



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

Response from the Faculty of Public Health to the Department of Health's *Smoke-free Elements of the Health Improvement and Protection Bill*

Introduction

The Faculty is an authoritative public health body which maintains and improves standards in the public health workforce to improve the health of the population. It does this through the following key areas of work: health improvement, health and social care standards, and health protection. In addition to maintaining professional and educational standards, the Faculty advocates on key public health issues.

Tobacco and tobacco smoke pollution (also known as environmental tobacco smoke or second-hand smoke) are key areas of focus for the Faculty, which actively works to highlight the harmful effects of these. It works in partnership with key organisations including ASH and the National Heart Forum, and is a member of the Clean the Air Coalition. It also supports the new Smoke-free Air Coalition. The Faculty has produced a briefing statement on tobacco smoke pollution (*Tobacco Smoke Pollution and Health* – attached for information) which provides an overview of the evidence on the health effects of secondhand smoke.

General comments

The Faculty welcomes the Government's commitment to improving health and tackling health inequalities through the inclusion of *Smoke-free Elements of the Health Improvement and Protection Bill*. The information set out in the consultation leads to one logical conclusion – **that comprehensive smoke-free legislation, encompassing all public places and workplaces, including all licensed premises such as pubs, bars and restaurants, is the only way forward if government is committed to protecting and improving health, and to reducing inequalities in health.**

The Faculty recognises that the consultation on *Smoke-free Elements of the Health Improvement and Protection Bill* is a positive step towards reducing the burden of disease and death, caused as a result of secondhand smoke, which includes:

- the death of more than two employed persons per working day in the UK (over 600 deaths per year)¹
- approximately 17,000 admissions to hospital of children aged under five years²
- 25-35% increased risk of an acute coronary heart disease event³
- 20-30% increased risk of lung cancer⁴
- significantly increased risk of stroke⁵
- decreased lung function⁶
- abnormal kidney function⁷

It is also widely recognised that secondhand smoke is a risk factor for:

- asthma – in both children and adults
- raised blood pressure

- lung infections, middle ear infection and illness in children
- Sudden Infant Death Syndrome (also known as cot death)
- low birthweight in babies and premature birth.

Not all of these are caused by occupational exposure to tobacco smoke, nor even to exposure in public places. However, the additional publicity associated with smoke-free workplaces and greater awareness among smokers of the harm their smoke causes others has also resulted in increasing proportions of private homes being smoke-free.

The Faculty notes that since the Scientific Committee on Tobacco and Health (SCOTH) produced its report on secondhand smoke in November 2004, new evidence of its health impact has come to light. The California Scientific Panel on Toxic Air Contaminants have updated their landmark 1997 CalEPA report on environmental tobacco smoke (secondhand smoke). One major new conclusion is that secondhand smoke is causally associated with breast cancer in younger, primarily premenopausal women.⁸

Public and government awareness of the effects of secondhand smoke has never been greater – as has support for comprehensive smoke-free legislation. This is evidenced by the strong support shown to the implementation of smoke-free legislation in the Republic of Ireland and now in Scotland (due March 2006). It has also been shown that support for smoke-free legislation has increased following successful implementation (as shown in the Republic of Ireland, Italy and Sweden for example).

Smoke-free legislation will also be introduced in Northern Ireland (following a period of consultation) and Wales – which has already voted in principle to end smoking in public places – will be granted powers to introduce legislation. Three major cities in England – Liverpool (its bill has now gone for a second reading before the House of Lords), Birmingham and London – are also making significant progress on introducing city-wide smoke-free legislation which would cover all public places and workplaces, including pubs, bars and restaurants. A MORI survey, commissioned by ASH, in 2004 also clearly demonstrated support across Great Britain, and across all social classes, for the implementation of smoke-free legislation in all enclosed workplaces.⁹ It is therefore clear that impetus is growing for England to become a smoke-free country.

Implementation of comprehensive smoke-free legislation without exemptions would help achieve the national cessation targets set by the Priorities and Planning Framework for 2003-2006, as well as those in the NHS Cancer Plan. Sure Start also has targets to reduce the number of hospital admissions for respiratory disease in children aged 0-4 years – evidence has shown that as many as 17,000 hospital admissions in the under fives occur yearly was as a result of secondhand smoke.

Evidence has shown that both the voluntary approach and installation of ventilation systems are inadequate and ineffectual in reducing the risk to workers and the public from secondhand smoke. Evidence from around the globe, including the Republic of Ireland, Norway, New York and California – which the UK government also acknowledges in its consultation – has also demonstrated that the implementation of comprehensive smoke-free legislation is workable, effective, and does not carry with it the suggested financial penalties to the hospitality industry (figures have remained relatively static). Smoking rates have gone down, and in Scotland, there has been a substantial rise in the number of people contacting smoking cessation services prior to the implementation of the smoke-free legislation in 2006.

This consultation presents a unique opportunity to significantly reduce, in one step, the gross inequalities and burden of death and disease that smoking and secondhand smoke cause.

The consultation sets out a number of questions. The Faculty will answer each of these in turn.

Proposed definition of smoke or smoking

Q.1 Does this definition raise any concerns, in particular that non-tobacco cigarettes are not covered?

The Faculty believes that all smoking – whether a tobacco or non-tobacco substance – poses a hazard to health. We would therefore suggest the definition includes a clear statement indicating that smoking any substance (whether it is tobacco or something other than tobacco) should be included in the definition – this would also include herbal cigarettes.

Definition of enclosed

Q.2 Views are invited on this approach to defining 'enclosed'. Does it give the owners of likely premises and enforcement authorities a sufficiently clear definition? If not, how might it be improved? Are there concerns that loopholes are being created?

Q.3 Views are invited on this proposal.

Questions 2 and 3 relate to the definition of enclosed public places and other 'notional' enclosed public places – such as bus shelters and sports stadia. The Government recognises the importance of clearly defining 'enclosed' public places to ensure effective implementation. The Faculty would support the definition as set out in questions 2 and 3. We support the inclusion of entrances and exits to public places – particularly health, education and social care workplaces which should be seen to lead by example. We would also suggest that a comprehensive list of areas classified as 'enclosed' is produced in final guidance. A statement could be included such as "premises covered by law but not limited to" to allow for the later inclusion of venues not initially considered. It should also include other public places such as shopping centres, car parks, entertainment premises such as discotheques, as well as areas such as train station platforms where one section is under cover but perhaps the remainder of the platform is not. For example, Birmingham New Street and Liverpool Street stations have been smoke-free for some time without problems.

However, there remains the question of enforceability – particularly with regards to areas such as bus shelters. Will someone standing in a bus queue – but not directly under the cover of the bus shelter – be infringing the law if they smoke? This is not to say that such areas should not be covered – merely that clear guidance is needed.

It should be clear that legislation applies at all times of the day and night.

Exceptions – all licensed premises (receive a longer lead-in time)

Question 4: Views are invited on this proposal. Are there any potential difficulties with using the Licensing Act 2003 that consultees would want to raise? Comments on the principle of a longer lead-in time for all licensed premises are also welcome.

No adequate reason is given in the consultation as to why licensed premises require a longer lead-in time. The Faculty strongly believes that legislation should be implemented on one date and as quickly as possible. A single date for implementation, covering all workplaces and public places – including licensed premises – would avoid confusion (Is a premise

smoke-free or not?) and promote equity, particularly within the hospitality industry. Such legislation should be in place by spring 2007 at the latest.

Implicit within this approach to the licensed trade are cultural attitudes towards alcohol ie. the place held by pubs and alcohol within society's psyche which government should not be seen to be reinforcing, and which in fact undermines what they are trying to achieve through their *Alcohol Harm Reduction Strategy for England*.¹⁰

Exception for Licensed Premises that do not Prepare and Serve Food Exemptions Generally

Question 5: Views are invited on the merits and practicability of this proposal. If a specific list is preferred, are there any things you would and would not want on such a list, recognising the current wish to, in essence, allow smoking only to continue in "drinking pubs"? Are there any major concerns about the impact on licensed businesses that will have to choose between food and smoking? Is the Choosing Health estimate of 10–30% of pubs choosing smoking likely to be borne out?

The risk from secondhand smoke is the same whether or not food is consumed on a premise. The exclusion from smoke-free legislation of pubs which do not serve food appears to bear more relation to what is socially acceptable than to health (ie. prohibiting smoking whilst people are eating is better etiquette than allowing smoking).

Exempting pubs and clubs (including private members clubs etc) will still leave many employees at great risk of exposure to secondhand smoke. The proposal to allow exemptions from the legislation would therefore create inequalities and continue to expose people to substantial health risks. The proportion of pubs that do not serve food – or that would choose not to do so – varies significantly by geographical location. 'Gastropubs' ie. pubs that serve food, are common in more affluent areas, which already have better health than the general population. 'Wet pubs' are more prevalent in less affluent areas, where more people generally smoke. Employees in these areas are therefore much less likely to be protected from occupational exposure to the carcinogens and other noxious chemicals in other people's smoke. The Government's current proposal (of smoke-free legislation with exemptions) will not only hinder their efforts to reach their targets to reduce inequalities, but differential treatment of 'food-led' and 'wet' pubs and private clubs are likely to exacerbate existing inequalities because of differential exposure to tobacco smoke pollution *per se*. There is also a greater likelihood of increased numbers of smoke-free homes and of smoking cessation amongst workers whose workplaces become smoke-free, unlike those workers where smoking continues to be permitted. This will also lead to increased inequalities.

To further illustrate the contradictory position proposed in this consultation, if exposure to asbestos were being discussed, it is highly unlikely that government would propose that workers in some parts of an industry would be protected from occupational exposure but those in a different part of the same industry would not be entitled to such protection by law.

Public opinion is strongly in favour of *all* workplaces being smoke-free. The latest Office of National Statistics survey on 'Smoking behaviour and attitudes' showed an increase in support for smoking restrictions in pubs, shopping centres, indoor leisure facilities and railways and bus stations.¹¹ Introducing smoke-free places encourages people to quit smoking. For example, the forthcoming implementation of smoke-free legislation in Scotland has prompted a significant rise in the number of people seeking help to quite smoking. Smoke-free legislation also reduces consumption of tobacco amongst smokers.

The Faculty understands that premises will have to apply for exemption status. This could prove costly and difficult to enforce. Encompassing all licensed premises within smoke-free legislation would avoid this. There is also the argument that implementation of smoke-free legislation will lead to decreased profitability for the hospitality industry and a fall-off in trade. The consultation itself provides evidence that this would *not* be the case.

The proposals to create exemptions to smoke-free legislation will give rise to a two-tier system. Smoke-free legislation, implemented on one date, and encompassing all pubs, clubs and bars will set a level playing field for all – a view supported by the licensed trade. There are also concerns that exemptions to smoke-free legislation would lead to a more complex licensing system, potentially adding to ‘red tape’ and creating more difficulties, as well as increasing implementation and enforcement costs.

Exempting a category of workplaces from smoke-free legislation may be subject to legal challenge under the Health and Safety at Work act (1974). Employees suffering adverse health effects linked to secondhand smoke in the workplace could bring action for damages under the Act. The hospitality industry and trade associations should be aware of this potential cost to the industry. The Faculty also recognises that there are questions relating to employment law. The Faculty would refer government to organisations such as ASH and the Chartered Institute of Environmental Health on this issue.

The Government clearly acknowledges and understands the risk to health from secondhand smoke. The proposal to exempt certain licensed premises, therefore, appears contradictory and counterproductive to the ultimate aim of protecting and improving health.

Exceptions – Residential Premises

Question 6: Views are invited on the above list of exceptions especially in respect of human rights aspect.

The Faculty understands the need to exempt certain premises such as individual dwellings or private accommodation. However, it does not feel that this is primarily a question of human rights. With regards to an individual’s ‘right’ to smoke, the Faculty would argue that workers’ exposure to readily avoidable health and safety risks (such as those posed by secondhand smoke) is an infringement of their human rights.

The Faculty notes that both Scotland and the Republic of Ireland have included exemptions, such as those listed in this consultation, within their own smoke-free legislation. In its response to the consultation carried out in Scotland on smoke-free legislation, ASH Scotland¹² made a number of general recommendations with which the Faculty would generally agree:

“...That where an exemption is granted, the agreed upon definition of the premises and any associated conditions ensure that in practice, and from the outset, such premises emphasise smoke-free, with designated smoking areas [if unavoidable, for example in prisons or mental health hospitals or hospices. The Faculty would also suggest ensuring that designated smoking areas are situated away from areas where there is a risk of exposing others to secondhand smoke.]

“...That a general statement be included in the regulations, similar to that used in the Republic of Ireland legislation¹³ to the effect that: *An exemption does not constitute a right to smoke and employers are still bound by a duty of care to take every possible step to protect their employees.*

“Exempt premises should be strongly encouraged to develop, implement and review a best-practice based smoking policy in order to protect staff and non-smokers from the health hazards associated with [secondhand-smoke].” The Faculty also suggests that this should include the development of work-based smoking cessation policies to help and support smokers to quit.

ASH Scotland also recommends that the regulations should state that an employee should be allowed the right to request that they are not exposed to secondhand smoke in their working environment, and that their employer – as part of their duty of care – should accord them this right.

It is widely recognised that people in prisons and mental health institutions suffer a significantly higher proportion of health inequalities in comparison with the general population. Protecting prisoners and prison staff from secondhand smoke is as important as it is for other sections of society. Prisoner health is now under the remit of the Department of Health, and a key goal should be to reduce smoking rates as part of improving overall prisoner health. The Faculty recognises that this is a long term goal but government should begin work now to tackle this issue.

With regards to mental health and psychiatric hospitals, many people with severe mental illness do not receive adequate treatment for their physical health. Mortality from cancer and cardiovascular diseases is higher in people with severe and enduring mental illness than in the general population. Improving physical health of people with mental illness would also contribute to achieving the Government’s targets on inequalities in health. Smoking should not be viewed as part of the therapeutic process. Emphasis should be placed on ensuring that patients receive the best possible care for their physical health in addition to their mental health. The Faculty welcomes the work carried out by the former Health Development Agency and NHS Trusts on minimising exposure to secondhand smoke in psychiatric settings.

Establishments such as day-care centres, and educational and health establishments should be included within smoke-free legislation.

The list of exemptions also includes adult hospices. Whilst the Faculty recognises the difficulties around people living in other people’s workplaces, it seems unrealistic to expect most smokers who are hospice residents to give up smoking. However, the Faculty is aware of anecdotal examples of hospices which have specifically created a room for resident smokers which staff and guests (unless they specifically wish to) are prohibited from entering (unless for emergencies). This would seem a realistic and workable way forward in this instance.

It is not clear from the consultation what is meant by “vehicles used for work by one person”. The Faculty assumes this refers to single, continuous occupancy. However, works vehicles should come under workplace jurisdiction and therefore should be smoke-free.

With regards to oil and gas platforms, the Faculty recognises that they are also residential dwellings for those working on them. However, the emphasis should be on creating a smoke-free environment. There should be designated smoking areas which are away from areas where there is a risk of exposing others to secondhand smoke.

Exceptions – membership clubs

Question 7: Views are invited on the proposal.

The Faculty does not believe that exemption status should apply to membership clubs. Staff employed by such clubs that continue to allow smoking would be left at risk from secondhand smoke. Nor have any special recommendations been proposed for those exempted clubs which admit children – who are at particular risk from secondhand smoke.

See also response to Question 6, above.

Exceptions – practical implications

Question 8: Will the introduction of this legislation present any practical difficulties in your workplace?

The Faculty of Public Health already operates a smoke-free policy within and external to the building. This has not caused any problems for staff or visitors.

Signage

Question 9: Views are invited on this proposal.

The Faculty supports the proposals outlined in the consultation.

Offences and penalties

Question 10: Views are invited on the level of penalties and the general approach on the three types of offence...and whether there should be higher penalties for repeat offences.

Question 11: Views are invited on the defences set out here.

The fines imposed seem rather low in comparison to those proposed by the Scottish legislation. The Republic of Ireland also has very high penalties for those who fail to comply with the smoke-free legislation. The Faculty would support the imposing of similarly high penalties in England to ensure legislation is adhered to in order to protect the public and workers' health.

Clear lines of accountability are required. Who would be liable for a failure to properly implement smoke-free legislation within a premise – would it be a member of staff or the manager? Clear guidance is required – particularly for those officers who will be enforcing the legislation – on who has ultimate responsibility for the enforcement of smoke-free legislation, and displaying of appropriate signage, within a smoke-free premise.

Guidance should also cover penalties for persistent offenders. Would persistent offenders face prosecution and/or lose their license?

In its response to Question 1, the Faculty suggested the inclusion of the smoking of any substance in the definition of smoke or smoking, this should also be included within the offences and penalties section.

Enforcement

Question 12: Views are invited on the approach outlined above. Comments are particularly welcome on how resource-intensive enforcement authorities might expect the enforcement to be.

The Faculty supports the proposal that local authority Environmental Health Officers will have the main responsibility for enforcing smoke-free legislation. As highlighted in our response to Question 6, there are concerns that exemptions to smoke-free legislation would lead to a more costly and complex licensing system, potentially adding to 'red tape' and creating more difficulties. Implementing a two-tier system (ie. with exemptions and partial exemptions) would prove more expensive than a comprehensive system – something demonstrated by the consultation.

There are strong advantages for simultaneous implementation of smoke-free legislation in all workplaces. The Republic of Ireland has achieved a compliance rate of over 90% from the outset and levels of enforcement work is decreasing because of this. Scotland has also agreed a similar system for implementation. It is important that pre- and post-legislation surveillance and research programmes are put in place to assess the effectiveness of legislation. Both the Republic of Ireland and Scotland have established such programmes.

Smoking at the bar

Question 13: Views are invited on how best to regulate a no-smoking at the bar policy in exempted licensed premises.

The Government acknowledges in its consultation that prohibiting smoking at the bar in exempted premises provides no health benefits for anyone in the premises. Smoke drifts, making any attempts at segregation futile. Evidence has shown that ventilation systems, which are expensive to install, are difficult to maintain and have little effect in addressing the health effects of secondhand smoke through their failure to remove carcinogens and other pollutants present in smoke – providing no protection for workers or members of the public. The Faculty does not therefore see the benefits of including this and advise that the only adequate option to protect the health of employees and members of the public is to implement comprehensive smoke-free legislation, without exemptions such as pubs, bars and clubs.

Timetable

Question 14: Views are invited on the best time for the law to come into effect. Does the end of December provide any particular challenges or opportunities?

The Faculty believes that the timetable for implementation of smoke-free legislation is much too long. In Scotland, the timetable for implementation is approximately 18 months – with legislation coming into effect in March 2006. Implementing legislation in the spring – say spring 2007 (midway between general elections, thus allowing time to measure its impact) – would allow smokers time to get used to smoking outside (in better weather) before the onset of winter.

Simple, comprehensive legislation without exemptions would be easier to implement on one date and easier to enforce.

Unintended consequences for binge drinking

Question 15: Views are invited on the level of risk this policy may present to the drive to tackle binge-drinking and on how any such risk can be mitigated.

There is the danger that exempting pubs that do not serve prepared food could encourage pubs which previously served food to remove food to allow smoking to continue. This could lead to 'stand-up' binge-drinking, rather than consuming alcohol with food, and will undermine the Government's alcohol harm reduction strategy which has been developed to tackle the growing problem of binge-drinking and alcohol-related violence.

There may be increased pressure on local food outlets near licensed premises which stop selling food in order to qualify for exemption. This is an issue recognised by the Government's *Alcohol Harm Reduction Strategy for England* as a main area of focus due to the levels of alcohol-related violence which frequently occurs in and around these areas.¹⁰

General points

Question 16: It has been suggested that the proposal in the white paper detailed here will result in smoking pubs and clubs being concentrated in poorer communities. The consequence of this is that the health benefits in reduced exposure to secondhand smoke and in reducing smoking prevalence, will be less in these communities than in better off communities, thereby exacerbating health inequalities. Views and evidence on this are invited.

Exempted pubs and clubs would generally be concentrated in disadvantaged communities. For example, in the borough of Corby, where mortality rates are significantly higher than the national average, 85% of pubs and bars would be exempt under the Government's proposals.

It has also been mooted that a potential unintended consequence of the proposed legislation is a possible increase in people who used to smoke in establishments which become smoke-free, smoking more at home. However, this is not supported by the evidence. A recent report of the Royal College of Physicians highlighted that introducing smoke-free policies and workplaces not only helps people to stop smoking but also increases the number of smoke-free homes.¹⁴

The consultation has also demonstrated that implementing comprehensive smoke-free legislation (without exemptions) would result in a net benefit in the region of £1,344m to £1,754m per year, compared with £998m to £1,586m for the Government's proposed option of legislation with exemptions. The Faculty does not understand the rationale behind choosing an option which reduces the net benefits.

The Government, through its White Paper, *Choosing Health: Making Healthy Choices Easier*, has demonstrated a strong and clear commitment to improving public health and reducing health inequalities. Implementing comprehensive smoke-free legislation without exemptions would reinforce this commitment. It would also result in the reduction of the numbers of children and adults suffering preventable disease and even death as a consequence of inhaling secondhand smoke. It would be a major step in enabling people to make healthy choices more easily.

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