THE KING'S FUND REPONSE TO THE CONSULTATION ON THE SMOKEFREE ELEMENTS OF THE HEALTH IMPROVEMENT AND PROTECTION BILL

This paper is a formal response by the King's Fund to the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill. The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding. We are a major resource to people working in health, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

Forthcoming research by the King's Fund (Jochelson 2005) shows that that government can improve public health through legislation that is universally applied. Legislation can bring about changes that individuals on their own cannot, and can help set a framework for encouraging healthier decisions. In particular legislation can be justified when its objective is to protect individuals who otherwise would be harmed by the activity of others.

Rather than condemning such interventions as being the products of a 'nanny state', it is more appropriate to view them as a form of 'stewardship' for the public good. Our research also shows that attitudes towards the limits of government intervention do change over time. Laws once heavily contested become normal and unnoticed and accepted This certainly applies to the smoking debate. A study in California, USA, which has had a decade-long comprehensive tobacco control programme, shows growing support, including among smokers, for comprehensive public smoking bans (Gilpin, Lee, Pierce 2004).

The King's Fund thus recommends that future policy should be based on the second option presented in the Consultation document, namely for national legislation to make all indoor public places and workplaces completely smokefree without exception. In support of this we present some evidence about the health and economic benefits of smokefree public and work places, and then respond to the questions outlined in the Consultation document.

1. EVIDENCE ABOUT THE BENEFITS OF SMOKEFREE LEGISLATION

1.1 Smokefree legislation reduces smoking prevalence and so reduces a cause of preventable morbidity and mortality.

About 26% percent of the UK's adult population smokes (14 million people). Smoking is on the increase among children aged 11 to 15 in England, and 13% in this age group smokes regularly (Department of Health 1998; ASH 2005a).

Smoking-related diseases include lung cancer, chronic lung disease such as bronchitis and emphysema, and coronary heart disease. Smokers also face a higher risk than non-smokers of cancers of the mouth, throat, oesophagus, larynx, pancreas, bladder and cervix (ASH 2005b). Full term infants born to women who smoke weigh about 200g less than those born to nonsmokers. (WHO IARC 2002). Smoking-related diseases cause about 114,000 deaths a year - about one fifth of annual deaths in the UK (Tobacco Information and Prevention Source).

Surveys suggest that most smokers want to quit. (National Statistics 2003) and by age 20, 80% of smokers regret having started to smoke (Jarvis 2004). A ban on smoking in public places and workplaces helps smokers reduce the number of cigarettes consumed, and encourages them to stop.:

- A review of 26 studies of smoke-free workplaces in four countries concluded that totally smoke-free work places are twice as effective in reducing consumption and prevalence as policies that restrict smoking to a few designated areas. Total workplace bans result in a 3.8% reduction in smoking prevalence, with each smoker consuming 3.1 fewer cigarettes per day (Fichtenberg & Glantz, 2002).

- A review of 19 American and Australian studies showed that smokers smoked up to 20% fewer cigarettes per day, and that more smokers quit and smoking prevalence declined where workplaces had smokefree policies (Chapman, Borland, Scollo, Ross, Brownson et al 1999).

- A 1998 study in New South Wales showed that being employed in a smokefree workplace increased the likelihood of living in a smokefree home for current and past smokers (Merom & Rissel 2001).

- An Australian study showed that the proportion of family homes with smoking restrictions doubled from 27% to 53%. Where one adult smoked the proportion with restrictions rose from 17% to 53% and where all adults smoked it increased from 2% to 32%. The presence of children was strongly associated with smokefree homes. Adults employed in smokefree workplaces were more likely to have smokefree homes, than those working where smoking bans were partial or absent. (Borland, Mullins, Trotter et al 1999).

- A study of the impact of smokefree legislation in California, USA, also showed that the number of smokefree homes had increased from 38% to 74% betweeen 1990 and 1999 and that nearly half of smokers had smokefree homes in 1999. The number of children and adolescents living in smokefree homes had also increased from 38% to 82% (Gilpin, Farkas, Emery, Ake, Pierce 2002).

A study estimated that if all workplaces in the UK became smoke-free then consumption per capita in the UK would drop by 7.6% and the tobacco industry has estimated it could be as much as 10% (Fichtenberg & Glantz, 2002).

Conclusion

Smokefree legislation reduces the prevalence of smoking and encourages smokers to smoke less or to quit. It also encourages smokers and nonsmokers to adopt smokefree policies at home, so lessening exposure of non-smoking partners and children to smoking and to tobacco smoke. Smokefree legislation is likely to lead to reduced morbidity and mortality from smoking related diseases. This is in keeping with Government targets to reduce by 2010 the death rates from cancer by 20%, and from coronary heart disease and stroke by 40%. It also supports the target to reduce adult smoking rates from 26% in 2002 to 21% or less by 2010.

1.2 Smokefree legislation offers protection from secondhand tobacco smoke (SHS) for smokers and non-smokers and removes causes of preventable morbidity and mortality associated with SHS.

Second hand smoke is a mixture of diluted sidestream smoke from the burning cigarette and mainstream smoke exhaled by smoker. Mainstream, sidestream and second hand smoke contain over 4,000 chemicals, many of which are irritants or toxic, and almost 70 of which carcinogenic. SHS has short and long term impacts on human health.

- In the short term it reduces lung function and coronary blood flow, can trigger asthma attacks, irritate eyes, cause headaches and nausea.

- In the long term, numerous studies show that exposure of nonsmokers to secondhand smoke increases their risk of lung cancer, and that the risk increases with increasing exposure. The WHO International Agency for Research on Cancer (IARC) estimates that the risk of lung cancer for nonsmokers living with a smoker increases by 20% for women and 30% for men due to their exposure to SHS. The risk for nonsmokers in a smoking workplace increases by 16-19% (WHO International Agency for Research on Cancer (IARC) 2002). The Scientific Committee on Tobacco and Health (SCOTH) estimates that an increased risk of 24% (SCOTH 2004: 3).

- Epidemiological studies show that exposure to SHS is associated with an increased risk of 25-30% of an acute coronary heart disease event. (WHO International Agency for Research on Cancer (IARC) 2002). SCOTH estimates a similar risk of 25% and notes that damage occurs at low exposures (SCOTH 2004: 3).

- In children it increases the risk of pneumonia and bronchitis, asthma, middle ear disease, decreased lung function and sudden infant death syndrome. It affects the growth of the developing foetus and is associated with low birthweight (SCOTH 2004: 4).

A recent study (Jamrozik 2005) estimates that in the UK the prevalence of passive smoking at work is 11%, and at home is 13%. It estimates that in 2003

- 617 people died from the effects of passive smoking at work, of whom 54 were long term hospitality industry employees

- more than 2,700 people aged 20-64 died due to the passive smoking at home

- 8,000 people over 65 died due to passive smoking at home, largely due to strokes and heart disease.

ASH (2002) estimates 2 million incidences of illness caused by passive smoking every year in the UK.

Smokefree legislation will remove exposure of smokers and nonsmokers to this preventable risk in public places and workplaces.

- A review of the impact of smoking bans and restrictions on levels of exposure to SHS showed that workplace bans reduced exposure to SHS, and that complete bans were associated with greater reductions in exposure than more limited restrictions (Ludbrook, Bird, van Teijlingen 2005).

- Before and after studies of smoking bans in the hospitality sector also show reductions in exposure to SHS and improvements (Ludbrook, Bird, van Teijlingen 2005). For example, a study of bartenders in San Francisco showed improvements in respiratory health within two months of implementing a ban on indoor smoking (Eisner, Smith, Blanc 1998). A study of restaurant and bar workers in New York before and after the complete ban on smoking in public places was introduced showed reduced cotinine levels among nonsmokers (cotinine is a nicotine by-product found in the body fluids of people who have inhaled tobacco smoke) and reduced self-reported respiratory symptoms (Farrelly, Nonnemaker, Chou, Hyland, Peterson, Bauer 2005).

- In the UK children's exposure to passive smoking has halved since the late 1980s due to fewer parents smoking and reductions on smoking in public places (Jarvis, Goddard, Higgins, Feyerabend, Bryant, Cook 2000)

Smokefree legislation may also influence smoking initiation rates among children

- A Canadian study shows that exposure to SHS during childhood increased the likelihood of children smoking in adolescence, and that avoidance of SHS influences children's decision not take up smoking (Becklake, Ghezzo, Ernst 2005).

- A US study found that bans on public smoking and living in a smokefree home reduced smoking uptake and prevalence among teenagers (Wakefield, Chaloupka, Kaufman, Orleans, Barker, Ruel 2000).

Smoking related illness costs the NHS approximately £1.7 billion a year (Department of Health 1998a). Smokefree legislation will lead to a fall in smoking prevalence and to reduced health costs.

- When Helena, Montana, USA banned smoking for six months in 2002 from all public buildings including restaurants, bars, and casinos admissions to a local hospital for heart attacks fell compared to the same months before and after the ban (Sargent, Shepard, Glantz 2004).

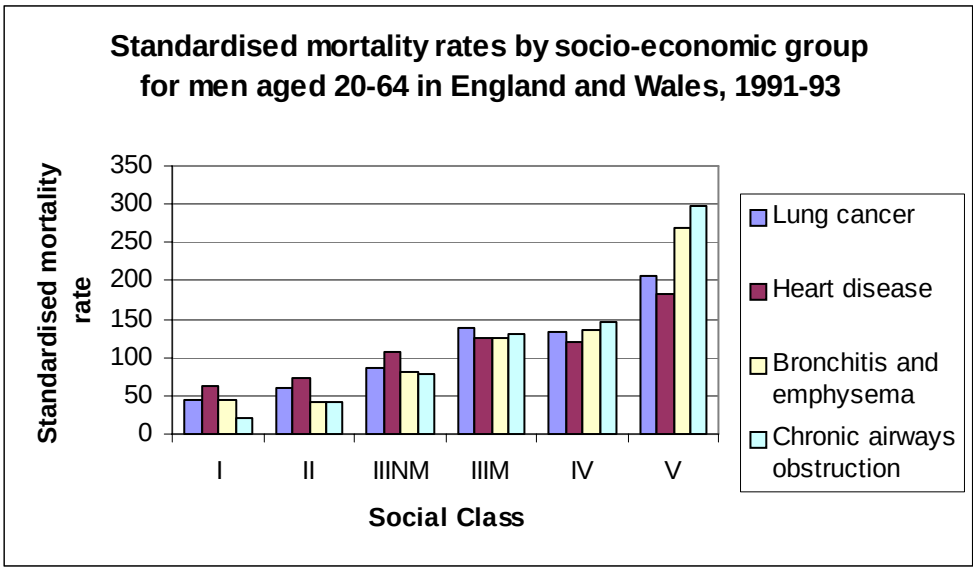
Conclusion

A ban on smoking in public places without exemption will protect smokers and nonsmokers from the effects of SHS and will remove causes of preventable morbidity and mortality associated with SHS. This is in keeping with the Government's targets to reduce mortality from cancer and heart disease, and its policies to improve life expectancy and children's health. It will also support policies to reduce smoking prevalence.

1.3 Smokefree legislation will reduce inequalities in smoking prevalence and create equity for all workers

Smoking prevalence is higher in low-income groups. In 2001, 34% of those in manual occupations smoked, compared to 15% of higher managers and professionals (Department of Health 2003). Smoking cessation rates are also lower. Between 1973 and 1996, smoking cessation rates increased from 25% to over 50% in higher income groups, but from 8-9% to 10-13% in poorer groups (Acheson 1998, in Richardson 2001). Higher rates of smoking translate into higher rates of illness and mortality (figure 1). It is estimated that half the difference in survival to 70 years between social classes I and V is due to higher smoking prevalence in class V (Department of Health analysis quoted in Wanless 2004).

Figure 1: Standardised mortality rates by socio-economic group for men aged 20-64 in England and Wales, 1991-93



Source: Health Development Agency (HDA) & ASH (2001). *Smoking and Health inequalities* http://www.hda-online.org.uk/downloads/pdfs/smoking_and_health_inequalities.pdf

The white paper, *Choosing Health* and the consultation document both favour a ban on smoking in public places and workplaces with exemptions pubs and bars not serving food, membership clubs that choose to allow smoking and places that are both workplaces and residences such as prisons, care homes, and psychiatric units.

A decision to introduce a ban with exemptions is likely to increase health inequalities. The white paper, *Choosing Health*, estimates that 10%-30% of pubs in England are drinking-only (Department of Health 2004) Evidence suggests that this is an underestimate, and also that many drinking-only pubs are in poorer areas.

- A study estimates that two thirds of pubs in deprived areas would be exempt compared to only a quarter in affluent areas as they do not serve food. When members clubs were included 40% of establishments in affluent areas and 80% in poorer areas would be exempt (Woodall, Sandbach, Woodward, Aveyard, Merrington 2005)

- A BMA survey found that the proportion of pubs that did not prepare and serve food on their premises was higher than the government estimate. In Leeds, for example, 88% of pubs did not serve food. The councils with the highest proportion of non-food pubs were in the north of England and the Midlands.(BMA 2005).

- Another study also showed that pubs serving food tend to be in less deprived areas and that a ban with exemptions will mean that only 46% of pubs in the most deprived areas will become smoke free compared to 70% overall (Lewis, Brown, Osborne, Crayford 2005).

A ban with exemptions is likely to enforce smoking norms in low-income areas.

The exemptions are also unfair to employees in the hospitality industry. Many of these jobs are also poorly paid, putting these workers in the low-income group, which has higher morbidity and mortality from smoking-related diseases. Workers do not have a choice about where they work. Employers should provide a safe environment for employees. A smoking ban with exemptions makes workers in the hospitality industry particularly vulnerable to unsafe working conditions that have a negative impact on their health.

Conclusion:
A smoking ban with exemptions does not support wider Government policy to reduce health inequalities by 2010. In particular it does not support targets to reduce the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 6% for cancer and 40% for heart disease and stroke. It also does not support the target to reduce the prevalence of smoking among routine and manual groups to 26% or less by 2010.

1.4 Smokefree legislation is not prejudicial to the economy, except to the tobacco trade

The tobacco and hospitality industry fear that a ban without exemptions will be prejudicial to their industries. This may be true for the tobacco industry, but not for the hospitality industry nor for the wider economy.

- Falling demand for tobacco does not mean falling employment. As studies of tobacco taxation policies show, money smokers once spent on cigarettes is spent on other goods and services generating other jobs to replace any lost from the tobacco industry (Jha and Chaloupka 2000).

- A smoke free law banning smoking in all workplaces was introduced in New York in 2003 and 97% of restaurants and bars are now smoke free. Since then business tax receipts have increased, as has employment indicating a positive effect for business (Smoke free Europe 2005: 32-33).

- A review for the Scottish Executive of the economic impact of smoking restrictions using sales tax and employment data found no statistically significant effect (Ludbrook, Bird, Teijlingen 2005).

It is estimated that 34 million working days are lost to British industry every year from smoking-related sick leave (ASH 2004a).

- Studies in Scotland, Ireland, Canada and the US show that smoke free policies result in higher productivity with time saved on absenteeism for ill health and smoking breaks, lower building maintenance costs and reduced employers liabilities for fire damage (Smoke free Europe 2005).

- The Chief Medical Officers Report for Britain (Department of Health 2003a) suggests that a smoke free law could benefit the UK economy by up to £2.7 billion. This includes up to £140 m saved through fewer sick days; £430m saved because of less production lost to cigarette breaks and £100m saved by not having to clean up behind smokers.

Conclusion

Smokefree laws without exemptions have not had a prejudicial economic impact on the hospitality industry. There are likely to be economic benefits for the economy from greater productivity, less illness and lower environmental maintenance costs.

2. RESPONSE TO CONSULTATION QUESTIONS

2.1. Should the legislation cover non-tobacco cigarettes?

Yes, otherwise it will be difficult to enforce the smoke free ban.

2.2. Is the definition of 'enclosed' appropriate?

The definition of 'fully enclosed' is clear. The definition of 'substantially enclosed' would need to be clarified in implementation guidance.

2.3. What about public places and workplaces that might fall outside the definition of 'enclosed' which might be smokefree?

The Act should restrict smoking wherever people are gathered together and could be exposed to SHS. The consultation document gives examples of bus shelters and sports stadia. Areas such as outside seating in pubs and restaurants should also be affected, as should outside work places where people are in close proximity.

2.4. Should licenced premises have a longer lead-in time?

No, introducing option 2 requires little investment by proprietors and could be implemented quickly. Licenced premises are also workplaces and should not receive special consideration. A universal ban is easier to introduce and administer and ensures equal operating conditions for all employers.

2.5. What are the merits of the proposals for licensed premises that do not prepare and serve food? Are there any concerns about the impact on licensed businesses that will have to choose between food and smoking? Is the *Choosing Health* estimate of 10-30 per cent of pubs choosing smoking likely to be borne out?

This question is relevant to option 4. How 'food' is defined and whether food is served on the premises could lead to misunderstanding by customers and proprietors and also opens up the possibility of loopholes. This imposes an enforcement and monitoring burden. Option 2 avoids these problems.

As discussed in 1.3 above the estimate of pubs choosing smoking is likely to be higher than 10-30%, and is likely to occur in deprived areas which already have higher smoking prevalence and smoking-related disease morbidity and mortality rates.

2.6. What premises should be exempt, especially on human rights grounds?

This question is relevant to option 4. There are important and difficult issues surrounding complete bans in premises such as some psychiatric wards or prisons where individuals are held against their will and may have no opportunity to move to another location where they would be able to smoke. Similar issues can arise in community care in which residents of shared flats or houses regard the premises as their home. The King's Fund believes that further work and discussion is needed to explore ways in which staff and users can be fully protected from SHS.

2.7. Should private membership clubs be exempt?

This question is relevant to option 4. There is no justification for exempting private clubs. These are also workplaces in which employees should be protected from SHS, as should non-smoking clientele.

2.8. Will the introduction of this legislation present any practical difficulties in some workplaces?

This question is relevant to option 4. The regulations should cover all workplaces in the same way.

2.9. Should appropriate signs be required by law?

Yes. A consistent symbol should be defined and enforced to ensure consistent impact and clear communication. Information about cessation services should also be provided alongside.

2.10. Are the penalties appropriate and should there be higher penalties for repeat offences?

Compliance with smoking ban regulation depends on a widespread consensus among smokers and non-smokers about the ethics of public smoking. In other countries regulations are enforced largely through peer pressure and social conformity, rather than financial or legal penalties (Jha and Chaloupka 2000). In Ireland almost total compliance with the ban has been reported (Department of Health 2004: 2).

However having signIficant financial and legal penalties also confirms the gravity of the offence and the clear intention of the regulation. The proposed penalties (£200, £200, £50) are small and not likely to act as a deterrent or warrant the cost of court proceedings. A higher penalty could be listed in the Bill with a provision for subsequent review. The Irish legislation mandates fines of up to 3000 Euros (£2,100).

The proposed three offence categories are reasonable. Local authorities should be able to revoke liquor licences for repeat offenders when their licences come up for review.

2.11. What defences should be allowed for the offence of failing to prevent smoking and displaying of no-smoking signage?

The proposed defences are a plea of ignorance, which is too weak. Owners or managers of premises should be able to show that they took reasonable steps to prevent smoking ranging from clearly displayed signs to direct requests to staff or customers to stop smoking.

2.12. How resource-intensive is enforcement likely to be?

Option 2 will be easier to enforce than option 4 as there is no potential for confusion around definitions of food or around exemptions.

The issue of resource use is best answered by enforcing bodies.

2.13. How should a no-smoking policy at the bar in exempted licensed premises be regulated?

This question is relevant to option 4. A ban on smoking within one metre of the bar will not protect bar staff or customers from SHS and will be difficult to enforce.

Studies show that although ventilation can remove the smell of tobacco smoke, it does not eliminate all cancer causing particles and gases from the air. To achieve pollution levels of ambient air, 'wind-tunnel' like rates of ventilation are needed. Where there are separate smoking areas with discrete ventilation systems pollution levels are reduced, but tobacco smoke drifts and staff and customers will still breathe SHS (Cains 2004; Kotzias et al undated). It is unlikely that the ban on smoking near the bar will have even the limited effectiveness of ventilation systems.

2.14. When should the law come into effect?

The proposed timetable allows for staggered implementation: enclosed public places and workplaces need to implement the proposed ban by the end of December 2007 and licenced premises by the end of 2008. This seems unnecessarily complicated. The public is already accustomed to smoking being prohibited on airlines, trains and the underground. A single date for implementation in all public places, including licenced premises, will be simplest and most clearly understood. This should be as soon as practically possible, given the time needed to enact the Bill.

2.15. Will smoking restrictions have an impact on the drive to tackle binge-drinking?

Option 4 is likely to encourage drinking as exempt pubs will only serve alcohol and there is no food to deflect customers' attention and spending potential. However until the law is implemented and the consequences monitored it is hard to assess the impact.

2.16. Will option 4 exacerbate health inequalities by concentrating smoking pubs and clubs in poorer communities?

Yes, option 4 will exacerbate health inequalities. As discussed in 1.3 most smoking-only pubs are in socially deprived areas. Low-income groups have a higher smoking prevalence and higher smoking related morbidity and mortality. Option 4 does not support the government's health targets to reduce health inequalities.

Conclusion

The King's Fund supports Option 2. We have provided evidence showing that a complete ban

- Reduces a cause of preventable morbidity and mortality from tobacco-related diseases due to smoking
- Removes a cause of preventable morbidity and mortality associated with exposure to second hand smoke
- Helps smokers to smoke less and to quit
- Reduces exposure of nonsmokers to second hand smoke
- Is associated with an increase in smokefree homes, thus reducing children's exposure to smoking and to second hand smoke, and reducing the risk of smoking uptake by teenagers
- Reduces health costs
- Reduces health inequalities in smoking prevalence
- Removes inequalities in working conditions by making all workplaces smoke free
- Is not prejudicial to the economy or the hospitality trade

Smokefree legislation without the exemptions for public houses also supports Government targets to reduce death rates from cancer and coronary heart disease, to reduce adult smoking rates, and to reduce health inequalities in these areas.

BIBLIOGRAPHY

Action on Smoking and Health (ASH) (2002). Press release. *2 million incidences of illness caused by second hand smoke in UK* www.ash.org.uk/html/press/971024.html

Action on Smoking and Health (ASH) (2004). *Fact sheet no. 16. The economics of tobacco. July 2004*. www.ash.org.uk

Action on Smoking and Health (ASH) (2004a) *Fact sheet no 2: Smoking illnesses and death* Accessed October 2004. www.ash.org.uk

Action on Smoking and Health (ASH) (2005a). *Fact sheet no 1. Who smokes and how much. January 2005*. www.ash.org.uk

Action on Smoking and Health (ASH) (2005b). *Fact sheet no 2: Smoking illnesses and death August 2005*. www.ash.org.uk

Anon (2003). 'Nurses too scared to enforce smoking bans', *Nursing Standard* 17 (34): 8.

Becklake M , Ghezzo H, Ernst P (2005). Childhood predictors of smoking in adolescence: a follow-up study of Montreal schoolchildren. *Canadian Medical Association Journal* 173 (4): 377-79.

BMA (2005). *Booze, fags and food*. www.bma.org.uk/ap.nsf/Content/boozefagsandfood

Borland R, Mullins R, Trotter L et al (1999). 'Trends in environmental tobacco smoke restrictions in the home in Victoria, Australia'. *Tobacco Control* 8: 266-71.

Cains T et al (2004). 'Designated 'no smoking' areas provide from partial to no protection from environmental tobacco smoke'. *Tobacco Control* 13: 17-22.

Chapman S, Borland R, Scollo M, Brownson RC et al (1999). 'The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States'. *American Journal of Public Health* 89 (7): 1018-23.

Department of Health (1998) *Statistics on smoking: England 1976-1996*. Statistical Bulletin 1998/25.

Department of Health (1998a). *Smoking Kills. A White Paper on Tobacco.* www.archive.official-documents.co.uk/document/cm41/4177/4177.htm

Department of Health (2003). *Tackling Health Inequalities: a programme of action.* London: Stationary Office.

Department of Health (2003a). *Health Check on the State of Public Health. Annual Report of the Chief Medical Officer 2003* www.dh.gov.uk/assetRoot/04/08/66/57/04086657.pdf

Department of Health (2004). *Partial Regulatory Impact Assessment. Choosing Health White Paper. Action on Second Hand Smoke*. www.dh.gov.uk/assetRoot/04/09/48/41/04094841.pdf

Eisner MD, Smith AK, Blanc PD (1998). 'Bartenders' respiratory health after establishment of smoke-free bars and taverns'. *JAMA* 280 (22): 1909-14.

El-Guelbaly N, Cathcart J, Currie S, Brown D, Gloster S (2002). 'Public health and therapeutic aspects of smoking bans in mental health and addiction settings', *Psychiatric Services* 53 (12): 1617-22.

Farrelly MC, Nonnemaker JM, Chou R, Hyland A, Peterson KK, Bauer UE (2005). 'Changes in hospitality workers' exposure to secondhand smoke following the implementation of New York's smoke-free law', *Tobacco Control* 14: 236-41.

Fichtenberg CM and Glantz SA (2002). 'Effect of smoke-free workplaces on smoking behaviour: systematic review' British Medical Journal 325:188-94.

Gilpin EA, Farkas AJ, Emery SL, Ake CF, Pierce JP (2002). 'Clean indoor air: advances in California, 1990-1999'. *American Journal of Public Health* 92 (5): 785-91.

Gilpin EA, Lee L, Pierce JP (2004). 'Changes in population attitudes about where smoking should not be allowed: California versus the rest of the USA', *Tobacco Control* 13 (1): 38.

Health Development Agency (HDA) & ASH (2001). *Smoking and Health inequalities*

www.hda-online.org.uk/downloads/pdfs/smoking_and_health_inequalities.pdf

Health Development Agency (2004). *Smoking and patients with mental health problems.* London: Health Development Agency.

Jarvis MJ, Goddard E, Higgins V, Feyerabend C, Bryant A, Cook DG (2000). 'Children's exposure to passive smoking in England since the 1980s: cotinine evidence from population survey'. *British Medical Journal* 321: 343-5.

Jarvis MJ (2004). 'Why people smoke'. *British Medical Journal* 328: 277-79.

Jamrozik K (2 March 2005). 'Estimate of deaths attributable to passive smoking among UK adults: database analysis. *BMJ online*: 1-5.

Jha P, Chapoupka F (2000). 'The Economics of Global Tobacco Control', *British Medical Journal,*

321: 358- 61.

Jochelson K (2005 forthcoming). *Nanny or steward? The role of government in public health*. London: King's Fund.

Kotzias D, Geiss O, Leva P, Bellintani A, Arvanitis A, Kephalopoulos S (no date). *Ventilation as a means of controlling exposure of workers to environmental tobacco smoke (ETS)* www.smokefreeeurope.com/assets/downloads/dimitrios_kotzias.doc

Lewis GH, Brown C, Osbrone DC, Crayford TJ (2005). *Partial smoking ban set to worsen health inequalities: cross-sectional study of public houses in England* (unpublished paper).

Longo DR, Ross C, Brownson RC, Kruse RL (1995). 'Smoking bans in US hospitals', *JAMA* 274 (6): 488-91.

Ludbrook A, Bird S, van Teijlingen E (2005). *International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places*. Ediburgh and Glasgow: NHS Health Scotland. www.hebs.com/researchcentre/pdf/InternationalReviewFullReport.pdf

Merom D and Rissel C (2001). Factors associated with smoke-free homes in NSW: results from the 1998 NSW Health Survey. *Australian and New Zealand Journal of Public Health* 25 (4): 339-45)

National Statistics (2003). *Proportion of smokers who would like to give up smoking altogether, by sex and number of cigarettes smoked per day: 1992 to 2003*: GHS 2003 www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=8844

Richardson K (2001). *Smoking, Low Income and Health Inequalities: Thematic Discussion Document*, report for Action on Smoking and Health and the Health Development Agency, www.ash.org.uk/html/policy/discussion.html

Sargent RP, Shepard RM, Glanz SA (2004). 'Reduced incidence of admissions of myocardial infrarction associated with public smoking ban: before and after study'. *British Medical Journal* 328: 977-980.

Scientific Committee on Tobacco and Health (SCOTH) (2004). *Secondhand smoke: review of evidence since 1998. Update of evidence on health effects of secondhand smoke*. London: Department of Health.

Smith CM, Pristach CA, Cartagena M (1999). 'Obligatory cessation of smoking by psychiatric inpatients', Psychiatric Services 50 (1): 91-94.

Smoke Free Europe (2005). Smoke free Europe makes economic sense. A report on the economic aspects of smoke free policies.

SmokeFree London, Mentality and ASH (2001). *Symposium report: Smoking and Mental Health. A symposium held on the 9th November 2001 at the Royal Pharmaceutical Society in London.* London.

Tobacco Information and Prevention Source, Centre for Chronic Disease Prevention and Health Promotion, United Kingdom factsheet. www.cdc.gov/tobacco/who/unitedki.htm

Wakefield MA, Chaloupka FJ, Kaufman NJ, Orleans CT, Barker DC, Ruel EE (2000). 'Effect of restrictions on smoking at home, at school and in public places on teenage smoking: cross sectional study'. *British Medical Journal* 321 (7257): 333-37.

Wanless D (2004). *Securing Good Health for the Whole population, Final report*, London: HMSO

Woodall AA, Sandbach EJ, Woodward CM, Aveyard P, Merrington G (2005). 'The partial smoking ban in licensed establishments and health inequalities in England: modelling study', *British Medical Journal* 331: 488-89.

WHO International Agency for Research on Cancer (IARC) Tobacco smoke and involuntary smoking vol 83. Lyon: IARC, June 2002. http://monographs.iarc.fr/htdocs/monographs/vol83/02-involuntary.html).