

40 Years of Hurt

The hyper-regulation of
smokers 1979-2019



Josie Appleton

forestonline.org

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August 2019

Foreword by Simon Clark

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Contents

About Forest	4
About the author	4
Author's note	5
Foreword	7
Introduction	11
1. What we have lost: the bases of tolerance	17
2. The stages of smoking regulation	19
3. Detachment of anti-smoking policy from public opinion	33
4. Sock puppets and the intolerant state	42
5. The next 40 years: towards a free society	44
Timeline 1979-2019	47

About Forest

FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco) was founded in 1979 to support and defend adults who choose to smoke a legal consumer product. We campaign against excessive regulations including comprehensive smoking bans and unnecessary government intrusion into people's personal lives and private spaces. High profile supporters have included the late Auberon Waugh, artist David Hockney, musician Joe Jackson and Oscar-winning screenwriter Sir Ronald Harwood.

About the author

Josie Appleton is director of the Manifesto Club, a civil liberties group. She coordinates the club's campaigns for freedom in everyday civic life – including campaigns against vetting, on-the-spot fines, booze bans and photo bans – and has authored dozens of reports on issues ranging from leafleting bans to the regulation of public space. As a journalist and essayist she comments frequently on contemporary freedom issues. Her book, *Officious: Rise of the Busybody State*, was published in autumn 2016.

Author's note

FOR THE PAST decade I have studied and campaigned against the growing hyper-regulation of everyday life. My work has not largely touched on smoking but in researching this report I found the same patterns that I have found in other areas, principally the erosion of principles of individual autonomy and the state incursion upon informal social spaces and private life. This leads me to conclude that the regulation of smoking is not *about* smoking. It takes exactly the same patterns as issues such as the regulation of activities in public spaces, or the increasing control of groups such as football supporters or the homeless.

The regulation of smoking is driven not by the specificities of this activity but by the new forms of state that have developed over the past two decades, a state that increasingly recognises no independent domain for civic or individual action whatsoever. I firmly believe that if we are to fight this trend we must ally the different interest groups who, after all, are affected in very similar ways by the same underlying phenomenon: that the cause of smokers must also be that of non-smokers, the cause of football supporters that of cricket followers, the cause of the homeless that of the well-housed.

Finally, although as a lifelong leftie I have no love for tobacco companies, or capitalist industry in general, it is always a pleasure to work with Simon Clark at Forest, whom I have known for many years. He is a true libertarian and a staunch political campaigner and has done much to stem or slow down the tide of incursive regulation described in this report.

Josie Appleton

August 2019

Foreword

ADDRESSING guests at Forest's 40th anniversary dinner in London in June, Mark Littlewood, director-general of the Institute of Economic Affairs, struck an appealingly optimistic note. "It may feel like 40 years of hurt, but that never stopped me dreaming. Freedom," he said, "is coming home."

I do hope he's right. A few months ago, during an 'In Conversation' event at the IEA, I was asked what was the biggest change I had noticed in the 20 years I have been director of Forest. "When I started," I replied, "there were voluntary agreements and codes of practice. Today there is far more legislation. Coercion has replaced common sense."

Reading Josie Appleton's report I am reminded how true that is. In 1999 (let alone 1979) policies on tobacco were often agreed without the need for legislation or heavy-handed regulation, and they were arguably more effective. As Josie notes, the sharpest fall in smoking rates in the UK took place between the mid Seventies and the early Nineties when there were relatively few laws concerning the sale, marketing, promotion or consumption of tobacco.

Smoking was increasingly prohibited in the workplace but that was a matter for individual employers in consultation with staff and the unions. No-smoking areas were becoming a feature of many pubs and restaurants, and some proprietors chose to ban smoking completely, but it was their decision not the government's.

Politicians and stakeholders, including the tobacco industry, generally got together and adopted reasonable policies that most people could agree with. The outcome, by and large, were measures that took into account the interests of all parties, including consumers. Increasingly however power and influence has shifted to professional activists and unelected mandarins in the Department of Health and quangos such as Public Health England.

Voluntary codes have given way to laws banning all tobacco sponsorship and advertising. Policies that allowed for smoking and non-smoking areas in the workplace, including pubs and

restaurants, were ruthlessly stubbed out. Even private members' clubs were forced to obey the arbitrary new laws.

'The pariah status of smoking does not reflect public mores,' writes Josie. And she's right. The tragedy is that many of the anti-smoking laws introduced in the new millenium do not reflect public opinion. The results of surveys and 'public' consultations have consistently been ignored or disregarded. The smoking ban was introduced despite surveys that showed that only 30 per cent of adults supported a comprehensive ban. (Even today opinion polls throughout the UK consistently find that a majority of adults are in favour of allowing separate smoking rooms in pubs and private members' clubs.) Plain packaging of tobacco was also pushed through parliament despite the fact that a public consultation generated a huge majority (2:1) opposed to the policy.

The consequence of such measures has been a gradual erosion of tolerance with a small but vociferous group of anti-smoking activists dictating government policy. Having been forced to smoke outside despite the fact that modern air filtration systems were perfectly capable of reducing environmental tobacco smoke to a level acceptable to most people, smokers today find themselves under attack from zealots who want smoking prohibited outside as well. 'Now,' writes Josie, 'our noses twitch at the slightest whiff of tobacco smoke.'

Launched in 1984, No Smoking Day went from being a well-meaning initiative that helped smokers who wanted to quit, to an event that positively encouraged an anti-smoking culture. But at least it was only one day. Today, thanks to the taxpayer-funded Stoptober campaign, smokers have to endure an entire month of state-sponsored nagging.

The increasingly brutal approach to smoking cessation is epitomised by Public Health England which is currently demanding that all NHS trusts ban smoking on hospital grounds, a policy that actively discriminates against patients who may be infirm or completely immobile. Taking advantage of people's physical condition to take away one of their few pleasures when they are at their most vulnerable, mentally as well as physically, is truly despicable.

Meanwhile punitive taxation (between 80 and 90 per cent of the cost of tobacco goes to the government) has one main aim – to coerce people to stop smoking. Low earners who can't or won't quit are pushed further into poverty, leading to more hardship. Despite this, anti-smoking policies are often characterised as an act of charity. Action on Smoking and Health, the anti-smoking pressure group that drives the anti-smoking agenda in the UK, likes to be described not as a political lobby group, which is more accurate, but as a 'quit smoking charity'. I fail to see what's charitable about whipping up hostility towards a significant minority of the population.

'Smoking,' writes Josie Appleton, 'is the canary for civil liberties.' Again, she's right. If we don't stand up for adults who enjoy smoking, what's next? Armed with the tobacco template, are public health campaigners going to move from informing the public about nutrition and healthy eating and drinking to banning more and more products that are deemed 'unhealthy' while dictating the amount of sugar, alcohol or calories we are permitted to consume?

Any review of the last 40 years would have to conclude that the freedom to choose what we eat, drink and smoke has been eroded alarmingly, to the extent that, in 2020, an entire category of tobacco – menthol cigarettes – will be prohibited. All is not lost, though. As the IEA's Mark Littlewood commented, when addressing Forest's 40th anniversary dinner:

"Fellow smokers and lovers of freedom, let's not worry about the tactical battles we may have lost. Let's make sure that in 2059, when we come together again to celebrate 80 years of Forest, that we are able to light up, drink up, and reflect that the battle for freedom has been won." Amen to that.

Simon Clark
August 2019



Introduction

FORTY years ago smoking was part of public life. People smoked on public transport and in the workplace, cigarettes were advertised on billboards and in magazines. Forty-three per cent of men and 36 per cent of women smoked cigarettes (55 per cent of men smoked tobacco products of some kind)¹ and smoking was a perfectly socially acceptable activity, in spite of general awareness of the health risks and the warning that ‘smoking can damage your health’ printed on every pack.

In 1978 Tyne and Wear Transport Committee had banned all smoking on public transport and the Central Middlesex Hospital became the first to introduce a smoking policy. In 1979 the anti-smoking lobby group Action on Smoking and Health (ASH) called for a ban on smoking in all workplaces and public places, and post offices were made smoke-free.² But these campaigns were generally posed in the reasonable terms of choice, with no-smoking areas being made available for the non-smokers who were by this time in a slight majority.

Today, in contrast, although smoking was until recently practiced by a fifth of the population, it has become a pariah act, increasingly hidden from public life. Smoking is excluded from all enclosed public places and some open air ones too (including station platforms, some parks and beaches, and entire hospital sites). Cigarettes are sold in packages emblazoned with grotesque images of people dying or rotting body organs. They cannot be publicly displayed in shops but must be hidden away in cupboards.

The official narrative is that smokers are killing themselves and others. Their smoking is to blame for their own poverty and mental health problems and they should not smoke in public or especially in front of children because not only are they making children sick, they are also setting a bad example by ‘role modelling’ this dangerous habit. If smokers are ill, in some health

1 Tobacco statistics, Cancer Research UK: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/tobacco#ref-3>

2 Key dates in the history of anti-tobacco campaigning, ASH, 21 February 2017: <http://ash.org.uk/information-and-resources/briefings/key-dates-in-the-history-of-anti-tobacco-campaigning/>

trusts they can be denied treatment until they kick the habit.³ Meanwhile lung cancer has become stigmatised as the 'smoker's disease', drawing little research time or money, and even non-smokers with the disease find that they receive an unsympathetic reception or are told that they 'got what you deserved'.⁴

At first sight this extreme intolerance towards smoking is puzzling, given the social liberalisation that has occurred in other areas. Gay people are now free to marry and raise a family with their same-sex partner, and gay sex and love has lost virtually all of its previous stigma. Transgender people can change their sex, on paper or in body, and the state will even pay for their operation. The stigma surrounding some controlled drugs has diminished and many police forces adopt a softer approach, especially towards marijuana use. Senior public figures and the Liberal Democrats periodically call for the legalisation of marijuana, playing down the negative health effects of the drug.

While cigarettes are now hidden from view, condoms have been taken out from under the counter and displayed next to the till, while the pharmacy Boots even displays sex toys and other sexual aids in full view.⁵ Previously taboo sexual practices such as S&M have become the subject of best-selling books and films. There is a broad tolerance and social acceptance of the full diversity of ethnicities or religions, and the 'social exclusion' of minority groups is frowned upon.

There is no rational explanation for the pariah status of smoking. The effects of smoking are not inherently antisocial. Unlike other drugs, smoking does not screw up your mind or ruin your memory. It does not leave you pasted on the floor or mumbling at the ceiling. A smoker is a perfectly functioning member of society. They can do their job well and be a good parent to their kids. Nicotine itself is not harmful and people can

³ NHS provokes fury with indefinite surgery ban for smokers and obese, Telegraph, 17 October 2017: <https://www.telegraph.co.uk/news/2017/10/17/nhs-provokes-fury-indefinite-surgery-ban-smokers-obese/>

⁴ Why non-smokers are getting lung cancer, BBC News, 25 June 2018: <http://www.bbc.com/future/story/20180625-why-the-rate-of-women-getting-lung-cancer-is-rising>

⁵ Sex toys for sale at Boots, Mail on Sunday, 9 January 2012: <https://www.dailymail.co.uk/news/article-2083701/Sex-toys-sale-Boots-displayed-near-healthcare-products-view-children.html>

find its effects beneficial to their lives, allowing them to stay calm and focussed, which helps them work better.

Of course smoking is a serious health risk to the smoker but the risk of dying from smoking is a matter of probability, an increased risk rather than a certainty. It is said that smokers will die on average ten years earlier than non-smokers, and 30-60 per cent of smokers will eventually die of their habit, but some smokers live to a ripe old age whereas an alcoholic's poisoning of their liver is an inevitable question of toxicology. Compared to a pursuit such as climbing – where on some faces a quarter or more of all who attempt it will die (Annapurna is 34 per cent and K2 is 26 per cent) and high-level climbers are lucky to make it to their forties – smoking is extremely safe.

Nor can it be explained by demographics. Until the emergence of vaping at least 20 per cent of the population smoked, a minority but still a substantial one, much greater than the proportions of gay or transgender people, or ethnic minorities. Any other habit practiced by one fifth of the population would receive some recognition and provision for it to be conveniently and pleasurably practiced.

The reason for this disparity lies in the changed form of the state and social authority. The old establishment has fallen, traditional family forms and religions have waned, leading to a loosening of previous moral taboos and stigmas that held sway and a new tolerance in areas of sexuality, ethnicity and religion. This has meant a welcome liberalisation of sexual mores and a greater tolerance of sexual preferences and religious differences. But at the same time there has been a rise of a new establishment that bases its authority on a more intense regulation of everyday life and personal conduct, including around health. This has meant the creation of a new intolerance in new areas, such as around smokers or others now judged to be 'anti-social'.

Whereas the old establishment celebrated family values, the following of a profession, loyalty to profession or country, the new establishment has the somewhat narrower goal of the non-disturbance of others and the physical maintenance of the body. The question of bodily health has become an ethic for the authorities, with the goal merely being that of maintaining the

body in good condition for as long as possible, consuming the recommended number of fruit and vegetables, abstaining from alcohol and tobacco, counting your steps with a pedometer, and taking 30 minutes of gentle exercise. Unsurprisingly many people find this an unsatisfying ethos which is why some of them continue to smoke, eat chocolate or practice risky activities or sports.

Today's new officialdom is more isolated than the old, which was rooted in social life through networks of institutions that stretched down to every neighbourhood, and founded in common beliefs and practices. By contrast the new officialdom is largely separate from society. Rather than reflect social mores it is an activist state that imposes policies upon people and acts upon them as if they were so much material for its policy projects. Rather than reflect public opinion or serve the public, the new officialdom has an autonomous existence. It has become (as I described it in my book *Officious*) a 'state structure for itself', separated from and set against civil society.

Smoking regulation embodies this split between state and civil society, between officialdom and people. The pariah status of smoking – and the regulations now imposed upon smokers – do not reflect the views of the majority of people who in opinion polls have consistently shown themselves to be more tolerant and supportive of provisions for smokers such as separate smoking rooms in pubs and clubs. After all, almost everyone has friends or family who smoke. Smokers are not some strange hostile other but part of families and communities, and most people therefore have an idea of why people choose to smoke. The pariah status of smoking does not reflect public mores. It has been consciously created and imposed by an activist officialdom.

Importantly this activist officialdom has only been possible because of the relations the state has developed with anti-smoking groups such as ASH, which are often funded by the public purse (see section 4). However it is not the case that these groups have hijacked public policy, nor is it simply the case that the state pays campaign groups to do its bidding. Rather, it is through these groups that the policies of an isolated officialdom can appear to be the subject of public demand and assent. The new establishment works through developing relations with

NGO groups that appear to be independent parts of civil society but in fact function as part of the state structure and the elite policy realm. These groups' appearance of independence – the fact that they are always demanding more restrictions and criticising the government for not going far enough – is essential for this form of policy making which involves the creation of a *pseudo-civil society*, allied with the state structure, which then formulates and imposes policies upon the real civil society.

This report begins with an outlining of the historical bases of tolerance and personal freedom (section 1) that formerly guided medical ethics as well as areas such as criminal law. These principles reflect the reality of life in civil society: the freedom demanded and exercised by individuals in their private acts and associations with one another. As the state has become detached from civil society, acting in its own interests, so these principles have inevitably been overridden and then forgotten, in smoking policy as other areas of policy. Yet it is a rediscovery and a defence of these principles that is essential if we are to turn around the increasing encroachment of the state in informal social life.



40 Years of Hurt

1. What we have lost: the bases of tolerance

There are three interconnected principles that form the basis of individual freedom and tolerance.

First principle: The virtue and authority of individual autonomy

This principle first developed in the 17th century Enlightenment, with the defence of the free conscience, the principle that individuals should be free to follow their convictions and seek their truth as they see fit. Whereas in the Middle Ages it had been acceptable to force heretics to see the error of their ways through torture and other painful means, in the early modern period the individual conscience should not be subject to force. In the view of 17th century philosopher Pierre Bayle, it was not a sin to err, only to go against one's conscience; the 'erring conscience' had rights to respect and toleration as much as any other.⁶

It became more important to be *free* than to be *right*, and with this the legitimation of the torture of heretics dissolved since the Church had justified its application of hot irons and pincers to the body of the erring as a charitable act, to enable them to see the error of their ways and return to the fold. With the principle of conscience, whether someone is right or wrong in their decisions became irrelevant: they should never be forced. This principle was later incorporated into modern medical ethics that assumes an absolute sovereignty of a person over their body. A person has the right to refuse life-saving treatment, for example, and they cannot be experimented upon against their will, even if it would be of general benefit to others.

Second principle: Tolerance

Tolerance means allowing the other person freedom to express their views or follow certain practices even if these conflict with your own. Prior to the modern period there had been instances of

⁶ La Tolerance, Julie Saada-Gendron, Flammarion, Paris, 1999

tolerance but these were a grudging matter of practical necessity, such as a means to rule a large empire or when two sides in a religious war were equally matched. In general, and certainly in the Middle Ages, social or religious differences were seen as destructive of social bonds: social relations could only be constituted through a single faith, practice and worldview. In the modern period, by contrast, tolerance became a virtue. Rather than a burden to be borne, it was seen as positive benefit.

In 1684 Basnage de Beauval argued for religious toleration on the basis that truth resulted from the 'confrontation of dogmas'; the 'opposition between two parties' serves to 'pressure and excite' one another to virtue. He saw conflict of opinion or practice as like a 'sting' which keeps one awake and shakes away ignorance, and argued that disputes between learned men were 'advantageous and useful for the public'.⁷

This principle of tolerance was the lived reality of urban civil society which is made up of this cacophony of different opinions, habits and styles. What people still enjoy in major cities is in part the invigorating experience of difference and variety, the fact that you see people living in quite different ways to you. Therefore tolerance means that it is in one's interests to seek not only one's own freedom of belief or habit, but that of others too – even (or perhaps especially) when other people's beliefs and habits are quite different to your own.

Third principle: The harm principle

This is the legal principle concerning the legitimate use of state coercion that emerges from the former principles. It was embodied in the French declaration of the Rights of Man and of the Citizen in 1789: 'Liberty consists in the freedom to do everything that injures no one else; hence the exercise of the natural rights of each man has no limits except those which assure to the other members of the society the enjoyment of the same rights.' This means that the legitimate use of state coercion can only be applied so much as a person interferes with the freedoms of others; it should not be employed in that person's own interests.

⁷ La Tolerance, Julie Saada-Gendron, Flammarion, Paris, 1999

It was the French revolutionary government's vigorous adherence to the harm principle that meant that it decriminalised homosexuality since it saw this was a 'victimless crime'. Although many members of the regime disapproved of homosexuality, and believed it immoral and harmful to the individuals concerned, their disapproval and belief was not reason enough to ban the practice. In *On Liberty* in 1859, John Stuart Mill gave the harm principle its fullest and most famous statement:

That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right... The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

This means that a person should never be forced or pressured to change their course of action because a different course is thought to be better or more beneficial for them. Put another way, people should not be coerced 'for their own good' because they - as the owner of body and mind, and author of their life - are the best and only legitimate judge of what is good for them.

2. The stages of smoking regulation

In the different stages of smoking regulation over the past 40 years we can see the gradual weakening, then complete destruction of these principles of autonomy and tolerance. The history of smoking regulation is a particular one but a similar pattern can be discovered in most areas of life - including alcohol regulation, public spaces regulation, food regulation - which all show the same shift towards an increasingly intrusive and then openly coercive state.

We can break the history of smoking regulations down into a number of different stages.⁸

1960s and 70s - Health warnings and advertising restrictions

After the first studies showing a correlation between smoking and lung cancer appeared in the 1950s, by the early 1960s the evidence was clear and government medical authorities made official statements on the dangers of smoking to health. In the 1960s and 70s the government worked with the tobacco industry to agree voluntary codes, such as banning cigarette advertisements on TV in 1965, adding health warnings to packets in 1971, limiting adverts at sporting events in 1972, and in 1980 getting the tobacco industry to agree budget cuts on poster advertising.

At this stage the role of government was to adequately warn people of the dangers to health and to ensure they were properly informed, as well as to counter the power and seduction of a tobacco industry with vast advertising revenue that would be used to cover up the negative health effects of its product. (Parts of the tobacco industry did not publicly admit the negative effects of tobacco until as late as the 1980s.) Here, state action remained within the classic domain of public health and welfare state regulation which seeks to protect people from the more rapacious element of market capitalism and to defend the goal of public health while also respecting individual autonomy. There was no question that smokers should be prevented from smoking, or pressured to give up, only that they should be informed of the dangers to their health and that this message should get through above the seduction and blare of tobacco advertising which for decades had presented the product as beneficial for health.

1980s and 90s - Supporting smokers to quit and no-smoking zones

It was in the early 1980s that anti-smoking first started to become an activist issue. Although ASH had been set up in 1971 it wasn't until 1984 that No Smoking Day was launched with a view to

⁸ This history draws on the document: Key dates in the history of anti-tobacco campaigning, ASH, 21 February 2017: <http://ash.org.uk/information-and-resources/briefings/key-dates-in-the-history-of-anti-tobacco-campaigning/>

encouraging smokers to quit. In the early Eighties there were the first symbolic statements by public authorities, including a 1983 campaign by Glasgow Council to make Glasgow smoke free by the year 2000, and in 1985 there was the launch of 'project smoke-free', an initiative against smoking in the north west of England. Anti-smoking was becoming something of a point of principle for some public authorities, a means by which they might make a statement, although these authorities were at this stage isolated examples.

Yet it is notable that policy in this period remained based on the principle of choice. Tellingly, ASH sought to encourage and support smokers 'who wanted to quit', not coerce those who did not. Some stop smoking campaigns involved incentives (including competitions, prizes and bonuses for people who gave up smoking) but they did not involve force. The autonomy of the smoker was still respected, albeit grudgingly. Moreover, there was no question of smoking being banned in all public places. The issue was merely the provision of more no-smoking zones so that people choose between 'smoking' or 'no-smoking'. The result was that no-smoking areas developed on public transport and in restaurants but there was still a choice.

Later a distinction was made between spaces where the public could choose to be present and those where they could not. In 1991 the Department of the Environment published a voluntary code suggesting that if members of the public were present from necessity (such as banks and post offices) such places should be no-smoking. If they were present from choice (bars or restaurants, for example) there should be a choice of smoking or no-smoking areas. Although ASH had called for a ban on smoking in all restaurants in 1987, in general it had to content itself with gaining more no-smoking zones in different areas whilst promoting the idea that people should have a choice.

1990s and 2000s - Passive smoking and public smoking bans

Studies finding a link between lung cancer and passive smoking appeared in the mid/late Eighties but it was in the early Nineties that the passive smoking issue really took off. This was not so much a matter of growing scientific evidence – which remained

uncertain and weak – but that it became a campaign issue for public and medical authorities. It was the supposed dangers of passive smoking that justified a series of bans on smoking in public places in the early Nineties, including the first non-smoking beaches in Bournemouth in 1994, the same year that MP Tessa Jowell sponsored a bill to ban smoking in all workplaces and public places. Smoking environments came to be seen as medically harmful, particularly for young children. In 1993 adoption agencies made the recommendation that children be placed with non-smokers in preference to smokers, and Richmond Council banned smokers from adopting children under ten.

From the beginning the passive smoking issue had as much an ideological basis as a scientific one. In studies today the increased risk to non-smokers from passive smoking is so slight that it requires very large samples in order to discover any statistical significance. Even for the spouses of smoking husbands, who have 40 years of daily exposure to cigarette smoke in an enclosed space, the statistical correlation is not a particularly clear or strong one. The current view is that passive smoking can increase the risk of lung cancer by around 10-30 per cent, a level of relative risk that is a long way from the over 1000 per cent increased risk experienced by smokers. (It is this difference in risk between active and passive smoking that led epidemiologist Richard Doll, who established the statistical link between smoking and lung cancer in the Fifties, to say that the passive smoking risk was ‘so small it doesn’t worry me’.)⁹

It is likely that passive smoking does increase the risk of lung cancer and other illnesses but by a very small amount, perhaps comparable to enjoying regular barbecues or open fires, or living in a major city. It is also likely that (as with active smoking) more intense exposures increase the risk, meaning that occasional exposure such as entering a smoky bar (or even working evenings in a smoky bar) would have much less effect than living with a smoking spouse for decades.

⁹ Passive Smoking - Is there convincing evidence that it's harmful? Independent, <https://www.independent.co.uk/life-style/health-and-families/health-news/passive-smoking-is-there-convincing-evidence-that-its-harmful-6102137.html>

The campaign against passive smoking was based not on the strength of medical evidence but on the political drive to restrict smoking. It was first and foremost an ideological campaign that constructed the medical evidence to suit its purpose. This was necessary because, at that stage, society still held to the harm principle, meaning that smoking could not be outlawed in public unless there was clear evidence of harm to others; harm to the smoker alone was not a viable justification. Therefore, if restrictions were desired, harm to others had to be proven or assumed and it was this desire by authorities to justify restrictions that led to the ideological construction of the passive smoking narrative.

It was the alleged threat of passive smoking that justified the first public smoking bans in California in the Nineties and Europe in the Noughties. First Ireland, then Norway and Scotland, then England and Wales where smoking was prohibited in all enclosed 'workplaces', including offices, restaurants bars, pubs and work vehicles. In England the 2006 Health Act involved two sleights of hand. First, it assumed that 'exposure to smoke' was a serious health risk; second, it defined spaces such as pubs and members' clubs as public places, rather than the private social spaces many people considered them to be..

It also made smoking in pubs and clubs an issue of employees being exposed to a health risk at work, akin to chemicals or dangerous machinery in factories, which brought it within the bounds of legitimate state legislation. (The definition of 'workplaces' even included personal vehicles used to drive a painter and decorator to work. Several tradesmen and taxi drivers have been fined for smoking while alone in their vehicle, which as a 'workplace' is required to be a 'smokefree space'.)¹⁰ These two sleights of hand showed that the harm principle and the principle of autonomy still retained a certain social authority since they had to be respected in appearance if not in practice. Evidence and logic had to be twisted in order to justify restrictions on smoking in a manner that did not violate these principles.

¹⁰ For example, Taxi driver pays smoking fine, Lancashire Post, 14 June 2017: <https://www.lep.co.uk/news/taxi-driver-pays-smoking-fine-1-8594777>;

It is also telling that the 2006 Act included a provision that exempted 'any premises where a person has his home, or is living whether permanently or temporarily (including hotels, care homes, mental health units, and prisons and other places where a person may be detained)'. This exemption suggested that, at this point, it would not be legitimate to regulate a person's private space or place of residence, even if this person were in state custody or care.¹¹ There remained a respect for the private space as a space of autonomy within which the person could act as they pleased; it was not legitimate for state regulation to incur within this domain. This was a view supported by health charities such as the King's Fund which said that 'patients who wish to smoke should be able to do so'. The charity supported indoor provisions for smokers such as smoking rooms: 'Where patients are living long-term in institutions that are in effect their homes it is reasonable that they should be allowed to smoke indoors in a way that does not affect staff and patients' access to a smoke-free environment.'¹²

This has all changed over the past decade. The principles of autonomy and tolerance have disappeared entirely from public policy, such that the state no longer has to pay lip service to these principles or to twist policies to make them appear to be respectful of freedoms. Now, there has been a move into open and direct coercion, with a series of more direct justifications for smoking bans. State regulation has moved into the domain of an individual's control over their body, the private space of the home, and the informal question of social influence and mores. From a formal respect for tolerance the state has now moved into the direct creation of intolerance towards smoking and smokers.

Post 2010 - the move into direct coercion

Since 2010 there have been entirely new kinds of restrictions on smoking which involve a direct coercion exerted over smokers.

¹¹ Health Act 2006: <https://www.legislation.gov.uk/ukpga/2006/28/part/1/chapter/1/cross-heading/smokefree-premises-etc>

¹² King's Fund response to consultation on smoke-free premises and vehicles: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Consultation-response-smoke-free-oct-2006.pdf

These include two new kinds of justifications. First, restriction in smokers' own interests, to improve their health or enable them to live a longer life which violates both the harm principle and the principle of individual autonomy. Second, restriction to prevent smokers from setting a bad example to others, and the deliberate encouragement of hostility towards smoking which violates the principle of tolerance. This new phase has involved a more direct exertion of state control, first over people's own bodies and health, and second over the question of social mores and the example people set to others.

Restrictions 'for your own good'

The first category of restriction is the banning of smoking in order to improve smokers' own health. This has become one of the primary justifications for all kinds of restrictions – including new bans on smoking in public places – but it has been most fully realised in relation to who are in effect wards of the state, such as residents in prisons, psychiatric institutions, and hospitals. In some cases – such as prisons and psychiatric institutions – smokers are absolutely denied the opportunity to smoke for the duration of their stay, including in outside areas, and they are given the choice between quitting or undergoing temporary abstinence.

The ban on smoking in prisons was fully enacted in 2018 after being rolled out over the previous two years. In 2013 Nice guidance recommended smoke-free hospitals and mental health units,¹³ and in 2018 Forest FOI research found that 90 per cent of the 40 mental health trusts in England did not tolerate smoking anywhere on hospital grounds.¹⁴ Smoke-free mental health units often confiscate tobacco products from people upon arrival and some conduct body searches for tobacco, even stopping patients' leave after the discovery of such items as a matchstick or cigarette paper.¹⁵

13 Nice guidance on smoking in acute, maternity and mental health services: <https://www.nice.org.uk/guidance/ph48>

14 Prejudice and Prohibition, Mark Tovey, Forest, March 2019: http://forestonline.org/files/3915/5222/7436/Prejudice_and_Prohibition.pdf

15 Should psychiatric hospitals completely ban smoking? Head-to-head, BMJ, 4 November 2015: <https://www.bmj.com/content/351/bmj.h5654/rapid-responses>

Aside from the questionable effectiveness of these policies (the vast majority of mental health patients restart smoking when they leave the institution, and the effect in prisons appears to be the rise of dangerous practices such as smoking nicotine patches, a black market in tobacco, and the increase of legal highs),¹⁶ these policies also represent a new stage in the disregard for principles of individual autonomy and tolerance. This is particularly objectionable in the case of mental health patients who have not done anything wrong and are in many cases have submitted themselves for treatment of their own volition.

Smoking is unrelated to their mental health issue. It is prohibited not because it is necessary for their recovery – indeed the trauma of forced cessation would cause additional difficulties for many patients – but merely because their position as temporary ward of the state gives the state an opportunity to impose no-smoking policies as a coercive condition. The state can do things to mental health patients that it is not able to do to the general population. As libertarian writer Christopher Snowden put it, it coerces them simply ‘because it can’.¹⁷

A less direct but still powerful coercion is exerted over the employees of certain health institutions who as salaried officials must abide by smoke-free policies that make it impossible to smoke during working hours, or travelling to or from work. (For example, they cannot smoke in uniform, while in work vehicles, anywhere on hospital sites, or at the entrance to the hospital site.) Employees who violate these policies can be subject to disciplinary action. In cases where the hospital site is large and their medical condition prevents them from leaving the site, many hospital patients are also subject to de facto bans. While it is understandable that a patient with a smoking-related illness would be strongly advised to quit, it is unreasonable that this prohibition is directed at all patients who smoke, including those present for entirely unrelated conditions. Again, it appears to be

¹⁶ Smoking ban in prison puts tobacco on most-wanted list, The Times, 23 July 2018: <https://www.thetimes.co.uk/article/smoking-ban-in-prison-puts-tobacco-on-most-wanted-list-gncpj5fs7>

¹⁷ 53rd Maudsley Debate: ‘This house believes smoking should be banned in psychiatric hospitals’: https://www.youtube.com/watch?v=qy53lqC_07M

a question of state authorities taking advantage of someone's physical incapacitation in order to impose lifestyle changes upon them.

What is notable is that these policies involve no mention or recognition of the principle of individual autonomy. The higher level of smoking for prisoners and mental health patients – over 60 per cent in mental health units and around 80 per cent in some prisons¹⁸ – is seen as a unacceptable 'health inequality' which health authorities are taking it upon themselves to rectify. Smoking bans are therefore presented as a charitable act on the part of the state, to show that they care about the health and welfare of its wards, and to remove them from their state of 'health inequality' to which they have been condemned. Here, the act of coercion – the removal of a lifestyle choice, perhaps one of the only that remains in conditions of incarceration or sectioning – is presented as an act of charity, helping that person to live a longer and healthier life. The harm principle is entirely dispensed with and there is a return to the medieval logic employed for the torturing of heretics. A person can be coerced 'for their own good'; they can be forced in order to direct them towards a correct or more beneficial pattern of conduct.

The question of what is good for a person becomes something that is administered from outside, by state authorities, whose primary concern appears to be the the survival and maintenance of people's bodies. Patients are offered behavioural support and nicotine replacement therapy, and this is seen as good enough since it relieves them of any physically painful symptoms associated with smoking withdrawal. The debate is merely whether the measure 'works' or not. There is no consideration of the matter of principle, of whether it is acceptable to exert force over someone in this way. We can see how psychiatry (in this area at least) has no sense of treating someone as a *person*, as someone with a capacity to make their own decisions. Yet treating patients with respect and autonomy is perhaps one of the important aspects of their treatment and eventual recovery,

18 Reducing high smoking rates among patients in mental health units, PHE, 4 June 2015: <https://www.gov.uk/government/news/reducing-high-smoking-rates-among-patients-in-mental-health-units>

a view expressed forcefully by a former psychiatric patient, 'S', in the Maudsley debate on smoking bans.¹⁹

Over time there are an increasing number of other groups being subject to direct coercion, including in their homes. An ASH report on smoke-free homes argues that no child should be exposed to smoke within the home and proposes smoking bans within certain categories of social housing.²⁰ There are already restrictions on smoking in your own home for a certain period prior to the visit of a public worker, including care workers or council workers visiting your home for another reason. The very presence of a public official means that the state defines your home as a 'workplace' for the duration of the visit and sets conditions on the activities you may carry out prior or during the visit.

Anti-smoking campaigners often argue that there is no 'human right' to smoke, and as proof they cite the Court of Appeal judgement in 2008 after Rampton Hospital in Nottinghamshire went smoke free. We can only respond that the courts have rubber stamped many incursions on liberties over the decades and that the question of a freedom is not something decided by the authorities or official institutions alone but is properly grounded in civil society's assertion of its rights and independence.

Restrictions to limit 'bad influence'

There is a second new category of restriction that is used to justify bans on smoking in the open air, including bans on visitors smoking on hospital sites, bans in parks, beaches and public squares, or outside schools or in children's playgrounds. In 2018 Forest research found that 72 per cent of the 130 acute health trusts in England did not tolerate smoking anywhere on hospital grounds. The Welsh government has moved to ban smoking in the outdoor grounds of hospitals, outside schools and in playgrounds.²¹

19 53rd Maudsley Debate: 'This house believes smoking should be banned in psychiatric hospitals': https://www.youtube.com/watch?v=qy53lqC_07M

20 Smoking in the home: New solutions for a Smokefree Generation, ASH, 20 November 2018: <http://ash.org.uk/information-and-resources/reports-submissions/reports/smoking-in-the-home-new-solutions-for-a-smokefree-generation/>

21 Smoking ban plan for playgrounds and hospital grounds, BBC News, 25 May 2018: <https://www.bbc.com/news/uk-wales-44224134>

Several schools have banned smoking outside school gates while many councils have introduced 'voluntary bans' on smoking in children's playgrounds (including, as of 2016, all 22 authorities in Wales). Five councils (including Leeds, Carlisle, Cheshire West and Cheshire, Daventry and Mansfield) have even used anti-social behaviour legislation to make it a criminal offence to smoke in playgrounds, making it subject to £100 on-spot fines and/or criminal prosecution.²² Smoking has been banned in two Bristol squares,²³ two Welsh beaches,²⁴ and in several London parks.

These are places where there is no conceivable risk from secondhand smoke, and indeed bans are no longer largely justified in these terms. Instead prohibition is largely justified as a means to reduce the *bad social influence* exerted by smokers upon others, particularly children who may see them smoking. A councillor who banned smoking in a London park said that seeing other people smoking sends a 'subliminal message about smoking' to young people.²⁵ England's chief medical officer supported a ban on smoking in children's play areas, saying she supported any policy that reduced 'active smoking and its role modelling in front of children'.²⁶

The Chartered Institute of Environmental Health supported a ban on smoking wherever children were present. 'We would like to see smoking being stubbed out wherever children play or learn ... This would not only include children's playgrounds but could see no-smoking zones extended to public parks, zoos and theme parks. Children should be able to have fun and enjoy themselves without seeing someone smoking and thinking this is normal behaviour.' This is a right not to be free from the harm of secondhand smoke but to be free of the *sight* of someone

22 Manifesto Club FOI research on PSPOs: <https://manifestoclub.info/category/pspos/>

23 Bristol bans smoking in outdoor public places, Telegraph, 2 February 2015: <https://www.telegraph.co.uk/news/health/news/11384564/Bristol-bans-smoking-in-outdoor-public-places.html>

24 Little Haven beach smoking ban to last indefinitely, BBC News, 29 April 2017: <https://www.bbc.com/news/uk-wales-south-west-wales-39737871>

25 The London park where smokers will be politely asked not to smoke, My London, 24 September 2018: <https://www.mylondon.news/news/west-london-news/london-park-smokers-politely-asked-15193365>

26 England's chief medical officer says smoking should be banned in parks and children's play areas, Daily Mail, 13 September 2015: <https://www.dailymail.co.uk/news/article-3232582/England-s-chief-medical-officer-says-smoking-banned-parks-children-s-play-areas.html>

smoking - a right for children and others not to have this activity 'role modelled' in front of them.

Equally, health institutions are concerned that people smoking outside the building or on site will give it a bad reputation. London Ambulance said 'the Trust has a duty to promote healthy lifestyle choices, well being and to encourage its staff to act as role models in this regard'.²⁷ Duncan Selbie, chief executive of Public Health England, wrote that, 'Hospitals are health promoting environments for all and cannot be a place for a behaviour that leads to the illness and death of so many.'²⁸ This is a change in the role of a hospital, from treating people's specific illnesses to a responsibility for promoting healthy lifestyles and ensuring that only healthy activities are carried out on its grounds. It is for this reason that smokers have in some places been pushed not only outdoors, or even off hospital sites, but away from the entrances of hospital sites so the institution is entirely free from the 'bad' image and influence associated with their habit.

Here we see the state move directly into the realm of 'morality law' where someone is restricted because of the bad example their actions or words may set for others. (Morality law remained as an illiberal category of British law until the 1960s with the direct regulating of public mores through obscenity prosecutions, as well as arcane controls such as the Lord Chamberlain censoring all theatre plays in the name of public decency.) As with former morality laws, the new smoking bans are particularly concerned with the bad influence set to vulnerable individuals such as children. Here, the state moves again into directly controlling the *influence and example* that people are setting for others; regulating behaviours not because they are directly harmful but because they allegedly have a *bad influence* upon others.

Plain packaging and display ban

The question of the regulation of cigarettes as commodities is not the primary concern of this report, which is focusing on the

²⁷ London Ambulance smoke-free policy: <https://www.londonambulance.nhs.uk/document-search/smoke-free-policy/>

²⁸ Smoke-free NHS, Duncan Selbie, 17 March 2017: <https://publichealthmatters.blog.gov.uk/2017/03/17/tobacco-free-nhs-troubleshooting-tips-for-hospitals/>

regulation of smoking and smokers. Yet it is worth noting that the regulations placed upon cigarettes as a commodity suggest a dim view of smokers and the public in general. Display bans seek to remove the item from temptation (as if, were cigarettes not visible, it would never occur to people to buy them). It also seeks to construct a new norm around the product (and the activity) as somewhat surreptitious and unacceptable and to be hidden behind curtains and cupboard doors, available only on special request. It makes the purchasing of cigarettes rather like asking for condoms or dirty mags in the newsagent in the old days.

Plain packaging, meanwhile, goes beyond providing the necessary public health warning and moves into the realm of shock propaganda designed to create negative associations with the product. The images on 'plain' packs of diseased feet or children in incubators sometimes bear only tangential relation to the actual health effects of smoking. They are not meant for public information but to shock, a stimulator to the lower brain centres, seeking a Pavlovian association of the product with disgust or instinctive distaste. While it was good for previous public policy to oppose the glitzy aspects of tobacco advertising and to inform the public of the health risks, plain packaging has taken the issue into an entirely different terrain.

The official stripping of any independent characteristics from the package, leaving only the brand name in the deliberately most undesirable font and colour, means that cigarette packages have become nothing more than adverts for anti-tobacco state bodies and their allied groups. The cigarette pack is now a billboard for state propaganda and instructions to the smoker. This is a strange event that has never occurred to another legal commodity in a free market society. The instructions to the smoker are issued in the lowest terms, appealing not to their reason but to their animal instincts of fear and revulsion.

What is unique and common about smoking regulation?

The trajectory of the regulation of smoking shows a progression from public information in the Sixties and Seventies, to regulation based on ideological passive smoking in the Nineties and Noughties, to the current phase (since 2010) of direct coercion. This

pattern of events shows the progressive extension of control and the disregarding of autonomy, but it was not until the last decade that this could be exercised openly and people could openly be coerced ‘for their own good’. This shows the importance of the shift within the past decade, whereby principles of autonomy and tolerance ceased to be even paid lip service within policy circles.

A similar development can be found in many other areas. For example, in the area of food regulation there has been a shift from public information about nutrition and healthy eating to the imposition of state targets for the quantity of sugar or calories to be contained in particular items.²⁹ In my work in defence of the rights of the homeless I have seen a similar exertion of direct coercion over homeless people. They can be issued with fines, even imprisoned, if they refuse to go along with officials’ recommendations for what is in their interests (for example, if they refuse to engage with authorities or refuse a place offered in a particular hostel). Here, official coercion – and the heartless issuing of fines to people who are without home or income – is represented by councils as a matter of ‘support’ and part of their policies of ‘caring’ for the homeless. They assume that they know what is best for a person and therefore they are able to justify the infliction of all manner of penalties upon a person as a charitable act, to guide them towards what is best for them.

What is missing from homeless policy – as from smoking policy – is any idea of the person as an autonomous individual who (notwithstanding bad luck or bad decisions) remains a person with rights to be respected and preferences that cannot be disregarded. Ultimately councils cannot understand that their offer of a hostel place or other support should be an *offer* and not an *order*, just as smoking cessation services have started to become an obligatory injunction in some service areas, rather than a service that people may choose to use or not. Of course, the question of being homeless is a very different one from the choice people make to smoke, yet there are striking parallels between the forms of regulation now imposed upon these two

²⁹ See PHE’s work on food reformulation: <https://www.gov.uk/government/collections/sugar-reduction>

groups. Although smoking and homelessness are very different issues, the regulation governing them has a common logic and origin, that of the officious state.

Therefore, although there are some unique features to the history of smoking regulation, the general pattern can be found in many other areas such as homeless policy. Again this suggests that what is concerned here is not the regulation of a particular unhealthy habit but the changing relations between state and society, with the extension of state regulation over personal conduct and the move into the direct coercion of citizenry.

3. The detachment of anti-smoking policy from public opinion

Ideally, in a democratic society, public policy should reflect public habits and opinion; when opinion changes then policy should change too. One would expect, as smoking rates declined, for more enclosed public spaces to become no-smoking, especially those that people have no choice but to enter. And yet, when 15 per cent (one in seven) of the population continues to smoke, one would expect for sensible provision to be made for them to practice their habit comfortably and conveniently. Instead, what we have seen since the 1980s, and particularly since 2000s, is that smoking policy has become detached from public opinion. It no longer reflects public opinion but rather is produced by an isolated state structure and imposed upon the population. The intolerance directed towards smoking is that of an anti-smoking lobby and state structure, whereas the general public has consistently shown itself to be more tolerant and more open to common sense accommodation of smoking in social life.

The lack of public demand for anti-smoking measures

Few of the coercive smoking measures have come with the backing of public opinion. Prior to the smoking ban being introduced in England in 2007 surveys for the Office for National Statistics found that only 30 per cent of the public wanted a comprehensive ban on smoking in public spaces. Instead, around six per cent supported smoking being allowed throughout pubs and bars, 45 per cent

wanted pubs to be predominantly 'smoke-free' with separate smoking rooms, and 19 per cent wanted smoking allowed but with 'smoke free' areas.³⁰

Therefore, public opinion favoured smoke-free pubs and bars (reflective of the fact that the majority of people no longer smoked) with separate smoking areas or rooms for those who wanted to light up. It is telling that 70 per cent of people supported smoking in some areas of the bar, in a population where, at that time, fewer than 25 per cent of adults smoked, suggesting a widespread social tolerance whereby people supported provision for a habit they themselves did not practice (though doubtless they would have had friends or family who did).

Ten years after smoking bans were introduced in Scotland, England and Wales, polls commissioned by Forest and conducted by Populus continued to find significant support for designated smoking rooms in pubs and clubs. In Scotland in 2016 54 per cent of the public supported designated smoking rooms with only two fifths (40 per cent) opposed to the idea. Almost half (49 per cent) of non-smokers in Scotland said there should be an option for indoor smoking rooms.³¹ In Wales in 2017 58 per cent supported smoking rooms in pubs with only 37 per cent opposed to the idea.³² (The figures were even higher among pub owners where 70 per cent of licensees supported separate smoking rooms.)³³ In a UK-wide poll the same year 48 per cent supported the provision of well-ventilated smoking rooms (compared to 42 per cent who were opposed to the idea, and nine per cent who were unsure).³⁴ It is remarkable that a full

30 Office for National Statistics

31 Over half of adults living in Scotland think pubs and private members' clubs, including working men's clubs, should be allowed to provide a well-ventilated designated smoking room to accommodate smokers, Forest, 24 March 2016 <http://forestonline.org/news-comment/headlines/allow-smoking-rooms-scotlands-pubs-and-clubs-say-campaigners/>

32 Almost 60 per cent of adults in Wales would allow smoking rooms in pubs and clubs, Forest, 26 March 2017: <http://forestonline.org/news-comment/headlines/almost-60-adults-wales-would-allow-smoking-rooms-pubs-and-clubs/>

33 Majority of licensees want smoking legislation amended for pubs, Morning Advertiser, 3 June 2012: <https://www.morningadvertiser.co.uk/Article/2012/07/03/Smoking-ban-five-year-anniversary-and-its-impact-on-pubs>

34 Public split on allowing separate smoking rooms in pubs and clubs, Forest, 29 June 2017: <http://forestonline.org/news-comment/headlines/public-split-allowing-separate-smoking-rooms-pubs-and-clubs/>

decade after the ban, when people would have become used to smoke-free public places, such a large proportion of the public was willing to consider an alternative to a comprehensive ban.

The introduction of a comprehensive smoking ban was also lacking in democratic assent since neither of the two main parties had supported the policy prior to the 2005 general election. Labour had come up with a compromise, banning smoking in restaurants and pubs serving food while leaving the rest to choose to be 'smoking' or 'non-smoking' (and leaving members of private clubs to make their own choice), while the Conservatives had supported only voluntary regulation.³⁵ The introduction of a complete ban was aided partly through the manipulative use of opinion polls. In polls commissioned by ASH prior to the ban pollsters found that only 49 per cent of people wanted smoking banned in pubs and bars (and presumably this was in a survey that didn't include the option of separate smoking rooms, which would have lowered this figure still further). A subsequent article by ASH director Deborah Arnott described how they used poll results in order to give the impression of support for the measure:

The poll also illustrated the very different answers you get depending on how the question is framed. This poll asked a number of different questions of the same respondents all in one interview (questions were rotated to ensure the responses were not biased by the order of the questions). For example, 90% of Labour voters agreed that all workers had a right to a smoke-free environment but only 74% wanted all enclosed workplaces, including public places, smoke-free. When asked if they wanted pubs and bars smoke-free, only 49% answered yes. The poll was used to argue that if the government framed the issue as a yes/no issue of workplace and public health and safety, then it would get majority support for comprehensive legislation.³⁶

35 Election 2005: Parties disagree over smokefree law, ASH, 21 April 2005: <http://ash.org.uk/media-and-news/press-releases-media-and-news/election-2005-parties-disagree-over-smokefree-law/>

36 Comprehensive smoke-free legislation in England: how advocacy won the day, Deborah Arnott et al, Tobacco Control, December 2007: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2807200/>

Therefore the polls used to back up public policy involved two sleights of hand: first, to remove the option of separate smoking rooms, which the majority would have supported; and second, to present the issue as a ban on smoking in ‘workplaces’ rather than in pubs and bars. (The Labour compromise agreement would have banned smoking in the bar area, the area near bar staff; yet the comprehensive ban turned the whole of the bar into a workspace.) As a result the Bill that was passed was one that was not supported by public opinion or even the main parties. The manipulation of opinion polls and other dubious tactics were presented by ASH as an example of skillful campaigning.³⁷ (Health secretary John Reid had told campaigners to ‘show us that there are votes in it’ - ie to show that there is public support for this measure – a request for democratic assent that ASH treated as an inconvenient obstacle to be overcome.)³⁸

Where authorities have carried out less partisan surveys into proposed smoking bans, such policies have often proved unpopular. In 2015 Brighton and Hove City Council dropped a proposal to ban smoking on beaches and in parks after overwhelming public opposition.³⁹ In contrast Swansea Council went ahead with a beach smoking ban but only after ignoring its own consultation, in which 61.7 per cent of people said they disagreed with the measure.⁴⁰ Surveys have found that complete smoking bans are as unpopular among prisoners as psychiatric patients. (Only 20 per cent of Scottish prisoners thought that a ban on smoking in prisons was a good idea.)⁴¹

Increasingly authorities have simply disregarded public opinion surveys that went against the anti-smoking policy, making it clear that this was not what the policy was based on. When

37 Smoke and Mirrors, Guardian, 19 July 2006: <https://www.theguardian.com/society/2006/jul/19/health.healthandwellbeing>

38 Smoke and Mirrors, Guardian, 19 July 2006: <https://www.theguardian.com/society/2006/jul/19/health.healthandwellbeing>

39 Brighton and Hove beach smoking ban bid dropped, BBC News, 16 December 2015: <https://www.bbc.com/news/uk-england-sussex-35112169>

40 Beach smoking ban: Swansea council ignored response to public consultation, Simon Clark, Taking Liberties, 28 April 2016: <http://taking-liberties.squarespace.com/blog/2016/4/28/beach-smoking-ban-swanea-council-ignored-response-to-public.html>

41 Prison Staff and Prisoner Views on a Prison Smoking Ban: Evidence From the Tobacco in Prisons Study, Nicotine and Tobacco Research, 26 May 2018: <https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/nty092/4996090>

a Scottish government survey found that two thirds of people opposed plans to ban smoking across all hospital grounds, the government merely restated the reasons why they would continue with the plans.⁴² When ASH was told of surveys showing support for separate smoking rooms, CEO Deborah Arnott responded:

“The benefits of smoke-free laws are not a matter of public opinion. The reason there is a complete ban on smoking in pubs, and smoking rooms in pubs are forbidden is that they do not protect the workers from the harmful effects of smoke. You can have an opinion poll that says people on construction sites should not have to wear helmets. So what? They are there to protect workers.”⁴³

While a decade ago ASH had to frame its proposals in terms of public opinion (even if these were manipulated), now it needs no such smokescreen, saying merely ‘So what?’. Smoking bans are now ‘not a matter of public opinion’ but a question for state bodies and state subsidiary groups such as ASH. Public policy is definitively separated from public opinion and democratic assent.

‘Denormalisation’ and the attempt to change public mores

The most recent development has been to justify smoking bans in terms of the ‘denormalisation’ of smoking: that is, the policy seeks to make smoking less acceptable, less visible, less ‘normal’. This is a fundamental shift in the justification for coercive legislation. Rather than claim that public opinion supports the measure, coercive legislation is justified as a means of moulding and changing public opinion. This means that the authority and legitimacy of the measure is not derived from the public. Rather, the measure is derived autonomously from the state structure, from its convictions of what is right or beneficial for the public.

42 Scots ‘oppose ban on smoking outside hospitals’, Scotsman, 6 September 2015: <https://www.scotsman.com/news-2-15012/scots-oppose-ban-on-smoking-outside-hospitals-1-3878910>

43 A poll has revealed almost 60 per cent of people want smoking rooms in Welsh pubs, Wales Online, 26 March 2017: <https://www.walesonline.co.uk/news/wales-news/poll-revealed-60-people-want-12797617>

An article by PHE director Duncan Selbie said that, ‘A tobacco-free NHS is about creating a “new normal”. Since 2007, people haven’t been able to smoke inside any hospital building, and don’t expect to be able to. Now we need to get them accustomed to not expecting to smoke anywhere on NHS premises’.⁴⁴ Here, coercive policies are justified as a means of *creating a new norm*. The policy seeks to ‘get them accustomed’ to new forms of conduct. Similarly the Welsh health secretary justified a measure to ban smoking outside hospitals, playgrounds and schools on the basis that it was ‘another step in the right direction to denormalise smoking in Wales’.⁴⁵

Such justifications are also common at a local level. Lancashire Primary Care Trust justified a complete smoking ban in the following terms: ‘Our aim is to develop a culture where smoking is viewed as unacceptable across our sites and for people to respect this ... Having shelters anywhere on site condones smoking and gives out the message to service users and visitors that it is acceptable behaviour.’⁴⁶ It becomes the responsibility of a public authority to create – and change – what is considered to be acceptable behaviour. A local councillor justified a ban on smoking in playgrounds on the basis that ‘These smoke free zones would help to promote a healthier environment, where smoking was not normalised’.⁴⁷

The role of the state in the *engineering of norms* is a new coercive step, worse still than obscenity or other ‘morality law’ in the past, which although it was intrusive nonetheless justified itself on the basis of public opinion. In 1965 Lord Cobbard, the last Lord Chamberlain responsible for the censoring of theatre plays, said that the Lord Chamberlain should ‘try to assess the norm of educated, adult opinion and if possible to keep just a touch ahead of it ... I have to make a positive effort to keep my

44 Smokefree NHS - troubleshooting tips for hospitals, PHE, 27 March 2017: <https://publichealthmatters.blog.gov.uk/2017/03/17/tobacco-free-nhs-troubleshooting-tips-for-hospitals/>

45 Wales to ban smoking outside schools, hospitals and playgrounds, Metro, 29 May 2018: <https://metro.co.uk/2018/05/29/wales-ban-smoking-outside-schools-hospitals-playgrounds-7588658/>

46 Lancashire NHS Trust: Smokefree FAQs: <https://www.lancashirecare.nhs.uk/Smokefree-FAQs>

47 Council set to ban smoking in Dundee playgrounds, Evening Telegraph, 7 February 2018: <https://www.eveningtelegraph.co.uk/fp/council-set-ban-smoking-dundee-playgrounds/>

own personal tastes, likes and dislikes out of the picture'. When public opinion changed, censorship changed too.

In 1957 Lord Scarborough recommended lifting the ban on homosexuality on the stage since ('unfortunately') 'this subject had now become one which was one much talked about' and that it would appear 'ostrich-like' and 'absurd' to disallow mention of it.⁴⁸ Therefore even the most elitist and internally bound British establishment of the past, which sought to censor the behaviour and conduct that could be presented in public, nonetheless grounded its exertion of power on the current norm of adult opinion. Today the state openly uses coercion for the creation of norms according to its own ideas about what should or should not be acceptable, saying only that 'people will get used to it'. The role of the public is reduced to that of mere material for policy to be *remodelled* along the lines decided by state authorities.

It is notable that this policy of 'denormalisation' is also seeking to create public intolerance towards a particular activity and, by extension, a particular group of people – smokers. The state, no less, is actively attempting to whip up hostility on the part of the majority towards a minority, an extraordinary fact in this age of inclusion and respect of minorities. This nasty element to anti-smoking policy was evident in the 'If you smoke, you stink' advertisements run by the NHS in 2005.⁴⁹ It is also evident in the 'denormalisation' work done in schools which represents smokers as a devilish breed who are stupidly damaging their own health while harming others. "Don't smoke, it's cruel," said a girl in ASH's smokefree playgrounds video.⁵⁰ She has been taught that smoking is not only unhealthy but 'cruel', a very morally loaded term. Encouraging children to protest has a Stalinist whiff about it, with one school staging a 'demonstration' by children in protest against parents smoking outside the school. Children, in school time, were being supervised by teachers to 'protest' against the behaviour of their own parents.⁵¹

48 The Lord Chamberlain's Blue Pencil, John Johnston, Hodder and Stoughton 1990, p172

49 If you smoke you stink, NHS advert: https://www.youtube.com/watch?v=LXIL_h52qSM

50 ASH Wales, Smokefree playgrounds: <https://ash.wales/campaign/playgrounds/>

51 Parents urged to stub it out in school 'smoking ban', Barnsley Chronicle, 18 May 2018: <https://www.barnsleychronicle.com/article/parents-urged-to-stub-it-out-in-school-smoking-ban>

The ineffectiveness of anti-smoking campaigns

As anti-smoking policy has become increasingly detached from the public so it has become less effective. As policy has ceased to respect people's autonomy it has become unable to understand how people make decisions or what is the function of particular habits in their lives. Policy occupies its own plane and the public is supposed to passively accept whatever target governments set. The Scottish government, for example, wants to reduce smoking rates in Scotland from 20 to less than five per cent by 2034.⁵² Westminster is following suit with some ministers calling for the UK government to 'eradicate' smoking in England by 2030.

Yet what is striking, looking at the question historically, is the remarkable ineffectiveness of coercive anti-smoking campaigns. The largest fall in smoking historically occurred between the 1970s and the early Nineties when the potential risks of smoking tobacco became increasingly well known. The steepest decline in smoking rates took place between 1973 and 1983 when there was a fall from 66 to 47 per cent of men using tobacco products, or 49 to 37 per cent for men smoking cigarettes, or 43 to 33 per cent for women smoking cigarettes.⁵³ This meant a 19 per cent reduction in the use of tobacco products in only a decade, or a 10-12 per cent reduction in smoking cigarettes. There was a further eight per cent fall in the next decade, from 37 to 29 per cent in men smoking cigarettes, and 33 to 27 per cent in women. Yet it is noticeable that when anti-smoking campaigns really started to kick off in the early Nineties smoking rates remained relatively static. Between 1993 and 2003 there was only a one per cent fall in men's smoking rates, and a three per cent fall in women's.

The workplace smoking ban – introduced in Scotland in 2006 and in England, Wales and Northern Ireland in 2007 – had remarkably little effect on the level of smoking with men's smoking rates remaining at 22 per cent from 2007 to 2012, and women's rates dropping a mere one per cent from 20 per cent to 19 per cent. The introduction of plain packaging in Australia in

52 Radical new plans revealed to turn Scotland smoke free by 2034, Scotsman, 21 June 2018: <https://www.scotsman.com/news/politics/radical-new-plans-revealed-to-turn-scotland-smoke-free-by-2034-1-4757543>

53 Tobacco Statistics, Cancer Research UK: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/tobacco#heading-Three>

2013 also had very little effect on smoking rates in that country. There was no significant decline in smoking rates between 2013 and 2016.

Yet there has been another effect at work, a recent sharp decline in smoking rates, which is due not to government policy but to the rise of vaping and its popularity as a substitute for smoking. Christopher Snowden noted that the shift in smoking rates in the UK occurred before the introduction of plain packaging. They correspond not with coercive measures but with the rise of vaping: 'Between 2012 and 2015,' wrote Snowden, 'the proportion of English adults who smoked dropped from 19.3 per cent to 16.9 per cent, and the decline between 2014 and 2015 was particularly sharp.'⁵⁴ As vaping increased in popularity, smoking rates fell to under 15 per cent in 2017.⁵⁵ This decline appears to be particularly significant for the fall in smoking rates among young people.⁵⁶

Significantly therefore the most effective public health measure of the past decade was not further restrictions on smoking, or the ban on the display of tobacco in shops or the prohibition of branded packs, but something far more subtle, and liberal. By not over-regulating a reduced risk product, the only substantial fall in smoking rates in the UK in the new millenium was almost certainly due to vaping, a consumer-led revolution that the public health establishment played little or no part in, and initially attempted to stifle. We see therefore that the more coercive and detached smoking policy has become, the less effect it has had on smoking levels and therefore upon public health.

54 The government's great triumph on smoking: it left e-cigarettes alone, Christopher Snowden, Spectator: <https://health.spectator.co.uk/the-governments-great-triumph-on-smoking-it-left-e-cigarettes-alone/>

55 Turning the tide on tobacco: Smoking in England hits a new low, PHE, 3 July 2018: <https://publichealthmatters.blog.gov.uk/2018/07/03/turning-the-tide-on-tobacco-smoking-in-england-hits-a-new-low/>

56 As Vaping Became Popular Among Young, Smoking Rates Fell, HealthDay News, 20 November 2018: <https://consumer.healthday.com/cancer-information-5/electronic-cigarettes-970/as-vaping-became-popular-among-young-smoking-rates-fell-739861.html>

4. Sock puppets and the intolerant state

The new coercive and intolerant state policy has been possible only because of the formation of a new *anti-smoking infrastructure*, a network of semi-independent bodies, linked together in collaborations and alliances, and sharing a common supply of state funding. This network includes campaign groups such as ASH, academic departments in the UK Centre for Tobacco and Alcohol Studies and smoke-free regional bodies. This infrastructure is gelled together with two elements: the common receipt of state funding by the different groups, and the common activist orientation towards central government and local state authorities.

First, on state funding. ASH England has long been funded by the Department of Health for around £150-200k per year; the Scottish government has given, on average, around £800k annually to ASH Scotland (out of a budget of £1.1 million),⁵⁷ while ASH Wales was recently given a grant of £417k over three years by the Welsh government.⁵⁸ In academia tobacco-control research is directly funded by the Department of Health or Medical Research Council; academic departments form into consortia such as the UK Centre for Tobacco and Alcohol Studies (CTAS), or now SPECTRUM,⁵⁹ to run multi-million pound projects largely dependent on state funding. Finally there are the regional bodies – that have included Fresh (North East), Smokefree South-West, and Tobacco Free Futures (North West) – that were largely funded by local authorities, each with an annual budget of around £800k.

These groups are (or were) state clients. (Following budget cuts by local councils, Smokefree South West and Tobacco Free Futures no longer exist.) Most are dependent on public funding and could not exist without it. Yet these groups also have an activist orientation, seeking to gain more restrictive tobacco control measures. ASH, which has repeatedly benefitted from

57 External Review of ASH Scotland 2014: <http://www.gov.scot/Resource/0045/00457246.pdf>

58 £400k to cut smoking in Wales, Welsh Government announces, BBC News, 3 April 2017: <https://www.bbc.com/news/uk-wales-politics-39473753>

59 UK Prevention Research Partnership (UKPRP) funding secured by UKCTAS academics, UKCTAS, 9 May 2019: <https://ukctas.wordpress.com/>

awards of public money, has been instrumental in driving most of the restrictive anti-smoking measures, including bans on smoking in public places, bans on smoking in cars with children, or smoke-free playgrounds in Wales. Academia is also activist, producing research in order to guide policy in a more restrictive direction. For example, UKCTAS claims in its annual report that it played a 'leading role' in bringing in plain packaging and the bans on smoking in cars with children.⁶⁰ Similarly, Smokefree South West claimed to have played a part in introducing the first outdoor smoking ban in England, in two squares in Bristol, while developing the 'smoke-free play parks' initiative.⁶¹

The different parts of the network are connected with one another. ASH has close working relations with the Department of Health and collaborates with the 'smoke free' regional bodies and academic departments. The different parts of the network author reports together, nominate one another for awards, speak at each other's conferences, and defend one another's public funding. They are formally linked together in groups such as the Smoke-Free Action Coalition or the former Tobacco Control Alliance. Another important linking element is the All Party Parliamentary Group on Smoking and Health. ASH holds the secretariat and hosts the APPG on its website.⁶² The APPG provides another forum for the exertion of pressure upon ministers and government, writing to ministers on subjects including plain packaging, smoking in cars, and the removal of public funding to tobacco control groups such as Smokefree South West.

The worrying nature of such practices has been pointed out in reports by Forest⁶³ and the TaxPayers' Alliance⁶⁴ and developed into a critique of 'sock puppets' in a series of reports by the Institute of Economic Affairs.⁶⁵ These reports dissected the unethical practice

60 UKCTAS Progress Report, September 2015: <http://ukctas.net/pdfs/UKCTAS-2013-15-Progress-Report.pdf>

61 Bristol trials smoke-free zones in two public squares, 2 February 2015: <http://www.bbc.com/news/uk-england-bristol-31081842>

62 See the APPG on the ASH website: <https://bit.ly/2TeOdIX>

63 Government lobbying government: the case of the UK tobacco control industry, Forest, October 2010 <https://bit.ly/2JSeW2D>

64 Taxpayer Funded Lobbying and Political Campaigning, TaxPayers Alliance, August 2009

65 Sock Puppets: How the government lobbies itself and why, Institute of Economic Affairs, June 2012 <https://iea.org.uk/publications/research/sock-puppets-how-the-government-lobbies-itself-and-why>

of 'government lobbying government', the use of public money to fund bodies to support certain government policies and the creation of 'fake charities'.

This development is not simply a matter of dubious practice, though it certainly is that. Instead, the formation of this anti-smoking network represents a new kind of state. The state is taking on a new form, which is as a network of semi-independent client bodies who play the role of demanding and affirming coercive policies. These bodies are funded with public money but they are also pressure groups, lobbying the government to change policy or complaining that the government has not gone far enough.

This is the way in which the state develops a network that takes on the role of a pseudo-populace or a pseudo-civil society. It means that public policy appears not to be born out of itself but to come from public demand since it is called for and affirmed by apparently independent groups and institutions. This is a necessary development in a society which is nominally democratic but where the state has become detached from public opinion and public representation. Therefore, as the state becomes detached from real civil society, it creates for itself a pseudo civil society which demands things of it and to which it can respond. Together these bodies and networks form an officious layer, which turns with open hostility against the real civil society and the real public.

It is this institutional development that has made possible the recent coercive phase of anti-smoking policy, and particularly the open disregard for public opinion and the attempt to mould public norms and practices. It is because of the state's relations with semi-independent agencies – the pseudo-civil society – that it can justify the most recent stage of restrictive anti-smoking policy.

5. The next 40 years: towards a free society

It is of course true that the anti-smoking policies of the past decade or two have left their stamp on social life. One change is that smoking bans have made smoking a more private act. When I was at university at the end of the 1990s, smoking was a *social* activity. Cigarette smoke meant the intertwining of bodies on a

dancefloor or in a darkened bar. Like most of my friends I smoked only occasionally and only ever socially. It was only late at night, drinks in hands, that cigarettes would be passed around and shared. (It was unclear who had actually brought them.) Through the removal of smoking from public spaces this social meaning of smoking has been largely removed. It is telling that a recent study found that few smokers enjoyed the social aspect of smoking, or the way it made them appear to others, citing instead more private or physical sources of pleasure.⁶⁶

The smoking ban has also changed public sensitivity to smoke, at a purely environmental level. While we non-smokers once happily entered smoky pubs, now our nose twitches at the slightest whiff of tobacco smoke. What was once normal has become noticeable and, for some, offensive. Yet in spite of all this the continuing public willingness to consider separate smoking rooms – and therefore provision for a habit they do not enjoy themselves – suggests a basic level of tolerance and humanity. This common sense attitude is also shown in the way in which no-smoking policies are often ignored in hospitals or mental health institutions, with many staff turning a blind eye. It means that smoking policy increasingly exists on two levels: that of the state with its pseudo-civil society network, and that of everyday life where people have to rub up against each other and live around each other, which they do with a much greater amount of flexibility and humanity.

The advantage of the current situation is that, for the first time in the history of anti-smoking policy, it is entirely clear what we are dealing with. Policy has cast aside the pretence that it is representing public opinion once and for all. With the policy of ‘denormalisation’ it is quite clear that this is an elite imposition on society, not reflecting society’s norms, but attempting to change them for its own. This elite project of norm-construction is a new development, a sign of an age where the state draws authority from itself.

66 The Pleasures on Smoking, Neil McKeganey, CSUR, December 2016: http://static11.sqspcdn.com/static/f/782462/27390673/1482788582747/CSUR_Pleasure_of_Smoking.pdf?token=ODO45epdV62Pr5xFzhAhP8%2FkFPk%3D

As I have said, the patterns that can be seen in smoking policy can also be seen in other areas. And yet things have gone further with smoking. In no other area has the elite project for the domination of civil society been so surely and openly stated. It is also the case that measures developed for smoking – such as display bans or plain packaging – are now being proposed for items including alcohol and ‘junk food’ such as sugary cereals. In this sense smoking is the canary for civil liberties. Measures that have been rolled out in smoking will be copied and pasted into other areas of life, as occurs when policy develops in an independent and internally networked arena.

The past 40 years is in some ways a bleak history, so far as liberty is concerned. And yet we must take stock in order to see what can be done in the next 40 years. What we have seen developing, with increasing clarity and forthrightness, is a new officious and intolerant state that exists in a realm separate from society, and which turns against that society in open hostility. It is this underlying shift that explains the regulation of smokers, just as it explains the regulation of other groups.

For the next 40 years we should set ourselves the task of turning around these coercive measures and rolling back the officious state in all areas of life. We should do this not because we love smoking but because we love freedom and believe that a free life is the best and only good one.

Timeline 1979-2019

1979

July – Main post offices become smoke-free.

1981

March – Cigarette tax increased by 14p on a pack of 20, the biggest percentage price rise since 1947.

1982

March – UK government announces two new voluntary agreements on advertising and sponsorship. The sponsorship agreement allows the industry to raise the prize money offered in sporting events to £6 million but advertisements for these events will have to carry a health warning.

October – UK government announces a new voluntary agreement with the tobacco industry to regulate advertising and promotion. Advertising materials at point-of-sale and over a certain size will have to carry a health warning and video cassettes will not be allowed to carry cigarette advertising.

1983

October – Independent Scientific Committee on Smoking and Health recommends the progressive reduction of tar levels in cigarettes over the next four years.

1984

February – National No Smoking Day is launched.

July – London Regional Transport bans smoking on Underground trains.

1985

February – London Regional Transport bans smoking on all Underground stations wholly or partly underground.

1986

March – Announcement of new voluntary agreement on tobacco advertising and promotion. Ban on tobacco advertising in cinemas and six new health warnings are introduced. Tobacco advertising in certain women's magazines with 200,000 readers, at least a third of whom are aged 16-24 is banned, as is advertising for brands with a tar level of 18mg and above. Industry agrees to spend £1 million a year to make it clear that cigarettes must not be sold to children under 16.

April – Protection of Children (Tobacco) Act makes it illegal to sell any tobacco product to children aged under 16. Previously the law applied only to smoking tobacco.

1987

January – UK government signs new voluntary agreement with the tobacco industry on sports sponsorship.

February – Independent Television ceases transmission of all tobacco-sponsored sports events.

December – Following the King's Cross Underground fire, in which 31 people died, London Underground bans smoking and tobacco advertising throughout the network.

1988

January – European Community (EC) proposes new upper limits on tar levels in cigarettes and to legislate on health warnings to appear on tobacco packaging and advertisements.

October – British Airways bans smoking on domestic flights.

1990

February – Virgin Atlantic launches first smoke-free flights to the USA.

May – British Rail announces it will phase out all smoking carriages on commuter trains running into London from within a 30-mile radius.

July – Air Canada makes all its flights between North America and Europe smoke-free.

1991

February – Smoking banned on all London Regional Transport buses.

March – Cigarette tax raised by approximately 16p.

July – Government announces a series of new, larger health warnings for tobacco packaging, in line with EC requirements. This is the first time that health warnings are legally required. They will cover 6% of the face of the pack. The minimum requirement under the terms of the directive is 4%.

September – Publication of new voluntary agreement that has provision for legally-required new health warnings on advertisements. Other provisions include a reduction over five years to half the number of shop front advertisements that were counted in July 1991; minor tightening

of the rules surrounding direct mailing; extension of the controls on advertising in women's magazines with no advertising allowed in new publications until total readership and readership by young women has been ascertained, and no tobacco advertising allowed at all in publications where one-third of the readership are young women aged between 16 and 24.

October – EC directive making tobacco advertising on television illegal comes into force.

December – Department of the Environment publishes a voluntary code of practice on smoking in public places. If the public is present from necessity (health premises, banks, post offices, local government premises etc), no smoking should be the norm. If the public is present from choice (for example in cafes, restaurants, pubs and community centres), separate provision should be made for smokers and non-smokers, unless it is impractical, in which case no smoking should be the norm.

1992

January – MEPs in the European Parliament vote in favour of banning tobacco advertising.

March – Children and Young Persons (Protection from Tobacco) Act 1991 comes into force. The new law makes it illegal to sell single cigarettes. It also requires warning notices, stating that it is illegal to sell tobacco to anyone under the age of 16, to be displayed at all points of sale including vending machines.

March – Chancellor adds 13p (a 5% increase) to the price of a packet of cigarettes.

July – UK government publishes a White Paper, The Health of the Nation. It eschews a ban on tobacco advertising but offers a higher target of prevalence reduction (to 20% in men and women by 2000) and a 40% reduction in cigarette consumption by the same year. For the first time licensed taxi drivers are promised legislation to enable them to ban smoking in their vehicles if they wish.

November – National Express, Britain's largest coach company, bans smoking on all its coaches.

December – Sale of tobacco in hospital shops cease.

1993

January – British Rail's Network South East bans smoking on most of its long distance commuter trains.

February – British Midland bans smoking on all domestic and international flights.

February – Tobacco retailers and vending machines must display a warning notice stating that it is illegal to sell cigarettes to children under the age of 16.

March – British Agencies for Adoption and Fostering recommends that babies and children up to the age of two should not be placed in households with smokers when equally suitable non-smokers are available.

April – Pub chain JD Wetherspoons introduces smoke-free zones in 54 of its pubs.

May – All Cathay Pacific Airways flights between Hong Kong and London Heathrow are to be smoke-free.

May – All National Health Service premises go smoke-free.

June – British Airways begins a trial of non-smoking transatlantic flights.

June – London Borough of Richmond imposes restrictions that will prevent smokers from adopting children under the age of ten.

July – UK government publishes new regulations that strengthen the health warnings on tobacco products other than cigarettes.

July – Singapore Airlines to offer daily non-smoking flights to London.

August – British Airways to make some European flights of under 90 minutes smoke-free.

September – BBC Broadcasting House goes smoke-free.

October – British Airways announces ban on smoking on some flights to New Zealand and Australia.

November – Chancellor announces that he intends to increase excise duty on tobacco products by at least 3% on average each year.

1994

July – House of Commons National Heritage Select Committee recommends an end to televising of tobacco-sponsored sport on terrestrial television channels and urges the UK government to negotiate similar controls on satellite channels.

December – UK government publishes details of a new voluntary agreement on tobacco advertising and promotion. Measures include increasing the size of health warnings on posters and banning tobacco advertising on billboards within 200m of school entrances.

1995

January – New agreement on tobacco sponsorship of sport comes into effect.

1996

June – Guernsey's State Parliament becomes the first government in the British Isles to impose a ban on tobacco advertising.

1997

May – New Labour government announces it will ban tobacco advertising and tackle smoking among the young. Health Secretary Frank Dobson says the government will ban tobacco sponsorship of sport but sporting bodies will be given time to find alternative sponsors.

December – European Council of Health Ministers votes to ban tobacco advertising throughout the European Union.

1998

May – European Parliament votes in favour of an EU directive to ban tobacco advertising and sponsorship. The directive is formally adopted by EU member states.

December – Government publishes a White Paper on tobacco control. It includes new targets to reduce smoking prevalence among adults and children, an NHS smoking cessation programme, a 'clean air' charter aimed at the hospitality trade and plans to further restrict smoking in the workplace through an Approved Code of Practice (ACoP).

1999

May – World Health Assembly backs resolution to begin work on a new Framework Convention on Tobacco Control (FCTC).

June – UK government announces plans to introduce a ban on tobacco advertising on 10th December 1999.

July – Health and Safety Commission releases a draft Approved Code of Practice on smoking in the workplace.

September – A voluntary code of practice, backed by the government, is launched by the hospitality trade to reduce exposure to ‘passive’ smoking in pubs, hotels and restaurants.

2000

June – Members of the European Parliament approve the draft directive on tobacco regulation and vote to increase the size of health warnings to cover at least 35% of the front and 45% of the back of the pack. The Council of Health Ministers subsequently approves the directive but rejects the MEPs’ proposal on health warnings, accepting instead the Commission’s original proposal of an increase to 25% of each pack surface.

September – UK’s Health and Safety Commission recommends the adoption of an Approved Code of Practice (ACoP) to restrict smoking in the workplace.

December – UK government publishes its Tobacco Advertising and Promotion Bill that aims to ban all forms of tobacco advertising throughout the UK.

2001

May – An EU directive requiring larger health warnings on tobacco packaging becomes law. Other measures to be phased in from 30th September 2002 include the removal of ‘misleading’ descriptors such as ‘light’ and ‘mild’ and a requirement by tobacco companies to disclose ingredients and additives by brand.

May – An EU directive that would place some restrictions on tobacco advertising is published. Under the proposals all press and radio advertising for tobacco will be banned, as will tobacco sponsorship of sport for events that take place in more than one EU country.

2002

Oct/Nov – A bill to ban tobacco advertising, which began as a private member’s bill in the House of Lords, is passed by parliament with the support of the government.

December – The EU directive on tobacco advertising is adopted. It covers only trans-border advertising and sponsorship but it allows member states to adopt stronger measures.

December – British Medical Association publishes a report calling for a ban on smoking in public places.

2003

January – New larger health warnings start to appear on cigarette packs as required by the EU Tobacco Products Directive.

February – First phase of the Tobacco Advertising and Promotion Act brings to an end tobacco advertising on billboards and in the print media and bans direct mail, internet advertising and new promotions.

March – A ban on smoking in all workplaces including bars is introduced in New York City.

May – Framework Convention on Tobacco Control is adopted by the 171 member states of the World Health Assembly.

July – Chief Medical Officer Sir Liam Donaldson challenges the UK government to ban smoking in public places.

2004

March – Ireland becomes the first country in the world to ban smoking in every workplace including pubs and bars.

November – UK government proposes a ban on smoking in the majority of workplaces but stops short of a total ban. Exemptions are proposed for private clubs and pubs that don't serve food.

November – Scotland's first minister says his government will introduce a total ban on smoking in the workplace including every pub and bar.

December – New Zealand becomes the third country in the world, after Ireland and Norway, to ban smoking in all enclosed public places.

2005

February – The first global health treaty, the Framework Convention on Tobacco Control, comes into force. It requires countries to commit to implementing a range of measures including a ban on tobacco advertising, measures to protect people from secondhand smoke, tax rises, and large clear health warnings on all tobacco products.

March – Guernsey becomes the first jurisdiction within the United Kingdom to enact comprehensive legislation to ban smoking in enclosed public places including all workplaces.

April – Scottish Parliament passes the Smoking, Health and Social Care (Scotland) Bill that will ban smoking in all enclosed public places. The law will come into force on 26th March 2006.

July – The final part of the Tobacco Advertising and Promotion Act 2002, banning tobacco sponsorship of global sports such as Formula One motor racing, comes into force. An EU Directive banning cross-border tobacco advertising and sponsorship takes effect at the same time.

October – Northern Ireland minister announces that smoking is to be banned in every workplace in the province from April 2007.

November – UK government publishes a health bill that sets out proposals for making workplaces smoke free. The bill proposes that exemptions are made for private members' clubs and pubs that do not serve food. The measures will apply to England only as Wales, Northern Ireland and Scotland have opted for comprehensive smoke-free workplaces.

2006

March – Scotland becomes the first country within the United Kingdom to implement smoke free legislation. Smoking is now banned in virtually all workplaces and enclosed public places including pubs and clubs.

May – UK government launches a consultation on proposals to include graphic warnings on tobacco products.

2007

January – UK government announces that the legal age for the purchase of tobacco will be raised to 18 from 1st October 2007.

April – Workplace smoking bans are enforced in Wales on 2nd April and in Northern Ireland on 30th April.

July – Smoking banned in all enclosed public places in England, including every workplace.

August – UK government announces that it will be compulsory for tobacco companies to include picture warnings on packs of cigarettes. Implementation to be phased in from October 2008.

October – Irish government launches a consultation on proposals to ban point of sale displays of cigarettes, tighter controls on the location and operation of cigarette machines, and the introduction of a register of tobacco retailers.

2008

July – Smoking ban extended to mental health units in the UK.

November – London Borough of Redbridge passes a policy banning the placing of children with foster carers who smoke.

2009

January – UK government announces measures to protect children from smoking. They require retailers to remove tobacco from public view and apply restrictions on access to cigarette vending machine.

February – Scotland unveils a tobacco control bill that includes a ban on the display of tobacco in shops, a ban on cigarette vending machines, a new registration scheme for shops selling tobacco products, on-the-spot fines for retailers who sell to under-18s, and sales bans against retailers who continually sell to underage smokers.

March – Manchester City Council bans smokers from fostering children.

September – Members of the Scottish Parliament vote in favour of new tobacco control measures including a ban on cigarette vending machines and point of sale display of tobacco products.

October – Westminster MPs vote in favour of banning the point of sale display of tobacco products. MPs also support a backbench amendment to outlaw cigarette vending machines in England, Wales and Northern Ireland.

November – Scottish government announces it will outlaw the purchase of tobacco by adults for persons under the age of 18.

November – Health Act 2009 receives Royal Assent. From 2011 large shops in England, Wales and Northern Ireland will be prevented from displaying tobacco products, and cigarette sales from vending machines will also be prohibited. Small shops have until 2013 to comply with the display ban.

2010

January – Smoking in cars with children present becomes an offence in the state of Victoria, Australia.

January – Finnish government declares that it intends to make Finland the first country to phase out smoking completely.

February – UK Government publishes 'A Smokefree Future: A Comprehensive Tobacco Control Strategy for England'. It includes a commitment to reviewing the case for standardised packaging of tobacco products.

February – European Council updates the directive on tobacco tax to raise the minimum excise duty on cigarettes and bring the tax on hand-rolled tobacco gradually into line with that of manufactured cigarettes.

March – Chancellor raises tobacco duty by 1% above inflation and makes a commitment to increase duty by 2% above inflation from 2011 to 2014.

April – Australian federal government announces plans to introduce standardised packaging of tobacco, removing all branding.

September – Vancouver Parks Board in Canada passes a bylaw making all the city's parks, beaches, golf courses and sports fields smoke free.

November – Health Secretary Andrew Lansley announces that the UK government will investigate the viability of introducing plain packaging of tobacco products.

2011

February – New York City Council approves bill to ban smoking in 1,700 city parks and along 14 miles of city beaches.

March – UK government announces a new Tobacco Plan for England that sets out national ambitions to reduce smoking rates among all adults from 21.2% to 18.5% by the end of 2015, with other specific targets for pregnant women and 15 year olds. The plan also commits to holding a public consultation on plain packaging.

March – Chancellor increases tobacco duty by 2% above inflation in the budget. The tobacco tax structure is also modified to narrow gap between the highest and lowest priced brands of cigarettes.

April – Scotland launches a new Register of Tobacco Retailers under the Tobacco and Primary Medical Services (Scotland) Act 2010. The register is part of a wider revamp of tobacco sales law. The Act also introduces the new offence of proxy purchasing and underage purchasing.

April – Australian government publishes draft legislation to require standardised packaging with graphic pictures of health warnings on all tobacco products.

June – Labour MP Alex Cunningham tables a Smoking in Private Vehicles Bill that calls for a ban on adults smoking in cars where children are present.

October – Sale of tobacco from vending machines is banned in England.

October – Boston Housing Authority (USA) announces that public housing will go smokefree in 2012 after the Federal Department of Housing and Urban Development approve the ban.

October – Welsh government announces that a ban on cigarette vending machines will come into force on 1st February 2012.

November – Nottingham City Council becomes the first local authority in the East Midlands to introduce a no smoking policy at playgrounds and around its school gates.

November – Australia will become the first country in the world to introduce plain packaging laws after the Senate passes the Federal Government's plain packaging laws for cigarettes, with amendments to the start date. The new packaging laws will come into effect in December 2012.

2012

March – Chancellor raises tobacco duty by 5% above inflation.

April – UK government launches a public consultation on plain, standardised packaging.

October – Department of Health launches the first mass quit smoking attempt dubbed 'Stoptober' for the month of October.

December – Australia becomes the first country in the world to require tobacco products to be sold in plain, standardised packaging.

December – EU Commission publishes a draft revised Tobacco Products Directive. One of the proposals is to increase the size of health warnings to 75% for both the front and back of cigarette packets and to make picture warnings mandatory throughout the EU.

2013

March – Chancellor raises tobacco tax by 2% above inflation.

March – Scottish government launches its Tobacco Control Strategy which includes a target to reduce adult smoking prevalence to 5% by 2034.

July – EU Parliament Environment and Public Health (ENVI) committee votes to accept the EU Commission's proposal to increase health warnings to cover 75% of cigarette pack surfaces along with other measures such as a ban on flavourings and slim cigarettes.

July – UK government publishes a summary report of the consultation on standardised tobacco packaging but the Health Secretary announces that the Government will not be proceeding with standard packaging until evidence on the impact of the measure in Australia has been assessed.

August – Train operators including C2C, Greater Anglia and First Capital Connect impose a ban on passengers using e-cigarettes in their stations.

November – UK government says it will introduce an amendment to the Children and Families Bill that will give the Secretary of State the power to introduce standardised packaging through regulations.

2014

January – UK government announces plans to ban the proxy purchasing of tobacco in England and Wales.

January – UK government announces its intention to ban the sale of nicotine containing products to children aged under 18 years old.

February – MPs back plans in the Children and Families Bill to ban smoking in cars carrying children in a free vote.

February – European Parliament approves the revised Tobacco Products Directive. Member states have two years to transpose the Directive into national law. New rules include picture warnings to cover 65% of the front and back of cigarettes and roll-your-own tobacco packs, packs of less than 20 cigarettes are prohibited, flavoured cigarettes, such as menthol, fruit and vanilla are prohibited, a regulatory framework for electronic cigarettes.

March – Children and Families Act 2014 is granted Royal Assent. The Act makes it an offence for an adult to buy cigarettes for anyone under 18 (proxy purchasing), gives the government powers to introduce regulations requiring standardised packaging for tobacco products, makes it an offence to smoke in a private vehicle carrying children, and makes it an offence to sell e-cigarettes to children under 18.

March – British Medical Association (BMA) calls for the ban of the sale of cigarettes and tobacco to anyone born after the year 2000.

March – Tobacco tax is increased by 2% above inflation and Chancellor George Osborne makes a commitment to sustain the increase each year until the end of the next parliament.

April – Welsh government's Public Health White Paper is published. It includes proposals that could make Wales the first part of the UK to ban the use of electronic cigarettes in enclosed public spaces.

June – UK government publishes draft regulations and announces a second consultation on the introduction of standardised packaging.

October – Electronic cigarettes are banned on all Transport for London (TfL) premises.

December – Government tables regulations to make it illegal to smoke in cars carrying children in England.

2015

January – Government announces it will press ahead with legislation on standardised packaging for cigarettes.

February – Bristol trials smoke-free zones in two public squares.

March – Standardised packaging regulations are passed in the House of Commons. They are also agreed in the House of Lords. The legislation will come into force from May 2016.

April – Ban on displaying tobacco in small shops comes into force throughout the UK.

May – Scottish public health minister announces a proposal to ban the sale of electronic cigarettes to under 18s.

October – New legislation in England and Wales makes it illegal to smoke in a vehicle carrying someone who is under 18.

October – Regulations come into force prohibiting the sale of electronic cigarettes to under 18s and the purchasing of tobacco or e-cigarettes by adults for children.

2016

May – European Union's revised Tobacco Products Directive and the UK law on standardised packaging come into effect on 20th May.

September – Chartered Institute of Environmental Health calls on local authorities to introduce more smokefree places where children 'play or learn'.

November – Chancellor announces plans to introduce a Minimum Excise Tax on cigarettes and to require the licensing of tobacco manufacturing equipment.

December – New law takes effect in Scotland that makes it an offence to smoke in a car when a child is present.

2017

July – UK government releases its new tobacco control plan for England, 'Towards a Smokefree Generation'. Targets include a pledge to reduce the prevalence of smoking among adults to 12% or less by 2022, to reduce the prevalence of smoking in pregnancy to 6% or less by 2022, and to make all mental health inpatient sites smoke free by 2018.

2018

June – Prisons minister Rory Stewart says all prisons in England are now 'smoke free'.

June – Scottish government's new tobacco control plan includes proposals for minimum pricing of tobacco and restrictions on the prevalence of tobacco retailers in certain areas.

November – Smoking banned in Scottish prisons.

November – Dundee City Council announces plan to ban workers from smoking and vaping during working hours.

2019

March – Cross-party group of MPs call for minimum age at which people can buy tobacco to be raised from 18 to 21.

May – Public Health England calls for all NHS trusts to ban smoking on hospital grounds.

June – England's Chief Medical Officer Dame Sally Davies says vapers should restrict their habit to their homes and gardens.

June – San Francisco becomes the first US city to ban sales of e-cigarettes.

June – Beverley Hills, California, bans sale of most tobacco products.

July – New York State to ban the sale of tobacco to persons under 21, joining 15 other US states that have approved similar policies.

July – Smokers at Sandwell and West Birmingham Hospitals Trust threatened with fines if they light up on hospital grounds.

July – UK government issues an ultimatum to industry to make smoked tobacco obsolete by 2030

*Primary source: Action on Smoking and Health
Additional information (2018-2019): Forest*



**This is a
Smoke Free Hospital**
Smoking is strictly
prohibited in buildings and
grounds

NHS Smoking Helpline (free) 0800 169 0 169

