidence for our inquiry. We also thank our specialist advisers, Professor John Britton of Nottingham University and Professor Martin Jarvis of University College London for the objective advice they gave us and for helping us disentangle the complexities of a difficult subject.

2 The health effects of secondhand smoke

9. Secondhand smoke (also known as environmental tobacco smoke, ETS, or 'passive smoking') is produced from two sources. The first is so-called 'mainstream smoke'; this is smoke which is puffed by the smoker, inhaled and then exhaled. The second is 'sidestream smoke', which is released into the ambient air from the smouldering tip of a lit cigarette between puffs. The constituents of mainstream and sidestream smoke are similar but their concentrations differ, in general being higher in sidestream smoke. The great majority of SHS consists of sidestream smoke.

10. Tobacco smoke contains more than 4,000 different chemicals, at least 50 of which are known carcinogens. These include benzo[a]pyrenes, aromatic amines and tobacco-specific nitrosamines. It also contains nicotine, toxins such as carbon monoxide and hydrogen cyanide and irritants such as acrolein. SHS consists of a gas phase and a particulate phase, the former including carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde, hydrogen cyanide and acrolein, the latter, the complex of compounds collectively termed tar, including benzene and benzo[a]pyrene. Nicotine is present in both the gas phase and the particulate phase.⁷

11. High levels of particulates are found in tobacco smoke. Dr Richard Edwards, a Senior Lecturer in Public Health at the University of Manchester, told the Committee:

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, much more than you do from traffic pollutants at the road side.⁸

12. The level of exposure to SHS can be measured in a number of ways. It is possible to measure directly the concentration of known constituents of SHS in the air. Surveys and questionnaires can collect information on a person's duration and frequency of exposure. Personal monitors can be used to measure exposure to nicotine or smoke particles. It is also possible to detect the constituents or metabolites of SHS in hair, blood, saliva or urine. In this way, the amount of SHS absorbed by a person can be assessed by levels of biomarkers such as nicotine (and, more usually, its breakdown product, cotinine) as well as by markers of DNA and protein damage.⁹

13. Since mainstream and sidestream smoke contain the same chemicals, exposure to SHS is likely to cause most, if not all, of the diseases caused by active smoking, but with a lower

7 Royal College of Physicians, *Going smoke-free: The medical case for clean air in the home, at work and in public places*, July 2005, ISBN 1 86016 246 0.

8 Q 72

9 See, for example, Report of the British Medical Association Board of Science and Education and Tobacco Control Resources Centre, *Towards smoke-free public places*, November 2002, p. 1.

absolute level of risk.¹⁰ Scientific studies have employed two main designs to investigate the effects of SHS on disease risk for non-smokers:

- The case-control study, which compares exposure to SHS of people with and without a particular disease and thereby determines whether people with a disease are more likely to have been exposed;
- The cohort study, which compares the incidence of disease in those with and without exposure to SHS prospectively over a period of time.

Many case-control studies have examined the effects of SHS by determining whether non-smoking women who have developed a smoking-related disease are more likely to have lived with a smoking partner than non-smoking women who do not have the disease. The focus has been predominantly on women because smoking has historically been much more common in men than in women.

14. A considerable body of evidence has accumulated over the last thirty years which has demonstrated with increasing certainty that exposure to SHS both causes illnesses and exacerbates existing ill health. In 1983, the Department of Social Services' Independent Committee on Smoking and Health affirmed a link between secondhand smoke and ill health, and, in 1988, went on to note that exposure to SHS could cause several hundred deaths from lung cancer in non-smokers in the UK each year. In 1986, the United States Surgeon-General had concluded that exposure to SHS presented a major risk to health.

15. More recently, the case that SHS is harmful to public health has been made by the Department of Health's Scientific Committee on Tobacco and Health. In 1998, it produced a report which concluded that exposure to SHS was a cause of lung cancer and heart disease in adults, as well as of a variety of diseases in children.¹¹ As a result, the report recommended restrictions on smoking in public places, and, where possible, a ban on smoking in the workplace. In 2004, SCOTH released *Secondhand Smoke: Review of evidence since 1998*, in which it concluded that:

- There is an estimated 24% increased risk of lung cancer in non-smokers exposed to SHS;
- There is an estimated 25% increased risk of heart disease in non-smokers exposed to SHS;
- Exposure to SHS is strongly linked to an elevated risk of pneumonia, bronchitis, asthma, middle ear infection, decreased lung function and sudden infant death syndrome in children.¹²

16. In July 2005, the Royal College of Physicians (RCP) published *Going smoke-free: The medical case for clean air in the home, at work and in public places*, a report on secondhand

¹⁰ See Ev 4, 6, 9, 17 and 23, Volume II

¹¹ First Report of the Scientific Committee on Tobacco and Health, March 1998.

¹² Report of the Scientific Committee on Tobacco and Health, *Secondhand Smoke: Review of evidence since 1998*, November 2004; see also World Health Organisation International Agency for Research on Cancer, *Tobacco Smoke and Involuntary Smoking*, IARC Monographs Volume 83, 2004.

smoke by the RCP Tobacco Advisory Group. This study presented a comprehensive survey of the available scientific data, as well as examining issues such as public response to potential smoke-free legislation and the likely health and economic effects of a ban on smoking in public places. It attempted to quantify the deaths attributable to SHS in the UK in 2003, and divided these deaths into those caused by exposure to SHS at home (the vast majority) and in the workplace.

17. The data were updated from those in a study by Professor Konrad Jamrozik, a public health specialist at the University of Queensland, which suggested that SHS caused approximately 12,200 deaths in the UK in 2003, of which a minimum of 500 were due to smoke in the workplace. Within that subsection, it was estimated that perhaps 50 deaths were due to smoke in hospitality industry workplaces. The Royal College of Physicians' report, in recording these figures, noted that the estimate of 12,200 deaths "is likely to be conservative".¹³ The study also noted that a large proportion of the deaths occurred in those aged under 65.

18. Recent evidence has also demonstrated a disturbing aspect of the epidemiology concerning exposure to SHS, namely that even low levels of exposure can cause a significant increase in the risk of heart disease. A cohort study published in the *British Medical Journal* in 2004 suggested that the risk of ischaemic heart disease¹⁴ in non-smokers who were exposed to SHS was comparable to that in regular smokers who smoked between one and nine cigarettes per day. Giving evidence to the Committee, Dr Allan Hackshaw, Deputy Director of the Cancer Research UK and University College London Cancer Trials Centre and a specialist in epidemiology and medical statistics, summed up the issue:

The relationship between passive smoking and lung cancer is linear, but for heart disease it is not. You only need a small amount of exposure and that gives you your big risk of heart disease. That has been shown in lots of studies of active smokers, as in passive smokers as well.¹⁵

19. The tobacco industry does not accept the weight of scientific evidence that SHS is a substantial hazard to the health of non-smokers. Dr Steve Stotesbury, Industry Affairs Manager and Chief Scientist for Imperial Tobacco Ltd, told the Committee that "the scientific evidence, if you take it as a whole—and that includes the lung cancer, heart disease and chronic bronchitis—is currently insufficient to establish that other people's tobacco smoke is a cause of any disease".¹⁶ He went on to cast doubt on the effect of SHS on the health of children, saying that there was "insufficient evidence" to demonstrate a link.¹⁷

20. Dr Stotesbury drew attention to a study carried out by Professors James Enstrom and Geoffrey Kabat which was published in the *British Medical Journal* in 2003. The study was

13 Royal College of Physicians, *Going smoke-free: The medical case for clean air in the home, at work and in public places*, July 2005, ISBN 1 86016 246 0.

14 Also known as coronary artery disease; the accumulation of fatty deposits on the walls of the coronary arteries, limiting the supply of oxygen to the heart muscle.

15 Q 83 [Dr Hackshaw]

16 Q 136

17 Q 147

an analysis of data collected by the American Cancer Society's Cancer Prevention Study, which monitored 118,094 Californian adults from 1959 to 1998. In particular, Enstrom and Kabat concentrated on the 35,561 non-smokers who were married to smokers, on the grounds that they would be exposed to SHS on a regular basis. The study concluded that exposure to SHS had no significant association with an increased risk of death from lung cancer or coronary heart disease.¹⁸

21. However, the study by Enstrom and Kabat has also been widely criticised. It was funded by the tobacco industry and supported by the Centre for Indoor Air Research (CIAR), a now-defunct group founded by, and financially dependent on, tobacco manufacturers. The methodology has also been questioned, on the grounds that it does not distinguish sufficiently clearly between people who were exposed to SHS and those who were not, and that it was based on a small subset of the American Cancer Society's data. The Chief Medical Officer, Professor Sir Liam Donaldson, concluded that Enstrom and Kabat "carried out a study with a flawed methodology which led them to the wrong conclusions".¹⁹

22. The central issue, as the Royal College of Physicians' report stressed, is the importance of examining and analysing all of the evidence rather than focusing on a single study. It noted that individual studies are susceptible to bias, but that systematic overviews and quantitative meta-analysis could address the problems inherent in the individual studies. Finally, it reported that "for studies of ETS effects on health there is an overall consistency within the published literature, derived from diverse locations and a variety of study designs, which is impressive".²⁰

23. Dr Hackshaw went on to summarise the scientific evidence:

Passive smoking you can think of as a mild form of active smoking, so it must be associated with some risk. There are many studies on active smoking. There have also been many studies in passive smoking in non-smokers. There are over 50 on lung cancer and they consistently show that the increase in risk is of the order of 25%. Similarly for the studies of heart attacks: they consistently show that the risk is of the order of about 25% [...] Estimates of the number of deaths were published in the BMJ [British Medical Journal] recently by Professor Jamrozik. That was a simple analysis based on various estimates of the prevalence of exposure, people who are exposed to passive smoke, the increase in risk associated with four specific disorders and the number of people who get lung cancer, heart disease, stroke and chronic lung disease each year, and if those estimates are put together in a formula you get a rough idea of how many deaths per year you can expect [...] The figure quoted in the report is about 12,000.²¹

18 James E. Enstrom and Geoffrey C. Kabat, *Environmental tobacco smoke and tobacco related mortality in a prospective study of Californians, 1960-98*, British Medical Journal, vol 326 (May 2003), p 1057.

19 Q 442

20 *Going smoke-free*, p 26.

21 Qq 65-66

The Chief Medical Officer told the Committee that “any doubts or scepticism about the health impact of secondhand smoke are resolved scientifically in my view”.²² He went on:

There have been syntheses of the research evidence by major international bodies and expert committees that have reviewed the validity of the research and essentially the risks to non-smokers of inhaling a smoker’s smoke through being exposed to 50 carcinogens, which is roughly the number of cancer causing chemicals in cigarette smoke, and to carbon monoxide. There are both short-term risks of an increased risk of clotting of the blood and therefore of a heart attack and longer-term risks such as cancer, coronary heart disease, chronic bronchitis and promoting asthma attacks in children.²³

24. We are convinced by the evidence of experts, including the Chief Medical Officer, the Royal College of Physicians, SCOTH, the US Surgeon General and the World Health Organisation, that secondhand smoke is a serious and preventable cause of death and ill-health.

22 Q 433

23 Q 434

3 Dealing with the health effects of secondhand smoke

25. Two main ways of dealing with the health effects of secondhand smoke have been suggested: better ventilation and restrictions on smoking in public places.

The effects of ventilation

26. While recognising the health effects of exposure to SHS, representatives of the licensed trade argued that ventilation of licensed premises is a better and less prescriptive alternative to a prohibition on smoking in public places and workplaces. They have further argued that ventilation is a solution which other countries in the European Union have found satisfactory. Mr Nick Bish, Chief Executive of the Association of Licensed Multiple Retailers (ALMR), a trade association for companies operating licensed retail business with pubs, bars, restaurants and clubs, told us:

The science definitely exists. The wind-tunnel point is not right. You do not need wind-tunnels to move air around. There is nothing magical about the particulates and carcinogens and things like that that will linger where all other contaminants will be removed. The technology exists for operating theatres with negative or positive pressure to keep them clear. The ventilation industry exists. It is an enormous industry. It must be doing something right somewhere. The Health and Safety Executive offer workers exposure limits and define those, and the ventilation industry provides the kit to deliver those answers.²⁴

Mr Bish went on to concede that ventilation was no longer (as the hospitality industry had perhaps previously thought) the whole answer to the problem, and that smoking cessation had now become a major plank of Government policy. Nonetheless, he maintained that ventilation could provide both comfort and safety for workers in the hospitality industry: “There is a solution there. If we want to do it, there is a way. The ventilation industry can do it... That is just science. It works.”²⁵

27. One of the chief scientific exponents of the efficacy of ventilation in licensed premises has been Dr Andrew Geens, a Senior Lecturer at the University of Glamorgan’s School of Technology Division of Built and Natural Environment.²⁶ In 2002, Dr Geens conducted a study of the ventilation system of the Airport Hotel, Manchester, measuring the carbon monoxide (CO), carbon dioxide (CO₂) and particulate levels on four consecutive days (Monday to Thursday) in December. The ventilation system was switched on during the second and fourth days and switched off during the first and third days. Dr Geens found that the CO₂ and CO levels were lower and rose less during the day on those days on which the ventilation system was operating, with CO levels reaching a maximum of 2–4 ppm when the ventilation was on compared to 10–14 ppm when it was switched off.

24 Q 316; for the view of the Gallaher Group, see Q 158.

25 Q 318

26 Ev 19, Volume II.

28. A further article by Dr Geens, co-authored by Dr Max Graham, also of the University of Glamorgan, appeared in the *Building Services Journal* of March 2005. This study focused on the Baker's Arms, a village pub in the Home Counties, in which particulate levels were measured over a period of time in October 2004. It concluded that "ventilation is effective in controlling the level of contamination", though it conceded that "ventilation can only dilute or partially displace contaminants and occupational exposure limits are based on the 'as low as reasonably practicable' principle".²⁷

29. In contrast, the efficacy of ventilation is widely rejected by medical experts. Professor Dame Carol Black, President of the Royal College of Physicians, told the Committee that "The only thing you do by improving ventilation, however good your ventilation system is, is you make the air smell rather better, you just circulate the air around, you do nothing to take away the carcinogens in that environment".²⁸ Mr Bill Callaghan, the Chairman of the Health and Safety Commission (HSC), reinforced this view: "The evidence is that although ventilation can remove the smell, it cannot tackle the issue of removing the carcinogens."²⁹ This opinion was also shared by Mr Shaun Woodward MP, Under-Secretary of State for Northern Ireland. Announcing plans for a comprehensive ban on smoking in enclosed public places for Northern Ireland, he stated "Ventilation doesn't work".³⁰

30. A study of nicotine levels and particulate levels in licensed premises was conducted in Manchester in 2005. Dr Edwards described a study in a public house in Cannock, Staffordshire, which had "state of the art filtration equipment".³¹ The effect of this equipment, according to Dr Edwards, was unimpressive. When the system was switched off, the levels of PM2.5 (a particulate frequently monitored in such experiments) were between 800 and 900, which is approximately 16 or 18 times higher than those on a very busy road. The filtration equipment reduced levels to 500 or 600.

You can say, yes, there is a reduction, maybe 30 per cent, 40 per cent, whatever the figure is, but a reduction to still a very high level is meaningless, and there is no evidence that ventilation reduces the level of carcinogens and the level of toxic components in secondhand smoke to levels which would protect health [...] [the hospitality and tobacco industries] make no claim about health effects. None of them has ever done that, and that is because they cannot.³²

31. Dr Edwards was particularly critical of Dr Geens's work. He questioned Dr Geens's methodology and presentation, pointing to the fact that the monitoring did not include evenings, when, he supposed, levels of SHS would be at their highest, and that Dr Geens

27 Andrew Geens and Max Graham, *No ifs or butts*, *Building Services Journal*, March 2005.

28 Q 73 [Dame Carol Black]

29 Q 418

30 *Smoking ban in all public places and workplaces*, 17 October 2005, www.northernireland.gov.uk/press. The Federal Occupational Safety and Health Administration (OSHA) in the US and the American Conference of Government Industrial Hygienists (ACGIH) have concluded that even proposed new technologies, such as displacement ventilation systems, which may reduce secondhand smoke exposure levels by 90% still leave exposure levels which are 1,500 to 2,500 times the acceptable risk level for hazardous air pollutants (see HC Deb, 14 December 2005, col 2104W).

31 Q 73 [Dr Edwards]

32 *ibid.*

presented percentage reductions, which, Dr Edwards alleged, were “meaningless” if they were simply “reducing from a very, very high level to a very high level”.³³

32. It has also been argued that proprietors and licensees would be reluctant to invest in expensive ventilation systems if, as the Government has strongly hinted, a comprehensive ban on smoking is only a few years away. Mr Woodward pointed out that this would be “a pretty unfair burden” to put on businesses.³⁴

33. 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.

Restrictions on smoking

34. Given the wide acceptance of the scientific evidence that SHS is harmful to the health of non-smokers and that ventilation is not an adequate solution to the problem, governments in many parts of the world have introduced restrictions and controls on smoking in public places and workplaces. Comprehensive smoke-free legislation, whereby smoking is prohibited in almost all public places and workplaces (with very limited exceptions), has now been introduced in Ireland, Norway, New Zealand, Australia, Italy and South Africa, as well as several states of the USA including New York, California and Delaware. Norway implemented its comprehensive ban on smoking in public after a partial ban was found to be unworkable.³⁵

33 Qq 73 [Dr Edwards], 75, 83 [Dr Edwards]; for Dr Geens’ response, see Ev 89, Volume III.

34 Q 510

35 Q 454

Table 1: Smoke-free legislation around the world

Country or state	Extent of smoking ban	Date of introduction
California, USA	All workplaces	January 1998
South Africa	All public places and workplaces (ventilated rooms allowed)	October 2000
Delaware, USA	All public buildings including workplaces	November 2002
Thailand	All air-conditioned buildings	November 2002
Florida, USA	All workplaces except stand-alone bars	July 2003
Ireland	All enclosed public places and workplaces	March 2004
Connecticut, USA	Bars, restaurants and workplaces with more than 5 employees	April 2004
India	All public places; smoking areas required in bars and restaurants	May 2004
Norway	Bars, restaurants and clubs	June 2004
New Zealand	All enclosed public places and workplaces	December 2004
Italy	All public places; ventilated smoking areas allowed	January 2005
Vietnam	All public places	January 2005
Australia	All enclosed public places and workplaces	Various (state-by-state legislation)

Data from www.clearingtheairscotland.com

35. A comprehensive ban on smoking in public places will be introduced in Scotland on 26 March 2006. A similar smoke-free policy has been announced for Northern Ireland (although, because of the current suspension of the Northern Ireland Assembly, it will have to be enacted by Parliament); this is due to be implemented in April 2007. The decision in principle to ban smoking in public places has also been taken by the National Assembly for Wales.

36. Commonly, the most contentious part of a smoke-free policy has been banning smoking where it is most prevalent—in the hospitality sector, and particularly in bars and pubs. Some countries have introduced concessions in this area; for example, the law in Italy provides for separate smoking areas with illuminated signs, automatic doors and an approved ventilation system. However, because of practical difficulties in creating such an environment in many premises, it is estimated that 97% of outlets in Italy have in fact

introduced a complete ban on smoking.³⁶ Similarly, in New York state provision was made for registered “cigar bars”: these are required to have been in operation since before 31 December 2001 (thereby preventing new establishments from opening in the wake of the smoking ban); they must derive at least 10% of their gross annual sales from tobacco products; and the sale of food must be incidental to the sale of alcoholic beverages and account for no more than 40% of the gross annual sales.³⁷

37. Another feature of smoke-free legislation has been the issue of exemptions for certain categories of workplace, mainly those which are also in some way a person’s dwelling place. Prisons, psychiatric institutions and residential care homes have fallen into this category. The residents of these institutions have a higher prevalence of smoking than the general population, and may face physical, mental and emotional difficulties in being prevented from smoking. We discuss this further in Chapter 6.

38. Comprehensive smoking bans have generally proved effective and popular with the public once they have been implemented. In the Republic of Ireland, studies have shown that levels of exposure to SHS among workers have been significantly reduced. The evidence from Ireland also suggests that levels of support increase as time goes by after the introduction of a ban. A survey one year after the ban came into force showed that 93% of respondents (including 80% of smokers) thought that it was a good idea, and 96% thought it had been a success. The introduction of the comprehensive smoking ban was also voted the ‘high’ of 2004 in a national poll by RTÉ (Radio Telefís Éireann, Ireland’s public service broadcaster).³⁸

39. Recent surveys carried out by the Office of National Statistics (ONS) suggested that 80% of the population in England supported a ban on smoking in workplaces, including restaurants, although less than 50% supported a complete ban on smoking in pubs and bars. However, the situation is changing rapidly. Ms Deborah Arnott, Director of ASH, told the Committee that in July 2005 UK respondents, when asked the same question as used in Ireland prior to the introduction of the comprehensive smoking ban there, showed higher levels of support in the UK (73%) than had existed in the Republic of Ireland before the smoking ban was introduced there (67%).³⁹

40. The only solution to the problem of SHS exposure is to prohibit smoking in public places and workplaces, including licensed premises. This approach has found increasing favour with governments around the world, and public opinion in the UK is moving very quickly in its favour. Moreover, the experience of the Republic of Ireland shows that smoke-free legislation becomes even more popular once it has been introduced.

36 *Smoking ban forced on Italy’s cafes*, 10 January 2005, www.telegraph.co.uk/news

37 *Cigar friendly New York*, 21 April 2003, www.cigaraficionado.com/cigar

38 Marie Killeen, Acting Director of Communications, Office of Tobacco Control, meeting with the Committee.

39 Q 429 and see Annex 2.

4 Justification for a ban

41. In this chapter we consider, in principle, the arguments for and against a ban on smoking in enclosed public places and workplaces; in later chapters we will look at the arguments for and against the Government's proposed exemptions for institutions where people live, and for clubs and some pubs. The justification for the principle of a ban is straightforward: workers have a right to be protected from SHS. The argument depends on two assumptions: that SHS is a significant danger to health and that other ways of mitigating this danger such as ventilation are impracticable and ineffective. Given the validity of these two assumptions, and the vast majority of expert opinion accepts them, a ban is justified. The situation is the same as it would be for any other health hazard. Workers should no more be exposed to SHS than to asbestos.

42. As well as workers, there are other vulnerable groups which particularly require protection from harm, including people with asthma, children and unborn babies.⁴⁰ It is also argued that people who have given up smoking should be protected from having to spend time with smokers, since smoking is a powerful addiction and ex-smokers are more likely to relapse if they have to mix with smokers.

43. There are indirect health benefits of a ban. First, it is expected that the amount smokers smoke will decrease and that some smokers will give up altogether. The Northern Ireland Minister of Health, Shaun Woodward MP, told us about his experiences when he was in New York, where there was a ban: because it was too much trouble to go outside for a cigarette, he gave up.⁴¹ The Government's partial Regulatory Impact Assessment estimates that "the total benefit, in reduced smoking, of moving from the current situation to completely smokefree indoor public places (including workplaces) is [...] a fall of around 1.7 percentage points in smoking prevalence in England".⁴² Secondly, a ban sends a powerful message that smoking and secondhand smoke is unhealthy; smokers will be reluctant to light up in front of their children, and the evidence demonstrates that as a result, more homes become smoke-free. These expected changes provide secondary arguments for a ban but do not in themselves justify a ban, as witnesses recognised.

44. There are several arguments against a ban. They include:

- The economic consequences for pubs and other hospitality industry businesses would be excessive;
- We want to live in a tolerant society which does not limit liberty or freedom of choice;
- The rights of smokers outweigh the risks to workers who are free to choose whether to do a dangerous job.

40 There are 5.1 m people in the UK with asthma, and cigarette smoke is the second most common asthma trigger in the workplace. 20% of people with asthma feel excluded from parts of their workplace because other people smoke there. Department of Health, *Consultation on the Smoke-free Elements of the Health Improvement and Protection Bill*, p 22, Ref: 269278 1p 1k Jun 05 (CWP).

41 Q 529

42 *ibid*, p 20.

45. There are concerns that not only could the economic consequences of a ban be disastrous for the hospitality industry, but they could also have serious social consequences, leading many village pubs, which are vital institutions, to close. It is claimed that in some villages the loss of the pub would mean the loss of the heart of the village. Professor Roger Scruton, a philosopher and writer, informed us:

For many people [...] the cigarette and the pint are bound by an indissoluble marriage, and a ban on smoking will therefore drive them from the pub. I believe that the pub, properly managed, frequented by respectable people of the neighbourhood and conducted under a regime of controlled social drinking is a huge social asset, and that to destroy it would have serious consequences, especially on the socialisation of the young.⁴³

46. There is also a strong feeling that we do not want to live in a society which readily bans activities; we may disapprove of other people's actions but we should be reluctant to ban them. This is a feeling shared by many people, but it is not an argument for never imposing a ban on an activity. Each issue has to be judged on its merits. If there is evidence that a substance is dangerous, people should be protected from it. Dr Richard Ashcroft, a medical ethicist from Imperial College, told us "The main way in which you can justify restricting someone's liberty is where they are causing harm to others".⁴⁴

47. Related to our desire to live in a tolerant society is the strongly held belief that smokers have a right to pursue a legal activity, especially in places like pubs where smoking is common and where, importantly, no one is forced to go. Judging by the opinion polls this argument is relatively popular, if decreasingly so. Some of the proponents of this view tend to ignore the rights of workers: when asked whether smokers should be allowed to smoke in pubs, people tend to agree and are more likely to oppose a ban on smoking; however, if asked about the need to protect bar staff many more will support a ban. As we have seen, according to *Choosing Health*, the public simultaneously believe that people should be protected from doing things which put the health of others at risk and that there should not be a complete ban in all licensed premises, an apparently contradictory position.⁴⁵

48. Other proponents of the view accept that there is a risk to workers but argue that other jobs are more dangerous and people choose where to work: if they are concerned about the risk to their health from a smoky environment, they can always find a less dangerous job. The Minister for Public Health, Caroline Flint MP, came close to this view, stating "I think we had to look at a way forward which [...] would give more choice for people to work [...] in smoke-free environment [...] and there will be more choice for every workers covered by our proposals".⁴⁶ In contrast, other witnesses argued that in practice many workers had little choice. There is little alternative to bar work for some people, such as students and single parents, who need the flexible arrangements and local availability the

43 Ev 117, Volume III

44 Q 88

45 Department of Health, *Choosing Health: Making healthy choices easier*, Cm 6374, November 2004, p 97, suggests that these views were based on an Opinion Leader Research survey, but no question on this issue is included in the survey.

46 Q 545

job offers.⁴⁷ We took evidence from a bar worker from Newcastle who pointed out that many young people are unaware of the risks they are running if they get a job in a smoky bar. Ms Pauline Robson told us:

I have worked in a pub for 35 years and 35 years ago smoking was not an issue. I did not even think about it when I was younger. It is only as you become more educated and when you see the advertisements that are coming on the television now—there is that new one where you see the clot going up the vein, it really freaks you out—that you are encouraged not to smoke. I work in a pub, we take about £40,000 per week, it is a busy pub and we have about 46 staff [...] I think a total ban would be the best thing. Everybody would know where they stood and there would not be some playing off against others. We owe the next generation good healthy living and we should show them an example.⁴⁸

49. Moreover, the argument that workers can choose where to work and therefore can decide whether to take on health risks goes against the grain of most legislation to protect workers.⁴⁹ The same point could have been made about child chimney sweeps.

50. Other jobs are by their nature more dangerous than working in a smoky bar, such as coal mining, or deep sea diving. However, in these jobs every effort is made to reduce the risks and eliminate unnecessary hazards. Moreover, the danger to coal miners, deep sea divers or trawler men is intrinsic to the task; the situation in bars is not the same. It is not essential that bar workers suffer exposure to carcinogens in secondhand smoke.

51. In balancing the economic effects on businesses and smokers' rights against workers' rights, we have to weigh up the likely effect on each group. The experience in Ireland suggests that the economic consequences of the ban on the hospitality industry have been slight and that smokers' suffering has been relatively trivial: if smokers want to smoke they go outside and do not seem to mind too much. In contrast, there is strong evidence that smoking in the workplace has significant effects. As we have seen, it is estimated that about 500 non-smokers each year die prematurely from inhaling secondhand smoke in the workplace; this is surely too high a price to pay for the right to smoke. We cannot accept that the right to smoke can justify these deaths. Workers have a right to be protected from harmful substances unless there is an overwhelming reason for undertaking the risk.

47 Q 383

48 Q 379

49 Q 383

5 The Government's proposals

52. In November 2004, the Government published a public health White Paper entitled *Choosing Health: Making healthy choices easier*.⁵⁰ The White Paper contained detailed proposals for creating a smoke-free environment in many public places and workplaces. Specifically, the Government pledged to ensure that:

- All public places and workplaces (with the exception of licensed premises) would be smoke-free;
- All restaurants would be smoke-free;
- All licensed premises in which food was prepared and served would be smoke-free;
- Smoking would be prohibited in the immediate area of the bar in all licensed premises;

However,

- Licensed premises which did not prepare and serve food would be free to choose whether or not to allow smoking, as would membership clubs.

It was acknowledged in the White Paper that special arrangements would have to be made for establishments such as prisons, hospices and long-stay residential care units, and the Government undertook to consult on the nature and scope of any exemptions from the general smoke-free legislation. The planned timetable was that all public places and workplaces (except licensed premises and those establishments exempted from the legislation) would be smoke-free by the end of 2007, while the provisions for licensed premises would come into force by the end of 2008.

53. In justifying the exemptions for some pubs and clubs, *Choosing Health* stressed the degree to which public opinion had informed its conclusions, particularly on the issue of smoking in public places, and referred to an Opinion Leader Research (OLR) survey commissioned by the King's Fund. Three-quarters of the respondents to this survey agreed with the proposition that people should be prevented from engaging in activities which damaged the health of others; but, the White Paper claimed, respondents did not believe that this meant it was necessary to introduce a complete ban on smoking in all licensed premises.⁵¹

54. The basis for these assertions is difficult to understand. The OLR survey demonstrated that 69% of those surveyed agreed that prohibiting smoking in public places would be an effective way of reducing the overall prevalence of smoking. The idea of a partial ban with exemptions was not a subject on which respondents to the OLR survey were questioned. Furthermore, *Choosing Health* itself accepted that public opinion on banning smoking was moving, arguing that there was popular support for some kind of legislative solution to the problem of smoking in public whereas no such support had existed in 1998, when *Smoking*

50 Department of Health, *Choosing Health: Making healthy choices easier*, Cm 6374, November 2004.

51 *ibid.*, p 97

Kills was published.⁵² **We find the assertions in *Choosing Health*, supposedly based on the evidence of opinion polls, misleading and unhelpful to the debate about public support. Moreover, recent research, detailed in Annex 2, shows that public support is moving rapidly and decisively in favour of a comprehensive ban on smoking in public places and workplaces.**

55. Appearing in front of the Committee in February 2005, the then Secretary of State for Health, the Rt Hon Dr John Reid MP, defended the approach towards smoking in licensed premises. He argued that a comprehensive ban, such as that by then in force in the Republic of Ireland, would encourage some smokers to drink and smoke at home, thereby increasing the exposure of non-smokers to SHS in the home.

I came to the conclusion that [a comprehensive ban] was not a good thing on health grounds, apart from anything else, because you get a displacement of smoking from some public areas to the home—and most of the evidence about passive smoking is about the home.⁵³

Dr Reid also dwelt on the need for any legislation which restricted smoking in public to balance the rights of those who wanted to enjoy a smoke-free atmosphere whether at work or as patrons in licensed premises and restaurants and of those smokers who wished to continue to smoke (a legal habit involving a legal substance) while at leisure in a public place.

56. Dr Reid further argued that the number of deaths in the hospitality industry—the sector in which some establishments would remain exempt from smoke-free legislation—attributable to exposure to SHS was very small. He estimated that there were between 40 and 50 deaths a year, and that the introduction of the legislation outlined in *Choosing Health* would reduce this to four or five deaths a year. This was “statistically insignificant in terms of any individual person” [sic].⁵⁴

57. During the summer of 2005, the Government carried out a consultation on the proposals contained in *Choosing Health*. In particular, it sought opinion on the definitions of ‘smoke’, ‘smoking’ and ‘enclosed’, on other public areas which should be smoke-free, on the exemption for licensed premises where food was not prepared or served and on the proposed longer lead-in time for licensed premises.

58. The responses to the consultation demonstrated little public support for the specific proposals contained in *Choosing Health*; the overwhelming majority of the 57,000 respondents (over 90%) favoured a simpler and more comprehensive ban on smoking in public places, while over 80% were opposed to licensed premises being granted a longer lead-in time. The “vast majority” also believed that membership clubs should not be exempted from the legislation.

52 *ibid.*, p 99

53 Minutes of Evidence taken before the Health Committee, *The Government's Public Health White Paper (Cm 6374)*, 23 February 2005, HC 358-i, Session 2004–05, Q 7.

54 *ibid.*, Q 51

59. When the Cabinet came to consider the proposals and the results of the consultation in order to agree the draft Health Bill in October 2005, it was widely reported that several Cabinet ministers, including the new Secretary of State for Health, the Rt Hon Patricia Hewitt MP, were in favour of broadening the scope of the legislation and introducing a comprehensive ban on smoking in public places like that in force in the Republic of Ireland. However, the Cabinet eventually agreed that the Bill should reflect the proposals originally set out in *Choosing Health* and included in the Labour Party's manifesto for the General Election of May 2005. Ms Hewitt also announced that the policy would be renewed after 3 years. She told us that the Department of Health would "monitor the impact from day one" and conduct a "full review" at the end of the 3 year period.⁵⁵ We list our proposals for a monitoring and evaluation strategy in Annex 1.

60. The Health Bill was published on 27 October 2005. Clause 2, section 1, states that "premises are smoke-free if they are open to the public", while section 2 stipulates that "premises are smoke-free if they are used as a place of work".⁵⁶ The exemptions to these smoke-free provisions are provided for in clause 3, section 1 of which begins "The appropriate national authority may make regulations providing for specified descriptions of premises [...] not to be smoke-free despite section 2".⁵⁷ It continues by providing examples of the sorts of premises which the regulations might exempt.

Examples of descriptions of premises which may be specified are the following, or any subset of the following—

- (a) premises where a person has his home, or is living whether permanently or temporarily (including hotels, care homes and prisons and other places where a person may be detained),
- (b) licensed premises,
- (c) premises in respect of which a club premises certificate is in force.⁵⁸

61. The Bill therefore gives only a very vague sense of the Government's intentions. Effectively, it stipulates that, for England, the Secretary of State for Health will, after the enactment of the legislation, lay before Parliament regulations which will provide the details of those public places and workplaces which are to be smoke-free.⁵⁹ This creates two main problems. The first is that it requires Parliament to scrutinise a Bill without knowing its detailed effects. The Government has made its broad intentions clear, but has not provided detail on the extent and implementation of the legislation in the face of the Bill. Given that the regulations will be so important a part of the smoke-free legislation, a draft should have been made available to the House before the Bill reached second reading. The second problem is that the regulations, when laid before Parliament, cannot be amended in the way that the Bill itself can be; they must be approved or rejected. This denies to

55 Minutes of Evidence taken before the Health Committee, *Responsibilities of the Secretary of State for Health*, 27 October 2005, HC 623, Session 2005–06, Q 4.

56 Health Bill, clause 2 (1–2) [Bill 69 (2005–06)]

57 *ibid.*, cl. 3 (1)

58 *ibid.*, cl. 3 (2)

59 In Wales, this will be a matter for the National Assembly to decide.

Members a choice, which many would wish to make, of approving some exemptions and rejecting others. **We recommend that two draft regulations be laid before Parliament: one to deal with exemptions for licensed premises and clubs, the other to provide for premises where a person has his home or is living.**

62. Another aspect of the Health Bill which requires comment is that Crown immunity applies. This means that government departments, including the Ministry of Defence and HM Prison Service, are not covered by the smoke-free provisions of the Bill. This appears not to have been the original intention. The Ministry of Defence submitted a document to the Department of Health's consultation on the draft bill, asking for exemptions, which suggests that it was believed that the Bill *would* include Crown property. Subsequently, the decision was reversed, but the Bill includes an exemption for prisons, although this can only apply to private prisons. **Neither the Department of Health nor any other Government witnesses made reference to the issue of Crown immunity during our inquiry. It is not mentioned in the Explanatory Notes to the Bill nor was any reference made by Ministers at the Bill's second reading. We find these omissions extraordinary especially as Crown Immunity removes the necessity for exempting many premises.**

6 Exempted institutions

63. While Crown properties including prisons will not be covered by the scope of the Bill, it is expected that regulations made under the Bill will provide exemptions for other residential premises from the smoke-free provisions contained in the Bill. These will be establishments which are, in some way, a person's dwelling as well as a public place and a workplace. Prisons have the additional complication of housing a population which is forcibly detained, and in some cases with difficult or uncompliant behaviour. Similar problems apply in psychiatric institutions.

Prisons and other penal institutions

64. The prevalence of smoking among prisoners is currently very high. It is expected that crown properties such as prisons and the MOD estate, although not included in the Bill, will adopt measures in accordance with its spirit. HM Prison Service suggests that smoking prevalence in prisons is in the region of 80%, and therefore much higher than among the general population. In addition, it has been suggested that smoking is a firmly entrenched feature of the culture within the Prison Service. Access to tobacco is regarded as a privilege rather than a right, but this allows it to be used as a powerful tool of discipline. While the Prison Service tries to ensure that non-smokers do not have to share cells with smokers, it admits that this is not always possible because of overcrowding.

65. The Prison Service set out in a memorandum to the Committee its approach to reducing and controlling smoking in prisons.⁶⁰ It committed itself to a review over the next three months (from November 2005) to consider and make recommendations on how the Service could proceed towards creating smoke-free environments in prisons, and proposed the following likely options for discussion:

- a) All prisons, as workplaces, should become completely smoke-free, with no smoking allowed anywhere within prison buildings.
- b) Adult prisoners who wish to smoke should only do so in their own cells or while exercising in the open air.
- c) Smokers and non-smokers should not be forced to share a cell in which smoking takes place.
- d) All juvenile establishments should become completely smoke-free on the model of HMYOI Wetherby and HMYOI Ashfield.

66. Following the review and the agreement of its recommendations, the Prison Service intends to put in place an implementation plan to carry out the proposals on a local basis as part of the health development plans of the NHS/prison partnerships. These will go ahead regardless of Crown immunity.

67. It is argued that prisons and other penal institutions should be given exemptions from the provisions of the Health Bill on two principal grounds. The first is that they are dwelling places as well as workplaces, and that therefore prisoners have a right to smoke as they would have in their homes. The Department of Health suggested to the Committee that prisoners might be able to exercise this right under the aegis of the European Convention on Human Rights.⁶¹

68. However, the Director-General of the Prison Service, Mr Phil Wheatley, seemed less concerned about the human rights aspects of a potential ban and stressed more heavily the second reason for exempting prisons: that to deprive prisoners of their ability to smoke would create significant control problems in an already volatile population.

It would create control problems in some establishments, there is no doubt about that. You do not know what you are in for in prison; you are deprived of most of the things you might ordinarily enjoy, and probably what you [the Committee] enjoyed last night are things the prisoners do not do, so to take yet another thing away will not be wildly popular with a group who are not always charming and pleasant in their behaviour, so I am not volunteering for a complete ban in every place.⁶²

69. Although there are great difficulties for some parts of the Prison Service, other parts are already smoke-free. The Committee heard evidence from Mr Paul Foweather, the Governor of HMYOI Wetherby, an institution which has been entirely smoke-free since January 2004 and which was subsequently given a National Clean Air Award. He explained that, after an in-depth study, he took the decision to make the establishment smoke-free on the grounds that he was obliged by the Health and Safety at Work Act 1974 to ensure the safety of his staff at work, and also because there were issues particular to juveniles in custody concerning exposure to smoking (some of the trainees in the care of the Prison Service are fifteen years old and therefore could not legally purchase tobacco outside the confines of their incarceration). However, Mr Foweather emphasised that a ban on smoking had to be accompanied by a comprehensive support network to reinforce the smoking cessation programme. He concluded that “I have now got a smoke-free environment which is healthier for staff, it is healthier for trainees, and there are some spin-offs for the juvenile agenda inasmuch as 69% of my trainees say that they have tried to stop before and been unable to”.⁶³ Nevertheless, he acknowledged that it would not have been possible to implement the policies he had introduced at Wetherby across the Prison Service; in high-security establishments he suggested that the “decision would have been even harder and much more difficult to impose because the risks would have been significantly greater”.⁶⁴

70. The Home Office expressed the view that prisons could not reasonably be expected to be treated in the same way as other workplaces. The Under-Secretary of State for the Home Department, Fiona Mactaggart MP, told the Committee that the Home Office had concentrated on making the working parts of prisons smoke-free, on ensuring that

61 Qq 38–39

62 Q 211

63 Q 229

64 Q 228

smokers and non-smokers did not have to share cells and on reducing the prevalence of smoking in prisons through smoking cessation programmes. However, she conceded that overcrowding meant that it was not possible to guarantee that a smoker and a non-smoker would not share a cell, noting that the Prison Service currently housed 77,471 people, above its certified normal accommodation.⁶⁵ She concluded that “it is difficult for us to be legally obliged in every part of a prison to impose smoke-free areas”.⁶⁶

71. One of the reasons that the Government is reluctant to ban smoking in prisons is the high prevalence of smoking; if fewer prisoners smoked, exemptions would be unnecessary. The Minister explained that smoking cessation programmes in prisons were carried out in partnership with general health provision for prisons; this was increasingly provided by primary care trusts as part of a programme of public healthcare. She acknowledged that there was progress still to be made in this regard.

Am I satisfied that some of the other things, in terms of smoking reduction and ensuring that smoke-free areas are effectively managed and so on? No, I think there is a distance to travel. I think we have to recognise that in the sets of pressures that the Prison Service is under this has not always come up as high as it should [...] we can make quite significant progress on this, and we must.⁶⁷

However, denying that lack of success in smoking cessation made prisons unattractive partners for primary care trusts, she countered that prisons had higher success rates in terms of smoking cessation, basic literacy qualifications and other targets than the general population.⁶⁸

72. We acknowledge that prisons represent a particular challenge in terms of smoke-free legislation due to the nature of the prison population. We are not, however, persuaded that preventing SHS exposure in prisons is any less a priority than any other workplace, or that the high prevalence of smoking among prison inmates is either a justification for exemption from the legislation or justification for the continued exposure of staff or prisoners to SHS. Rather, we see the high prevalence of smoking as evidence of a substantial and currently unmet need for effective smoking cessation services in prisons, and a possible failure of duty of care to both prisoners and staff. Furthermore, simply exempting prisons from the decision that workplaces should be smoke-free is unsatisfactory since it will provide no impetus for the Prison Service to go further in working towards increasingly smoke-free environments within prisons.

73. We recognise HM Prison Service’s intention to work towards a smoke-free environment within prisons but are not persuaded that there is any reason why the policies applied in most prisons should be any less comprehensive, or implemented any later, than those for any other workplace. However, we also recognise that compliance may be difficult to achieve in some circumstances. From the date that the legislation comes into force in England, all smoking at work by prison staff should cease and the

65 Q 535

66 Q 534

67 Q 538

68 Q 541

Home Office should set a target of making the interior of all prisons smoke-free. Prisons should maintain the power to make special provisions for individual prisoners in high-security institutions who are particularly difficult to manage, but this provision must not involve the exposure of staff or other prisoners to SHS. Smoke-free policy in prisons should be supported by the provision of full smoking cessation support to all smokers who want to stop smoking.

74. We see no justification for any exemption for Young Offenders' Institutions. HMYOI Wetherby is an example of good practice which should be applied throughout all similar institutions. The Home Office should set an early target date for making all Young Offenders' Institutions smoke-free.

Psychiatric institutions

75. Smoking prevalence among the mentally ill, and especially among those with severe mental illness who are in some kind of institutional care, is also very high. The pressure group Rethink suggested that it might be as high as 70%, which would make it of the same order of magnitude as the prevalence among the prison population.⁶⁹ There are other special circumstances attendant on those with severe mental illness; they can be detained against their will, and, unlike people with other health problems, they can also be restricted in their movement, meaning it is not always possible for them to smoke in an unenclosed public area.⁷⁰

76. It is also argued that people suffering from severe mental illness should not be subject to a smoking ban. Rethink noted that "people with severe mental illness can very often have problems with their desire to give up smoking". Moreover, some of the drugs used in smoking cessation, such as Zyban, can be unsuitable for those taking anti-psychotic medication.⁷¹

77. On these grounds, Rethink proposed that psychiatric institutions be exempted from the ban on smoking in the workplace contained in the Health Bill, and that a longer-term approach should be adopted instead.⁷² Mr Paul Corry, Rethink's Director of Campaigns and Communication, told the Committee:

I think it is difficult to imagine a situation at the moment where you could introduce a complete smoking ban in all psychiatric units given that a significant proportion of the people who are using them will be there under compulsion. However, what I do think we need to do is move from a situation where we are today to a point in the future where we have a complete smoking ban and that will require specific targeted interventions for people with severe mental illness to help them and encourage them, rather than coerce them, to give up smoking.⁷³

69 Q 233

70 See also Ev 15, Volume II.

71 Q 233

72 Ev 72, Volume II.

73 Q 237

78. Others, including the Royal College of Nursing, did not agree with Rethink's approach. Mr Ian Hulatt, the RCN's Mental Health Adviser, explained to the Committee that to exempt psychiatric institutions from a ban on smoking would only serve to exacerbate existing health inequalities. He noted that people with severe mental illnesses such as schizophrenia will die ten years younger than the general population, are twice as likely to be obese and twice as likely to suffer from diabetes.⁷⁴ While he acknowledged that there were some situations in which patients suffering from severe mental illness might not be suitable for immediate smoking cessation, he reiterated that the control of smoking in psychiatric institutions was both achievable and necessary, concluding that "it needs to be done sensitively, but it can be achieved".⁷⁵

79. The Committee also heard evidence from Mr Paul Thain, Director of Modernisation and Strategic Development for Norfolk and Waveney Mental Health Partnership NHS Trust. Mr Thain's Trust introduced a smoking cessation policy in April 2004 which prohibited smoking on its premises. He explained that the reasoning behind the policy had been twofold: firstly, to reflect the Trust's responsibilities as an employer under the Health and Safety at Work Act and afford protection to its staff from the harmful effects of SHS; and secondly, to support and help those patients with severe mental illness who would have additional health difficulties if also addicted to tobacco. He went on to say that there were certainly circumstances under which smoking was allowed. Patients who were smokers when they came under the care of the Trust had their smoking recorded on their care plan as a clinical issue and had that clinical issue addressed at an appropriate time, before which point they would be permitted to smoke, though only in unenclosed public places. Mr Thain noted that the success of the programme meant that the Trust was considering going completely smoke-free. In view of the experience at Norfolk and Waveney, Mr Thain did not support the case for psychiatric institutions being exempted from smoke-free legislation.

80. High levels of smoking in psychiatric institutions are not inevitable. The experience in Norfolk and Waveney is an example of what can be achieved by a creative and positive approach in a difficult environment, and a model of good practice which can be applied to all other institutions. Therefore psychiatric institutions should not be granted a simple exemption from the smoke-free provisions of the Health Bill. An early target date should be set for making such establishments smoke-free, with separate outdoor areas (secure if need be) set aside for patients to smoke at the minimum risk to staff and other patients. In addition, measures should be put in place to tackle the high prevalence of smoking and challenging targets set for its reduction. Psychiatric institutions should become smoke-free workplaces for staff along with other NHS premises by the end of 2006.

The Ministry of Defence

81. The Ministry of Defence will not be bound by the provisions of the Bill due to Crown immunity.⁷⁶ Nevertheless, it welcomed the broad thrust of the Government's policy of

74 Q 249

75 Q 256

76 Not printed.

banning smoking in public places and workplaces, and in its response to the Department of Health's consultation stated that the proposals outlined in the Health Bill "sit very well with our policy of a carefully managed cessation of smoking, and also with our healthy lifestyle and fitness strategies".⁷⁷ The MOD also expressed its determination to abide by the spirit of the legislation, but cautioned that there would be some areas which would require either derogation from parts of the legislation or interpretation in a specifically military context.

82. The MOD's concerns were in two main areas. The first focused on circumstances in which a prohibition on smoking might impair operational capability; the second revolved around the need to balance the general aim of a smoke-free workplace against the individual's right to smoke in his or her private dwelling, in circumstances in which the workplace and the private dwelling were essentially the same. The Deputy Chief of the Defence Staff (Health), Vice-Admiral Rory McLean, told the Committee that, in attempting to get the balance right, the MOD has "a golden rule that we have been developing, and we have been doing this for some time, and the golden rule is that we will protect the rights of non-smokers not to have to inhale the smoke of others".⁷⁸

83. In terms of operational capability, the MOD noted that health and safety standards on UK sovereign bases were, under normal circumstances, at least as rigorous as those required by UK law. However, under circumstances in which, in order to maintain operational effectiveness or to comply with local legislation, it would not be practicable to comply with UK legislation regarding smoking in the workplace, the MOD suggested during the consultation that legislation should empower the Secretary of State for Defence to issue a certificate of exemption from smoke-free regulations "in the interests of national security or operational capability". It also proposed that provision be made for the Secretary of State to revoke such exemptions on issue of a further certificate at any time.⁷⁹

84. With regard to exemptions for premises which were analogous to an individual's private dwelling space, the MOD sought these for three main categories of location:

- a) Single Living Accommodation; the MOD expected to be allowed to implement minimum guidelines which reflected the rigour of the legislation but which allowed local commanders a degree of flexibility in dealing with long-stay single accommodation, on the model of the proposals for student residences. Under questioning, Vice-Admiral McLean stated that it was the MOD's intention to segregate those in multi-accommodation into smokers and non-smokers, and where such segregation was not possible that it would be the presumption that accommodation should be smoke-free and smoking should only be allowed outside;⁸⁰
- b) Submarines; in its consultation response, the MOD noted that submarines could be on operational deployment for periods of several months, the vast majority of which time would be spent submerged. Given that it would be impossible to provide separate living accommodation or an 'unenclosed' smoking area, smoking is currently permitted on

77 Ministry of Defence submission to the Department of Health, *Consultation on the Smokefree Elements of the Health Improvement and Protection Bill*.

78 Q 475

79 This provision does not apply since the Government's decision to exempt the Crown from the Bill.

80 Q 483

submarines (in two compartments, one forward, one aft), but the MOD only requested a temporary derogation beyond December 2006, as it was moving towards an entirely smoke-free submarine fleet, which it intends to implement in 3 or 4 years' time;

- c) Royal Fleet Auxiliary Tankers; the MOD noted that it was not feasible on safety grounds to allow smoking on the weather deck of all types of vessels, Royal Fleet Auxiliary Tankers in particular, and therefore wished to make alternative arrangements in those limited instances, such as the establishment of designated smoking compartments.

85. In view of the different legislation regarding smoking in the workplace and public places in different parts of the United Kingdom, Mr Chris Williams, Finance and Secretariat Branch Leader at the Ministry of Defence, told the Committee: "Because we know Scotland is going to implement their regulations first, that we will be taking the implementation date for us as effectively the Scottish date [26 March 2006]"⁸¹

86. We welcome the Ministry of Defence's commitment to controlling smoking in the workplace, and recognise that the MOD is already working towards creating more smoke-free environments. We also welcome the MOD's 'golden rule' that non-smokers should not be exposed to other people's smoke. However, we are not persuaded that MOD workplaces should be treated any differently from other workplaces, and are concerned that exemptions in, for example, submarines will lead to continued, avoidable and unnecessary exposure of service personnel to SHS.

87. The Ministry of Defence should eliminate all smoking in the workplace and in public places. Smoking should not be permitted in shared living accommodation or in communal areas of living quarters in any circumstances. Smokers should be allowed to smoke only in individual private quarters.

Hospices and other healthcare premises

88. The treatment of smoking in other healthcare premises is sometimes contentious. *Choosing Health* contained a commitment that the National Health Service, along with central government departments, would be smoke-free by the end of 2006.

89. The Committee received a memorandum from Help the Hospices, the national charity for the hospice movement, in which it was argued that hospices should be included in the exemptions granted by regulation. Help the Hospices contended that hospices were the private dwelling places of patients, and that to ban smoking would, for lifelong smokers, be contrary to the purpose of hospice care, namely "to improve quality of life at the end of life". Help the Hospices also maintained that it would not be practical to limit smoking areas in hospices to outdoor, unenclosed areas, as many patients were unable to leave their beds.⁸² On the other hand, as the Chief Medical Officer argued, others think that hospices, like other healthcare premises, should be smoke-free in order to protect both patients and staff.

81 Q 494

82 Ev 46, Volume II

90. We recognise that there are difficulties. Nevertheless, staff in hospices should be afforded the same protection from SHS as workers in any other sector. Hospices should not be exempt from smoke-free legislation. Compliance with a smoke-free policy should be a condition of admission to hospices and there should be a comprehensive programme of smoking cessation support. Similarly, the staff of nursing homes should be afforded the same protection, and these premises should therefore be smoke-free.

91. We also considered the case of nurses and other care workers whose duties require them to visit patients in their own homes. The Royal College of Nursing believes that nurses should be protected. Mr Hulatt observed that “we have a situation where it is culturally considered almost inappropriate to challenge the client not to do it [smoke while being visited] and it is things like that that need changing”.⁸³

92. We agree with the Royal College of Nursing that care workers who visit patients in their own homes should be protected as far as possible from the harmful effects of SHS. To that end, employers should seek to ensure that patients are aware that they should not smoke while being visited, and that care workers should have the right to refuse to enter a home or room in which a patient is smoking.

7 Exemptions for licensed premises

The Government's proposals

93. Appearing before the Committee, the Secretary of State for Health defended the exemptions of clubs and some pubs from the smoke-free provisions of the Bill on the grounds of public support.⁸⁴

The manifesto commitment [to introduce a partial ban for licensed premises] was based on a very, very extensive public consultation that you will be aware of which was reflected in the position we put forward in the *Choosing Health* White Paper, and that is what we are legislating for in this Bill.⁸⁵

94. The Minister for Public Health expanded on this reasoning, explaining:

We had to look at a way forward which would address public health issues, would give more choice for people to work and enjoy social time in a smoke-free environment, give more choice to workers [...] every worker in England will benefit to a certain degree from our proposals, but balanced with that was what we also had in terms of what the public thought.⁸⁶

She later explained to the House of Commons that “we have had to grapple with the problem of reconciling health issues with what the public want”, arguing that public opinion was an important factor in ensuring compliance.⁸⁷ The rationale, therefore, appeared to be that the exemptions for some licensed premises were necessary to satisfy public opinion.

95. The responses to the Government's consultation on the smoke-free elements of the Health Bill give a different picture. There were more than 57,000 responses to the consultation, around 50,500 being from individuals and over 4,000 from owners or operators of licensed premises, with the remainder coming from organisations such as NHS trusts, primary care trusts and trades unions. On the specific issue of exemptions for licensed premises which do not prepare or serve food, the Government received 41,833 responses. Over 90% of these did not support of the proposal for exemptions. 41,641 responses were received on the subject of an exemption for membership clubs. Again, the vast majority of respondents did not agree with the proposal to exempt such establishments.⁸⁸

96. In response to the argument that workers in establishments intended to be granted exemptions would be exposed to the harmful effects of SHS, the Government proposed introducing an ‘exclusion zone’ of perhaps a metre around the bar area in which smoking

84 For licensed premises which do not prepare or serve food and for membership clubs in respect of which a club premises certificate (according to the Licensing Act 2003) is in force.

85 Minutes of Evidence taken before the Health Committee, *The Responsibilities of the Secretary of State for Health*, 27 October 2005, HC 623, Session 2005–06, Q 10

86 Q 545

87 HC Deb, 29 November 2005, col 236

88 www.dh.gov.uk/Consultations/ResponsesToConsultations/fs/en

would be prohibited. Caroline Flint stressed that “there will be protection for those bar workers [in exempted premises] as well, because we are consulting on how we can make the area around the bar smoke-free”.⁸⁹

97. The data from opinion polls undermines the Government’s case for a partial ban. The ONS Omnibus survey for 2004 demonstrated that 64% of respondents supported restrictions on smoking in pubs, while a YouGov poll conducted in December 2005 on behalf of ASH showed that 71% of respondents in England and Scotland supported legislation to make all workplaces, including pubs, bars and restaurants, smoke-free.⁹⁰

98. In addition, the Government’s proposals for ‘protecting’ bar staff in ‘smoking pubs’ are completely ineffective. There is no evidence to suggest that creating a smoke-free area of a metre around the bar would in any way mitigate the harmful effects of SHS. The Deputy Chief Medical Officer, Dr Fiona Adshead, admitted to the Committee:

The recommendation that there should be a prohibition on smoking within a metre of the bar was not based on evidence of protecting health; it was essentially about trying to reduce the amount of noxious exposure, the irritant effect of smoke, within that distance [...] it is not a recommendation that was put forward on health evidence grounds.⁹¹

Workers in exempted establishments will therefore be exposed to a hazard at work to which comparable workers in other establishments will not.

Objections to the Government’s proposals

99. Interested parties have raised objections to the Government’s proposals for a partial ban on smoking on the following main grounds:

- If SHS is a hazard to workers sufficient to justify legislative action, then 100% of workers should be afforded protection, and in particular bar workers, who have some of the highest levels of exposure to SHS.
- Exempting membership clubs will allow smoking in premises to which children have access.
- Employers have a legal duty of care to their employees; a partial ban does not adequately discharge that duty.
- A partial ban would create considerable uncertainty for bar staff that could be exploited by customers.
- Allowing some licensed premises and clubs to continue to permit smoking will create unfair competition in the licensed trade.

89 Q 547

90 See Annex 2 for details.

91 Q 6

- Allowing smoking in ‘drink-only’ pubs and membership clubs will widen health inequalities, as these establishments are often concentrated in deprived areas.
- The continuation of smoking in some licensed premises will hinder attempts to reduce the wider prevalence of smoking.
- The adverse consequences of a comprehensive ban advanced by the former Secretary of State, Dr Reid MP, are exaggerated and have no evidentiary basis.
- Public opinion is moving rapidly in the direction of support for a comprehensive ban.
- Legislation should be clear and simple to understand if it is to be easily and efficiently enforced.

100. The moral case for a comprehensive rather than a partial ban was put to the Committee by Mr Michael Ainsley, of the GMB, who described the Government’s proposal as the “coward’s way out” and, of SHS in the workplace, noted that “why people want to expose themselves to it is amazing, but why somebody should expose someone else to it is criminal”.⁹² The Government accepts that workers should not be exposed to a hazard but at the same time excludes those most at risk from protection. Dr Edwards told the Committee, “What you are saying is that you are having a regulatory proposal where the people at most risk with the heaviest exposure are exempted, and that to me does not make any sense whatsoever.”⁹³

101. The gaming industry also raised the issue of the exposure of children to SHS. Mr Simon Thomas pointed out that exempting membership clubs from a ban on smoking would create an environment in which people could eat and smoke, and into which children would be allowed; this, he suggested, would be “completely against all of the principles of this smoking legislation”.⁹⁴

102. There is a strong legal case in favour of a comprehensive rather than a partial ban. The duty of care which employers have to their employees includes the duty to protect them from the harmful effects of SHS. Representatives of the hospitality industry told the Committee that they were apprehensive that workers in exempted institutions could bring claims against their employers under Health and Safety legislation, as the Health Bill would effectively acknowledge that SHS posed a significant hazard to workers’ health.⁹⁵ The Chief Executive of the British Hospitality Association (BHA), Mr Bob Cotton, whose members employ 600,000, stated that over 90% of his members preferred a comprehensive to a partial ban on smoking in licensed premises.⁹⁶

103. The issue of unfair competition within the hospitality industry was also of particular concern. Mr Rob Hayward, Chief Executive of the British Beer and Pub Association (BBPA), highlighted the problem:

92 Q 367

93 Q 72

94 Q 360 [Mr Thomas]

95 Q 285 ; see also Ev 1, Volume II.

96 Q 283

If you are saying certain premises [can allow smoking], specifically a venue as against another one further down the street, that will cause the problems that John [Hutson, Chief Executive of J.D. Wetherspoon] has just referred to, because people will migrate, so that is not the route that we would prefer.⁹⁷

104. Considerable unease was also expressed with regard to the proposed exemption for membership clubs. Mr Bish, Chief Executive of the ALMR, described the idea as “totally inappropriate” and lacking in “consistency or [...] logic”. He went on:

It is not equitable, it is not fair on the staff who would work in the club, and it is not fair on the businesses that, as it were, are just down the road competing for the same trade. You would end up with a non-smoking, local community pub and a smoking club just down the road, and there will be a migration of customers.⁹⁸

105. This concern was echoed by representatives of the gaming industry, who suggested that to exempt membership clubs would inevitably lead to a migration of customers away from those gaming establishments—bingo halls, seaside arcades, adult gaming centres—which were not membership clubs. Sir Peter Fry, Chairman of the Bingo Association, suggested that a partial ban on smoking with an exemption for membership clubs would lead to the closure of around 150 bingo halls nationwide but the figure would be reduced if there were a total ban.⁹⁹

106. Health inequalities were emphasised by a number of different groups. Professor Dame Carol Black, President of the Royal College of Physicians, told the Committee that “preventing smoking in public places is the most certain way of narrowing the mortality gap that we see in cardio-respiratory disease between those of high and low income”.¹⁰⁰ She further told us that, because licensed premises which do not prepare or serve food are concentrated in less affluent areas, workers and customers in such establishments would be disproportionately exposed to the harmful effects of SHS. “This partial ban would simply disadvantage the poor in this country and it would make the gap between good health for the poor and for the rich even larger.”¹⁰¹ Representatives of the hospitality industry gave varying estimates of the number of pubs which would stop serving food in order to be allowed to permit smoking; Mr Bish of the ALMR suggested that, after the implementation of a partial ban, some 20% of pubs (amounting to 12,000 establishments) would not serve food, while Mr Hayward of the BBPA suggested a figure of 34%.¹⁰² Mr Tim Clarke, Chief Executive of Mitchells and Butlers, a chain owning around 2,000 pubs, has indicated that perhaps 20% of the chain’s establishments would stop serving food in order to allow smoking, and that these would be concentrated in the North and Midlands. “These proposals effectively incentivise some pubs to take out food—a retrograde step reversing

97 Q 325

98 Q 301

99 Q 352

100 Q 72

101 Q 85

102 Qq 289–91

the progress of a generation.”¹⁰³ He went on to describe the Government’s proposals as “laughable” and “ridiculous”.¹⁰⁴

107. The Local Government Authority (LGA) presented data to the Committee which demonstrated the extent to which ‘drink-only’ pubs were concentrated in areas of deprivation: in Easington in County Durham, for example, 81% of the pubs in the most deprived areas did not serve food as opposed to 20% in the least deprived areas; while in Southwark, 47% of pubs in the most deprived areas did not serve food while only 18% of pubs in the least deprived areas did not do so.¹⁰⁵ Clearly, then, the workers and customers most exposed to the harmful effects of SHS as a result of the Government’s proposals would be those in the most deprived areas of the country.

108. It has also been argued that, while a comprehensive ban on smoking in public would contribute to an overall reduction in smoking prevalence, a partial ban of the sort contained in the Health Bill would not have the same effect, due to the continued presence of social smoking in some premises and the apparently mixed message from central government. The Chief Medical Officer told the Committee that the partial ban “loses out on the opportunity to reduce the prevalence of smoking” and “signals to the public that a drink and a smoke go hand-in-hand when all the efforts on smoking and tobacco control have been aimed at de-normalising smoking”.¹⁰⁶ Professor Dame Carol Black, emphasised the merits of a comprehensive ban: “If [...] you really put a lot of effort and energy into providing them [smokers] with all the facilities to give up and you add on top this legislation [...] I think we would see a decrease in smoking”.¹⁰⁷

109. Mr Nick Adkin, Programme Manager on Tobacco at the Department of Health, suggested that a partial ban could be as effective as a comprehensive one in reducing smoking prevalence.

A comprehensive ban would reduce smoking rates by 1.7 percentage points. Our policy will reduce smoking rates by up to 1.7 percentage points [...] it could be as good.¹⁰⁸

110. The figure of 1.7 percentage points was calculated as part of the partial Regulatory Impact Assessment contained in the Department of Health’s consultation document.¹⁰⁹ However, that calculation was based on a complete ban on smoking in public; it is not clear on what basis Mr Adkin reaches the conclusion that a partial ban could have an effect up to the same level.

111. The partial Regulatory Impact Assessment attempts a cost/benefit analysis of the four options based on consultation responses. The analysis of health benefits puts the value of

103 *Anti-smoking bill will push 400 M&B pubs to stop food*, 1 December 2005, www.guardian.co.uk

104 *‘Laughable’ ban on smoking will fail, says M&B*, 1 December 2005, www.telegraph.co.uk/money

105 Q 410 [Cllr Rogers]

106 Q 448

107 Q 113

108 Qq 578–80

109 Department of Health, *Consultation on the Smokefree Elements of the Health Improvement and Protection Bill*, June 2005, p 20

averted deaths from secondhand smoke for customers as £75 million for voluntary action, £350 million for a full ban, £0–£350 million for local powers, and £150–£250 million for a ban with the food/non-food exception. The RIA sets out how these figures were derived in Annex C. Based on the report’s own assumptions the difference between a full and a partial ban is up to 200 preventable deaths a year.¹¹⁰

112. Giving evidence to the Committee in February 2005, the then Secretary of State for Health, Dr Reid MP, had advanced several arguments in favour of a partial ban rather than a comprehensive ban, most prominent among which was the contention that to ban smoking in all licensed premises would lead to increased levels of smoking in the home.¹¹¹ Dr Reid admitted at the time that the basis for his contention was “anecdotal”¹¹², and the Committee has now heard evidence from various different parties which suggest that Dr Reid’s view is, in fact, wrong. Caroline Flint admitted to the Committee:

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.¹¹³

Similarly, Dr Adshead told the Committee that “there is not any current evidence that would support that view”.¹¹⁴

113. The issue of public opinion was one on which the Government placed particular emphasis. Presenting the Bill to Parliament for its second reading, the Secretary of State remarked:

We are responding to the clear wish of the public to be protected from other people’s smoking in public places, especially restaurants, on the one hand, and on the other hand allowing people who want to have a cigarette with a drink to do so.¹¹⁵

114. However, the Public Health Minister admitted that support for a comprehensive ban was probably already of the order of 50% of the population, and further conceded that “there is a movement in terms of public opinion”, noting that support had grown from around 20% in 2003 to 31% in 2004 and by 2005 stood at 49%.¹¹⁶ Evidence from a recent YouGov poll suggests that support is now even higher, standing at between 66 and 71%.¹¹⁷

110 *ibid.*, p.33–34

111 Minutes of Evidence taken before the Health Committee, *The Government’s Public Health White Paper (Cm 6374)*, 23 February 2005, HC 358–i, Session 2004–05, Q 8.

112 *ibid.*

113 Q 571

114 Q 36

115 HC Deb, 29 November 2005, col 153

116 Q 553

117 See Annex 2

It is not clear, therefore, why the Government has chosen to defend the partial smoking ban on the grounds of public opinion.

115. The final argument proposed in favour of a comprehensive rather than a partial ban was that the former would be simpler, more intelligible and therefore easier to enforce. This was the view of representatives of the hospitality industry, the gaming industry, the trades unions, the Health and Safety Commission (HSC) and the Local Government Association (upon whom the regulatory burden would chiefly fall), the Chartered Institute of Environmental Health (CIEH) and the Chief Medical Officer, as well as a spectrum of opinion which the Committee heard during its visit to the Republic of Ireland. Mr Bill Callaghan, Chairman of the HSC, was clear:

If you have simple regulation, that is much [more] easily enforced and I would say you are going to get good self-regulation. A clear regulation where everyone knows what is going to happen is going to be much simpler to enforce than on which has a degree of complexity.¹¹⁸

Councillor David Rogers, Chairman of the Community Well-Being Board of the Local Government Association, added that the LGA had estimated that a ban with the proposed exemptions would cost 50% more to enforce than a simpler, more comprehensive ban.¹¹⁹ We address in more detail issues of compliance and enforcement in the next chapter.

116. The Government's proposals for a ban which exempts 'drink-only' pubs and membership clubs are unfair, unjust, inefficient and unworkable, because:

- **all workers should be protected from SHS;**
- **children, who have access to clubs, should not be exposed to SHS;**
- **it is likely that a partial ban will be disputed in the courts by bar workers;**
- **a partial ban will create unfair competition;**
- **a partial ban will widen health inequalities;**
- **public opinion now supports a comprehensive ban;**
- **legislation should be clear and simple if it is to be easily enforceable.**

117. A broad range of opinion has argued that a comprehensive ban would achieve the Government's stated aims in a much more satisfactory fashion than a complex partial ban, and that from the commercial perspective of the hospitality and gaming industries, a comprehensive ban is also the preferred option. We find it hard to understand how the strong evidence base, clear public support, and the results of the Department's own Regulatory Impact Assessment can be ignored.

118 Q 406

119 Q 407

8 Compliance

118. It is widely believed that compliance is dependent on public support, and that if a prohibition on smoking is sufficiently popular, it will be largely self-enforcing. Mr Graham Jukes, Chief Executive of the CIEH, told the Committee that “the real key to good enforcement is voluntary compliance”.¹²⁰ This was also the very clear message which the Committee received during its visit to Dublin.¹²¹

119. The Government believes that the need for public support reinforces the case for a partial rather than a comprehensive ban. The Minister for Public Health explained to the Committee:

We have had to think very strongly about issues around enforcement, and I know there are lots of different views on that, but part of the reason why the voluntary bans and restrictions have been so successful is that they have gone with the grain of public opinion and therefore they have been pretty much self-enforcing.¹²²

120. The evidence which the Committee has heard substantially contradicts the Government’s contention that public opinion is not yet ready for a ban. The evidence also indicated that, in addition to an adequate level of public support, compliance requires: clarity in the legislation, so that it is easily intelligible; an adequate regulatory framework including appropriate fines; and committed political leadership.

Public support

121. The responses to the consultation carried out by the Department of Health demonstrated that the idea of exemptions for ‘drink-only’ pubs and membership clubs commanded little, if any, public support. Other surveys demonstrate that public support for a comprehensive ban is now at or around 50%, which would be adequate to ensure widespread compliance.¹²³ Indeed, a recent survey by YouGov shows levels of support of nearly 70%.¹²⁴ The Committee has also heard from the Director of ASH that support for a comprehensive ban on smoking is at a higher level in the UK now than it was in the Republic of Ireland prior to their introduction of a ban.¹²⁵

Clarity

122. A range of organisations argued strongly that a ban should be clear, simple and intelligible. The organisations included those upon whom the burden of regulation and enforcement will fall. Mr Derek Allen, Executive Director of Local Authorities Coordinators of Regulatory Services (LACORS), explained:

¹²⁰ Q 414 [Mr Jukes]

¹²¹ See Annex 3

¹²² Q 545

¹²³ Q 420

¹²⁴ See Annex 2

¹²⁵ Q 429

The emphasis for us is really about self-regulation, it is about supporting businesses with compliance [...] it is important that legitimate businesses can be supported in complying and making it simple and transparent in terms of the legislation, and that is helpful. Having a two-tier system will make enforcement difficult.¹²⁶

Mr Jukes added that “the Government is trying to make something very complex out of what is quite a simplistic way of approach to protect all workers”.¹²⁷

123. The hospitality industry took a similar view. Mr Cotton, Chief Executive of the BHA, described achieving compliance with a partial ban as “totally impossible”.¹²⁸ Mr Bish, Chief Executive of the ALMR, added that “if there is clarity, compliance comes through”.¹²⁹ The Committee also heard numerous representations from the Republic of Ireland which stressed the importance of a simple regulatory regime in achieving widespread compliance.¹³⁰ Mr Hayward of the BBPA told the Committee that, while he believed that the Government’s proposals were enforceable, the regulatory burden would nonetheless be very high.¹³¹

124. The Committee also heard evidence that the proposed partial ban would send out a confused message because of its complexity. Mr Ainsley of the GMB, which has taken a particular interest in the issue of the protection of workers from SHS in the workplace, said:

If the Government are serious about this then you have to change the culture. If you send mixed messages about it is banned, it is not banned, it is banned here, it is not banned there, then you are not going to change the culture. You are not going to do what you set out to do in the first place.¹³²

125. While the exemptions for ‘drink-only’ pubs and membership clubs were the principal focus of criticism, concerns were also raised about the inadequate or confusing terminology upon which the partial smoking ban depends. Mr Allen told the Committee that the definitions of ‘enclosed’ and ‘partially enclosed’ were excessively complex, based on a percentage of coverage, since these could require detailed measurements to be made to determine their status under the law. He added that “we are saying we need to look at simplicity, e.g. should it be a single wall with a roof [...] so you can see that and it is pretty obvious to everybody that that is considered to be enclosed”.¹³³ The CIEH also questioned the Government’s proposed definition of the sort of products which a licensed premises could serve without being classified as serving ‘food’: the suggestion of shelf-stable pre-packed products was unsatisfactory because “that does not include a pickled onion or a

126 Q 408 [Mr Allen]

127 Q 408

128 Q 303

129 Q 304 [Mr Bish]

130 Marie Killeen of the Office of Tobacco Control told the Committee that well over 90% of premises in the Republic of Ireland were compliant with the ban there.

131 Qq 305–06

132 Q 387 [Mr Ainsley]

133 Q 416

pickled egg and it is that kind of ludicrous analogy that beggars belief".¹³⁴ The Government acknowledged these potential problems in the Regulatory Impact Assessment aspect of its consultation, but, despite the overwhelming rejection of the proposals in the response to the consultation, has decided to press ahead regardless.¹³⁵

126. The Government's proposals would be given added complexity by the fact that a comprehensive ban will be introduced in Scotland in March 2006 and is planned for Northern Ireland and Wales. The position would therefore be that different regulations governed smoking in public in different parts of the United Kingdom, making the regulations in England less intelligible still.

Fines

127. A third plank of an efficient and enforceable regulatory regime is a system of penalties which is sufficient to act as a deterrent and in particular to prevent wilful illegality by proprietors. The Government has proposed that there should be three types of offence—smoking in an area in which it is prohibited; failure by the proprietor to prevent smoking in an establishment in which it is prohibited; and failure to provide adequate signage;¹³⁶ and that the fines should be £50 for an individual who infringes the ban and £200 for the proprietor of the premises upon which the infringement occurs (although these penalties are not stipulated on the face of the Bill). Caroline Flint defended the fines on the basis that "we are not in this sense trying to criminalize people, we are trying to get their support and, in effect, to change their behaviour".¹³⁷ These fines are very low compared to those in the Republic of Ireland, where penalties of up to €3,000 are levied. These higher fines are aimed at publicans who deliberately flout the law. Without comparable fines, it is hard to see how wilful and sustained non-compliance will be avoided in England.¹³⁸

Political leadership

128. Finally, a successful ban requires strong and committed political leadership. In the Republic of Ireland, the then Minister of Health, Micheál Martin TD, made the introduction of a comprehensive ban on smoking the centrepiece of his tenure of the Department of Health and Children, and engaged with a wide variety of bodies in order to secure and promote the legislation. **Political support for a smoking ban in the Republic of Ireland is in stark contrast to the approach of the UK Government which has been muddled and vacillating. Policy towards the control of smoking in public places and workplaces has been a litany of good intentions undermined by faint-heartedness. The strong public health message embodied by *Smoking Kills*, the White Paper of 1998, has been hedged about with so many qualifications and exemptions that the legislation to**

134 Q 415

135 Department of Health, *Consultation on the Smokefree Elements of the Health Improvement and Protection Bill*, June 2005, pp 29–30.

136 *ibid*, p. 31.

137 Q 594

138 The Committee found that, in the Republic of Ireland, 93% of hotels were compliant with the legislation; 99% of restaurants; 90% of licensed premises; and 97% of other premises. The Office of Tobacco Control noted that 96% of all indoor workers reported having smoke-free workplaces. The number of prosecutions was very small (13 to the end of 2004). All of this indicates very widespread compliance.

protect non-smokers from the harmful effects of secondhand smoke has lost its clarity of purpose. Nor has the Government chosen to represent the ban on smoking primarily as an issue of worker protection, as was done in the Republic of Ireland, but instead as a more nebulous ‘public health’ measure. As a result of this failure of leadership, the Chief Medical Officer, who admitted that he considered resigning over the issue, described the Government’s legislation as putting “Britain among the laggards of public health policy-making internationally rather than the global leaders”.¹³⁹

129. We conclude that there are four key components to achieving widespread compliance:

- an adequate level of public support;
- clarity and simplicity in the regulations governing a ban;
- a framework of penalties which adequately and appropriately target those who fail to comply with the law, in particular those who deliberately flout the law;
- strong and committed political leadership.

130. The last three of these are sorely lacking in the Government’s proposals. Widespread compliance through a high degree of self-regulation will only be achieved by a comprehensive ban without exemptions for any licensed premises or membership clubs.

9 Conclusions

131. Many distinguished scientists in this country and elsewhere have examined the now considerable body of evidence which shows the health effects of secondhand smoke. The World Health Organisation, the Chief Medical Officer, the Royal College of Physicians, SCOTH and the US Surgeon General have all concluded that secondhand smoke is a serious risk to health. Faced by these conclusions the previous Secretary of State for Health, Dr Reid MP, concluded that secondhand smoke was dangerous and proposed to introduce a ban on smoking in most workplaces. We support this ban.

132. However, Dr Reid also decided on two main groups of exemptions: for institutions where people live such as prisons, psychiatric institutions and nursing homes; and for clubs and pubs which do not serve food. Unfortunately, we are unable to judge their precise nature because the Bill provides that they are to be specified in regulations and no draft of these regulations has been published. This is unacceptable. The Government must publish a draft of the regulations before the report stage of the Bill. The situation is made worse because Crown properties are not included in the Bill. The Government should have informed the House of this important fact at an early stage. That it did not has been very misleading. We are also surprised that neither the MOD, the Director-General of HM Prison Service nor the Home Office Minister told us that their institutions were not covered by the Bill.

133. Institutions which are also dwellings, such as prisons, MOD properties and hospices, present special difficulties. These institutions plan to ban smoking to a greater or lesser extent. At least one mental health trust and two Young Offenders' Institutions have already implemented a ban. Others should follow suit, although we recognise that there may be a case for carefully provided exemptions, for example in high security prisons. Staff should not smoke on the premises.

134. The exemption for clubs and pubs where food is not served is illogical. It means that the workers who are most exposed to secondhand smoke, and therefore most at risk, will not be protected. We have sought from the Government a convincing rationale for this decision but have not found one. It defies logic. Dr Reid justified the policy before the Committee in February 2005 on a number of grounds, including the fact that few bar workers would die from exposure to SHS in pubs.

135. Subsequently the Government's explanation for its policy has changed. In her appearance before us, the Minister for Public Health was very well briefed, but the oral evidence she gave us was unconvincing. We doubt that she believes in the policy she espoused. Cutting through the Minister's answers, her defence of Government policy amounted to a statement that 'we must take people with us'. On further examination this is nothing more than the dubious contention that because a majority of the population were opposed to it, a ban in pubs should not be introduced because the public would not comply with it. The Government does not oppose a comprehensive ban in principle. It is implicit in what both she and the Secretary of State told us that once opinion polls indicate that a small additional shift in public support for a total ban, the Government will have no objection to one. In fact, this has already occurred. A majority of the population now support a ban.

136. The Minister also tried to suggest that the Government would protect workers by banning smoking within one metre of the bar, but under questioning admitted that this would not provide health benefits. The Government is to hold a further consultation about protecting bar workers but it is hard to see its purpose since only a ban will provide that protection.

137. The proposed exemptions for clubs and non-food pubs are opposed by the hospitality industry because they are unclear and will create unfair competition: pubs where smoking is banned will lose business to clubs, so will bingo halls. Even those in the industry opposed to a ban would prefer a comprehensive ban to the proposed legislation. The exemptions are also condemned by those interested in public health on the following grounds: they will discourage the growing culture of eating while we drink; instead they will encourage an old-fashioned culture of drinking without food in 'smoking' pubs. The exemptions will undermine the Government's goal of reducing health inequalities: drink-only pubs are concentrated in deprived areas. Finally, the exemptions fly in the face of medical opinion. The Chief Medical Officer told us that the Government's rejection of a comprehensive ban went against his advice; this is the first time his advice on a public health matter has been rejected. He came close to resigning over this issue. The exemptions are not in line with other legislation to protect workers' health as the Health and Safety Commission and trade unions pointed out: workers are not normally exposed to unnecessary danger regardless of public opinion.

138. The exemptions will reduce compliance and make enforcement more difficult. Adding to these problems are the low fines which will be insufficient to deter publicans who wilfully ignore or obstruct the legislation. The Government's proposals are a recipe for chaos.

139. During the inquiry the Committee visited Ireland. There we were able to see in operation an effective comprehensive ban with no exemptions for any pubs or clubs. It has been a great success. The exposure to carcinogens in bars has greatly decreased and improvements to bar workers' health is already apparent. After the ban came into effect, it rapidly became more popular: it was voted the best thing to have happened in 2004 in the New Year's Eve poll at the end of the year. The key to success, we were told, is clarity and political support, which ensured compliance. In England, unfortunately, we find muddle and confusion, Cabinet wrangles and half-hearted political commitment.

140. Since secondhand smoke is a danger to workers' health, all workers, especially bar staff who are most at risk, deserve protection. Bar staff should not have to suffer conditions which are unsafe and avoidable. The Government should introduce a comprehensive ban which includes all pubs and clubs which employ staff. As in Ireland, it would be a popular measure, which would become more popular after it had come into effect. We agree with the President of the Royal College of Physicians that: "There is nothing that this Government could do for health that would be better than to actually bring in this ban, absolutely nothing."¹⁴⁰

Conclusions and recommendations

1. We are convinced by the evidence of experts, including the Chief Medical Officer, the Royal College of Physicians, SCOTH, the US Surgeon General and the World Health Organisation, that secondhand smoke is a serious and preventable cause of death and ill-health. (Paragraph 24)
2. 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. (Paragraph 33)
3. The only solution to the problem of SHS exposure is to prohibit smoking in public places and workplaces, including licensed premises. This approach has found increasing favour with governments around the world, and public opinion in the UK is moving very quickly in its favour. Moreover, the experience of the Republic of Ireland shows that smoke-free legislation becomes even more popular once it has been introduced. (Paragraph 40)
4. In balancing the economic effects on businesses and smokers' rights against workers' rights, we have to weigh up the likely effect on each group. The experience in Ireland suggests that the economic consequences of the ban on the hospitality industry have been slight and that smokers' suffering has been relatively trivial: if smokers want to smoke they go outside and do not seem to mind too much. In contrast, there is strong evidence that smoking in the workplace has significant effects. As we have seen, it is estimated that about 500 non-smokers each year die prematurely from inhaling secondhand smoke in the workplace; this is surely too high a price to pay for the right to smoke. We cannot accept that the right to smoke can justify these deaths. Workers have a right to be protected from harmful substances unless there is an overwhelming reason for undertaking the risk. (Paragraph 51)
5. We find the assertions in *Choosing Health*, supposedly based on the evidence of opinion polls, misleading and unhelpful to the debate about public support. Moreover, recent research, detailed in Annex 2, shows that public support is moving rapidly and decisively in favour of a comprehensive ban on smoking in public places and workplaces. (Paragraph 54)
6. We recommend that two draft regulations be laid before Parliament: one to deal with exemptions for licensed premises and clubs, the other to provide for premises where a person has his home or is living. (Paragraph 61)
7. Neither the Department of Health nor any other Government witnesses made reference to the issue of Crown immunity during our inquiry. It is not mentioned in the Explanatory Notes to the Bill nor was any reference made by Ministers at the Bill's second reading. We find these omissions extraordinary especially as Crown Immunity removes the necessity for exempting many premises. (Paragraph 62)

8. We acknowledge that prisons represent a particular challenge in terms of smoke-free legislation due to the nature of the prison population. We are not, however, persuaded that preventing SHS exposure in prisons is any less a priority than any other workplace, or that the high prevalence of smoking among prison inmates is either a justification for exemption from the legislation or justification for the continued exposure of staff or prisoners to SHS. Rather, we see the high prevalence of smoking as evidence of a substantial and currently unmet need for effective smoking cessation services in prisons, and a possible failure of duty of care to both prisoners and staff. Furthermore, simply exempting prisons from the decision that workplaces should be smoke-free is unsatisfactory since it will provide no impetus for the Prison Service to go further in working towards increasingly smoke-free environments within prisons. (Paragraph 72)
9. We recognise HM Prison Service's intention to work towards a smoke-free environment within prisons but are not persuaded that there is any reason why the policies applied in most prisons should be any less comprehensive, or implemented any later, than those for any other workplace. However, we also recognise that compliance may be difficult to achieve in some circumstances. From the date that the legislation comes into force in England, all smoking at work by prison staff should cease and the Home Office should set a target of making the interior of all prisons smoke-free. Prisons should maintain the power to make special provisions for individual prisoners in high-security institutions who are particularly difficult to manage, but this provision must not involve the exposure of staff or other prisoners to SHS. Smoke-free policy in prisons should be supported by the provision of full smoking cessation support to all smokers who want to stop smoking. (Paragraph 73)
10. We see no justification for any exemption for Young Offenders' Institutions. HMYOI Wetherby is an example of good practice which should be applied throughout all similar institutions. The Home Office should set an early target date for making all Young Offenders' Institutions smoke-free. (Paragraph 74)
11. High levels of smoking in psychiatric institutions are not inevitable. The experience in Norfolk and Waveney is an example of what can be achieved by a creative and positive approach in a difficult environment, and a model of good practice which can be applied to all other institutions. Therefore psychiatric institutions should not be granted a simple exemption from the smoke-free provisions of the Health Bill. An early target date should be set for making such establishments smoke-free, with separate outdoor areas (secure if need be) set aside for patients to smoke at the minimum risk to staff and other patients. In addition, measures should be put in place to tackle the high prevalence of smoking and challenging targets set for its reduction. Psychiatric institutions should become smoke-free workplaces for staff along with other NHS premises by the end of 2006. (Paragraph 80)
12. We welcome the Ministry of Defence's commitment to controlling smoking in the workplace, and recognise that the MOD is already working towards creating more smoke-free environments. We also welcome the MOD's 'golden rule' that non-smokers should not be exposed to other people's smoke. However, we are not persuaded that MOD workplaces should be treated any differently from other workplaces, and are concerned that exemptions in, for example, submarines will lead

to continued, avoidable and unnecessary exposure of service personnel to SHS. (Paragraph 86)

13. The Ministry of Defence should eliminate all smoking in the workplace and in public places. Smoking should not be permitted in shared living accommodation or in communal areas of living quarters in any circumstances. Smokers should be allowed to smoke only in individual private quarters. (Paragraph 87)
14. We recognise that there are difficulties. Nevertheless, staff in hospices should be afforded the same protection from SHS as workers in any other sector. Hospices should not be exempt from smoke-free legislation. Compliance with a smoke-free policy should be a condition of admission to hospices and there should be a comprehensive programme of smoking cessation support. Similarly, the staff of nursing homes should be afforded the same protection, and these premises should therefore be smoke-free. (Paragraph 90)
15. We agree with the Royal College of Nursing that care workers who visit patients in their own homes should be protected as far as possible from the harmful effects of SHS. To that end, employers should seek to ensure that patients are aware that they should not smoke while being visited, and that care workers should have the right to refuse to enter a home or room in which a patient is smoking. (Paragraph 92)
16. The Government's proposals for a ban which exempts 'drink-only' pubs and membership clubs are unfair, unjust, inefficient and unworkable, because:
 - all workers should be protected from SHS;
 - children, who have access to clubs, should not be exposed to SHS;
 - it is likely that a partial ban will be disputed in the courts by bar workers;
 - a partial ban will create unfair competition;
 - a partial ban will widen health inequalities;
 - public opinion now supports a comprehensive ban;
 - legislation should be clear and simple if it is to be easily enforceable. (Paragraph 116)
17. A broad range of opinion has argued that a comprehensive ban would achieve the Government's stated aims in a much more satisfactory fashion than a complex partial ban, and that from the commercial perspective of the hospitality and gaming industries, a comprehensive ban is also the preferred option. We find it hard to understand how the strong evidence base, clear public support, and the results of the Department's own Regulatory Impact Assessment can be ignored. (Paragraph 117)
18. Political support for a smoking ban in the Republic of Ireland is in stark contrast to the approach of the UK Government which has been muddled and vacillating. Policy towards the control of smoking in public places and workplaces has been a litany of good intentions undermined by faint-heartedness. The strong public health message embodied by Smoking Kills, the White Paper of 1998, has been hedged about with so

many qualifications and exemptions that the legislation to protect non-smokers from the harmful effects of secondhand smoke has lost its clarity of purpose. Nor has the Government chosen to represent the ban on smoking primarily as an issue of worker protection, as was done in the Republic of Ireland, but instead as a more nebulous 'public health' measure. As a result of this failure of leadership, the Chief Medical Officer, who admitted that he considered resigning over the issue, described the Government's legislation as putting "Britain among the laggards of public health policy-making internationally rather than the global leaders". (Paragraph 128)

19. We conclude that there are four key components to achieving widespread compliance:
 - an adequate level of public support;
 - clarity and simplicity in the regulations governing a ban;
 - a framework of penalties which adequately and appropriately target those who fail to comply with the law, in particular those who deliberately flout the law;
 - strong and committed political leadership. (Paragraph 129)
20. The last three of these are sorely lacking in the Government's proposals. Widespread compliance through a high degree of self-regulation will only be achieved by a comprehensive ban without exemptions for any licensed premises or membership clubs. (Paragraph 130)

Annex 1: Monitoring and evaluation

The Government's monitoring and evaluation strategy should include the following:

- Use of the Health Survey for England to monitor changes in non-smokers' exposure at the level of the whole population. The Survey has recorded cotinine levels in the population of England for the past ten years, and analyses have already been made of the changes in non-smokers' exposure over that time. Saliva sampling for cotinine should therefore be retained as a core part of the Health Survey for England.
- Before-and-after studies of exposure to SHS in the workplace, especially in pubs, with both food and non-food pubs adequately represented in the sample. An analogous study has been carried out in the Republic of Ireland and reported in the *British Medical Journal*.¹⁴¹ Such studies should highlight the differential impact of the legislation on workers in food and non-food pubs, as well as the overall benefit of smoke-free legislation.
- Studies of the economic impact of the legislation.
- Surveys of public opinion to gauge the level of support for smoke-free legislation. The ONS Omnibus Survey, sponsored by the Department of Health, currently includes questions assessing public opinion on this matter every year in October/November, but the Omnibus is conducted monthly, allowing more frequent tests to be made.
- Checks on compliance, to monitor whether the legislation is being observed; how many breaches are recorded; whether the food provisions are being circumvented by the provision of take-aways or nearby food outlets, as some have suggested may happen.
- Checks to establish how many licensed premises (1) stop serving food in order to allow smoking to continue (and the socio-economic characteristics of the areas in which they are situated) and (2) go out of business altogether.
- Monitoring of national smoking prevalence to see if there is any evidence of an impact (and a comparison with the 1.7% decline projected by the Regulatory Impact Assessment). This could also be done through the Omnibus Survey.

¹⁴¹ Shane Allwright, G. Paul et al., *Legislation for smoke-free workplaces and the health of bar workers in Ireland: before and after study*, *British Medical Journal*, vol 331, pp 1117–19

Annex 2: Public opinion

1. The Office of National Statistics carries out a multi-purpose survey called the Omnibus Survey to provide data to Government departments and other public bodies. The survey is carried out most months. The results for 2004 were used to create a picture of public attitudes towards smoking in public places and restrictions thereon.

2. 64% of respondents supported restrictions on smoking in pubs, an increase from previous years (56% in 2003, 48% in 1996). When asked in more detail about smoking restrictions, 47% thought that pubs should be mainly non-smoking with smoking allowed in designated areas, while only 16% thought that pubs should be mainly smoking with designated non-smoking areas. 31% thought that smoking should not be allowed anywhere, a significant increase in the figure from the previous year (20%).

3. *Choosing Health* referred to the findings of an Opinion Leader Research (OLR) survey, which, it said, demonstrated that people “do not [...] believe that this [protecting workers from SHS] requires a complete ban in all licensed premises”. The survey was published in June 2004 and was commissioned by the King’s Fund. However, the research does not seem explicitly to support this contention. 68% of respondents thought that a ban on smoking in workplaces, including pubs, bars and restaurants, would be the most effective way to reduce the health risks of smoking. There was no question inquiring whether or not people believed that something less than a complete ban is necessary.

4. ASH has pointed to other surveys to demonstrate that public support for a ban on smoking in public is substantial and growing. A poll conducted for ASH by BMRB (the British Market Research Bureau) in July 2005 asked: “The Government has announced plans to make most enclosed public places smokefree from 2008. Would you support a proposal to make ALL enclosed workplaces, including pubs and restaurants, smokefree?” It found that 73% of respondents agreed with the proposition (although support was only 42% among smokers). This confirms the findings of a MORI poll of April 2004, which found that 54% strongly supported the introduction of legislation similar to that in Ireland, with 25% tending to support it (79%, therefore, being broadly in favour).

5. ASH has also commissioned surveys from YouGov which reinforce the picture of increasing public support for a ban on smoking in public. The way in which the question is framed is important; respondents can be asked whether or not they support the introduction of a ban on smoking in all public places and workplaces, including pubs and bars; or they can be given a list of public places and workplaces and asked which they think should be smoke-free. When YouGov posed the latter question in August 2005, only 41% of respondents indicated that pubs and bars should be smoke-free. However, another YouGov survey conducted in December 2005 asked both questions. In response to the first, more general question, around 70% of respondents supported a comprehensive ban (71% in England and Scotland, 70% in Wales and 78% in Northern Ireland). When the second, so-called ‘à la carte’ question was posed, the number of respondents choosing pubs and bars as places which should be smoke-free was slightly (but not significantly) lower: 66% in England, 70% in Scotland, 67% in Wales and 71% in Northern Ireland. This indicates firstly that the phrasing of the question affects the results, but also that there is now a substantial majority of opinion in favour of a comprehensive ban. Moreover, opinion is

clearly moving very swiftly in favour of a comprehensive ban; support which was at 41% in August 2005 has become 66–70% in the space of four months.

6. The Chairman appeared on BBC Radio 4's *You and Yours* to participate in a phone-in discussion on smoking in public. The BBC subsequently produced an analysis of the responses to the discussion from members of the public.¹⁴² Over a two-week period, the producers of the programme received over a thousand e-mails, telephone calls and letters. Of these responses, 60% were in favour of a comprehensive ban. Only 22% favoured no ban. There was no support for the Government's proposals for a partial ban. Some respondents also expressed concern that the Government's proposals would widen health inequalities. One wrote "This policy will add to health inequalities between rich and poor as most pubs that don't serve food are situated within the poorest communities".¹⁴³

7. Responses to opinion polls clearly depend on the questions which are asked. However, what is clear is that there is a trend of growth in public support for the idea of a comprehensive ban on smoking in public places and workplaces. The Committee has also heard from the Director of ASH that public support in the UK is currently higher than it was in Ireland prior to the introduction of the smoking ban there.¹⁴⁴ ASH has also pointed out that support for a ban in New York was only 30% when it was introduced. Yet New York and the Republic of Ireland have successfully implemented a ban on smoking in public.

142 Ev 119, Volume III.

143 Ibid.

144 Q 429

Annex 3: Health Committee visit to Dublin

7–9 November 2005

The Committee met:

Dr Shane Allwright and Ms Marie Killeen, Office of Tobacco Control

Mr Tadg O’Sullivan, Chief Executive, Vintners’ Federation of Ireland

Mr John Power, Chief Executive, and Mrs Anne O’Carroll, Irish Hotels Federation

Mr Henry O’Neill, Chief Executive, Restaurants Association of Ireland

Professor Luke Clancy, ASH Ireland

Mr Eamon Corcoran, Principal, and Mrs Siobhan McEvoy, Chief Environmental Health Officer, Department of Health and Children

Mr Seamus Cramer, Irish Prison Service

Mr Bernard Harbor, IMPACT and Mr John Douglas, MANDATE

Timetable of the Irish smoking ban

November 1999 – The Oireachtas Joint Committee published a report on Health and Smoking.

March 2002 – Public Health (Tobacco) Act passed by the Dáil Éireann.

May 2002 – Enactment of section 2 of the Public Health (Tobacco) Act which established the Office of Tobacco Control (OTC) as a statutory body.

November 2002 – The Irish Government proposes a ban in restaurants and pubs where food is served.

January 2003 – A report jointly commissioned by the OTC and the Health and Safety Authority, “The Health Effects of Environmental Tobacco Smoke in the Workplace”, highlights effects of passive smoking and calls for a ban on smoking in all workplaces, including bars.

30 January 2003 – Irish Government announces ban. It was opposed by the Vintners’ Federation of Ireland (VFI), which describes it as ‘unworkable, untenable and unenforceable’, arguing that ventilation was effective, a claim which was challenged by Environmental Health Officers. The ban was supported by unions: MANDATE called for bar workers to be protected, stating that 150 died in Ireland every year from ill-health caused by passive smoking.

March 2004 – Ban introduced, but with exemptions for prisons, Garda Station detention areas, nursing homes, hospices, religious order homes, central mental hospital, psychiatric hospitals, residential areas within third level education institutions, hotel, guesthouse and B&B bedrooms.

December 2004 – In a national poll conducted by RTÉ, Ireland’s public service broadcaster, the smoking ban is voted the high point of 2004.

March 2005 – Bertie Ahern claims ban has been a great success with few problems of compliance and forecasts of collapse in pub trade have not been borne out. A survey carried out by the trades unions says 90% of Dublin bar workers approve of ban. According to the Irish Central Statistical Office, bar sales declined by 5.3% in the full year after the ban was introduced – but it was claimed that this was only slightly above the decline in the bar trade (4% per year) which began in 2001. A journalist noted:

‘Bars have facilitated them [smokers] in a variety of ways, often providing outside tables, gas heaters and ashtrays, and sometimes building on patios and lean-to shelters. This in turn has added a new dimension to social intercourse as the open-air smokers discuss the ban and other topics.’

October 2005 – The OTC’s Annual Report declared that bar retail sales by volume had increased during the most recent three-month period (year-on-year) following four years of decline. The number of people employed in the bar sector also jumped by 1,400 to 23,200. Compliance with the ban was high. The VFI, in contrast, replied that according to the Central Statistics Office 7,600 jobs were lost in the hospitality sector the first year after the ban which meant a net loss of 6,200 jobs since the ban began. The VFI also claimed that as many as 200 pubs, mainly in rural areas, have gone out of business since the smoking ban was introduced in March last year.

A study funded by OTC found a significant reduction in bar workers exposure to secondhand smoke following the ban (salivary cotinine concentrations dropped by 80% which was far greater than the fall in Northern Ireland bar staff). There is some evidence that home exposure declined after the ban.

The Office of Tobacco Control (Dr Shane Allwright and Ms Marie Killeen)

The idea of banning smoking in public places grew out of two Dáil inquiries, in 1999 and 2001, and was enshrined in the Public Health (Tobacco) Act of March 2002. This legislation prohibited smoking in public places and workplaces and created the Office of Tobacco Control as an independent statutory agency to advise on and co-ordinate the enforcement of the ban.

A joint scientific committee comprising representatives from the Office of Tobacco Control and the Health and Safety Authority, as well as independent scientists, produced a report on secondhand smoke in January 2003, which found that SHS is a Category A carcinogen as well as a causal factor in several other serious diseases. It also found that ventilation and voluntary arrangements were ineffective in controlling SHS in public places.

The primary aim of the legislation was to protect third parties (especially workers) from the harmful effects of SHS. It was based on strong scientific foundations, from within the Republic of Ireland and from abroad. There was clear and committed political leadership behind the ban and a broad base of public support.

High levels of public support for a ban on smoking were found. 67% of those surveyed (including 40% of smokers) supported the legislation before its introduction, and research conducted by the Department of Health and Children found 82% supported the ban once it was in force. In addition, it was voted the high point of 2004 in a national poll conducted

by RTE. A survey carried out one year after the ban's introduction found that 98% of respondents believed workplaces were healthier; 96% believed the law had been a success; and 93% thought it was a good idea.

Compliance has also been very high. In more than 45,000 inspections, the National Tobacco Control Inspection Programme found that 93% of hotels, 99% of restaurants, 90% of licensed premises and 97% of other premises were compliant, while 92% of premises inspected by the Health and Safety Authority complied with the ban. There were very few prosecutions for breaching the legislation (13 to the end of 2004; approximately 50 to date).

There was little or no substantial adverse effect on the economy. Restaurants and hotels reported no negative impact; representatives of the bar trade claimed that sales had fallen by 15–25%, but data from the Central Statistical Office pointed to a much shallower decline, which may have been attributable to pre-existing trends. There was a small decline (2.4%) in the number of people employed in the bar trade, but this decline has halted and the figures are now increasing.

The factors contributing to the success of the smoking ban were:

- A comprehensive and intelligible law with few exemptions;
- Well-prepared and adequately resourced implementation;
- Sustained and committed political leadership;
- Support of a broad base of interested parties;
- Active information campaign to build public awareness;
- Public confidence that the legislation was workable.

The Vintners' Federation of Ireland (Mr Tadg O'Sullivan, Chief Executive)

The Vintners' Federation of Ireland (VFI) was created in 1973 by the merger of smaller associations, to represent the interests of individual publicans. It currently has around 6,000 members.

The VFI accepted that cigarette smoke could be unpleasant and uncomfortable for non-smokers and workers, but said that it simply didn't know if it was harmful to health, and believed there to be no conclusive scientific evidence. However, if smoking is so harmful, why is it allowed at all? It did not believe that legislation was the appropriate way to tackle the problem.

The statistics used to support a ban on smoking were not wholly reliable; in particular, the number of deaths among bar staff attributable to SHS exposure had been hugely exaggerated.

The consumption of tobacco and alcohol in the home has increased significantly as a result of the ban; health experts have suggested that there may be a link with the increased number of domestic fires.

There had been major adverse effects for the licensed trade. Volume on-sales, having risen from 1990 to 2000, fell slightly between 2001 and 2003, but then fell significantly in 2004

[the year the ban was introduced]. There were significant job losses in the hospitality industry in 2004, despite a growth in jobs in the broader economy. Rural areas have seen significant numbers of pub closures—as many as 500 in the Republic of Ireland as a whole. The VFI believes that the ban on smoking has been a major contributory factor. The VFI also contested the OTC's use of data from the Central Statistical Office, particularly the claim that employment in the hospitality sector had risen to 23,000, when, it is clear, there are well over 50,000 people employed in the sector. The VFI says the OTC figures are therefore false.

The VFI was of the opinion that, far from the ban on smoking being simple, it had been the subject of considerable confusion and had been interpreted differently by different people, especially Environmental Health Officers.

The Irish Hotels Federation (Mr John Power, Chief Executive, and Mrs Anne O'Carroll)

The Irish Hotels Federation (IHF) represents hotel and guest house owners. It was founded in 1937 and represents approximately 1,000 establishments, employing 57,000 people.

The IHF accepted the health arguments in favour of a ban on health and safety grounds. There was a duty of care on the part of employers in the hospitality industry with regard to workers, and this extended to protection from the harmful effects of SHS.

The introduction of the ban on smoking in public had generated considerable positive media coverage, and the hospitality industry in general had benefited from this.

There were no alternatives. There was a lack of conclusive evidence on the efficacy of ventilation, despite the work of Dr Andrew Geens in this field.

The Restaurants Association of Ireland (Mr Henry O'Neill)

The Restaurants Association of Ireland (RAI) is the recognised representative of the restaurant trade. It was formed in 1970 and represents more than 600 restaurants of all kinds.

The RAI supported the introduction of smoke-free legislation. It had concerns over the enforcement of the ban, whether the responsibility for infractions would lie with the smoker or the proprietor and which sectors would be exempt, and was the only organisation to request a meeting with the Minister of Health.

A survey carried out by the RAI found that 68% of patrons favoured a ban, and 70% of members agreed. The organisation therefore gave its official backing to the legislation.

The RAI found that there was no downturn in business after the introduction of the ban; indeed, if anything, there had been an increase in trade. There had been complete compliance and no prosecutions for infringing the ban. A partial ban of the kind proposed for England and Wales would have been unworkable.

ASH Ireland (Professor Luke Clancy)

ASH Ireland is a campaign group which was established in 1992 as a joint venture by the Irish Cancer Society and the Irish Heart Foundation. It aims to reduce the prevalence of smoking and educate the public about the dangers of smoking.

The ban on smoking in public places was not a consumer protection issue, a smoking cessation measure or an issue of tobacco control. It was a measure for the protection of workers in the workplace, based on human rights.

The ban had been important in effecting a significant cultural change with regard to the public's view of smoking and the harmful effects of SHS.

More comprehensive research was needed on the effects of a ban on smoking in public, particularly on the economic impact. It was hoped that the UK would conduct such research if it introduced smoke-free legislation.

Department of Health and Children (Mr Eamon Corcoran, Principal, and Mrs Siobhan McEvoy, Chief Environmental Health Officer)

The Department clarified a number of outstanding issues for the Committee.

The definition of a 'workplace' in the context of a ban on smoking was the same as that to which health and safety legislation applies – the ban on smoking was promoted largely as a health and safety and worker protection issue. It was necessary because ventilation was deemed "ineffective" to counter the harmful effects of SHS. It was felt to be important to engage with the trades unions in promoting the ban as a matter of workers' rights.

Figures from the Central Statistical Office demonstrated that bar sales declined by 4.4% in 2004, but this was part of a trend which had begun in 2002. Cigarette sales, by contrast, fell 8.7% in 2004 after a fall of only 3.4% the previous year.

There had been closures of rural pubs, although it was not known how many. This should be seen as part of trend. Many family-owned rural pubs operate on very small margins and may close when a new generation inherits.

The impact of the ban overall on smoking is somewhat unclear; however, the prevalence of smoking among the young remains a problem. No evidence has been found to support a theory that the ban has led to higher levels of smoking in the home; nor is there any evidence of cross-border trade with Northern Ireland increasing. Although there had been some decline in bar trade, this could in part be attributable to anxieties about changes in the licensing system; currently, pub licences may be sold, often for substantial sums, but there are fears that deregulation may reduce their value significantly.

The Irish model for a smoking ban was "coherent and enforceable", and compliance has been extremely high. The model proposed for England was not one which would have been adopted in Ireland.

The Irish Prison Service (Mr Seamus Cramer)

There are currently 3,200 prisoners in custody, of whom 100–120 are women. Smoking prevalence is extremely high; between 80 and 85% of male prisoners smoke, while the rate among women is virtually 100%.

The current policy is that prisoners are only allowed to smoke in their cells or in outside areas. However, a more detailed smoking policy for prisons is currently at a draft stage.

The Department of Health does not believe that the European Convention on Human Rights applies to prisoners' right to smoke.

The Irish experience demonstrated the importance of local-level enforcement and pragmatism in allowing exemptions.

IMPACT and MANDATE (Mr Bernard Harbor and Mr John Douglas)

IMPACT is the Irish Municipal, Public and Civil Trade Union. It is Ireland's leading public sector trades union and has 54,000 members in health, local authorities, the civil service, education, community and voluntary organisations, semi-state companies and aviation. MANDATE was formed in 1994 by the amalgamation of IDATU (the Irish Distributive and Administrative Trade Union) and INUVGATA (the Irish National Union of Vintners, Grocers and Allied Trades Assistants) and is a union of retail, bar and administrative workers.

The trades unions in Ireland were intimately involved in the evolution and the implementation of the ban on smoking. They stressed the importance of strong political leadership combined with broad political consensus; of a level playing field as a result of the regulations; and of significant penalties for non-compliance. The level of public support for the ban was high and increasing. They also emphasised the importance of the presentation of the smoking ban as an issue of protecting workers in the workplace.

A survey conducted for MANDATE one year after the implementation of the ban suggested that 80% of their members felt that their health had improved.

Conclusion

The ban on smoking in public places was regarded by most of the people we met as a success. The main factors in ensuring compliance and public support have been:

- An emphasis on the issue of the protection of workers' health;
- Strong and committed public leadership;
- Broad political consensus and engagement with interested parties;
- A positive campaign to inform and prepare public opinion;
- Clear and simple regulations which are easily intelligible;
- Limited exemptions based on pragmatic decisions;
- A robust regulatory framework with significant penalties.

Formal minutes

Thursday 15 December 2005

Members present:

Rt Hon Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Mr Paul Burstow

Mr Ronnie Campbell
Dr Doug Naysmith
Dr Richard Taylor

The Committee considered the draft Report (Smoking in Public Places), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 140 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary be read and agreed to.

Annexes be read and agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Several Memoranda and a paper were ordered to be reported to the House.

[Adjourned till Thursday 12 January at 9.30 am.]

Witnesses

Thursday 20 October 2005

- Dr Fiona Adshead**, Deputy Chief Medical Officer and **Mr Nick Adkin**, Project Manager on Tobacco, Department of Health Ev 1
- Professor Dame Carol Black**, President, **Dr Richard Edwards**, Senior Lecturer in Public Health, University of Manchester, **Dr Richard Ashcroft**, Reader in Biomedical Ethics, Imperial College and **Dr Allan Hackshaw**, Deputy Director of Cancer Research UK and UCL Cancer Trials Centre, University College London, Royal College of Physicians Ev 8
- Dr Steve Stotesbury**, Industry Affairs Manager and Chief Scientist, Imperial Tobacco Ltd (UK), **Ms Christine Mohrmann**, Head of UK Corporate Affairs, Philip Morris Ltd and **Mr Barry Jenner**, Director of UK Business, Gallaher Group plc Ev 17

Thursday 17 November 2005

- Mr Phil Wheatley CB**, Director General, HM Prison Service, **Mr Paul Foweather**, Governor, HM Young Offenders' Institute Wetherby, **Mr Paul Thain**, Director of Modernisation and Strategic Development, Norfolk & Waveney Mental Health Trust, **Mr Ian Hulatt**, Mental Health Adviser, The Royal College of Nursing and **Mr Paul Corry**, Director of Campaigns & Communications, Rethink Severe Mental Illness Ev 25
- Mr Rob Hayward OBE**, Chief Executive, British Beer and Pub Association, **Mr John Hutson**, Chief Executive, J.D. Wetherspoon, **Mr Nick Bish**, Chief Executive, Association of Licensed Multiple Retailers, **Mr Bob Cotton OBE**, Chief Executive, British Hospitality Association and **Mr Tony Payne CBE**, Chief Executive, Federation of Licensed Victuallers Associations Ev 35
- Mr Simon Thomas**, Managing Director, Thomas Holdings Ltd, **Sir Peter Fry**, Chairman and **Mr John Carpenter**, The Bingo Association Ev 43
- Mr Hugh Robertson**, Trades Union Congress, **Mr Vincent Borg**, UNISON, **Mr Michael Ainsley**, GMB, **Mr Brian Revell** and **Ms Pauline Robson**, TGWU Ev 45

Thursday 24 November 2005

- Mr Bill Callaghan**, Chairman, Health and Safety Commission, **Ms Deborah Arnott**, Director, Action on Smoking and Health (ASH), **Councillor David Rogers OBE**, Local Government Association (LGA), **Mr Derek Allen**, Executive Director, Local Authorities Coordinators of Regulatory Services (LACORS), **Mr Graham Jukes**, Chief Executive and **Mr Ian Gray**, Policy Officer for Health Development, Chartered Institute of Environmental Health Ev 51
- Professor Sir Liam Donaldson**, Chief Medical Officer Ev 58
- Vice Admiral Rory McLean CB, OBE**, Deputy Chief of the Defence Staff (Health), and **Mr Chris Williams**, Finance and Secretariat Branch Leader, Ministry of Defence Ev 62
- Mr Shaun Woodward**, a Member of the House, Under-Secretary of State for Northern Ireland, Northern Ireland Office, **Ms Pat Osborne**, Head of Investing for Health Branch, and **Mr Jim Gibson**, Deputy Principal, Investing for Health Branch, Department of Health, Social Services and Public Safety Northern Ireland Ev 66
- Caroline Flint**, a Member of the House, Under-Secretary of State for Public Health, **Fiona Mactaggart**, a Member of the House, Under-Secretary of State for the Home Department, and **Mr Nick Adkin**, Tobacco Programme Manager, Department of Health Ev 70

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1	Thompsons Solicitors (SP 02)	Ev 1
2	Royal College of Nursing (SP 03)	Ev 2
3	Royal Pharmaceutical Society of Great Britain (SP 04)	Ev 4
4	Asthma UK (SP 05)	Ev 6
5	Thomas Holdings Ltd (SP 07)	Ev 11
6	CLIC Sargent (SP 09)	Ev 12
7	Imperial Tobacco Limited (SP 11)	Ev 13
8	Tobacco Manufacturers' Association (SP 12)	Ev 14
9	The Roy Castle Lung Cancer Foundation (SP 13)	Ev 14
10	Sainsbury Centre for Mental Health (SP 14)	Ev 15
11	Gallaher Group plc (SP 15)	Ev 17
12	The Imported Tobacco Products Advisory Council (SP 16)	Ev 17
13	Dr Andrew Geens (SP 17)	Ev 19
14	Philip Morris Limited (SP 18)	Ev 20
15	Smoking Control Network (SP 19)	Ev 21
16	Lloydspharmacy (SP 20)	Ev 22
17	Cancer Research UK (SP 21)	Ev 23
18	Southwark NHS Primary Care Trust (SP 22)	Ev 27
19	SmokeFree Liverpool (SP 23)	Ev 27
20	The Association of Licensed Multiple Retailers (SP 24)	Ev 28
21	Society of London Theatre and Theatrical Management Association (SP 25)	Ev 29
22	Chartered Society of Physiotherapy (SP 26)	Ev 33
23	British Heart Foundation (SP 27)	Ev 33
24	Smoke Free North East (SP 28)	Ev 36
25	British Lung Foundation (SP 29)	Ev 40
26	Ken Livingstone, Mayor of London (SP 30)	Ev 41
27	Tobacco Workers' Alliance (SP 31)	Ev 42
28	Royal College of Physicians of Edinburgh (SP 32)	Ev 43
29	Help the Hospices (SP 33)	Ev 46
30	Hunters & Frankau Ltd (SP 34)	Ev 48
31	Rank Group Gaming Division (SP 35)	Ev 49
32	British Medical Association (SP 36)	Ev 51
33	British Beer and Pub Association (SP 37)	Ev 58
34	The Royal Society for the Promotion of Health (SP 38)	Ev 70
35	Rethink (SP 39)	Ev 71
36	Ms Nicola Mills (SP 40)	Ev 72
37	National Institute for Health and Clinical Excellence (SP 41)	Ev 73
38	Birmingham Smoke Free Coalition (SP 42)	Ev 75
39	Local Government Association and Local Authorities Co-ordinators of Regulatory Services (SP 43)	Ev 81
40	Chartered Institute of Environmental Health (SP 44)	Ev 83

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1	Department of Health (SP 01)	Ev 86
2	Supplementary memorandum by Thomas Holdings Ltd (SP 07A)	Ev 87
3	Supplementary memorandum by Imperial Tobacco Limited (SP11A)	Ev 88
4	Supplementary memorandum by Gallaher Group Plc (SP 15A)	Ev 88
5	Supplementary memorandum by Dr Andrew Geens (SP17A)	Ev 89
6	British American Tobacco (SP 45)	Ev 92
7	Business In Sport and Leisure (SP 46)	Ev 93
8	Prison Service (SP 47)	Ev 95
9	The Bingo Association (SP 48)	Ev 97
10	Faculty of Occupational Medicine of the Royal College of Physicians (SP 49)	Ev 98
11	Supplementary memorandum by Dr Allan Hackshaw, Royal College of Physicians (SP 50)	Ev 98
12	Supplementary memorandum by Dr Richard Edwards, Royal College of Physicians (SP 51)	Ev 99
13	Action On Smoking and Health (ASH) (SP 52)	Ev 103
14	Royal College of Physicians (SP 56)	Ev 114
15	Professor Roger Scruton (SP 57)	Ev 117
16	BBC Radio 4: You and Yours (SP 58)	Ev 119

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

K Wass

David Paterson

Adrian Kerton MSc.

Mr Steve Jones

Jo Barrett

Robert Feal-Martinez

Supplementary memorandum from the Department of Health

Supplementary memorandum from ASH