Government response to the House of Commons Health Committee's First Report of Session 2005-06: *Smoking in Public Places*

Cm 6769

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Government response to the House of Commons Health Committee's Report *Smoking in Public Places*

Introduction

1. The House of Commons Health Committee published its report *Smoking in Public Places* on 15 December 2005. This Command Paper sets out the Government's response to the recommendations in that report.

2. The medical and scientific evidence of the risks to health of smoking and of exposure to secondhand smoke is well established. Through the *Choosing Health* White Paper[1], the Government has set out a clear strategy to tackle smoking, as well as the effects of smoking on others. Smoking is known to be the principal cause of premature death in the United Kingdom.

3. One key aspect of the Government's strategy is to shift the balance significantly in favour of smoke-free enclosed public places and workplaces through legislation to reduce levels of exposure to secondhand smoke. Through the inclusion of smoke-free provisions in the Health Bill[2], which is currently being considered by Parliament, the Government has taken steps to ensure that workplaces and enclosed public places will become smoke-free.

4. The Government's objectives through smoke-free legislation are to:

    - reduce the risks to health from exposure to secondhand smoke
    - recognise a person's right to be protected from harm from secondhand smoke and to enjoy smoke-free air
    - increase the benefits of smoke-free enclosed public places and workplaces for people trying to give up smoking so that they can succeed in an environment where social pressures to smoke are reduced
    - save thousands of lives over the next decade by reducing both exposure to secondhand smoke and overall smoking rates

[1] Published by the Department of Health on the web at:
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor

[2] HL Bill 76 *Health Bill* (2006). TSO, London. Published on the web at:
www.publications.parliament.uk/pa/ld200506/ldbills/076/2006076.htm

Taking action on secondhand smoke-the situation in the United Kingdom and overseas

5. Smoking rates in England have fallen from 28 per cent in 1998 to 25 per cent in 2004, resulting in around 1.2 million fewer smokers. The Department of Health has a target to reduce this further to 21 per cent or less by 2010, and to reduce smoking among routine and manual groups to 26 per cent or less over the same time period—from the 2003 level of 32 per cent.

6. The Government aims to achieve reductions in smoking prevalence through an integrated combination of policies, which will help the 70 per cent of smokers who say they want to quit to be successful[3]. One important policy initiative has been to raise awareness of the health risks from secondhand smoke (for example, the smoking children *"if you smoke, I smoke"* media campaign, the more recent *"secondhand smoke is a killer"* campaign and new pack warnings including *"smoking seriously harms you and others around you"*). We have also encouraged public places and workplaces to become smoke-free voluntarily.

7. Through the provisions within the Health Bill, smoke-free enclosed public places and workplaces will become the norm. The vast majority of enclosed public places to which members of the public have access in the course of their daily work, business and leisure will be covered by smoke-free legislation, with the exception of some very specific places that will be exempted. In covering virtually all enclosed public places and workplaces, smoke-free legislation will cover trains, buses, taxis, shops, schools, healthcare facilities, sports centres, offices, factories, cinemas, pubs, restaurants and membership clubs. In addition to the protection from secondhand smoke that will be afforded through the provisions of the Health Bill, employers will continue to have a duty of care to protect the health, safety and welfare at work of all their employees under the Health and Safety at Work Act 1974[4].

8. Across the world, as the evidence of the risks associated with secondhand smoke exposure has accumulated, action has been taken to reduce people's exposure to secondhand smoke. Ireland introduced a ban on smoking in enclosed public places and workplaces in March 2004. In America, California has had a state-wide ban on smoking in public places since 1998, whilst New York passed smoke-free legislation in 2003. In total, nine US states have smoke-free legislation in place that provides for completely smoke-free restaurants and bars. These laws have proved effective in protecting people from secondhand smoke. The *Journal of the American Medical Association* documented a significant improvement in respiratory health among bartenders after the passage of the Californian smoke-free workplace legislation[5]. In New York, cotinine levels[6] in non-smoking bar and restaurant staff declined by 85 per cent[7]. Montana saw a

[3] Lader, D. and Goodard, E. (2004). *Smoking-related Behaviour and Attitudes, 2004*. Office for National Statistics, London.

[4] Further advice is available from the Health and Safety Executive on the web at: **www.hse.gov.uk/contact/faqs/smoking.htm**

[5] Eisner, M., Smith A. and Blanc P. (1998). "Bartenders' respiratory health after establishment of smoke-free bars and taverns" in *JAMA*, 1998:280, pp.1909-1914.

[6] Cotinine is a major metabolite of nicotine. Exposure to nicotine can be measured by analyzing the cotinine levels in the blood, saliva, or urine. Since nicotine is highly specific for tobacco smoke, serum cotinine levels track exposure to tobacco smoke and its toxic constituents. More information on cotinine is available on the web at: **www.cdc.gov/tobacco/research_data/environmental/factsheet_ets.htm**

[7] *The State of Smoke-Free New York City: A One-Year Review* (2004). NYC Department of Finance, NYC Department of Health and Mental hygiene, NYC Department of Small Business Services, NYC Economic Development Corporation, New York.

40 per cent drop in hospital admissions for heart attacks during a 6 month period of smoke-free workplaces[8]. In Ireland, almost total compliance with the ban has been reported, with surveys showing that 97 per cent of premises inspected are compliant in respect of the smoking prohibition, and 99 per cent of all smokers who visited a pub either smoke outside or do not smoke at all. In Ireland, almost one in five smokers chose not to smoke at all when out socialising[9].

9. Across Europe, there are moves towards smoke-free places, with complete bans in place in Norway and Ireland, and partial bans in Finland, Sweden, Slovenia, Austria, France, Spain and Italy. In the United Kingdom, all countries have committed to introduce Ireland-style legislative bans. Scotland's smoke-free legislation came into force on 26 March 2006.

10. In addition, parties to the World Health Organisation's Framework Convention on Tobacco Control (FCTC) are required to adopt and implement measures that provide for protection from secondhand smoke. The FCTC is the first global treaty on public health and as of February 2006 had been ratified by 124 countries, including the UK. The Convention, which came into force in February 2005, states in Article 8 that:

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

11. The FCTC is a major step forward in tackling smoking on a global level. During the first Conference of Parties[10] in February 2006, parties agreed to take forward work to develop international guidelines on protection from exposure to tobacco smoke.

The scientific evidence for taking action on secondhand smoke

12. The health risks from secondhand smoke were set out in the 1998 report of the Scientific Committee on Tobacco and Health (SCOTH)[11]. The report recommended restrictions on smoking in public places and workplaces to protect non-smokers and concluded that exposure to secondhand smoke was a cause of a range of medical conditions, including:

    - lung cancer
    - ischaemic heart disease
    - asthma attacks
    - childhood respiratory disease
    - sudden infant death syndrome

[8] Sargent, R. *et al* (2004)."Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study" in *BMJ*, 5 April 2004.

[9] Ireland Office of Tobacco Control (2004). *Smoke-Free Workplace Legislation Implementation Progress Report*, Dublin.

[10] Annual meeting of parties to the FCTC.

[11] Scientific Committee on Tobacco and Health (1998). *Report of the Scientific Committee on Tobacco and Health.* TSO, London.

13. In 2004, SCOTH published a second report on secondhand smoke[12], which reviewed the evidence that had become available since the publication of its first report in 1998. The Committee concluded in its 2004 report that the additional evidence reviewed reinforced the conclusions made by SCOTH in 1998 about the health risks associated with exposure to secondhand smoke. Furthermore, SCOTH highlighted the publication of new evidence since 1998 that makes an association between secondhand smoke and reduced lung function.

The benefits of smoke-free legislation

14. Smoke-free legislation will have significant benefits for public health. After Third Reading of the Health Bill in the House of Commons, the Chief Executive of Cancer Research UK, Professor Alex Markham, commended the smoke-free provisions in the Bill as "the most important advance in public health since Sir Richard Doll identified that smoking causes lung cancer fifty years ago"[13].

15. In terms of reducing levels of smoking, the benefit of moving from the present situation to completely smoke-free enclosed workplaces and public places is estimated at around a 1.7 percentage point fall in smoking prevalence, equivalent to approximately 600,000 fewer smokers in England. Overall, smoking is estimated to cost the NHS around £1.5bn a year, and a reduction in smoking rates will reduce that burden. A 1.7 percentage point reduction in the current smoking rate of 25 per cent would mean an estimated annual saving of £100m to the NHS[14].

16. Smoke-free legislation will lead to a number of additional health, economic and environmental benefits including:

    - reduced costs from sickness absence
    - greater efficiency through reduction in time lost by smoking breaks through the closure of smoking rooms, as evidence shows that smokers going outside to smoke take less work time than smokers going to smoking rooms[15]
    - safety benefits such as reduced fire risks[16]
    - reduced cleaning and maintenance costs[17]

[12] Scientific Committee on Tobacco and Health (2004). *Second hand smoke: Review of evidence since 1988.* TSO, London.

[13] Cancer Research UK press release *"Smokefree success! MPs vote for smokefree public places"* issued on 15 February 2006, available on the web at: **www.cancerresearchuk.org/news/pressreleases/smokefreesuccess_15feb06?version=1**

[14] Figures sourced from the *Partial regulatory impact assessment for smoke-free aspects of the Health Bill,* published by the Department of Health on the web at:
http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT_ID=4121917&chk=sUauD

[15] World Bank (1999). *Curbing the Epidemic: Governments and the Economics of Tobacco Control.* World Bank, Washington.

[16] Parrott S, Godfrey C and Raw M. (2000). "Costs of employee smoking in the workplace in Scotland" in *Tobacco Control* 9, pp.187-192.

[17] World Bank (2002). *Smoke-free workplaces*, published on the web at:
www1.worldbank.org/tobacco/AAG%20SmokeFree%20Workplaces.pdf

- increased well being for people suffering from conditions including asthma[18]
- reduced levels of death and disability among those smokers who quit as a result of action to make more places completely smoke-free

17. The Government is grateful to the Health Select Committee for its detailed consideration of the issues surrounding the introduction of smoke-free legislation, many of which are complex. The Government's response to the Health Select Committee's conclusions and recommendations are set out below.

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)

The Government agrees with the Health Select Committee's conclusion that there is a clear and extensive body of evidence that secondhand smoke exposure is hazardous, and is particularly concerned by the conclusions of the 2004 report of the Scientific Committee on Tobacco and Health (SCOTH) that secondhand smoke exposure is a cause of:

- lung cancer
- ischaemic heart disease
- asthma attacks
- childhood respiratory disease
- sudden infant death syndrome

The Government has also noted the classification of secondhand smoke by the World Health Organisation's International Agency on Research into Cancer (IARC) in 2002 as a known human carcinogen.

We would also draw attention to the statement in Article 8 of the World Health Organisation's (WHO) Framework Convention on Tobacco Control (FCTC), unanimously supported by the World Health Assembly of the WHO, that:

> *"Parties recognise that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability".*

Recognising the evidence on secondhand smoke the Government undertook, as a manifesto commitment, to bring forward legislation to protect people from the harmful effects of secondhand smoke. This commitment has been turned into reality very quickly with inclusion of smoke-free provisions within the Health Bill, which is currently before Parliament. Smoke-free legislation will protect people in virtually all enclosed public places and workplaces (apart from some very specific exemptions) from exposure to the hazards of secondhand smoke.

[18] Asthma UK report that there are 5.1 million people in UK with asthma and cigarette smoke is the second most common asthma trigger in the workplace. They found that "20 per cent of people with asthma feel excluded from parts of their workplace because other people smoke there. This inhibits their daily life as well as opportunities for promotion and development". Further details are available on the web at: **www.asthma.org.uk/news_media/news/smoking_in.html**

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 contaminates. Ventilation offers cosmetic improvements but does not represent a sufficient response to the health and safety risks inherent in SHS. (Paragraph 33)

The Government recognises the lack of evidence that ventilation provides a real solution to the health risks associated with secondhand smoke. Any requirement for the installation of ventilation would be significantly costly and, considering the lack of effectiveness, an unjustifiable burden for business.

For these reasons, the Government does not consider ventilation to provide an effective solution to the problem of secondhand smoke, and ventilation requirements have not been included as part of the Health Bill.

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)

The Government agrees with the Health Select Committee that the only genuine solution to the problem of secondhand smoke exposure is to ensure that enclosed and substantially enclosed public places and workplaces become smoke-free. This solution is also the one clearly favoured by the House of Commons, given the amendments made to the Health Bill during Report Stage.

It is important to also recognise that over 95 per cent of deaths associated with secondhand smoke are estimated to be due to exposure in the home. The Government is continuing to work to ensure that people are aware of the risks associated with secondhand smoke, especially to children.

In developing legislation to shift the balance towards smoke-free public places and workplaces, the Government closely examined similar arrangements in places across the world. The experience of implementing smoke-free legislation in the Republic of Ireland is particularly encouraging, given the high levels of public support for smoke-free public places and workplaces, and the self-enforcing nature of the legislation.

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)

The smoke-free provisions in the Health Bill, as amended at Report Stage of the Bill in the House of Commons, will afford virtually all employees protection from secondhand smoke. As all enclosed and substantially enclosed public places (apart from some limited exemptions) will become smoke-free, the benefits of this legislation will extend to everyone.

We would argue that international experience has shown that comprehensive smoking bans have very little demonstrable impact in economic terms on the hospitality industry. The Government has carefully evaluated this international evidence and has every reason to expect that a similar pattern will emerge in England once smoke-free legislation has been implemented. Indeed, some argue that more people might be encouraged into venues such as pubs, clubs and restaurants if they are smoke-free.

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)

In developing proposals as part of the *Choosing Health* White Paper, the Government did take prevailing public attitudes and a wide range of opinion polls into account.

The Health Select Committee's report draws attention to one poll commissioned by the King's Fund and conducted by Opinion Leader Research (OLR). This poll, however, looked only at whether a ban on smoking might be an effective way of reducing smoking prevalence. Proposals in *Choosing Health* on secondhand smoke were based on a wider assessment than just the aforementioned OLR research. *Choosing Health? A consultation on action to improve people's health: Consultation analysis final report*[19], published by the Department in March 2005, refers to some seven different opinion polls and surveys run between October 2003 and October 2004, which looked at specific questions regarding preferences around the development of smoke-free policies. The consideration of the outcomes of all of these polls informed the judgements on public attitudes in the development of proposals on smoke-free policies in *Choosing Health*.

[19] Published by the Department of Health on the web at:
http://www.dh.gov.uk/Consultations/ResponsesToConsultations/ResponsesToConsultationsDocumentSummary/fs/en?CONTENT_ID=4106017&chk=utuMSG

The Government recognises that public support for smoke-free legislation has strengthened rapidly, especially since the publication of the *Choosing Health* White Paper in 2004. However, even in July 2005, the Royal College of Physicians acknowledged in their report *Going Smokefree*[20] that *"the only public places for which less than half the population supported smoke-free legislation were pubs, bars and nightclubs"*.

Further evidence of quickly shifting public opinion on smoke-free enclosed public places and workplaces came through the publication of an opinion poll conducted over the period 2-7 December 2005 by polling firm YouGov[21]. The poll asked respondents the following question: *"The Government has announced plans to make most public places smoke-free. Would you support a proposal to make ALL workplaces, including all pubs and all restaurants smoke-free?"*. Table one details the results of the poll.

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

Table one: "The Government has announced plans to make most public places smoke-free. Would you support a proposal to make ALL workplaces, including all pubs and all restaurants smoke-free?" Results of YouGov poll conducted over the period 2-7 December 2005

This strengthening public support was one of the reasons why the Government facilitated a free vote during Report Stage of the Health Bill in the House of Commons on the extent of exemptions from smoke-free legislation.

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)

The Health Bill, as amended during Report Stage in the House of Commons, removes the ability for exemptions to be made for any licensed premises or clubs[22]. Therefore, it is likely that this recommendation is no longer applicable.

[20] Royal College of Physicians of London (2005). *Going Smoke-free: The medical case for clean air in the home, at work and in public places,* RCP Publications, London.

[21] The opinion poll was commissioned by Cancer Research UK and the public health charity Action on Smoking and Health (ASH). Interviews were conducted by YouGov using an internet panel survey with residents in England, Scotland, Wales and Northern Ireland aged 18 years and over. Sample sizes: England 1,995, Scotland 565, Wales 563, N Ireland 477: Total 3,600. Further details are available on the web at: **www.ash.org.uk**

[22] Apart from any area within a licensed premises of membership club where a person has his or her home, or is living whether permanently or temporarily.

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)

Through convention, legislation is not usually binding on Crown land. The Health Bill is no exception. No specific reference was therefore made since this legislation followed this usual convention.

While Crown Immunity does remove the requirement for specific premises to be exempted from smoke-free legislation, it is important that plans are in place for such places to become smoke-free, keeping in the spirit of the legislation. Strategies are in place which will see all central government and NHS buildings[23] in England become totally smoke-free by the end of 2006. Specific issues surrounding prisons, mental health units and the Armed Forces are discussed below.

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 or 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)

[23] With the exception of mental health units. Specific arrangements for mental health units will be announced shortly.

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)

(Taking into account recommendations 8, 9 and 10)

The Government is acutely aware of the need to strike a balance between the rights of prisoners to smoke and the rights of non-smoking prisoners and the people for whom a prison is their workplace to be protected from secondhand smoke.

The Home Office and Department of Health have created a Steering Group on the Restriction of Smoking in Prisons to consider the issues concerning smoking within prisons, and to advise Ministers on the implications of the Health Bill, including the protection of members of staff and other inmates from secondhand smoke. The steering group has membership that encompasses the wide range of stakeholders in this area, including representatives from staff associations.

As the Health Select Committee noted, there are already initiatives underway in prisons across England to encourage prisoners to stop smoking. The Government takes supporting prisoners to quit smoking seriously. Following a successful pilot in 2001-02, the Government has invested £1.5 million over three years in smoking cessation programmes for prisoners. Such initiatives are important given that it is estimated that up to 80 per cent of prisoners smoke, and quit rates amongst prisoners are proving to be as good as or better than those in the wider community.

On the issue of smoking in Young Offenders' Institutions, the Government has noted the Health Select Committee's recommendation but will await advice from the Steering Group on the Restriction of Smoking in Prisons on how smoke-free arrangements could be implemented. Some Young Offenders' Institutions, including Wetherby and Ashfield, are already smoke-free.

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)

The Government has made it clear that there is no intention to prevent individuals smoking in premises, or areas of premises, that are considered to be private residential space.

The issue of smoking in psychiatric institutions is complex and is a matter that is currently under consideration. The Government is considering evidence and recommendations from a range of sources, including the Health Select Committee, before any final decisions are made.

A balance needs to be found between allowing people to smoke in their own residential spaces, and protecting others from secondhand smoke exposure, including the other people who call the premises home and the people who work there. If smoking is to be permitted in psychiatric institutions, or indeed in any other premises where people are living either permanently or temporarily, such as prisons or adult care homes, suitable arrangements will need to be found to provide adequate protection from exposure to secondhand smoke. Persons living in such places should be encouraged, wherever possible, to smoke outdoors, and the Government would encourage such premises to make outdoor spaces available.

We agree that people working in places that are also the residential space of someone else should be required to smoke outdoors. For example, if designated smoking rooms are to be allowed in psychiatric institutions they should not be for use by members of staff.

The Government is committed to reducing smoking prevalence and has set ambitious reduction targets as part of the Department of Health's Public Service Agreement. The Government will continue to encourage people in all communities to quit smoking and would encourage efforts within psychiatric units to reduce levels of smoking amongst patients.

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)

(Taking into account recommendations 12 and 13)

The Ministry of Defence, in consultation with the Department of Health, is currently considering the detailed policy issues concerning the implementation of smoke-free arrangements amongst the Armed Forces. The Ministry of Defence recognises the need to replicate, as far as reasonably practicable in a service context, the principles of smoke-free legislation contained within the Health Bill.

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)

The Government believes that adult hospices fall within the category of premises that act both as residential space and a workplace. The issue of smoking in adult hospices is controversial, and, like psychiatric institutions, the Government is listening to a range of views on the matter. At present, we remain of the view that an exemption from smoke-free legislation for adult hospices is appropriate, which is the approach taken within smoke-free legislation in Ireland and Scotland.

Draft regulations on premises to be exempted from smoke-free legislation will be published and will be subject to public consultation. Regulations will then require Parliamentary approval through the affirmative procedure.

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)

The Government recognises the guidance the Royal College of Nursing provides to their members regarding visiting the homes of people who smoke, and would encourage employers to ensure that, when applicable, employees have the right to refuse to enter the home, or a particular room, of a person who is smoking. However, it is important that this should not be to the detriment of the clinical care a patient should receive. The Department of Health will look to develop guidance in this area, with the input of stakeholders, before smoke-free legislation is implemented.

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)

(Taking into account recommendations 16 and 17)

Amendments made to the Health Bill at Report Stage of the Bill in the House of Commons demonstrate an agreement with the principle of this recommendation amongst MPs. Without pre-empting the outcome of consideration of the Health Bill in the House of Lords, the Government has begun to prepare arrangements to implement smoke-free legislation that will not provide any exemption for venues that operate under a premises license or a club premises certificate.

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)

(Taking into account recommendations 18, 19 and 20)

This Government has done more than any other to protect people from the harmful effects of tobacco, and the United Kingdom is internationally recognised as being at the forefront of smoking prevention and tobacco control. The publication of the *Smoking Kills* White Paper[24] in 1998, and the *Choosing Health* White Paper in 2004, is evidence of this Government's commitment to reduce the impacts on health of smoking, to reduce number of people who die each year from smoking-related illnesses and to tackle the health-inequalities that are inextricably associated with smoking.

The Government agrees with the Health Select Committee's conclusion of the components necessary to achieve widespread compliance with smoke-free legislation. We believe that these components are in place.

The Government is committed to delivering smoke-free legislation. Public support for smoke-free public places and workplaces is higher than it is has ever been and regulations that will be made under the provisions in the Health Bill will be the subject of widespread consultation and stakeholder input to ensure clarity and simplicity. We believe the revised framework of penalties relating to offences within the Health Bill, announced by the Government during Report stage in the House of Commons, are appropriate and proportionate, and will encourage compliance. Nevertheless, the Government would prefer smoke-free provisions in the Health Bill to be self-regulating, and expects, through the delivery of sensible and easily enforceable legislation, this will be the case.

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[24] Published by the Department of Health on the web at:
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