The Ban on Smoking in Public Places (2007)

Starting Point

For over forty years, government public health policies have increasingly focused on reducing the toll of death and disease from tobacco use. These initiatives have reduced smoking prevalence from 70% of men in 1962 (the year the Royal College of Physicians published their groundbreaking study that concluded smoking was a cause of lung cancer) to 24% in 2005.[1] But smoking still accounted for around a hundred thousand deaths a year, with passive smoking blamed for some eleven thousand of these deaths.[2] Moreover, smoking was increasingly shown to be a significant driver of health inequalities. Evidence on the health impacts of passive smoking (and declines in the proportion of the population who smoked) increased the focus on smoking in public places. In 1998, the Labour government published the first ever white paper dedicated to tobacco and continued the tradition of relying on a voluntary approach to control smoking in public places. By the early 2000s, it was clear that levels of compliance with the voluntary ban were low and there was increasing pressure inside government and outside to move to a statutory ban. But this would constitute a step change in government willingness to regulate private behaviours and risked considerable opposition in parliament and beyond. The Labour Party's 2005 manifesto proposed only a partial ban. Now the full ban on smoking in public places is widely accepted and general compliance is high. The case study looks at how this particular landmark in the decades-long effort to reduce smoking rates was achieved, despite deep ambivalence within government.

Policy background

Efforts to determine the health implications of smoking had begun before World War Two, but the breakthrough came when Richard Doll and Austin Bradford Hill conducted the first large-scale study into the link between smoking and lung cancer.[3] In September 1950, they published their preliminary findings in the *British Medical Journal*, based on a survey of lung cancer patients in 20

[1] See Nicholas Wald and Ans Nicolaides-Bouman (eds.), *UK Smoking Statistics* (Oxford: Oxford University Press, 1991); and ONS, *General Lifestyle Survey 2009: Smoking and Drinking Among Adults* (2011).

[2] See Konrad Jamrozik, 'Estimate of Deaths Attributed to Passive Smoking among UK Adults: Database Analysis', *British Medical Journal*, vol. 330 (2005), p. 812.

[3] For the background on Doll and Bradford Hill's pioneering research and a discussion of smoking policy in the 1950s, see Charles Webster, 'Tobacco Smoking Addiction: A Challenge to the National Health Service', *British Journal of Addiction*, vol. 79 (1984), pp. 7-16; and Virginia Berridge, 'Public Health in the 1950s: The Watershed of Smoking and Lung Cancer', in Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public health in Britain, 1945-2000* (Oxford: Oxford University Press, 2007), pp. 23-51.

London hospitals, which confirmed the link between smoking and lung cancer for the first time. In a follow up report, published in December 1952, they concluded that *"the association between smoking and carcinoma of the lung is real"*.[4] Despite growing medical evidence about the dangers of smoking, the government was reluctant to intrude into what was perceived as an issue of personal responsibility. In an internal Ministry of Health memorandum from May 1956, Rab Butler, Lord Privy Seal, articulated the reasons why direct government action was ruled out:

> *From the point of view of social hygiene, cancer of the lung is not a disease like tuberculosis; nor should the government assume too lightly the odium of advising the general public on their personal tastes and habits where the evidence of the harm which may result is not conclusive.*[5]

However, the medical establishment was moving to recommend a more active policy stance. In March 1962, the Royal College of Physicians published *Smoking and Health*, which noted that 70 per cent of men and 43 per cent of women smoked, and went on to argue that *"there can be no doubt of our responsibility for protecting future generations from developing the dependence on cigarette smoking that is so widespread today."*[6] *Smoking and Health* reviewed the evidence from more than 200 epidemiological and biological studies, and concluded that smoking is a cause of lung cancer, bronchitis and probably contributes to coronary heart disease. In order to curb the rising consumption of tobacco, it recommended tougher laws on cigarette sales, advertising and smoking in public places.

The medical profession and others began pushing for a comprehensive strategy to reduce smoking prevalence. In 1964, the Cohen Report on Health Education, produced by the Central and Scottish Health Services Council, marked a shift in the nature of public health from local information giving to a greater degree of central publicity, using habit-changing campaigns and social surveys, as well as advocating a rethinking of the profession of health educators as persuaders. The Cohen Report also called tobacco advertising *"propaganda"* and argued that it had to be countered. When Labour took power in 1964, Health Minister Kenneth Robinson, a former GP, introduced legislation to ban cigarette advertising on television, which came into effect on 1 August. During the 1970s, health activism steadily increased and the government responded with more initiatives designed to curb smoking's appeal. There was a twin track strategy for smoking policy during the decade. This consisted of harm reduction (safer cigarettes and product modification), an approach that had public health and industry support, and the promotion of outright abstinence, which became the public health strategy par excellence by the end of the decade.[7] In 1971, the Royal College of Physicians established Action on Smoking and Health (ASH) as a 'ginger group' to put pressure on the government and educate the public about the dangers of smoking. Government health

[4] Cited in Stephen Lock, Lois Reynolds and E. M. Tansey (eds.), *Ashes to Ashes: The History of Smoking and Health* (Amsterdam: Rodopi, 1998), p. 166.

[5] Ministry of Health papers, MH 55/2232, 'Memorandum by Lord Privy Seal' (1 May 1956), cited in Berridge, *Marketing Health*, p. 46.

[6] Royal College of Physicians, *Smoking and Health: Summary of a Report of the Royal College of Physicians of London on Smoking in Relation to Cancer of the Lung and Other Diseases* (London, 1962).

[7] See Virginia Berridge, 'The Rise of Health Activism in the 1970s: The Health Pressure Group', in Berridge, *Marketing Health*, pp. 161-84.

warnings were introduced on all cigarette packets sold in the UK, following an agreement between the government and the tobacco industry.

Under the 1979-97 Conservative government, the emphasis was on voluntary measures and taxation as the means of reducing tobacco use. In 1983, a Royal College of Physicians report outlined the dangers of passive smoking for the first time. In 1986, new advertising and promotion guidelines were agreed, including the banning of tobacco advertising in cinemas and a range of new health warnings. In 1988, a report by the Independent Scientific Committee on Smoking and Health concluded that non-smokers have a 10-30% higher risk of developing lung cancer if exposed to other people's smoke. In the 1993 Budget, the Conservative government introduced a tobacco duty 'escalator' that committed them to raising tobacco duties by at least 3% per year in real terms.

During this period, several government funded agencies used their funds to promote action outside the government – for example, the Health Education Authority during the 1990s funded a QC to draft a private members bill to ban tobacco advertising that Labour MP Kevin Barron promoted. Civil society organisations such as ASH, set up to help make the public case for action on tobacco, were funded by government. One of the distinguishing features of the Anglophone countries who tended to be in the lead on tobacco control measures was the leadership role assumed by medical professionals – in countries where doctors continued to smoke there was much less action. In the 1950s, the cigarette manufactures had enjoyed very strong links to top officials in the Department of Health, but these were long since gone. By the 1990s, experts saw their role as providing evidence and synthesising public data to make the case for government action, against the pressure from the tobacco industry in the other direction.

The new Labour government had a mixed start on tobacco issues – it raised the tax escalator from 3% to 5% real annual increases, but had to back down on a proposal to exempt Formula 1 from the EU directive on tobacco advertising and sponsorship in a row over a donation from Formula 1 boss Bernie Ecclestone. Tessa Jowell, who was appointed as the UK's first Minister of Public Health in 1997, was a passionate campaigner on smoking (her father had been a chest physician) and she had an *"overriding ambition to tackle health inequality"*.[8] Smoking remained a huge driver of the differences in life expectancy between the north and the south. However, in the period 1997-2001, the government suffered from a *"terror of being seen as an agent of the nanny state"* and *"the curse of the Daily Mail"*.[9] So the emphasis in *Smoking Kills* (1998), the first government White Paper specifically on smoking, was on education, voluntary agreements and nicotine replacement therapy – all designed to make it easier for people to give up smoking, and to reduce the uptake amongst children and young people. These proposals were followed by a growing number of calls for government to act on the significant health gains of going smoke-free. The government appointed Scientific Committee on Tobacco and Health issued a report in 1998 stating that passive smoking is a cause of lung cancer and coronary heart disease in adults. In 2002, the British Medical Association (BMA) called for a ban on smoking in public places because of the threat to non-smokers. As far as

[8] Institute for Government, Policy Reunion on the Smoking Ban (9 May 2011); details available at: http://www.instituteforgovernment.org.uk/our-events/101/policy-reunion-reducing-smoking-rates

[9] IfG Policy Reunion.

tobacco policy was concerned, it was becoming clear that legislation on passive smoking was the next key battleground.

Initiation

As evidence mounted about the risks of passive smoking, there was a reciprocal shift in public attitude. By the late 1990s, smoking had already been banned in many offices, as well as enclosed public places such as cinemas and transport, but only in a few pubs, bars and restaurants. As such, these hospitality venues became the focus of the debate over whether legislation was required to protect staff and customers from exposure to passive smoking. The government continued to favour industry self-regulation. In July 1999, the Health and Safety Commission proposed an Approved Code of Practice on passive smoking at work.[10] Although a code of practice was drafted, this approach was never implemented due to concerns from the hospitality industry and tobacco manufacturers about profits and job losses. Meanwhile, the Department of Health decided to work with the hospitality trade to draw up a voluntary agreement. Launched in September 1999, the Public Places Charter was signed by 14 industry associations. The agreement stated that 50% of all premises should adopt a formal smoking policy and 35% of these should restrict smoking to designated areas or introduce adequate ventilation. Yet, despite making progress towards these targets, the proportion of smoke-free venues only increased from 1% to 2% and no strategy was in place to extend these measures.[11]

The government's Chief Medical Officer, Dr. Liam Donaldson, wanted to use his position to make the case for stronger action. In June 2003, his annual report for 2002 was about to be published with a recommendation that the UK should move to a mandatory ban on smoking in public places, as voluntary agreements were not reducing the health risks from passive smoking quickly enough: *"Very serious consideration should be given to introducing a ban on smoking in public places soon."*[12] Not only was this a bold departure from government policy, but it also faced unforeseen difficulties. Donaldson has described the timing of the report as *"terrible"* due to the resignation of the then Health Secretary, Alan Milburn, on the eve of the intended publication date. Since the annual report was always independently compiled, it was only shown to ministers the night before publication. Donaldson had spoken to Milburn about the report, but that night the Secretary of State stepped down from government. John Reid was appointed in Milburn's place and there was a short delay in publication. However, the eventual release of the CMO's report meant it was inevitable that the issue of a ban had to be addressed in time for Labour's 2005 election manifesto.

The initial media reaction to the CMO's proposal was hostile on the leader pages, although the health journalists, who were briefed by the CMO on the evidence base, were supportive. His position was also championed by a strong and growing stakeholder movement with ASH and the RCP very prominent and backed up by the British Medical Association and other health charities.

[10] *Proposal for an Approved Code of Practice on Smoking at Work: Consultative Document* (1999).

[11] BMA, *Towards Smoke-free Public Places* (2002), pp. 18-19; and Deborah Arnott, et al. 'Comprehensive Smoke-free Legislation in England: How Advocacy Won the Day', *Tobacco Control*, vol. 16 (2007), p. 423.

[12] *Annual Report of the Chief Medical Officer 2002* (Department of Health, 2003), p. 24.

The public health activism of these organisations had built up since the 1970s and increasingly *"assumed a high-profile, media-conscious stance, opposing any notion of risk reduction."*[13] Within government, Donaldson could use his network of regional Public Health directors, and the public Big Smoke debates, a series of regional consultations organised by local health commissions in partnership with the Department of Health, stirred up a lot of public interest. Department of Health economists were less convinced about the immediate benefits from reducing passive smoking compared to other public health interventions, but they did see potential for significant health gains if the effect of the ban was to discourage uptake especially among 16-18 year old workers. Government action could also be justified as a protection for all employees due to the dangers of exposure to second hand smoke. After all, the UK had signed up to the constitution of the World Health Organization that states *"enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"*.[14] Making it more inconvenient to smoke also held out the prospect of encouraging people to quit and discouraging others from taking up the habit in the first place.

On the other hand, arguments against a ban were made by representatives of the hospitality trade and lobbyists for the tobacco industry. In particular, much attention was given to the potential impact on the hospitality industry with warnings about the damaging economic consequences. It was claimed that a ban would reduce the number of customers and lead other to spend less time and money in pubs. However, a review of 97 studies from around the world showed no evidence to support such fears.[15] At the time, while the exact economic consequences in the UK context remained contested, the regulatory assessment noted *"there is a lack of international evidence to support a prediction of a drop in sales in the hospitality industry"*.[16] It was also argued that comprehensive legislation would discriminate against smokers as it infringed their personal freedoms. Smokers' pressure groups such as FOREST supported a policy of separate spaces for smokers and non-smokers. Anti-smoking campaigners pointed out that this was not necessarily practical for all venues, as some were too small or could not afford to introduce ventilation systems, and it did not resolve the issue of staff exposure to smoke. As smokers were still free to smoke elsewhere, the aim of legislation was couched in terms of protecting the health of non-smokers rather than stopping people from exercising their legal right to smoke.

As the debate raged on, there were two critical decisions in the process. The first was whether to go for legislation or not. It was clear that the existing voluntary approach was not working since only a handful of pubs had gone smoke-free. The failure of self-regulation forced ministers to adopt tougher measures. In this respect, ASH regarded the contribution of John Reid as critical, as only a minister with his degree of clout in the Cabinet could overcome resistance to legislation in this area. Reid had been a heavy smoker, only quitting 18 months before taking office, and he was

[13] Virginia Berridge, 'Militants, Manufactures, and Governments: Postwar Smoking Policy in the United Kingdom', in Eric A. Feldman and Ronald Bayer (eds.), *Unfiltered: Conflicts Over Tobacco Policy and Public Health* (Cambridge, MA: Harvard University Press, 2004), p. 129.

[14] Constitution of the World Health Organization; available at http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

[15] See Michelle Scollo, et al. 'Review of the Quality of Studies on the Economic Effects of Smoke-free Policies on the Hospitality Industry', *Tobacco Control*, vol. 12 (2003), pp. 13-20.

[16] *Partial Regulatory Impact Assessment: Choosing Health White Paper* (2004), p.5

sceptical about calls for a comprehensive ban. Speaking at a Labour Big Conversation event in June 2004, Reid cast the issue in terms of class by suggesting people from *"lower socio-economic backgrounds have very few pleasures and one of them is smoking."*[17] The widespread reporting of these comments proved an important turning point. As the media ran with the story, Deborah Arnott of ASH thought it became clear that not only did the public care about the issue, but also public opinion was running ahead of the politicians. ASH lobbied John Reid, who agreed to meet them and then decided to go for legislation. The next key decision was what should be in the legislation.

Options

Although it had been agreed within Cabinet that action on smoking in enclosed public places was justified, the proportionality of the state's intervention remained open to debate. The underlying contention concerned the extent to which the exercise of an individual's rights should be allowed to impinge on the rights of others. There was no question of making smoking illegal; the issue was about how to minimise smoking's capacity to injure others while it remained a lawful activity. There were constant discussions with the CMO on the extent of the ban. John Reid's view was that there should be an exemption for private members' clubs, as these organisations could vote and decide to allow members to smoke with other consenting adults in private. Furthermore, Reid was concerned that comprehensive legislation might lead people to smoke more in the home, increasing the exposure of children. The government therefore ended up with a hybrid proposal to exempt private members' clubs and public houses that did not serve food. Reid thought this was a compromise that would be acceptable to the public. However, some in the Department of Health and outside doubted that this proposal was workable. Research also revealed that pubs that did not serve food were concentrated in poorer communities and the legislation therefore risked exacerbating health inequalities rather than reducing them. This was an area where a number of Cabinet ministers had sharply opposing views, not least because there were a large number of former health ministers who were sympathetic to the ban in other government departments.

During the course of 2004, a series of events kept smoking bans high on the political radar. In March 2004, in what Taoiseach Bertie Ahern described as *"landmark legislation"*, the Republic of Ireland introduced the toughest anti-smoking laws in Europe with a complete ban in workplaces.[18] In November, the UK government's White Paper *Choosing Health: Making Healthy Choices Easier* appeared and proposed introducing a smoking ban in workplaces by 2008, with an exemption for pubs that do not serve food and private members clubs. The legislation would apply to England and Wales, but the Welsh Assembly stated that it would amend the Bill to create a comprehensive ban when it gained Royal Assent in England. During the following month, the UK ratified the World Health Organisation's Framework Convention on Tobacco Control, the world's first international treaty on public health. Anti-tobacco campaigners continued to make the argument that everyone

[17] Cited in Patrick Wintour and Colin Blackstock, 'Let poor smoke, says Health Secretary', *The Guardian* (9 June 2004; available at: http://www.guardian.co.uk/uk/2004/jun/09/smoking.politics

[18] 'Ireland Stubs Out Smoking in Pubs', *BBC* (29 March 2004); available at: http://news.bbc.co.uk/1/hi/3577001.stm

should have the right to a smoke-free workplace and pushed the government to honour its international commitments.

The prospect of legislation was now inevitable. While the public health community was united in its message that there had to be a total ban, one of the effects of the partial ban plan was to divide the hospitality industry. The representative trade bodies were concerned at the proposal to exempt private members clubs and non-food establishments, as they wanted to see a level playing field. In the view of Deborah Arnott, the initial hybrid policy formation was critical in swinging the hospitality industry behind a total ban in a way which they would not have been if the government had, for example, proposed a smoking room option. Furthermore, environmental health officers, who would have to enforce the ban, were engaged by Department of Health policy officials in order to make sure the legislation was workable and they took the view that a partial ban would be difficult to implement.

Meanwhile, pressure for a comprehensive ban continued to build. In March 2005, a *British Medical Journal* report published the most authoritative data yet on the impact of passive smoking with research suggesting it killed 11,000 a year in the UK. Three months later, Members of the Scottish Parliament voted by 83 to 15 to introduce a ban on smoking in public places in Scotland from March 2006. Employers failing to enforce the ban could face fines up to £2,500 and smokers who defied the new legislation would be liable to pay a £1,000 penalty.[19] Meanwhile, discussions over the smoking ban in England broke down at Cabinet level, causing the Bill to be delayed. John Reid retained doubts about the wisdom of an outright ban. He continued to raise concerns that a total ban might simply transfer smoking into the home, with a knock-on negative effect for the health of children and believed individuals should have the option to choose to go to an establishment which allowed smoking. On the other hand, proponents of stricter measures pointed out the higher rate of smoking in predominately manual and working class areas of the country and that many of those pubs and private clubs unaffected by the legislation were located in these areas. As such, a uniform application of the law would not only provide clarity for the public and be easier to implement, but also prevent the policy from worsening health inequalities.

Decision

The hybrid proposal appeared in the Labour Party's manifesto for the May 2005 general election. After Labour secured victory, John Reid was replaced as Health Secretary by Patricia Hewitt and she had to decide how to take the legislation through Parliament. The Cabinet itself was still split on the proposal and there was a strong external campaign running for comprehensive measures.

At the beginning of the new Parliament, Kevin Barron was appointed chair of the Health Select Committee. As he was a known longstanding advocate of measures to curb tobacco use, having sponsored a Private Member's Bills in the 1990s, Barron took his appointment as a signal from government to engage the Select Committee on the issue. He therefore decided to hold an inquiry

[19] 'Smoking ban law approved by MSPs', *BBC* (30 June 2005); available at: http://news.bbc.co.uk/1/hi/scotland/4635029.stm

into the legislation on smoking in public places while it was under consideration by Parliament. At the start of those hearings, a majority of the eleven members were not in favour of a complete ban. But the Committee took evidence in Ireland to see the ban in practice (including in a pub in Killarney) and during the hearings Northern Ireland announced it was going for a complete ban, which was a *"gift to the Committee"* and they brought in the Northern Ireland Secretary to give evidence.[20] They also took evidence from the CMO who said there should be a complete ban – and when a member asked Sir Liam if he would consider his position if this was not introduced, he said he would, which *"lit the blue touch paper"* – though he had not given prior thought to saying this at the hearing.[21]

On 27 October 2005, the Health Improvement Bill was published. As the compromise clause for private member clubs and non-food public houses remained, criticism came from both pro- and anti-smoking lobbies, although there was a growing consensus within the hospitality trade that restrictions should apply across the sector in order to ensure fair competition. Given the exemption, there was a fear that some pubs would simply stop serving food to avoid the ban. Patricia Hewitt appeared before the Health Committee on the day that the Bill was published and suggested that *"any way forward has both advantages and disadvantages"*. She admitted that the government faced a *"very difficult balance that we are trying to strike between protecting employees from second-hand smoke and respecting the rights of a minority of adults to do something that is perfectly legal"*. Furthermore, the Secretary of State acknowledged that *"the vast majority of people want a complete ban" and the trend of public opinion against smoking meant "it is only a matter of time before we do have a complete ban."*[22] By the time the inquiry reported on 19 December 2005, nine of the Committee's eleven members signed up to an amendment to get rid of the exemptions for private member clubs and non-food pubs. One effect of the Select Committee hearings was to establish a cross-party consensus for legislative action, which proved a crucial tipping point. Its timing and the fact that members' opinions moved was regarded by Liam Donaldson as *"absolutely perfect"*.[23]

Separately, and behind the scenes a coordinating group was meeting every Monday to plan tactics with Kevin Barron. The group, which included representatives from ASH and the All-Party Parliamentary Beer Group, produced a spreadsheet with the expected voting intention of every MP. Since the tobacco industry's key argument was economic, that legislation would harm the hospitality trade, evidence from New York and Ireland was used to show this was not the case. Advocates for the ban were keen to gain insights from those involved in introducing similar restrictions abroad, especially on how to sell the change publicly. The key messages were to frame the issue positively, 'smoke-free' rather than 'ban', and offer useful soundbites on the unsustainability of a partial ban. In the words of one New York official, *"you can't create a half-chlorinated swimming pool"*.[24] Yet, some lessons transferred better than others. The worker protection argument that was central to the debate in the US, with its highly litigious culture, was

[20] IfG Policy Reunion.

[21] IfG Policy Reunion.

[22] Examination of Witnesses: Rt. Hon. Patricia Hewitt and Sir Nigel Crisp, 'Minutes of Evidence', Select Committee on Health (27 October 2005); available at: http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/623/5102702.htm

[23] IfG Policy Reunion.

[24] IfG Policy Reunion.

thought by Liam Donaldson to have played less well in England. In contrast to collaborative approach of the anti-smoking lobby, what was notable on the other side was how the tobacco industry failed to build significant alliances.[25]

A key moment came when the opposition decided to give its members a free vote on the ban. This came at a moment when, within government, there was considerable restlessness over a number of difficult whipped votes. The Prime Minister indicated that he did not regard the smoking ban, even though a manifesto commitment, as being of the same importance as other controversial issues at the time and this opened the way for a free vote on the government side. The issue for the ban campaigners then became how to get a big enough majority in the Commons to withstand pressure in the Lords. On 14 February 2006, when the first vote was won, many MPs who had originally voted against the total ban ended up voting with the ayes for completely smoke free enclosed workplaces and public places in England by a majority of 200.[26] This enabled passage through the Lords, despite Lord Tebbit arguing in favour of reverting to the Labour manifesto commitment. The way in which Tony Blair and Gordon Brown voted was regarded as an important signal to others, and campaigners encouraged them to support the amendments on the grounds that otherwise they would end up having to implement a measure which they had voted against. In December, the government announced that a smoking ban in England would come into effect from 1 July 2007.

Consensus

The final policy was the culmination of a popular consensus that government was right to intervene in matters of public health. A preference for direct measures had been built up over decades through incremental changes and the sustained efforts of campaigners. By 2006, public opinion appeared to strongly favour a comprehensive ban, with 90% supporting restrictions on smoking in restaurants, 85% at work and 66% in pubs. Even 79% of smokers were in favour of a ban in restaurants, but only just over a third supported the same measures in pubs. In contrast, 69% of ex-smokers and 80% of those who had never smoked were in favour of the ban in pubs.[27] Overall, when questioned about the new legislation, the ONS survey found 53% strongly agreed, 24% agreed, 7% neither agreed nor disagreed, 11% disagreed and 4% strongly disagreed.[28] As internal debate raged within Cabinet, the mobilisation of public opinion was paramount. Although there was growing support for regulation, there continued to be concerns raised about public opposition to the ban and fears of widespread non-compliance, which did not happen.

The Conservative Party had been long-term proponents of self-regulation, as the party's *Action on Health* manifesto (2005) stated: *"We do not believe that food producers are to blame if people eat unhealthily, or that pubs are to blame if people drink or smoke. There we shall seek voluntary, not*

[25] See Deborah Arnott, et al. 'Comprehensive Smoke-free Legislation in England: How Advocacy Won the Day', *Tobacco Control*, vol. 16 (2007), pp. 423-8.
[26] 'Smoking Ban in All Pubs and Clubs', *BBC* (14 February 2006); available at: http://news.bbc.co.uk/1/hi/uk_politics/4709258.stm
[27] ONS, *Smoking-related Behaviour and Attitudes* (2006), p. 93.
[28] Ibid, p. 94.

statutory solutions to public health problems."[29] However, sensing the opportunity to embarrass the government, Tory MPs had been given a free vote on the Bill. Fearing a backbench rebellion, Labour followed suit and gave their MPs a free vote. Meanwhile, the Liberal Democrats had already made a commitment to support the passing of comprehensive smoke-free legislation in order to protect workers and tackle health inequalities. Although a majority of Conservative MPs still voted in favour of an exemption for private member clubs, such has been the perceived success of the policy that no party has seriously debated revisiting and revising the measures.

Reflections

At the Institute's policy reunion, there was general agreement on the panel that the move to smoke-free public places was a victory for Parliament and showed the power of Select Committees in establishing a basis for political action. The process that led to the ban had created a tipping point in willingness to contemplate legislative action that was now being followed through in the coalition Government's tobacco plan which built on and even went further in some respects than earlier Labour proposals.

In particular, the introduction of a comprehensive ban on smoking was a move that went with the grain of public opinion. In other countries (for example, Ireland, Scotland and Turkey) government action had, through strong ministerial leadership, pushed ahead of public opinion, but in England the government had lagged behind the public. Countries such as Norway which had opted for the 'smoking room' route (which might have been enacted if the government had proposed it in England, as it would have been supported by the hospitality industry) have moved to a full ban – so the change may well have come to England, but later, even if 'smoking rooms' had been introduced initially. For anti-tobacco lobbyists, the example of earlier action in similar jurisdictions proved a useful. In particular, rather than far-off examples in California and Australia, the Republic of Ireland provided a pioneering case study of effective legislation that was on Britain's door-step. Meanwhile, Scotland, Wales and Northern Ireland demonstrated the potential for Westminster to gain policy insights from devolved administrations.

Nonetheless, it was vital that there was a robust evidence base for action, marshalled over the years by a unified public health community, and an effective framing of the issue. In particular, the leadership role of the Chief Medical Officer should not be underestimated. The CMO is a unique position in government combining internal management responsibilities within the NHS, and as an adviser to ministers, with the ability to take a public stance. The process was kick-started when Liam Donaldson published his annual report for 2002 that recommended the introduction of a ban. This was a critical factor in persuading ministers to accept that the voluntary approach favoured previously by the government had failed to deliver. The willingness of a powerful Secretary of State to push the case for legislative action was also hugely valuable.

[29] Cited in George Jones, 'Tories will "empower" young people to resist sex, drugs and drink', *The Telegraph* (17 February 2005); available at: http://www.telegraph.co.uk/news/uknews/1483728/Tories-will-empower-young-people-to-resist-sex-drugs-and-drink.html

Efforts to promote comprehensive legislation were further aided by the tactical use of the Health Select Committee under a committed Chair, which built a cross party consensus on the case for action. Effective campaigning by external pressure groups combined with the Health Select Committee and the Chief Medical Officer to apply pressure from various perspectives. A key turning point came when the hospitality trade shifted to support a comprehensive ban. In a case of unintended consequences, the government's decision to adopt a model of legislative action based on exemption, rather than propose a uniform introduction of 'smoking rooms', threatened to unlevel the playing field in the hospitality industry. This proved decisive in getting them to support a full ban as a preferable option and therefore split the opponents of the ban. This coalition of interest groups and specialists helped move public opinion to a position where it was in advance of political opinion and created an environment to go further. At the same time, the tobacco industry failed to build any sort of effective alliance to oppose it.

More generally, the most effective action on smoking over the last forty years occurred in countries where there was a combination of leadership from the medical community, leadership from within the policy community – both committed civil servants and ministers, and from wider civil society, creating a public climate conducive to action. In some cases, such as the Republic of Ireland, individual ministers led public opinion and forced the pace of action; in others like England, ministers followed the movement in professional and public opinion. What changed was a growing confidence in government, its resolve stiffened by the health community and popular support, and a hardening of the evidence around the impact of passive smoking, whose effects had first been identified in the 1980s. It was the coming together of these factors that finally made a 'whole of population' intervention such as the smoking ban politically palatable.

List of Participants at Policy Reunion

Name	Role during this 'Policymaking Process'
Rt. Hon. Lord Reid of	Secretary of State for Health, 2003-2005

Cardowan	
Sir Liam Donaldson	Chief Medical Officer, Department of Health, 1998-2010
Rt. Hon. Tessa Jowell MP	Minister for Public Health, 1997-1999, and Secretary of State at the Department of Culture, Media and Sport, 2001-2007
Rt. Hon. Kevin Barron MP	Chair of the Health Select Committee, 2005-2010
Deborah Arnott	Director, Action on Smoking and Health (ASH), 2003 to Present
Prof. John Britton	Professor of Epidemiology, University of Nottingham, and Chair of the Royal College of Physicians' Tobacco Advisory Group
Steve Woodward	Director of ASH Australia, 1981-93; Deputy Director, ASH UK, 1993-4