COMMITTEE ON SMOKING IN PUBLIC PLACES
REPORT

Chair's Foreword

In the early 1950's the Committee on Air Pollution, chaired by Sir Hugh Beaver, concluded that the London smog of 1952 had contributed to the high number of people dying from bronchitis, pneumonia and other respiratory diseases. In the light of these findings the Government passed the Clean Air Act of 1956 to reduce sulphur dioxide levels. It has taken half a century for us to appreciate the damage done to our health from breathing in environmental tobacco smoke in enclosed areas and to act to reduce that danger. The Committee on Smoking in Public Places is recommending that the National Assembly for Wales seeks the powers to ensure that we can have clean air indoors.

The Committee was established in June 2004 and one of its first tasks was to define "public places". Our initial working definition was "*all or part of a building to which the public has access, either as of right or with the permission of the owner or occupier of the building"*. Following the Committee's visit to Ireland, and in view of the weight of the evidence we have received on the harmful effects of environmental tobacco smoke, the Committee has taken the view that the definition should be broadened to include the workplace.

I am pleased that the Committee's report has been agreed unanimously by the Committee. I believe that our recommendations could make a significant impact upon the health of the people of Wales. We now look to the National Assembly for Wales to endorse the Committee's recommendations and to the Government in Westminster to legislate to enable the Welsh Assembly Government to implement them.

On behalf of the Committee, I should like to thank all those who have given written and oral evidence to the Committee, some of whom travelled from distant parts of the United Kingdom. We are also very grateful to everyone in Ireland, the Government and its agencies, the vintners and the unions, who shared their experiences with us when we visited in February.

Val Lloyd AM
Chair

May 2005

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1. Introduction

1.1 On 22 January 2003, the First Assembly voted in favour of a motion which called upon the UK Government *"to bring forward a public Bill relating to Wales which would provide that the Assembly could, by statutory instrument, prohibit all smoking with tobacco in such public buildings as may be specified in that instrument. The purpose and effect of any such Bill and any statutory instrument made under it would be to reduce the exposure of employees and members of the public to the well-documented and proven life-threatening dangers by environmental tobacco smoke."*[1] The motion received all party support.

1.2 On 8 June 2004, the Second Assembly resolved to establish an additional committee under Standing Order 8 to advise on the banning of smoking in public places.[2]

1.3 The motion specified the terms of reference for the Committee as to:

> i) consider current evidence on relevant issues, including the health risks of environmental tobacco smoke and the economic impact of restrictions on smoking in public places;
>
> ii) review developments in the UK and Ireland relating to the introduction of restrictions on smoking in public places (including the debates on Baroness Finlay's and Lord Faulkner's Private Members' Bills, the response to the UK Government consultation on devolving powers to local authorities to introduce smoking bans at work and in public places, the outcome of the Scottish Executive consultation on smoking in public places, and the experience of implementing the workplace smoking ban in Ireland);
>
> iii) consider the experiences in other countries where a ban has been introduced; and
>
> iv) report to the Assembly by 25 May 2005 on its conclusions.

1.4 The Committee first met on 15 July when it agreed its programme of work and plans for public consultation. The issues identified for consultation were:

- The health risks of environmental tobacco smoke.
- The economic impact of restrictions on smoking in public places.
- The impact of a ban in reducing the prevalence of smoking, i.e. whether a ban would encourage people to give up smoking or not to take it up.
- The effectiveness of extractor fans and other ventilation equipment to remove tobacco fumes from the atmosphere.
- Human rights arguments in respect of smokers and non-smokers.

- Enforcement.

1.5 The Committee received 97 responses to the public consultation. The Committee met on eight occasions to take oral evidence and to discuss the evidence received. In February 2005 Members visited the Republic of Ireland to assess the impact of the ban on smoking in the workplace that was introduced in March 2004.

2. Summary of Conclusions and Recommendations

2.1 The Committee concluded that:

- there is overwhelming evidence that environmental tobacco smoke is damaging to health;

- ventilation equipment is not capable of removing the majority of health damaging particulates from the atmosphere;

- there is no evidence that the introduction of a ban would have an overall negative impact on the economy;

- while acknowledging the right of people to smoke a product that is obtainable legally, this right should be exercised responsibly. The majority of the public who do not smoke should be able to go to their place of work and other enclosed public places without risk to their health.

2.2 The Committee therefore recommends:

1. that the National Assembly for Wales should press the UK Government for the powers that would enable it to introduce a ban on smoking in enclosed workplaces and enclosed public places (with specified exceptions) within a timescale of two to three years.

Exceptions should be made for:

- private dwellings, which may also be a place of work;
- designated areas in long-stay hospital units;
- designated areas in residential and nursing homes;
- designated areas of prisons;
- designated bedrooms or suites in hotels and guest houses, which are occupied solely by a smoker or with others who consent to their smoking, in accordance with the smoking policies of the management.

Employers should not be able to require non-smokers to service or clean designated areas.

2. The Committee would encourage the tourism and hospitality industries to prepare for the introduction of a ban by promoting the benefits of a smoke-free atmosphere to attract more non-smokers.

3. Public education, encouragement and support to quit should be stepped up in advance of the ban being introduced. Specific innovative measures should be targeted at children and young people to discourage and prevent them from experimenting and becoming addicted.

4. Enforcement should be the responsibility of local authorities.

5. Arrangements for enforcement and monitoring should be established in time for implementation. The Welsh Assembly Government should consider a compliance hotline and other tools such as an interactive web site for handling queries.

6. Discussions should start as soon as possible between the Welsh Assembly Government and the local authorities on the resource implications of the work.

7. There should be a concerted public information campaign as soon as a decision to introduce a ban is made. This should continue for the first year of implementation. Consideration should be given to commissioning a public relations company to undertake some of the work. The campaign should cover issues such as:

- delivering core messages about the dangers of second hand smoke; positive attitudes towards smokers and helping them to quit;
- information leaflets for different audiences, including employers, hoteliers, publicans and employees;
- press and media briefing;
- innovative ways of putting across the message, for example by briefing appropriate organisations and personnel across Wales to act as local spokespeople and to be pro-active with local media;
- identify innovative ways to get messages across; and
- develop advertising material;

8. The Welsh Assembly Government should establish a steering group comprising the main stakeholders, including the Welsh Local Government Association (WLGA), Chartered Institute of Environmental Health, the Health and Safety Executive, National Public Health Service, local health boards, trades unions, employers and the voluntary sector to ensure that there is a common understanding and presentation of the issues. There could be sub groups for the development and field testing of sector specific material.

9. There should be additional resources for, and promotion of, smoking cessation services. The services and the helpline should be well briefed and resourced to meet increased demand.

10. The Welsh Assembly Government should ensure that implementation of the ban is linked with other tobacco control activities.

11. The Welsh Assembly Government should work with tourist bodies, and in particular the licensed trade, to encourage and support the transition to smoke-free environments and to develop the marketing opportunities it will offer.

3. The Evidence

3.1 The Committee has considered all the evidence it received in writing and orally, together with its findings from its visit to Ireland and the reports from the three regional committees of the Assembly that looked at the subject in meetings early in 2005. The evidence includes information on action by the UK Parliament and Government, the Scottish Parliament and Executive and in other countries.

The Health Risks of Environmental Tobacco Smoke (ETS)

3.2 Most of the evidence cited to show that ETS is detrimental to health centred on six key documents. The authors of the documents have used evidence from numerous studies that have been peer reviewed and have carried out empirical analyses to show causal evidence of the health impacts. These five studies were produced over a period of six years and their findings each replicate those of the other reports.

3.3 The 1997 report of the California Environmental Protection Agency concluded that there was sufficient weight of evidence of a causal relationship between ETS exposure and developmental problems in babies; sudden infant death syndrome; some respiratory illnesses; lung and nasal sinus cancer; and cardiovascular disease. The report also found suggestive evidence of a causal link with spontaneous abortion, cervical cancer and further respiratory related problems.[3]

3.4 In 1998 the Scientific Committee on Tobacco and Health (SCOTH) published a report commissioned by the four UK Health Departments.[4] This concluded that ETS exposure:

- is a cause of lung cancer and, in those with long term exposure, the increased risk is in the order of 20-30%;
- is a cause of ischaemic heart diseases, and if current published estimates of magnitude of relative risk were validated, such exposure would represent a substantial public health hazard;
- is a cause of serious respiratory illness and asthmatic attacks in infants and children when parents smoke in their presence;
- is associated with sudden infant death syndrome, the main cause of post-neonatal death in the first year of life. The association is judged to be one of cause and effect;
- is likely to be a causal association with middle ear disease in children, linked with parental smoking.

3.5 SCOTH issued an update report on 16 November 2004 reviewing evidence since its report of 1998.[5] It concluded that knowledge of the hazardous nature of second-hand smoke has consolidated over the previous five years, and that this evidence confirms that second-hand smoke is a serious public health risk.

3.6 In 1999 the World Health Organisation published its conclusions following consultation on environmental tobacco smoke and child health.[6] It found that:

> ETS is a real and substantial threat to child health, causing death and suffering throughout the world. ETS exposure causes a wide variety of adverse health effects in children, including lower respiratory tract infections such as pneumonia and bronchitis, coughing and wheezing, worsening of asthma, and middle ear disease. Children's exposure to environmental tobacco smoke may also contribute to cardiovascular disease in adulthood and to neurobehavioural impairment.

3.7 The report also concluded that maternal smoking during pregnancy is a major cause of sudden infant death syndrome (SIDS) and other well-documented health effects, including reduced birth weight and decreased lung function. In addition, the consultation noted that ETS exposure among non-smoking pregnant women can cause a decrease in birth weight and that infant exposure to ETS may contribute to the risk of SIDS.

3.8 In his report for 2002 the Chief Medical Officer for England included a section on ETS.[7] His introduction to the section stated:

> Exposure to other people's cigarette smoke (second-hand smoke, passive smoking, environmental tobacco smoke) can: increase the risk of contracting smoking related diseases such as cancer and heart disease; place extra stress on the heart and affect the body's ability to take in and use oxygen; trigger asthma attacks; increase the chances of sudden infant death syndrome (SIDS); and harm children and babies even more than adults.

3.9 In 2002 the British Medical Association's (BMA) Board of Science and Education published a report in collaboration with the Tobacco Control Resource Centre.[8] The report summarised the scientific and medical knowledge on the nature and scale of the health effects of passive smoking:

- in adults, second-hand smoke increases the risk of lung cancer by some 20-30 per cent and the risk of coronary heart disease by 25-35 per cent. In children, exposure to second-hand smoke increases the risk of lower respiratory tract illnesses, asthma, middle-ear infection and sudden infant death syndrome.
- Certain population groups are particularly vulnerable: children, pregnant women, people with existing cardiovascular or cerebrovascular disease, and those with asthma and other respiratory disorders. Moreover, those in lower socioeconomic groups are at greater risk of exposure than those in better-off groups.
- There is no safe level of exposure to tobacco smoke, and adverse effects can be seen at low levels of exposure.

3.10 Ash Wales and the paper from the University of Aberdeen referred to the report of the International Agency for Research on Cancer, produced in 2002

and published in 2004 by the World Health Organisation, which reviewed links between passive smoking and cancer and concluded that tobacco smoke is carcinogenic to humans. This report presents international scientific concensus.[9]

3.11 The following studies are also significant.

3.12 A study in Helena, Montana USA, looked at whether there was change in hospital admissions for myocardial infarction (heart attack) while a local law banning smoking in public and in workplaces was in effect.[10] This found that during the six months in which the ban was in place the number of admissions of people from Helena fell significantly, while those admitted to the same hospital from outside Helena rose. When the ban was removed, the number of admissions from Helena increased. A commentary on the study suggested that although the study was small it focussed attention on a subset of literature on secondhand smoke and its consequences. The literature seems to indicate that relatively small exposures to toxins in tobacco smoke seem to cause unexpectedly large increases in the risk of acute cardiovascular disease.[11]

3.13 The Scottish MONICA study showed the effects of non-smokers exposed to ETS mainly at work having a significant reduction in pulmonary function.[12]

3.14 A study showing that workers in premises permitting customer smoking reported a higher prevalence of respiratory and irritation symptoms than workers in smoke-free workplaces. Concentrations of salivary cotinine found in exposed workers in this study have been associated with substantial involuntary risks for cancer and heart disease.[13]

3.15 Professor David Cohen of the University of Glamorgan, has undertaken a study modelling the economic and health impact of a ban on smoking in public places. The model predicts:

> The estimated effect of eliminating exposure to environmental tobacco smoke (ETS) in public places in Wales is an annual reduction in deaths from lung cancer and coronary heart disease of 253 with a possible additional reduction in deaths from stroke and respiratory diseases of 153.
>
> There may be an additional annual reduction in deaths of between 60 and 180 if active smoking is reduced as a result of the smoking ban.[14]

3.16 The report of the Office of Tobacco Control, Ireland, on the first year of smoke-free workplaces says:

- that in a study of pubs in Dublin where exposure levels in 24 pubs before and after the ban have been analysed, there has been a significant reduction in particulate levels – Ave PM10 by 53 per cent and Ave PM2.5 by 87.6 per cent;

- a study of 81 bar workers before the introduction of the smoke-free law and a year later indicates a reduction in breath carbon monoxide levels. The results show that for the 56 workers whose tests have been completed and analysed there has been a 45 per cent reduction in non-smokers and a 36 per cent reduction in ex-smokers.[15]

3.17 A study undertaken for Smokefree London, published in the *British Medical Journal* estimated deaths from passive smoking in the UK. It found that passive smoking at work was likely to be responsible for 617 deaths a year, including 54 in the hospitality industry. This would equate to one-fifth of all deaths from passive smoking in the general population aged between 20 and 64 years and up to half of such deaths of employees in the hospitality industry.[16]

3.18 Of those organisations which gave evidence to the Committee, only FOREST,[17] the Tobacco Manufacturers' Association,[18] and the National Association of Cigarette Machine Operators[19] contended that there is no evidence that ETS could be significantly detrimental to the health of non-smokers.

3.19 Four scientific studies were cited in support of this view. The Committee noted that three of these were produced in the early 1990s before much of the evidence of harm had been established. However, one longitudinal study which followed a large cohort was published in 2003 by the British Medical Journal.[20] The cohort comprised over 188,000 adults who were followed from late 1959 until 1998, with particular focus on 35,500 who had never smoked but had spouses with smoking habits. The report concluded that:

> The results [of the study] do not support a causal relation between environmental tobacco smoke and tobacco related mortality, although they do not rule out a small effect. The association between exposure to environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed.

3.20 A commentary on the study drew attention to some of the methodological limitations of the study, particularly the small sample size resulting in very wide confidence intervals, and suggests that there is a need to replicate the study in a larger geographical area using before/after trend analysis and external control areas. [21]

3.21 Following critical letters in response to the report an editorial comment was published defending the Journal's decision to publish the findings and saying that the question of whether passive smoking kills was difficult as methods were inadequate and the question had not been definitely answered[22].

Conclusion

3.22 *The Committee concluded that there is overwhelming evidence that exposure to environmental tobacco smoke is a significant risk to the health of non-smokers. Eliminating the exposure of people in enclosed workplaces and in other enclosed public places would produce considerable health gains.*

The Effectiveness of Extractor Fans and Ventilation Equipment in Removing Tobacco Smoke from the Atmosphere

3.23 Many of those who gave evidence opposing any ban on smoking in public places claimed that ventilation equipment could provide protection from the adverse effects of tobacco smoke. Two witnesses with direct experience of ventilation and air cleaning equipment gave oral evidence to the Committee.

3.24 The Air Cleaner Manufacturers' Association said in oral evidence that it is possible to produce machines that remove both particles and gases. Machines used in operating theatres are capable of producing air quality at 99.997 per cent purity in terms of removing particles.[23]

3.25 Dr Andrew Geens of the University of Glamorgan provided information on tests that he had undertaken. He said that his studies had shown that air quality can be difficult to define and measure but that, if the customer is prepared to pay, the industry can provide the equipment, if correctly briefed.[24] His studies had not been peer reviewed.

3.26 The British Medical Association (BMA) claimed that ventilation cannot protect against the health risk of passive smoking.[25] They advised the Committee that ventilation does not remove the fine particulate matter that is breathed most deeply into the lungs and into the thorax and that filtered tobacco smoke has the same potential to cause cancer in a cell system as unfiltered tobacco smoke. Their view was supported by, among others, the Chartered Institute of Environmental Health[26], the Public Health Association Cymru[27] and Ash Wales[28] [29] [30]. Ash Wales and Professor Gerard Hastings contended that it would take an air flow comparable to a wind tunnel or tornado to be in any way effective.

3.27 The Committee has considered this evidence and whether ventilation could provide adequate protection to non-smokers in the work place and other public places.

Conclusions

3.28 *The Committee accepted that ventilation could not remove all harmful tobacco substances from the atmosphere. These substances would be inhaled by non-smokers before they reached the equipment. Furthermore, for equipment to operate at the levels of effectiveness for which it was designed,*

it needed to be properly maintained and used. It would be both costly and difficult to enforce this. Therefore the Committee does not accept that ventilation is an effective or feasible solution.

3.29 The Committee recognises the right of people to smoke in their own home and that smokers who are living in long term care institutions need special consideration. Similarly, people staying in hotels and guest houses should be able to smoke in the rooms they occupy solely, or with others who consent to their smoking, ***subject to the policies of the management.*** *Non-smokers should not be required to service and clean such rooms.*

Recommendation

1. The Committee therefore recommends that the National Assembly for Wales should press the UK Government for the powers that would enable it to introduce a ban on smoking in enclosed workplaces and enclosed public places with the following exceptions:

- **private dwellings, which may also be a place of work;**
- **designated areas in long-stay hospital units;**
- **designated areas in residential and nursing homes;**
- **designated areas of prisons;**
- **designated bedrooms or suites in hotels and guest houses, which are occupied solely by a smoker or with others who consent to their smoking, in accordance with the smoking policies of the management.**

Employers should not be able to require non-smokers to service or clean designated areas.

The ban on smoking should be introduced within a timescale of two to three years.

The Economic Impact of a Ban

3.30 Most of the evidence and submissions to the Committee on the economic impact of a ban related to the tobacco and hospitality industries.

Tobacco Industry

3.31 The Committee received little tangible evidence on the impact of a ban on the tobacco industry itself. The Tobacco Workers Alliance said in evidence that there was already a trend of closure and down-sizing in factories manufacturing tobacco products in the UK, due to mechanisation and some constraints on exporting. They were concerned that further jobs would be lost.[31]

3.32 In Ireland sales of cigarettes have fallen since the ban was introduced. Amicus in Ireland pointed out that all manufacturing industry in Ireland was in

decline. In the last six years there had been ten closures or down-sizing of tobacco product manufacturing plants in the republic, resulting in a 50 per cent reduction in jobs in the industry. Amicus said that consumption had reduced in response to a number of public health initiatives and higher taxation on cigarettes. Manufacturers were moving production to Eastern Europe where there is still a market and labour costs are lower.[32]

The Hospitality Sector

3.33 The Tobacco Workers' Alliance submitted that the high profile bans in New York and Dublin have resulted in thousands of job losses in pubs and bars.[33] The Tobacco Manufacturers' Association told the Committee that a study undertaken for the Scottish Licensed Trade Association predicted a seven per cent reduction in the value of bar sales, a ten per cent reduction in the value volume and a 5.9 per cent reduction in employment following the introduction of a ban in Scotland[34].

3.34 Members of the Committee met representatives of the Vintners Federation of Ireland from South West Ireland during their visit in February. They said that around 7,500 jobs had been lost in the hospitality sector since the introduction of the ban, but a number of other factors had resulted in the trade going through a difficult time when the ban was announced. In Co. Kerry there are 380 pubs and publicans had reported a downturn of 25 to 30 per cent since the introduction of a ban, with ten licensees selling their licences. [32] The Committee has not been able to confirm this.

3.35 Licensed Victuallers (Wales) Ltd said in their evidence to the Committee that the viability of 50 per cent of the pubs in Wales would be at risk if a ban were introduced. Twenty one per cent of pubs are social drinking pubs run by the landlord with little or no paid help. It was estimated that 65 per cent of the customers of these pubs are smokers. Most of these pubs would close or not provide an income equivalent to the minimum wage. Low turnover in these pubs is said to be due to people preferring to buy their drink more cheaply elsewhere for home consumption. In a survey of publicans in the Rhondda, most of those questioned said that they would have to lay off staff, and 42 publicans (52.5 per cent) said their pub would probably close.

3.36 The Licensed Victuallers estimated that the impact on trade in the remaining 50 per cent of pubs would vary, but was estimated to be a reduction in the region of 10 to 15 per cent with consequential job losses.

3.37 The Licensed Victuallers would accept restrictions on smoking such as those proposed by the UK Government for England.[35]

3.38 Professor Gerard Hastings of Stirling University referred to 21 studies examining the financial impact for pubs and restaurants of becoming smoke free. The report published by the VicHealth Centre for Tobacco Control in Australia reviewed 97 studies that made statements about the economic impact of smoke free policies on the hospitality industry [36] Twenty one of these had met the strict criteria for methodological quality. Of these 21

studies none had found any negative impact. He also said that none of the studies that indicated the reverse had been published in a scientific journal.[37]

3.39 The Chartered Institute of Environmental Health cited an article in the *New York Times* on 1 April 2004, reporting that business tax revenue from New York's hospitality venues had increased by 12 per cent in the first nine months following the introduction of a ban.

3.40 Research in the first 15 cities in the United States that had prohibited smoking in the enclosed areas of restaurants found no statistically significant effect, either on total retail restaurant sales or on the ratio between sales in smoke-free cities and sales in comparison cities.[38] Similar results were found in a study in North Carolina.[39]

3.41 Discussions with Sean Power TD, Minister of State, Department of Health and Children, and officials confirmed that there were a number of factors that had led to a downturn in pub trade. There was a trend in moving away from drinking in pubs and bars where drinks are expensive, to buying alcohol more cheaply in supermarkets and off-licences for home consumption. Brewers had introduced a price rise to coincide with the introduction of the ban. Drink / driving laws had been tightened.[32] However, fears about job losses in the hospitality industry had not been realised. Dublin had promoted itself as " a breath of fresh air".[32] Fáilte Ireland, the tourism authority, reported record numbers of visitors in 2004 and a steady level of employment in the hospitality sector in 2004 compared with 2003. The smoking ban has never registered high on their Tourism Barometer, which reflects the main concerns of people in the tourism business.[40]

3.42 Professor David Cohen's model of economic and health predictions for Wales estimates that the annual effect on the hospitality sector would be in the range of -£48 million to £131 million, with the most likely estimate £42 million.

3.43 In addition, his model estimates the wider economic impact as follows:

> Savings to the NHS from reductions in both passive and active smoking are estimated to be in the range of £3.5 million to £10 million with a most likely estimate of £5 million.
>
> Productivity gains from reductions in sickness absence related to both passive and active smoking are estimated to be in the range £3.6 million to £5.2 million with a most likely estimate of £4.5 million.
>
> Economic impacts on workplaces comprise a loss of productivity due to an increase in the number of smoking breaks by workers currently working in establishments with no restrictions on smoking (range -£0.4 million to 0) and positive impacts from savings from reduced smoking related fire damage (£6.0 million) and cleaning costs (£7.6 million).

The annual effect on the hospitality sector in Wales is estimated to lie in the range -£48 million to £131 million with a most likely estimate of £42 million. The net effect on the Welsh economy, however, will be smaller than this as any change in spending will be redistributed to or from other sectors of the economy.

The total effect of eliminating exposure to environmental tobacco smoke is estimated by applying money values to the health gains (avoided illness and avoided death) and adding these to the economic impacts on the NHS and the wider economy. The most likely estimate for the full annual effect is £177 million (undiscounted range = £32 million to £319 million). This is equivalent to £66 million when discounted to take account of the timing of effects (discounted range = £12 million to £118 million), with a net present value over 30 years of £2,158 million (net present value range = £332 million to £3,903 million)."[14]

Conclusion

3.44 The Committee found that where bans have been introduced there is no credible evidence of an overall negative impact on the hospitality industry or the wider economy. It recognises that some smaller businesses may have difficulty in adapting to the changes and opportunities a smoking ban would bring. It notes that many of these are already struggling to maintain viability.

Recommendation

2. The Committee would encourage the tourism and hospitality industries to prepare for the introduction of a ban by promoting the benefits of a smoke-free atmosphere to attract more non-smokers.

The Impact of a Ban in Reducing the Prevalence of Smoking

3.45 Some respondents to the written consultation suggested that it is too early to assess whether a ban would reduce prevalence and that the bans in New York and Ireland were accompanied by tax increases on tobacco products.

3.46 The BMA and Ash Wales referred to estimates that had been made that a ban on smoking in the workplace would lead to a reduction in the percentage of adults who smoke from the current level of 27 per cent to 23 per cent.[41] The Public Health Association said that in California, only 15 per cent of people now smoke. In Ireland sales of cigarettes have fallen since the ban was announced in January 2003 (from 7,015.6 million in 2002 to 6,295.3 million in 2003 and an estimated 5,330.6 million in 2004)[42].

3.47 The BMA submitted that 70 to 80 per cent of people who smoke wished to give up and Ash Wales said that consumption had been shown to fall where bans were in place[43] [44]. The Chartered Institute of Environmental Health referred to a study of smoking related behaviour and attitudes that also

indicated that most smokers would like to quit.[45] Professor Gerard Hastings quoted a study which found that smokers in a smoke-free workplace are nearly twice as likely to give up as other workers. Those who do not quit reduce their consumption by two to three cigarettes a day.[46]

3.48 Ann Ludbrook, of the University of Aberdeen, said that there is evidence from Australia that public attitudes to smoking in front of other people changed following a ban and people smoke less in their own home.[47] Professor Hastings also said that there was evidence that the more controls put on tobacco use, the more cautious people become and the less likely they are to smoke in the home, exposing children to smoke[48].

Conclusion

3.49 The Committee agrees that a ban on smoking should reduce prevalence. Smoking is an addiction which the majority of smokers would wish to overcome. The Committee notes that in Ireland the new law was accompanied by high profile initiatives to encourage and support people in quitting.

Recommendation

> **3. Public education, encouragement and support to quit should be stepped up in advance of the ban being introduced. Specific innovative measures should be targeted at children and young people to discourage and prevent them from experimenting and becoming addicted.**

Human Rights Arguments in Respect of Smokers and Non-smokers

3.50 The Tobacco Workers' Alliance pointed out that tobacco is a legal product and smokers should not be vilified or marginalised.[49]

3.51 Ash Wales referred to Article 3 of the UN Convention on Human Rights which states that "Everyone has the right to life, liberty and security of person". Ash takes the view that the involuntary inhaling of second-hand smoke threatens the quality and length of life.[50]

3.52 Wales TUC quoted the case of Dryden v Greater Manchester Health Board where the court found that the complainant had no right to smoke at work.[51] The Chartered Institute of Environmental Health contended that a challenge to a ban on grounds of human rights would be likely to fail in the light of the judgement in the case of Markx –v-Belgium.[52]

Conclusion

3.53 The Committee acknowledges the right of people to smoke a product that is obtainable legally. It takes the view that this right should be exercised responsibly. The right of the majority of the public who do not smoke to be

able to go to their place of work or other enclosed public places without risk to their health outweighs the right of smokers to smoke in those places.

Enforcement

3.54 Under the legislation in Ireland, a person smoking in a prohibited place is guilty of an offence. The occupier, manager or any other person in charge of a place where a contravention occurs is also guilty of an offence. It can be a defence that they have taken all reasonable steps to secure compliance. Guidance was issued to pub licensees and staff on the steps that should be taken if someone breaks the law. The Irish Government opened free phone and e-mail lines and encouraged members of the public to report breaches. All reports are followed up. In Ireland, environmental health officers (EHOs) are responsible for enforcement in the hospitality industry, with support from staff from the Office of Tobacco Control, who work with the Industry. Forty additional EHOs were recruited to cover the additional work load.[32]

3.55 From the outset there has been a high rate of compliance in Ireland. The Office of Tobacco Control's report on the first year shows that overall there was 94 per cent compliance.[15]

3.56 The Welsh Local Government Association (WLGA)[53] and the Chartered Institute of Environmental Health[54], which are both supportive of a ban, take the view that local government environmental health departments should be responsible for enforcement. Given the shortage of environmental health officers, both organisations take the view that the work should be undertaken by trained technical assistants or trading standards officers.

3.57 The Chartered Institute of Environmental Health considered that a total ban should not be difficult to enforce. A partial restriction where smoking might be allowed in segregated or ventilated areas, or areas where food is not served would be virtually impossible to enforce. Monitoring the efficacy of ventilation systems would require high levels of expertise.[55]

3.58 The WLGA said that the Confederation of Scottish Local Authorities had estimated the likely costs to authorities as £6 million in the first two years of a ban.[56] The Welsh Assembly Government should work closely with the WLGA in drawing up plans for implementation and enforcement. These plans must be fully developed and costed to allow the Welsh Assembly Government to identify the additional funds that local government and other partners may need to fulfil their obligations.[56]

3.59 A written submission on behalf of the four Chief Constables in Wales said that they did not foresee any additional burden on the police if enforcement followed the models in Ireland and New York, where it is the responsibility of environmental and public health agencies. The police's involvement would be under the Licensing Act of 1964, which requires them to assist with the removal of a person from licensed premises on demand from the licensee.[57]

Conclusions

3.60 The Committee notes the Chartered Institute of Environmental Health's view that a partial ban would be almost impossible to enforce. The Committee accepts this and also takes the view that a partial restriction, with smoking permitted in segregated or ventilated areas, would not remove all damaging particulates or prevent their spreading to restricted areas.

3.61 The Committee notes that it is the view of both the WLGA and the Chartered Institute of Environmental Health that enforcement should lie with local authorities in view of their responsibility for environmental health.

3.62 The Committee also accepts the WLGA's submission that discussions of plans for enforcement and implementation should start in good time.

3.63 Although not strictly within the Committee's terms of reference, the Committee is aware that much of the success of the Irish legislation is the result of a long lead-in time and careful and well co-ordinated preparation by all the agencies. This is perceived to have been key to the ease with which the law is enforced.

Recommendations

3.64 The Committee therefore recommends:

4. Enforcement should be the responsibility of local authorities.

5. Arrangements for enforcement and monitoring should be established in time for implementation. The Welsh Assembly Government should consider a compliance hotline as well and other tools such as an interactive web site for handling queries.

6. Discussions should start as soon as possible between the Welsh Assembly Government and the local authorities on the resource implications of the work.

7. There should be a concerted public information campaign as soon as a decision to introduce a ban is made. This should continue for the first year of implementation. Consideration should be given to commissioning a public relations company to undertake some of the work. The campaign should cover issues such as:

- **delivering core messages about the dangers of second hand smoke; positive attitudes towards smokers and helping them to quit;**
- **information leaflets for different audiences, including employers, hoteliers, publicans and employees;**
- **press and media briefing;**

- **innovative ways of putting across the message, for example by briefing appropriate organisations and personnel across Wales to act as local spokespeople and to be pro-active with local media;**
- **identify innovative ways to get messages across; and**
- **develop advertising material;**

8. The Welsh Assembly Government should establish a steering group comprising the main stakeholders, including the WLGA, Chartered Institute of Environmental Health, the Health and Safety Executive, National Public Health Service, local health boards, trades unions, employers and the voluntary sector to ensure that there is a common understanding and presentation of the issues. There could be sub groups for the development and field testing of sector specific material.

9. There should be additional resources for, and promotion of, smoking cessation services. The services and the helpline should be well briefed and resourced to meet increased demand.

10. The Welsh Assembly Government should ensure that implementation of the ban is linked with other tobacco control activities.

11. The Welsh Assembly Government should work with tourist bodies and in particular the licensed trade to encourage and support the transition to smoke-free environments and to develop the marketing opportunities it will offer.

1. National Assembly for Wales Named Day Motion NDM1270 tabled on 10 December 2002
2. National Assembly for Wales Named Day Motion NDM1974 tabled on 28 May 2004
3. The 1997 California Environmental Protection Agency (EPA) *Health effects of exposure to environmental tobacco smoke*
Full report:
http://www.oehha.org/air/environmental_tobacco/finalets.html
Executive Summary: http://www.oehha.org/pdf/exec.pdf
4. The 1998 Joint Department of Health, Department of Health and Social Services, Northern Ireland, The Scottish Office Department of Health and the Welsh Office *Report of the Scientific Committee on Tobacco and Health (SCOTH Report)* http://www.archive.official-documents.co.uk/document/doh/tobacco/part-2.htm
5. Scientific Committee on Tobacco and Health (SCOTH) *Secondhand Smoke: Review of Evidence since 1998 Update of evidence on health effects of secondhand smoke*
http://www.advisorybodies.doh.gov.uk/scoth/PDFS/scothnov2004.pdf
6. The World Health Organisation (WHO) 1999 *International consultation on environmental tobacco smoke and child health: consultation report*
http://www.who.int/tobacco/research/en/ets_report.pdf
7. *The Chief Medical Officer (CMO) for England's Annual Report 2002*
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/AnnualReportsBrowsableDocument/fs/en?CONTENT_ID=4094860&MULTIPAGE_ID=4873781&chk=dOaScU
8. British Medical Association (BMA) 2002 *Towards smoke-free public places* http://www.bma.org.uk/ap.nsf/Content/Smokefree
9. IARC Monographs Vol 83 *Tobacco Smoke and Involuntary Smoking.* International Agency for Research on Cancer, Lyon, France, 2004, ISBN 92 832 1283 5
10. Sargent RP, Shepard RM and Glantz SA: BMJ 2004; 328; 977-980 (published 24 April 2004)
11. Pechacek TF, Babb S: BMJ 2004; 328; 980-983 (published 24 April 2004)
12. Chen R, Environmental tobacco smoke and lung function in employees who never smoked: the Scottish MONICA study *Occup Environ Med* 2001; 58; 563-568
13. MN Bates, J Fawcett, S Dickson, R Berezowski and N Garrett Tobacco smoke exposure. *Tobacco Control* 2002;11;125-129
14. David Cohen and Cathy Lisles, University of Glamorgan: *Modelling the Impact of a Ban on Smoking in Public Places in Wales*
15. Office of Tobacco Control: *Smoke Free Workplaces in Ireland A One Year Review*
16. Jamrozik K: BMJ 2005; 330; 812 (published 9 April 2005)
17. National Assembly for Wales: Record of Proceedings - 23 September 2004 Question 68
18. National Assembly for Wales: Record of Proceedings - 10 February 2005 Question 419
19. National Assembly for Wales: Record of Proceedings - 11 November 2004 Question 105

20. Enstrom JE, Kabat GC: BMJ 2003; 326; 1057 (published 17 May 2003)
21. Pechacek TF, Babb S: BMJ 2004; 328; 980-983 (published 24 April 2004)
22. Smith R Comment from the Editor BMJ 2003;327:505 (published 30 August 2003)
23. National Assembly for Wales: Record of Proceedings - 11 November 2004 Question 161
24. National Assembly for Wales: Committee on Smoking in Public Places - 11 November 2004 (SPP(2)-03-04(p.2)
25. National Assembly for Wales: Record of Proceedings - 23 September 2004 Question 7
26. National Assembly for Wales: Record of Proceedings - 13 January 2005 Question 305
27. National Assembly for Wales: Record of Proceedings - 13 January 2005 Question 322
28. National Assembly for Wales: Record of Proceedings - 23 September 2004 Question 86
29. Griffiths J. *Tobacco at Work, Guidelines for local authorities. Achieving the best outcomes.* NHS Health Scotland / ASH Scotland / Convention of Scottish Local Authorities. Edinburgh, 2004. ISBN 1 84485 111 7
30. Repace J, Kawachi I, & Glantz SA Fact sheet on second hand smoke *1999.* Online at: http://www.repace.com/factsheet.html
31. National Assembly for Wales: Record of Proceedings - 13 January 2005 Questions 247 to 261
32. National Assembly for Wales: Committee on Smoking in Public Places - 17 March 2005 (SPP(2)-03-05(p.4)
33. National Assembly for Wales: Committee on Smoking in Public Places - 13 January 2005 (SPP(2)-01-05(p.4)
34. National Assembly for Wales: Record of Proceedings - 10 February 2005 Question 416
35. National Assembly for Wales: Record of Proceedings - 10 February 2005 Questions 434 to 447
36. Scollo M, Lay A, Hyland A and Glantz SA. Review of the qualities of studies on the economic effects of smoke-free policies on the hospitality industry. *Tobacco Control* 2002;12: 13-20.
37. National Assembly for Wales: Record of Proceedings - 9 December 2004 Question 172
38. Glantz SA, Smith LRA. The effect of ordinances requiring smoke-free restaurants and bars on revenues. A Follow-up. American Journal of Public Health 1997; 87: 1687-1693 http://www.apha.org/journal/abstracts/abs1oct.htm
39. Adam O Goldstein, MD, Sobel, RA. Environmental tobacco smoke regulations have not hurt restaurant sales in North Carolina; University of North Carolina School of Medicine; 1998 http://www.ash.org.uk/html/publicplaces/html/pubbrief.html
40. Fáilte Ireland press notice dated 6 January 2005
41. The Wanless Report, (February 2004) *Securing Good Health for the Whole Population.* Available online from the Treasury website at: http://www.hm-

treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm
42. Revenue Commissioners Data - 1994 to 2004
43. Farrelly MC, Evans WN, Sfekas AE. The impact of workplace smoking bans: results from a national survey. *Tobacco Control* 1999; 8: 272–277
44. BBC Press Release 9 September 2004
45. Lader D and Meltzer H. 2002. *Smoking related behaviour and attitudes.* ONS 2003
46. Bauer JE, Hyland A, Li Q, Steger C, Cummings KM (forthcoming). Longitudinal Assessment of the Impact of Smoke-Free Worksite Policies on Tobacco Use. Under review for the *New England Journal of Medicine*
47. National Assembly for Wales: Record of Proceedings - 13 January 2005 Question 327
48. National Assembly for Wales: Record of Proceedings - 9 December 2004 Question 181
49. National Assembly for Wales: Committee on Smoking in Public Places - 13 January 2005 (SPP(2)-01-05(p.4)
50. National Assembly for Wales: Committee on Smoking in Public Places - 23 September 2004 (SPP(2)-02-04(p.4)
51. Dryden v Greater Glasgow Health Board 1992
52. Marckx-v-Belgium A/31 (19790 2 EHRR 330)
53. National Assembly for Wales: Record of Proceedings - 10 February 2005 Question 346
54. National Assembly for Wales: Record of Proceedings - 13 January 2005 Question 313
55. National Assembly for Wales: Record of Proceedings - 13 January 2005 Question 307; 308
56. National Assembly for Wales: Record of Proceedings - 10 February 2005 Question 346
57. Written evidence on behalf of the four Welsh Chief Constables dated 1 November 2004

ANNEX

RESPONDENTS TO WRITTEN CONSULTATION

*** Denotes those who also gave oral evidence**

1	Air Cleaner Manufacturers Association*
2	Amicus
3	Ash in Wales*
4	Association of Licensed Multiple Retailers
5	Asthma UK Cymru
6	Board of Community Health Councils in Wales
7	Bridgend Local Health Board
8	British Heart Foundation
9	British Hospitality Association
10	British Institute of Innkeeping
11	British Lung Foundation
12	British Medical Association Wales*
13	British Thoracic Society
14	Caerphilly Health Alliance
15	Cancer Research UK Cymru
16	Cardiff & Vale NHS Trust
17	Cardiff & Vale NHS Trust University Hospital of Wales – Brenda Rees, Head of Midwifery and Nursing
18	Cardiff Health Alliance
19	Carmarthenshire County Council
20	Carmarthenshire Local Health Board
21	Chartered Institute of Environmental Health, Wales*
22	Chief Constables of Wales
23	Christopher Bailey
24	City & County of Swansea Environment Department
25	Clive James
26	Conwy Community Health Council
27	Council of the City and County of Swansea – Environment Cabinet Advisory Committee
28	Cwmtillery Ward Partnership Board*
29	D E Davies
30	D J Walters
31	D J Watkins
32	Denbighshire County Council
33	Diabetes UK Cymru
34	E. Jones
35	Federation of Environmental Trades Association
36	Forest*
37	Gallaher Group Plc
38	Geraillt N Williams
39	Glenys & Roy Harding
40	Graham Cross
41	Gwent Community Health Council

42	Gwynedd Local Health Board & Council
43	Health Professions Wales
44	Ian Walsh & Iris Chalenor
45	J R Freeman & Son
46	Jack and Pat Whittard
47	John Ridge
48	Joint submission from New York Nightlife Association, Empire State Restaurant and Tavern Association and the United Restaurant and Tavern Owners
49	Kate Weston
50	Katie Burgess
51	Keith Downey
52	Licensed Victuallers (Wales) Ltd*
53	Lucy Kay
54	Mary Jones
55	Merthyr Tydfil County Borough Council
56	Monmouthshire Health Alliance
57	Mr A. J. Fox
58	Mr and Mrs Thomas
59	Mr J. Edwards
60	Mr E. Jenkins
61	Mrs Margaret Howells
62	Mrs S. Seaward
63	Mrs T. Owen
64	National Association of Cigarette Machine Operators*
65	National Childrens Home Cymru
66	National Public Health Service
67	Neath & Port Talbot Community Health Council
68	North Wales Fire and Rescue Service*
69	Pembrokeshire Local Health Board
70	Phillip Morris Ltd
71	Pontypridd Constituency Labour Party
72	Pontypridd Rhondda Community Health Council
73	Professor David Cohen, University of Glamorgan* Health Economics Research Unit
74	Public Health Association Cymru*
75	Robin Cullen
76	Rosemary and David Rees
77	Roy Castle Lung Cancer Foundation
78	Royal College of Physicians
79	Samantha McIntosh– member of The Chartered Society of Physiotherapy
80	Swansea Local Health Board
81	The Chartered Society of Physiotherapy
82	The Imported Tobacco Products Advisory Council
83	The Royal College of Midwives
84	Tobacco Manufacturers' Association*
85	Tobacco Workers' Alliance*

86	University of Aberdeen*
87	University of Glamorgan*
88	University of Stirling and the Open University, Centre for Tobacco Control Research - Professor Gerard Hastings*
89	University of Wales College of Medicine
90	Vale of Glamorgan Local Health Board
91	Wales Council for Voluntary Action
92	Wales Tourist Board
93	Wales TUC Cymru*
94	Welsh Consumer Council
95	Welsh Local Government Association*
96	Welsh Public Health Association
97	Wrexham Local Health Board