Health and Public Services Committee

Towards a smoke free London

Response to smokefree elements of the Health Improvement and Protection Bill

September 2005

The Health and Public Services Committee Membership & Terms of Reference

The membership and terms of reference for the Committee were agreed at the meeting of the Assembly on 11 May 2005. Geoff Pope replaced the original Liberal Democrat Member from 15 June 2005.

Joanne McCartney **Chair**	Labour
Elizabeth Howlett **Deputy Chair**	Conservative
Angie Bray	Conservative
Jennette Arnold	Labour
Geoff Pope	Liberal Democrat
Darren Johnson	Green

Terms of Reference

1. To examine and report from time to time on -
    - the strategies, policies and actions of the Mayor and the Functional Bodies
    - matters of importance to Greater London as they relate to the promotion of health in London and the provision of services to the public (other than those falling within the remit of other committees of the Assembly) and the performance of utilities in London.
2. To liaise, as appropriate, with the London Health Commission when considering its scrutiny programme.
3. To consider health matters on request from another standing committee and report its opinion to that standing committee.
4. To take into account in its deliberations the cross cutting themes of: the achievement of sustainable development in the United Kingdom; and the promotion of opportunity.
5. To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

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Comments on the findings and recommendations of this report are welcomed. Any comments will be considered as part of the review and evaluation of the work on this issue.

1. Introduction

1.1 The London Assembly Health and Public Services Committee welcomed the opportunity to respond to the government consultation on the Smokefree elements of the Health Improvement and Protection Bill. It is clear that much thought and effort has gone into developing the proposals since the White Paper *Smoking Kills* was first published in 1998. We were pleased to see the developing health improvement measures, and more particularly the commitment to protect individuals from the health risks of exposure to second-hand tobacco smoke. The substance of this report was submitted as a response to the government consultation in September 2005.

1.2 The Greater London Authority has a statutory role to improve the health of Londoners and it is within this context that the response was submitted. The London Assembly's cross-party Health and Public Services Committee, is responsible for investigating health related issues and responding to consultations on the same, on its behalf. The promotion of health is also one of three cross-cutting themes embedded in the Assembly's work.

Assembly work on smoking in public places

1.3 The debate on the right to smoke in enclosed public places has intensified over recent years. As a result, a range of legislative measures has been, or are in the process of being implemented in countries across the world, including Ireland, Holland, Norway and the United States, to mention a few.

1.4 In July 2001, the Assembly established a cross-party Smoking in Public Places Investigative Committee, which Jennette Arnold chaired, to examine existing scientific work on the damage to health from passive smoking and to review the existing regulations relating to smoking in public places. Our report published in March 2002, makes a series of recommendations on policy approaches towards achieving smokefree public places, educating and informing the public to the dangers of passive smoking, and the need for more research on passive smoking and its effects.[1]

1.5 The Assembly published an interim report in October 2003[2], and since November 2004 Jennette Arnold continued to investigate issues, and follow developments on smoking in public places as rapporteur on behalf of the Health and Public Services Committee. Our work has focused on establishing an overview of the varying approaches to implementing smokefree legislation in different cities across Europe, and also on developing an understanding of the implications for London in the wake of similar legislation.

1.6 Jennette Arnold visited the cities of Dublin[3] and Liverpool[4], carried out desk based research on developments in other cities and countries such as New York

[1] Scrutiny of Smoking in Public Places in London, London Assembly, March 2002. Available at: www.london.gov.uk/assembly/reports/health/smoking_report.pdf
[2] Available at: www.london.gov.uk/assembly/past_ctees/health/2003/healthoct14/healthoct14item05.pdf
[3] Dublin's Smoke Free Pubs, London Assembly, March 2005. Available at: www.london.gov.uk/assembly/reports/health/smoking_public.pdf

and Norway, engaged with one on one discussions with a variety of stakeholders across London, and commissioned a survey seeking the views of a random selection of London pub landlords on the government's proposals. The full results of this survey are at Annex C, however, the following section provides a brief overview of the findings.

1.7 We are grateful to the various stakeholders that have taken the time to engage in this very important debate and share invaluable information, which has helped to inform this response.

Telephone survey of London Public Houses

1.8 One hundred public house landlords were surveyed, two-thirds from chain pubs and a third from independent pubs in all but one of the London boroughs. There was a fairly even split of respondents from inner London boroughs – 53 per cent, and outer London boroughs– 47 per cent. The results showed that a higher proportion of independent pubs allowed smoking throughout compared with pubs that are part of a chain. Pubs that prepared and served food were less likely to allow smoking throughout, and sixty-two per cent of the respondents agreed that the availability of food did help to prevent drunkenness and disorder.

1.9 There was some concern about the effect the legislation would have on trade. Seventy per cent of the respondents were concerned that they would see a decrease in trade. But as we show in paragraphs 3.32 – 3.36 of this response, similar concerns were expressed, by the trade in Ireland and Norway. The emerging statistics show that negative economic impact has been relatively minor.

1.10 Seventy-eight per cent of respondents agreed that a ban on smoking where food is on sale would prompt people to move to pubs where smoking is allowed. And twenty-eight per cent of those who currently serve food said that a partial ban as proposed in Option 4 would affect their policy on serving food.

The consultation options

1.11 The consultation document on the Smokefree elements of the Health Improvement and Protection Bill identifies four possible approaches to the smokefree legislation, and sets out the pros and cons of each. They are:

- **Option 1**, Continue with a voluntary approach
- **Option 2**, National legislation to make all indoor public places and workplaces completely smoke-free (without exemptions)
- **Option 3,** Legislation giving local authorities new powers to control second-hand smoke in indoor public places and workplaces
- **Option 4**, National legislation to make all indoor public places and workplaces completely smoke-free (with exemptions)

[4] Report to the Health and Public Services Committee, April 2005. Available at www.london.gov.uk/assembly/health_ps/2005/healthpsapr19/healthpsapr19item07.pdf

1.12 The consultation document also invites comments on proposed definitions and range of exemptions to be included as part of the fourth option. It is clear from reading the document that Option 4 is the preferred choice. However, the complications and inconsistencies that are likely to arise, in terms of interpreting the nuances of the definitions within the legislation and enforcing them is likely to render this option impracticable to implement or administer; more detailed comments on this are provided later on in this response. We are also concerned that legislative measures under Option 4 will leave a proportion of workers unprotected from the dangers of second-hand smoke. To do so is to work against the whole concept of health equalities.

1.13 In line with the British Medical Association, the Royal College of Nursing,[5] ASH - Action on Smoking and Health,[6] the TUC,[7] the Chartered Institute of Environmental Health,[8] and other organisations researching and campaigning on this issue, we believe that smokefree legislation without exemptions, the second option, paves the way for a more workable and practical solution. It presents a level playing field for all, in terms of understanding, interpreting and enforcing the legislation. Most importantly it will ensure that all workers are free to work in completely smoke-free work environments.

1.14 The statements and supporting evidence set out in the remainder of this report seek to emphasise the practicality and achievability of Option 2, national legislation on banning smoking in all indoor public places and workplaces.

Structure of the response

1.15 The remainder of this document:

- Outlines the key points of our response,
- Provides specific comments on the key areas noted in the consultation document, (with the exception of definition of 'prepare and serve food', and signage –comments on these key areas can be found in Annex C), and
- Makes concluding comments on the proposal.

2. Key points

- Option 2 paves the way for a more workable and practical solution. It presents a level playing field for all, in terms of understanding, interpreting and enforcing the legislation. Most importantly it will ensure that all workers are free to work in completely smokefree work environments.
- The proposed definition of smoke or smoking should not be restricted to tobacco substance or mixture. Consideration needs to be given to how

[5] BMA Press release dated 2 March 2005. Available at www.bma.org.uk
[6] See www.ash.org.uk/
[7] TUC Press release dated 24 June 2005. Available at www.tuc.org.uk
[8] Chartered Institute of Environmental Health response to the consultation on the smoke free elements of the Health Improvement and Protection Bill, dated September 2005. Available at: www.cieh.org/

other harmful substances can be included in the definition. **A proposed alternative would be to define the activity, that is the act of smoking, as opposed to the nature of the substance.**

- **Further clarity is needed on the proposed definition for substantially enclosed places.** The legislation aims to be self-policing. It is therefore important for owners of premises, enforcement authorities and the general public to have a clear understanding of what constitutes a substantially enclosed place.
- Longer lead-in time for licensed premises will mean that some workers will continue to be exposed, unfairly, to the harmful effects of second-hand smoke.
- The general approach on the three types of offence seems reasonable. But more consideration needs to be given to the level of penalties - whether they are sufficiently high enough to act as a deterrent and to encourage enforcement, particularly given the high court costs that are likely to be incurred. **We would recommend increased penalty levels in general and higher penalties and/or loss of licences for persistent offenders.**
- Defendants should be required to provide more robust evidence of due diligence, for example, providing clear written records of when, and how often they approach the person suspected of smoking tobacco.
- Irrespective of the group or groups of enforcement officers responsible for enforcement there will be additional demand on resources, in terms of time, personnel and money. **Arguably, this extra demand can be considerably reduced if Option 2 is adopted.**
- Based on the experience in Ireland, there is no reason why a universal approach to timing cannot be adopted. **We would suggest that the legislation is implemented by spring/summer of 2007, to possibly coincide with National No Smoking Day.**
- **A national approach to advertising, educating and informing the public is necessary to aid any further shift in culture that may be needed.** There may also be scope for regional governments to build on national campaigns to encourage local participation.
- **A wholesale approach to completely smoke-free legislation is vital and can only be fully effective if implemented at national level.**
- **The impact of the partial smokefree legislation would work against the stated Government objective of reducing health inequalities due to smoking.**

3. Responses to key areas of the consultation document

Proposed definition of smoke or smoking

3.1 The proposed definition refers to smoke as 'smoke tobacco or any substance or mixture which includes it'.[9]

3.2 The exclusion of non-tobacco cigarettes from the proposed definition is problematic. Enforcement personnel will be placed in the difficult position of issuing Fixed Penalty Notices, based on instantaneous judgement calls, without the benefit of expert analysis, which may subsequently show that the seized substance does not contain tobacco.

3.3 There are also concerns that herbal cigarettes contain tar (estimated between 3-7 mg), and produce levels of carbon monoxide similar to tobacco cigarettes and have undesirable health consequences.[10]

3.4 The proposed definition of smoke or smoking should not be restricted to tobacco substance or mixture. Consideration needs to be given to how other harmful substances can be included in the definition. **A proposed alternative would be to define the activity, that is the act of smoking, as opposed to the nature of the substance.**

Smokefree enclosed public places and workplaces

3.5 Experts within the industry have argued that ventilation and air-cleaning equipment can provide effective protection against second-hand smoke.[11] However, we spoke to a number of people, who argued that manufacturers of ventilation equipment could not guarantee that their equipment would eradicate all the noxious chemicals produced by cigarette smoke. This has been confirmed by a number of scientific studies[12] The Irish Government considered but swiftly abandoned proposals from the trade to bring in ventilation equipment as a halfway measure.[13]

3.6 The National Assembly for Wales' Committee on Smoking in Public Places did not accept ventilation as an effective or feasible solution. It concluded that ventilation could not remove all harmful tobacco substances from the atmosphere, and that for equipment to operate at the levels of effectiveness for

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[9] Department of Health Consultation on the smokefree elements of the Health Improvement and Protection Bill, June 2005, p5. Available at

[10] SmokeFree London Forum consultation response, August 2005. Available at

[11] Paragraph 3.24 Committee on Smoking in Public Places Report, May 2005. Available at: www.wales.gov.uk

[12] De Gids, W.F. & Opperhuizen, A. (2004). Reduction of exposure to environmental tobacco smoke in the hospitality industry by ventilation and air cleaning. RIVM report 340450001
Kotzias, D., Geiss, O., Leva, P., Bellintani, A. Arvanitis, A. & Kephalopoulos, S. (2005). Ventilation as a means of controlling exposure of workers to environmental tobacco smoke (ETS). www.smokefreeeurope.com/assets/downloads/dimitrios_kotzias.doc

[13] London Assembly report: Dublin's Smoke Free Pubs – A Rapporteur visit to Dublin, March 2005. Available at www.london.gov.uk/assembly/reports/health.jsp

which it was designed, it would need to be properly used and maintained; it would be both costly and difficult to do to enforce.[14]

Definition of enclosed

3.7 The consultation document defines a fully enclosed placed where it is completely enclosed on all sides by solid floor-to ceiling walls, windows, or solid floor-to-ceiling partitions. This definition is quite clear. Less clear is the definition of a substantially enclosed place. A place is said to be substantially enclosed where it is at least partially covered by a roof and has walls, and both surfaces make up more than 70 per cent of the total notional roof and wall area. The proposed total notional roof and wall area will be equivalent to the total area of the wall surfaces if the walls were continuous.

3.8 **Further clarity is needed on the proposed definition for substantially enclosed places.** The legislation aims to be self-policing. It is therefore important for the owners of premises, enforcement authorities and the general public to have a clear understanding of what constitutes a substantially enclosed place. Lack of clarity will undermine public perception and create opportunities for loopholes. Simplicity, clarity and transparency in legislation, is what is needed.

Exceptions

Licensed premises

3.9 Longer lead-in time for licensed premises will mean that some workers will continue to be exposed, unfairly, to the harmful effects of second-hand smoke (SHS). A key finding from the Dublin visit was that the Irish Government kept the focus of the debate around the proposals on eradicating the harmful effects of SHS, and on it being a public health issue aimed at protecting workers. Pubs were viewed first and foremost as places of work. The Government reasoned that if bank workers and hairdressers were protected by law then pub and bar workers should enjoy the same protection.[15]

3.10 It is also difficult to see what added benefit a longer lead-in time would bring. On 1 June 2004, Norway introduced smoke-free bars and restaurants. The evaluation report published one year on confirms that 90 per cent of employees reported a high degree of compliance under a comprehensive ban compared to 51 per cent when there were designated smoking areas.[16]

3.11 The Irish Government rejected the argument that segregated areas in pubs and bars could be kept as smoking areas. They argued that staff remain at risk, unless working places are completely smoke free.[17]

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[14] Paragraph 3.28 Committee on Smoking in Public Places Report, May 2005. Available at: www.wales.gov.uk

[15] For more details read the London Assembly report: Dublin's Smoke Free Pubs – A Rapporteur visit to Dublin, March 2005. Available at www.london.gov.uk/assembly/reports/health.jsp

[16] P6, Smoke-Free bars and restaurants in Norway. Available at: www.globalink.org/documents/2005smokefreebarsandrestaurantsinNorway.pdf, www.ashscotland.org.uk

[17] London Assembly report: Dublin's Smoke Free Pubs – A Rapporteur visit to Dublin, March 2005. Available at http://www.london.gov.uk/assembly/reports/health.jsp

Psychiatric hospitals and units/Residential care homes

3.12 The proposals to exempt psychiatric hospitals and units, and residential care homes from the smoke-free legislationshould be reconsidered. The physical needs and well-being of mental health patients and those in long-stay adult residential care homes should not be overlooked in this debate. The need for protection from the dangers of second-hand smoke and the provision of appropriate support mechanisms to remove tobacco addiction/dependency is as equally applicable to these individuals, as it is to any other members of the general public.

3.13 While it has been argued that smoking occupies a unique place in the culture of psychiatric care, there is little evidence that smoking cessation intervention, or smoking abstinence, has any negative effects on the psychological well-being of people with mental health problems. On the contrary there is evidence to suggest that smoking cessation interventions can be effective among people with mental health problems.[18] What is required, is changed practice by professionals with responsibility for the care of these individuals. However, we are mindful that careful consideration will need to be given to how to manage tobacco addiction/dependency for these groups.

Offences and penalties

3.14 Comments are invited on the level of penalties, the general approach on the three types of offence, and whether there should be higher penalties for repeat offences. The general approach on the three types of offence seems reasonable. But more consideration needs to be given to the level of penalties, - whether they are sufficiently high enough to act as a deterrent and encourage enforcement, given the high court costs that are likely to be incurred.

3.15 The proposed maximum penalty level of £200 seems rather low. Particularly when compared with the maximum level of £2,500 announced to the Scottish Parliament in November 2004,[19] the 3,000 euro or £2,100 fine in Ireland,[20] and the penalty levels set in New York.

3.16 In New York, employers found violating the law are liable for fines and penalties that increase with the number of violations. First violation fines range from $200 - $400 or £280 - £560. Second violation fines (within 12 months of the first) range from $500 - $1,000 or £280 - £560. Third or subsequent violation fines range from $1000 - $2,000 or £560 - £1,120. In addition permits may be revoked if the law is violated three times during a 12 month period.[21] **We would recommend increased penalty levels in general and higher penalties and/or loss of licences for persistent offenders.**

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[18] Information taken from Presentation to the Tobacco Control Conference 11 – 12 July 2005, by Wandsworth NHS Teaching Primary Care Trust – Challenges in Mental Health

[19] First Minister's speech, 10 November 2004. Available at: news.bbc.co.uk/1/hi/scotland/4000283.stm

[20] Daily Telegraph/Independent, 29 March 2004. Available at:

[21] New York: Smoke-free City A Case study for SmokeFree Liverpool by Jon Dawson Associates. Available at: smokefree.ash.positive-dedicated.net/images/pdfs/new_york_case_study%20Smokefree%20Liverpool.pdf

Defences

3.17 A defendant is required to produce evidence that he or she was not aware, could not reasonably be aware or had requested the an individual to stop smoking and informed them that they were committing an offence. This approach relies on a presumption of lack of knowledge. **Defendants should be required to provide more robust evidence of due diligence, for example, providing clear written records of when and how often an individual suspected of smoking is approached.**

Enforcement

3.18 The evidence suggests that legislation for smokefree public places and workplaces, without exemptions – Option 2 - is easier to apply. The one-year on report published by Norway said that a total ban seemed easier to enforce and comply with compared to the earlier smokefree zones legislation"[22] In Ireland compliance with the smokefree workplace legislation is high. Ninety-four per cent of all workplaces inspected by the Irish Office of Tobacco Control were smoke-free. Ninety-six per cent of people feel the smoke-free law is a success.[23]

3.19 It is proposed that Local Authority enforcement officers will be responsible for enforcement. We are told that the responsibility split between the various groups, for example food safety officers, trading standard officers, technical officers and environmental officers will depend on how the local authorities are structured when the proposed legislation comes into effect. We have been informed that on a practical level, much of the responsibility will fall to environmental officers and trading standards officers. These officers will be required to incorporate the additional requirements of this legislation alongside already challenging workloads.

3.20 **Irrespective of the group or groups of enforcement officers responsible for enforcement, there will be additional demand on resources, in terms of time, personnel and money. Arguably, this extra demand will be considerably reduced if Option 2 is adopted.** The Health and Safety Commission recently expressed a similar view, arguing that a simpler regime, with fewer and less complex exemptions, will aid enforcement by Local Authorities.[24]

Smoking at the bar

3.21 Views were invited on how best to regulate a 'no-smoking at the bar policy' in exempted licensed premises; this would apply if Option 4 is adopted. The suggestions are to define bar areas and to stipulate the distance, for example one metre from the bar. Such restrictions would not protect bar workers because tobacco smoke is not static and will drift to the bar even if it is smoked one metre away.It will also be difficult for enforcement officers to provide 'hard' evidence of non-compliance.

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[22] p 24, Smoke-Free bars and restaurants in Norway. Available at: www.globalink.org/documents/2005smokefreebarsandrestaurantsinNorway.pdf

[23] Office of Tobacco Control, Smoke-Free Workplaces in Ireland A One-Year Review. Available at: www.otc.ie

[24] ASH Press release, 1August 2005. Available at: www.ash.org.uk

Timetable

3.22 The consultation document proposes three stages to implementing the legislation. By the end of 2006, all central government departments and the NHS will be smoke-free. Enclosed public places and workplaces, except licensed premises will be smokefree by the end of 2007. The arrangements for licensed premises will be in place by the end of 2008. In paragraph 3.9 above, we have already given reasons why additional lead-in time for licensed premises is unnecessary.

3.23 Based on the experience in Ireland, there is no reason why a universal approach to timing cannot be adopted. We would suggest that the legislation is implemented by spring/summer of 2007. It may even be possible to coincide implementation with National No Smoking Day.

3.24 However there are key lessons to be learned from the Irish experience. Emphasis needs to be placed on education and transition, so that the public is clear about the intended purpose and requirements of the legislation. This can be achieved by ensuring that:

- Employers, unions and the public are given sufficient time to adjust to the smoke-free legislation, and
- A clearly-focussed education and information campaign is undertaken to help build and maintain support for the measure.[25]

3.25 In Dublin, there was a lead-in period of 12 months with concerted campaigns of advertising and education. The one-year on review published earlier this year confirmed a high compliance rate, 94 per cent, and widespread support from employers, managers, proprietors, employees and the smoking and non-smoking."[26]

3.26 A national approach to advertising, educating and informing the public is necessary to aid any further shift in culture that may needed. There may also be scope for regional governments to build on national campaigns to encourage local participation. Implementing the legislation in 2007, allows a reasonable amount of time, some 12 to 15 months to raise public awareness and ensure that appropriate support and information mechanisms are put in place.

Unintended consequences for binge-drinking

3.27 The *Choosing Health* White Paper states that the '…profitability of providing food will be sufficient to outweigh any perverse incentive for pub owners to choose to switch.' That is to stop serving food instead of imposing a smoking ban. 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.

3.28 In the survey we commissioned respondents were asked how much they agreed or disagreed that the availability of food helped to prevent drunkenness and disorder in pubs and bars. Sixty-two per cent agreed that the availability of

[25] Lessons learned from Ireland's smoke-free law – the case for similar UK-wide legislation. Available at: www.ash.org.uk

[26] Office of Tobacco Control, Smoke-free Workplaces in Ireland A One-Year Review, p5

food did help prevent drunkenness and disorder, while 27 per cent disagreed. It is not clear that the profitability of providing food will prevent publicans deciding to switch. Our survey showed that if Option 4 were to be implemented, some publicans would be likely to change their policy on serving food in order to allow smoking to continue.[27]

Health inequalities

3.29 In November 2004 when the Government launched the White Paper on Public Health, the then Secretary of State for Health, John Reid, claimed that only between 10 to 30% of pubs fell into the category of not serving prepared food. Results from the BMA survey, *Booze, fags and food*,[28] challenge these figures, showing clear divisions between regions and within cities.

3.30 The recently published findings of a survey conducted in the North West of England[29] confirms the BMA study. Liverpool John Moores University and the University of Manchester conducted co-ordinated surveys of 1150 pubs and bars across 14 local authorities across the North West of England, to assess whether pubs and bars in disadvantaged areas would be less likely to prepare and serve food, and more likely to allow smoking.

3.31 They found that 44% of the pubs and bars across a large area of North West England do not serve food and would be exempt from smokefree legislation when it comes into force, much higher than the 10-30% predicted by the government. The authors concluded that the impact of the partial smokefree legislation would *"work against the stated Government objective of reducing health inequalities due to smoking"*.

3.32 Divisions within London were highlighted by a survey conducted by the Evening Standard in May 2005. Outer London boroughs such as Enfield, Hounslow and Sutton, would be completely smoke-free, as would a vast majority of others in the West End, Westminster, Southwark and Camden. However, boroughs such as Barking and Dagenham where eight in 10 pubs do not serve food London will remain largely unaffected by the legislation, as proposed.[30]

Increased litter

3.33 A strong point that came through from our research in Dublin was the potential for significant increase in litter. Smoking related litter is London's most widespread litter problem and there are concerns that the problem will worsen once smoke-free legislation comes into force.[31] Careful consideration will need to be given to counteractive measures for dealing with the potential increase.

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[27] Annex 3, Telephone Survey of London Public Houses, 6.3 *Would the ban affect policies on serving food?*

[28] Published on 12 May 2005. Available at: www.bma.org.uk/ap.nsf/Content/boozefagsandfood

[29] Published on 1 September 2005. *The impact of partial smokefree legislation on health inequalities*. Available at: www.cph.org.uk/tobacco

[30] Published on 12 May 2005 – The puffers guide to London boroughs.

[31] Greater London Authority Press Release, dated 23 September 2004. Available at: http://www.london.gov.uk/view_press_release.jsp?releaseid=4369

Economic concerns

3.34 It is only natural that representatives in the hospitality trade are concerned about the economic impact of smoke-free legislation. Their concerns are shared with colleagues in Ireland, Norway, New York, and no doubt, in other countries actively considering legislation. Reports show that the negative impacts are not as significant as first anticipated.

3.35 The Ireland Retail Sales Index[32] available from the Central Statistics Office, shows that there has been a decline in the volume of bar sales since 2001. Bar sales declined in volume by 4.4 per cent in 2004, while the decline for the previous year was 4.2 per cent. Economic analysts suggest that this continuing downward trend is due to a number of factors including high prices, changing lifestyles and shifting demographic patterns.[33]

3.36 Statistics are in the process of being complied for Norway. However, the available date shows relatively minor economic impacts – a six per cent decrease in sales of beers from breweries to pubs offset by a 2.8 increase in sales to supermarkets, with little change in the sales turnover index.[34]

3.37 The New York one-year review report found that business tax receipts in bars and restaurants had increased by 8.7 per cent.[35]

3.38 While we acknowledge that the respondents to the survey we commissioned said that they expected smoke-free legislation would cause a decrease in trade, British Beer and Pub Association representatives were clear that they would rather see a level playing field and that business planning to accommodate smoke-free legislation under Option 4 would prove incredibly difficult.

Private legislation

3.39 The move by Liverpool City Council, the Association of London Government and partner London boroughs to pursue private legislation to provide completely smoke-free public places and workplaces, is an important one. As is the launch of Glasgow Tobacco Strategy in January 2005.[36] In the absence of legislation the latter provides a useful precedent to build on. However **a wholesale approach to completely smoke-free legislation is vital and can only be fully effective if implemented at national level.**

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[32] Central Statistics Office, Retail Sales Index available at: www.cso.ie/releasespublications/pr_services.htm

[33] Office of Tobacco Control, Smoke-free Workplaces in Ireland A One-Year Review, p10

[34] Smoke-free bars and restaurants in Norway 2005, p25. More information available at www.sirus.no or www.uib.no/psyfa/hemil

[35] Campaign for tobacco-free kids, press release date 29 March 2004, available at: tobaccofreekids.org/Script/DisplayPressRelease.php3?Display=737

[36] Glasgow Tobacco Strategy, available at: www.smokingconcerns.com/pdf.pl?file=smoking/news/TobaccoStrategyfinal.pdf

4. Concluding points

4.1 The significant risks of exposure to second-hand smoke are indisputable. The priority issues here are safeguarding the health of all individuals and ensuring that all employees have the right to work in smoke-free environments.

4.2 Allowing a longer lead-in time for licensed premises would leave some workers unprotected from the harmful effects of second-hand smoke. Therefore we have recommended a universal approach to implementation as opposed to a phased one.

4.3 A level playing field is essential to effectively implement and administer smokefree policies that are practical, clearly defined, and easily understood by everyone. Also critical to implementation is ensuring that the public and businesses are well informed and supported. In terms of understanding, interpreting and enforcing the legislation, we would make the following recommendations:

- The definition of smoke or smoking should be based on the act of smoking, rather than the nature of the substance.
- The proposed definition for substantially enclosed places should be clarified.
- The proposed penalty levels should be increased, particularly for persistent offenders.

4.4 The Health Improvement and Protection Bill provides the perfect opportunity for the government to take its place alongside Ireland, Scotland and Wales in introducing comprehensive smokefree policies to improve the health of the nation.

4.5 A partial ban based on Option 4 would *"work against the stated government objective of reducing health inequalities due to smoking"*[37] and would be confusing, difficult to implement and costly to enforce. Implementing the legislation on the basis of Option 2 – completely smokefree public places and workplaces without exemptions - will pave the way for a practical, workable solution.

[37] BioMed Central Press Release, 1 September 2005. Available at www.biomedcentral.com

Annex A

List of Stakeholders

UK

British Beer & Pub Association

GMB, London

Health at Work

Liverpool City Council

Liverpool City Primary Care Trust

SERTUC

Smokefree Liverpool

The Roy Castle Lung Cancer Foundation

Republic of Ireland

Chairman of ASH Ireland

Chief Executive of the Vintners Federation

Department of Health

Dublin City Council

Leaders of the Restaurants Association of Ireland and the Irish Hotels Federation.

Office of Tobacco Control

Senior officers from the Irish trade unions MANDATE and IMPACT

Annex B

This investigation was agreed by Health and Public Services Committee 9 November 2004. It was led by Jennette Arnold AM acting as a rapporteur on behalf of the Committee. Two distinct phases to the work plan were approved:

- Establishing an overview and evidence base for how bans have been introduced in different cities.
- Discussion with key stakeholders (including employers, trade unions, ALG and the boroughs) to establish an appropriate strategy for London.

The key issues were:

- An agreed definition of "public places";
- The different implementation strategies
- Involvement of public and key stakeholders
- Enforcement policy
- The costs and benefits to business
- Links to the Primary Care Trusts' cessation programmes

The Government launched the consultation on relevant parts of the Health Improvement and Protection Bill in June 2005. The submission of a response therefore became a major focus of the investigation and this report is based on the Committee's response to that consultation.

Annex D - How to order translations

How To Order

For further information on this report or to order a copy, please contact Ijeoma Ajibade, Scrutiny Manager, on 0207 983 4397 or email at ijeoma.ajibade@london.gov.uk

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