STATES OF JERSEY

RESTRICTION ON SMOKING IN ENCLOSED WORKPLACES

Lodged au Greffe on 22nd June 2005
by the Health and Social Services Committee

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

(a) to agree, in principle, that smoking should be prohibited in enclosed workplaces; and

(b) to charge the Health and Social Services Committee to consult on the detail of the Law and then to bring forward for approval the appropriate legislation to give legal effect to the decision contained in paragraph (a).

HEALTH AND SOCIAL SERVICES COMMITTEE

REPORT

Restriction on smoking in enclosed workplaces – in principle proposition of the Health and Social Services Committee

Having monitored the development of anti-smoking legislation in other jurisdictions, and having observed the effectiveness of such legislation in practice, the Health and Social Services Committee has now decided to seek to prohibit smoking in enclosed workplaces.

The Health and Social Services Committee is committed to tackling smoking on health grounds and to this end it has lodged the Draft Restriction on Smoking (Amendment) (Jersey) Law 200-. If approved, this Law will, amongst other measures, ban smoking in places that serve food for consumption on the premises. At the time of the debate, during which 'in principle' approval was gained for these measure, it was argued that the ban should be extended to all enclosed public places. However, at that time, the concept of banning smoking in such places as bars and nightclubs was comparatively novel and largely untested in western jurisdictions. Since that time we have seen the broad and successful adoption of such laws in jurisdictions such as Ireland and New York. Notwithstanding significant doubts expressed during the introduction of these measures, they have proven to be a practical and workable means of providing significant protection to the health of the public.

The Committee therefore propose that the necessary work be undertaken to extend smoking restrictions in Jersey to enclosed workplaces (broadly in line with the Irish legislation introduced in 2004). If this proposition is approved the department would carry out a detailed consultation exercise in order to determine the best approach for the legislation to take.

Developments

As members will appreciate, this topic is dynamic and recent global developments, most notably in Ireland, have demonstrated how a wider ban, that focuses on enclosed workplaces, can gain political and public acceptance and work in practice.

In Ireland most enclosed workplaces became smoke-free by law on 29th March 2004, under provisions in the Public Health (Tobacco) Acts, 2002 and 2004. Since then offices, shops, factories, bars, restaurants and other enclosed workplaces have been smoke-free. In effect, Ireland has banned smoking in virtually all workplaces. The purpose of such legislation is to protect workers and members of the public from exposure to tobacco smoke.

Passive smoking

Some of the immediate effects of passive smoking include eye irritation, headache, cough, sore throat, dizziness and nausea. Adults with asthma can experience a significant decline in lung function when exposed, while new cases of asthma may be induced in children whose parents smoke. Short-term exposure to tobacco smoke also has a measurable effect on the heart in non-smokers. Just 30 minutes' exposure is enough to reduce coronary blood flow.

In the longer term, passive smokers suffer an increased risk of a range of smoking-related diseases. Non-smokers, who are exposed to passive smoking in the home, have a 25% increased risk of heart disease and lung cancer. A major review by the Government-appointed Scientific Committee on Tobacco and Health (SCOTH) concluded that passive smoking is a cause of lung cancer and ischaemic heart disease in adult non-smokers, and a cause of respiratory disease, cot-death, middle-ear disease and asthmatic attacks in children. A more recent review of the evidence by SCOTH found that the conclusions of its initial report still stand, i.e. that there is a "causal effect of exposure to second-hand smoke on the risks of lung cancer, ischaemic heart disease and a strong link to adverse effects in children". A review of the risks of cancer from exposure to second-hand smoke by the International Agency for Research on Cancer (IARC) noted that "the evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in never smokers". A study published in the British Medical Journal, in June 2004, suggests that previous studies of the effects of passive smoking on the risk of heart disease may have been under-estimated. The researchers found that blood cotinine levels among non-smokers were associated with a 50-60% increased risk of heart disease.

In terms of deaths from second-hand smoke, whilst the relative health risks from passive smoking are small in comparison with those from active smoking, because the diseases are common, the overall health impact is large. Professor Konrad Jamrozik, formerly of Imperial College London, has estimated that domestic exposure to second-hand smoke in the U.K. causes around 2,700 deaths in people aged 20-64 and a further 8,000 deaths a year among people aged 65 years or older. Exposure to second-hand smoke at work is estimated to cause the death of more than 2 employed persons per working day across the U.K. as a whole (617 deaths a year), including 54 deaths a year in the hospitality industry. This equates to about one-fifth of all deaths from second-hand smoke in the general population and up to half of such deaths among employees in the hospitality trades.

Regarding risk to young children – almost half of all children in the U.K. are exposed to tobacco smoke at home. Passive smoking increases the risk of lower respiratory tract infections such as bronchitis, pneumonia and bronchiolitis in children. One study found that in households where both parents smoke, young children have a 72% increased risk of respiratory illnesses. Passive smoking causes a reduction in lung function and increased severity in the symptoms of asthma in children, and is a risk factor for new cases of asthma in children. Passive smoking is also associated with middle-ear infection in children as well as possible cardiovascular impairment and behavioural problems.

Infants of parents who smoke are more likely to be admitted to hospital for bronchitis and pneumonia in the first year of life. More than 17,000 children under the age of 5 are admitted to hospital in the U.K. every year because of the effects of passive smoking. Passive smoking during childhood predisposes children to developing chronic obstructive airway disease and cancer as adults. Exposure to tobacco smoke may also impair olfactory function in children. A Canadian study found that passive smoking reduced children's ability to detect a wide variety of odours compared with children raised in non-smoking households. Passive smoking may also affect children's mental development. A U.S. study found deficits in reading and reasoning skills among children even at low levels of smoke exposure.

Exposure to passive smoking during pregnancy is an independent risk factor for low birth weight. A recent study has also shown that babies exposed to their mothers' tobacco smoke before they are born grow up with reduced lung function. Parental smoking is also a risk factor for sudden infant death syndrome (cot death).

Conclusion

The harmful effects of passive smoking are well-documented and demonstrated by a significant volume of scientific work. The fact is that a significant majority of people do not smoke, and a significant majority of those who do smoke, actually wish to give it up. Obviously this measure will be unpopular in some quarters and is likely to receive opposition from some businesses. However, now that there is clear evidence from other jurisdictions that such a ban can work, and even have business advantages, the Committee believes the States should signal its intention through supporting this proposition. Adoption of an 'in principle' proposal will give businesses and the wider community a sufficiently long lead in time before the measures come into effect.

Financial and manpower statement

Consultation and development of the proposals will be carried out within existing departmental resources. If approved, some law drafting time will be required to prepare a Jersey law based on the Irish legislation. Enforcement would be carried out within existing Health Protection resources.