EXPLANATORY MEMORANDUM TO

THE SMOKE-FREE (VEHICLE OPERATORS AND PENALTY NOTICES) REGULATIONS 2007

SI 2007 No. 760

1. 1.1 This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

1.2 This memorandum contains information for the Joint Committee on Statutory Instruments.

2. Description

2.1 The Regulations specify requirements for vehicle operators and penalty notices for the purposes of the smoke-free requirements that will come into force on 1st July 2007.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Background

4.1 This instrument relies on the powers in Part 1, Chapter 1, and Schedule 1 of the Health Act 2006 (c.28) and defines requirements under smoke-free legislation by:

- setting out duties to prevent smoking in smoke-free vehicles; and
- defining the form of penalty notices.

4.2 This is the fourth instrument to be made that sets out the detail required for smoke-free legislation. It follows the:

- Smoke-free (Premises and Enforcement) Regulations 2006 No. 3368
- Smoke-free (Exemptions and Vehicles) Regulations 2007 No. [DN: TBA]
- Smoke-free (Penalties and Discounted Amounts) Regulations 2007 No. [DN: TBA]

4.3 A fifth set of regulations will be made subsequently to set out the requirements for signage under smoke-free legislation – the Smoke-free (Signs) Regulations. The regulations are currently in the standstill period as required under the Technical Standards Directive. They will be subject to the negative resolution procedure.

4.4 A Commencement Order will be made together with the signage regulations.

5. Extent

5.1 The Smoke-free (Vehicle Operators and Penalty Notices) Regulations apply to England.

5.2 The Health Act 2006 also provides regulation-making powers for the National Assembly for Wales. Separate, but similar legislation, has been implemented in Scotland and is to be implemented in Northern Ireland in April 2007.

6. European Convention on Human Rights

6.1 The Minister of State for Public Health has made the following statement regarding Human Rights:

6.2 As the Smoke-free (Vehicle Operators and Penalty Notices) Regulations are subject to the negative resolution procedure and do not amend primary legislation, no statement is required in respect of these regulations.

7. Policy background

7.1 The medical and scientific evidence of the risks to health from exposure to secondhand smoke is well established and documented. The Government's independent Scientific Committee on Tobacco and Health (SCOTH) has confirmed that secondhand smoke is a substantial public health hazard, and recommended restrictions on smoking in public places and workplaces to protect non-smokers.

7.2 The Government therefore introduced smoke-free legislation in the Health Act 2006 with the aim of:

- reducing the risks to health from exposure to secondhand smoke;
- recognising a person's right to be protected from harm and to enjoy smoke-free air;
- increasing 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; and
- saving thousands of lives over the next decade by reducing both exposure to hazardous secondhand smoke and overall smoking rates.

7.3 Smoke-free legislation will mean that virtually all enclosed public places and workplaces will become smoke-free. This means that in England all enclosed or substantially enclosed parts of all pubs, clubs, membership clubs, cafés, restaurants, shopping centres, offices, and all public and work transport, will become smoke-free.

7.4 Smoke-free legislation is not a "smoking ban". The Government respects individual autonomy, including a person's right to choose whether to smoke. The legislation will protect others from exposure to harmful secondhand smoke.

7.5 There has been much public and media interest in the introduction of smoke-free legislation.

7.6 A three-month consultation on the draft regulations ran from July to October 2006. Around 550 responses were received, many of them very detailed, from a range of stakeholders. The Department of Health has made a number of changes to draft regulations based on consultation responses. The most notable change to this instrument is that:

- enforcement authorities can add information to fixed penalty notices to facilitate financial or administrative processing.

7.7 A full analysis of consultation responses is available on the Department's website at:

http://www.dh.gov.uk/Consultations/ResponsesToConsultations/fs/en

8. Impact

8.1 A final Regulatory Impact Assessment is attached to this memorandum.

9. Contact

9.1 Kay Thomson at the Department of Health Tel: 020 7972 4495 or e-mail: kay.thomson@dh.gsi.gov.uk can answer any queries regarding the instrument.

FINAL REGULATORY IMPACT ASSESSMENT FOR REGULATIONS TO BE MADE UNDER POWERS IN PART 1, CHAPTER 1 OF THE HEATH ACT 2006 (SMOKE-FREE PREMISES, PLACES AND VEHICLES)

Introduction

1. The *Choosing Health* White Paper[1] set out the Government's proposed action on secondhand smoke. This is a full final Regulatory Impact Assessment (RIA), which was first published alongside the *Choosing Health* White Paper in November 2004, then published in an updated form as part of the consultation run by the Department of Health from 5 June 2005 on the proposed smoke-free elements of the Health Improvement and Protection Bill[2]. The partial RIA was updated again on the introduction of the Health Bill into the House of Commons, on the introduction of the Health Bill into the House of Lords and for inclusion within the consultation document on proposed smoke-free regulations, to be made under powers in the smoke-free chapter of Health Act 2006.[3]

2. This RIA sets out options for action, including the identifiable impacts on business and on health as a result of taking action in this area, and where applicable includes implementation costs associated with proposed regulations. This RIA applies to proposals for England only.

Objective

3. The Government's objective through this legislation is to:

- reduce the risk to health from exposure to secondhand smoke;
- recognise a person's right to be protected from harm 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 and, as a result; and
- save thousands of lives over the next decade by reducing overall smoking rates.

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1 Department of Health (2004). *Choosing Health: Making healthy choices easier*. Department of Health, London. Available at: **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor**

2 Department of Health (2005). *Consultation on the Smoke-free Elements of the Health Improvement and Protection Bill*. Department of Health, London. Available at: **www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4118566&chk=LBiiaW**

3 The latest version of the partial RIA for the Health Bill is available at: **www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT_ID=4121917&chk=sUauD**

Background

4. Smoking rates in England have fallen from 28 per cent in 1998 to 24 per cent in 2005—meaning around 1.6 million fewer smokers at 2005 population levels. The Department of Health has a target to reduce smoking rates further to 21 per cent or less by 2010, and to reduce smoking amongst routine and manual groups to 26 per cent or less over the same time period (from the 2005 level of 31 per cent).

5. The Government aims to achieve reductions in smoking prevalence through an integrated combination of policies that will help the 70 per cent of smokers who say they want to quit to be successful.[4] 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"* and the *"secondhand smoke is a killer"* media campaigns and new warnings on tobacco packs). The Department of Health has also recently run a consultation on the inclusion of pictorial warnings on tobacco packs. We have also encouraged public places and workplaces to become smoke-free voluntarily.

6. Through the provisions of the Health Act 2006, smoke-free enclosed public places and workplaces will become the norm. Virtually all 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, early years settings, 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 Act, 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.[5]

7. 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, including the passing of smoke-free legislation. Ireland's smoke-free legislation for enclosed public places and workplaces came into operation in March 2004. In the United States of America, California has had state-wide smoke-free legislation for public places since 1998, while New York passed smoke-free legislation in 2003. In total, 12 US states have comprehensive smoke-free legislation in place, which includes 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.[6] In New York, cotinine levels[7] in non-smoking bar and restaurant

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

5 Further advice is available from the Health and Safety Executive at: **www.hse.gov.uk/contact/faqs/smoking.htm**

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

7 Cotinine is a major metabolite of nicotine. Exposure to nicotine can be measured by analysing 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 at: **www.cdc.gov/tobacco/research_data/environmental/factsheet_ets.htm**

staff declined by 85 per cent.[8] Montana saw a 40 per cent drop in hospital admissions for heart attacks during a 6-month period of smoke-free workplaces.[9] In Ireland, almost total compliance with the legislation 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 smoked outside or did not smoke at all. In Ireland, almost one in five smokers chose not to smoke at all when out socialising.[10]

8. Progress reports from the following countries and US states that have introduced smoke-free legislation have been drawn on during the compilation of this RIA:

a. **Norway:** *Norway's Ban on Smoking in Bars and Restaurants: A Review of the First Year*[11]

b. **Ireland:** *Smoke-free Workplaces in Ireland: A One Year Review*[12]

c. **New Zealand:** *The Smoke is Clearing: Anniversary Report 2005*[13]

d. **New York, USA:** *The State of Smoke-Free New York City: A One-Year Review*[14]

e. **California, USA:** *Eliminating Smoking in Bars, Taverns and Gaming Clubs: The California Smoke-free Workplace Act*[15]

9. Across Europe, there are moves towards smoke-free places, with comprehensive smoke-free legislation in place in Norway and Ireland, and partial legislation in Finland, Sweden, Malta, Spain and Italy. In the UK, all countries have committed to introduce smoke-free legislation to include completely smoke-free pubs, clubs and restaurants, as well as other enclosed public places and workplaces. Scotland's smoke-free legislation came into force on 26 March 2006.

10. In addition, parties to the World Health Organization's Framework Convention on Tobacco Control (FCTC)[16] are required, *inter alia*, to adopt and implement measures that provide protection from secondhand smoke. The FCTC is the world's first public health treaty, and was adopted

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

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

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

11 Available at: **www.shdir.no/tobakk/english/tobacco_control_in_norway/review_of_the_first_year_of_norway_rsquo_s_ban_on_smoking_in_bars_and_restaurants_22156**

12 Available at: **www.otc.ie/article.asp?=article271**

13 Available at: **www.moh.govt.nz/moh.nsf/0/7EC01E1971949178CC2570D20019E782/$File/SmokeClearing.pdf**

14 Available at: **www.nyc.gov/html/doh/downloads/pdf/smoke/sfaa-2004report.pdf**

15 Available at: **www.dhs.ca.gov/tobacco/documents/pubs/smoke-freeworkplacecasestudy.pdf**

16 A full version of the FCTC, together with supporting information, is available at: **www.who.int/tobacco/framework/en/**

unanimously by 192 countries during the 56th World Health Assembly in May 2003. The convention came into force in February 2005, and the United Kingdom has ratified the convention, together with 141 other member states.

11. The FCTC is an evidence-based treaty, with the objective to:

> "…protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke".

12. The FCTC recognises in its preamble that "scientific evidence has unequivocally established that tobacco consumption and exposure to tobacco smoke causes death, disease and disability…". Furthermore, the treaty obliges parties to the Convention to "provide for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and other public places and, as appropriate, other places".

Rationale for Government intervention

13. The health risks from secondhand smoke were set out in the 1998 report of the Scientific Committee on Tobacco and Health (SCOTH).[17] 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; and
- sudden infant death syndrome.

14. In 2004, SCOTH published a second report on secondhand smoke,[18] 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 further 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. More recently, a report published in June 2006 by the

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

18 Scientific Committee on Tobacco and Health (2004). *Secondhand smoke: Review of evidence since 1988*. TSO, London.

US Surgeon General, on the health consequences of involuntary exposure to tobacco smoke,[19] concluded that:

- secondhand smoke exposure causes disease and premature death in children and adults who do not smoke;
- children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections ear problems and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children;
- exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer; and
- scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

15. In general, the health benefits of action to provide protection from secondhand smoke include the following:

- reduced illness and mortality from the medical conditions associated with exposure to secondhand smoke;
- gains in life expectancy to smokers giving up as a result of smoke-free workplaces; and
- gains in life expectancy from reduced smoking uptake.

16. The benefits of lives saved can be converted into monetary terms using standard Government Economist calculations. Estimates of lives saved can be made by comparing the current levels of exposure to secondhand smoke both in the workplace and in enclosed public places with the levels in the suggested options, and reducing the known risk of mortality accordingly. Ranges are necessarily wide as there is a lack of evidence to inform more exact figures. Lives may also be saved by reductions in smoking rates based on the implementation of smoke-free legislation.

17. Secondhand smoke in indoor places not only harms non-smokers, but also harms smokers and makes it difficult for the 70 per cent of smokers who say they want to quit[20] to succeed. Completely smoke-free policies in indoor places will assist those people who want to quit but are deterred by the continuation of smoking in indoor public places. International evidence (based on looking at the impact of smoke-free legislation in a range of settings) estimates that completely smoke-free policies in workplaces indoors can reduce smoking prevalence by up to 4 percentage points.[21] The 4 percentage point maximum figure is based on moving from a situation where there are no smoking restrictions (ie, smoking is allowed freely in all enclosed public places and workplaces) to the implementation of

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19 U.S. Department of Health and Human Services (2006). *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Washington DC.

20 Department of Health/Office for National Statistics (2003) *Statistical Bulletin 2003/21 – Statistics on smoking: England*. Office for National Statistics, London.

21 West, R. (2002). “Banning smoking in the workplace”. *BMJ*, 325, pp 174–175.

comprehensive smoke-free policy (ie, all enclosed public places and workplaces required to be smoke-free by law).

18. However, substantial progress in smoke-free public places and workplaces has already been achieved. In England, 51 per cent of people already say their workplace is completely smoke-free, and a further 37 per cent work in places where smoking restricted in some way.[22] After adjusting for the progress made so far, it is estimated that a move from the current situation to all indoor public places and workplaces being entirely smoke-free might reduce smoking rates among the general population by 0.7 percentage points. This figure is the estimated reduction delivered due to reductions in smoking as a direct result of people's own place of work becoming completely smoke-free.

19. In addition, there will be a reduction in overall smoking due to more places being smoke-free outside the smoker's own workplace, although rates of such reduction is more difficult to estimate. For the purposes of the RIA it is estimated that the wider benefit is a reduction in overall prevalence of 1 percentage point. This estimate was reached by combining evidence as to the current distribution of the workforce by degree of smoking restriction with evidence as to the effect on smoking cessation of different degrees of smoking restriction. The estimate of the numbers of people who are expected to quit smoking as a result of smoke-free legislation is based on restrictions in pubs and bars (as these are estimated to be the most significant smoking venues). It extrapolates from the workplace adjusting for the different period of enforced abstinence and an estimate of the time smokers spend in pubs.

20. Overall, the total benefit in reduced smoking of moving from the current situation to completely smoke-free indoor public places (including workplaces) is therefore estimated at about a 1.7 percentage point fall in smoking prevalence in England. Overall, smoking is estimated to cost the NHS about £1.5 billion a year, and a reduction in smoking will reduce that burden. A 1.7 percentage point reduction in current smoking prevalence rates of 25 per cent could mean an estimated annual saving of £100 million to the NHS.

Current situation/voluntary route

21. In 1998, the Government set out a package of measures in the public health White Paper *Smoking Kills*[23] to reduce the estimated 120,000 deaths caused by smoking every year and increase awareness of the risks associated with secondhand smoke. At the time, the Government made clear that "completely smoke-free enclosed public places are the ideal", but "[did] not think that a universal ban on smoking in all public places is justified while we can make fast and substantial progress in partnership with industry".

22. Since publication of the White Paper in 1998, the Department of Health has taken action to increase awareness of the risks associated with secondhand smoke through the following:

- UK's first ever media and education campaign;

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22 Taylor, T., Lader, D. and Goodard, E. (2005). *Smoking-related Behaviour and Attitudes, 2005*. Office for National Statistics, London.

23 Department of Health (1998). *Smoking Kills: A White Paper on Tobacco.* Department of Health, London. Available at: **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006684&chk=AqVFgM**

- funding to facilitate the development of a smoke-free communities network and resultant template to help communities move towards smoke-free status on a voluntary basis; and

- funding of Regional Tobacco Policy Managers who have, as a part of their roles, worked to increase local awareness of the risks associated with secondhand smoke and worked with local partners to encourage the creation of more smoke-free places in their regions.

23. In *Smoking Kills*, the Government announced a voluntary agreement, led by the hospitality industry, in which signatories were to commit to "increasing provision of facilities for non-smokers and the availability of clear air". The detail behind this was later formally launched as the *Public Places Charter*. The Charter provided for written policies for venues to state whether they are smoking or non-smoking, provision of non-smoking areas, air cleaning and ventilation, signs, monitoring, staff training and sharing of practice. The industry agreed to have a national industry-led scheme for signage. Alongside the Charter, the following targets were also set:

- Half all pubs (of which there are over 60,000 in the UK) and half the members of the Restaurant Association (which represents over 10,500 group and individual restaurants) should have a formal written smoking policy and signs; and

- 35 per cent of these premises should restrict smoking to designated and enforced areas and/or have ventilation that meets the agreed standard ("good practice" category).

24. An independent evaluation in 2003 showed that the key target had not been met and that only 43 per cent of pubs had a formal written smoking policy and appropriate signage in place, although of these, 53 per cent were in the "good practice" category.[24] Nearly half of pubs that were Charter compliant allowed smoking throughout and only a handful were entirely smoke-free. Health ministers, in response to the Charter Group report, stated that they were disappointed with the lack of progress. Significant progress in developing new plans for voluntary change had been made by the hospitality industry since the launch of the Charter, but there was still much more that could be done to protect people from secondhand smoke in public places.

Benefits of action on secondhand smoke

25. The economic and environmental benefits of smoke-free legislation for individuals, society and industry include:

- reduction in NHS expenditure through reduced smoking prevalence (estimates can be derived from annual cost to the NHS from smoking, reduced by the estimated drop in smoking prevalence);

- reduced costs from sickness absence;

- improvement of lives for people living with respiratory conditions including asthma;[25]

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[24] The Charter Group (2003). *The Public Places Charter on Smoking: Industry Progress Report*. The Charter Group, London.

[25] Asthma UK report that there are 5.1 million people in the 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

- greater efficiency through reduction in time lost by smoking breaks (through closure of smoking rooms as smokers going outside take less work time than smokers going to smoking rooms);[26]

- safety benefits such as reduced fire risks;[27]

- reduced cleaning and maintenance costs;[28]

- reduction in death and disability among those smokers who quit as a result of action to make more places completely smoke-free; and

- benefits to manufacturers of stop-smoking aids.

26. The following sections attempt to quantify these benefits.

Costs of action on secondhand smoke

27. In general, costs of action to provide protection from secondhand smoke may include the following. The costs for individual courses of action are also estimated separately below as they will have greater or lesser levels of these costs.

28. **Implementation costs:** Depending on the option chosen, costs to industry will vary. There has been speculation that there could be a major negative impact on the hospitality industry from bans on smoking in enclosed venues. While the issues surrounding the economic effects of banning smoking in hospitality venues continue to be debated, the World Health Organisation suggests that various studies have revealed that smoke-free legislation does not damage trade and therefore do not have a negative impact on the hospitality sector[29] and according to the World Bank, the fears of the hospitality industry that smoke-free laws may damage business are largely unfounded.[30] A 2003 study compared the quality of evidence and conclusions about the economic impact of smoke-free legislation on the hospitality industry, based on the type of data used, how the studies were designed, analysed and interpreted, and the source of funding. The study concluded that all of the best designed studies

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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 at: **www.asthma.org.uk/news_media/news/smoking_in.html**

26 World Bank (1999). *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. World Bank, Washington DC.

27 Parrott, S., Godfrey, C. and Raw, M. (2000). "Costs of employee smoking in the workplace in Scotland". *Tobacco Control*, **9**, pp 187–192. The authors of the article estimate that 18 per cent of fire damage is caused by smokers' materials along with matches. As well as the direct cost to businesses, insurance premiums are higher to cover this.

28 World Bank (2002) *Smoke-free Workplaces*. World Bank, Washington DC. Available at: **http://www1.worldbank.org/tobacco/AAG%20SmokeFree%20Workplaces.pdf**

29 World Health Organisation (2006). *Legislating for smoke-free workplaces.* World Health Organisation, Copenhagen.

30 World Bank (2002). *Smoke-free workplaces at a glance.* World Bank, Washington DC.

reported either no effect or a positive effect on sales and employment in restaurants and bars where smoke-free legislation had been implemented.[31]

29. Looking at some of the specific evidence from jurisdictions that have implemented smoke-free legislation supports these views. For example, there have been reports of falling bar sales in Ireland following the introduction of smoke-free laws (and indeed, responses to earlier public consultations from the pub industry quote figures of declining volume sales in pubs in Ireland of between "10 per cent and 15 per cent" and "as much as 25 per cent"). However, Irish retail sales data from the Central Statistics Office shows bar sales falls after the ban are in line with year-on-year falls since 2000[32] and evidence shows that since 2004, bar sales have again risen.

30. Through public consultation, the British Beer and Pub Association (BBPA) cited a report from AC Nielsen that indicates a downturn in trade in Scotland since the introduction of smoke-free legislation in March 2006, compared with the same period last year. However, the study found that the average Scottish pub serves an extra 91 main meals per week and liquor sales, by value, had climbed 2.9 per cent at Scottish pubs in mid-2006, compared with figures from the previous year.[33] A Cancer Research UK commissioned poll found that one in four Scots were likely to visit pubs and bars more often since the introduction of smoke-free laws[34]. In November 2006, the pub firm JD Weatherspoons reported that the group, which has 39 pubs in Scotland, saw sales rise 5.2 per cent after the implementation of smoke-free legislation, compared with the corresponding period last year, saying that smoke-free legislation had boosted sales of food and attracted new customers.[35]

31. A survey by *The Times* has shown that pubs in England that have already banned smoking indoors have seen profits rise by an average of 50 per cent. In the survey, *The Times* contacted 100 pubs that had voluntarily banned smoking within the past three years. Nine out of ten landlords reported that they were selling more food. Nearly half said that drinks profits had increased by 37 per cent on average, while a third said that drinks profits had stayed the same.[36]

32. The BBPA have also cited a research predicting a decline in pub numbers from 60,331 to 56,966 by 2011, suggesting that a significant element in the decline will be the wet-led (drinks only) sector. The decline of pubs that only serve drinks has been a long-term historical trend in the sector. Gala Coral Group, along with other bingo operators, suggest since smoke-free legislation was implemented in Scotland, profits in Scottish bingo clubs has been down by 38%, resulting in the closure of seven bingo clubs, with the loss of over 300 jobs. It is not clear the extent to which smoke-free legislation has played a role in these changes in the bingo sector in Scotland. Indeed, the full economic impact on any specific sector may only become clear after some years, although the health benefit of smoke-free legislation for workers and patrons will be realised quickly. Given the evidence from other countries, as well as experience in England, the Department of Health understands that it is likely to be prevailing economic, structural and cultural issues, rather than the introduction of smoke-free legislation, which will be primary cause of any significant decline in the sector.

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31 Scollo, M. et al. (2003). "Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry", *Tobacco Control*, 12, pp 13–20.

32 From Central Statistics Office, Ireland (2004) *Retail Sales Index (20 August 2004)* CSO, Dublin. Available at: **www.cso.ie**

33 "Scotland: Food rises, drink falls" in *Morning Advertiser*, 7 September 2006.

34 Details available at: **info.cancerresearchuk.org/news/pressreleases/2006/june/176807**

35 "Smoking ban good for sales says pub firm" in *The Scotsman,* 3 November 2006.

36 "Business is booming for pubs that ban smoking" in *The Times,* 16 October 2006.

33. **Enforcement costs:** The Health Act 2006 provides powers for the specification of enforcement authorities for smoke-free legislation, together with setting out the powers and duites of enforcement authorities. Depending on the option chosen, there may be enforcement costs for central and local government. Local authorities are identified as being best placed to enforce smoke-free legislation, and we expect that in most local authorities, the work would primarily be undertaken by environmental health officers. A substantive set of estimates were commissioned from an independent expert enforcement consultant by the public health charity Action on Smoking and Health (ASH). The Chartered Institute of Environmental Health (CIEH) did not submit separate enforcement estimates but drew attention in their response to this work. The Department of Health has worked with the Local Government Association (LGA) to ensure that amounts available for enforcement are realistic, including reference to the costs of enforcement in Scotland and anticipated costs in Wales.

34. **Education and communication:** Education and communication will be needed to support implementation of smoke-free legislation, regardless of what option is chosen. For example, it is normal to set up a helpline to support the implementation and enforcement of smoke-free legislation, as well as making the public fully aware of the changes. Costs for this RIA are estimated based on the experience of current Department of Health tobacco education and awareness campaigns.

35. **Losses to the Exchequer from tax:** As action on secondhand smoke is likely to mean that some smokers will quit or smoke less, there may be a loss to the Exchequer from taxes on cigarettes. This can be measured using the reduction in the amount smoked per day by continuing smokers and the tax per cigarette. Estimates have been adjusted by reducing the figure by around a quarter to reflect the proportion of cigarettes consumed that do not attract UK tax/duty. Nevertheless, it should be borne in mind that there is an overarching Government target to reduce smoking substantially by 2010. So reductions to the Exchequer are anticipated as a result of delivering the Government's target of smoking rates of 21 per cent or less by 2010 (equivalent to 2 million fewer smokers in England). This also applies to the next item.

36. **Loss of profit to the tobacco industry and tobacco retailers:** As action on secondhand smoke is likely to mean that some smokers will quit or smoke less, the tobacco industry and tobacco retailers may see a loss of profits. This is estimated as unlikely to exceed 10 per cent of the tax loss.

37. **Unintended consequences:** There may be unintended consequences of action, including costs to local authorities or businesses in cleaning up or providing disposal facilities for cigarette butts in outdoor public places. Though it should be remembered that a very significant reduction in total smoking related litter has already been achieved through there being a reduction in prevelance equivalent to some 1.6million fewer smokers in 2005. Smokefree legislation will contribute further to this by reducing smoking rates. It has also been suggested that there might be some increase in anti-social behaviour from smokers drinking on the streets or at home, rather than in licensed premises. Although the police do not have direct responsibilities for enforcement of smoke-free legislation, consideration has been given, based on other jurisdictions' experience, as to how they might be affected, for example in cases where smokers refuse to leave a smoke-free area. These are recognised, but the potential costs are likely to be relatively small, and therefore figures are not included in the cost/benefit table, reflecting responses to the consultation on this point which was raised during the consultations that this RIA has been subject to.

38. **Production losses and consumer surplus losses:** Some costs can be expected from smokers who were previously able to smoke indoors at work now being required to take smoking breaks outdoors (see below for elaboration of production losses and consumer surplus).

The options

39. Four options have been identified:

Option 1: *Continue with a voluntary approach;*

Option 2: *National legislation to make all indoor public places and workplaces completely smoke-free (with minimal exemptions);*

Option 3: *Legislation giving local authorities new powers to control secondhand smoke in indoor public places and workplaces; or*

Option 4: *National legislation to make all indoor public places and workplaces completely smoke-free (with exemptions as proposed in* Choosing Health*).*

40. Further detail is set out below, together with a table of estimated costs and benefits. These are the four options identified in the development of the Health Bill. This RIA builds on the pre-existing RIA for the Health Act 2006, as the costs and benefits of the Act and smoke-free regulations are inextricably linked. Given that it is option 2 that will be delivered through the Health Act 2006 after its consideration by Parliament, this RIA builds on that option.

Option 1: ***Continue with a voluntary approach***

41. Option 1 is to continue a voluntary approach to reducing secondhand smoke. Employers and businesses would be encouraged to take steps to make more places smoke-free, and the dangers of secondhand smoke would continue to be communicated in media campaigns, but there would be no statutory requirement for smoke-free places, or enforcement of them.

Benefits of Option 1

42. Paragraphs 21 to 24 set out the situation as it currently stands. Given the history of voluntary change, the option of doing nothing would seem likely to result in only limited progress (especially in the hospitality sector, as seen with the lack of progress towards the Government's stated ideal through the voluntary approach taken since 1998). The benefits set out could be limited in comparison with the other three options. If we assume that indoor workplaces without smoking prohibitions are those least willing to apply them, we could estimate that only half will voluntarily choose a ban. For other indoor public places, largely the hospitality industry, for illustrative purposes it is assumed that half the customers would be protected from secondhand smoke, but that smokers would be accommodated, and therefore none would stop or cut down. Accordingly, the cost and benefits of Option 1 have been estimated as half those in Option 2 (see the table at paragraph 64). We have continued to use this estimate reflecting responses to the consultation on this point which was raised in the partial RIA.

43. In September 2004, following a series of meetings with Government ministers, and in response to the *Choosing Health* White Paper consultation, a group within the hospitality industry launched an initiative for further voluntary action to provide for:

- 35 per cent of the trading space in their pubs and bars to become no-smoking by December 2005, moving progressively to 80 per cent by 2009;
- 50 per cent food consumption areas in pubs to become no-smoking by December 2005; and
- no-smoking "at the bar" and "back of house" (including cellar and food preparation areas) by December 2005.

Costs of Option 1

44. The costs to Government in implementation and enforcement are considered to be zero, as this would be voluntary change, although the voluntary approach may benefit from ongoing media campaigns funded by the Department of Health. Again, we have estimated the other costs (for example loss of tobacco revenues from any fall in tobacco sales) at half those of Option 2. Costs to business will be dependent on how much action is taken voluntarily, including any initial cost of going smoke-free, and cost/benefits of the effect of doing so.

Risks of Option 1

45. This initiative does not cover the whole of the hospitality industry, initially it was five large companies covering approximately one-third of pubs. The BBPA, in one of their consultation responses, report that around a half of pubs were committed to the initiative. Even if completely successful, there would still be significant exposure to secondhand smoke for people in the premises and no guarantee of anyone being able to find a smoke-free pub or bar. This would mean possibly little or no demonstrably increased protection from secondhand smoke, and no reason for the Department of Health to believe that smoking rates would decrease significantly.

Option 2: ***National legislation to make all indoor public places and workplaces completely smoke-free (with minimal exemptions)***

46 Option 2 would be to legislate to make virtually all indoor public places and workplaces across the country completely smoke-free. No exemptions could be made for the hospitality industry or membership clubs. For other premises, exemptions would only be provided in a extremely limited number, based on very specific grounds, as provided for in the Health Act 2006. The models for this option are smoke-free legislation in place in Ireland (implemented March 2004), Norway (implemented June 2004) and New Zealand (implemented December 2004).

47. National legislation would provide protection from the health risks of secondhand smoke and would lead to considerable benefit over and above existing voluntary arrangements, with a potential benefit well in excess of £3 billion annually (including savings for the NHS and through increased productivity for industry). This is principally from the value of averted deaths from employees smoking, from a reduction in customers' exposure to secondhand smoke and lower initiation of smoking. Of the five options, this option offers the highest levels of the benefits set out in paragraph 25, including the highest reductions in prevalence, deaths from secondhand smoke, cleaning and fire risk, and increases in productivity across England. Details of the methodology followed for assessing

the costs and benefits are discussed in more detail in the published economic paper *Smoke-free workplaces and public places: Economic Analysis.*[37]

Costs of Option 2

48. There would be some cost to industry to implement Option 2, including the display of no-smoking signage (the Department of Health has undertaken to make signage available free of charge) and for premises that have an exempted from legislation in meeting specific requirements. The costs associated with the implementation of regulatory requirements are detailed below. There would also be a cost to Government to enforce the legislation. The Department of Health, working with the LGA, has been estimated at around £30m in the first year, based on enforcement costs in Scotland and anticipated costs in Wales. International evidence suggests that as compliance for smoke-free legislation builds extremely quickly once implemented, and therefore in subsequent years, enforcement costs are estimated to be significantly less.

49. Potential implementation costs of the hospitality industry are discussed above. Costs, including loss to the Exchequer and to the tobacco industry and retailers as well as consumer surplus are detailed in the table at paragraph below.

Risks of Option 2

50. The main risk of Option 2 is that comprehensive smoke-free legislation may not reflect public opinion completely, and may therefore be more controversial and more difficult to enforce. The Office for National Statistics 2005 survey showed 86 per cent of people in favour of restrictions at work and there are similarly high levels of support for complete bans in most public places and workplaces. For pubs, the figures are 65 per cent for restrictions in pubs and 33 per cent for "no smoking allowed anywhere" in pubs when asked to choose between this and three other options: mostly smoke-free with smoking area; mostly smoking with smoke-free area; and smoking allowed throughout.[38] Between 2003 and 2004 there was a significant shift in public attitudes towards smoke-free and completely smoke-free especially. In December 2005, a YouGov poll, commissioned by Cancer Research UK and ASH, showed that 71 per cent of respondents would "support a proposal to make all workplaces, including all pubs and all restaurants, smoke-free". Moreover, experience from Ireland and other jurisdictions has not identified a significant enforcement problem.

51. Legislation for smoke-free enclosed public places and workplaces without exceptions would need to take careful account of those places which are an individual's *de facto* home, for example prisons or long-stay residential care units. Other countries around the world that have such legislation, have some exceptions of this type.

Option 3: ***Legislation giving local authorities new powers to control secondhand smoke in indoor public places and workplaces***

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37 Department of Health (2005). *Smoke-free Workplace and Public Places: Economic Analysis*. Department of Health, London. Available at: **www.dh.gov.uk/assetRoot/04/10/27/66/04102766.pdf**

38 Taylor T, Lader, D. and Goodard, E. (2004). *Smoking-related Behaviour and Attitudes, 2005*. Office for National Statistics, London (tables 6.13 and 6.20).

52. Option 3 is to legislate to give local authorities the power to make local legislation on smoke-free places. Local authorities would have the choice to regulate in their area based on local consultation and tailoring the regulation to local needs. They could also choose not to legislate at all.

Risks of Option 3

53. This option would certainly be a longer term and more unpredictable route. In practical terms, the costs and benefits would not be known until the intentions of local authorities of implementation was known. The main risk is that this may result in a confused system across the country, with businesses, workers and customers having to adapt to different regimes running in neighbouring local authorities; and there is every possibility that some local authorities may not make use of the legislation at all. This option is also the route that the hospitality industry clearly favour the least, and have stated (though not quantified) there will be costs involved for businesses operating nationally in ensuring multiple different sets of local legislation, potentially with different exemptions, are adhered to. Further, businesses in the leisure industry with premises on the border of a local authority which had smoke-free legislation might lose smoking customers to businesses in the adjacent local authority, although there would be some offsetting of customers looking for smoke-free premises.

Benefits and costs of Option 3

54. Consideration of the option of allowing local authorities the power to implement a ban within their own boundaries may not be that different in terms of impact from a national ban, with or without exceptions. It is reasonable to assume that impact would eventually extend to the vast majority of the population. Many large city authorities across England have already declared their intention to go smoke-free if empowered to do so.

55. In those countries such as the USA, Canada and Australia where local laws/ordinances have been introduced, the pattern has been one of growing momentum, with city after city adopting a smoke-free measure until entire states/provinces have adopted a complete ban. For example, in California, the first local ordinance was introduced in 1988. By 1995 there were 286 cities with smoke-free provisions, and comprehensive state-wide legislation legislation was introduced in 1998, 10 years after the passing of the first local ordinance.[39] Therefore, this option may be considered as having no greater or lesser impact than national legislation, if the entire country eventually adopted smoke-free legislation. In the cost/benefit table, implementation costs for Option 3 are given as 'unknown', as we do not know what requirements local authorities might put in place.

Option 4: ***National legislation to make all indoor public places and workplaces completely smoke-free (with exemptions as put forward in*** **Choosing Health*)***

56. Option 4 would be similar to Option 2, including certain exemptions to mirror public opinion. The *Choosing Health* White Paper proposed a possible set of enclosed public places affected and exceptions as described below.

57. All enclosed public places and workplaces (other than licensed premises which are dealt with below) would be smoke-free. Licensed premises would be treated as follows:

- all restaurants would be smoke-free;

[39] Stevens. C. (2003). The California Tobacco Control Program: A Model for Change. Presentation. March 2003.

- all pubs and bars preparing and serving food would be smoke-free;
- other pubs and bars would be free to choose whether to allow smoking or to be smoke-free;
- in membership clubs the members would be free to choose whether to allow smoking or to be smoke-free; and
- smoking in the bar area would be prohibited everywhere.

58. Special arrangements would be looked at for certain establishments that are a individual's *de facto* home, for example, prisons and residential care units. The full range of costs and benefits, quantified, are set out in the table below.

Benefits of Option 4

59. This option is likely to provide the benefits set out in paragraph 25 above, at a level below that of Option 2, but at a much greater level than in Option 1. The loss of benefit in comparison with Option 2 would be likely to be in some enclosed workplaces (for example, non-food pubs). Again, as smokers would be accommodated, we cannot predict the degree to which smokers' behaviour would change as a result of the exemptions in licensed premises. Therefore, the benefits from reductions in deaths due to customers giving up are estimated, at this stage, as between zero and the full benefits in Option 2, though it is unlikely that the actual benefit would be at the extremes of this range. Overall there would be a reduction in secondhand smoke and, for the purposes of this partial RIA, it has been estimated that more than half the deaths from secondhand smoke would be averted (see the table at paragraph 64).

Costs of Option 4

60. Costs would include costs to enforce the legislation as with Options 2 and 3. The costs, however, were estimated in the partial RIA accompanying the consultation as "likely to be higher" than Option 2 given the added complexities associated with legislation of this type.

Risks of Option 4

61. A risk of this proposal is that food-led licensed premises, pubs in particular, may make a choice to stop serving food in favour of allowing smoking, therefore reversing the recent trend towards pubs being more than simply a place to drink alcohol (however we have been unable to quantify this risk). It was estimated that 10-30 per cent of pubs might fall into the category of not "preparing and serving food".[40] In response to an earlier consultation, the BBPA and ASH submitted estimates of how many pubs fall into this category and how many might change as a result of the policy. The BBPA estimated a figure for July 2005 of 19 per cent of pubs "not preparing and serving food" and estimated that 20 per cent of the food pubs would discontinue food sales. An ASH-commissioned independent survey estimated that 29 per cent of pubs would currently fall into the "not preparing and serving food"

[40] Department of Health (2004). *Choosing Health: Making healthy choices easier*. Department of Health, London. Available at: **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor**

category, and that this would increase to 40 per cent (therefore some 16 per cent would discontinue serving food). It was also estimated that these smoking pubs could predominate in more deprived areas.

62. The hospitality industry submitted evidence that increased costs would be associated with this option, with pubs that choose to end food incurring costs such as removing kitchens and laying off food preparation staff. The benefits estimated for Option 4 are smaller with regard to economic and environmental benefits, because the exceptions to a total ban would largely affect the hospitality industry where people are exposed to secondhand smoke. Therefore, as Option 4 would have lower impact on exposure to secondhand smoke than Option 2, for the purposes of this partial RIA they are estimated at 40 per cent of the comprehensive legislation benefits.

Net sum of all costs and benefits

63. The table below gives a cost/benefit analysis of the four options that reflect the consultation responses and data submitted. The benefits for Options 1, 3 and 4 have been derived from Option 2, comprehensive legislation. Option 3 has the capability of equalling Option 2's effects, but with the possibility, though unlikely, of no impact at all. It has been suggested that the lower bound of Option 3 should be Option 1 – that is, giving local authorities powers to legislate would at the very worst be no better than the voluntary change. However, this assumes that Option 1, the voluntary change proposal as set out in paragraph 41, would still be honoured even if Option 3 were followed. Because the consequences for Option 1 of following Option 3 are not clear, we have decided not to make such an assumption. Options 1 and 4 are estimated as having less overall benefit than Option 2 as they deliver fewer completely smoke-free enclosed public places and workplaces.

Cost/benefits of action on secondhand smoke

64. These costs are estimates based on the information received from past consultations on smoke-free legislation ran by the Department of Health. Where costs are from previous research, we have not updated them to current prices. The table is to be used as a guide rather than a definitive costing of the options.

Benefits	***Option 1:*** **Voluntary action**	***Option 2:*** **Full ban**	***Option 3:*** **Local powers**	***Option 4:*** **Comprehensive smoke-free legislation with food/non-food exception**
Annual benefits £m				
Health benefits				
a) Averted deaths from secondhand smoke:	4	21	0-21	21
Employees	75	350	0-350	150-250
Customers[41]				

[41] Employees are those benefitting from smoke-free policies at their workplace. Customers are people making

b) Averted deaths from smokers giving up:					
	Employees	800	1,600	0-1,600	1,600
	Customers	-	180	0-180	0-180
c) Averted deaths from reduced uptake of smoking		275	550	0-550	550
Economic and environmental benefits					
d) NHS expenditure saved through reduced smoking prevalence		20	100	0-100	40-100
e) Reduced sickness absence		14-28	70-140	0-140	28-140
f) Production gains (from reduced exposure to secondhand smoke)		68-136	340-680	0-680	306-612
g) Safety benefits (damage, fire, injuries etc)		13	63	0-63	57-63
h) Reduced cleaning and maintenance costs		20	100	0-100	90-100
Total benefits		**1,289-1,371**	**3,374-3,784**	**0-3,784**	**2,842-3,616**

use of smoke-free enclosed public places.

Costs[42]		***Option 1:*** **Voluntary action**	***Option 2:*** **Full ban**	***Option 3:*** **Local powers**	***Option 4:*** **Comprehensive smoke-free legislation with food/non-food exception**
Annual costs £m					
i)	Implementation of regulatory requirements[43]	-	0-5	Unknown (dependent on local decisions)	0-5
j)	Enforcement[44]	-	30	0-20+	46
k)	Education and communication	-	1	Unknown (dependent on local decisions)	1
l)	Revenue losses to the Exchequer from decline in cigarette sales:				
	Employees	428	859	0-859	859
	Customers	-	113	0-113	0-113
m)	Losses to the tobacco industry and retailers	43	97	0-97	86-97
n)	Unintended consequences	-	-	-	-
o)	Production losses (smoking breaks)	215	430	0-430	430
p)	Consumers' surplus losses to continuing smokers	80	155	0-155	155

[42] Based on international evidence, hospitality industry turnover effects are not included as there is no expected significant change.

[43] Many of these will be one-off rather than annual costs.

[44] In first year of implementation. International evidence suggests that as compliance for smoke-free legislation builds extremely quickly once implemented, and therefore, subsequent years are estimated to be significantly less.

Total costs	**766**	**1685-1690**	**0-1684+**	**1577-1706**
Net benefit	***523-605***	***1689-2094***	***0-2100[45]***	***1265-1910***

Equity and fairness (including race equality assessment)

65. Consideration has been given to whether these measures will have any disproportionate impacts, including in the context of race equality issues. We do not consider that these measures will disadvantage any particular group. Evidence shows that smoking prevalence is particularly high among poorer people and in deprived areas. We are committed to doing all we can to reduce prevalence of smoking in these groups and areas, to protect people from the health risks of exposure to secondhand smoke and reduce the likelihood of taking up the habit that may bring premature death or serious illness. As action will affect all groups equally, we do not think that there are race equality issues associated with action on secondhand smoke. However, we recognise that different cultures use tobacco differently. One example is restaurants where waterpipes are smoked. Under Options 2 and 4, smoking would not be allowed in these food-based premises. According to World Health Organization (WHO) advice, "using a waterpipe to smoke tobacco poses a serious potential health hazard to smokers and others exposed to the smoke emitted", and "secondhand smoke from waterpipes is a mixture of tobacco smoke in addition to smoke from the fuel, and therefore poses a serious health risk for non-smokers". The WHO therefore recommends that "waterpipes should be prohibited in public places consistent with bans on cigarette and other forms of tobacco smoking".[46]

Competition assessment

66. A competition assessment has been undertaken following RIA guidance. Based on this assessment a simple competition assessment is set out. The options cover all businesses in England where activity takes place in an enclosed public place, including workplaces. Outside the hospitality sector no significant competition issues were identified. The biggest impact of action on secondhand smoke will be for the hospitality sector and, within the sector, for those businesses that have made least progress in becoming smoke-free (for example, cinemas are almost universally smoke-free whereas smoke-free pubs are very rare).

- **Option 1** is a continuation of existing policy and does not give rise to any issues based on the filter test.

- **Option 2** provides for a level playing field to business, with no increased entry costs (indeed it will decrease entry costs to the pub sector as expensive ventilation currently used will no longer need to be installed or maintained).

[45] Net benefit likely to be less when presently unknown costs of implementation, and education and communication are included.

[46] World Health Organization (2005). *Waterpipe Tobacco Smoke: Health effects, research needs and recommended actions by regulators*. WHO, Geneva.

- **Option 3** may result in impact on competition between businesses in different jurisdictions. This may result in smokers moving from a legally required smoke-free public place in one local authority to a smoking public place in the neighbouring local authority. There is potential for higher entry costs if a local authority were to decide to require specified ventilation in local legislation.

- **Option 4** would result in a decision for licensed public places about whether to serve food or not. As with Option 2 this route may decrease rather than increase barriers to entry for similar reasons in premises that will be smoke-free. The exemption of Qualifying (members) Clubs from the legislation presents competition issues that were raised by the hospitality industry in responses to the consultation. Their concern is that smoking will continue unrestricted in these clubs, while other premises and hospitality venues will have to choose either to be: completely smoke-free but prepare and serve food; or allow smoking but no longer prepare and serve food.

Rural proofing

67. We have also considered the impact of these measures in relation to rural areas and consider that they will not have a different or disproportionate impact on people living in rural areas. It has been suggested that rural pubs might be disproportionately affected, however, no quantifiable evidence was provided in response to the consultation to support this concern. It may be that local powers (Option 3) would result in different decisions in rural versus urban communities.

Costs to small business

68. The Department has consulted with relevant stakeholders and Department of Trade and Industry's Small Business Service to consider the impact of the range of the proposal and the listed exceptions to establish whether these measures would have a disproportionate impact on small and medium-sized enterprises. Business concerns raised about the legislation were almost exclusively from the pub trade. For most other businesses, no specific small business impact concerns were raised. However, for the pub trade the strongest objections have been to Option 4 as this was felt to present an unfair choice between smoking and providing food: with the choice of one or the other likely to result in increased costs to the business or loss of revenue.

Monitoring and review

69. Any action taken will need to be monitored to measure its effectiveness. If Options 2 or 4 are the final outcome, Health ministers have committed that a review of legislation will be completed three years after implementation. The Department of Health will also monitor the progress of compliance and enforcement from the implementation of the legislation.

Enforcement and sanctions

70. These are set out in paragraph 33. The enforcement is proposed in these regulations to be through local authorities for Option 2.

Public consultation

71. Together with proposals for regulations to be made under powers in Part 1, Section 1 of the Health Act 2006 (Smoke-free premises, places and vehicles), this RIA was included as part of a full public consultation conducted by the Department of Health over the period 17 July to 9 October 2006[47]. The consultation document asked a number of specific questions regarding proposals for smoke-free regulations, and invited comments on other aspects included within the consultation, including the RIA.

72. Over 550 responses were received from stakeholders to the consultation, with over half of respondents specifically supporting option 2. No respondents expressed support for options 1, 3 or 4. A number of specific comments were received, which have been incorporated within the relevant parts of the RIA. The Department of Health has separately published an analysis of the consultation responses received, which is available on the Department of Health website.

Summary and recommendation

73. Option 4 was the originally preferred option, as it offers the highest level of benefits possible taking into account the original desire for limited exceptions from smoke-free legislation for enclosed public places and workplaces, which would offer smokers some enclosed public places in which to continue to smoke. Option 4 was therefore brought forward in the Health Bill as introduced in October 2005. However, as a result of strong feelings inside and outside Parliament and changing public opinion, the Government facilitated a free vote at Report stage in the House of Commons on how far smoke-free legislation should extend, which resulted in the amendment of the Health Bill to ensure that licensed premises and membership clubs could not be exempted from smoke-free legislation. The amendments were also supported during a free vote at Report stage of the Health Bill in the House of Lords. *Therefore, option 2 is the Department of Health's preferred option as it is not only the most supported option by stakeholders but also because it will create a consistency in levels of protection from secondhand smoke across England, and is consistent with legislation already in place in Scotland. Option 2 is also one of the options with the highest net benefit*.

74. The table below sets out a summary of the four options.

Option 1	Option 2	Option 3	Option 4
Least restrictive and costly but may not make significant progress	Most effective but may be seen by the public as too restrictive, as minimal exemptions are identified. However, supported by majority of MPs at Report stage in the House of Commons and peers at the Report stage in the	Potentially equally as effective as Option 2, but with no guarantee of action, no way of predicting what type of action would be taken, and no guarantee of a timescale for action	The original preferred *Choosing Health* option—it offered some degree of choice for customers and licensees but is likely to be less effective in reducing smoking and protecting from secondhand smoke than a total ban

[47] Department of Health (2006). *Smoke-free Premises and Vehicles: Consultation on proposed regulations to be made under powers in the Health Bill*. Department of Health, London. Available at: **www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4139521&chk=nsxuNP**

	House of Lords, and is the preferred option.		
Net benefit: £523-605	***Net benefit: £1,689-2,094***	***Net benefit: £0-2,100 (but is likely to lower, depending on local decisions on implementation)***	***Net benefit: £1,265-1,910***

Delivery plan and building compliance

75. Smoke-free legislation will be implemented in England at 6am on Sunday, 1 July 2006. The Department of Health is committed to supporting stakeholders to ensure they will be ready to comply with smoke-free legislation upon implementation. The Department has already commenced an ambitious communications, media relations and stakeholder outreach programme, which includes the creation of a Ministerial Reference Group, made up of representatives from key stakeholder organisations. The Department of Health will produce guidance for business, making it available in a variety of ways. Other measures the Department of Health will employ to support implementation will include the creation of a Smoke-free England website, a freephone support line, and attending conferences and exhibitions in the lead-up to implementation of legislation to answer questions that stakeholders might have.

76. With respect to enforcement, the Government's intention is to create a supportive environment where people are encourage to comply with the new legislation. Experience in other countries that have implemented smoke-free legislation shows that compliance builds very quickly after implementation. The approach to enforcement will be non-confrontational, focused on raising awareness and understanding to ensure compliance, and enforcement officers will work closely with local businesses to build compliance through education, advice and support. We expect that enforcement action will be considered only when efforts to encourage compliance have failed. Any enforcement action that is taken will be fair, proportional and consistent. Enforcement inspections will be based on risk and, where possible, combined with other regulatory inspections to reduce burdens on business. Through the Chartered Institute of Environmental Health, the Department of Health will be making training available for all local authorities, to ensure a consistent approach to enforcement across England. Local authorities with enforcement duties will be funded in line with the New Burdens Doctrine.

Notes on derivation of figures

77. **Calculation of value of life years:** The mortality benefits from smoking cessation are converted into life years gained using epidemiological evidence as to the increase in life expectancy associated with smoking cessation. Each life year gained is valued at £30,000. This value of a life year, in turn, is derived from (a) the Department for Transport's value of a statistical life, about £1 million and (b) statistics showing that the average road death leads to a loss of about 35 years of life years.

Benefits

78. **Averted deaths from secondhand smoke:** The deaths averted from secondhand smoke are calculated separately for the workplace and public places. The estimates rely on a combination of factors: (a) estimates of prevalence of exposure to secondhand smoke in different locations and (b) epidemiological evidence as to the dangers of these levels of secondhand smoke exposure. The reductions in mortality are then converted into life years lost, and evaluated in money terms using similar assumptions as in deaths averted by smoking cessation. For a complete ban the benefit in public places is £350 million and in the workplace £21 million. Option 1 uses 20 per cent of these figures to illustrate the assumption that voluntary action would deliver much less than a ban. Option 4 is assumed to deliver less than half the secondhand smoke protection associated with comprehensive smoke-free legislation for customers because of the exemptions in the hospitality sector. Among workers the protection is, across the workforce, practically the same as for Option 2.

79. **Averted deaths from smokers giving up:** The numbers giving up were estimated by combining evidence as to (a) the current distribution of the workforce by degree of smoking restriction and (b) evidence as to the effect on smoking cessation of different degrees of smoking restriction. Those stopping were assumed to gain on average one year of life expectancy, valued at about £30,000. The estimate of the numbers giving up as a result of a ban in public places is based on restrictions in pubs. It extrapolates from the workplace ban adjusting for the different period of enforced abstinence and an estimate of the time smokers spend in pubs.

80. **Averted deaths from reduced uptake of smoking:** This estimate is based on the number of young people who take up smoking at work, and evidence as to lower uptake in environments where smoking is restricted.

81. **Reduced sickness absence and production gains:** The production gains relate to employees working more productively in smoke-free environments. Gains are also made from reduced time off work through smoking-related illness. The figures are based on the ACoP RIA.[48]

82. **Safety benefits:** Safety benefits include damage, deaths, injuries, cost to fire services, and administration costs. Individually they are too small to be included so are rolled together. These are also based on the ACoP RIA.

83. **Cleaning costs:** These are also based on the ACoP RIA.

84. **For Option 4:** As the exceptions to comprehensive legislation will largely affect the hospitality industry, these economic effects will be less great – they have been estimated at 90 per cent of a total ban.

Costs

85. **Implementation of regulatory requirements:** This figure incorporates the cost of fitting closing mechanisms on the doors of the estimated number of rooms likely to by designated as rooms for smoking in premises that can access an exemption under proposed regulations. The figure includes costs of hardware (£15) and fitting (£35) per door. Nevertheless, it is likely that these costs are going to be at the lower end of this estimate, as rooms for smoking (including individual bedrooms) should be classified as *higher fire risk* rooms under current and incoming fire regulations. This means that it is

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48 Health and Safety Commission (1999) *Proposal for an Approved Code of Practice on Passive Smoking at* Work: Consultative Document. HSC, London.

likely that rooms where smoking takes places would need to meet stricter requirements for fire protection, and therefore it is likely that such rooms would already be fitted with equipment such as self-closing fire doors *before* regulations are implemented in summer 2007. Nevertheless, for completeness, costs up to installing door closing mechanisms on estimated rooms for smoking have been included in the table of costs and benefits. Respondents to the consultation suggested that the installation of self closing doors in designated rooms for smoking in prisons could not only present safety and security issues, but would cost around £2 million to install. As a result, this proposal has not been included in final regulations.

86. We estimate that training costs associated with the implementation of regulations will be £1 million per annum. The Department of Health will produce a range of guidance documents and other resources for businesses to incorporate into their pre-existing staff training arrangements. Most businesses already train staff where smoking rules apply. The policy in Option 2 (comprehensive smoke-free legislation with minimal exemptions) will make this training more straightforward as rules will not vary from workplace to workplace.

87. We anticipate that other costs associated with implementing proposed regulations will be minimal, including:

a. **Requirement that rooms to have a ceiling and floor and, except for doors and windows, to be enclosed by solid, floor-to ceiling walls:** We expect that premises that will be able to access an exemption will already have bedrooms or rooms for smoking in existence, and will not need to undertake any reconfiguration works.

b. **Written designation of rooms for smoking by management:** We do not expect that this requirement will present any significant burden, as we are simply requiring premises managers to keep a written note on their files of the rooms within the premises that are designated for smoking. We have no plans to require premises managers to complete forms or send designations to any other parties.

c. **Ensuring that ventilation systems in rooms for smoking do not ventilate into any smoke-free parts of premises:** After discussions with stakeholders, the Department of Health is not able to estimate what impact this requirement might have on businesses, if any. We would welcome input from stakeholders who wish to provide figures on the cost of this proposed regulatory requirement. To be clear, this does not require the installation of ventilation where smoking rooms are allowed, rather that where ventilation exists in smoking rooms it should not circulate air from that room to another smoke-free part of the premises.

d. **No-smoking signage and markings on doors of rooms for smoking:** We expect that costs of displaying signage will be minimal, as the Department of Health intends to provide signage that meets requirements to businesses free of charge in the lead-up to implementation. Proposed signage requirements are likely to be less complex than the signage that would be required for Option 1, while signage requirements for vehicles seek to maximise no-smoking signage that is currently in place.

88. **Production losses:** These relate to smokers taking smoking breaks away from workplaces that previously allowed smoking in the workplace. The figures are based on the ACoP RIA.

89. **Consumer surplus:** Consumer surplus is the value a consumer places on the opportunity to consume goods or services over and above the price. Smokers unable to smoke at work lose consumer surplus. This can be thought of as the compensation which would be required to induce them voluntarily to accept a ban, or, alternatively, the sum they would be prepared to pay to bribe the employer not to impose a ban. The amount is estimated by calculating the price rise (given evidence as to the "elasticity of demand") which would induce smokers to cut down by the amount associated with a ban. The loss of consumer surplus is equal to half this price rise times the amount smoked. As each option has a potentially different effect on smoking, the consumer surplus estimates will vary for different options.

Declaration

I have read the Regulatory Impact Assessment and I am satisfied that the benefits justify the costs.

Signed

Caroline Flint

Caroline Flint MP
Minister of State for Public Health
Department of Health

7th March 2007