Passage of the

Smoking, Health and Social Care (Scotland) Bill 2004

SPPB 85

Volume 1
Passage of the
Smoking, Health and Social Care (Scotland) Bill 2004

SP Bill 33 (Session 2), subsequently 2005 asp 13

SPPB 85

Volume 1: Before Introduction and Introduction
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Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:

- Introduction, followed by publication of the Bill and its accompanying documents;
- Stage 1: the Bill is first referred to a relevant committee, which produces a report informed by evidence from interested parties, then the Parliament debates the Bill and decides whether to agree to its general principles;
- Stage 2: the Bill returns to a committee for detailed consideration of amendments;
- Stage 3: the Bill is considered by the Parliament, with consideration of further amendments followed by a debate and a decision on whether to pass the Bill.

After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the
Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available for sale from Stationery Office bookshops or free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

However, the Health Committee was assisted in its Stage 1 consideration of the Bill by the work it had previously undertaken on the Prohibition of Smoking in Regulated Areas (Scotland) Bill (a Member’s Bill introduced by Stewart Maxwell MSP – “the Stewart Maxwell Bill”). In fact, the Stage 1 Report on that Bill was originally re-published as Annex E of the Stage 1 Report on the Bill to which this volume relates. In this volume, however, the Stage 1 Report on the Stewart Maxwell Bill is included in the “Before Introduction” section, rather than as Annex E to the Stage 1 Report on the Bill to which this volume relates (albeit that this Bill was introduced just prior to publication of the Stage 1 Report on the Stewart Maxwell Bill). To assist in the understanding of the Stage 1 Report on the Stewart Maxwell Bill, a number of other documents relating to that Bill are also included in the “Before Introduction” section (in fact, everything that would have been included had a Passage of the Bill volume been produced for that Bill). Although not formally debates on the Stewart Maxwell Bill, relevant minutes and Official Report extracts from two debates on smoking which took place while that Bill was under consideration are also included. No further proceedings took place on the Stewart Maxwell Bill after publication of the Stage 1 Report – the Bill was eventually withdrawn on 21 July 2005, shortly before the Bill to which this volume relates was enacted.

The original Financial Memorandum for the Bill to which this volume relates contained some erroneous figures. Only the corrected version is included here. The Finance Committee’s consideration related to that corrected version.

A letter from the Minister for Health and Community Care dated 31 January 2005 was included in Annex C of the Stage 1 Report; however, the paper that the letter
refers to was omitted in error – it is included here after the Stage 1 Report (note that Annex A to that paper was included in the Stage 1 Report, while Annexes B and C are no longer available). A piece of supplementary written evidence from the STUC was similarly omitted and is again included here after the Stage 1 Report. Also included at this point in the volume is a copy of the Scottish Executive’s consultation paper on draft regulations under Part 1 of the Bill, which was supplied to the Health Committee during Stage 1 but not included in the Stage 1 report.

The report of the Finance Committee was included in Annex A of the Stage 1 Report. Additional material relating to that Committee’s consideration of the Bill (including written submissions and the Official Report of the oral evidence taken) which was not so included is included here after the Stage 1 Report.

Letters sent to the Health Committee after publication of its Stage 1 Report (by the Scottish Executive and by Imperial Tobacco Limited) are included here before the minute and Official Report extracts relating to the Stage 1 debate, along with a letter from the Subordinate Legislation Committee sent just prior to the Stage 1 debate (the response to that letter is included in “After Stage 1” section of this volume). Letters sent after the Stage 1 debate (by the Scottish Executive and by the Tobacco Manufacturers’ Association) are included in the “After Stage 1” section.

The Health Committee agreed at its meeting on 10 May 2005 to consider the Bill in a non-standard order. The relevant minute extract is included in this volume. The Committee also took oral evidence at its meeting on 17 May 2005, as well as considering Stage 2 amendments – again, all relevant material (including written submissions received) is included in this volume.

The Scottish Executive provided factual briefings on some Stage 2 amendments. These are included after the relevant Marshalled List and Groupings where available.

Further letters from the Scottish Executive during Stage 2 and prior to Stage 3 (the latter providing an updated version of the regulations to be made under Part 1 of the Bill) are included at the relevant points.

There are various references in this volume to documents which were to be provided to the Health Committee which are not included here (for example, the minute of the Health Committee meeting on 22 February 2005 included in Annex B of the Stage 1 Report refers to draft regulations on pharmacy contracts being provided for Stage 2), due to them no longer being available.

Forthcoming titles

The next titles in this series will be:

- SPPB 86: Management of Offenders etc. (Scotland) Bill 2005
- SPPB 87: Environmental Assessment (Scotland) Bill 2005
- SPPB 88: Licensing (Scotland) Bill 2005
- SPPB 89: Housing (Scotland) Bill 2005
Mr Stewart Maxwell: Proposed Regulation of Smoking Bill—Proposal for a Bill to regulate smoking in enclosed premises open to the public where food is supplied and consumed. (lodged 3 July 2003)

Supported by: Bruce Crawford, Michael Matheson, Eleanor Scott, Mr Rob Gibson, Jim Mather, Brian Adam, Robin Harper, Patrick Harvie, Mike Pringle, Nicola Sturgeon, Rosie Kane, Chris Ballance, Richard Lochhead, Colin Fox, Tommy Sheridan
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Schedule 1 —Exempt spaces
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Prohibition of Smoking in Regulated Areas (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to prohibit persons from smoking in regulated areas; and for connected purposes.

1 Regulated areas

(1) Subject to subsections (2) to (5), any enclosed public space is a regulated area—

(a) while food is being supplied and consumed; and

(b) during the prescribed period before food is supplied and consumed, in that space.

(2) When an enclosed public space is a regulated area under subsection (1), an enclosed connecting space is also a regulated area for the purposes of this Act.

(3) The spaces specified in schedule 1 to this Act are not regulated areas.

(4) In this Act, “prescribed period” means 5 days or such longer period as the Scottish Ministers may by order prescribe.

(5) In this section—

“connecting space” means any space directly connected to an enclosed public space by an opening, provided that both spaces are under the same ownership or control;

“enclosed” in relation to any space, means a single space which, except for any opening, is completely enclosed on all sides whether permanently or temporarily;

“opening”, means a door, sliding partition, window, hatch or other similar opening which is capable of being closed; and

“public space”—

(a) means a space to which the public or a section of the public has access, on payment or otherwise, as of right or by virtue of express or implied permission; and

(b) without prejudice to the generality of paragraph (a), includes spaces within any of the places specified in schedule 2 to this Act.
2  **Power to amend meaning of “regulated area”**

   (1) The Scottish Ministers may by order amend this Act for the purpose of amending the definition of “regulated area” so as to add such places as they think fit.

   (2) Before making any order under subsection (1), the Scottish Ministers must consult such persons, or groups of persons, as they consider appropriate.

3  **Offence to smoke in regulated area**

   (1) Any person who smokes in a regulated area is guilty of an offence.

   (2) It is a defence for an accused charged with an offence under subsection (1) to prove that the accused did not know, and could not reasonably be expected to have known, that the area was a regulated area.

4  **Offence to permit smoking in regulated area**

   (1) If a person to whom subsection (2) applies knowingly permits a person to smoke in a regulated area, the person to whom that subsection applies is guilty of an offence.

   (2) This subsection applies—

   (a) during the period while food is being supplied and consumed, to—

   (i) the owner, occupier, manager or any other person for the time-being in charge of the regulated area; and

   (ii) the owner, manager or any other person for the time-being in charge of the food operation in the regulated area; and

   (b) during the prescribed period before food is supplied and consumed, to the owner, occupier, manager, or any other person for the time-being in charge of the regulated area.

   (3) For the purposes of any proceedings under subsection (1), an accused has the requisite knowledge if the accused (or any employee or agent of the accused) knew or ought reasonably to have known that the person was smoking in the regulated area.

   (4) It is a defence for an accused charged with an offence under subsection (1), to prove that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence to avoid the commission of the offence.

5  **Offence to fail to display signs**

   (1) Signs must be clearly displayed inside and outside a regulated area indicating that smoking is not permitted.

   (2) If signs are not displayed in accordance with subsection (1), or regulations made by virtue of subsection (4), any person mentioned in section 4(2)(a)(i) and (ii) is guilty of an offence.

   (3) It is a defence for an accused charged with an offence under subsection (2) to prove that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence to avoid the commission of the offence.

   (4) The Scottish Ministers may by regulations—

   (a) prescribe the number, type, style and content of signs to be displayed; and
(b) prescribe the manner in which signs are to be displayed.

(5) Before making any regulations under subsection (4), the Scottish Ministers must consult—

(a) the Scottish Licensed Trade Association;

(b) the Scottish Tourist Forum;

(c) the Brewers’ and Licensed Retailers’ Association of Scotland;

(d) the British Hospitality Association; and

(e) such other bodies as the Scottish Ministers consider appropriate.

6 **Penalty**

A person guilty of an offence under section 3, 4 or 5 is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

7 **Bodies corporate etc.**

(1) Where an offence under section 4 or 5 which has been committed by a body corporate other than a local authority is proved to have been committed with the consent or connivance of, or is attributable to, any neglect on the part of—

(a) a director, manager or secretary, member or other similar officer of the body corporate; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the body corporate, is guilty of the offence and liable to be proceeded against and punished accordingly.

(2) Where an offence under section 4 or 5 which has been committed by a local authority is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) an officer or member of the authority; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the authority, is guilty of the offence and liable to be proceeded against and punished accordingly.

(3) Where an offence under section 4 or 5 which has been committed by a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a partner; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the partnership, is guilty of the offence and liable to be proceeded against and punished accordingly.

(4) Where an offence under section 4 or 5 which has been committed by an unincorporated association other than a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a person who is concerned in the management or control of the association; or

(b) any person who was purporting to act in any such capacity,
that person, as well as the unincorporated association, is guilty of the offence and liable to be proceeded against and punished accordingly.

8  Crown application

(1) The provisions of this Act and of orders or regulations made under it bind the Crown.

(2) No contravention by the Crown of any provision of this Act or of any orders or regulations made under it makes the Crown criminally liable; but the Court of Session may, on the application of any public body or office-holder having responsibility for enforcing that provision, declare unlawful any act or omission of the Crown which constitutes such a contravention.

(3) Despite subsection (2), any provision of this Act, or of any orders or regulations made under it, applies to persons in the public service of the Crown as it applies to other persons.

9  Orders and regulations

(1) Any power of the Scottish Ministers under this Act to make orders or regulations is exercisable by statutory instrument.

(2) Any power under this Act to make orders or regulations includes power to make—

(a) different provision for different cases and for different classes of case; and

(b) such incidental, supplementary, consequential, saving or transitional provision as the Scottish Ministers consider necessary or expedient.

(3) A statutory instrument containing—

(a) an order under sections 1(4) or 2(1) is not to be made unless a draft of the instrument has been laid before, and approved by a resolution of, the Scottish Parliament; and

(b) regulations under section 5(4) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

10  Interpretation

In this Act—

“food” has the same meaning as in section 1 of the Food Safety Act 1990 (c.16) except that in this Act “food” does not include—

(a) drink; or

(b) biscuits, nuts, potato crisps, chewing gum, confectionery and other similar products;

“food operation” means any business, undertaking, event or activity where food is supplied and consumed;

“local authority” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994 (c.39);

“prescribed period” has the meaning given by section 1(4);

“regulated area” is to be construed in accordance with section 1;
“smoke” means smoke, hold or otherwise have control over, an ignited smoking product, and “smoking” shall be construed accordingly;
“smoking product” means any tobacco or other product that is intended to be smoked; and
“supplied” includes food supplied—
(a) free of charge; or
(b) by way of sale.

11 Short title and commencement

(1) This Act may be cited as the Prohibition of Smoking in Regulated Areas (Scotland) Act.

(2) This Act comes into force as follows—
(a) this section and sections 1, 5(4), 5(5), 9 and 10 come into force the day after the date of Royal Assent; and
(b) the remainder of this Act comes into force at the end of the period of six months beginning with the date of Royal Assent.
SCHEDULE 1

(introduced by section 1(3))

EXEMPT SPACES

1. Any enclosed space within a vehicle used for the carriage of members of the public for reward including, but not limited to, buses, trains, aircraft, hovercraft and ships or other vessels.

2. Any enclosed space, within any of the following premises, which is wholly or mainly used for the supply of food to, and consumption of food by, persons residing in the premises—
   (a) any health service hospital within the meaning of section 108(1) of the National Health Service (Scotland) Act 1978 (c.29);
   (b) any independent health care service within the meaning of section 2(5) of the Regulation of Care (Scotland) Act 2001 (asp 8);
   (c) any state hospital provided under section 102(1) of the National Health Service (Scotland) Act 1978;
   (d) premises providing a care home service within the meaning of section 2(3) of the Regulation of Care (Scotland) Act 2001; or
   (e) prisons, remand centres, detention centres, young offenders institutions and other similar establishments.

SCHEDULE 2

(introduced by section 1(5))

PUBLIC PLACES

1. Clubs, centres or other places for the purpose of providing facilities for social, cultural or recreational activities or for physical education or training.

2. Places providing day care of children within the meaning of section 2(20) of the Regulation of Care (Scotland) Act 2001 (asp 8).

3. Places providing support services within the meaning of section 2(2) of the Regulation of Care (Scotland) Act 2001 (other than places providing support services which are wholly or mainly used as a private dwelling).

4. Hotels and other similar establishments (including private function suites and private conference rooms within such establishments).

5. Places of work other than places which are wholly or mainly used as a private dwelling.

6. Schools within the meaning of section 135(1) of the Education (Scotland) Act 1980 (c.44).

7. Colleges and other institutions providing further education within the meaning of section 1 of the Further and Higher Education (Scotland) Act 1992 (c.37) and section 1(5)(b) of the Education (Scotland) Act 1980.

8. Universities and other institutions providing higher education within the meaning of section 38 of the Further and Higher Education (Scotland) Act 1992.
Prohibition of Smoking in Regulated Areas (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to prohibit persons from smoking in regulated areas; and for connected purposes.

Introduced by: Mr Stewart Maxwell
On: 3 February 2004
Bill type: Member's Bill
PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL

EXPLANATORY NOTES

(CONTENTS)

1. The following documents are published to accompany the Prohibition of Smoking in Regulated Areas (Scotland) Bill introduced in the Scottish Parliament on 3 February 2004:
   - Explanatory Notes;
   - a Financial Memorandum; and
   - the Presiding Officer’s Statement on legislative competence.

The Financial Memorandum and Presiding Officer’s statement are required under Rule 9.3 of the Parliament’s Standing Orders. A Policy Memorandum is printed separately as SP Bill 20–PM.
EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Non-Executive Bills Unit on behalf of Stewart Maxwell, the member in charge of the Bill. They have been prepared in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

SUMMARY OF AND BACKGROUND TO THE BILL

4. The Bill is directed at smoking and, in particular, aims to prevent people from being exposed to the effects of passive smoking in public areas where food is being supplied and consumed.

5. The Bill does this by:
   - defining areas where smoking is not permitted (regulated areas);
   - making it an offence to smoke in regulated areas;
   - making it an offence for owners, occupiers and the like to knowingly permit smoking in regulated areas;
   - requiring signs to be clearly displayed inside and outside regulated areas; and
   - providing that offences can be prosecuted summarily.

COMMENTARY ON SECTIONS

Section 1: Regulated areas

6. Section 1 sets out the areas to which the Bill will apply. These are described as regulated areas.

7. Subsection (1) provides that any enclosed public space is a regulated area while food is supplied and consumed in that space. It also makes a similar provision during a prescribed period before food is supplied and consumed. Smoking in a regulated area is made an offence by section 3 and permitting smoking in such an area is made an offence by section 4.

8. “Enclosed” and “public space” are defined in subsection (5): an “enclosed” space being a single space which is fully enclosed except for openings, and “openings” being doors and windows and the like which are capable of being closed. The Bill relates to spaces and not rooms. Therefore where different rooms are separated by a gap that is not capable of being...
These documents relate to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

closed - for example an arch, a passageway or a stairway - these rooms (and the gap which connects them) will form part of the same enclosed space for the purpose of the Bill.

9. “Public spaces” are spaces that the public, or a section of the public, has access to; including those they pay to enter. The definition covers cafes, restaurants and bars, and larger buildings like hotels, railway stations, airports, shopping centres and the like. Schedule 2 provides a non-exhaustive list of places that are covered by the definition including, for example, private clubs and places of employment.

10. The prescribed period provided for in subsection (1)(b) is defined in subsection (4) as a period of 5 days or such longer period as the Scottish Ministers may provide by an order made by statutory instrument. Establishing such a period is intended to ensure that eating areas are free from the effects of smoke. This may take varying times depending upon the size of the area, the decoration and room coverings and the rate of change of fresh air to remove smoke particles. A period of 5 days is taken as a minimum period to allow for an average room, typically furnished to be relatively clear of the harmful effects of smoke particles.

11. Power is given to Scottish Ministers to extend the period. It might be appropriate to do this if it can be determined that harmful effects linger for longer than 5 days. An order extending the period cannot be made until the Parliament has approved a draft of the order by resolution (this procedure is commonly known as the affirmative procedure – see section 9(3)(a)).

12. Subsection (2) aims to prevent smoke from drifting into the eating space. This is achieved by requiring an enclosed buffer area between areas where smoking takes place and eating areas. This buffer area will be any enclosed space directly connected to the regulated area in which food is, or at the end of the prescribed period is to be, supplied and consumed. These spaces are referred to in the Bill as “connecting spaces” which, in terms of subsection (2) are also regulated areas. A space will not be a connecting space if it is not connected to the enclosed public space by an opening. Additionally, for a space to be a “connecting space” it and the enclosed public space must be under the same ownership or control (see subsection (5)).

13. Subsection (3) introduces schedule 1 to the Bill. Schedule 1 lists spaces which are exempt from the provisions of the Bill. Paragraph 1 of schedule 1 provides that the Bill will not apply to vehicles used as a method of transportation by the public at a cost to them. This includes but is not limited to, buses, trains, aircraft, hovercraft, ships and other vessels.

14. Paragraph 2 of schedule 1 exempts premises where a section of the public may be compelled to reside for periods of time. This is to avoid restrictions on people who are unable to exercise a choice with regard to the environment in which they eat. The exemption only applies to the areas where the people residing in the premises eat and not to areas such as staff or public restaurants. This exemption covers places such as hospitals (psychiatric and general), residential care establishments, prisons, remand centres, detention centres and similar establishments.

Section 2: Power to amend meaning of “regulated area”

15. Section 2 gives powers to the Scottish Ministers to amend the meaning of “regulated area” by order made by statutory instrument. This power is however restricted to extending the
areas covered by the Bill and cannot be used to remove areas. Any such order cannot be made until the Parliament has approved a draft.

16. Subsection (2) requires Scottish Ministers to consult before making any such order.

Section 3: Offence to smoke in regulated area

17. This section makes it an offence for anyone to smoke in a regulated area. It will be a defence against any charge for accused persons to prove that they did not know, and could not reasonably have known, that they were in a regulated area. This could arise in instances where for example signs (see section 5) had been removed or not displayed. The onus is however on the accused to prove this.

Section 4: Offence to permit smoking in regulated area

18. Section 4(1) makes it an offence for those in charge of regulated areas to knowingly permit smoking. The persons liable are specified in subsection (2).

19. During the period while food is being supplied and consumed persons liable are the owner, occupier, manager or any other person for the time being in charge of the regulated area (subsection (2)(a)(i)) and the owner, manager or any other person for the time being in charge of the food operation in the regulated area (subsection (2)(a)(ii)). Food operation is defined in section 10 as any business undertaking, event or activity where food is supplied and consumed, and thus applies to outside caterers and others supplying food for consumption in the regulated area.

20. During the 5 day period before food is supplied and consumed the owner, occupier, manager, or any other person for the time being in charge of the regulated area will be liable (subsection (2)(b)). Therefore to avoid committing the offence the 5 day smoking free period must be allowed to elapse before food is supplied and consumed.

21. Subsection (3) provides that accused persons under section 4 are liable if they, or anyone working for them or representing them, knew or ought reasonably to have known that smoking was taking place. It will therefore not be a defence for accused persons to argue simply that they did not know smoking was taking place.

22. Subsection (4) provides a defence for anyone accused of the offence in subsection (1). That defence is that they or anyone working for them or representing them had taken all reasonable precautions and had tried to the best of their ability to avoid committing the offence. It is considered that this will require the taking of positive measures such as asking the person to stop smoking, asking them to leave the premises or calling the police, and training staff to keep vigilant and to take similar action.

Section 5: Offence to fail to display signs

23. Section 5 requires ‘no smoking’ signs to be displayed inside and outside the regulated area. The owner, occupier, manager and any other person in charge of the regulated area and the
These documents relate to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

owner, manager or any other person in charge of the food operation are liable for failure to display such signs. Failure to display signs is an offence.

24. Subsection (1) requires signs to be clearly displayed so that they are visible both inside and outside the regulated area.

25. By subsection (2) the responsibility for ensuring signs are in place, and therefore the liability for failure, rests with the same persons who are liable for the permitting smoking offence during a period when food is being supplied and consumed (see paragraphs 18 to 22 above).

26. Under subsection (3) it is defence for anyone accused of failing to display signs to prove that they or anyone working for them or representing them as agent took all reasonable precautions to ensure that signs were in place as required.

27. Subsection (4) gives Scottish Ministers power by regulations to prescribe the requirements of signage. This power is to prescribe the number, type and style required as well as their size and content. They could also prescribe the manner in which signs must be displayed.

28. In making regulations for signs, the Scottish Ministers could, for example, complement the requirements for prohibitive signs provided for under the Health and Safety (Safety Signs and Signals) Regulations 1996 (SI 1996/341).

29. Before making regulations subsection (5) requires Scottish Ministers to consult certain bodies closely connected with the licensed and restaurant trade, being the Scottish Licensed Trade Association, the Scottish Tourist Forum, the Brewers’ and Licensed Retailers’ Association of Scotland and the British Hospitality Society. Ministers shall also consult with such other bodies that they consider appropriate.

Section 6: Penalty

30. Section 6 sets the penalties on summary conviction for the offences in sections 3, 4 and 5 as the maximum of level 3 on the standard scale (currently £1000). Summary criminal proceedings take place before the district or sheriff court (without a jury).

Section 7: Bodies corporate etc.

31. A number of places where food is supplied and consumed will be owned and managed by corporate and similar bodies. Section 7 applies the offences in sections 4 and 5 to these bodies corporate and to individuals, who exercise control within an organisation.

32. The bodies to which section 7 applies are:
   - bodies corporate (other than local authorities);
   - local authorities;
These documents relate to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

- Scottish partnerships; and
- unincorporated associations.

33. In certain circumstances a director, partner, officer or employee (or any other person specified) of one of the above organisations will be guilty of an offence as well as the organisation itself. This arises when they consent to, or connive in, the commission of an offence by the organisation, or if their negligence results in the commission of an offence by the organisation.

**Section 8: Crown application**

34. Many public spaces where food is supplied and consumed will be operated and controlled by the Crown.

35. Section 8(1) applies the provisions of the Bill, including any orders or regulations made under it, to places operated by the Crown.

36. However under subsection (2) the Crown itself cannot be held criminally liable for committing an offence under the provisions of this Bill. A public body or office holder who has responsibility for enforcing any of the provisions in the Bill can make an application to the Court of Session, to declare that any specific breach of the provisions of the Bill by the Crown is unlawful.

37. Although the Crown itself cannot be prosecuted, subsection (3) ensures that the provisions in the Bill apply to people in the public service of the Crown. Thus Crown servants can be prosecuted for offences under sections 4, 5 and 6.

**Section 9: Orders and regulations**

38. Section 9 sets out the procedure which must follow at Parliament before any Regulations made by Scottish Ministers come into force.

39. Subsection (1) provides that the powers given to the Scottish Ministers under the Bill are exercisable by statutory instrument.

40. Subsection (2) allows orders and regulations to make different provisions for different cases. This provides a flexible approach should for example different types or sizes of premises require different orders.

41. Subsection (3)(a) provides that any statutory instrument containing an order under section 1(4) (prescribed period) or 2(1) (definition of regulated area) cannot be made until Parliament has approved a draft of the order by resolution (commonly known as affirmative procedure).
42. Subsection (3)(b) provides that any regulations made under section 5(4) (regulations in respect of signs) comes into force unless the Parliament passes a resolution to annul them (commonly known as negative resolution procedure).

Section 10: Interpretation

43. ‘Food’ is defined as having the same meaning as in section 1 of the Food Safety Act 1990 (c.16). However to allow bars and public houses etc to allow smoking while continuing to sell bar snacks the definition of food in this Bill does not include drink or biscuits, nuts, crisps, confectionery and the like.

44. ‘Smoke’ is defined widely to ensure that it includes a person holding or having control over a lighted cigarette, pipe, etc (see following paragraph) even if they were not actually inhaling.

45. ‘Smoking product’ is defined as tobacco or any product that is intended to be smoked. This ensures that smoke from smoking products other than tobacco is included, for example herbal cigarettes. It also ensures that cigars and pipe smoking are included.

46. “Supplied” is defined to include food provided free such as a buffet, or given free when a drink is purchased, or provided as an enticement to stay in the premises. Food which has been sold is also included in this definition of supplied.

Section 11: Short title and commencement

47. Various provisions commence the day after Royal Assent to allow preparatory work to take place for full commencement 6 months later.

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FINANCIAL MEMORANDUM

INTRODUCTION

48. Costs from the provisions of this Bill will fall on owners / proprietors of premises where food is supplied and consumed. There will also be costs on the Courts and the Procurator Fiscal Service. In each case costs are not large and for businesses are likely to be more than offset by savings in other areas.

COSTS ON THE SCOTTISH ADMINISTRATION

Estimating compliance with the provisions

49. It is difficult to accurately predict how many businesses will comply with the provisions in the Bill. Therefore to estimate the rate of compliance it is useful to look at the compliance rate in other jurisdictions. In New York, it was found that in the first six months of the Smoke-
Free Air Act 2002, the compliance rate was 98%.\(^1\) There are similarities with the enforcement regime in New York to that proposed for this Bill, in each jurisdiction proprietors are liable to prosecution when smoking occurs in designated areas.\(^2\)

50. Information from the Food Standards Agency in Scotland estimates that there are approximately 32,000 premises in Scotland where food is supplied and consumed. Taking a direct comparison with the New York figure that 2% of premises will not comply gives a figure of 640 who may not initially comply in Scotland.

51. The Bill makes it an offence to permit smoking in regulated areas as well as creating the offence of smoking in such areas. It can therefore be reasonably anticipated that compliance rates will be high. The implications for owners/proprietors of non-compliance could lead, in licensed premises, to licenses being revoked or not renewed.

**Estimating the number of prosecutions for owners/proprietors committing and offence.**

52. It is likely that enforcement will be carried out in a comparable way to that of certain Road Traffic Offences, for example drivers and passengers who do not wear a seat belt. Such offences generally come to light when other offences are committed as opposed to being routinely targeted for direct enforcement action.

53. Information from the Driver and Vehicle Licensing Agency (DVLA) indicates that 71% of adults (over 18s) in the United Kingdom hold a driving licence. For Scotland this percentage provides a figure of 2,813,834 people.\(^3\)

54. A survey carried out in 1998 by the Scottish Executive found that 86% of vehicle occupants comply with the requirement to wear seat belts. Using this figure we can estimate that 14% of drivers in Scotland do not comply with the requirements. This gives us a figure of 393,936 for non compliance.

55. The average number of prosecutions in respect of seat belt offences between 1995 and 2000 was 30,234.\(^4\) Comparing this figure with the earlier numbers who do not comply suggests that prosecution rates are around 7.6%.

56. Using the non-compliance total of 640 from paragraph 50 and applying the prosecution rate of 7.6% gives a figure of 49 prosecutions of proprietors/owners. It can be anticipated that there will be at least a similar number of individuals prosecuted given the requirements in the Bill.

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1 Testimony of Nancy Miller, Assistant Commissioner for Tobacco Control, NYC Department of Health and Mental Hygiene, 16 September 2003
2 Local Laws of The City of New York 2002 No.47
3 DVLA Today, Issue 24, 2003
**Estimated cost of prosecutions**

57. A prosecution may not necessarily involve court action given the availability of fiscal warnings and fines although court action is an option. The court involved for a summary prosecution could be either the District Court or Sheriff Court with the former perhaps more likely. It is estimated that the time involved in each prosecution would average ½ hour.

58. Based on information supplied for other Bills by the Scottish Court Service and the Procurator Fiscal Service each hearing costs £220. In addition to this there will be a cost of approximately £40 on the Procurator Fiscal Service for the preparation of papers for the hearing.

59. This gives a total of £260 per hearing. Given the low numbers anticipated it can be reasonably expected that these costs can be subsumed within existing running costs. No new staff members would be expected to be required for such a low volume of cases.

**Current expenditure by Scottish Executive**

60. NHS Health Scotland is allocated £1.5 million a year\(^5\) in order to target smoking prevention activity (including passive smoking). Prevention activities to date include mass media campaigns, such as Club Smoking and Stinx, school based initiatives and community based programmes. 96% of schools in Scotland now provide education on tobacco. In the period 2003-2004 the amount being spent on raising public awareness of the issues surrounding passive smoking is expected to be around £200,000.

**COSTS ON LOCAL AUTHORITIES**

61. Environmental Health Officers employed by Local Authorities are given no specific role in enforcement although they are likely to mention breaches in reports they make following visits and also to report other cases to the Police. These actions do not represent any significant addition to their workload; no additional visits are required of them under the Bill.

62. It is not anticipated that the provisions should impose any direct costs on local authorities other than in their capacity as owners/proprietors of premises where food is supplied and consumed. Those costs are detailed in the following section of this memorandum.

**COSTS ON INDIVIDUALS, COMPANIES AND OTHER BODIES**

**Costs on owners/proprietors**

63. Costs will fall on people who run establishments that have to comply with the new law. However it is expected that these costs will be minimal and relate entirely to signage. The costs of signage should be more than offset by savings arising from reduced cleaning, decoration and other similar type costs. There will no longer be any need to supply ash trays. There might also be reductions in insurance premiums arising from reduced fire risks in non-smoking premises.

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\(^5\) Written Answer given by Mr Tom McCabe (15 December 2003) S2W-4693
64. Many premises already use signs to designate existing no-smoking areas. It can be anticipated that designating entire rooms could reduce the overall costs of signage given that individual table signs would no longer be necessary as they are replaced by more general signage.

65. The Bill does not require a set number of signs and the number in each area will vary depending upon such factors as size and layout. Costs will therefore vary but taking a need for 5 signs for an average sized room as the norm, businesses might incur costs of £25 - £50. However as indicated these are not wholly additional costs and are likely to be more than offset by other savings.

66. There is also clear evidence from other jurisdictions that there will be no loss of trade costs to businesses. Further details about this can be found in the policy memorandum at paragraphs 29 to 37.

Ventilation costs

67. The Scottish Voluntary Charter on Smoking in Public Places (the Charter) encourages premises to consider staff and customer comfort and to improve air quality. One way of achieving this encouraged by the Charter is by way of ventilation systems. Two of the Charter smoking policies apply to venues that have ventilation that meets the Charter Standard.

68. The cost of installing a ventilation system sufficient to meet the Charter Standards will vary depending upon such factors as size of rooms, age of building and location. To fit a ducted system which will entitle premises to display the ventilation related Charter signage can cost £2000 to £50,000 and require regular maintenance for optimal performance.6

69. In addition to the cost of installation and maintenance, ventilation systems increase heat loss from premises and there will be a consequential rise in heating bills.

70. Ventilation costs in this regard will no longer need to be incurred by premises which supply or allow consumption of food following enactment of the Bill.

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

71. On 2 February 2004, the Presiding Officer (George Reid) made the following statement:

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6 Figures from information supplied by Parliamentary Office of Science and Technology, October 2003, Number 206
“In my view, the provisions of the Prohibition of Smoking in Regulated Areas (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

1. This document relates to the Prohibition of Smoking in Regulated Areas (Scotland) Bill introduced in the Scottish Parliament on 3 February 2004. It has been prepared by Stewart Maxwell, the member in charge of the Bill with assistance from the Parliament’s Non-Executive Bills Unit and is submitted to the Parliament in accordance with Rule 9.3.3A of Standing Orders. The contents are entirely the responsibility of the member and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 20–EN.

POLICY OBJECTIVES OF THE BILL

2. The objective of the Bill is to prevent people, including children, from being exposed to the effects of passive smoking in certain public areas. The Bill does not prevent people from smoking in all public places, it focuses on areas where food is supplied and consumed.

3. The Bill should be considered as part of the process of safeguarding the health of the people of Scotland from the effects of tobacco smoke. It should also raise awareness of the dangers of both passive smoking and smoking, while at the same time assisting to change the attitudes of the public towards smoking in general. It is to be hoped that it will also encourage people who want to stop smoking, and help ex smokers from relapsing, by providing a smoke-free environment.

BACKGROUND

Health issues

4. About 30% of adults in Scotland currently smoke, around 1.2 million people. Smoking tobacco produces two main types of emissions: sidestream smoke, directly from the burning of tobacco and mainstream smoke, the smoke exhaled by the smoker. Being exposed to these types of smoke is commonly known as passive, involuntary or second hand smoking, this type of smoke is also known as environmental tobacco smoke (ETS).
5. The United States Environmental Protection Agency (USEPA) has classified ETS as a Class A human carcinogen for which there is no safe level of exposure. This puts ETS in the same class as asbestos, arsenic, benzene and radon gas. The USEPA has estimated that exposure to ETS is responsible for 3000 lung cancer deaths per year in the USA and recent research by them has shown that ETS also causes heart disease. The research shows that there are 10-20 times as many ETS related deaths from heart disease as there are from lung cancer.

6. In June 2002, the World Health Organisation International Agency for Research on Cancer (IARC) classified ETS as a human carcinogen. ETS contains five regulated hazardous air pollutants, 47 regulated hazardous wastes, and more than 50 known or suspected cancer causing agents along with other chemicals that increase blood pressure, damage the lungs and cause abnormal kidney function. It is a known cause of cancers, cardiovascular and respiratory diseases. The IARC has concluded that there is sufficient evidence that involuntary smoking (exposure to second hand tobacco smoke or ETS) causes lung cancer in humans.

7. The Chief Medical Officer for England and Wales, in his Annual Report for 2002, advocates that a key part of tackling the health risks of smoking is to protect people (both smokers and non-smokers) from the effects of tobacco smoke. He states that inhaling ETS is “unpleasant and a direct hazard to health”. He concludes that restrictions on smoking in public places and overall smoking reduction are the key strategies to reduce second hand smoke exposure. The first recommended action in his report is that “very serious consideration should be given to introducing a ban on smoking in public places soon”.

8. The British Medical Association (BMA), in its report *Towards Smoke Free Public Places*, states that an estimated 1000 people a year die in the United Kingdom as a result of being exposed to ETS. The report also contains a list of known health effects where there is conclusive proof that passive smoking can be the cause. In adults this includes lung cancer, coronary heart disease, asthma attacks in those already affected, onset symptoms of heart disease and worsening of symptoms of bronchitis. In children this includes cot death, ear infections, respiratory infections, development of asthma and asthma attacks in those already affected. Other proven health effects of passive smoking include shortness of breath, coughing, nausea, headaches and eye irritation. The BMA states that there is also substantial evidence to show that passive smoking can lead to strokes and to low birth weight and premature babies.

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1 US Environmental Protection Agency (June 1994), *Setting the record straight: second hand smoke is a preventable health risk.*
3 California Environmental Protection Agency Office of Environmental Health Hazard Assessment (1997) *Health Effects of Exposure to Environmental Tobacco Smoke.*
4 World Health Organisation International Agency for Research on Cancer, (June 2002) (Vol 83), *Tobacco Smoke and Involuntary Smoking*
6 World Health Organisation International Agency for Research on Cancer, (June 2002) (Vol 83), *Tobacco Smoke and Involuntary Smoking*
8 British Medical Association (2002,Page 3), *Towards Smoke Free Public Places,*
This document relates to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

9. In reply to a written question\(^9\) in November 2003, the Deputy Minister for Health quoted from a report\(^10\) by the Royal College of Physicians that it is estimated that as many as 17,000 hospital admissions in a single year of children under the age of five are due to parental smoking.

10. Non-smokers who are exposed to ETS in the workplace have their risk of lung cancer increased by 16-19%.\(^11\) Passive smoking also increases the possibility of an acute coronary event by 25-35%.\(^12\)

**Current restrictions**

**United Kingdom restrictions**

11. In the UK, for the most part, it is left up to individual organisations to specify smoking restrictions in public places. Legislative provision to restrict smoking tends to be narrow in scope, for example employers are required to ensure that there are arrangements to protect non-smokers from discomfort caused by tobacco smoke in rest rooms or rest areas. Other legislation exists to give operators the power to control smoking on trains\(^13\) and to ban smoking on domestic flights.\(^14\) Workers in food industries are prohibited from smoking in places where food is handled or stored.

12. The Government’s 1998 White Paper on Tobacco, *Smoking Kills*, recognised the importance of protecting people from passive smoking and acknowledged that ETS is a clear health risk.\(^15\) The Government chose not to legislate, but to take action, in partnership with businesses, to produce voluntary measures to curb smoking in public places and workplaces.

**Scottish Voluntary Charter**

13. In May 2000, the Scottish Executive produced the Scottish Voluntary Charter on Smoking in Public Places (the Charter). The Charter is co-sponsored by Nicorette and promoted by the Scottish Licensed Trade Association, the Scottish Tourism Forum, the Brewers’ and Licensed Retailers’ Association Scotland and the British Hospitality Association.

14. The Charter’s aims were to achieve a 10% increase in provision in sites having:

- smoking policies (rising from 46% to 56% of establishments);
- written smoking policies (from 25% to 35%);
- signage close to entrances (from 16% to 26%); and
- non-smoking areas (from 39% to 49%).

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\(^9\) S2W-3999, 24 November 2003
\(^10\) Royal College of Physicians, (1992) *Smoking and the young: a report of a working party of the Royal College of Physicians*
\(^12\) Law, MR., Morris, JK. And Wald, NJ., (1997), *British Medical Journal*, 315:973-9v
\(^13\) Transport Act 1962 (c.46)
\(^14\) Air Navigation (No.2) Order 2000 (SI 2000/1562) articles 66 and 122
\(^15\) Government White Paper on Tobacco, (1998, Chapter 1) *Smoking Kills*,
15. The Charter is voluntary and gives organisations a choice as to the level of smoking restriction, if any, they want to impose. It is not necessary to impose any restriction on smoking to be compliant with the Charter. Implementing a smoking policy implies no provision for the protection of non-smokers from the effects of passive smoking. There are no sanctions or methods of enforcement linked to the Charter.

16. In 1999, in anticipation of the Charter’s launch, a baseline study was conducted of 1007 businesses in the leisure industry. This study established that 58% allowed smoking throughout the premises, 31% had smoking restrictions in place and 8% had a total ban on smoking. Two thirds of the businesses surveyed agreed that non-smoking should be the standard in public places.

17. In January 2003 a follow up survey on the 1999 study was carried out. Two of the main aims were to determine the proportion of businesses that have smoking policies in place and to measure the extent of compliance with the Charter. In total 1574 businesses were contacted, 974 businesses responded (62%), with 11% refusing to participate. Overall of the 974 businesses that responded 249 (26%) were from public houses and bars and 188 (19%) were restaurants.

18. The results of this survey which illustrates the extent to which the Charter had achieved its aims are as follows:

- sites with smoking policies (2000, 46%, target 56%, 2003, 68%);
- sites with written smoking policies (2000, 25%, target 35%, 2003, 34%);
- sites with signage close to entrances (2000, 16%, target 26%, 2003, 36%); and
- sites with non smoking areas (2000, 39%, target 49%, 2003, 61%).

19. With the exception of the final objective above, no-one will have had their exposure to ETS reduced, in any way, by any of the above activity.

20. The detailed survey results show that 44% of public houses had a smoking policy. In 71% of those public houses the smoking policy was to permit smoking throughout. 83% of restaurants had a smoking policy, with 29% of them permitting smoking throughout. 21% of restaurants had banned smoking but no public house or bar had a smoking ban throughout.

21. Overall in 2003, of the 759 businesses in the food and entertainment sector who responded to the survey, 68% stated they had a smoking policy in place. Of those with a smoking policy in place, only 11% actually banned smoking in their premises.

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17 MVA for Ash Scotland and NHS Health Scotland (2003) Smoking in Public Places – a follow up survey of the Scottish Leisure Industry
22. Both the 2003 survey and the 1999 baseline survey show that the figure, among businesses, for awareness of the Charter is static at 45%. Being aware of the Charter does not necessarily mean being compliant with it.

23. Given that 6 out of 10 businesses complying with the Charter were in fact unaware of its existence, the results could indicate that businesses are introducing smoking policies for reasons other than the influence of the Charter.

24. The Deputy Minister for Health has acknowledged that the results of the 2003 survey were disappointing, as was the fact that the survey was unable to verify enforcement of non-smoking areas.19

Restrictions in other countries

25. Since 1995, the Republic of Ireland has had regulations in place that prohibit smoking in many public places including eating places. Further regulations coming into force in 2004 will prohibit smoking in licensed premises and clubs; this includes bars, restaurants, and hotels. The person(s) responsible for the premises are those liable for any breaches of the regulations.

26. In Sweden, all indoor public areas must be smoke free. In 1988, Norway introduced anti-smoking legislation in many of its public places. In 1995 these restrictions were extended to include restaurants and other establishments that serve food and drink.

27. In New York, smoking has been banned in restaurants and various other public places since March 2003. Mayor Bloomberg who proposed the new law stated ‘You have a right to smoke, you just don’t have the right to make someone else sick and kill them, and that’s what second hand smoking does’.20

28. Australia, Canada, California and Singapore are other jurisdictions that have legislation in place in relation to smoking and ETS. Legislation is also forthcoming in New Zealand.

Economic issues

29. As indicated a number of other countries have introduced restrictions on smoking in public places. It is a frequent claim, often made by groups backed by tobacco interests, that restrictions will have a devastating affect on businesses and employment. Numerous studies have been carried out to measure the impact on business of smoking restrictions.

30. In 2002 a review21 was undertaken of 97 studies which had made statements in relation to the economic impact of smoke-free laws on the hospitality industry. The review compared the quality of evidence and conclusions reached about the economic impact of smoke-free laws based on the type of data used, the design, analysis and interpretation of studies and the funding

19 Scottish Executive News Release SEhd517/2003
20 www.nietrokers.nl/e2/n01013.html (source New York Daily News)
source. The studies considered covered areas in the United States, Australia, Canada, England, New Zealand, Hong Kong, South Africa and Spain.

31. The review suggested three criteria to judge study quality for policy makers set out by Siegel\textsuperscript{22}. The three factors suggested were:

- was the study funded by a source clearly independent of the tobacco industry?
- did the study objectively measure what actually happened, or was it based on subjective predictions or assessments?
- was it published in a peer reviewed journal?

32. Of the 97 studies 35 concluded that there was a negative impact on businesses. These 35 studies were all funded by the tobacco industry, and none of them used all three criteria.

33. There were 21 studies which met all three criteria, all of which found that smoke-free restaurant and bar laws had no negative impact on revenue or jobs.

34. The review concluded that policy makers can act to protect patrons from the effect of second hand smoke “confident in rejecting predictions that there will be an adverse economic impact”.

35. Various studies have consistently shown that the ban in New York has not had a detrimental effect on the City’s restaurant business\textsuperscript{23} and one such study concluded that having a smoking ban in place increased restaurant profits.\textsuperscript{24} New York City’s Department of Health and Mental Hygiene issued a press release in July 2003 showing that employment in New York’s restaurants and bars had increased in comparison to the same period the year before.\textsuperscript{25}

36. Figures quoted by the London Health Commission as part of their “Big Smoke Debate” show that 82% of tourists want compulsory smoke-free areas in pubs and bars.

37. The above results from the “Big Smoke Debate” along with the fact that the majority of people in this country are non smokers and object to others smoking near them (see paragraph 96), mean that going smoke free should represent an economic opportunity rather than a threat for the hospitality industry.\textsuperscript{26}

\textsuperscript{22} Siegel M., (1992) “Economic Impact of 100% smoke-free restaurant ordinances”, Smoking and restaurants: a guide for policy makers
\textsuperscript{25} NYC Department of Health and Mental Hygiene, Press Release, Employment up in City Bars and Restaurants since Implementation of the Smoke Free Air Act, 23 July 2003.
\textsuperscript{26} Annual Report of the Chief Medical Officer for England and Wales, 2002.
How the Bill will work

Regulated areas

38. The Bill will apply to enclosed places open to the public where food is supplied and consumed. This will include private clubs and function suites. In practice places that will initially be covered include:

- licensed premises where food is served;
- cafes;
- restaurants;
- sandwich shops with seating;
- eating places in larger buildings, e.g. hotels, supermarkets, railway stations, airports, shopping centres, covered markets, leisure centres, sports stadiums, museums, conference centres, visitor centres, day care centres, colleges, universities, membership clubs and workplaces; and
- places where food may be served from time to time, e.g. church halls, hotel function suites and conference rooms.

39. The restriction on smoking applies to these premises at all times when food is supplied and consumed. It also applies in the period of five days prior to any food being served. This flexibility allows proprietors to vary the use of their premises to meet local circumstances while limiting exposure to ETS, particularly those premises that are multi-purpose due to limited local availability.

40. The Bill does not apply to beer gardens or outdoor tables. Nor does it apply to licensed premises where food is not supplied and consumed, or where the only food supplied is bar snacks like crisps and nuts. It provides landlords with a clear choice in relation to the use made of their premises in relation to smoking restrictions.

41. The Bill gives power to Scottish Ministers to extend the restrictions of the Bill to any other places in the future.

Supplied and consumed

42. The Bill covers the supplying of food for consumption and is not restricted to the sale of food. Supply covers food supplied without direct payment, for example food provided at conferences, weddings and other functions in regulated premises. It also covers food ‘given away free’ whether as part of any promotion or otherwise. This is in keeping with the policy that nobody should suffer from exposure to smoke while consuming food in regulated areas.

Signage

43. The Bill requires owners and persons in control of premises to display signs to make it clear to customers and staff the areas where smoking is not permitted. It will be necessary to have sufficient signage to ensure that no reasonable person could inadvertently be unaware of the restrictions.
44. Further powers are given to Scottish Ministers to make additional regulations about signs. Any such regulation can only be made after consulting with interested parties.

Enforcement

45. It is not the primary policy intention to see numerous prosecutions for the offences created by the Bill. The aim is that the creation of the requirement will lead to a change in attitudes by smokers and assist those who want to stop smoking. Similar intentions as to attitudes were behind seat belt laws and more recently restrictions on using mobile phones when driving. In each case the core issue is one of safety. Compliance with seat belt legislation is generally high as are initial indications about using mobile phones while driving. Compliance with existing smoking restrictions on trains, in cinemas and theatres is extremely high with no significant ongoing resistance being reported.

46. Enforcement of the smoking restrictions in the Bill is through the criminal law. It will be an offence to smoke in a regulated area while food is being supplied or consumed. To ensure that the atmosphere is smoke-free for future diners the offence also applies in an area where food is to be served within the next five days.

47. Owners and persons in charge of premises will also commit an offence by permitting smoking in areas covered by the Bill. It will be a defence that they have taken all reasonable steps to prevent smoking. Steps will include having signs prominently displayed requesting smokers to desist as well as other measures to remove them from the restricted areas. Failure to display signs will itself be an offence.

48. By penalising proprietors as well as smokers it is anticipated that non compliance will be extremely low and essentially self policed. The police will however be able to take action, either on their own initiative or in response to information received from other customers, staff or members of the public. This will include environmental health officers (EHOs) who regularly monitor premises in relation to other statutory requirements.

49. Any complaints received or prosecutions made in respect of the offences in this Bill can be brought to the attention of and taken into account by the Licensing Boards when considering applications under the Licensing (Scotland) Act 1976 (c.66). Thus ignoring the restrictions could lead to licensees not having licenses renewed.

50. Should the law be regularly flouted in certain places it remains open to the police to respond to local concerns and to target offenders and offending premises. Unlike the other offences mentioned, this Bill carries a requirement on proprietors to self-police with consequential penalties for failure.

51. If a person is found guilty of any of the offences under this Bill they are to be liable, on summary conviction, to a fine not exceeding level 3 on the standard scale (currently set at £1000). The Procurator Fiscal on receiving a report from the police has options available short of prosecution. An offender could be cautioned or a conditional offer of a fixed penalty offered. If a summons is issued this would be to either the district or sheriff court.
CONSULTATION

52. There have been two member-led consultation exercises to obtain the views of those affected by the Bill.

**Initial consultation**

53. “The Regulation of Smoking Bill: A Consultation” was issued in November 2001 by the former MSP, Kenneth Gibson, to assist him in formulating the policy for his proposed Member’s Bill.

54. The consultation gathered views and comments from industry and other organisations on the regulation of smoking in enclosed premises. Copies were sent to organisations and individuals identified as having an interest in the proposed legislation. Others requested and were sent copies. In total 145 copies were issued, others were able to electronically access the consultation. The consultation sought views on eight specific questions as well as general comment.

55. Thirty nine responses were received covering replies from 43 organisations.

56. Of the 39 responses, 9 were received from the tobacco industry / licensing industry. The remainder came from health organisations, charities, local authorities and tobacco control groups.

**Question 1: To what extent is ventilation a useful tool in combating ETS?**

57. Eighteen of the 28 respondents to this question stated that ventilation was not a useful tool in combating ETS. This included Macmillan Cancer Relief, ASH Scotland, Royal College of Nursing and Royal College of Physicians, Edinburgh.

58. Seven respondents indicated that it was their view that ventilation was a useful tool in combating ETS when designed and maintained properly. These responses were from local authorities, the Scottish Licensed Trade Association and Honeywell, a manufacturer of air ventilation systems.

**Question 2: How has the Voluntary Charter and/or the Approved Code of Practice (ACoP) had an impact on the adoption of non-smoking policies?**

59. Ten respondents said that there was little evidence that the Charter has made much difference, while 11 said the voluntary Charter was inappropriate or did not go far enough and legislation was required. five respondents said the Charter is working.

**Question 3: How do you feel about smoking restrictions in restaurants and/or in pubs serving food?**

60. In total 27 (70%) of the respondents’ favour some type of restriction on smoking where food is served. A variety of reasons were given for this, five responses said that it was unacceptable that people were involuntarily exposed to smoke. Four respondents said that
restrictions were required to protect staff and customers. Eight respondents said that smoking should be restricted by having separate areas for smokers away from the serving of food. Two respondents said that they did not agree with smoking restrictions and four were opposed to an outright ban.

**Question 4: What type of impact, financially or otherwise, will smoking regulations have on trade, tourism and health in Scotland?**

61. Twenty two (56%) of the respondents did not expect smoking regulations to have a negative impact on trade and tourism. 12 respondents said that it would have no detrimental effect on tourism and trade. Eight respondents anticipated more tourists would use a place where a strict smoking policy was adhered to. In addition, eight of the respondents said that smoking regulations would provide a better environment for tourists.

62. Five respondents felt a guaranteed smoke-free atmosphere would increase business.

63. The organisations representing the licensing trade and tobacco organisations suggested smoking restrictions would have a negative impact on business. They noted that tourism had suffered following foot and mouth and the aftermath of September 11th. They feared that many people would go out of business and many jobs would be lost should people choose to stay at home to smoke.

**Question 5: What time scale should be followed in the implementation of the legislation?**

64. All respondents agreed a period for implementation was required, responses ranging from as soon as possible to 10 years. A majority were keen for implementation as soon as practicable.

**Question 6: Who should be responsible for breaches of the legislation?**

65. A variety of suggestions were made. Four said the police, eight said the licensing board, four said health and safety officers and 1 said the local fire authority. Fifteen said that EHOs should be responsible for breaches of the legislation with 14 saying no authorities should be involved and that the owner / proprietor or manager of the establishment should be responsible for any enforcement.

**Question 7: How should this legislation be enforced?**

66. There was a varied response on penalties and enforcement. Thirteen respondents said that compliance with alcohol licensing regulations with the ultimate sanction of the removal of the licence was the way to enforce the legislation. Six respondents said that the proprietor should be responsible for enforcement, this would be voluntary with no criminal sanctions. Eight respondents said that it should be enforced through food safety legislation, which is controlled by environmental health. Nine respondents felt that fines should be imposed for people who breached the legislation.

67. Concerns were raised about the possible enforcement of any smoking regulation. Four respondents said smoking regulations were impossible to enforce and that enforcement will not work if significant numbers of the population decide to ignore the law.
Question 8: Do you support a legislative measure of this nature coming into force in Scotland?

68. Twenty one (54%) of the respondents supported legislation to regulate smoking. Sixteen (40%) of the respondents wanted legislation to be accompanied by a clear public information campaign to ensure people understand and support regulation in this area.

Stewart Maxwell’s consultation

69. To supplement the initial consultation in July 2003 the Member wrote to all those who had responded inviting them to make any additional points. He also wrote to those who had not responded to the initial consultation offering them a further opportunity to contribute.

70. Some organisations reviewed and strengthened their original response. The additional responses showed a continuing support for the introduction of legislation in respect of banning smoking where food is served. Two local authorities who provided additional information stated that they had been investigating the possibility of either restricting or banning smoking in public places by using local byelaws. A third local authority has since implemented smoking restrictions in licensed premises where children’s meals are being served; this was achieved through conditions imposed by its Licensing Board.

71. Responses received from organisations involved in both cancer research and care indicates that they believe Scotland is falling behind other countries in addressing the problem of ETS.

72. The Member has carefully considered the responses received to both exercises in formulating the Bill. It is his belief, supported by research findings, that business fears over loss of trade are unfounded (see paragraphs 29 to 37 above). He also accepts that other research findings show a high percentage will comply with the restrictions when in place and believes that enforcement will not be a major problem. Figures issued by New York City Council show that in the first six months after their Smoke-Free Air Act 2002 came into force, compliance was recorded at 98%.27

ALTERNATIVE APPROACHES

73. Arising from the consultation responses were five main alternative approaches considered by the Member.

(i) Smoking regulation provided for by the Licensing (Scotland) Act 1976 (c.66)

74. The first approach considered was to make it a condition of an alcohol licence granted under the Licensing (Scotland) Act 1976 that the premises would be non-smoking.

75. The Bill seeks to ensure that smoking does not take place in an enclosed space where food is supplied and consumed and this may not necessarily apply to the whole of the premises.

27 Testimony of Nancy Miller, Assistant Commissioner for Tobacco Control, NYC Department of Health and Mental Hygiene, 16 September 2003
This document relates to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

The Bill also allows food to be served in an area where smoking has previously taken place after a smoke-free period of five days.

76. Not all premises where food is sold are licensed; therefore a separate mechanism would also need to have been included to provide for non licensed premises. Not all licensed premises sell food and such a requirement would have imposed a restriction on all premises.

77. The considered approach would not have been proportionate to the aims of the proposal and indeed would not, by itself, have succeeded in bringing about the aims of the Bill.

(ii) Enforcement by environmental health officers

78. A number of respondents suggested that EHOs would be the appropriate people to enforce the legislation. Those Scottish EHOs employed by local authorities visit premises where food is handled and routinely prepare reports observing breaches of legislative requirements particularly under Food Safety and Health and Safety regimes.

79. The focus of EHOs’ activity is towards education and encouragement of proprietors although they have powers to issue Improvement and Prohibition notices under certain statutes. In other cases, where they observe breaches of the law, they make reports direct to the Procurator Fiscal and subsequently provide evidence at court. Direct reporting to the Procurator Fiscal is covered by guidance issued by the Crown Office, having developed over time without the need for a statutory basis.

80. The enforcement activities of EHOs are directed at the proprietors of premises and they do not normally enforce the law against ordinary members of the general public.

81. Following discussion with EHOs it was not considered appropriate to alter their existing relationship with the general public. It would be undesirable to have a different approach to enforcement for proprietors and individuals and thus no specific role for EHOs is contained in the Bill.

82. It is recognised, however, that EHOs will be present in premises and are likely to observe if there is, or has been, smoking in regulated areas. These matters can, without any further statutory authority, be drawn to the attention of proprietors during visits to premises. It is also expected that breaches will be reported as part of EHOs professional responsibilities to promote public health in the same way as for any other crime they observe not covered by direct reporting agreements. It would be possible for the Scottish Executive to promote this role for EHOs by drawing the provisions in the Bill to the attention of officers by way of circular to local authorities and EHO professional organisations.

(iii) Air treatment systems (ventilation and filtration)

83. The third approach considered was that of requiring premises to install air treatment systems throughout to help reduce the effects of ETS. Air treatment systems are largely of two types. The first is a filtration system that draws the smoke filled air through a filter; it filters the particles, removing the visible smoke and leaving the harmful chemicals present.
84. The second type is a ventilation system that re-circulates the air; these are ineffective when dealing with smoke filled air. For ventilation systems to be effective in clearing the air, the speed of air circulation would require to be so high it would result in the appearance of a tornado like gale blowing inside the building.\(^\text{28}\)

85. While any improvement in air quality is to be welcomed, ventilation can only reduce exposure to ETS and not eliminate it.\(^\text{29}\) Although it may provide a more comfortable environment for customers, it does not provide effective protection against the health hazards associated with passive smoking. Only 12% of ETS is made up of particles the rest takes the form of gases which contain many of the most harmful chemicals. These chemicals are still present in the air once the visible tobacco smoke has disappeared.

86. Studies have shown that smoke particles attach themselves to surfaces in rooms and these surfaces themselves become a secondary source of ETS pollution.\(^\text{30}\) The particles over time detach themselves and reform as concentrates in the air.

87. The UK Government\(^\text{31}\), states that “no system of ventilation provides adequate protection against ETS”. Furthermore, in response to a written question\(^\text{32}\), the Deputy Minister for Health stated that the Scottish Executive does not endorse ventilation systems as being effective in reducing the health risks associated with passive smoking.

88. The clear conclusion from numerous studies is that ventilation systems at best only partially remove the ETS particles and have little or no effect on the gases containing the harmful chemicals.

**(iv) Prohibit smoking in all public places**

89. The Member also considered a total ban on smoking in all public places.

90. The approach taken is more about protecting non-smokers, allowing them to exercise their right to eat in places that are free from smoke. The Member accepts that there are limits to what can be achieved within the scope of a Member’s Bill. He fully acknowledges that this Bill is part of a process of legislative action combined with education campaigns to raise public awareness in respect of the issue of smoking in society.

**(v) Maintain the status quo**

91. The fourth alternative considered was to wait and monitor further the progress of the Voluntary Charter. The Charter allows businesses to comply whilst having no smoking restrictions. Latest results show that only 11% of businesses in the Food and Entertainment


\(^{29}\) Health and Safety Executive, (1997) *Passive Smoking at Work* (Leaflet)


\(^{31}\) Government Paper on Tobacco, Smoking Kills, 1998

\(^{32}\) S2W-542 , 12 June 2003
sector are smoke-free, meantime the health of the people of Scotland continues to be affected by ETS.

92. In September 2002 in response to a Petition\textsuperscript{33} submitted to the Parliament on smoking in public places, the Scottish Executive stated that they “have not ruled out statutory restrictions on smoking in public places but Ministers believe such restrictions would be premature as long as substantial progress was made in partnership with owners and managers”.

93. Overall, the findings of the 2003 survey indicate that the industry has made some but not substantial progress towards complying with its own targets. Neither signage nor written policies have a direct impact on the health risks of ETS. Notably it is possible to comply with the terms of the Charter without providing any smoke-free areas.

94. It is clear that although the Charter appears to meet most of its original targets it has been ineffective in reducing the risks of passive smoking. It is difficult to see how it can be effective since the objectives set will not, in themselves, lead to any reduction in exposure to ETS.

95. The Member does not believe that the Charter will lead to a reduction in the ill-health and deaths caused by passive smoking.

Public attitudes towards smoking

96. A do nothing approach is not supported by public opinion surveys which have repeatedly shown that the majority of smokers as well as non-smokers want to see a wider smoke-free environment. The 2002 Smoking related Behaviours and Attitudes survey published by the Office of National Statistics\textsuperscript{34} show that 87\% of people agree that smoking should be restricted in restaurants. Among current smokers the number agreeing to a restriction was 71\%. The figures reported favouring restrictions have consistently risen over the years.

97. For the first time ever 50\% agree with smoking restrictions in bars. The Bill would not apply to bars unless they were serving food. This figure indicates a degree of support for wider measures than are proposed.

98. A survey reported by the Tobacco Manufacturers Association in September 2003 indicated that only 9\% thought the smoking situation was fine as it is, with 75\% indicating some improvements are required in pubs, clubs and bars. The same survey showed that 7 out of 10 non-smokers have real concerns about smoking in clubs and bars.

Pizza Hut

99. Over the last few years Pizza Hut, when refurbishing existing restaurants and opening new ones, have made them completely no smoking. This was in response to feedback from customers and managers who had noted that the smoking areas were rarely used and were effectively ‘dead areas’. In August 2003, Pizza Hut announced that they were to become the

\textsuperscript{33} Firrhill High School, Edinburgh. Petition 503, Petition to Ban Smoking in Public Places
\textsuperscript{34} Office of National Statistics, \textit{Smoking Related Behaviour and Attitudes 2002}
This document relates to the Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) as introduced in the Scottish Parliament on 3 February 2004

first restaurant chain to introduce no smoking in all of its 500 premises throughout the United Kingdom. Pizza Hut took this action to protect their customers and staff from the dangers of passive smoking. This step reflects the public mood since 80% of the public favour smoking restrictions in public places.35

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

100. The Bill does not discriminate on the basis of gender, race, disability, marital status, religion or sexual orientation.

101. The Bill will have a positive effect on certain groups, particularly those suffering from chest and other respiratory complaints. Such people will, following implementation, have more choice available to them in relation to places to eat due to the absence of smoke.

Human rights

102. The Bill is fully compliant with the European Convention on Human Rights.

103. The aim of the Bill is to protect public health by reducing exposure to ETS. This legitimate aim in the general interest must be borne in mind when considering any potential interference with individual human rights.

104. The Bill does raise issues under Article 6(2) in relation to the rights of an accused to be presumed innocent until proven guilty of an offence. The statutory defences provided in relation to the three offences in the Bill place a burden on the accused to prove the matters referred to in the defences. Such a reverse burden of proof may, in certain circumstances interfere with the presumption of innocence. In this Bill, the defences concern matters within the knowledge of the accused, and they are therefore considered to be compatible with Article 6(2).

105. The Bill raises issues in relation to Article 8, in that it may be suggested that prohibiting smoking in certain places interferes with a person’s right to respect for private life. However the Bill does not prevent people from smoking; it merely prevents smoking in regulated areas. The Bill also exempts from regulated area status eating places in premises where persons may be forced to reside for periods of time, such as prisons, hospitals or residential workplaces. It is considered that the Bill is compatible with Article 8.

106. The Bill also raises issues in relation to the Article 1 Protocol 1 right to peaceful enjoyment of possessions, in connection with the rights of proprietors of premises affected by the Bill. The provisions in the Bill are not considered to constitute a deprivation of property in the sense of Article 1 Protocol 1, however the Bill may be seen as a measure controlling the use of property. It is thought, however, that such control of use as the Bill achieves is proportionate and strikes a fair balance between the rights of individual proprietors and the general interest in

35 Office of National Statistics, Smoking Related Behaviour and Attitudes 2002
protecting public health by reducing exposure to ETS in public places. The Bill is considered to be compatible with Article 1 Protocol 1.

**Island and rural communities**

107. The Bill has no disproportionate effect on rural or island communities. The Bill recognises the limited availability of places where food is supplied in such communities. And also that in a number of locations food may be supplied and consumed in village halls which are used for a variety of events. To make provision for these locations the Bill permits smoking at events provided no food is supplied or consumed. Food can be supplied and consumed in such places after a period of five days has elapsed during which the effects of the smoke will have largely dissipated.

**Local government**

108. The Bill has no specific impact on local government other than as set out at paragraphs 78 to 82 of this memorandum in relation to the operation of EHOs.

**Sustainable development**

109. The Bill will have no impact on sustainable development.
Health Committee

1st Report 2005

Stage 1 Report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill
Health Committee

1st Report, 2005 (Session 2)

Stage 1 Report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill

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- Claire Repper, Mile End School
Dr Helene Irvine, Greater Glasgow Health Board
Garry Coutts, Highland NHS Board
Gillian Lee, NHS Grampian
Paul Ballard, NHS Tayside
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Stewart Maxwell MSP

28 September 2004 (21st Meeting Session 2 (2004))

Written Evidence
Stewart Maxwell MSP
Deputy Minister for Health and Community Care

Oral Evidence
Stewart Maxwell MSP

ANNEX D: OTHER WRITTEN EVIDENCE
Remit:

To consider and report on matters relating to health policy and the National Health Service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care.

Membership:

Roseanna Cunningham (Convener)
Mr David Davidson
Helen Eadie
Janis Hughes (Deputy Convener)
Kate Maclean
Duncan McNeil
Shona Robison
Mr Mike Rumbles
Dr Jean Turner

Committee Clerking Team:

Clerk to the Committee
Simon Watkins

Senior Assistant Clerk
Tracey White

Assistant Clerk
Roz Wheeler

Committee Assistant
Lynn Stewart
The Committee reports to the Parliament as follows—

INTRODUCTION

1. The Prohibition of Smoking in Regulated Areas (Scotland) Bill (SP Bill 20) was introduced in the Parliament on 3 February 2004 by Stewart Maxwell MSP. The Parliamentary Bureau subsequently referred the bill to the Health Committee as lead committee on 10 February 2004.

2. The provisions of the bill conferring power to make subordinate legislation were referred to the Subordinate Legislation Committee under Standing Orders Rule 9.6.2. Under Standing Orders rule 9.6.3, the Finance Committee considered the Financial Memorandum to the bill. The reports of both these Committees are attached at Annex A.

BACKGROUND

3. The Prohibition of Smoking in Regulated Areas (Scotland) Bill seeks to prevent people from smoking in certain enclosed public places. The objective of the bill is to prevent people from being exposed to the effects of passive smoking in those enclosed public areas.

4. The Explanatory Notes and the Policy Memorandum which accompany the bill detail the main policy objectives of the bill. The Policy Memorandum states that—

   The Bill should be considered as part of the process of safeguarding the health of the people of Scotland from the effects of both passive smoking and smoking, while at the same time assisting to change the attitudes of the public towards smoking in general. It is to be hoped that it will also encourage people who want to stop smoking, and help ex-smokers from relapsing, by providing a smoke-free environment.
5. Section one of the bill states that any enclosed public area is a regulated area while food is being supplied or consumed in that place. It makes a similar provision during a prescribed period before food is supplied or consumed. This section also requires that there is an enclosed buffer area between areas where smoking takes place and eating areas.

6. Section 2 gives power to Scottish Ministers to amend the meaning of regulated areas by order made by statutory instrument.

7. Sections 3 and 4 make it an offence to smoke in a regulated area and to permit someone to smoke in a regulated area respectively. Section 5 also makes it an offence for the person in charge of a regulated area to fail to display ‘no smoking’ signs. The penalties on summary conviction for these offences are set at a maximum of level 3 on the standard scale (currently £1000).

CONSULTATION

8. The Policy Memorandum indicates that the member in charge of the bill consulted organisations and individuals who had previously been targeted by, or had responded to, an initial consultation for a proposed member’s bill on the same issue by former MSP, Kenneth Gibson.

9. The only discernable difference between the proposals is that Kenneth Gibson’s bill called for the regulation of smoking in enclosed premises open to the public where food is sold and consumed, whereas Stewart Maxwell’s bill does not stipulate that food must be sold, instead prohibiting smoking in areas ‘where it is supplied and consumed’.

10. The initial consultation document was issued to organisations and individuals identified as having an interest in the proposed legislation in November 2001. In total 145 hard copies were issued and the document was also available electronically. Thirty-nine responses were received.

11. In July 2003, the member in charge of the bill wrote to all those who responded to the initial consultation and to those who had been issued a consultation document but had not responded offering them a further opportunity to contribute. The member also made the consultation available electronically. Twenty-nine responses were received, the majority of which simply noted their continued support of a ban on smoking in regulated areas. The Committee is content with the level of consultation undertaken by the member in charge of the bill.

EVIDENCE TAKEN BY THE COMMITTEE

12. The Committee issued a formal call for written evidence on 12 February 2004 and received 323 responses. Of these responses, 270 supported the general principles of the bill.

13. While the call for written evidence did not specifically ask about support for a more extensive ban than that specified by section one of the bill, a number of respondents indicated that they would also support a ban in all enclosed public
places. In a sample of 50 per cent of the written submissions around half of respondents indicated support for a full ban.

14. The Committee took oral evidence over the course of 5 meetings on 8, 15, 22 and 29 June 2004 and on 28 September 2004. Annex B contains the relevant extracts from the minutes of these meetings. The Committee heard from the following organisations: ASH Scotland; NHS Health Scotland; FOREST; the Tobacco Manufacturers’ Association; AMICUS; the British Hospitality Association Scotland Committee; the Cosmopol Bar and Restaurant; Greater Glasgow Health Board; Highland NHS Board; NHS Grampian; NHS Tayside; the British Medical Association; the Faculty of Public Health in Scotland; the Royal College of Nursing; Dundee City Council; the City of Edinburgh Council; Dumfries and Galloway Council; Scotland CAN (Cleaner Air Now); Cancer Research UK; the Roy Castle Lung Cancer Foundation; and New York City Department of Health and Mental Hygiene, Bureau of Tobacco Control.

15. The Committee also heard oral evidence from Shona Hogg, Simon Hunter and Lea Tsui from Firrhill High School; Findlay Masson, Callum McPherson and Claire Repper from Mile End School; Mr Tom McCabe MSP, Deputy Minister for Health and Community Care; Dr Mac Armstrong, Chief Medical Officer and Amber Galbraith, Principal Procurator Fiscal Depute, Crown Office.

16. Stewart Maxwell MSP gave evidence on 29 June 2004 and again on 28 September 2004, supported on both occasions by officials from the Scottish Parliament Non-Executive Bills Unit and the Directorate of Legal Services.

17. The Committee is grateful to our various witnesses for taking time to give evidence and for submitting written evidence for the Committee’s consideration. Their oral and written evidence is set out at Annex C. The Committee would also like to record its thanks to others who responded to its call for written evidence. All responses to the Committee’s call for evidence can be found on the Committee’s web page.¹

 GENERAL PRINCIPLES OF THE BILL

18. In considering the general principles of the bill, the Committee sought to address a number of issues, including:

- Whether there is evidence of adverse health effects from exposure to passive smoking;
- Whether there is evidence that a partial ban on smoking in public places will have a positive impact on public health;
- Whether a range of alternative approaches could fulfil the aims of the bill;
- The likely economic impact of the bill;
- The extent to which the provisions of the bill are enforceable; and
- Public attitude to a legal ban on smoking.

¹ http://www.scottish.parliament.uk/business/committees/health/inquiries-04/ros/he04-smo-000.htm
Health effects from exposure to passive smoking

19. The objective of the bill is to prevent people being exposed to the effects of passive smoking in certain public places, specifically those areas in which food is supplied and consumed. The accompanying policy memorandum states that, ‘The Bill should be considered as part of the process of safeguarding the health of the people of Scotland from the effect of tobacco smoke’. The Committee was, therefore, interested to review the evidence about the health effects from exposure to passive smoking.

20. A substantial body of scientific work on questions relating to the impact of passive smoking on public health was brought to the attention of the Committee, both in written submissions and at various oral evidence sessions. A significant majority of those who contributed to the Committee’s inquiry cited evidence of adverse health consequences from environmental tobacco smoke. Among the evidence submitted there was some variation of views as to the risk level, but none of the evidence suggested that there was zero risk.

21. In its written submission Greater Glasgow Health Board suggested that consultants in public health medicine are of the view that environmental tobacco smoke “is now incontrovertibly linked with a wide range of diseases and causes of premature death” (SPICe Briefing 04/39). Its representative, Dr Helene Irvine listed a range of conditions associated with or exacerbated by passive smoking such as increased risk of cot death, upper and lower respiratory infection, asthma in children, lung cancer, ischaemic heart disease and stroke in adults.

22. Dr Laurence Gruer, public health consultant, NHS Health Scotland, told the Committee –

The accumulation of evidence over the past few years has been substantial. There is undeniable evidence that environmental tobacco smoke is noxious and that it contains a number of chemicals and gases that are harmful to health. A variety of different studies have shown that people who are exposed to environmental tobacco smoke over the long term are at increased risk of conditions that are associated with smoking, such as lung cancer and heart disease. (Col 946)

23. Dr Gruer went on to highlight particular immediate, risks from passive smoking for people with pre-existing heart conditions. He similarly indicated that passive smoking can cause problems for people with a tendency to asthma or other respiratory conditions and can lead to lower birth weights for the babies of mothers exposed to smoke during pregnancy. He acknowledged that the health risks from passive smoking are much less than the risks from actual smoking but indicated, nonetheless, that the risk accumulates over time.

24. Dr Sinead Jones, director of the BMA’s Tobacco Control Resource Centre, referred to work conducted by the International Agency for Research on Cancer, which concluded that passive smoking increases the risk of lung cancer by between 20 and 30 per cent. This work also suggests that risks are higher where exposure is higher and that when exposure is removed risks go down.
Among the various organisations from which the Committee took evidence, only FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco) and the Tobacco Manufacturers’ Association disputed that passive smoking is a significant risk to the health of non-smokers.

Simon Clark, director of FOREST, told the Committee –

Although it is very difficult to prove that passive smoking is not harmful, bodies such as the Health and Safety Commission and the GLA [Greater London Authority] have spent much time and effort taking evidence from all sides and have found it impossible to justify the introduction of legislation that bans smoking completely. (Col 962)

Similarly the Tobacco Manufacturers’ Association (TMA) argued that there is insufficient scientific evidence to justify a ban on smoking in regulated public places. In its written submission it pointed out that a vast body of epidemiological studies into environmental tobacco smoke have, of necessity, considered the experience of non-smokers living with smoking spouses. The TMA acknowledged that a small increased risk of developing lung cancer has been identified for non-smokers in these circumstances but argued that it is only of limited relevance to equate on-going domestic exposure to occasional exposure in an enclosed public space where food is supplied and consumed.

However, when he was asked his views about whether there is any greater danger or higher degree of safety in being exposed to smoke in one setting or another, the Chief Medical Officer, Dr Mac Armstrong told the Committee –

…environmental tobacco smoke is a health hazard. There is no safe level of exposure. It is a highly carcinogenic substance that contains class A carcinogens. No matter where you come into contact with it, it is always dangerous. (Col 1114)

On the basis of the written and oral submissions it received, the Committee accepts that evidence exists of adverse health effects from passive smoking.

Health impact of a partial ban on smoking

Among those who expressed concerns about adverse health effects from passive smoking there was a consensus that, by reducing exposure to second-hand smoke through a partial ban in public spaces, the bill could make a positive contribution to public health in Scotland. However, while welcoming the proposed ban in regulated areas as an important step, a number of witnesses suggested that the partial ban did not go far enough.

Maureen Moore, chief executive of ASH Scotland, indicated that her organisation would prefer to see smoking banned in the workplace to protect the health of workers and those visiting workplaces, stating –

Although we welcome the focus on reducing the general public’s exposure to smoke in areas where food is consumed, we do not see, from a public
health point of view, a rational distinction between exposure to smoke where there happens to be food and exposure to smoke in any other public situation. (Col 949)

32. Dr Sinead Jones, BMA, expressed similar concerns about workers’ health. She told the Committee –

The people who are forced to be in bars and restaurants for the longest time are usually the staff. Bar and restaurant staff are among the workers who are most heavily exposed to second-hand smoke. Making bars and restaurants smoke free would have an immediate impact on the respiratory health of such staff. That has been shown in studies in California, where such a ban took place. The bill is a worthwhile measure – we would not want to let the best be the enemy of the good. (Col 1041)

33. In its written submission public services union UNISON indicated support for the general principles of the bill while stressing the importance of smoking policies in the workplace to protect all workers from the adverse effects of environmental tobacco smoke.

34. In oral evidence to the Committee, Geoff Earl of the Royal College of Nurses also expressed support for a partial ban on smoking in so far as it would protect workers in the service industry. However, he also made clear that his organisation’s policy is that all workers should have a right to work in a smoke-free environment. Along with other witnesses with health service experience, he described situations where medical staff encounter environmental tobacco smoke in the course of their work (for example, where exceptions are made to non-smoking polices for terminally ill patient and long-term psychiatric care and when community nurses require to make home visits). He told the Committee -

Some of the arguments against the bill have centred on individual rights. If a person wishes to exercise an individual right to smoke, they can do so, but they cannot force somebody else to work in a smoky environment. (Col 1042)

35. On the other hand, Andy Matson from the trades union Amicus, while indicating that health and safety of the workforce is paramount, suggested that ‘engineering’ solutions should be found to deal with tobacco smoke in the workplace.

36. As well as seeking to protect people from adverse health impacts from second-hand smoke, according to its policy memorandum, the bill also seeks to assist in changing attitudes to smoking; to encourage people to stop smoking; and to help ex-smokers from relapsing by providing a smoke-free environment.

37. Garry Coutts of Highlands NHS Board was among a number of witnesses expressing support for this approach. He told the Committee –

The vast majority of people, including the majority of smokers, already support a ban in restaurants - in Highland, 75 per cent of people support such a ban. The public are coming with us, but we need legislation to help
support the majority of the public. At the moment, the public are a step or two ahead of the legislation. If we can take a bold step forward, that will help people who run smoking cessation classes and assist folk who want to stop smoking. (Col 1027)

38. Dr McWhirter, from the Faculty of Public Health in Scotland, also indicated that a ban could be of assistance to people who would like to give up but find it difficult to do so. He cited evidence from surveys carried out by the Faculty on a three yearly basis indicating that people find it hard to stop smoking where other people in the family smoke, where there is smoking in the workplace and where there is smoking in the places in which they socialise. Professor Gerard Hastings of Strathclyde University cited a review published in the British Medical Journal in 2002 which concluded that a ban on smoking increases quit rates by around 3.8%.

39. The Committee also received submissions suggesting that smoking in public places undermines campaigns to dissuade potential smokers from smoking in the first instance.

40. On basis of the written and oral evidence it received, the Committee accepts that evidence exists that a partial ban on smoking in public places would impact positively on public health.

Alternatives to the bill

41. The Committee considered whether alternatives to a legal ban on smoking in regulated areas could be further promoted as means of achieving the objectives set out in the bill’s policy memorandum. Views were, therefore, sought from witnesses about the efficacy or otherwise of modern ventilation systems. Views were also sought about the scope for promoting positive health outcomes and reduced smoking rates by developing the existing voluntary charter on smoking and further public smoking-cessation campaigns. As indicted elsewhere in this report, a number of witnesses proposed a ban in all enclosed public spaces or a ban in all workplaces as an alternative to a ban on smoking where food is served.

Promoting better ventilation

42. The policy memorandum accompanying the bill quotes from a UK government publication which states that ‘no system of ventilation provides adequate protection against ETS [environmental tobacco smoke]’. It similarly records that the Scottish Executive does not endorse ventilation systems as being effective in reducing the health risks associated with passive smoking.

43. A number of witnesses were critical of the suggestion that improved ventilation of regulated areas could provide adequate protection against the effects of environmental tobacco smoke. Dr Gruer, NHS Health Scotland, talked of ventilation giving a false sense of security because ‘ventilators do not filter out a number of the most noxious constituents of tobacco smoke’. Similarly Dr Nancy Miller, assistant commissioner of the New York City Department of Health and

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2 1998 White Paper on Tobacco, Smoking Kills, Department of Health
Mental Hygiene, expressed concern that filtration devices ‘give the impression the workers are protected when the reality is that they are not’.

44. Simon Clark of FOREST offered a contrary view. He told the Committee –

…we are clearly moving in the right direction because the hospitality industry has made great steps voluntarily in introducing more no-smoking areas and ventilation systems exist that can prevent smoke drift. That is one of the problems that people have mentioned. The fact that there is a certain amount of smoke drift from smoking areas into non-smoking areas is a valid criticism. However, ventilation systems exist that can provide an air curtain. (Col 967)

45. Andy Matson of AMICUS, also suggested that ventilation systems should be used to protect workers in workplaces where smoking is permitted. However, Professor Hastings, Centre for Tobacco Control, University of Strathclyde, compared ventilation of areas where smoking is permitted to ‘trying to empty a bath while the taps are still on’.

46. The Committee accepts that there is evidence that improved ventilation of regulated areas would not provide an adequate alternative means of achieving the objectives of the bill.

Developing the existing voluntary charter and other voluntary initiatives

47. A range of views were expressed about the potential for a development of the existing voluntary charter and other voluntary initiatives as a means of achieving the objectives of the bill.

48. A number of witnesses were critical of the existing voluntary charter on the basis that it is about informing the public about smoking policies in certain premises rather than necessarily controlling tobacco use and exposure to second hand smoke. Proprietors of premises can comply with the charter without offering any non-smoking areas within their premises.

49. Tim Lord, chief executive of the TMA acknowledged criticisms of the voluntary charter but noted, nonetheless, that with one exception all the targets set by the Scottish Executive in relation to the Charter had been exceeded. He, therefore, suggested that the Scottish Executive set ‘aggressive’ targets and timescales for the hospitality sector on the provision of smoke-free areas and premises and consider legislation only if such an approach is unsuccessful.

50. Stephen Leckie, chairman of the British Hospitality Association Scotland Committee also suggested that the bill is premature. He expressed his organisation’s view that a voluntary approach to smoking policy in public places should continue to be pursued. Should this approach be considered not to have worked in future years and if the results of public consultation indicated support,

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3 The Scottish Voluntary Charter on Smoking in Public Places was launched by the Scottish Executive in May 2000. The Charter’s aims were to achieve a 10% increase in provision in sites having: smoking policies; written smoking policies; signage close to entrances; and non-smoking areas.
the BHA’s preference would be for a total ban across Britain rather than “one that is sectored to some areas in Scotland”.

51. Dr Sinead Jones, BMA, told the Committee that voluntary approaches were worth trying but expressed concern that after five years of a voluntary charter less than 1 per cent of pubs in Scotland are smoke-free. She commented further that three months after a ban was introduced in Ireland\(^4\) 96 per cent of pubs were smoke-free.

52. Dr Nancy Miller, New York City Department of Health and Mental Hygiene, was similarly critical of relying on a voluntary approach to smoking policy. Acknowledging that there were a number of smoke-free bars in New York City before the introduction of the smoke-free air law in 2002\(^5\), she told the Committee -

> We felt we needed to provide a level playing field of protection for all workers, all areas of the economy and all establishments, as well as providing business with a level playing field. We cannot have some establishments voluntarily comply with fire codes or other occupational laws that regulate businesses or protect workers, so we felt that we had to make the law on smoking apply uniformly throughout the city so that all workers would be protected. (Col 1104)

53. The Committee is of the view that the existing voluntary charter is not strong enough and that the voluntary approach does not provide an alternative means of achieving the objectives of the bill.

Public smoking-cessation campaigns

54. Rather than necessarily providing an alternative to a ban (partial or otherwise) a number of witnesses suggested to the Committee that a public smoking-cessation campaign could or should be supported by a ban.

55. Maureen Moore, ASH Scotland, suggested that allowing smoking on an unrestricted basis undermined attempts to discourage young people from becoming smokers, by making the activity appear ‘normal’.

56. Similar sentiments were expressed by Firrhill High School pupil Lea Tsui who told the Committee –

> If young kids who are out with their parents see people smoking in restaurants, they think that smoking is normal. However, if they do not get used to seeing people smoking around them as they grow up, it will become second nature for them not to smoke. (Col 1012)

57. Dr Helen Irvine, Greater Glasgow NHS Board told the Committee –

> I have the highest regard for my colleagues who are involved in health promotion and smoking cessation, but I am afraid that I regard the control of

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\(^4\) In March 2004 the Republic of Ireland introduced a ban on smoking in all places of work.

\(^5\) The New York Smoke-free Air Act 2002 bans smoking in virtually all workplaces.
smoking in public places – ideally, a ban – as far and away the most critical measure…until we physically prevent people from smoking, we will not be able to do anything about our high prevalence of smoking. (Col 1021)

58. Similarly, a number of witnesses suggested to the Committee that it was important that any tobacco control measure was backed up by specific support, in the form of a tobacco action plan, to help those who want to stop.

59. The Committee is of the view that while there is evidence of positive outcomes from smoking-cessation campaigns, their impact has been too slow and they do not provide an adequate alternative means of achieving the objectives of the bill. However, the Committee is also of the view that such campaigns would provide necessary and important support to any smoking ban.

Economic Impact

60. The Committee heard conflicting evidence about the economic impact of smoking bans in other parts of the world. Tim Lord, Tobacco Manufacturers’ Association, cited a report from the Licensed Vintners’ Association of Ireland recording a decline in business of between 12 and 15 per cent.

61. In contrast, the one-year review of the New York City Smoke-Free Air Act of 2002 in March 2004 by the New York City Department of Health and Mental Hygiene, Finance, Small Business Services and the New York Economic Development Corporation found increases in employment, the number of venues openings, the number of tax receipts and the number of liquor licences.

62. In discussing the potential economic impact of the bill, Andy Matson, Amicus, suggested there could be implications for jobs in a range of sectors. Although unable to offer a quantification of the likely job loss, he listed the following occupations as under some threat: the sales forces of the major tobacco companies; vending machine engineers; and those employed in the hospitality industry.

63. Similarly Peter Allan, policy planning manager, Dundee City Council indicated that the traders in Dundee offered no specific projection of the likely economic impact of the bill but spoke about the attitudes of traders in his locality. He told the Committee –

    Traders in Dundee tell us that they would prefer smoking to be dealt with through a voluntary arrangement, but that if there were to be legislation they would like it applied consistently across the trade…. so that it would not affect competition. (Col 1074)

64. In his evidence to the Committee, Stephen Leckie from the British Hospitality Association indicated that his members would be unhappy about any provisions requiring costly alterations to premises indicating that, in the fullness of time, and with proof of public support, a more general ban on smoking may be preferable.
65. Addressing questions relating to economic impact, Simon Clark, FOREST, described the experience of some non-smoking pubs in the UK. He indicated that some pubs have made an economic success of non-smoking policy but that others had been ‘forced’ to reverse their bans after a few months because of negative impact on revenue. He said that while his organisation supports non-smoking pubs they were an ‘economic risk’.

66. The Committee heard conflicting evidence about the economic impact of smoking bans in other countries and is of the view that it is too soon to make a conclusive assessment.

Enforcement issues

67. It will be an offence under the bill to smoke in a regulated area or for the owner or person in charge of premises to allow smoking in a regulated area. It will also be an offence to fail to display the signage necessary to make it clear to customers and staff the areas where smoking is not permitted.

68. However, the bill’s policy memorandum states that it is not the primary policy intention to see numerous prosecutions for the offences created by the bill. Rather, the aim is to create a change in attitudes among smokers and to assist those who want to give up.

69. The Committee was keen, nonetheless, to ascertain views about the enforceability of the bill.

International experience

70. In response to questions on the issue of enforceability a number of witnesses suggested that enforcement would not necessarily be a significant issue pointing to compliance rates in other locations in which bans are in operation, such as New York and Ireland.

71. Maureen Moore, ASH Scotland, cited work carried out by the Office of Tobacco Control in Ireland which reported the 97 per cent of premises inspected under the smoke-free workplace legislation were compliant with the law. She suggested that, as was the case with earlier seatbelt legislation, accompanying the bill with education and continual reinforcement measures would reduce the need for legal enforcement.

72. Garry Coutts, chairman of Highlands and Islands Health Board told the Committee –

   People are agonising over the issue of penalties and enforcement, but that is a secondary argument. Evidence from other parts of the world indicates that enforcement has not been a big issue once a ban has been put in place. (Col 1036)

Practicalities of the ban

73. However, a number of witnesses raised some concerns about the practicalities of the ban in smoking in regulated areas, as proposed in the bill. Stephen Leckie, British Hospitality Association, for example, indicated that the five-day
rule, which restricts smoking in regulated areas for a period of five days prior to any food being served there, would create ‘huge difficulties’ for the hospitality industry, causing confusion for customers and for people organising events. He also raised questions in relation to liability of owners, lease-holders and managers in relation to breaches of the law. Similarly Arun Randev, the proprietor of a restaurant in Glasgow, expressed concern about potential difficulties for owners in the restaurant trade arising from the bill’s provision that smoking also be banned in ‘connecting spaces’.

Enforcement officers
74. The explanatory notes accompanying the bill indicate that environmental health officers employed by local authorities are given no specific role in enforcement although they are likely to mention breaches in reports they make following visits and also to report other cases to the police. It goes on to say, therefore, that these actions do not represent a significant addition to their workload.

75. Commenting on the enforcement of the bill Gordon Greenhill, environmental health officer, City of Edinburgh Council, told the Committee –

It is optimistic to suggest that the bill, as currently drafted, would be cost neutral for local authorities…….complaints would be made and an extra burden would be placed on authorities during inspections. It would be another piece of work that would have to be done. There are 17,000 premises in Edinburgh alone in which we enforce the health and safety at work regulations. If legislation adds another factor, the time that inspections take would increase and the frequency of inspections would reduce. (Col 1070)

76. He went on to suggest that consideration be given to adding a responsibility for enforcement to the remit of new local authority teams to be set up to enforce the Antisocial Behaviour etc (Scotland) Bill.

77. Liz Manson, operations manager of the policy and performance unit of Dumfries and Galloway Council, also suggested to the Committee that enforcement arrangements required to be clarified, commenting that environmental health officers would be happy to assume responsibility ‘provided that resources were made available’.

78. The member in charge, however, stressed during oral evidence sessions that the main responsibility for dealing with incidents of smoking in regulated areas would fall to the police.

Legal enforceability
79. In a written submission to the Committee the Crown Office and Procurator Fiscal Service (COPF) offered a number of comments on the enforceability of the bill as drafted, as summarised below:

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6 ‘Connecting space’ is defined in the bill as ‘any space directly connected to an enclosed public space by an opening, provided that both spaces are under the same ownership or control’.
80. **Section 1:** The COPF submission raised concerns about the complexity of the terms of the bill suggesting: that prohibited behaviour is not precisely defined making alleged offences difficult to prove; that a wide range of evidence would require to be led and witnessed to show that the space in which an alleged offence occurred was a ‘regulated area’; and that the definitions of ‘public space’ and ‘enclosed space’ are ambiguous. COPF also raised concerns about the application of the five-day rule.\(^7\)

81. **Section 3:** In relation to section 3 the COPF submission indicated that the offence of smoking in a regulated area, taken together with the definition of ‘smoke’ and ‘smoking product’ would have wide application. It suggested that ‘this could mean that any person holding a cigarette, for however short a period, or even sitting beside a cigarette in an ashtray, could be convicted of this offence’.

82. **Section 7:** Section 7 of the bill introduces the possibility of committing an offence by negligent action of an officer or a corporate body. The COPF submission stated that, ‘to criminalise negligent conduct is a significant extension to criminal liability in Scotland and certainly merits very careful consideration’.

83. **Section 8:** Section 8 of the bill provides that while the Crown may not be found criminally liable, any ‘public body or office-holder having responsibility for enforcing that provision’ may apply to the Court of Session for a declaration of unlawfulness. The COPF submission suggested a lack of clarity about who should pursue such an application and in the case that it is intended that the COPF itself should do so, argued that this may be a ‘significant’ and ‘perhaps inappropriate’ extension of its role.

84. Responding to the Committee in writing about the COPF submission, the member in charge of the bill, Stewart Maxwell MSP clarified the way in which the bill defines ‘enclosed space’, stating that the definition is ‘clear and precise’ and that whether or not a room is enclosed for the purposes of the bill is a ‘simple matter of fact’. He made similar points in relation to the definition of ‘connecting space’. He disputed a suggestion made by COPF that the definitions could encompass a large building in its entirety.

85. Stewart Maxwell did, however, concur with the view that the bill widely defines ‘public space’. He indicated that this was a deliberate policy in order to include a lot of public places and protect as many people as possible, citing precedent in the Dog Fouling (Scotland) Act 2003, the Public Order Act 1986 and the Criminal Justice and Police Act 2001. He acknowledged that the wide definition would catch certain places that might otherwise be thought private but clarified that it was not the policy intention to cover private homes.

86. Stewart Maxwell dismissed the COPF view on the application of the ‘five-day rule’ saying that account had not been taken of the signage requirements of

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\(^7\) The bill would prohibit smoking in a regulated during a prescribed period before food is served and consumed. ‘Prescribed period’ is defined as ‘5 days or such longer period as the Scottish Ministers may by order prescribe’.
He similarly dismissed the COPF argument in relation to the range of evidence and number of witnesses that would require to be presented to prosecute a case, drawing comparisons with prosecutions under other criminal provisions.

87. Responding to COPF criticism in relation to section 3 of the bill, Stewart Maxwell disputed the suggestion that someone merely sitting beside a cigarette burning in an ashtray could be convicted of an offence, highlighting that the definition of ‘smoke’ actually says ‘smoke, hold or otherwise have control over…’.

88. In relation to COPF observations on section 7, Stewart Maxwell flagged up the use of similar provisions in recent years by the Scottish Executive in a number of pieces of legislation, specifically the Regulation of Care (Scotland) Act 2003; the Water Industry (Scotland) Act 2002; the Protection of Children (Scotland) Act 2003 and the Building Scotland Act 2003.

89. In relation to COPF observations on the Crown liability provisions set out in section 8, Stewart Maxwell’s submission stated that –

The provision was included so that the Bill will comply with what I understand to be Executive policy: that the Crown should normally be subject to any Bill in the same way as any other person, except with regards to criminal liability for contravention of any regulatory measure 8.

90. Stewart Maxwell highlighted similar powers in existing legislation, specifically the Transport (Scotland) Act 2001; the Water industry (Scotland) Act 2002; the Building (Scotland) Act 2003 and the Food Safety Act 1990.

Public Attitude

91. The Committee was keen to ascertain the level of public support, or otherwise, for a ban on smoking in regulated areas. A substantial majority of the written submissions received expressed support for the objectives of the bill.

92. In addition a number of witnesses cited a variety of public opinion studies suggesting support for some form of tobacco control, including a recent MORI poll in the UK that offered extrapolated figures for Scotland showing 77 per cent support for a ban on smoking in public places. (Col 955)

93. Professor Hastings, director of the Centre for Tobacco Control Research, Cancer Research UK, told the Committee about a study of adult smokers he had recently concluded. That survey revealed that more than 80% regretted having started smoking. He went on to say that smokers often support radical action on tobacco control as a means to support their attempts to stop.

8 Stewart Maxwell’s letter of 20 July 2004 is reproduced at Annex C.
94. However, Simon Clark, FOREST, suggested that in coming to a view on the general principles of the bill the Committee should consider the issue of choice for individuals. He advocated a compromise position, telling the Committee –

We do not believe that people have a right to smoke wherever they want. We are saying that there are some people who want to give up smoking, but why should other people be discriminated against just because there are some people who wish to quit? Surely the ideal scenario is a society in which there are bars and restaurants and other public places where people who wish to smoke can go, and plenty of other, non-smoking places where those who wish to give up and do not want to be tempted and non-smokers who are bothered by other people’s tobacco smoke can go. (Col 971)

95. He suggested that it should be matter for individual proprietors, in consultation with their customers and staff, to decide an appropriate smoking policy. He went on to say that this would offer a range of difference venues that people can choose to go into and work in.

96. In his evidence to the Committee, on 29 June, Deputy Minister for Health and Community Care, Tom McCabe MSP, commended the objectives of the bill to the extent that its intention is to restrict the number of places where people can smoke and to reduce the health impacts of second-hand smoke. However, the Minister reserved his position on the bill, saying that a more robust and comprehensive approach is required to achieve these objectives. He said that it would be premature for the Scottish Executive to come to a view about tobacco control in advance of the conclusion of the major public consultation exercise he launched in early June 2004. He indicated that, to date, the Executive had issued in excess of 210,000 freepost response forms and that the consultation exercise was scheduled to conclude in the third week in September. The Minister went on to tell the Committee that he was committed to announce a view on the outcome by the end of the year.

97. The member in charge of the bill indicated in his oral evidence, on 29 June, that it was his view that the information submitted orally and in writing to the Committee over the course of its Stage 1 inquiry, added to the body of scientific and other reports on the issue, was sufficient to justify a wider ban on smoking in public places than that proposed in the bill.

98. He also told the Committee that it was his view that by amending the definitions of regulated areas the coverage of the proposed ban could be extended to apply to all enclosed public places.

99. Stewart Maxwell subsequently confirmed in writing\(^9\) that it would be his intention to amend the Bill at Stage 2, based on the evidence received by the Committee, extending the areas covered and, in particular, breaking the linkage with food.

\(^9\) Stewart Maxwell’s letter of 28 September 2004 is reproduced at Annex C.
FINANCIAL MEMORANDUM

100. Under rule 9.6.3 the Committee is required to consider and report on the bill’s Financial Memorandum, taking into account any views submitted by the Finance Committee.

101. The Financial Memorandum published to accompany the bill states that costs from its provisions will fall on owners/proprietors of premises where food is supplied and consumed and that there will also be costs on the Crown and Procurator Fiscal Service.

102. In its report, the Finance Committee concluded that the assumptions in the Financial Memorandum do not give a fair reflection of the likely cost to on-premises licensed outlets of a partial ban. Commenting on evidence received from the Scottish Licensed Trade Association relating to the potential for lost trade and the potential costs of structural changes to accommodate separate smoking and non-smoking areas the Finance Committee suggested that such costs would be higher if there was a partial ban rather than a total ban on smoking.

103. While recognising that distinct non-smoking areas may encourage custom from people who previously did not visit pubs for medical reasons, the Finance Committee also recorded its doubts about whether the savings identified in the Financial Memorandum can be realised.

104. The Finance Committee also noted that there has not been a sufficient time lapse for the full impact of smoking bans in New York and Ireland to be properly assessed.

105. Finally, the Finance Committee concluded that, as a result of the ‘five day rule’, monitoring compliance with the ban may prove more complex than suggested in the Financial Memorandum. It stated that, ‘it would seem unlikely, therefore, that any additional costs for enforcement could be met from within existing resources’.

106. The Committee also heard evidence that the Financial Memorandum underestimates the potential costs for local authorities in relation to enforcement activities and draws this to the attention of Scottish Ministers. (Col 1070)

SUBORDINATE LEGISLATION

107. The Committee is required to consider and report on proposed powers to make subordinate legislation, taking into account any views submitted by the Subordinate Legislation Committee.

108. The bill confers three delegated powers on Scottish Ministers exercisable by orders or regulations made by statutory instrument. The Subordinate Legislation Committee approves each of the powers, offering a number of comments.
Section 1(4) Extension of the “prescribed period”

109. Section 1 provides that any enclosed public space is a regulated area while food is being supplied and consumed and during the period of five days (the “prescribed period”) prior to food being supplied or consumed. The purpose of the prescribed period is to ensure that eating areas are free from the effects of earlier smoking.

110. Section 1(4) gives power to Scottish Ministers by order to extend the prescribed period beyond five days should scientific developments in the future indicate that a longer period is required to clear a typical furnished room of harmful smoke particles.

111. While approving the power and the procedure chosen, the Subordinate Legislation Committee drew attention to the fact that the power to extend the minimum period is not mirrored by a power to reduce the period should clearing a room of the effects of smoking in a shorter period become possible.

Section 2(1) The definition of a regulated area

112. As the bill is currently drafted, regulated areas relate solely to enclosed public spaces where food is supplied and consumed. Section 2 gives power to Scottish Ministers to amend the definition of regulated area to extend the provisions of the bill to other areas. This power can not, however, be used to remove any of the areas covered by the bill. Subsection (2) places a requirement on Scottish Ministers to consult with appropriate bodies or persons before they make any orders to extend the provision of the bill to other areas.

113. The Subordinate Legislation Committee considered whether subordinate legislation would provide a sufficient level of scrutiny for potentially controversial proposals to extend the areas caught by the bill. It noted that, ‘while the first line of the bill refers to “smoking in regulated areas” it does not, at that point, refer to public areas. It therefore seemed possible that the bill would be open to amendment making any area, private or public, indoors or an outside area, a regulated area for the purposes of the bill’.

114. In oral evidence to the Subordinate Legislation Committee, the member in charge of the bill indicated that it was not the intention of the provision to allow for the regulation of open public spaces or any private spaces and that he intended to lodge an amendment so that the power could not be used to regulate any private space.

115. On the basis of the explanations and undertakings given by the member in charge the Subordinate Legislation Committee approved the power and the affirmative procedure as appropriate.

Section 5(4) Signage requirements

116. Section 5(1) provides that signs should be clearly displayed inside and outside regulated areas indicating that smoking is not permitted. It is an offence if a person in charge of a regulated area fails to display such signs.
117. Section 5(4) gives power to Scottish Ministers to make regulation, subject to annulment, prescribing the detailed requirements for the content of signs and the manner in which they are displayed. Section 5(5) places a requirement on Scottish Ministers to consult with certain bodies representative of the hospitality industry before making any regulations in respect of signs.

118. While the Subordinate Legislation Committee had no issue with this provision in its current form it noted that if the definition of “regulated area” were to be extended then the provision could require some amendment. It also reported that “there appeared to the committee to be a possible practical difficulty inherent in listing particular bodies in that such lists can rapidly become out of date”.

119. Having considered these points the member in charge subsequently wrote to the Subordinate Legislation Committee advising of his intention to bring forward an amendment at Stage 2 to replace section 5 (5) and which will ensure that Scottish Ministers consult with such bodies that are representative of persons affected by the bill before making any regulation under section 5(4).

120. While approving the provision and the annulment procedure chosen as appropriate, the Subordinate Legislation Committee drew attention to the undertaking of the member in charge.
SUMMARY OF MAIN CONCLUSIONS

121. The Prohibition of Smoking in Regulated Areas (Scotland) Bill would ban smoking in enclosed public places where food is served and consumed. The objective of the bill is to help safeguard people from the adverse health effects of tobacco smoke.

122. On the basis of the written and oral submissions it received, the Committee accepts that evidence exists of adverse health effects from passive smoking.

123. On basis of the written and oral evidence it received, the Committee accepts that evidence exists that a partial ban on smoking in public places would impact positively on public health.

124. The Committee is of the view that the existing voluntary charter is not strong enough and that the voluntary approach does not provide an adequate alternative means of achieving the objectives of the bill.

125. The Committee is of the view that while there is evidence of positive outcomes from smoking-cessation campaigns, their impact has been too slow and they do not provide an adequate alternative means of achieving the objectives of the bill. However, the Committee is also of the view that such campaigns can provide important additional support to any smoking ban.

126. The Committee heard conflicting evidence about the economic impact of smoking bans in other countries and is of the view that it is too soon to make a conclusive assessment.

127. The Committee supports the general principles of the bill in so far as they go. It is the view of the majority of the Committee that a partial ban on smoking in enclosed public places is not sufficient to achieve the objectives of the bill and that, therefore, the bill does not go far enough. This point appears to have been conceded by the member in charge of the bill. The Committee acknowledges, in any case, that the bill may have been overtaken by events.
ANNEX A: REPORTS FROM SECONDARY COMMITTEES

Finance Committee

Report on the Financial Memorandum of the Prohibition of Smoking in Regulated Areas (Scotland) Bill

The Committee reports to the Health Committee as follows—

Background

1. Under Standing Orders, Rule 9.6, the lead committee in relation to a Bill must consider and report on the Bill’s Financial Memorandum at Stage 1. In doing so, it is obliged to take account of any views submitted to it by the Finance Committee.

2. This report sets out the views of the Finance Committee in relation to the Financial Memorandum on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, for which the Health Committee has been designated by the Parliamentary Bureau as the lead committee at Stage 1.

Financial Memorandum

3. The Bill seeks to make it an offence to smoke, or permit smoking, in areas where food is being supplied or consumed. In such premises where smoking has been permitted, there must be five ‘smoke free’ days (the ‘five day rule’) before food may be supplied or consumed again. In addition to the promotion of a healthier lifestyle, the Bill aims to raise awareness of the dangers of smoking and passive smoking, engender a change in public attitudes towards smoking in public and assist people who wish to stop smoking by contributing towards a smoke free environment.

4. In looking at the financial implications of the Bill, the Committee considered the impact it would have on the owners and proprietors of premises where food is supplied and consumed. The Financial Memorandum published to accompany the Bill states that there are only minor anticipated costs associated with the Bill and that businesses are likely to benefit from savings in other areas. The Financial Memorandum identifies that businesses will incur costs of between £25 - £50 each to provide no-smoking signage. The Financial Memorandum estimates that the Bill will lead to approximately 49 prosecutions per year and, although it does not estimate how many prosecutions will result in court actions, it states that the Scottish Court Service will face costs of £260 for each prosecution in court. The Presiding Officer has determined that there is no requirement for a Financial Resolution for this Bill.

Consideration by the Committee

5. At its meeting on 1 June 2004, the Finance Committee took oral evidence on the Financial Memorandum from the following—

Stuart Ross, Chairman of the Year, and Colin Wilkinson, Secretary, Scottish Licensed Trade Association; then

Colin Cook, Head, Substance Misuse Division; Mary Cuthbert, Alcohol and Smoking Team Leader, and Calum Scott, Economic Adviser, Analytical Services Division, Health Department, Scottish Executive; then
6. In addition, the Committee considered written evidence from the Scottish Court Service, Federation of Small Businesses in Scotland (FSB Scotland), the Substance Misuse Division, Scottish Executive Health Department and the Scottish Licensed Trade Association (SLTA). The Committee also received further written evidence from the Scottish Beer and Pub Association. These submissions are attached at Appendix 1.

7. The Committee would like to express its gratitude to all those who took the time to provide evidence in relation to this Financial Memorandum. In the light of recommendations of previous Finance Committee reports that Scottish Executive officials should also provide evidence on non-executive bills, it welcomes the evidence officials submitted.

Summary of Evidence

Impact on Business - Costs

8. The Financial Memorandum states that the expected costs of the Bill will be minimal and relate entirely to signage.\(^1\) Although the Financial Memorandum sets out that all businesses where food is supplied or consumed will be affected by the Bill, the Committee’s consideration focussed on its affect on on-premises licensed outlets (for example pubs, sports and social clubs).

9. In its written evidence, FSB Scotland challenged the assertion that the Bill will not have significant financial implications.

“The consultation [conducted by Mr Stewart Maxwell MSP] suggests that proprietors have to make a straightforward choice between serving food or allowing clients to smoke ... either of these actions will have a significant impact on turnover, and could potentially make small, marginally profitable businesses unviable.”\(^2\)

10. In oral evidence, the SLTA stated that, where practical, most licensees would want to create a separate area for smoking and drinking and another for non-smoking and eating. It argued that as food sales provide, on average, around 20% of turnover and contribute towards the drinks trade, licensees would be reluctant to stop selling food. As the SLTA also estimates that 65% of pub-goers are smokers, it projected that 5,000 of the 11,500 on-premises licensed outlets that currently serve food would carry out the required structural alterations to create these separate areas, at a cost of £85m. The SLTA also estimates that annual revenue costs will increase by £110m, largely as a result of extra staff required to supervise the separate areas.\(^3\)

11. During discussion, the Committee heard from SLTA that this estimated capital cost of £85m does not include the costs associated with providing fire escapes or disabled access. It is likely, therefore, that the provision of these facilities will add to the capital cost.

12. In its written evidence, the Scottish Executive also recognised that businesses will have to incur costs for the necessary structural alterations if on-premises licensed

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\(^1\) Paragraph 63, Financial Memorandum.

\(^2\) Written submission from Federation of Small Businesses, Appendix 1.

\(^3\) Stuart Ross, Official Report, 1 June 2004, col. 1464-5.
outlets wish to continue serving food and allow smoking. In their oral evidence, however, officials stated that they did not consider that the number of pubs which would carry out these alterations would be as high as that anticipated by the SLTA.

13. Mr Stewart Maxwell clarified in his questioning of the SLTA that the Bill does not require businesses to undertake any work which would result in these costs. The SLTA responded by stating that the Bill would oblige licensees to make a decision on whether to create these separate areas in order to continue to permit smoking and supply food. The SLTA argued that these alterations would be carried out by businesses who wish to avoid a significant loss of income:

“It does not force any capital spend on anyone, but there would be serious revenue ramifications for premises if there was no capital spend.”

14. The SLTA argued that the costs to business would be lessened if several amendments were made to the Bill. The SLTA set out its argument for a 'ratcheted approach', whereby premises would gradually introduce non-smoking measures by banning smoking at the bar; then 20-30% of the premises; and then a total ban. The Association also stated that a requirement for designated non-smoking, as opposed to separate and un-connected, areas would negate the need for businesses to undertake expensive structural alterations. The SLTA said that this, combined with efficient ventilation systems, would create a smoke-free environment for diners. The SLTA also commented that it would prefer that the 'five-day rule' requirement is removed from the Bill as it believes it is too prescriptive.

15. Whilst the Committee recognised that these suggested amendments to the Bill would significantly reduce its financial impact on some businesses, it was concerned that they would also significantly impact on the Bill's policy intention. Without separate areas being required for diners, the Committee is aware that diners would continue to be affected by smoke from other customers. As Ted Brocklebank commented:

“... the smoke does not know which of the tables are smoke free. People may not be smoking at the bar, but they will be smoking elsewhere, and the smoke goes wherever it wishes to go.”

16. In his evidence, Mr Stewart Maxwell also stated that the measures proposed by the SLTA would not create a smoke free environment and made reference to several pieces of research to support this view.

Impact on Business - Savings
17. The Financial Memorandum states that the Bill will lead to savings for business, especially in relation to reduced cleaning, decoration and other similar type costs. The Committee noted that the Financial Memorandum did not provide detail on the projected savings and sought to identify whether these savings could be realised in order to offset the projected costs.

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4 Written submission from Scottish Executive Health Department, Appendix 1.
9 Paragraphs 48 and 63, Financial Memorandum.
18. In his oral evidence, Mr Stewart Maxwell stated that:

“Pubs will make massive savings as they will need to redecorate less often, have lower insurance costs, be less at risk from fires and not have to install extremely expensive ventilation systems, which is especially problematic for small pubs.”

19. In its written evidence, FSB Scotland stated that “... it is extremely improbable that these [reduced insurance premiums] will be proportionate to the costs and lost revenue ...”. In addition, the SLTA was not persuaded that the savings would be as significant as Mr Stewart Maxwell asserted and claimed that “... there would be a less smoky atmosphere and perhaps people would not have to paint places as often, but other than that I cannot see where any economic benefits would come from”.

20. The Committee explored the issue of whether a smoking ban may encourage more custom from people who currently avoid going to pubs due to the smoky atmosphere. Mr Stewart Maxwell agreed that this is likely to be the case, especially if people suffer from certain illnesses. Mr Maxwell provided evidence suggesting that asthma sufferers and those with lung problems currently avoid visiting pubs as it exacerbates their illness.

Impact on Business – Experience of Other Countries
21. In the Financial Memorandum and during oral evidence, the Member in charge of the Bill highlighted the experience and success of smoking bans in other countries, namely the bans in New York, Ireland and Norway. Mr Maxwell provided statistics suggesting that businesses had not experienced any loss of trade and that compliance with the ban is between 97 – 100%. Mr Maxwell argued that it is reasonable to assume that a ban will be similarly successful in Scotland.

22. In oral evidence, the SLTA stated that it felt that these examples could not be used to support the argument for a smoking ban in Scotland. It was doubtful that these bans have been as successful as suggested by Mr Maxwell and provided data from the United Restaurant and Tavern Owners of New York which found that customer numbers had fallen by 20-30% since the introduction of the ban. In addition, the SLTA argued that there is a stronger culture of drinking in pubs in Scotland, as opposed to drinking in bars or hotels where food is usually consumed in separate areas. Thus, it argued, the implications for businesses in Scotland would be more costly as structural alterations would be required to allow a separate area for smoking and drinking and another for non-smoking and eating.

23. In discussion, the Committee agreed that Scotland has a different drinking culture, which should be taken into account when considering examples of smoking bans in other countries. In addition, the Committee felt that as the Irish ban has not been in force for a full year, it might be too early to draw firm conclusions.

Compliance and Enforcement of the Ban
24. In estimating the rate of compliance with the ban, the Financial Memorandum compares the Bill with a similar statute in the state of New York where the compliance

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11 Written submission from FSB Scotland, Appendix 1.

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23
rate was 98%. It is anticipated that the compliance rate for this Bill will be similar, partly as the offence to permit smoking in a regulated area means that proprietors/owners will have a vested interest in adhering to the law. It is intended that licensees themselves will enforce the ban and that no additional work will fall on environmental health officers. The Financial Memorandum suggests that prosecutions under the Bill will be similar to those in relation to seat belt offences and that costs can be accommodated within existing resources.

25. In written evidence, the Scottish Court Service stated that, on the basis of the information provided in the Financial Memorandum, the impact on the Scottish Court Service should be negligible and capable of being absorbed within the existing resources.\(^{15}\)

26. In its written and oral evidence, the Scottish Executive suggested that the rate of compliance may be lower than predicted in the Financial Memorandum, at around 90 – 98%. Scottish Executive officials reasoned that the ban is more complex than the ban in New York due to the ‘five day rule’, which would make it more difficult to identify premises breaching the ban and supplying food within the five day period.

27. The Scottish Executive officials also suggested that the prosecution rate for offences under the Bill may be higher than the comparison with seat belt offences may suggest, as it would be easier to identify non-compliance. The Scottish Executive officials stated that this could create costs for the Scottish Court Service of between £1,560 and £41,600. Officials confirmed, however, that these costs could still be absorbed within the Scottish Court Service’s existing budget.

28. In relation to the enforcement of the smoking ban, Scottish Executive officials suggested in its written evidence that additional costs may be created. Officials suggested that one full time environmental health officer may be required by each local authority, at a cost of £1.027m per year, in order to ensure that the ban is being complied with. Officials also suggested that a phone line may be required in order for the public to report breaches of the ban. In oral evidence, officials stated that they had based their assumptions on the Irish example.

29. In response, Stewart Maxwell confirmed that the onus will fall on licensees to enforce the ban and cited examples of other offences which licensees must similarly uphold.\(^{16}\) It is expected that environmental health officers will incorporate ensuring that the ban is being upheld within their routine visits to premises and, thus, the Bill will not add substantially to their workload. With regards to the phone line which Scottish Executive officials considers may be used, Stewart Maxwell reminded the Committee that there is no requirement under the Bill for such a phone line and that it has been scaled down in Ireland after two months as it was deemed unnecessary.\(^{17}\)

Conclusions and Recommendations

30. The Committee identified several areas that it recommends the Health Committee consider during its scrutiny of the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

31. During the course of its consideration of the Financial Memorandum, the Committee’s discussion touched on many issues and assumptions which could determine the

\(^{15}\) Written submission from the Scottish Court Service, Appendix 1.


\(^{17}\) Stewart Maxwell, Official Report, 1 June 2004, col. 1492.
financial implications of the Bill, for example, in relation to how businesses would respond to a smoking ban and the implications of the Bill for NHS Scotland. The Finance Committee did not have time to consider on all these complex issues during its scrutiny of the Financial Memorandum, and recommends that the Health Committee may wish to consider such issues during its scrutiny.

32. Whilst the Committee is content that a smoking ban in regulated areas will have only minor financial implications for the hospitality sector, the Committee has concerns that greater costs may fall to on-premises licensed outlets. The Committee notes the evidence from the SLTA that businesses may face a loss of trade under a ban, and that such premises will, in order to prevent this, seek to undertake potentially expensive structural alterations to create separate areas for smoking and drinking and another for non-smoking and eating. Whilst the Committee is unable to verify whether the costs suggested by the SLTA are robust, it recognises that such costs will have a significant impact, especially on smaller premises. In this context, the Committee believes that the assumptions in the Financial Memorandum do not give a fair reflection of the likely costs and that these costs would be higher than if premises ban smoking altogether.

33. The Committee is doubtful, therefore, of whether the savings identified in the Financial Memorandum can be realised. The Committee recognises, however, that distinct non-smoking areas may encourage custom from people who previously did not visit pubs for medical reasons due to the smoky environment.

34. The Committee also has concerns that comparisons with smoking bans in other countries should not be made without reference to Scotland’s drinking culture. The Committee is also aware that there has not been a sufficient time lapse for the full impact of the smoking bans in New York and Ireland to be properly understood. The Committee recommends that the Health Committee may wish to consider these wider issues during its consideration of the Bill.

35. The Committee believes that, as a result of the ‘five day rule’, monitoring compliance of the ban may prove more complex than suggested in the Financial Memorandum. It would seem unlikely, therefore, that any additional costs for enforcement could be met from within existing resources.
APPENDIX A

SUBMISSION FROM SCOTTISH COURT SERVICE

The Bill seeks to introduce new categories of offence which would result in additional cases coming before the courts. However, the Financial Memorandum indicates, on the basis of experience of similar legislation in other jurisdictions, that the number of cases reaching the sheriff courts is likely to be small. Hence the impact upon the Scottish Court Service should be negligible and capable of being absorbed within the existing resources.

Alan Swift
Acting Chief Executive

SUBMISSION FROM THE FEDERATION OF SMALL BUSINESSES IN SCOTLAND

The Federation of Small Businesses is Scotland’s largest direct-member business organisation, representing 18,000 members. The FSB campaigns for an economic and social environment which allows small businesses to prosper. Representing a large number of hospitality and catering business across Scotland, the Federation welcomes this opportunity to comment on the detail of the proposals contained within the Financial Memorandum. The FSB intends carrying out more detailed consultation of its members on smoking restrictions following the publication of the Scottish Executive’s anticipated consultation document on passive smoking.

Whilst we support the public health objectives of the present Bill, we believe that the Financial Memorandum underestimates the real costs that these proposals would have to businesses. It will have an impact on many licensed premises’ turnover and the current wording would require almost all small establishments serving food to invest in significant alterations or ban smoking throughout their premises, even in areas where food is not served.

Costs on Individuals, Companies and Other Bodies

Loss of Trade

We disagree with the assertion that, “There is also clear evidence from other jurisdictions that there will be no loss of trade costs to businesses.” Evidence from other countries on the impact of a smoking ban on customer levels in pubs is contradictory. The introduction of the ban on smoking in public places in Ireland is so recent that any analysis of its impact must be regarded as at best provisional, and the relevance to Scotland of the impact of bans in other countries is questionable.

The Financial Memorandum makes no mention of the differential impact of the Bill on different types of establishment. For example, many pubs rely on a small number of customers for a significant proportion of their regular turnover, and there is a perception that this group of clients is most likely to stop visiting premises where smoking is banned.

Provisions of Bill

The Bill would ban smoking in small, single roomed premises where any kind of food is served. The only alternatives for proprietors would be to stop serving food, which makes up the majority of many establishments’ profits, or to carry out expensive alterations to set up areas with a so-called ‘buffer zone’. The consultation suggests that proprietors have to make a straightforward choice between serving food or allowing clients to smoke, but as
argued above, either of these actions will have a significant impact on turnover, and could potentially make small, marginally profitable businesses unviable.

Many establishments currently allow smoking in the Public Bar but prohibit it in areas where food is being served, but under the Bill this will no longer be permissible where there is a connecting door between the rooms. The current wording of Section 1, sub-section 2 extends the proposed prohibition to any enclosed space adjoining a controlled area, which will effectively ban smoking in any part of premises which serves food, even if no food is served in that particular area. Obviously, blocking off doors and connecting corridors to establish buffer zones as required by the Bill would be expensive and often impractical due to emergency exits, access to toilets and so on.

We therefore suggest deleting Section 1 subsection 2 so the ban only applies to controlled areas and not adjoining areas, as this subsection would have the unintended consequence of banning smoking in all parts of any establishment that serves food, even in areas where food is not served.

Signage and Training
The costs to business of extra signage are acknowledged in the Financial Memorandum, and we agree that these would not be significant. As with all changes in regulations, additional training of staff would be required which would also have a cost to business.

Savings
The Memorandum suggests that non-smoking premises are likely to enjoy reduced insurance premiums but there is no detail on the scale of these savings and it is extremely improbable that these will be proportionate to the costs and lost revenue outlined above.

FSB Scotland

SUBMISSION FROM SUBSTANCE MISUSE DIVISION, SCOTTISH EXECUTIVE HEALTH DEPARTMENT

Introduction
1. The Finance Committee has invited officials for views on the assumptions in the Financial Memorandum regarding the costs that will fall as a consequence of the Bill to the Scottish Executive and for any views on the overall figures and assumptions contained in the Financial Memorandum. A full Regulatory Impact Assessment has not been prepared on the Bill but this paper outlines officials’ preliminary views on the assumptions made within the Financial Memorandum.

2. It should be noted that, to inform future policy on smoking in public places, the Scottish Executive is shortly to undertake a wide-ranging consultation and evidence gathering process. While legislative action is clearly an option, the Scottish Executive is currently adopting a neutral position in relation to the Bill on the basis that it is premature to reach a decision on legislation until we have time to review and consider all the evidence from the consultation in its entirety.

COSTS ON THE SCOTTISH ADMINISTRATION.

Compliance, prosecution and smoking prevention
3. The Financial Memorandum assumes compliance rates based on evidence from New York and prosecution rates from prosecutions in respect of seat belt offences. It also refers
to current expenditure devoted to smoking prevention activity which includes passive
smoking although makes no assumptions about future expenditure.

4. Financial assumptions made in the memorandum are based on a 98% compliance
rate, a 1.52% annual prosecution rate and prosecution costs of £260 per hearing. On this
basis it estimates that 640 licensed premises may not comply initially and, with the applied
prosecution rate assumption, 10 prosecutions of proprietors/owners each year at a cost of
£2600. It concludes that these costs are low and, therefore, could reasonably be absorbed
within existing budgets

5. More recent evidence from New York\textsuperscript{27} suggests that the compliance rate may be
slightly lower at 97%. The more complex nature of the measures contained in the Bill would
also suggest a higher rate of non-compliance initially. Moreover, it could be argued that
prosecution rates could also be higher than assumed because it may be easier to catch non-
compliance with a smoking ban than non-compliance with the seatbelt law.

6. With this in mind and for illustrative purposes only if we assume a compliance rate of
between 90 and 98% and an assumed prosecution rate of between 1 and 5% per annum
this would produce prosecution costs ranging from £1560 to £41,600. Again this range of
costs is comparatively small and could reasonably be absorbed within existing budgets.

COSTS TO LOCAL AUTHORITIES

7. The Financial Memorandum assumes no additional enforcement officers would be
required to enforce the Bill. However, in Ireland, primarily as a result of the newly introduced
blanket ban on smoking in the workplace with only few exemptions, an additional 41 people
have been hired with a specific remit to deal with tobacco control. It could be argued,
therefore, that the more complex nature of the proposals contained in the Bill would present
much more of an enforcement challenge than is the case in Ireland. It would seem not
unreasonable to assume, therefore, 1 fulltime environmental health officer in Scotland per
local authority would be necessary, this would add an additional burden of £1.156m pa.
Additional costs could also be incurred to “police” the ban outwith core working hours.

8. Another potential cost (highlighted in a number of the local authority submissions on the
Bill) is the resource requirement for information provision in support of novel legislation of
this type. In Ireland, for example, a compliance help-line has been set up which allows
customers to phone and report alleged breaches of the ban. A very rough estimate might
suggest a cost of £50-100K for the first year based on the Irish experience.

COSTS ON INDIVIDUALS, COMPANIES AND OTHER BODIES

9. The Financial Memorandum suggests that compliance costs for businesses would be
minimal -£25-50 each. However, this only takes into account the estimated cost of new
signage. Account is not taken of the cost of structural alterations which would be necessary
if an operator wishes to allow smoking to continue in some parts of the premises while food
is served elsewhere. To avoid this burden, some venue operators might opt either to ban
smoking completely or to stop serving food altogether.

10. In terms of impact on income, the Financial Memorandum assumes there will be no
loss of trade/income to businesses and points to evidence (in the policy memorandum) that
laws banning smoking in restaurants and bars in other countries had no negative impact
either on revenue or jobs. While, there is evidence from New York—where a complete ban
is in place—of an increase in business for bars and restaurants, with tax revenues up by

\textsuperscript{27} The state of a smoke-free New York City: A one year review.
8.7% (April 2003-January 2004), it is impossible to tell from the available information to date the extent to which this is due to the smoking ban as opposed to other relevant factors.

SUBSTANCE MISUSE DIVISION
SCOTTISH EXECUTIVE HEALTH DEPARTMENT
25 MAY 2004

SUBMISSION FROM THE SCOTTISH LICENSED TRADE ASSOCIATION

We are here representing the Scottish Licensed Trade Association which has a membership of approximately 2,200 licensees. Most of our members are self-employed business people engaged in trading in pubs and hotels but we also represent some restaurateurs, entertainment club owners and take home operators.

My name is Stuart Ross and I hold the position of Chairman of the Year of the SLTA which is akin to a non-executive role on the board of directors of a company. I am also Chief Executive of the Belhaven Group Plc which is Scotland’s largest regional brewery with turnover in excess of £100m per annum, an estate of 240 pubs and in excess of 1,400 members of staff. I have been able to use information obtained within Belhaven to help the SLTA prepare this submission as we are endeavouring to address the financial implications of the Bill not just on the membership of the SLTA but on the wider field of the entire Scottish licensed trade including sports and social clubs.

I am joined today by Colin Wilkinson who is the Secretary of the SLTA and the pivot of the organisation in terms of member services and administration. The SLTA offices are based in the west end of Edinburgh.

We have approached our submission in the following manner, addressing three questions:

1. How will the licensed trade react to the Bill?
2. What will be the capital cost of providing non-regulated areas?
3. What will be the ongoing annual revenue cost to the trade in terms of compliance with the Bill through operating both regulated and non-regulated areas?

Question 1 – How will the licensed trade react to the Bill?

We see four options.

(a) Licensed outlets will cease to supply food in regulated areas which will therefore become non-regulated.

or (b) licensed outlets will continue to supply food and impose a ban on smoking in regulated areas.

or (c) where licensed outlets already have segregated areas, food will be served in one regulated area with another area being a non-regulated area where smoking is permitted.

or (d) licensed premises will create segregated areas in order to enable food to be supplied in the regulated area and to allow smokers to continue to drink (but not eat) in the non-regulated area.

It is our submission that options (c) and (d) will be heavily favoured by most members in the trade as licensees will not want to concede food turnover (which we estimate at 20% of total take) but neither will licensees wish to put wet sales at risk by disallowing smoking
completely. Many public houses serve food until mid-evening hours and thereafter prioritise wet sales.

Table 1 attached shows that there is a total of approximately 11,500 on-premise licences in Scotland, including registered clubs. Based on a survey of Belhaven pubs and other information available to us, including much estimation and guesstimation at this stage, we contend that almost 50% of Scottish licensed premises would opt to provide segregation – 5,000 in total.

Of that 5,000, we estimate that 50% would choose to create a new bar in the segregated area in order to comply with the level of supervision which is necessary to properly control and manage the sale of alcohol in accordance with the 1976 Act.

**Question 2 - What will be the capital cost of providing non-regulated areas?**

Can I now refer you to Table 1, attached to this paper. We estimate that the capital cost of compliance with the Bill will be in the region of £85m. However, costs may be well in excess of that, depending on the views of local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled.

Segregation may prove to be more difficult for many outlets than has been suggested in this memorandum. Businesses not able to provide regulated and non-regulated areas will suffer competitive disadvantage which will result in financial failure due to loss of turnover. It is impossible to put a figure against this, particularly in the short time span available to us since we received your invitation to address the Finance Committee.

The figures used in Table 1 have been derived from a survey completed within Belhaven where we assessed 38 pubs individually and calculated the costs involved in providing segregated areas in each of them (in 7 of the pubs it was not practical to segregate). We then averaged the costs over the 31 pubs where segregation is thought to be feasible.

The capital costs can be split into three main areas:

- Creating a segregated area through the building of walls, partitions, etc with a vestibule space in order to ensure that the non-regulated areas do not come within the definition of “connecting spaces”. This averages £8,000 per pub.

- Providing additional ventilation in non-regulated areas where smoking will become more prevalent as smokers eschew regulated areas, particularly later in the evening trading period. This averages £4,000 cost per pub.

- Providing a bar and gantry facility in the non-regulated area. The cost to do so has been estimated at £2,000 per square metre x 5 metres, averaging £10,000 cost per pub.

Can I now talk you through the table in a bit more detail.

**Question 3 – What will be the ongoing annual revenue cost to the trade in terms of compliance with the Bill through operating both regulated and non-regulated areas?**

Can I now refer you to Table 2, attached to this paper and, again, I would like to communicate to the Committee the assumptions made in preparing it.

It is our contention that the total cost of compliance to the licensed trade will be £110m per annum and we believe this to be a conservative estimate.
Can we now comment on paragraph 63 of the Explanatory Notes to the Bill. It would appear that the sponsor of the Bill is clearly of the view that no adjustment would be made to licensed premises in the manner which we have suggested. We believe it is hugely simplistic, and wholly unrealistic, to suggest that the licensed trade would react to the Bill by maintaining the status quo in terms of operational modus operandi, thus implementing a total ban on smoking in premises where food is served. To do so would simply create a divide in the licensed trade between wet driven/smoking pubs and food driven/non-smoking pubs. Whilst this may be the sponsor’s objective, the commercial implications for individual licensees are so material that dramatic changes would be made in the physical structure and operational modus operandi of the majority of licensed premises.

We have not had time to challenge the statement made in paragraph 66 of the Explanatory Notes to the Bill where it is stated that “there is clear evidence from other jurisdictions that there will be no loss of trade costs to businesses”. We would ask the Committee, through the Convener, if he would allow us further time to study the policy memorandum at paragraphs 29 to 37 and respond with our views on it at a later date. Our members are extremely fearful of the financial and economic impact of a ban on smoking in public places and it is very important from our point of view to understand any fact-based information provided from countries where smoking has either been totally banned or partially banned along the lines of this Bill. Can the Convener advise us how we can gain access to the aforesaid policy memorandum.

Thank you for having invited the SLTA to make this submission which we hope you have found both helpful and informative.

Stuart Ross
May 2004
### Table 1

**LICENSED TRADE COMPLIANCE COSTS – CAPITAL**

<table>
<thead>
<tr>
<th>Licence Type</th>
<th>Number of Licensed Outlets</th>
<th>Estimated Number Providing Non Regulated Areas</th>
<th>Capital Cost of Creating Non Regulated Areas (£8,000 per unit)</th>
<th>Capital Cost of Ventilation in Non Regulated Areas (£4,000 per unit)</th>
<th>Capital Cost of Provision of Bar in Non Regulated Areas (£10,000 per unit) 50% of Outlets Only</th>
<th>TOTAL CAPITAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leased Tenanted Pubs</td>
<td>900</td>
<td>600</td>
<td>£4,800,000</td>
<td>£2,400,000</td>
<td>£3,000,000</td>
<td>£10,200,000</td>
</tr>
<tr>
<td>Managed Pubs</td>
<td>500</td>
<td>400</td>
<td>3,200,000</td>
<td>1,600,000</td>
<td>2,000,000</td>
<td>6,800,000</td>
</tr>
<tr>
<td>Independent Pubs</td>
<td>4,600</td>
<td>2,500</td>
<td>20,000,000</td>
<td>10,000,000</td>
<td>12,500,000</td>
<td>42,500,000</td>
</tr>
<tr>
<td>Clubs</td>
<td>2,200</td>
<td>1,000</td>
<td>8,000,000</td>
<td>4,000,000</td>
<td>5,000,000</td>
<td>17,000,000</td>
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<td>Hotels, Restaurants,</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>3,300</td>
<td>500</td>
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<td>2,000,000</td>
<td>2,500,000</td>
<td>8,500,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11,500</strong></td>
<td><strong>5,000</strong></td>
<td><strong>£40,000,000</strong></td>
<td><strong>£20,000,000</strong></td>
<td><strong>£25,000,000</strong></td>
<td><strong>£85,000,000</strong></td>
</tr>
</tbody>
</table>

Notes:
1. Cost of creating segregated area based on a survey of 38 Belhaven pubs and “averaged”.
2. Cost of ventilation is average expense of two new units.
3. Cost of provision of bar, with gantry, based on £2,000 per sq. metre x 5 metres.
4. This schedule ignores cost of additional fire escape provision which may well be necessary.
5. This schedule ignores cost of providing satisfactory access/egress for disabled customers.
THE PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL

LICENSED TRADE COMPLIANCE COSTS – REVENUE

1. Additional cost of labour to staff bars created in non-regulated areas:

   1 member of staff for 98 hours per week per pub = 98 hours
   1 additional member of staff for 47 hours per week per pub = 49 hours
   Total number of additional hours per week per pub = 147 hours
   Rate per hour (average) = £5
   Additional labour cost per pub per week = £735
   Employer's cost at 12% = £88
   Total additional labour cost per pub per week = £823
   Total additional labour cost per pub per annum = £42,796

   Number of pubs creating bars in non-regulated areas = 2,500

   Annual cost to the trade in terms of increased labour = £107,000,000

2. Additional annual energy cost in respect of power supply to the bar area for dispense equipment, hot water, downlighting, etc £500 per pub

   Number of pubs as above = 2,500

   Annual cost to the trade in terms of increased energy = £1,250,000

3. Additional annual cleaning and consumable charges in order to maintain required standard of hygiene in the bar area and to provide sufficient glassware, etc £600 per pub

   Number of pubs as above = 2,500

   Annual cost to the trade in terms of increased cleaning and consumable expenses = £1,500,000

Total additional annual cost = £109,750,000
SUBMISSION FROM SCOTTISH BEER AND PUB ASSOCIATION

Further to your letter of 2 June 2004 in relation to the above, we do of course welcome the opportunity of being involved in the consultation.

Within the content of your correspondence you specifically asked that we consider the SLTA’s submission for further comment or additional figures.

Firstly, by way of general comment, we would advise that Stuart Ross, who led the SLTA submission as their Chairman of the Year, is an immediate Past President of Scottish Beer & Pub Association and is currently a member on our Executive Board.

The financial model presented covered the whole hospitality sector within the licensed trade and we wholly endorse the paper presented and have nothing to add in relation to the costs implications on compliance to the proposed Bill.

Gordon Millar
Chief Executive
22 June 2004

SUBMISSION FROM STEWART MAXWELL

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2 June 2004

Dear Des

Prohibition of Smoking in Regulated Areas (Scotland) Bill

At the meeting of the Finance Committee on 1 June 2004, I undertook to provide additional information to the Committee relating to questions asked by Jeremy Purvis MSP in respect of smoking cessation rates and savings to the National Health Service in Scotland.

In their response to the Health Committee’s call for evidence, The Royal College of Physicians of Edinburgh state that “International evidence indicates that a ban on smoking in public places reduces smoking rates by 4% as well as reducing the risks associated with second hand smoke (Fitchenberg, British Medical Journal 2002; 325:188-91)”
The Chief Medical Officer, in his Annual Report for 2003 *Health in Scotland 2003*, estimates that smoking accounts for 35,000 hospital admissions each year, with the cost to the NHS in Scotland an estimated £200 million.

Yours sincerely

Stewart Maxwell MSP  
Member in Charge of the Bill

cc: Susan Duffy, Clerk to the Finance Committee  
    David Cullum, Head of the Non Executive Bills Unit
The Committee reports to the Health Committee as follows—

1. At its meetings on 11th and 25th May 2004 the Subordinate Legislation Committee considered the delegated powers provisions in the Prohibition of Smoking in Regulated Areas (Scotland) Bill. The Committee submits this report to the Health Committee, as the lead committee for the Bill, under Rule 9.6.2 of Standing Orders.
Committee remit
1. Under the terms of its remit, the Committee considers and reports on proposed powers to make subordinate legislation in particular Bills or other proposed legislation and on whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

2. The term "subordinate legislation" carries the same definition in the Standing Orders as in the Interpretation Act 1978. Section 21(1) of that Act defines subordinate legislation as meaning “Orders in Council, orders, rules, regulations, schemes, warrants, bye-laws and other instruments made or to be made under any Act”. “Act” for this purpose includes an Act of the Scottish Parliament. The Committee therefore considers not only powers to make statutory instruments as such contained in a Bill but also all other proposed provisions conferring delegated powers of a legislative nature.

Report

Introduction
3. This Member's Bill, introduced by Stewart Maxwell MSP, aims to prevent people, including children, from being exposed to the effects of passive smoking in certain public areas, specifically in areas where food is supplied and consumed.

4. The Bill contains three powers to make delegated legislation and has therefore been referred to the Committee for consideration of these powers. The Member in charge of the Bill has supplied a subordinate legislation Memorandum for the assistance of the Committee in its consideration of these powers.

5. This Memorandum and the Bill's Accompanying documents set out a detailed description of the Bill's contents and its underlying policy. The memorandum is reproduced at Appendix 1.

6. In brief, the Bill makes it an offence (punishable by a fine of level 3 on the standard scale) to smoke in certain public areas defined in the Bill (“regulated areas”) and requires “no smoking” signs to be displayed inside and outside those areas. The areas covered by the Bill are those where food is served but power is conferred on the Scottish Ministers to extend the ban imposed by the Bill to other public areas.
Delegated Powers

7. As mentioned above, the Bill confers a total of three delegated powers on the Scottish Ministers exercisable by orders or regulations made by statutory instrument. The Committee reports on each in turn.

Section 1(4) Extension of the “prescribed period”

Introduction

8. Section 1 provides that any enclosed public space is to be a regulated area while food is being supplied and consumed and during the period of five days (the “prescribed period”) prior to food being supplied and consumed. The purpose of the prescribed period is to ensure that eating areas are free from the effects of earlier smoking.

9. Section 1(4) gives power to the Scottish Ministers by order to extend the prescribed period beyond five days. The period of five days is considered to be the minimum period that should be allowed for a typical furnished room to be clear of harmful smoke particles but scientific developments in the future may indicate that a longer period should be allowed. The Member in charge of the Bill considers that in such an event the prescribed period should be capable of being extended without requiring a further Bill. As this is a power to modify the effect of primary legislation, affirmative resolution procedure is proposed for its exercise.

Report

10. The Committee agreed that, in principle, the subject matter of the proposed power is suited to the use of delegated rather than primary legislation and that affirmative procedure is appropriate for a power to amend primary legislation. The Committee therefore approves the power and the procedure chosen. The Committee also draws to the attention of the lead committee for its own consideration the fact that the power is to extend the minimum period and there is no power to reduce the period should clearing a room of the effects of smoking in a shorter period become possible.

Section 2(1) The definition of regulated area

Introduction

11. The meaning of regulated area is established by section 1, as outlined above. Section 1(5) contains a definition of ‘public space’ for the purposes of defining a “regulated area”. For the avoidance of any doubt, section 1(5)(b) introduces schedule 2 which makes it clear that spaces within the public places listed in that schedule are also included in the definition of a regulated area. Certain types of space are specifically exempted from being considered as regulated areas by virtue of section 1(3) which introduces schedule 1.

12. At the moment, regulated areas relate solely to enclosed public spaces where food is supplied and consumed. Section 2 gives power to Scottish Ministers to amend the definition of regulated area to extend the provisions of the Bill to apply to other areas. This power cannot, however, be used to remove any of the areas covered by the Bill. Subsection (2) places a requirement on the Scottish Ministers to consult with appropriate bodies or persons before they make any orders under subsection (1). Any order under this power will be subject to affirmative procedure.

Report

13. The Committee noted that this is a Henry VIII power of some width. Although any exercise of the power is subject to affirmative procedure and there is a requirement for consultation, any proposal to extend the areas caught by the Bill, it seemed to the
Committee could well prove to be controversial. The power would extend, for example, to amending the definition of “public space” and removing the exemptions in schedule 1. The Committee considered whether, given the subject matter, subordinate legislation even if subject to affirmative procedure, would provide a sufficient level of scrutiny.

14. The Committee noted that while the first line of the Bill refers to “smoking in regulated areas” it does not, at that point, refer to public areas. It therefore seemed possible that the Bill would be open to amendment making any area, private or public, indoors or an outside area, a regulated area for the purposes of the Bill. The Committee asked Stewart Maxwell, the Member in Charge of the Bill, for further clarification of the intention behind the provision.

15. Mr Maxwell responded that it was not the intention of the provision to allow for regulation of open spaces or private space. If an amendment was required to the Bill to make that clear, he would be happy to consider supporting it.

16. The Committee returned to consideration of the provision at its meeting on 25th May. At the meeting, Mr Maxwell informed the Committee that he intended to lodge an amendment to the section so that the power could not be used to regulate any private space. The Committee welcomed the undertaking from the member but asked for clarification from Mr Maxwell about the status of hotel rooms under the Bill and more open public spaces.

17. Mr Maxwell replied that, for the purposes of the Bill, hotel rooms would be considered private spaces. Once they are hired out and guests have a key to them, they become private spaces and would not, therefore, be caught under the Bill. Hotel function suites and meeting rooms would, however, be considered to be public spaces. On open spaces, there is a clear distinction between an "enclosed public space" that is completely enclosed and places that are wide open.

18. There is no policy intention to create restrictions or regulated areas in wide open spaces. There are also places that fall between the two, which the bill does not cover. At the moment, a regulated area could not be created for somewhere that is partially enclosed. As the policy memorandum points out, a beer garden that was attached to premises, or that was located outdoors and next to regulated premises, would not be included. Whether or not such places would be included at some point in future would be a matter for the Parliament to consider.

19. The Committee was grateful to Mr Maxwell for this further explanation and the undertaking to amend the power to the effect indicated. The Committee therefore approves the power on the basis of that undertaking and the affirmative procedure as appropriate.

Section 5(4) Signage requirements

Introduction

20. Section 5(1) provides that signs should be clearly displayed inside and outside regulated areas indicating that smoking is not permitted. It is an offence if a person in charge of a regulated area fails to display such signs.

21. The Bill does not specify detailed requirements with regard to signage, because it is not considered appropriate to include precise, technical details of this sort within primary legislation. However, section 5(4) gives power to the Scottish Ministers to make regulations, subject to annulment, prescribing the detailed requirements for the content of signs and the manner in which they are to be displayed. Section 5(5) places a
requirement on the Scottish Ministers to consult with certain bodies representative of the hospitality industry before making any regulations in respect of signs.

Report
22. This appears to the Committee to be a suitable use of delegated powers. The requirement to display signs is not dependent on the making of regulations and offences against the regulations are provided for in the Bill itself.

23. The Bill includes a requirement on Ministers to consult with certain bodies listed in subsection (5) before making any regulations in exercise of the power. While there does not appear to be any issue with the drafting of this provision in its current form, if the definition of “regulated area” were to be extended then this provision could require some amendment. Also, there appeared to the Committee to be a possible practical difficulty inherent in listing particular bodies in that such lists can rapidly become out of date.

24. Mr Maxwell agreed to consider this point and subsequently wrote to the Committee to inform members of his intention to bring forward an amendment at Stage 2 to replace section 5(5) and which will ensure that the Scottish Ministers consult with such bodies that are representative of persons affected by the Bill before making any regulations under section 5(4). The text of Mr Maxwell’s letter is reproduced at Appendix 2.

25. Again, the Committee is grateful to Mr Maxwell for this undertaking which it draws to the attention of the lead committee for its information. The Committee therefore approves the provision and the annulment procedure chosen as appropriate.

26. There are no further delegated powers in the Bill on which the Committee sees any need to comment.
Appendix 1  

MEMORANDUM TO THE SUBORDINATE LEGISLATION COMMITTEE BY THE MEMBER IN CHARGE OF THE BILL, STEWART MAXWELL MSP

PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL PROVISIONS CONFERRING POWER TO MAKE SUBORDINATE LEGISLATION

Purpose

1. This memorandum has been prepared by Stewart Maxwell MSP, the Member in charge of the Bill. It has been provided to assist the Subordinate Legislation Committee with their consideration, in accordance with Rule 9.6 of the Parliament’s Standing Orders, of provisions in the Prohibition of Smoking in Regulated Areas (Scotland) Bill conferring powers to make subordinate legislation. It describes the purpose of each such provision, explains why the matter is to be left to subordinate legislation and explains the choice of procedure.

Policy Context

2. The Bill aims to prevent people including children, from being exposed to the effects of passive smoking in certain public areas. The Bill does not prevent people from smoking in all public places, it focuses specifically on areas where food is supplied and consumed.

3. The Bill should be considered as part of the process of safeguarding the health of the people of Scotland from the effects of tobacco smoke. It will help raise awareness of the dangers of both passive smoking and smoking, while at the same time assisting to change the attitudes of the public towards smoking in general. It is to be hoped that it will also encourage people who want to stop smoking, and help ex smokers from relapsing, by providing more smoke free environments in public places.

Content of the Bill

4. The Bill:

- Defines areas where smoking is not permitted (regulated areas);
- Makes it an offence to smoke in regulated areas;
- Makes it an offence for owners, occupiers and the like to knowingly permit smoking in regulated areas;
- Requires signs to be clearly displayed inside and outside regulated areas; and
- Provides that offences can be prosecuted summarily.

Delegated Powers

5. The Bill confers a total of three delegated powers on the Scottish Ministers. All of the powers are new and no existing powers are being amended or repealed. The powers are explained in detail in the following paragraphs. By virtue of section 9(1) all of the delegated powers under the Bill are exercisable by orders or regulations made by statutory instrument.

Section 1(4) Extension of the “prescribed period”

Powers conferred on: The Scottish Ministers
Powers exercised by: Order made by statutory instrument
Parliamentary procedures: Affirmative resolution of the Scottish Parliament

6. Section 1 sets out the criteria for regulated areas. Any enclosed public space is to be a regulated area while food is being supplied and consumed and during the prescribed period prior to food being supplied and consumed. The purpose of the prescribed period is to ensure that eating areas are free from the effects of earlier smoking by allowing a reasonable amount of time between the last occurrence of smoking and the next supply and consumption of food. This is to allow time for the harmful smoke particles in the air to clear. The time taken for the removal of these particles varies and is dependant on the size of the area and the rate of change of fresh air amongst other things.

7. Section 1(4) sets this prescribed period at 5 days. The order making power contained in Section 1(4) gives power to the Scottish Ministers to lengthen the prescribed period. No power is given to the Scottish Ministers to reduce the length of the prescribed period to less than 5 days.

8. It is submitted that this is an appropriate matter for subordinate legislation as it could be determined at a future date, through scientific developments, that the harmful smoke particles linger for a longer period. In that event, the prescribed period should be capable of being extended without requiring a further Bill. This is a power to modify the effect of primary legislation, and so affirmative resolution procedure is considered appropriate.

Section 2(1)

The definition of regulated area

Power conferred on: The Scottish Ministers
Power exercised by: Order made by statutory instrument
Parliamentary procedure: Affirmative resolution of the Scottish Parliament

9. The meaning of regulated area is established by section 1, as outlined above. Section 1(5) contains a definition of ‘public space’ as a space to which the public or a section of the public has access, on payment or otherwise, as of a right or by virtue of express or implied permission. For the avoidance of any doubt, section 1(5)(b) introduces schedule 2 which makes it clear that spaces within the listed public places are also included in the definition of a regulated area. Certain types of space are specifically exempted from being considered as regulated areas by virtue of section 1(3) which introduces schedule 1.

10. Currently the definition of a regulated area focuses solely on enclosed public spaces where food is supplied and consumed. Section 2 gives power to Scottish Ministers to amend the definition of regulated area to extend the provisions of the Bill to apply to other areas. This power cannot be used to remove any of the areas covered by the Bill. Subsection (2) places a requirement on the Scottish Ministers to consult with appropriate bodies or persons before they make any orders under subsection (1).

11. It is submitted that this is an appropriate matter for subordinate legislation. It is considered that this is an appropriate matter for affirmative resolution procedure as any order made under this power would amend primary legislation.

Section 5(4): Signage requirements

Power conferred on: The Scottish Ministers
Power exercised by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament
12. Section 5(1) provides that signs should be clearly displayed inside and outside regulated areas indicating that smoking is not permitted. Section 5(2) makes it an offence if person(s) in charge of a regulated area fail to display such signs. These signage requirements will serve to focus the mind of proprietors, and will make it clear to customers and staff that an offence may be committed if smoking takes place in the regulated area. The Bill does not specify detailed requirements with regard to signage, because it is not considered appropriate to include precise, technical details of this sort within primary legislation.

13. Section 5(4) gives power to the Scottish Ministers to make regulations prescribing the detailed requirements for the content of signs and the manner in which they are to be displayed. Section 5(5) places a requirement on the Scottish Ministers to consult with certain bodies representative of the hospitality industry before making any regulations in respect of signs.

14. It is submitted that the details of the content of signs and the manner in which they are to be displayed are appropriate matters for subordinate legislation. It is thought to be appropriate that the Scottish Ministers should have the power to decide on the details, having consulted with interested parties. It is considered that this is an appropriate matter for negative resolution procedure due to the administrative nature of the regulations.

Stewart Maxwell MSP  
Member in charge of the Bill

12\textsuperscript{th} January 2004
Appendix 2

Dear Convener,

Prohibition of Smoking in Regulated Areas (Scotland) Bill

At the meeting of the Subordinate Legislation Committee on 11th May 2005, Christine May and Alasdair Morgan raised the issue that the bodies named in section 5(5) of the Bill may cease to exist, leaving it open for the Scottish Executive to consult only with such bodies as they felt appropriate.

I am writing to confirm to you that it is my intention to bring forward an amendment at Stage 2 to replace the existing section 5(5) and which will ensure that the Scottish Ministers consult with such bodies that are representative of persons affected by the Bill before making any regulations under section 5(4).

Yours sincerely,

Stewart Maxwell MSP
Member in charge of the Bill

25th May 2004
ANNEX B: EXTRACTS FROM THE MINUTES

HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

8th Meeting, 2004 (Session 2)

Tuesday 16 March 2004

Present:
Mr David Davidson Christine Grahame (Convener)
Helen Eadie Janis Hughes (Deputy Convener)
Kate Maclean Mr Duncan McNeil
Shona Robison Mike Rumbles
Dr Jean Turner

The meeting opened at 2.01 pm

**Item in private:** The Committee agreed (by division: For 7, Against 1, Abstentions 0) to take the item (Members Bills) in private.

**Members’ Bills (in private):** The Committee considered further action in relation to evidence and agreed to write to a selection of organisations.

The meeting closed at 2.43 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

12th Meeting, 2004 (Session 2)

Tuesday 4 May 2004

Present:

Mr David Davidson Christine Grahame (Convener)
Helen Eadie Janis Hughes (Deputy Convener)
Kate Maclean Mr Duncan McNeil
Shona Robison Dr Jean Turner

Also present: Ms Sandra White.

Apologies: Mike Rumbles

The meeting opened at 2.03 pm

Items in private: The Committee agreed to take the item (Prohibition of Smoking in Regulated Areas (Scotland) Bill) in Private.

Prohibition of Smoking in Regulated Areas (Scotland) Bill (in private): The Committee agreed possible witnesses for Stage 1.

The meeting closed at 5.36 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE
EXTRACT FROM THE MINUTES
15th Meeting, 2004 (Session 2)
Tuesday 8 June 2004

Present:
Mr David Davidson Christine Grahame (Convener)
Helen Eadie Janis Hughes (Deputy Convener)
Kate Maclean Mr Duncan McNeil
Shona Robison Mike Rumbles

Also present: Stewart Maxwell and Elaine Smith.

Apologies: Jean Turner.

The meeting opened at 2.01pm

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence from—

Panel 1
Maureen Moore, Chief Executive, ASH
Dr Laurence Gruer OBE, NHS Health Scotland;

Panel 2
Simon Clark, Director, FOREST
Tim Lord, Chief Executive, Tobacco Manufacturers’ Association; and

Panel 3
Andy Matson, Regional Officer, AMICUS
Stephen Leckie, Chairman, British Hospitality Association Scotland Committee
Arun Randev, Proprietor.

The meeting closed at 5.08 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

16th Meeting, 2004 (Session 2)

Tuesday 15 June 2004

Present:

Mr David Davidson  Christine Grahame (Convener)
Helen Eadie      Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Jean Turner

Also present: Stewart Maxwell, Nanette Milne and Jamie Stone.

The meeting opened at 2.03pm

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence from—

Panel 1
Shona Hogg, Pupil, Firrhill High School
Simon Hunter, Pupil, Firrhill High School
Lea Tsui, Pupil, Firrhill High School
Findlay Masson, Pupil, Mile End School
Callum McPherson, Pupil, Mile End School
Claire Repper, Pupil, Mile End School.

Panel 2
Dr Helene Irvine, Consultant in Public Health Medicine, Greater Glasgow Health Board
Garry Coutts, Chairman, Highland NHS Board
Gillian Lee, Programme Manager, NHS Grampian
Paul Ballard, Consultant in Health Promotion, NHS Tayside; and

Panel 3
Dr Peter Terry, Deputy Chairman, Scottish Council, British Medical Association
Dr Sinead Jones, Director, Tobacco Control Resource Centre, British Medical Association
Dr Malcolm McWhirter, Convener, Scottish Affairs Committee, Faculty of Public Health in Scotland
Geoff Earl, Lothian Member, Scotland Board, Royal College of Nursing.

The meeting closed at 4.51 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

17th Meeting, 2004 (Session 2)

Tuesday 22 June 2004

Present:
Mr David Davidson  Christine Grahame (Convener)
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Jean Turner

Also present: Stewart Maxwell

Apologies: Mike Rumbles

The meeting opened at 2.01pm

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence from—

Panel 1
Peter Allan, Policy Planning Manager, Dundee City Council
Gordon Greenhill, Environmental Health Manager, Regulatory Services Department, City of Edinburgh Council
Liz Manson, Operations Manager, Policy and Performance Unit, Dumfries and Galloway Council; and

Panel 2
Marjory Burns, Scotland CAN (Cleaner Air Now)
Professor Gerard Hastings, Director, Centre for Tobacco Control Research, Cancer Research UK
Christine Owens, Head of Tobacco Control, Roy Castle Lung Cancer Foundation.

The meeting closed at 4.42 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE
EXTRACT FROM THE MINUTES
18th Meeting, 2004 (Session 2)
Tuesday 29 June 2004

Present:

Mr David Davidson   Christine Grahame (Convener)
Helen Eadie         Janis Hughes (Deputy Convener)
Kate Maclean        Mr Duncan McNeil
Shona Robison       Mike Rumbles
Jean Turner

Also present: Stewart Maxwell

The meeting opened at 2.05 pm

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence from—

Panel 1
Dr Nancy Miller, Assistant Commissioner, New York City Dept of Health and Mental Hygiene, Bureau of Tobacco Control;

Panel 2
Tom McCabe MSP, Deputy Minister for Health and Community Care
Dr Mac Armstrong, Chief Medical Officer
Amber Galbraith, Principal Procurator Fiscal Depute, Crown Office; and

Panel 3
Stewart Maxwell MSP
David Cullum, Non-Executive Bills Unit
Catherine Scott, Directorate of Legal Services.

The meeting closed at 5.15 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACTS FROM THE MINUTES

20th Meeting, 2004 (Session 2)

Tuesday 21 September 2004

Present:

Roseanna Cunningham (Convener)  Mr David Davidson
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Jean Turner

Also present: Rob Gibson, Carolyn Leckie, Mrs Nanette Milne and Mr Jamie Stone.

The meeting opened at 2.04 pm

Prohibition of Smoking in Regulated Areas (Scotland) Bill (in private): The Committee agreed to seek further information and, on this basis, to defer consideration of its Stage 1 report until its next meeting.

The meeting closed 4.24 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

21st Meeting, 2004 (Session 2)

Tuesday 28 September 2004

Present:

Roseanna Cunningham (Convener)  Mr David Davidson
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Jean Turner

The meeting opened at 2.00 pm

Items in private: The Committee agreed to take item 4 (Prohibition of Smoking in Regulated Areas (Scotland) Bill) in public. The Committee agreed (by division: For 5, Against 3, Abstentions 0) to consider item 5 in private.

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence from—

Stewart Maxwell MSP;

David Cullum, Non-Executive Bills Unit; and

Mark Richards, Directorate of Legal Services.

Prohibition of Smoking in Regulated Areas (Scotland) Bill (in private): The Committee agreed to request an extension to the deadline for completion of the bill at Stage 1 from the Parliamentary Bureau until 28 January 2005.

The meeting closed 3.07 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

29th Meeting, 2004 (Session 2)

Tuesday 7 December 2004

Present:

Roseanna Cunningham (Convener) Mr David Davidson
Helen Eadie Janis Hughes (Deputy Convener)
Kate Maclean Mr Duncan McNeil
Shona Robison Mike Rumbles
Jean Turner

The meeting opened at 2.01 pm

Items in private: The Committee agreed to take the item (Prohibition of Smoking in Regulated Areas (Scotland) Bill) in private (by division: For 3, Against 3, Abstentions 0; agreed to on the Convener’s casting vote).

Prohibition of Smoking in Regulated Areas (Scotland) Bill (in private): The Committee considered a draft Stage 1 report.

The meeting closed at 3.38 pm.

Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

30th Meeting, 2004 (Session 2)

Tuesday 14 December 2004

Present:

Roseanna Cunningham (Convener)  Mr David Davidson
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Jean Turner

Also present: Mary Scanlon

Apologies: Mike Rumbles

The meeting opened at 2.03 pm

Item in private: The Committee agreed to take the item (Prohibition of Smoking in Regulated Areas (Scotland) Bill) in private.

Prohibition of Smoking in Regulated Areas (Scotland) Bill (in private): The Committee agreed its Stage 1 report.

The meeting closed at 2.57 pm.

Simon Watkins
Clerk to the Committee
ANNEX C – ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

8 June 2004 (15th Meeting, Session 2 (2004)) – Written Evidence

SUBMISSION FROM ASH

Introduction

ASH Scotland welcome the opportunity to submit comments in response to the consultation on the Regulation of Smoking Bill, and we ask to be called to give oral evidence to the committee. We are delighted to support the Bill, which focuses attention on the vitally important issue of smoking in public places, and we would like to see it taken further in a number of respects, which are outlined below.

A ban on smoking in public places is absolutely central to addressing public health in Scotland. Tobacco is the biggest cause of death and ill-health in Scotland, claiming over 19,000 lives each year and costing the NHS in Scotland an estimated £200 million on hospital treatment annually. Smoking rates remain consistently higher in Scotland than in the UK as a whole for both genders; 30% v 29% for males and 30% v 25% for females in 2000. This means that around 1.2 million Scots currently smoke.

There is however considerable variation in smoking rates across Scotland, reflecting socioeconomic trends. Smoking rates have been found to vary between postcode areas from 15% to 71%. Rates are more than five times higher among women and three times higher among men in the most disadvantaged groups than in the most affluent.

Health risks

The Bill is only partial in its current form. If the Bill is passed, it will not apply in the majority of public places where environmental tobacco smoke (ETS) causes harm. Thus many workers and members of the public will continue to be affected by the health risks of ETS.

ETS has been labelled “carcinogenic to humans” by the WHO’s International Agency for Research on Cancer (IARC). It has also been labelled a “class A human carcinogen” by the US Environmental Protection Agency, along with asbestos, arsenic, benzene and radon gas.

ASH Scotland is concerned that the explicit relationship between food and smoke-free places reinforces the view that ETS is primarily a comfort issue, rather than a health issue. A recent study showed that this was the predominant perception in Scotland. However, research clearly demonstrates that ETS causes a range of serious health conditions.

Environmental Tobacco Smoke and Adult Health

Exposure to ETS has been established as a cause of heart disease, lung cancer, and stroke. Research has demonstrated an 82% increased risk of stroke, a 25-35% increased risk of heart disease, and a 20-30% increased risk of lung cancer associated with passive smoking in both men and women. Even brief exposure can affect the coronary circulation in non-smokers, and a recent Scottish study demonstrated that non-smokers exposed to ETS in the workplace may have their lung function reduced by up to 10%. It has also been estimated that ETS in the workplace poses 200 times the acceptable risk for lung cancer and 2000 times the acceptable risk for heart disease.

Environmental Tobacco Smoke and Child Health

Exposure to ETS can cause asthma in children, and may increase the severity of the condition in children who are already affected. ETS is cited by up to 80% of asthmatics...
as a trigger for further attacks\textsuperscript{xxi}. Children are also at a higher risk of developing an atopic eczema when exposed to ETS, and genetically predisposed children are at higher risk of developing allergic sensitisation against house dust mites\textsuperscript{xxii}.

Children whose parents smoke also have an increased risk of lower respiratory illness such as pneumonia, bronchitis, croup and bronchiolitis, and an increased risk of respiratory symptoms such as breathlessness, phlegm, coughing and wheezing. ETS is also cause of reduced lung function and middle ear disease, including recurrent ear infections\textsuperscript{xxiii}. It is estimated that each year, more than 17,000 children under five are admitted to UK hospitals because of respiratory illness caused by exposure to ETS\textsuperscript{xxiv}. ETS is also a cause of cot death (sudden infant death syndrome (SIDS))\textsuperscript{xxv xxvi}. The UK Confidential Inquiry into Stillbirths and Death in Infancy\textsuperscript{xxvii} estimated that in families where only the father smoked, risk of SIDS was increased 2.5 times; where both parents smoked, it was increased almost 4 times (odds ratio 3.79).

Exposure to ETS during pregnancy is linked to an increased risk of premature birth\textsuperscript{xxviii}. Pregnant women exposed to other people’s tobacco smoke are about 20% more likely to have a low birth weight baby\textsuperscript{xxix}, and while the reduction in birth weight is not itself a risk for most babies, it could compound health problems for those with additional health problems or risk factors. Despite the health risks outlined, almost one in three pregnant women in the UK is exposed to ETS in the workplace\textsuperscript{xxx}.

\section*{Equity and Enforcement}

Current smoke-free legislation in many other countries applies in all public places, for example in New Zealand, Italy, Malta, Uganda, Romania, and in parts of the US and Australia. There are many reasons why this is important, including issues of equity. The public health case for smoking restrictions is clear, particularly for protecting employees exposed to ETS, and while we support the Proposed Regulation of Smoking Bill, we are concerned about the implications of introducing a legislative approach that treats people differently according to where they are. If the current ban is implemented, people would be protected in a pub that serves food, but not in a pub that doesn’t serve food. In this respect ASH Scotland believes that the proposed Bill does not go far enough to protect workers and other members of the general public from the harmful effects of ETS. There are also issues of enforcement to consider. Transparent legislation, which applies to everyone, is easier to enforce than legislation that applies only to some types of buildings or applies differently at different times of the day (e.g. when food is being served). Smoking restrictions in pubs and bars have lower levels of public support than other public places\textsuperscript{xxxi}. On this basis it will be easier to enforce if legislation is introduced that applies in all public places.

\section*{International Perspective}

In other countries, smoke-free legislation has been successfully used to restrict smoking in public places. This establishes protection for those who are at highest risk, namely those who are exposed to ETS at work, while also protecting other members of the public. Although smoking in the workplace is an issue that is reserved to the Westminster Parliament, ASH Scotland believes that effective and comprehensive public places legislation could be framed to cover the majority of Scottish workers, as well as the general public. A recent calculation of the possible impact of a smoking ban in workplaces in Glasgow alone suggested that up to 1,000 fewer people a year would die of heart disease, respiratory disease and cancer\textsuperscript{xxxi}. Not only would a workplace ban save lives, but research also suggest that employees in workplaces with smoking bans have higher rates of smoking cessation than employees where smoking is permitted\textsuperscript{xxxi xxiv}. Total
workplace bans appear to have a positive effect on employee’s attitudes, encouraging more individuals to quit, and increasing confidence levels regarding successful outcomes\textsuperscript{xxv}. Tobacco control is complex, and different approaches are required in order to achieve positive outcomes. A substantial amount of money has been invested in Scottish smoking cessation services, and these services must be supported by a workplace ban for maximum effect.

The recent UK-wide ‘Your NHS’ survey found that 77\% of Scottish respondents want a ban on smoking in all public places, slightly higher than the UK average of 73\%\textsuperscript{xxvi}. The findings of this poll are similar to those of the 2002 Office of National Statistics survey\textsuperscript{xxviii}, where over four-fifths of UK respondents agreed there should be restrictions on smoking at work (86\%), in restaurants (88\%) and in other public places such as banks and post offices (87\%). Public support for smoking restrictions has been steadily increasing since 1996 (percentages increasing from 81\% to 86\% in favour of restrictions at work; 85\% to 88\% in restaurants, 48\% to 54\% in pubs, and in other public places from 82\% to 87\%). This clearly demonstrates that the public is demanding action to end smoking in the workplace and enclosed public places.

**Ventilation**

It is very clear that the measures proposed to address smoking in public places in the white paper *Smoking Kills* are not providing effective smoke free public places. The Health and Safety Executive have stated that ventilation systems cannot be seen as an acceptable solution to the problem of ETS. Ventilation is a short-term measure that can increase comfort by removing particle matter. However, ventilation does not remove harmful gases that are present in ETS. There is no safe level of exposure to ETS, and so ventilation does little to reduce the significant health-risks associated with passive smoking\textsuperscript{xxviii} xx\textsuperscript{ix}. The ventilation standards promoted by AIR (Atmosphere Improves Results) in the Public Places Charter on Smoking (2001) state that a minimum of 12 air changes per hour are required for an average sized room, in order to judge ventilated air as ‘safe’. However, based on this recommended ventilation rate for a pub at full occupancy, it is estimated that 5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer during his or her working life. It would require tornado-like quantities of ventilation, in excess of 10,000 air changes per hour, to produce levels of risk acceptable to bar staff from ETS\textsuperscript{x}.

**The Voluntary Charter**

An estimated 1,000 lives would be saved each year if workplaces were smoke-free\textsuperscript{xvi}. Currently, under the Voluntary Charter, businesses can choose the level of smoking restriction that they want to impose, if any. It is possible to put up a sign that says ‘smoking permitted throughout’ and comply with the Charter, without doing anything to provide smoke-free areas. Even where designated smoking areas are provided, they often continue to expose people in the vicinity to ETS, and they increase the exposure to smokers by concentrating them in one place. Recent research has demonstrated that the voluntary approach does not work in Scotland. More than 7 in 10 pubs still permit smoking throughout, as do nearly 4 in every 10 leisure industry sites\textsuperscript{xvii}. Seventy percent of the public do not smoke, but only 18\% of public places are currently smoke free\textsuperscript{xviii}.

**Economic Impacts**

Some UK businesses have concerns that a ban on smoking in public places would have a negative impact on business, but this has not been shown to be the case in other countries where smoking in public places is already banned. An assessment of 97 studies found that no-smoking policies in US restaurants and bars have not harmed business\textsuperscript{xvi},
on the contrary many businesses have been shown to profit from such a ban. Studies in
nine US and Canadian venues suggest that ETS causes a net loss of trade for the
hospitality industry by causing offence to non-smokers from odour, irritation and health
concernsxlv. In health terms, the California ban on smoking in bars has provided both
immediate and longer-term respiratory benefits for smoking and non-smoking
bartendersxlvii. Furthermore, a recent reportxlviii highlights that one year after New York
City’s ban, business tax receipts for restaurants and bars increased 8.7% from April 2003
– January 2004, compared to the same period in 2002-2003. Employment in the
restaurant and bar industry is now at it’s highest in over a decade. Similarly, a recent
report from Ireland suggests that smoking bans do not have an adverse effect on sales in
the hospitality sector, and may, in fact, have a positive effectxlix.

Concluding Comments

ASH Scotland has no doubt that legislation on smoke-free public places is needed in
Scotland, and we are delighted to support the proposed Bill as a step in the right direction.
We also believe that any legislation introduced should be as effective as possible, and
must therefore reflect both best practice from elsewhere, and the demonstrated health
risks associated with ETS. The accumulating evidence is clear. It is now time to
protect Scottish workers from the hazardous impacts of environmental tobacco smoke.

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viii US Environmental Protection Agency. Respiratory health effects of passive smoking: Lung cancer and
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xiii See Footnote 12
xv See Footnote 14
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A Killer on the Loose. An Action on Smoking and Health special investigation into the threat of passive smoking to the UK workforce. ASH (Action on Smoking and Health), 2003.


SUBMISSION FROM NHS HEALTH SCOTLAND

Thank you for inviting NHS Health Scotland to submit evidence to the Health Committee on the above Bill.

In January 2004, NHS Scotland and ASH Scotland jointly published a report, Reducing Smoking and Tobacco Related Harm: a key to transforming Scotland's health. This comprehensive report reviewed the convincing evidence that environmental tobacco smoke (ETS) is harmful to the health of non-smokers. The evidence to this effect is well summarised in the Policy Memorandum which accompanies the Bill. The Health Scotland report also found that whilst there had been welcome progress in making certain enclosed public spaces e.g. aircraft, trains, and cinemas smoke-free, progress had been much more limited in places where food and drink are consumed and in a wide range of other work places. NHS Health Scotland also endorses the conclusion reached in the Policy Memorandum that the available evidence suggests that the introduction of legislation to ban smoking in restaurants and bars has no medium to long-term impact on revenue or jobs.

The committee will be aware that many countries now prohibit smoking in places where food is sold and consumed. However, the most recent trend, for example in New York City and Ireland, has been to focus on prohibiting smoking in the workplace - which automatically includes places where food is sold and consumed, but has much wider scope. As the Bill's Policy Memorandum itself concludes, "other countries or parts of countries have successfully introduced smoking bans covering a much wider range of premises without adverse economic impact." A recent study from Finland indicates that a wider ban on smoking in the workplace can also have a major impact on overall smoking prevalence (see Annex).

The proposed legislation would mean that both the customers and the staff who serve them in premises serving more substantial amounts of food would be protected from ETS but those where only drink and bar snacks are sold and in a wide range of other premises would continue to be exposed to ETS. There is no public health rationale to justify such a distinction. The evidence would therefore favour measures that would have wider scope than those proposed in the present Bill.

Annex

Four-year follow-up of smoke exposure, attitudes and smoking behaviour following enactment of Finland's national smoke-free work-place law

RESEARCH REPORTS
1Finnish Institute of Occupational Health, Helsinki, Finland
2Provincial State Office of Southern Finland, Helsinki, Finland

ABSTRACT
Aims: This study evaluated the possible impact of national smoke-free work-place legislation on employee exposure to environmental tobacco smoke (ETS), employee smoking habits and attitudes on work-place smoking regulations.

Design: Repeated cross-sectional questionnaire surveys and indoor air nicotine measurements were carried out before, and 1 and 3 years after the law had come into effect.
Setting: Industrial, service sector and office workplaces from the Helsinki metropolitan area, Finland.

Participants: A total of 880, 940 and 659 employees (response rates 70%, 75% and 75%) in eight workplaces selected from a register kept by the Uusimaa Regional Institute of Occupational Health to represent various sectors of public and private workplaces.

Measurements: Reported exposure to ETS, smoking habits, attitudes on smoking at work and measurements of indoor air nicotine concentration.

Findings: Employee exposure to ETS for at least 1 hour daily decreased steadily during the 4-year follow-up, from 51% in 1994 to 17% in 1995 and 12% in 1998. Respondents' daily smoking prevalence and tobacco consumption diminished 1 year after the enforcement of legislation from 30% to 25%, and remained at 25% in the last survey 3 years later. Long-term reduction in smoking was confined to men. Both smokers' and non-smokers' attitudes shifted gradually towards favouring a total ban on smoking at work. Median indoor airborne nicotine concentrations decreased from 0.9 μg/m3 in 1994-95 to 0.1 μg/m3 in 1995-96 and 1998.

Conclusions: This is the first follow-up study on a nationally implemented smoke-free workplace law. We found that such legislation is associated with steadily reducing ETS exposure at work, particularly at workplaces, where the voluntary smoking regulations have failed to reduce exposure. The implementation of the law also seemed to encourage smokers to accept a non-smoking workplace as the norm.
Do you support the general principles of the Bill and the key provisions it sets out?

No. Smoking is ALREADY severely restricted in enclosed public places. According to the Office for National Statistics (ONS), 86% of UK companies have a policy on smoking at work. Pubs, clubs, cafes and restaurants represent the few remaining places where smokers are generally accommodated and even there we see increasing restrictions and, occasionally, prohibition.

According to the Policy Memorandum, “The Bill should be considered as part of the process of safeguarding the health of the people of Scotland from the effects of tobacco smoke. The United States Environmental Protection Agency has classified ETS as a Class A human carcinogen for which there is no safe level of exposure. Non-smokers who are exposed to ETS in the workplace have their risk of lung cancer increased by 16-19%. Passive smoking also increases the risk of an acute coronary event by 25-35%.”

FOREST does NOT accept that passive smoking is a significant risk to the health of non-smokers. Interviewed on Radio 4’s ‘Desert Island Discs’, Professor Sir Richard Doll, the first scientist to establish a link between lung cancer and primary smoking, actually commented: ‘The effects of other people smoking in my presence is so small it doesn’t worry me’ (23rd February 2001).

In July 1999, in its draft Approved Code of Practice on Smoking at Work, the Health and Safety Commission declared that, ‘Proving beyond reasonable doubt that passive smoking at a particular workplace was a risk to health is likely to be very difficult, given the state of the scientific evidence [our emphasis]

We do not believe that there is a convincing case for yet more law. It is not currently reasonably practicable to ban smoking in all such workplaces: in some cases, because it would not be commercially viable, and in others because it would interfere with personal freedoms.’

In April 2002, following an exhaustive six-month investigation during which written and oral evidence was supplied by organisations including ASH, Cancer Research UK and FOREST, the Greater London Assembly Investigative Committee on Smoking in Public Places declined to recommend ANY further restrictions on smoking in public places. According to Angie Bray, joint author of the report, ‘After taking evidence from all sides, including health experts, it was decided that the evidence gathered did not justify a total smoking ban’ (Daily Telegraph, 5 July 2003).

In May 2003 the British Medical Journal published the results of a study that seriously questioned the impact of environmental tobacco smoke on health. According to the study, one of the largest of its kind, the link between environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed.

In terms of establishing a clear causal connection between exposure to ETS and illness in non-smokers, the anti-smoking industry has continually failed to prove its case. In the words of Dr Richard Smith, editor of the British Medical Journal (30 August 2003), ‘We must be interested in whether passive smoking kills, and the question has not been definitively answered.’ The second justification for the Bill is that it will help reduce the number of people who smoke. (“It is to be hoped that [the Bill] will also encourage people
who want to stop smoking, and help ex-smokers from relapsing, by providing a smoke-free environment.

Banning smoking with a view to making it physically more difficult for people to smoke is social engineering. It ignores the important concept of personal responsibility and adopts the outdated notion that ‘nanny knows best’. Of course, government has a role to play educating people about the health risks of smoking, drinking too much or eating too much of the ‘wrong’ type of food. Politicians do NOT, however, have the right to force people to change their lifestyle in these areas.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

A total ban on smoking where food is served should be a last resort not a first option. Alternatives that do not appear to have been considered include (i) compulsory smoking and no-smoking areas in pubs and restaurants of a certain size; (ii) compulsory ventilation to an agreed standard, regularly checked and maintained, to improve air quality in venues that serve food; or (iii) a licensing system that allows proprietors to apply for a smoking licence in the same way that they can apply for a licence to serve alcohol or stay open to a certain time. Good ventilation, properly maintained, will ultimately remove the need to restrict or even ban smoking. The best systems should enable smokers and non-smokers to share the same space without causing any inconvenience to the latter. This, in our view, is the moderate, progressive way forward – using modern technology to overcome potential points of conflict.

Better ventilation should be encouraged because it also removes other air pollutants, from dust mites and dead skin to the chemicals in paints and furnishings, that we don’t hear much about because, unlike tobacco smoke, they are largely invisible.

Decisions on banning smoking should be made on a case-by-case basis, taking into account a number of factors including size of venue etc. Clearly, the larger the venue the easier it is to separate smokers from non-smokers by providing smoke free zones and designated smoking areas. Guidelines could be introduced so that new restaurants over a certain size be given a licence only on condition that they include smoke free and designated smoking areas separated by a fixed wall.

The Bill exempts ‘biscuits, nuts, potato crisps, chewing gum, confectionery and other similar products’ but does not exempt pies, sandwiches and other bar snacks (hot or cold) which are common to pubs and clubs where the principal activity is drinking and socialising not eating and where snacks such as pies and sandwiches are often consumed standing up. Instead of banning smoking, it is quite likely that such establishments will simply remove such food from the range of snacks available, thus reducing consumer choice. Banning smoking could have a serious effect on business. Although a handful of pubs have reported increased business since banning smoking, history is littered with examples of establishments that have banned smoking only to experience a drop in custom, sometimes quite dramatically, with the result that some have had to reverse the policy months later.

According to Brian Nolan, chief executive of the United Restaurant & Tavern Owners of New York, ‘Almost all bars, and some restaurants in New York City and State, have experienced a radical downturn in bar business, and that downturn is directly related to the smoking ban. In reality, most bars urgently need a rescue package or smoking exemption due to the significant downturn in bar business.’
Although there are reports that suggest an upturn in business in New York since the smoking ban, why would bar owners lie about the figures? After all, the hospitality industry is not in business to keep smokers happy. They're in business to make money and if they thought, for one second, that they could make more money by banning smoking, they would do it overnight.

What are your views on the quality of consultation, and the implementation of key concerns?

According to the Policy Memorandum, “The Member [Stewart Maxwell] has carefully considered the responses received...in formulating the Bill.” With respect, Stewart Maxwell has shown little evidence of having an open mind on the issue of smoking in public places. He has dismissed evidence provided by groups such as FOREST, evidence that has been taken very seriously by government bodies such as the Health & Safety Commission and the Greater London Authority Investigative Committee on Smoking in Public Places. It is one thing for a Member to have strong feelings about a subject: it is quite another for an elected representative to apparently dismiss information that casts doubt on his no doubt well-intentioned beliefs, when the legislation he proposes will have such a drastic impact on the lifestyle of so many people. It is also legitimate to ask where this Bill is leading us. According to the Policy Memorandum, “The Bill does not prevent people from smoking in all public places, it focuses on areas where food is being supplied and consumed.’ Later, however, its adds (somewhat chillingly), “The Bill gives power to Scottish Ministers to extend the restrictions of the Bill to any other places in the future.”

These conflicting statements make it abundantly clear that the anti-smoking lobby in Scotland will not be satisfied with banning smoking in establishments where food is consumed – they will undoubtedly come back with demands for further restrictions, including a blanket ban on smoking in ALL public places, as implemented in Ireland.

Taken to its logical conclusion, this Bill could encourage and even promote an anti-smoking culture that may result in outright discrimination to the extent that some smokers could even be denied employment. In America, some companies now breathalyse employees when they arrive at work to check whether they have been smoking, in their own time, on their way to work. You may think this won’t happen but the whole anti-smoking strategy is based on what campaigners like to call ‘the next logical step’.

In California, where smoking has been banned in enclosed public places since the mid Nineties, they are several steps ahead of us. In 2002 Los Angeles Council announced plans to ban smoking in all open air parks. According to American anti-smokers it was ‘the next logical step’. Since then smoking has been banned on some coastal footpaths. The next ‘logical step’ will no doubt be a ban on smoking in the home or even in the garden, lest a wisp of smoke should drift over the garden fence and contaminate the houses of non-smokers.

What has happened in America, says FOREST supporter and musician Joe Jackson (who lived in New York for 20 years), is the result of a “very persistent, well-organised, well-financed propaganda war” against smoking. In our view, this Bill is part of the same well-organised, well-financed propaganda war.

In short, the Prohibition of Smoking in Regulated Areas (Scotland) Bill promises to be highly restrictive and detrimental to both business and the consumer.

Worse, the Policy Memorandum that accompanies it is a highly pejorative document that wilfully ignores a great deal of important information about the alleged effects of passive smoking and other smoking-related issues.
SUBMISSION FROM TOBACCO MANUFACTURERS’ ASSOCIATION (TMA)

Introduction

The TMA is the trade association representing the interests of UK tobacco manufacturers and this submission is made on behalf of its principal members – British American Tobacco, Gallaher and Imperial Tobacco.

The TMA was not contacted in the Member-led consultation in the first Scottish Parliament undertaken by the former MSP, Mr Kenneth Gibson, on his proposal for The Regulation of Smoking Bill. Thus the TMA was not then included in the initial consultation undertaken by Mr Stewart Maxwell in July 2003.

The TMA therefore greatly welcomes the opportunity afforded by the Health Committee’s invitation for evidence on the Bill. Respectful of the Committee’s request for brief submissions, the comments stated here are in short form. Should the Committee wish for further elaboration of this evidence, or any other additional information, the TMA would be pleased to respond, either in writing or by way of oral evidence.

The objectives of the Bill

At paragraphs 2 and 3 of the Policy Memorandum, the Bill is stated to have a number of objectives, namely to: prevent people, including children, from being exposed to the effects of passive smoking in certain public areas; raise awareness of the dangers of passive smoking and smoking; assist in changing the attitude of the public towards smoking, and encourage smokers who want to quit smoking and help ex-smokers from relapsing.

The TMA does not believe it to be appropriate or legitimate that the last three of those aims should be objectives of this legislation. That they should be stated to be so appears to betray a much broader agenda than the principal stated purpose of this Bill and its provisions.

The public health justification for the Bill

The TMA therefore believes that it is appropriate only to consider the Bill in the context of its first stated objective. This objective appears to be founded on pronouncements of various authorities which are cited in paragraphs 5 to 10 of the Policy Memorandum.

Many statistical studies have investigated possible associations between environmental tobacco smoke (ETS) and commonly referred to as tobacco related diseases. Such studies have well recognised, serious limitations. Their findings have also been inconsistent and, even where a positive association has been indicated, it has been of a very low order of relative risk - well below that normally regarded as indicating a causal link. Nonetheless, the authorities have taken the contrary view and believe that ETS damages the health of non-smokers.

Relative risk is the ratio of the risk of disease or death among those exposed to ETS to the risk among those who are unexposed. It may be expressed in a number of ways, and for popular consumption is often expressed in terms of percentages. For example, the authorities generally accept the meta-analysis of a number of epidemiological studies undertaken by Hackshaw et al. This reported an estimated excess risk in non-smokers living with smokers, as compared with non-smokers living with non-smokers, of 26% in respect of lung cancer. This, to the ordinary person unfamiliar with risk assessment and
statistical method, gives the impression of the risk being high. In fact, what the figure means is that, in the case of a non-smoker living with a smoker, the risk is 12.6 persons per 100,000 people, as opposed to 10 per 100,000 for non-smokers living with non-smokers. Expressed in an alternative way, it means that a non-smoker living with a smoker may have their risk of lung cancer increased from 0.010% to 0.0126%.

Most importantly, however, such a finding, as small and tentative as it is, has only very limited relevance, if any at all, with regard to exposure to ETS in a so-called public place, such as food businesses to which the Bill would apply. The vast body of ETS epidemiological studies have, of necessity, comprised data concerning non-smokers living with smoking spouses. They are therefore based on recollections, retrospective over a span of years – often a great many – of the non-smoker’s exposure to the smoking of their partner. They have not been about non-smokers living in a non-smoking household being exposed to ETS on an occasional basis in an “enclosed public space” where food is supplied and consumed.

In short, the TMA does not believe that the Bill is justified on public health grounds. The evidence about non-smokers living with smokers, when considered as a whole, is not sufficiently reliable or robust, let alone relevant, to justify the imposition of prohibitions on smoking in an “enclosed public space” where food is supplied and consumed. If, nonetheless, the Bill does proceed further, there is an obligation on the part of its promoter to bring forward robust and convincing evidence to support the public health claim on which it is founded.

**Human rights**

At paragraph 102 of the Policy Memorandum accompanying the Bill, it is stated that the Bill is fully compliant with the European Convention on Human Rights (ECHR). This assertion is, however, dependent upon the Bill being a measure the aim and effect of which is to protect the public health by reducing exposure to ETS. As indicated above, the TMA does not believe that the Bill is justified or has been justified on public health grounds. It has not been demonstrated that the provisions of the Bill are necessary.

The TMA believes that the Bill is susceptible to challenge both with regard to Article 8 of the ECHR (infringing the right to respect for private life) and also Article 1 Protocol 1 (a measure controlling the use of property). The Bill is not proportionate and does not strike a fair balance between the rights of individual proprietors and the general interest in protecting public health, given the absence of any direct evidence that ETS presents a risk to the health of non-smokers in the places where the Bill would prohibit smoking.

**‘Public enclosed places’**

The places referred to in the Bill are not “enclosed public spaces” in the correct sense of that term. The Bill recognises that at clause 1(5), where the term “public space” is defined as meaning “a space to which the public or section of the public has access, on payment or otherwise, as of right or by virtue of express or implied permission”.

Some spaces may be public in the sense that they are in places owned or operated by government or similar authorities. Some may be public in the sense that they are spaces that belong to everyone and nobody in particular, say, an enclosed shopping centre, or an airport, theatre, or a ferry etc. The vast majority of enclosed places to which the Bill applies, however, are privately owned and operated places in respect of which owners or operators have a right, which they consider should be maintained, of managing their business as they determine. They currently have the freedom to allow customers to smoke, to forbid it, to provide separate facilities for smokers and non-smokers, to improve...
ventilation and air quality, or to make other rules. It is obviously in their best interests to have regard for policies that meet both the demands and preferences of their customers and the duties that they have with regard to the health, safety and welfare of their employees. Customers are under no obligation to give their custom to a particular establishment; they may take their wallet elsewhere and choose to whom they give their business. Choice is what customers consistently show that they want.

The TMA is firmly of the belief that it is wrong, and should be both politically and socially unacceptable, that control over private places should be seized by this Bill. It would be surprising also if owners and operators were prepared to surrender their right to control who enters their premises and how they wish to run their business in a way that is in the best interests of their customers and employees. The law should not be used to prohibit smoking in any private enclosed places. Tobacco products may legally be sold retail to any person over the age of 16 and the state has long been quite prepared to tax them highly, reaping for the exchequer as much as almost £10 billion a year. To smoke is not illegal.

A regulated area

The Bill defines a regulated area as being any “enclosed public space” while food is being supplied and consumed and during a period of 5 days (which may be varied by regulations) before food is supplied and consumed; and a regulated area includes any “connecting space” (also defined in the Bill) directly connected to the “enclosed public space”.

The consequence of the inclusion of connecting spaces within regulated areas in which smoking would be an offence, would effectively mean that the Bill would determine that smoking would be prohibited in any part of a great many premises. This is a consequence of the pernicious provisions of clause 1 (1), (2), (4) and (5) and the absence of any flexibility whatsoever in these provisions.

The provisions would disproportionately affect many businesses with small premises, or premises in which it would not be practicable or economically feasible to create individual non-smoking and smoking enclosed spaces. These are obviously also likely to be businesses of a small economic scale, but may be businesses which are particularly valued by the community. Such businesses may be the only one, or one of very few, in a particular area, where the owner or operator wishes to accommodate all his customers, and where his customers feel likewise and are content with the smoking policies which are applied.

Ministers may amend the definition of “regulated area”, so as to add such places as they think fit. Whilst such an order under clause 2 is subject to consultation with persons they consider to be appropriate, and also the affirmative procedure, the provision calls for the Bill to be considered in a much wider context than simply the food businesses to which it is currently related, and in respect of which the provisions laid out in clause 1 would be inappropriate and as unworkable as they would be if applied only to food businesses.

Offences and enforcement

The Bill creates three criminal offences – smoking in a regulated area, permitting smoking in a regulated area and failing to display mandatory signs (to be specified by regulations) inside and outside a regulated area. The TMA does not believe that the creation of such offences is a proportionate or sensible measure.
The TMA’s beliefs with regard to the inappropriateness of the creation of the three criminal offences are substantially reinforced by the deliberate omission from the Bill of any provisions dealing with enforcement. An attempt is made to explain the reasons for this decision, and how it is anticipated that the Bill will be respected and enforced, at paragraphs 45 to 51 of the Policy Memorandum. Those explanations are unconvincing. The TMA believes that the Bill underestimates the difficulties of ensuring compliance with a Bill, the provisions of which with regard to regulated areas that also include “connecting spaces” would severely test compliance, even of the most willing owner or operator. The decision to omit provisions for enforcement is also likely severely to test the presumption that there would be widespread willingness to comply with the Bill.

The practical implications

The Financial Memorandum (at paragraphs 63 to 70) seeks to convey, by totally inadequate consideration, the impression that the cost implications for most of the businesses affected by the Bill would at worst be minimal and for many be of a positive nature. This would not be the case. Under the heading of “economic issues” (at paragraphs 29 to 37 of the Policy Memorandum), great reliance is put on a review by Scollo et al. That review claims to have rejected any studies with which there had been a link by way of research funding with the tobacco industry. Of the remaining 62 studies, all bar 21 were rejected on the grounds that they did not meet the criteria adopted by the reviewers.

Scollo et al is not an objective review of all the evidence available and should not be relied upon. It is for those in and representing the hospitality sector to make their own representations on the Bill. However, given the real world experience of businesses in other countries, rather than anti-smoking propaganda, it would be surprising if hospitality businesses in Scotland considered that implementation of the provisions of the Bill would give rise to increased trade and greater profitability.

Those businesses that would benefit most by the Bill would be those able to comply with the Bill and to allow smoking in their premises, without incurring substantial building alteration costs. Others would effectively be penalised. A restaurant, perhaps in a hotel, with a bar that could not be closed off from the restaurant (allowing for an intervening connecting space), or could only achieve that at unaffordable costs of alteration, would not be able to permit smoking in the bar; albeit that it could then provide food at the bar additional to biscuits, nuts, potato crisps, confectionery and, intriguingly, chewing gum (clause 10).

Alternative approaches

The TMA believes that in the account of the consideration of alternative approaches laid out in the Policy Memorandum, and particularly at paragraphs 91 to 95, the Bill is less about practical measures to accommodate both smokers and non-smokers, and to reduce exposure to other people’s smoke, than it is about an outright ban on smoking. Voluntary self regulation, which is increasingly delivering results, is ruled out in favour of prohibition, coercion and the creation of criminal offences. That is not the preferred route of the public generally. The Policy Memorandum itself, at paragraph 96 cites the publication of the Office of National Statistics in which it is reported that 87% of people agree that smoking should be restricted in restaurants. Restrictions are not bans and bans are not what the public wants. When asked how the restrictions felt appropriate should be achieved, opinion polls have shown that the imposition of a ban is favoured only by a minority of people.
Conclusion

The TMA does not believe that the Bill is justified on public health grounds and no relevant detailed evidence has been produced in support of the Bill in that regard. The Bill inappropriately creates criminal offences and does so without adequate provisions for enforcement. The provisions are such that they make it impossible for smoking to be permitted in any enclosed place where food is supplied and consumed and, in many businesses, impossible for them to permit smoking in other places within the premises. Such a prohibition imposed by way of legislation is not the regulatory route preferred by the public generally. Market forces and the voluntary adoption of self-regulatory smoking policy measures are achieving rapid progress in the adoption of smoking policies that meet the preferences of customers and reduce the exposure of non-smokers to the smoke of others. The TMA believes that this is the most appropriate way of accommodating smokers and non-smokers.

SUBMISSION FROM THE BRITISH HOSPITALITY ASSOCIATION

Introduction

The British Hospitality Association (BHA) has been representing the hotel, restaurant and catering industry for 90 years. The BHA represents all sections of the industry with some 3000 establishments in Scotland - not just the large organisations but also thousands of individually owned hotels. Hospitality and tourism is one of the largest industries in Scotland, employing some 190,000 people and contributing £4 billion to the economy (5 per cent of GDP).

The BHA Scotland is a signatory to the Scottish Executive’s Voluntary Charter on Smoking in Public Places alongside the Scottish Licensed Trade Association and the Scottish Beer and Pub Association. In England and Wales we are members of The Charter Group, underlining our commitment to the creation of an environment where non-smokers are not adversely affected by the effects of passive smoking.

As an organisation we recognise that within society the majority of the population are non-smokers and that this should be reflected in the policies of the hospitality industry as a whole, and within individual establishments. In addition, as responsible employers our members recognise that employee exposure to tobacco smoke should be as low as practically possible, but we do not believe that legislation is the appropriate vehicle for achieving this aim.

General Principles

The BHA believes that significant progress has been made using the voluntary approach. Independent research evaluating the uptake and impact of The Scottish Voluntary Charter was published by the Scottish Executive on 23 September 2003. The research demonstrated that progress was being made under the Charter and that the voluntary approach was working. Indeed, the Deputy Minister for Health and Community Care, Tom McCabe stated that he “welcomed the progress made under the Scottish Voluntary Charter on Smoking in Public places and was particularly pleased to note the increase in the number of premises which offer smoke free areas.”

Although, concern was expressed at the speed of progress this can be addressed through “an extension of the voluntary approach,” as suggested in A Breath of Fresh Air for Scotland. A review is currently being undertaken by The Charter Group for England and Wales and the Scottish Charter could be reviewed following the Scottish Executive consultation process. The Scottish Charter has demonstrated that it is an effective policy
option delivering benefits, reducing the impact of smoking in public places. Legislation should be the last resort when all other policy options have been exhausted. We believe that we have not yet reached that stage.

Furthermore, when the Scottish Executive published its Tobacco Control Action Plan, A Breath of Fresh Air for Scotland, it announced that, “it would sponsor a major public debate on actions to minimise the impact of second-hand smoke…involving a range of conventional and innovative opportunities to contribute to the dialogue.” The Scottish Executive is committing considerable resources to this consultation process, including the commissioning of an International Review.

This review will form a vital piece of evidence that should be analysed in detail before any legislation should be considered. The review will involve a study of international experience and evidence on the health and economic impact of action to control passive smoking. We believe that the Scottish Executive consultation and evidence gathering process should be allowed to run to completion so an informed decision can be made whether to extend the voluntary approach or to proceed with legislation.

The other key principle of the Bill is to “raise awareness of the dangers of both passive smoking and smoking”. There appears to be no evidence to suggest that legislation is required to raise awareness of the health implications of smoking. The Health Education Board for Scotland and more recently NHS Health Scotland have conducted high profile and successful campaigns in this area. Indeed, the Scottish Executive as a key part of its consultation process will be conducting an awareness raising campaign specifically designed to present evidence in an accessible way.

While legislation can help form public opinion in certain instances, it is generally accepted that statutory controls are only enforceable when they ‘reflect rather than attempt to force public opinion on what remains an issue of personal behaviour’. Therefore, we are not convinced that legislation is required to meet the objective of raising public awareness. Furthermore, the Scottish Executive awareness raising campaign should be allowed to take place and then assessed to see what further course of action is actually required, be it an extension of the voluntary approach or legislation.

Consultation Process

Due to resorting issues the two member-led consultations carried out in relation to the Regulation of Smoking Bill will not be as comprehensive or as wide-ranging as the Scottish Executive consultation on the same issue. Policy decisions in this area and any possible legislation will benefit from as much evidence as possible. Therefore, we would like to see the outcome of the comprehensive Scottish Executive consultation process prior to legislation in this area being progressed further.

Practical Implications

The proposals contained in the draft Bill have serious implications for our members that do not appear to have been taken into consideration in the Bill’s Financial Memorandum. The assertion that costs for businesses are likely to be offset by savings in other areas is unsubstantiated. As outlined below to comply with the legislation structural changes could be required to some premises. While, the cost savings from no longer needing to supply ash trays is negligible.

The Financial Memorandum also refers to “clear evidence from other jurisdictions that there will be no loss of trade costs to business”. As part of its consultation process the Scottish Executive, International Review will examine the true economic impact of tobacco
controls. This research will help address concerns over the research quoted in the Policy Memorandum and reinforces our position that the Scottish Executive consultation process should be allowed to proceed before a decision is taken on the need for legislation or the extension of the voluntary approach.

**We have three particular concerns with the proposals:**

**Regulated Areas**
As presently drafted, major changes would be required to the properties of our members. For example, a large restaurant with a bar area would be required to make extensive structural changes to separate the bar area from the seated area. In addition, hotels which currently have effective smoking policies would be required to make similar changes to ensure that they could provide an area where residents who wished to smoke could do so.

It is inevitable that, under the proposed legislation, smaller establishments – many of them serving smaller rural communities where there is no alternative establishment – would be forced to make a decision between selling food or allowing customers to smoke.

Furthermore, the definition of a regulated area would severely restrict the use of venues for a range of events impacting on the economic viability of that venue. For example, in the case of a function room in a sports stadium that is used as a bar for corporate hospitality where no food is served on a match day it could not then be used for five days a significant period of the following week. This would have a significant impact on the business plan and financial viability of that venue.

**Offence to Permit Smoking in Regulated Areas**
The hospitality industry is currently facing recruitment difficulties which we are working hard as an industry to address. However, by making employees liable for prosecution and fines the Bill will undermine strenuous efforts to make the hospitality sector a more attractive career option. In addition, industry staff will be placed in the difficult and potentially dangerous position of having to police the act, instructing individuals that they cannot use a product which is otherwise legal.

**Offence to fail to display signs**
The BHA views the obligation placed on Scottish Minister by section 5(5) to consult with industry bodies, including the BHA on signage as being a crucial element of the Bill. However, we would like to take this opportunity to point out the minor typographical error in paragraph 29 of the Explanatory Notes where the British Hospitality Society rather than the British Hospitality Association is referred to.

**Bodies Corporate etc**
The structure of some of our members businesses involves premises being leased from them or managed on their behalf. As currently drafted this section appears to suggest that they will be proceeded against even in circumstances where they are not in day to day control of their business. This is not compatible with natural justice.

**Conclusion**
In conclusion, the BHA supports the voluntary approach to the control of smoking in public places. The Breath of Fresh Air report, "welcomes] the progress made under the Charter and believes that it demonstrates the progress which can be made through partnership with the business community in this most challenging of sectors. We believe that the extension of this approach is the best option and only once significant progress is no longer being made under the Voluntary Charter should legislation be considered. The aim
of the Charter is to eliminate smoking in public places through sustained progress over a number of years.

Furthermore, we believe that the Scottish Executive consultation process should be allowed to proceed and the conclusions fed into the policy making and legislative process. It would appear premature to proceed with legislation at this stage when a comprehensive consultation process is about to get underway and a Ministerial Advisory Group on Tobacco has recently been formed.

It is our assertion that the Bill as proposed would be difficult to enforce fairly and equitably. It is difficult to see how it would achieve extra health protection benefits beyond those already deliverable through an effective Voluntary Charter.

2 A Breath of Fresh Air for Scotland, The Scottish Executive. Page 24
3 Ibid. Page 25

SUBMISSION FROM AMICUS

Do you support the general principles of the Bill?

Amicus supports the health-oriented intentions of the Bill but needs to be reassured about any knock-on effects for its members. Amicus as the UK’s largest private sector union represents a diverse range of interests from our members in the Health sector to those in Food, Drink and Tobacco, to those in Heating and Ventilation. We have smoking and non-smoking members of the union. As a trade union we believe that the interests of all people should be considered. The Bill does not accommodate this.

Are there any omissions from the Bill that you would like to see added?

The Bill ignores the wider implications for employment. Amicus Scotland has members in tobacco company sales forces and vending machine companies, whose livelihoods would be threatened by a ban and the inevitable removal of vending machines currently present in many of the regulated areas covered by the Bill.

Although the Bill attempts to re-assure about the economic implications for the hospitality industry, it does not consider some of the possible knock-on effects on other jobs in Scotland. The Bill should make for provision for those workers who may face job security or redundancy as a direct result of the Bill’s implementation.

Amicus has stated that solutions could be found by greater restrictions but without prohibition: improved ventilation, more non-smoking areas, banning smoking in serving areas and at bars.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Amicus is concerned about the practical implications for employees in the hospitality trade who may be called upon to enforce the Bill. The Bill is clear that manager’s and proprietors would be those liable. However, it is unclear as to the pressures that employees may face to enforce the Bill on a day-to-day basis.
SUBMISSION FROM MR A RANDEV

With reference to your proposal to regulate smoking where food is served I wish to register my disapproval of such action, when the licensed trade has made huge strides in improving the situation through the Voluntary Charter on smoking.

As a member of the Scottish Licensed Trade Association and a forward thinking publican, I have supported the Charter since the beginning. I consulted with my customers to make sure that I was offering their preferred smoking policy and decided to provide both a non smoking dining area and a smoking bar. This has worked very well and we make sure we monitor customer’s opinions by providing them with comment cards. I have never received any complaints. We as an industry also exceeded the targets set for us by ASH and the Health Board and yet we are now threatened with further controls.

Your proposals would be impossible for me to comply with as I couldn’t build a wall through the middle of the premises to separate off the non smoking area from the smoking area. Your bill would also infringe on the preference of many of my regular smoking customers, who currently choose to sit in the smoking bar area and eat, as well as a proportion of my afternoon trade who like to have a cigarette over a coffee and a snack.

I understand you are trying to offer more non-smoking areas for people who are bothered by smoke, but I believe the solution to the issue should be about choice. It should not be dictating to people how they should behave, or forcing premises like mine to sacrifice part of their trade, when we have already made sure we are offering what our customers want.

I strongly feel that the Voluntary Charter is the way forward – offering choices to customers, properly advertised on the outside of premises, so that customers can decide where they want to go. In this way people can enjoy food and drink in the situations that they prefer, be that smoking or not, without damaging the trade of hardworking licensees.
The Convener: If members can keep up, we move on to agenda item 2, which is stage 1 consideration of the Prohibition of Smoking in Regulated Areas (Scotland) Bill. Papers HC/S2/04/15/2 through to HC/S2/04/15/8 have been circulated.

As I have previously advised, we hope to have three sessions of approximately 45 minutes. If crisp questions and crisp answers mean that we get through the sessions faster than that, so much the better for life. I propose that we have a break before we take evidence on the Breastfeeding etc (Scotland) Bill.

Before I call our first panel, I ask the committee that it delegate authority to me to deal with witnesses’ expenses. Is that agreed?

Members indicated agreement.

The Convener: I welcome panel 1, which consists of Maureen Moore, who is chief executive of Action on Smoking and Health Scotland, and Dr Laurence Gruer OBE, who is from NHS Health Scotland. We will move straight to questions. I think that I have the first question—I am going too fast even for myself—so let me ask that. Witnesses should feel free to answer, but they should not feel obliged to answer each and every question.

FOREST—Freedom Organisation for the Right to Enjoy Smoking Tobacco—and others claim that the risk from second-hand smoke has been exaggerated. How do you answer that criticism?

Dr Laurence Gruer (NHS Health Scotland): The accumulation of evidence over the past few years has been substantial. There is undeniable evidence that environmental tobacco smoke is noxious and that it contains a number of chemicals and gases that are harmful to health. A variety of different studies have shown that people who are exposed to environmental tobacco smoke over the long term are at increased risk of conditions that are associated with smoking, such as lung cancer and heart disease. The excess risk compared with the risk for non-smokers is between 20 per cent and 30 per cent.

Evidence suggests that, if people who have pre-existing heart disease are suddenly exposed to tobacco smoke, their blood circulation and blood flow to the heart go down very quickly. It is beginning to look as though people can have a heart attack that is precipitated by being exposed...
to that situation. We also know that people who have a tendency to asthma can either develop asthma or have it worsened by exposure to tobacco smoke. There are a range of conditions in young children, which I could elaborate on.

The Convener: Could you name some?

Dr Gruer: There is clear evidence that women who are exposed to passive smoke during pregnancy have lighter babies on average than women who are not exposed to passive smoke. The amounts are small—the babies are perhaps an average of 40g to 50g smaller—but the evidence is consistent, so it looks as though babies are failing to develop properly in that situation.

The Convener: Where does the figure of 40g to 50g come from? What kind of cigarette smoking is going on for that to be inhaled by a pregnant woman?

Dr Gruer: Sorry?

The Convener: What does that figure relate to in terms of smoking?

Dr Gruer: It relates to the weight of the baby.

The Convener: If a baby is on average 2.5kg—

The Convener: I am a pounds and ounces person. I am sorry. That is how I got lost.

Dr Gruer: The difference is about an ounce and a half; it is a small amount, but it is consistent.

Babies are also more likely to develop ear infections, upper respiratory tract infections and asthma, and there is a higher incidence of sudden infant death syndrome in the very young.

The Convener: Is that from passive smoking by the baby?

Dr Gruer: That is right.

Maureen Moore (Action on Smoking and Health Scotland): It is important that people understand that FOREST, which represents itself as being for the rights of smokers, is a tobacco industry-funded group—it gets 98 per cent of its funding from the tobacco industry. The tobacco industry has consistently tried to oppose the introduction of bans on smoking in the workplace.

The evidence is clear and irrefutable. The Scientific Committee on Tobacco and Health concluded that there is a cause and effect relationship between passive smoking and ischaemic heart disease and, as Laurence Gruer says, cancer.

It is important to bear in mind the context within which FOREST operates.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): This is a debate for the experts. Rather than FOREST, we will go straight to the Tobacco Manufacturers Association and to the problem that it highlights in relation to communicating the risks in the debate. The submission states that analysis of studies “reported an estimated excess risk in non-smokers living with smokers, as compared with non-smokers living with non-smokers, of 26% in respect of lung cancer. This, to the ordinary person unfamiliar with risk assessment and statistical method, gives the impression of the risk being high. In fact, what the figure means is that, in the case of a non-smoker living with a smoker, the risk is 12.6 persons per 100,000 people, as opposed to 10 per 100,000 for non-smokers living with non-smokers.”

The Convener: Will you state, for the Official Report, from which submission you are quoting?

Mr McNeil: The submission from the Tobacco Manufacturers Association, not from FOREST.

Maureen Moore: The tobacco industry.

Mr McNeil: Yes. Does that not highlight the problem that we have with communicating with people? We all accept that smoking kills. The debate is about whether passive smoking has the impact that you say it has. We are not communicating that effectively. We are not winning the argument. There seems to be a standstill, with scientists on one side or the other.

Maureen Moore: Do you mean that we are not communicating effectively to the Scottish public?

Mr McNeil: Yes. Volume does not equal substance in those studies.

Dr Gruer: It is undoubtedly the case that the risks from passive smoking are much less than the risks for people who smoke cigarettes. It is clear that people who smoke inhale far larger quantities of the poisonous substances than do people who inhale them through exposure to other people’s smoke, but the extra risk is certainly significant compared with the risk for a person who is not exposed to tobacco smoke, and the risk accumulates over time. The more smoke that someone is exposed to over a longer period of time and the more dense the smoke, the more likely they are to be affected. Moreover, as I said earlier, we are talking not only about death but about the exacerbation of existing conditions such as asthma and bronchitis. We are talking about a lot of people.

Mr McNeil: Will the bill reduce the level of smoking at home or will it increase it? Will people stay at home and drink and smoke more—in front of children, spouses and other members of the family?

Maureen Moore: We commend Stewart Maxwell for introducing the bill. ASH Scotland
wants a ban on smoking in the workplace, to protect people there. If we bring down smoking rates in the workplace, it helps people to stop smoking. There is a cause and effect, and the effect will also go back to people’s homes. The areas with the highest rates of smoking are the areas of deprivation, where smoking is almost normalised. Workplace smoking policies are poor. We are trying to send out a message to young people that smoking is dangerous, yet it is normal to allow smoking everywhere, which encourages people to smoke. We go round in a continuous circle, which new smokers join; we must cut that circle. One of the most important policies that we should put in place is getting smoking out of the workplace in Scotland.

The Convener: I think that Duncan McNeil was referring to displacement smoking. Would Dr Gruer like to comment on that?

Dr Gruer: I could not exclude the possibility that some people might smoke more at home if they could not smoke in a restaurant, but I have not seen any evidence to suggest that that would happen.

I endorse what Maureen Moore has said. Although we welcome the focus on reducing the general public’s exposure to smoke in areas where food is consumed, we do not see, from a public health point of view, a rational distinction between exposure to smoke where there happens to be food and exposure to smoke in any other public situation. What is needed is much wider control of exposure to passive smoking, rather than control only where food is consumed. Evidence suggests that wider control is likely to create environments that not only protect people who are not smokers but encourage people who are smokers in their efforts to give up. It is often very difficult for people to give up, so we should reduce their exposure to the cues to smoking. There is often a link between cigarettes and eating a meal, or between cigarettes and having a drink.

Mr David Davidson (North East Scotland) (Con): I want to go back to what Maureen Moore said about deprivation and about how protecting people in the workplace could lead to people stopping smoking. People who are not in employment—and there will be many of them in areas of deprivation—will not be encouraged to stop smoking by a workplace ban. What is ASH’s view on that?

Maureen Moore: People who are not in work go to community centres and other places that are workplaces, so they would be protected by a workplace ban. People who are not in employment do not just stay in their houses, do they? They go out to public places. Therefore, if we bring in a ban that covers all workplaces in Scotland, where the majority of people are, it will also have an impact on unemployed people.

Mr Davidson: I take your point. Does ASH have any figures on where unemployed people attend and where they occupy themselves?

Maureen Moore: I do not have figures with me but we have an information service that could find out for you.

The Convener: We would be grateful if you could provide the committee with those figures.

Janis Hughes (Glasgow Rutherglen) (Lab): In ASH Scotland’s written submission, you suggest that the explicit relationship in the bill between food and a smoking ban reinforces the view that the bill is more about comfort than about health. Will you elaborate on that view?

Maureen Moore: We are concerned about the limitations of the bill. If it is brought in for only one section of the population, people will find ways round it. They will stop serving food, and smoking will continue.

Janis Hughes: Do you have any evidence from places where smoking has been banned to suggest that that will happen?

14:15

Maureen Moore: The international evidence is that a ban should be introduced through workplace legislation. Smoking should not be banned in only one sector such as pubs or the licensed trade. I am concerned that, in Scotland, the debate continues to be about customers in pubs and clubs. A ban should protect people in the workplace. People who work in bars do not have the choice of leaving the bar, because they must earn a living, so they should be protected.

Mr Davidson: I will continue on the same theme. In your submission, under the heading “International Perspective”, you say that, in Glasgow,

“fewer people a year would die of heart disease, respiratory disease and cancer”,

and you refer to other people’s work. You also suggest that statistical evidence shows that smoking bans produce

“higher rates of smoking cessation”.

Could you give us some figures now for the Official Report?

Maureen Moore: My submission says:

“A recent calculation of the possible impact of a smoking ban in workplaces in Glasgow alone suggested that up to 1,000 fewer people a year would die of heart disease, respiratory disease and cancer”.

That was sourced from the chief medical officer's annual report of 2003. What other figures did you want?

Mr Davidson: It would help to have the direct reference for the information further down the page.

Maureen Moore: Are you talking about total workplace bans?

Mr Davidson: Yes.

Maureen Moore: Moher et al say that there is "Consistent evidence that workplace tobacco policies and bans can decrease cigarette consumption during the … day by smokers".

That was based on a systematic review of the Cochrane tobacco addiction group’s trials register in November 2002, abstracts from international conferences and checks of bibliographies of identified studies and reviews for additional references. We can send you that information.

Mr Davidson: The references are fine. I just wanted them to be on the record as the basis of your comment.

Dr Gruer: We submitted the abstract of one such study, which was from Finland. It suggested that one year after enforcement of the legislation there to implement no-smoking policies in the workplace, the average prevalence of smoking among the workers who were studied had decreased from 30 per cent to 25 per cent. The 5 per cent drop in that year remained for the next three years.

The Convener: As David Davidson knows, all the references should be in the public domain through the papers that have been submitted for this meeting and previous papers.

Mr McNeil: Dr Gruer mentioned a Finnish report that described a drop in the prevalence of smoking after a ban. Was that ban supported by measures such as buddy systems or patches? People are suspicious about the debate and the organisations that are involved in it because the selective use of facts damages their case. Organisations do not want to be painted as wanting to make tobacco illegal. It is important to say that some such studies were supported by patches and other initiatives that should have to be adopted before a ban.

Dr Gruer: Any sensible approach to dealing with tobacco in society would ensure that a measure such as the one that is proposed is accompanied by support to help people to stop smoking altogether. As smoking is an addiction, many people find it extremely difficult to stop. We know of ways to increase the success rate significantly by providing different sorts of support.

Maureen Moore: That is absolutely right. It should be in a tobacco act. The Executive has just launched a new tobacco action plan, of which smoking in public places is only one arm. There must also be cessation support, action on smuggling, prevention and education for young people. A ban on smoking in public places should sit within a whole tobacco action plan.

Shona Robison (Dundee East) (SNP): You said earlier that ASH wants a total workplace ban and that you do not feel that Stewart Maxwell’s bill goes far enough. For the record, do you see Stewart Maxwell’s bill as progress and as something better than what we have at the moment, and will you be supporting its aims?

Maureen Moore: Absolutely. We support Stewart Maxwell’s bill and, despite the caveat that you mentioned, we commend him for taking this action.

Janis Hughes: You say that a blanket ban on smoking in all public places would be preferable, but do you not think that such a ban would be difficult to enforce and would place an undue demand on enforcement agencies?

Maureen Moore: No. Ireland has just introduced a ban. It is still early days, but the Office of Tobacco Control in Ireland has done some work on the enforcement of the ban since its introduction. Its report found that 97 per cent of premises inspected under the smoke-free workplace legislation were compliant with the law. That is a high compliance rate. When we knew that getting into a car without a seatbelt could kill us, we legislated overnight to get people to use seatbelts. The legislation was accompanied by education and continual reinforcement, and people now use their seatbelts. Our work shows that smokers respect restrictions when they are in place. Some people may over-egg the pudding in relation to ensuring that people are not abusing a law that is in force. Evidence from New York is very positive indeed, and smoking rates there have come down by about 11 per cent since smoking was banned in the workplace.

Janis Hughes: So the ban is seen to be effective not due to the enforcement agencies but due to voluntary means?

Maureen Moore: The enforcement is there in Ireland, but inspectors have found that people are complying with the ban because they support it. A recent MORI poll showed that people in Scotland support a ban on smoking in the workplace and in public places. Nobody wants to put their health at risk to that extent. If your risk of heart disease and lung cancer is raised by between 20 and 30 per cent because of people smoking, that is unacceptable.
Janis Hughes: The voluntary scheme that has been in place has not been very successful. If it has not been successful, why do you think that the public will suddenly become compliant with a legal ban and not put undue demand on enforcement agencies?

Maureen Moore: The voluntary charter that is in place just now is for the leisure industry, and that approach is fundamentally flawed, because it is not about extending smoke-free areas but about informing customers that premises are smoking or no smoking. All that people have to do to comply with the voluntary charter is to put up a sticker, so of course that will not extend smoke-free areas.

Dr. Gruer: A ban would be successful if its overall conditions were broadly acceptable to the great majority of the public, but there would have to be sufficient teeth to enforce the ban and to ensure that the small proportion of people who might try to evade it could be brought to book. That seems to be the case in Ireland, where there are significant fines for the premises if someone is found to be smoking, so there is a big incentive for the owner of an establishment to ensure that people comply. That seems to be quite a clever mechanism for ensuring enforcement.

Mr. McNeil: It is fairly important to record that, when we legislate, it should be in support of public opinion. Only a few months ago, Mac Armstrong said that Scottish public opinion was not ready for a smoking ban. Tom McCabe, the Deputy Minister for Health and Community Care, has put on record his recognition of the gains that have been made from the voluntary charter. Given that background and given that the bill creates three criminal offences, do you think that the proposed legislation is proportionate to the problem?

Maureen Moore: Are you asking about a ban on smoking in the workplace?

Mr. McNeil: I am asking whether it is proportionate for the Parliament to legislate to put in place three criminal offences: smoking in a regulated area, permitting smoking in a regulated area and failing to display mandatory signs. The bill does not say how we should enforce those measures, which is a serious omission.

Maureen Moore: A ban on smoking in public places should be enforced. Such bans have never been respected in countries where they have been introduced. That is why I was trying to convey my anxiety about enforcement of the ban against all those people who decide to smoke where it is not allowed. For us, the limitation of the bill is that it does not ban smoking in the workplace. ASH Scotland believes that there should be such a ban, to protect the health of workers in Scotland.

The Convener: I have seen somewhere that it is not within the competence of the Scottish Parliament to ban smoking in the workplace, although I may be wrong.

Maureen Moore: You are right.

The Convener: There are restrictions in the bill in order to make it competent.

Mr. Davidson: Members of the Irish Government sat in this room and told us that it took 14 years to get to the position that they have reached. You appear to want us to get there overnight. That means that we would not be winning hearts and minds, proceeding on a gradual basis and allowing an educational process to work. Have you given up on that approach? Do you think that legislation is the only way in which to solve the smoking problem, bearing it in mind that the bill covers only one aspect of that?

The Convener: I ask Dr. Gruer to speak first.

Dr. Gruer: In Britain, there has been a gradual change in attitudes towards smoking in public places over a number of years, as evidence has built up. That development seems to be accelerating, as people recognise that the approaches that have been taken in other countries are bearing fruit. We can learn rapidly from other countries. We do not have to spend another 14 years cogitating on what is happening if we can see that a country next door is able to achieve something worthwhile.

From recent surveys of the general public, there appears to have been a substantial shift in mood. People have seen huge benefits in places where smoking has been banned, such as the London underground, trains and planes. We are seeing the benefits of the restrictions that have been placed on smoking in a number of areas in the past few years and we can build on those.

Mr. Davidson: Where does education sit in this process? The bill would hit adults who already smoke. What about the next generation? Is education finished, or does it have a role?

Dr. Gruer: Education has an important role to play. We have not done nearly enough to get across to young people—especially kids under the age of 13, many of whom have already started to smoke—exactly what they are getting themselves into when they smoke. They have no idea that smoking is a powerfully addictive behaviour. They think that they can have a few puffs and stop whenever they like. Evidence demonstrates that very quickly—often in a matter of weeks—kids are addicted to cigarettes and find it very difficult to stop smoking. We are not getting across to kids well enough the true dangers of cigarettes.

The Convener: I would like to develop that point, but we should keep to the bill. David Davidson has asked about education, which is an interesting issue, but we should bear in mind the
fact that we still have many questions to put. We are aware of the background of failed campaigns and of the invincibility of youth.

Shona Robison would like to ask a supplementary. She should relate that to her previous question to Maureen Moore, so that we can move on.

14:30

Shona Robison: David Davidson mentioned the need to win hearts and minds. Will you remind us of the results of the recent MORI poll? Do the results suggest that the public might be ahead of politicians in considering not just a ban on smoking in places that serve food, but a wider ban?

Maureen Moore: We must bear in mind the fact that different polls ask different questions. Certainly, a MORI poll in the United Kingdom that extrapolated the figures for Scotland showed something like 77 per cent support for a ban on smoking in public places.

Shona Robison: Do you deduce from that that the public might be ahead of politicians in wanting things to move ahead quickly?

Maureen Moore: There is real anxiety that a ban might turn people off, but the evidence does not suggest that that is the case. I know that the people who telephone ASH Scotland probably represent just one section of the population, but I consistently hear from, for example, people who have heart disease, people who have young children and pregnant women who do not go to public places because they are worried about their health. I hear from people who are concerned that they can take no action to protect their health in the workplace. We should not underestimate the concerns of the Scottish population.

Mr McNeil: I think that you acknowledge that there is a difference between asking a member of the public whether they support a ban on smoking in public places and whether they support restrictions on smoking in public places.

The Convener: Was there a question in there?

Mr McNeil: No, I just say that for the record.

Shona Robison: Can we clarify what question the MORI poll asked?

Maureen Moore: I have not seen all the questions. There are different polls and tabloid newspapers run their own polls, which produce different results.

The Convener: The committee can find out what the question was so that we can establish to what the figure of 77 per cent related.

Helen Eadie (Dunfermline East) (Lab): In some large public offices, smoking policies exist that restrict smoking to a designated smoking room. Often, however, there is a problem with the waft of smoke to neighbouring rooms. Do you have a view on the bill’s provision that a “connecting space” that is adjacent to a regulated area should also be a non-smoking area?

Maureen Moore: Yes. The problem when smoking is restricted, especially in big pubs, is that smoke wafts across. The smoke must be eliminated completely, so there must be a door or wall between smoking and non-smoking areas.

Helen Eadie: Is that adequate? Smoke, by its nature, is insidious and creeps everywhere.

Maureen Moore: A room would have to be physically protected from the smoke.

Helen Eadie: Extractor fans are needed, too.

Maureen Moore: Ventilation systems do not protect people from the health risks of passive smoking. We want smoking to be eliminated from the workplace.

Kate Maclean (Dundee West) (Lab): I was interested in what you said in your submission about ventilation and workplaces, because I am concerned, as is NHS Health Scotland, that the bill would protect some categories of employee but not others, depending on the nature of the business of the establishment. I was interested to read that even when the ventilated air in a bar has been judged safe, because the ventilation system provides for “a minimum of 12 air changes per hour”, it is estimated that “5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer”.

Have I understood your submission correctly?

Maureen Moore: Yes. Bar staff are the most affected because they work in the places where there are least likely to be smoking policies.

Kate Maclean: In effect, you are saying that, even if what might be regarded as good ventilation is in place and people are not made uncomfortable by smoke, five bar staff out of every 100 will contract a smoking-related illness.

Maureen Moore: Ventilation does not protect people, but it is being promoted by the tobacco industry, which says that the issue is about choice. It says, “Put ventilation in. That is the answer.” A lot of people are spending thousands of pounds doing that, rather than removing smoke from the workplace.

Kate Maclean: I am concerned about that, because in some of the evidence that we have
heard and in some of the written submissions that we have received ventilation has been proposed as a solution. I know that, although people can feel quite comfortable when they are in a ventilated area, they can still be suffering the effects of passive smoking, so only an outright ban would effectively protect employees.

Maureen Moore: Yes.

Dr Gruer: I agree. Ventilators do not filter out a number of the most noxious constituents of tobacco smoke, so ventilation gives a false sense of security. Ventilation systems work even less well if people who are smoking are close to those who are not smoking, because the smoke drifts across. Anyone who flew in an aeroplane before there was a complete ban on smoking in aircraft will know that, if they sat with someone smoking behind them, the smoke—even though it was supposed to be taken away at the rear—wafted around, which was unpleasant.

Kate Maclean: I realise that the issue of employee safety is reserved to Westminster, but we have a health interest in employees’ safety. An outright ban in all public places would be most effective in health terms.

Dr Gruer: That is the ideal, if your aim is to ensure that people who do not want to breathe tobacco smoke are not obliged to.

Mr McNeil: To achieve what you want to achieve, is the ultimate aim that people should not be allowed to smoke at all, including in, for example, public parks? Other countries are moving to the next phase—they are going beyond banning smoking in public spaces to banning it on public highways and in parks. Is that where ASH wants to go? Does it support a complete ban on smoking?

Maureen Moore: I speak for ASH Scotland. We want a ban in the workplace or in public places that are semi-enclosed or enclosed buildings. That does not mean public parks. There are rules for lots of things in society. When we have a product whose use affects other people’s health, we should take action to ensure that public health is protected. We do that with speed limits and we do it with seat belts. We do not allow other carcinogens in the workplace and we certainly should not be allowing this carcinogen in the workplace.

Mr McNeil: Do you support a total ban—

Maureen Moore: In the workplace.

Mr McNeil: Just in the workplace?

Maureen Moore: Yes.

Mr McNeil: You could never see yourself supporting a ban in a picnic area.

Maureen Moore: Why would we do that?

Mr McNeil: Because somebody could be smoking next to somebody else.

Maureen Moore: We hope that people will respect the people whom they are with. I have lots of smokers in my family and I know lots of smokers—

Mr McNeil: Some of my best friends are smokers.

Maureen Moore: I used to smoke. This is not about getting at smokers; it is about protecting public health and ensuring that we have policies to do that. That is all. ASH Scotland is not an organisation—

Mr McNeil: We will hear evidence later that some states in America are moving on from public enclosed spaces to outdoor spaces. I put on the record the fact that I am a reformed smoker; I stopped smoking 22 years ago. I believe that smoking kills and that people should not start smoking. However, we may have different views on how we encourage them to stop smoking and whether we should use legislation to do so.

The Convener: Not everyone should feel that they have to declare how long ago they stopped smoking.

Mr McNeil: I was responding to the implications of the witness’s statement.

The Convener: I understand, but I meant what I said. I do not want to take up time. If committee members are finished, I invite Stewart Maxwell to ask some questions.

Mr Stewart Maxwell (West of Scotland) (SNP): I want to clarify a couple of points that have come up. On public attitudes, you mentioned the MORI poll. Do you know of any other polling or survey evidence that supports the view that the public in Scotland support a full ban in public places?

Dr Gruer: No. However, given yesterday’s announcement by Tom McCabe that the Executive would start a public consultation on banning smoking in public places, we can expect that a substantial amount of excellent information on what the public think will become available over the next three or four months. By the end of that period, we will be in a good position to know exactly what the public’s attitude is.

Mr Maxwell: Is Maureen Moore aware of any other surveys?

Maureen Moore: There is other evidence, but I tend not to talk about the polls because I would need to see the questions that they asked. We could find more evidence if you like.
Mr Maxwell: I am simply trying to clarify that polls other than the MORI poll have shown support for a ban on smoking in public places. In front of me, I have a list of at least eight other such polls and surveys. As I am sure you are aware, the survey that was conducted by the Office for National Statistics also showed public support.

At present, the bill would apply only to places where food is supplied and consumed. That follows examples from other countries across the world that have started by banning smoking in those areas and have moved on to wider bans. The bill should be viewed in that light and as a progressive measure. If the will of the Parliament is not to go for a full ban in one go, would it be reasonable for it to legislate progressively towards a complete ban on smoking in public places?

Maureen Moore: We support the bill because we see it as a positive first step forward, but we expect that the ban would be extended. We want smoking in the workplace to be outlawed eventually.

Dr Gruer: If the next few months were to show that there was no support for an overall ban, a ban on where food is served could be a useful first step. However, now that we have seen what has happened in other countries, there is a realistic prospect of moving a bit more quickly. The problem about starting where the bill suggests is that it might then take a long time before we could move forward to other areas. It is also a little hard to determine the rationale behind focusing simply on places where food is consumed when places serving food such as crisps and other snacks would be excluded. That seems a rather arbitrary distinction. We are talking about finding a way of preventing members of the public and employees from being exposed to tobacco smoke, whether or not they are in a situation where food is being consumed.

Mr Maxwell: David Davidson mentioned education programmes. Should the attempt to denormalise smoking among adults and in society in general be part of such programmes so that we educate young people that smoking is not normal?

Dr Gruer: Absolutely.

Mr Maxwell: I assume that Maureen Moore agrees with that.

Maureen Moore: I support that. NHS Health Scotland recently had a whole load of adverts on passive smoking in the workplace, in the pub and at home. That covers the whole spectrum.

Mr Maxwell: On the voluntary charter, can you confirm that it is perfectly possible for pubs and other licensed premises to comply with all four parts of the charter without providing any protection against the dangers of passive smoking?

Maureen Moore: Absolutely.

Dr Gruer: That is correct.

Mr Maxwell: In other words, the fact that premises comply with the voluntary charter does not mean that there is protection for workers or customers in those premises.

Maureen Moore: Yes.

Dr Gruer: That is right.

The Convener: Stewart Maxwell has asked what we in the trade call leading questions. Does anyone have any further questions?

Mr Davidson: Maureen Moore said that the ban would not be an attack on smokers. What element of choice should people have?

Maureen Moore: What do you mean by "choice"?

Mr Davidson: People want to do different activities. You said that any attack should not be against smokers as such but against smoking, which we hope to wean people off. If I may link back to what I said earlier, we want to prevent a new generation from smoking, but we have a current generation that is in the middle of it all. What provisions of choice should those people have or do you not believe that they should have any choice?

Maureen Moore: If a person uses a product that affects other people’s health, they must use it responsibly. Whatever a person does, they must do so responsibly. A ban on smoking would be no different from the speed limit, which I have to drive within and which is a public health initiative to protect people. Of the Scottish population, 70 per cent do not smoke and 30 per cent smoke. Most smokers want to stop. A ban in the workplace would help smokers to stop—as Laurence Gruer said, it would reduce their exposure to the cues to smoking. A ban would be positive for everybody. If somebody wants to smoke, they can do so, as long as it does not affect other people.

Dr Gruer: In a just and fair society, we must provide choice within limits. It is up to society to determine to what extent people can exercise their choices. If an action is potentially harmful to other people, we must consider carefully how the choice to act in that way might be limited for the benefit of the wider community. If a choice has no impact on other people, I am happy for people to exercise it.

The Convener: That concludes our questions. I thank both the witnesses.
We will now hear from the second panel. While we wait for the nameplates to be changed, I remind members that the relevant papers are HC/S2/04/15/4, from FOREST, and HC/S2/04/15/5, from the Tobacco Manufacturers Association. I welcome Simon Clark, the director of FOREST, and Tim Lord, the chief executive of the Tobacco Manufacturers Association.

Mr Davidson: What evidence can the witnesses produce to back the view that environmental tobacco smoke is not a significant health risk?

Tim Lord (Tobacco Manufacturers Association): That is a good point with which to start. All the various epidemiological studies demonstrate that the risk factor involved in passive smoking would not normally be deemed to be significant. Normally, in epidemiology, studies look for a risk factor in excess of 2, or sometimes 3, but studies on passive smoking show an average risk factor of about 1.25 or 1.26. The studies that have been undertaken are not conclusive proof that passive smoking causes disease and are not sufficient in themselves to warrant a ban on smoking in public places.

The issue is complicated. If I may be so bold, I encourage the committee to have experts on epidemiology explain the background. Rather than take my word for it, committee members should hear from epidemiologists about relative risk and the studies that have been done so that they can understand the evidence. The Greater London Authority did that when it considered the issue and it concluded that the evidence was not sufficient to justify a ban on smoking in public places.

Simon Clark (FOREST): In recent years, there have been several investigations into the effects of passive smoking. For example, in 1999, the Health and Safety Commission carefully examined the issue, because it was thinking about introducing an approved code of practice on smoking at work. After taking evidence from all sides of the smoking debate, it concluded that the state of the scientific evidence made it very difficult to prove a link between passive smoking and ill health. Members might well point out that that happened in 1999, but the approved code of practice has never been introduced. Presumably, if outstanding proof of a link existed, a code would have been introduced.

Tim Lord mentioned the GLA, which set up a special committee to examine the matter. That committee met in November 2001 and, like this committee, took evidence from all sides of the smoking debate. When it published its report in April 2002, Angie Bray, one of the co-authors, said:

"After taking evidence from all sides, including health experts, it was decided that the evidence gathered did not justify a total smoking ban."

Last year, the British Medical Journal published the results of a huge American study that covered a database of 116,000 people over many years. The study, which went through a rigorous peer review process before it was published in the BMJ, concluded that the health risks of passive smoking might have been exaggerated. Although it is very difficult to prove that passive smoking is not harmful, bodies such as the Health and Safety Commission and the GLA have spent much time and effort taking evidence from all sides and have found it impossible to justify the introduction of legislation that bans smoking completely.

Mr Davidson: What about the statistics on which other groups in favour of the bill have based their evidence?

Simon Clark: I find it interesting that, a couple of weeks ago, the Royal College of Physicians published a report claiming that one bar worker dies a week as a result of passive smoking. My simple question is: where is the hard evidence for that? The RCP has been quick to come up with estimates and calculations, but I am afraid that it has produced no hard evidence whatsoever. Estimates and calculations are not sufficient when it comes to formulating legislation that will provoke a severe social change throughout Scotland and the United Kingdom. We have to be careful with statistics because people can use them to make all sorts of arguments. People who say that passive smoking kills must come up with some hard evidence.

Again, I will quote the editor of the BMJ, Dr Richard Smith, who is no fan of tobacco. In fact, he resigned a previous post at the University of Nottingham because it took sponsorship from British American Tobacco. Last year, he said:

“We must be interested in whether passive smoking kills, and the question has not been definitively answered.”

The question needs to be answered definitively before we pass draconian legislation that bans smoking in all public places.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I want to direct my question at Tim Lord. Does your product kill people?

Tim Lord: Yes, through direct smoking.

Mike Rumbles: So you accept and believe that your product kills people. In light of the responses that you and your colleague have just made, do you believe that passive smoking kills people? A yes or no would be helpful.

Tim Lord: No, I do not.

Mike Rumbles: That is very helpful.

I strongly believe in an individual’s freedom to choose what they want to do with their lives. You have accepted that smoking kills people and I feel
that it is up to them whether they want to smoke cigarettes and kill themselves. However, the bill is about the effect of people's choices on other people. Do people who go into a restaurant or a bar that serves food have a right to breathe clean air?

Tim Lord: In this day and age, it is completely reasonable for pubs and restaurants to have smoke-free environments to allow people to choose whether to smoke when they go in—

Mike Rumbles: Do they have a right to breathe clean air? I would prefer a yes or no answer to that question.

Tim Lord: I am not willing to give such an answer, because it is premised on whether breathing in other's people smoke—in other words, passive smoking—is harmful or not.

Mike Rumbles: I will give you an example of what I mean, if I may. Two people walk into a restaurant. One of them has a problem with their lungs and they are offered a seat in a no-smoking area. They are enjoying their meal out together, when somebody lights up a cigarette at the other end of the room and the smoke comes across. The person with the lung problem suffers because of the cigarette smoke wafting into the area. Are you trying to tell me that that scenario does not happen?

Tim Lord: Of course not, because there are restaurants in Scotland in which there are smoking sections and no-smoking sections in the same room. We believe that there should be a greater provision of smoke-free areas; the issue is how to achieve that and whether legislation is needed. If we believed that passive smoking was a cause of disease, the debate would be different. All that we are saying is that the evidence does not demonstrate that it is a cause of disease. We ask you to examine that evidence and have an expert in epidemiology explain it to you so that you can make an informed judgment.

The Convener: It would be for the committee, having had all the evidence, to decide whether it wished to take any such further evidence.

Mike Rumbles: To sum up—I want to ensure that this is absolutely clear—you admit that smoking kills people, but you do not admit that passive smoking kills people.

Tim Lord: Correct.

Mike Rumbles: You also refuse to answer my specific question about whether people in Scotland have the right to breathe clean air if they go out for a meal. You will not say yes or no to that.

Simon Clark: May I answer that question?

Mike Rumbles: I asked Tim Lord.

Tim Lord: I am saying that there should be greater provision of smoke-free areas and smoking areas, because people may or may not like to have smoke around them when they are eating. I am also saying that people should have that information before they walk into a bar or restaurant so that they know what to expect.

Mike Rumbles: Are you saying that, if somebody walked into a completely free and clean atmosphere and somebody else lit up in another part of the room, they would have no right to eat in a clean atmosphere?

Tim Lord: If a room is designated as a no-smoking area, nobody should light up in it. There are things that all pubs and restaurants should do: they should have signage up at their entrances telling customers what to expect so that the customers know. A bar or restaurant is a private place that is owned by a businessman and individuals do not have to go into it. It is important that people know what to expect when they walk into the bar or restaurant; the need for more no-smoking areas is consistent with that. Pizza Hut is a good example of that, as I am sure you are aware. The company knows that parents go to its restaurants with their children, so it decided to ban smoking, because it felt that the restaurants were an inappropriate place for children to be exposed to smoke. I think that that is absolutely right.

The Convener: I will let Mr Clark in when I get supplementary questions.

Kate Maclean: Mr Lord, in your submission and in response to David Davidson’s question, you said that a number of epidemiological studies have been carried out. How many studies have been carried out and when were they carried out? Moreover, your submission says that the studies assessed the risk of lung cancer in non-smokers who lived with smokers. Have any other assessments been made of other smoking-related illnesses in passive smokers or non-smokers who live with smokers?

Tim Lord: There certainly have been other studies on risks other than lung cancer, which produced the same sort of risk factor as the one that I mentioned. On the number of studies, I think that there have been about 60 on lung cancer, but I will have to confirm that for you, which I will be happy to do after the meeting.

Kate Maclean: Do you know when the studies were carried out?

Tim Lord: Not off hand, but I will give you the answer to that with pleasure.

15:00

Kate Maclean: You and Mr Clark will both be interested in studies that have been conducted on
passive smoking. Are you aware of whether more scientific evidence comes down in favour of your argument or in favour of the argument that passive smoking affects other people’s health?

Tim Lord: I think that about 60 studies have been done on lung cancer. From analyses of those—work that third parties have done, not that we have done—the average risk factor is 1.26 or, sometimes, 1.3. Those numbers are quoted to demonstrate a higher risk of someone getting cancer if they live with a smoker as opposed to a non-smoker. The numbers are frequently headlined as showing a 26 per cent or 30 per cent increase in the risk of getting cancer. That is a misleading way of representing the results of those studies. In fact, we quote in our submission what the percentages represent, which is a marginal increase in the risk of getting cancer. In epidemiology, when the risk factor is below two, the risk is not normally deemed to be significant, as the result could be explained by external factors such as biases, confounding factors and so on. In the language that many groups use, there will be a 100 per cent increase in risk, but that will not normally be deemed to be significant if the risk factor is below two. That is not me talking; that is epidemiologists talking.

The Convener: It would be helpful to the committee if you were to give us a list of those research surveys that contain that information so that we can examine it.

Kate Maclean: The majority of people in Scotland have a general impression that passive smoking is dangerous to health. It would surprise me if that were not the case. I would have thought that well-funded organisations such as yours would be able to refute that impression if it were not the case.

Tim Lord: It is a matter of interpretation of the statistics. For reasons that are difficult to understand, many people interpret those kinds of risk factors as demonstrating significant increases in risk, but epidemiologists around the world would not agree with that interpretation.

Simon Clark: I return to the original question: do people have a right to breathe clean air? I have no doubt about my answer to that—people do not have a right to breathe clean air. Let us get the question into perspective; we have to be practical about the matter. We live in an urban, industrial society. We are surrounded by car fumes; we are surrounded by chemicals from furnishings, carpets, wallpaper and paint work. In our society, nobody has a right to breathe clean air. In a perfect world and a utopian society, of course we would all like to breathe clean air, but that is not how the world is.

Therefore, we need to come up with practical solutions, which is what this situation is all about. It is not about ideology and telling people that they have to give up smoking because it is a dirty, disgusting habit; it is about accepting the fact that there are still 1.2 million smokers in Scotland and 13 million smokers throughout the UK. Some of those people want to give up smoking, but a great many wish to continue. Therefore, we have to find ways of accommodating smokers without inconveniencing the non-smokers.

I agree completely with what Tim Lord said earlier—that we are moving in the right direction. The hospitality industry has made great strides in recent years to introduce more non-smoking areas and to improve ventilation—perhaps we can go into ventilation in more detail later on. A number of pubs in Glasgow and Edinburgh are already going non-smoking and that trend will accelerate over the next few years. For example, by the end of this year, the Laurel Pub Company hopes to turn 50 or 60 of its 630 pubs into non-smoking pubs. I reckon that if that company is left to its own devices to pursue those types of policies on a voluntary basis, probably 200 or 300 of its pubs will go non-smoking over the next two or three years. The company has said clearly that it does not want all its pubs to go non-smoking and it certainly does not want legislation to force it to ban smoking completely because it says that, in some of its pubs, 70 per cent of the customers smoke. It is a question of finding some acceptable compromise. I do not accept that people in an urban, industrial society have a right to breathe clean air. To speak of rights in this argument is dangerous; we do not talk about smokers’ rights. We have dropped that type of language, which was used 10 or 15 years ago.

The Convener: It seems that you are talking about the rights of someone to choose or choose not to smoke.

Simon Clark: I disagree—I think that it is a question of being practical. Many people choose to smoke, but they do not have a right to light up wherever they want to—that is the point. Ten to 15 years ago, people would say, “If I want to smoke, I’ll smoke,” but I do not know any smoker nowadays who thinks that they can walk into a room such as this one—in which, I presume, there is a no-smoking policy—and light up. That is what I mean by rights. We have dropped talk about smokers’ rights in that respect.

Equally, it is important to discuss examples such as that which Mr Rumbles mentioned involving somebody suffering from a problem with their lungs and walking into a pub in which people are smoking. A person in such a situation—which is not common—will have to adapt their lifestyle to suit their illness, just as a person who suffers from...
asthma must adapt. My wife suffers from asthma, which is set off by cat and dog hair, and she must adapt her life accordingly. She does not demand legislation that bans cats and dogs. An interesting fact is that the number of asthma cases has tripled in the past 30 years, while the number of smokers has halved, so it is wrong to draw a connection automatically between asthma and smoking. Furthermore—

The Convener: I do not think that the committee would say that the increase in the number of asthma cases could simply be put down to cigarette smoke. There are other reasons for that increase in society.

I would like to stop you there, if I may. I was going to let in Mike Rumbles to deal with the right to clean air. Shona Robison can then ask a supplementary question and we can go straight on to the next issue.

Mike Rumbles: I am grateful for Simon Clark’s response because his colleague was reluctant to—

Simon Clark: He is not my colleague. We represent separate organisations.

Mike Rumbles: Your fellow witness was reluctant to give me a yes or no answer. You have been straightforward and have made the remarkable statement that nobody has the right to clean air. I also noticed that you did not deal with the example that I gave. If I may be so bold, I said that I have experience—let me put it that way—of trying to find hostelleries and restaurants in which people do not smoke, so that a person can sit down of an evening and have a meal out. You are saying that it is up to them and that they can go somewhere else. You have no sympathy whatever with anybody who has a health problem or a disability who is trying to get out of the house and with anybody who has a health problem or a disability. Of course I have sympathy. We are saying that people have a right to breathe clean air. If a person believes that people have a right to breathe clean air, they should go out into Princes Street. I am sorry, but we are not living on the same planet if such people think that the air in Princes Street is clean. Those people should also campaign to ban all cars.

The Convener: I would like to move on, please. Shona Robison has a question.

Shona Robison: You say that passive smoking has no detrimental health effects.

Simon Clark: No. We are not saying that passive smoking has no side effects, but that the evidence does not justify a total ban on smoking in public places. I am aware of 123 studies.

Shona Robison: I turn to the evidence. Are you aware that the United States Environmental Protection Agency has classed environmental tobacco smoke as a class A human carcinogen—a cancer-causing agent? Do you think that the agency is wrong?
Simon Clark: Let me put it this way. As long ago as 1992, the US Environmental Protection Agency claimed that there was a link between passive smoking and lung cancer. In 1997, its report was thrown out by a federal court in the United States because it was alleged that the agency had fiddled the figures to come up with its results.

Shona Robison: I did not ask you about that. I asked whether you disputed the claim that environmental tobacco smoke is a class A human carcinogen.

Simon Clark: I am sure that there are carcinogens in environmental tobacco smoke, but there are also carcinogens in cups of coffee. Why are we picking just on cigarettes?

Shona Robison: Because environmental tobacco smoke is a class A human carcinogen. The Environmental Protection Agency has not classed a cup of coffee as a class A human carcinogen, but it has classed tobacco smoke in that way.

Simon Clark: That may be true, but it is still necessary to provide hard evidence that people are dying as a result of passive smoking. That case has not been proved.

Shona Robison: Let us argue through the issue. If you accept that tobacco smoke is a class A human carcinogen, do you not also accept that it is unlikely to be good for human health?

Simon Clark: That is like trying to prove a negative. It is up to you to prove that passive smoking is killing people and clearly that case has not been made. The Health and Safety Commission has examined the matter.

Shona Robison: Is your argument not reminiscent of the way in which the tobacco industry used to argue that smoking was not dangerous to human health? It is not long since the tobacco industry argued that it was for others to prove that smoking was dangerous.

Simon Clark: The issue of passive smoking was first raised as long ago as 1975, so the anti-smoking lobby has had almost 30 years to prove the case that passive smoking is killing people. Clearly, it has still not done so. I will give members a brief history lesson.

The Convener: No—we do not want a brief history lesson.

Shona Robison: How long did it take the tobacco industry to accept that smoking was dangerous?

Simon Clark: You are addressing that question to the wrong person. Tim Lord represents the tobacco industry.

Shona Robison: FOREST is funded by the tobacco industry.

Simon Clark: What point are you trying to make?

Shona Robison: I am making the point that your interests may be similar in some respects.

Tim Lord: Believe or not, we are trying to be reasonably objective. We do not conduct studies of passive smoking. Such studies have been done by third parties over a considerable period and have produced results. The results show what epidemiologists call risk factors. As I have said before, those factors are not at a level that would normally be deemed to show a significant relationship. The risk factors for other products, such as diesel fumes, are much higher, but it is not concluded that there is a need for legislation in those areas. That is why I suggested, slightly boldly, that it would be good for the committee to have an epidemiologist explain to it exactly how the methodology works, what a reasonable result is and how to interpret results. We do not see that there is a relationship of the sort that has been suggested. We do not say that passive smoking is not detrimental to human health, but that we do not know and we do not think others know.

We are talking about smoking in public places. All studies of passive smoking have been done in the home. Some have been done over 30 or 40 years; one has been done over 20 years. People are asked how much they were exposed to smoking more than 20 years ago by their spouse, who will often have passed away. First, there is a recollection issue. Secondly, the studies relate to in-home smoking, rather than smoking in public places, which we are discussing today.

Shona Robison: I am sure that the committee will want to examine the studies in more depth. In your evidence you say that preventing people from smoking amounts to social engineering. Is discouraging smoking not a social good?

Simon Clark: We have always said that Government has a clear role to play in educating people about the health risks of smoking, of eating too much and of drinking too much, but when it comes to enforcing a smoking ban in order to make people give up, that is a form of social engineering, which is wrong. It is not what democratic Governments should be about. There is a clear element of choice in this argument.

There are two reasons why the people behind the bill would like to ban smoking. First, it is to encourage and help people to give up. Secondly, it is because of passive smoking. Perhaps we have gone round in circles with the passive smoking
argument, but we do not believe that it is the role of a democratic Government to introduce legislation to force people to give up. By all means educate, but we should have education, not legislation.

Shona Robison: Your submission states:

“it ignores the important concept of personal responsibility and adopts the outdated notion that ‘nanny knows best’.”

Does nanny know best about making people wear seat belts?

Simon Clark: Personally, I do not think so, but people have accepted that law over the years. I do not think—

Shona Robison: Did you disagree with that law being brought in?

Simon Clark: I was only a child when it was brought in, so I did not have a strong view on it.

Shona Robison: Do you think that it is unnecessary?

Simon Clark: It is one of those things that people have accepted over the years. Government has to draw a line as to how far it goes. For example, there is a lot of talk in the obesity debate about banning junk food advertising that is aimed at children. There is talk about increasing taxation on fatty foods and dairy products. That is relevant to this debate, because we have to start asking ourselves how far Government is going to encroach on people’s lives and choices. I believe strongly that people should be allowed to make choices.

To return to what Tim Lord said, we must emphasise that we are looking at a compromise solution. We do not believe that people have a right to smoke wherever they want. We are saying that there are some people who want to give up smoking, and no doubt a smoking ban will help them, but why should other people be discriminated against just because there are some people who wish to quit? Surely the ideal scenario is a society in which there are bars and restaurants and other public places where people who wish to smoke can go, and there are plenty of other, no-smoking places where those who wish to give up and do not want to be tempted and non-smokers who are bothered by other people’s tobacco smoke can go.

I am a non-smoker, and I can honestly say that I have never been bothered by other people’s tobacco smoke. I know a lot of people like me. It is a question of coming up with choices.

The Convener: I do not share that view. Meals and atmospheres are destroyed by cigarette smoking.

You say that people have choices, but what choice do workers have, even if there are designated areas, when they have to go in and out of them? If one accepts that passive smoking endangers health and can endanger life, why should those people be put in that position?

Simon Clark: I do not want to be boring, but I return to the point that it has never been proven conclusively that passive smoking—

The Convener: But if you accept that premise, having designated areas will not work.

Simon Clark: I accept that, but there are many of us, including some scientists, who do not accept that premise, which is crucial to the argument.

Bar workers do have a choice. I have never seen a bar worker in handcuffs being frogmarched into a pub and being told to work behind the bar. It simply does not work like that. In a few years’ time, there will be a lot of no-smoking bars and restaurants, where those people who choose to work in a completely smoke-free atmosphere can work.

We have made great improvements in recent years in the number of no-smoking areas. We have no problem with, for example, a ban on smoking at the bar. If people choose to exert that option, that is fine. It is up to the individual owner to discuss those things with their work force. That is what real local democracy should be about. It is for the owner to speak to his customers and work force and find a policy on smoking that they are happy with. There will then be a range of different venues that people can choose to go into and work in.

The Convener: Does Tim Lord wish to comment on the effect on employees of having designated areas?

Tim Lord: The industry feels that the current situation is unacceptable. We feel that there should be many more no-smoking bars and no-smoking facilities. The question then is how we get to that point. Independent of the science, our view is in some ways the same as the view that lies behind the bill, but we are asking how we can deliver more smoke-free places—for the benefit of workers and the smoking and eating public—without going so far as to have a ban. May I talk a little about how that might be done?

The Convener: I will certainly let you back in later, but a couple of members have supplementary questions, so you may develop the point with them.

Mike Rumbles: This evidence session has convinced me as never before that I will support the bill. Because of the strength of the evidence that we have heard, I waive my right to ask any further questions of these witnesses.
Kate Maclean: I want to ask a brief question that I hope will require only a yes or a no. It is about choice. If we have the status quo, or a situation in which there are smoke-free areas in restaurants and bars, should someone who has a baby or a child be allowed to take that baby or child into the smoking areas?

Tim Lord: Common sense suggests that that would be very unwise.

Kate Maclean: But should they be allowed to?

Tim Lord: By law?

Kate Maclean: Or by a voluntary code.

Tim Lord: It would be very unwise to expose children and babies to smoke in any form. Doing so would not make sense.

Kate Maclean: If passive smoking carries only a negligible risk, why would it be a problem to allow children to be exposed to it?

Tim Lord: I accept that there is an inconsistency, but I just think that it would be unwise. That is why I support what Pizza Hut did. Pizza Hut understands who go to its restaurants—children and their parents—and understands that parents want their children to eat their pizzas and drink their cokes in a smoke-free environment. Pizza Hut delivered that, which showed common sense.

Kate Maclean: What does Simon Clark think?

Simon Clark: It is interesting that the local council in Dundee gave bars the choice: either they could have a children’s licence or they could allow people to smoke.

Kate Maclean: Well, the condition for the children’s certificate was that bars would have to provide a smoke-free area for children.

Simon Clark: Yes and I thought that that was a good compromise. It gave an element of choice to owners as to whether they wanted to aim their businesses at a family clientele, or at adults only, allowing smoking throughout. The compromise reached was reasonable and could be considered nationally.

Kate Maclean: But interestingly, all the Dundee licensees withdrew from having children’s certificates. However, my original question was, if we do not legislate and instead leave things to choice—and obviously it will be parents who make the choice because children and babies cannot—should parents be allowed to take children or babies into the smoking part of the restaurant rather than the non-smoking part?

Simon Clark: I do not think that you can legislate for that. Ultimately, the argument comes back to what Tim Lord was saying about smoking in the home. If you legislate to stop parents taking their children to a smoking area, you will find a fine line between that and legislating to stop parents smoking in the home, which would be a dangerous road to go down. If you were realistic, you would say that if there is a risk to children, it will be in the home and not in public places.

I am a parent with children aged nine and seven, and I have no problem finding bars that are virtually smoke free. I take them to J D Wetherspoon, for example, which has very large no-smoking areas and I can honestly say that we are not surrounded by a fog of cigarette smoke.

Helen Eadie: I want to ask about a theme raised by the convener—that of the rights of employees. I remember that, in 1995 or 1996, a particular court case featured heavily in the national newspapers, in which an individual had taken their employer to court. Was there an outcome to that case, and how many such cases have come to court? How many industrial tribunals have there been? Have things always been settled out of court? What sort of figures have been involved?

Simon Clark: I cannot claim that my knowledge is definitive, but I understand that in the 25 years since the arguments about passive smoking were first made, only two cases have come to court in the United Kingdom in which an employee has tried to sue their employer over illness caused by passive smoking. One of those cases was in Scotland—that is probably the case to which you are referring—and one was in England. In both cases, the plaintiffs lost due to a lack of evidence. Last year a person who had worked for about 13 or 14 years in a Chinese casino in London received £50,000 in compensation, but the casino did not admit liability. I think that one or two other cases might have been settled out of court in which people received about £4,000 or £5,000, but I would have to look that up.

Obviously, it is a difficult area. Inevitably, some companies settle out of court because they do not want to bear the cost of an expensive court case. If they win—and the evidence suggests that they probably will win, because no such case has been proved in court—they will probably not recover their costs from the plaintiff.

The Convener: The flip side is that if they were to lose the case, a principle would be established in the law and many cases would be opened up.

Simon Clark: Sure. However, to my knowledge, that has not happened yet.

The Convener: I just added that for balance.

Tim Lord: I would be happy to write to the committee if it wants a more definitive answer.
**The Convener:** We can find out for ourselves whether there has been litigation in the Court of Session or in tribunals.

**Janis Hughes:** What are your views on the potential economic impact of the bill?

**Tim Lord:** That question might be best asked of people in the hospitality trade. The people who run pubs and restaurants understand their business better than I do. I can report only what I have heard about the impact on businesses in other parts of the world, but there are not many countries in which smoking has been banned in public places.

In Ireland, where the ban has been introduced only recently, there seem to be two issues: compliance, and the economic impact. Compliance seems to be quite high. Indications from the Government and the hospitality trade are that the percentage of compliance with the ban is in the high 90s. Recently the Licensed Vintners Association of Ireland produced a report that said that its pubs are reporting that business is down by 12 to 15 per cent.

**Simon Clark:** We heard that news from Ireland just last week.

In New York, both sides are spinning like mad to try to prove that the hospitality industry is losing money or that it is making more money. The United Restaurant and Tavern Owners of New York has clearly said that some bars—not all, but some—have lost as much as 40 per cent of their business since the smoking ban and the New York Nightlife Association says that some clubs have lost up to 15 per cent of their business. Why would those organisations make those figures up? Believe me, the hospitality industry is not in business to keep smokers happy; it is in business to make money. If the industry thought that it was making more money as a result of the smoking ban, I am sure that it would be delighted and that its representatives would be the first people to say so. However, reports from New York and now Ireland indicate that there is a problem.

I will mention what happened to some non-smoking pubs in this country. Some pubs have reported that their policy has been a great success and I have no doubt that that is true. Because relatively few pubs introduce a no-smoking policy, the ones that do so get a lot of publicity, which means that they get more customers. Equally, however, many pubs have been forced to reverse a ban on smoking a few months after introducing it. For example, last year on the Isle of Man a pub banned smoking but reversed the ban three months later because it had lost revenue. The same thing happened in Chester, where the first pub in the town went non-smoking in December but reversed the policy in March. There was a well-publicised case in February when the University of Leeds student union bar—the biggest student union bar in Europe—banned smoking. In a month, it lost £26,000 in revenue and had to reverse the ban. It is a bit hit and miss at the moment.

I think that there is a niche market for no-smoking pubs and we would welcome such an initiative. We would be the first people to support any individual pub or restaurant that goes no smoking because we genuinely want there to be more choice. If more pubs and restaurants go no smoking, that supports our argument that the hospitality industry can be left to devise a reasonable choice of policies of its own volition, without the need for legislation to force it down that route. We very much support no-smoking pubs, but banning smoking in a pub is an economic risk. That is why the hospitality industry is naturally nervous about doing it.

In a widely publicised statement a few weeks ago, Tim Martin, the managing director of J D Wetherspoon, said that he would support a blanket ban on smoking by 2006, because he wanted a level playing field. He said that if Wetherspoon unilaterally banned smoking, it would lose business to other pubs, so it is clear that the industry is nervous about it.

**Janis Hughes:** You mentioned evidence from New York and I notice that you have also referred to it in your written submission. Is there any published evidence to back that up?

**Simon Clark:** Yes. I can give you the quotations that we have received from the United Restaurant and Tavern Owners of New York.

**Janis Hughes:** Those are quotations, but I am interested in the statistics to back them up. We have heard of a report that says that business tax receipts were up by 8.7 per cent in the nine months to January of this year.

15:30

**Simon Clark:** That came from the city authorities, but we must bear it in mind that smoking had already been banned in restaurants in New York, so the city authorities were just tying up the loose ends by banning smoking in bars. When they talk about the hospitality industry, they include Starbucks, McDonald’s and all those sorts of places. We have to remember that New York has been recovering from a severe downturn after 9/11, so the economy was on the way up anyway.

**Tim Lord:** It is fair to say that the figure that you have quoted is an accurate number and one that I have heard mentioned before. The other number that I have seen is the statistic on employment in New York city, which shows that after 9/11
employment levels in the so-called hospitality industry dropped dramatically but have now risen to the same levels as at 9/11. In the whole of New York state, the number is up by about 10,000. To say that that rise of 10,000 and the 9.2 per cent increase in receipts—I think that that was the figure that you quoted—are purely due to the smoking ban is a jump because, at the same time, there has been an uplift in the US economy. Having lived in New York myself, I know that the economy there tends to go up and down quite dramatically. It would be interesting to get that analysis done. I have not seen an analysis that can relate rises in employment or in receipts solely to the smoking ban.

**Simon Clark:** The New York Nightlife Association polled 240 New York establishments; 78 per cent of respondents said that the smoking ban had had a negative effect on business and 28 per cent said that revenues had dropped dramatically. On average, establishments reported a 17 per cent decline in the numbers of waiters and waitresses they employed and there was an 11 per cent decline in the number of bartenders.

**The Convener:** From what paper are you quoting those figures? Can we have a copy of it?

**Simon Clark:** Of course you can. The information is from our website, but we got the figures directly from the New York Nightlife Association. I can get you the original fax.

**Janis Hughes:** How do you respond to the argument that, as 70 per cent of people do not smoke, a smoking ban would benefit bars because people such as me would be more inclined to go to them if they had a smoke-free environment?

**Simon Clark:** There are many non-smokers, like me, who do not mind a slightly smoky atmosphere. We are no longer living in the 1950s, when 80 per cent of the male population smoked and when, by all accounts, pubs, bars, restaurants and even business venues were incredibly smoky places.

**Janis Hughes:** Some of them still are.

**Simon Clark:** I accept that there are still places like that, but there are many places where one can go these days that are not particularly smoky and where a little smoke does not bother many of the people. Again, the matter comes down to choice. Some non-smokers would be attracted to smoke-free bars, but the results of bars so far have been a bit hit and miss. I mentioned some pubs in the UK; some have done quite well by banning smoking and others have found that their revenues have dropped dramatically.

**Helen Eadie:** The bill proposes a ban on smoking in regulated areas. Do you have a view on which areas should be regulated?

**Tim Lord:** I do not think that we should have regulated areas and I do not think that we should have legislation to ban smoking. However, I believe, and the industry believes, that there should be many more smoke-free restaurants and pubs, either through a regime of completely smoke-free restaurants and pubs or through a system of partially non-smoking places.

We think that the solution to that would be for the Scottish Executive to set targets for the hospitality industry on smoke-free pubs and areas, and on preventing smoking at the bar, for example. Although people are not very happy with the outcome of the charter that is referred to in the policy memorandum to Mr Maxwell’s bill, it is interesting to note that, with one exception, all the targets that the Scottish Executive set were exceeded dramatically, so it appears that the hospitality industry can deliver.

We suggest that the fifth option in Mr Maxwell’s bill ought to have been a second voluntary agreement that set aggressive new targets with timescales within which they should be delivered. Legislation should be brought in if the industry could not deliver on that.

**Helen Eadie:** May I ask a supplementary question, convener?

**The Convener:** I was trying to keep to the specific issue of which areas should be regulated. I take it that the witnesses have no views about that.

**Tim Lord:** No.

**The Convener:** That is really the answer.

**Helen Eadie:** I wanted to ask about the Health and Safety Commission’s approved code of practice on passive smoking. I am told that, when that is implemented, it will have the effect of banning smoking in most working places. Do you not support the view that there should be a designated area?

**Tim Lord:** There is not an ACOP on the table at the moment.

**Helen Eadie:** We have received evidence that states:

“The Health and Safety Commission’s Approved Code of Practice on Passive Smoking will, when implemented, effectively ban smoking in most workplaces.”

**Tim Lord:** I am sorry. My understanding is that, although the Government was considering having an ACOP—it was in the Government’s white paper, “Smoking Kills”, in 1998—the idea has since been shelved. From talking to a member of the House of Lords, where the matter was being discussed, my understanding is that the Health and Safety Commission is no longer progressing the ACOP.
Helen Eadie: Perhaps we can check that.

Mr Davidson: I have a follow-up to Helen Eadie’s question about regulated spaces. Mr Maxwell’s bill refers to an area that is called a “connecting space”—in other words, a space that creates an air lock, as opposed to just a door, which can blow backwards and forwards and allow smoke to pass through. What is your view on that as part and parcel of the proposal that separate areas be provided in pubs and restaurants?

Tim Lord: That and the five-day rule will make the bill very complicated to implement. Given the geography and layout of many pubs, it would be difficult to maintain choice. The designation of a “connecting space” seems to be an unnecessary complication. Does that answer help?

Mr Davidson: Yes.

Simon Clark: I agree with Tim Lord. Individual proprietors need the flexibility to develop policies that suit their businesses. In a large pub or restaurant, there is obviously a much greater opportunity to have a separate smoking room that keeps the smokers well away from the non-smokers.

Other bars could implement a ban on smoking at the bar. A few months ago, I was in Swansea, where the first no-smoking bar in Wales had recently been introduced. We welcomed that. Just down the road from that bar, there is a pub where the landlord is a smoker and, because he does not want children in his pub, the clientele is made up entirely of adults. He has, however, introduced a ban on smoking at the bar, on the ground that it is not pleasant for his bar staff to have smoke wafting over the bar. He has enforced that by telling customers that they will not be served if they smoke at the bar. Everyone accepted that amicably and I think that that is the way we should be looking to go. Each individual bar or restaurant should devise a policy that suits its circumstances.

Mr Davidson: The bill states that, as well as the regulated area, there would be an air lock—a clean area—between the regulated area and the smoking area. What do you think about that? It will continue to be part and parcel of Mr Maxwell’s bill if the bill is agreed to in its present form. Obviously, there is an economic issue. An area away from the bar in which smoking was allowed would not be the same as what would be required under the bill: we want opinions specifically on the bill.

Simon Clark: My feeling is that that provision would complicate matters. I suspect that it is designed to make it harder for places to have smoking areas and that its result would be, in essence, a smoking ban. I do not understand how the idea of an air lock, or space between two areas, would work.

Mr McNeil: References have been made to the white paper “Smoking Kills”. ASH’s written submission states that the measures in that paper would clearly not be effective. You will have a chance to respond on that point. ASH also cites the Health and Safety Executive’s point that “ventilation systems cannot be seen as an acceptable solution” and argues that, as a consequence, the voluntary charter is unworkable. Given the questions about how quickly the hospitality industry has reached the present situation and the problem of complacency, are we facing legislation because of the industry’s inactivity and failure to address the issues by providing smoke-free spaces?

Tim Lord: I will talk about the charter in Scotland, although there is also a charter for the UK. In the “Smoking Kills” document, the Government’s strategy on passive smoking had two aspects. One was a possible approved code of practice, which has been shelved, and the other was a public places charter with targets, which was a voluntary agreement between the hospitality industry and Government.

The Scottish Executive set specific targets in its charter, which are referred to in the policy memorandum to Mr Maxwell’s bill. The target for sites with smoking policies was 46 per cent, but the industry hit 68 per cent. I will not go through all the targets, but my point is that the hospitality industry over-delivered on what was asked of it in the charter, with the exception of one target, on which it was 1 per cent down. The industry delivered what was asked of it.

It is different to consider whether the requirements in the charter were aggressive enough. As I said, the hospitality industry in Scotland has delivered when it has been asked to. People are now saying that what was done was not enough, which is fair, but as the next step, why not ask for what you want—such as no smoking beside bars, or smoke-free pubs—and set targets in conjunction with the industry to give it time to deliver? So far, the industry has delivered what has been asked of it. My interpretation is that people are now saying that the targets were not aggressive enough and that there has not been enough change, but it is unreasonable to say that after the event. Why not set aggressive targets and timescales and give the voluntary approach a chance? If the industry does not deliver, Parliament could legislate.

Mr McNeil: The point is that the industry’s response seems to have been lacklustre given that, in the meetings that we have had with the industry, the representatives have been screaming foul. From your description, the industry was able to better the targets, but if the industry had
approached the problem in that way, you would not be sitting here today.

**Tim Lord:** I do not know about that. The industry feels that it has overachieved on many of the targets on which the Scottish Executive asked it to deliver. We are surprised by the fact that the response has not been, “Well done; you did good.” Given that the industry has over-delivered, I am not sure that its response has been lacklustre. If you are now saying that you want a different picture, I am sure that the industry will not say that it will not do that. I am sure that the industry can deliver on new targets if you make it clear what you want.

The policy memorandum for Mr Maxwell's bill mentions four options on how to address passive smoking, one of which is the existing voluntary approach. We feel that there should be a fifth option, which is to take the voluntary approach, to ratchet it to where you want it to be and give those targets to the hospitality industry, talk to its members and so on. That is not our business, but there is no reason why that could not be done, given what they industry has achieved to date.

**Mr McNeil:** What proposals have been made by organisations to ratchet that approach up and create another option?

**Tim Lord:** I am aware that there have been conversations with the Deputy Minister for Health and Community Care in Scotland. It is not my business.

**Mr McNeil:** Is nothing in the public domain yet?

**Tim Lord:** There is nothing that I am aware of. The hospitality industry is a different industry—it is not our industry. Debates are taking place and I know that down at Westminster there are debates between the hospitality industry and the Secretary of State for Culture, Media and Sport and the Secretary of State for Health on how to move forward. That strikes me as being a pragmatic United Kingdom way of going about dealing with the situation on the basis of what is successful. The figures are in Mr Maxwell's policy memorandum.

15:45

**The Convener:** I will bring in Stuart Maxwell. Will five minutes be enough?

**Mr Maxwell:** I hope so.

**The Convener:** We want to move on.

**Mr Maxwell:** I will cover as much as I can in as short a time as possible.

I will start with health. Do you accept that smoke contains 4,000 chemicals, 50-plus cancer-causing agents, 47 regulated hazardous wastes and a variety of other noxious contaminants? Are you trying to argue that those carcinogens and chemicals do not do people any harm just because they do not happen to be holding the cigarette?

**Tim Lord:** Exhaled smoke, second-hand smoke, passive smoke—whatever you want to call it—is completely different from the smoke that someone inhales into their lungs when they put a cigarette to their mouth. Such smoke is severely diluted, aged and, in measurable terms, contains fewer components. It is different from the smoke that someone who smokes a cigarette inhales into their lungs.

**Mr Maxwell:** Are you saying that it does not contain 50 known cancer-causing agents, 47 regulated hazardous wastes and 4,000 chemicals?

**Tim Lord:** I am saying that it is completely and utterly different from what someone who smokes a cigarette inhales. I am not sure of the exact figures or exactly what it is. You are at an advantage over me in having the figures in front of you.

**Mr Maxwell:** I have scribbled them down on a bit of paper. The figures are widely known. The British Medical Association and many others have published analyses of what is contained in second-hand smoke. I wondered whether you agree or disagree with that, but we will move on.

**Tim Lord:** I cannot disagree specifically with the figures that you have quoted, but what I can say is what I did say, which is that such smoke is fundamentally different to the stuff that a smoker inhales. That probably explains the different results that are produced in epidemiology.

**Mr Maxwell:** We will agree to disagree on that point and I will move on.

On choice, you mentioned earlier that there would be no choice for smokers if a ban was introduced and that they would have to stay at home. Could you point to the section of the bill that forces smokers to stay away from bars if a smoking ban is introduced?

**Tim Lord:** I do not think I said what you suggest. Have I written that somewhere?

**Mr Maxwell:** You said that smokers would be given no choice and that they would be forced out of bars and restaurants.

**Tim Lord:** I accept that your bill is a halfway house—as I think you said last year—in the sense that it is not a complete ban, but a ban on smoking where food is served. That means that if your bill were to be put on the statute books there would still be smoking areas or smoking pubs that did not serve food. There would be less choice.
Mr Maxwell: How would there be less choice? What would stop a smoker going into a restaurant if the bill were passed?

Simon Clark: Of course, there would be nothing to stop a smoker going into a non-smoking pub, but you would be discriminating—I used the word discrimination earlier—against people who choose, when they go out in the evening, to go to a pub or a restaurant and smoke. What I find disagreeable about your bill is that it would introduce a blanket ban on smoking in all places where food is served. That means that there would be nowhere for smokers who like to go out in the evening and smoke with their food or have a drink to go. That seems to be extraordinarily draconian. We are not saying that every place that serves food should allow smoking. We would have no problem if, in a few years' time—and if there were overwhelming public demand—the majority of restaurants and pubs were no smoking.

Why should we ban smoking in all places where food is served? The bill is wrong, because it does not distinguish between restaurants and pubs that serve food. There are many pubs that serve only pies and sandwiches, for example. I presume that they would, under the bill, have to choose between allowing people to smoke and selling pies and sandwiches.

Mr Maxwell: I thought that you would support that approach, because it involves choice.

Simon Clark: The member is right. However, consumers would have less choice because they would not be able to have a pie and a pint in a pub. The bill would reduce choice. It would mean that a heck of a lot of people would drink without having anything to eat. Given all the drinking problems that exist, that is not a particularly good idea.

Mr Maxwell: For a moment, we will stick to the argument about choice. What would you say to a young person with asthma who wants to pursue a career in the bar and restaurant industry? What should be their career choice? Should they accept that they will have to damage their health further by working in smoky atmospheres, or should they give up their ambition to work in the hospitality industry?

Simon Clark: We are working towards a situation in which there will be more no-smoking bars and restaurants. I cannot emphasise enough the fact that we are not against proprietors' introducing a ban if they think that it would be good for their businesses. However, the reality is that if a person has an ailment they must sometimes adjust their life accordingly. Many people have nut allergies, but do we ban every food that contains nuts? We must adapt our behaviour according to our circumstances. I hope that we are moving towards a situation in which many more people who have asthma will be able to work in a non-smoky atmosphere. One cannot always blame asthma on smoking. There is now a considerable amount of research that suggests that it is related to diet and genetic factors.

The Convener: I know that Stewart Maxwell would like to ask a lot of questions, but we have another batch of witnesses to hear from. He may ask one long last question, including as many bits as he likes. Later he will be able to give evidence to us and to respond in his own time to what has been said.

Mr Maxwell: I will make a couple of quick points. The publication from New York to which I referred concerns specifically bars and restaurants, rather than the wider hospitality industry. Earlier, you asked why I was not seeking to ban cars, which produce far worse toxic fumes than cigarettes. The New York study addressed that question. The study states:

“The Department found that the average air pollution levels in bars that permitted smoking were as much as 50 times higher than at the entrance to the Holland Tunnel at rush hour.”

Do you accept that that is the case and that the issue of fumes from cars, which you mentioned earlier, is a red herring?

Simon Clark: I do not accept that argument and would need to examine the research to which the member refers. Even if the statement were true, we must still ask whether passive smoking is harming people who work in pubs and restaurants. I do not think that Mr Maxwell has proved that.

The Convener: I am sorry to interrupt Stewart Maxwell's questioning, but he will have a fair cut at the witnesses' evidence when he gives evidence and we put those points to him. I thank our second panel of witnesses.

I refer members to papers HC/S2/04/15/6, HC/S2/04/15/7 and HC/S2/04/15/8. Here is a man who is ready for business; he has got the jacket off already and the sleeves rolled up.

Andy Matson (Amicus): No, convener, it is too warm. Some ventilation might be helpful.

The Convener: It is very warm here. I take it that the witnesses sat through the previous evidence, which is helpful. I welcome Andy Matson, regional officer of Amicus; Stephen Leckie, chairman of the British Hospitality Association Scotland committee; and Arun Randev, a proprietor. I invite Helen Eadie to start the questions.

Helen Eadie: Thank you—
The Convener: I beg your pardon, but it is Janis Hughes to start. The lack of ventilation is getting to me, too.

Janis Hughes: My question is similar to one that I asked of the previous panel and it is directed to all the witnesses. What are your views on the bill's economic impact?

Andy Matson: The Amicus written submission concentrates primarily on what we regard as being omissions from the bill on employment matters. I am sure that it will come as no surprise to the committee to hear that trade unions take a view on legislation that might impact on the security or otherwise of employment, whether that happens to be this bill or legislation that would impact, for example, on the business of BAE Systems or Thales Ltd. Our approach is at least consistent.

Janis Hughes: I want to ask you specifically about your written submission, which states: “The Bill should make provision for those workers who may face job security or redundancy as a direct result of the Bill's implementation.” Can you say more about that? What kind of provisions would the bill need for your concerns to be allayed?

Andy Matson: It becomes difficult to say that something has happened as a direct result of a piece of legislation. Issues are going through various chambers in Scotland and south of the border, from considering whether to ban the advertising of tobacco products to regulations that would have point-of-sale implications. All those, in conjunction with the bill, could impact on jobs. We believe that special provision should exist in statute to compensate individuals who find themselves out of employment, where it can be clearly demonstrated that job X, Y or Z has been lost as a direct result of legislation's impact on a particular sector of the economy, rather than its happening through employees’ choice or that of their employers.

Janis Hughes: Do you accept that it would be difficult to prove such a direct result?

Andy Matson: I think that I said that. Over the years, employers have given copper-bottomed guarantees to trade unions that there would be no redundancies as a result of the introduction of new technology, but redundancies have continued to take place.

The Convener: Do you not also agree that it would set a dangerous precedent in law if people were compensated because it was deemed that they had lost their jobs or some of their income through the introduction of new legislation? I remember discussion of that issue during consideration of the Protection of Wild Mammals (Scotland) Bill. Such compensation would set a precedent that would open up the coffers.

Andy Matson: I am sure that it would set a precedent, but one must sometimes be bold and radical.

The Convener: I do not know why you looked at me when you said that. I put it to you as a supplementary observation merely that such compensation would cause huge difficulties in law.

Andy Matson: I accept that there are obvious difficulties in many areas, but if there is willingness, a degree of radicalism can sometimes be helpful.

The Convener: You need to speak to Andy Kerr about that.

Mr Davidson: I will ask the same question that I asked the previous panel, on the requirement for smoke-free areas between regulated areas. Before I do so, will the two witnesses who represent the industry—who provide the service and who have invested in it—like to comment on the general implications and the practicality of provision of regulated areas?
am also a hotelier in my own right. I manage and direct Crieff Hydro, which is Scotland’s leading leisure hotel—I say that in case members have not come across it.

**The Convener:** That is the plug. However, I do not think that many people read our *Official Report.*

**Stephen Leckie:** The British Hospitality Association’s view is set out pretty clearly in our letter of 20 April to the committee. The only change that I would make to that letter is that, on regulated areas, we refer to “corporate hostility” instead of “corporate hospitality”.

As far as the economic impact on hoteliers and the hospitality industry is concerned, our view is that the voluntary approach works for us, and we continue to sustain that view. The Government or Parliament might decide that that approach is not working, but our view would be that Stewart Maxwell’s bill is not enough because it is a halfway house and there are too many anomalies and question marks in it. Those include, for example, the five-day rule and the questions about what food is and where it will be served. If the bill’s aim is to help people not to suffer from the effects of passive smoking, what about pubs that do not provide food at all? Our view is that we should stick to the voluntary approach and in future years, if need be, after consultation has taken place, we can go for a formal nationwide ban on smoking in public areas.

**Mr Davidson:** You have been here for most of the afternoon, so you heard the evidence from other groups about the practical aspects of providing choice and separate areas. Do you agree that if there is to be real choice, there must be physical separation?

**Stephen Leckie:** Yes. I also accept that there is some argument and debate about ventilation—some people say that ventilation works and some say that does not. In our little establishment at Crieff Hydro, we have ventilated spaces. Someone on one side of a counter—a five-foot high barrier—might tell me that they can tell that smoking is taking place on the other side. However, that depends on the power of the ventilation, on how much one is prepared to spend on it, and on whether the air is brought in from outside or recirculated. We could debate ventilation all day long.

**Mr Davidson:** When Mr Maxwell eventually gives evidence, we will probably ask him why his bill would require the additional space—I think he believes that one physical barrier is not sufficient. Does the BHA subscribe to the idea that research is needed to establish whether ventilation barriers are effective, or is the onus on Mr Maxwell?

**Stephen Leckie:** We would ask for further evidence and proof that such barriers work. As far as the practicality of providing barriers is concerned, establishments and premises are all different. Some pubs and restaurants of a certain size may not be able to fit in a separate room. I do not think that it is possible to create a real barrier unless one adds ventilation, and that has a considerable cost. Our members would be unhappy about going down a route that involved such costs while the consultation that was announced yesterday was taking place and the jury was still out on what was going to happen. They will not commit to costs until they know where the Government intends to take us.

**Shona Robison:** You talked about the current consultation and seemed to suggest—you can correct me if I am wrong—that it may end up coming down on the side of a total ban. In your view, would the industry learn to accept that and get on with it?

**Stephen Leckie:** Yes. That is what I believe and it is what the BHA believes. If the voluntary charter is not working, and however the results of the consultation process are marketed, if a total ban is the view of everybody in Britain, a nationwide ban should prevail rather than one that is sectored to some areas in Scotland.

**Shona Robison:** Do you think that that is going to happen?

**Stephen Leckie:** Would you like me to reach for my crystal ball?

**Shona Robison:** What is your gut feeling?

**The Convener:** That was put so charmingly to woo you into answering.

**Stephen Leckie:** Is it working in Dublin? Yes, it is working in Dublin. We have been through all that this afternoon. Before I answer your question, however, I would like to know who sponsored the research that showed that businesses there have done better or worse as a result of the total ban. I am not clear about the truth of that. The policy memorandum to Stewart Maxwell’s bill states:

“There were 21 studies which met all three criteria, all of which found that smoke-free restaurant and bar laws had no negative impact on revenue or jobs.”

However, that is diametrically opposed to what the earlier witnesses referred to. I do not think that any of us around this table is able to anticipate the effect of a nationwide ban on smoking in public places.

**Shona Robison:** Let us go back to something that you said about ventilation. You suggested that someone in the ventilated space in your hotel would not know that someone was smoking on the other side of the barrier. Do you not accept that it is not about whether someone can smell the smoke, but about the health arguments
surrounding what is in the smoke and the chemicals that are left in the air? Those chemicals would remain in the air even if people could not smell the smoke. Are you aware of that argument?

Stephen Leckie: Yes, but I have yet to be convinced that that is the situation. If someone cannot smell the smoke, does it exist? If the smoke has been tucked away, surely the particles have been shut away. I am not yet convinced by that argument.

The Convener: Would you care to comment on the fact that, although the Irish have gone down the road of a total ban, it does not seem to bother them that that might affect the economy?

Stephen Leckie: That is what they are claiming. If that is the case, that is good news from the point of view of the hospitality association. However, our starting point has to be that the voluntary approach is working and has increased the number of people who have adopted some sort of smoking policy.

The Convener: I understand that but, in Ireland, it is felt that the economic argument has been made as well as the health argument.

Stephen Leckie: Having read the documents supporting Stewart Maxwell’s bill and heard the evidence that was given this afternoon, I do not think that the economic argument has been put to bed yet. Some claim that the economy is up; some claim that it is down; some claim that there is no difference.

Mike Rumbles: I would like to pursue that point, as I am a little confused about what you believe. You said clearly that you prefer the current scenario of a purely voluntary approach. I understand that. However, you then said that you do not like the halfway-house approach that the bill takes, which is to ban smoking only where food is served in enclosed spaces. You would prefer us to go the whole hog—I think that is the phrase that you used. I do not quite understand the logic of that approach. Could you elucidate, please?

Stephen Leckie: It is difficult for us to disagree with the aim of the bill, which is to prevent people from being exposed to smoking. Nevertheless, the question is whether the bill is the right solution. In our view, the answer is no because there are too many anomalies, inconsistencies and flaws that leave it open to debate and interpretation. An example of that concerns places where food is being served. The five-day rule would create huge issues for the hospitality industry. If, for instance, you were to have a week-long conference in the room that we are in and serve food at the end of the week, you would have to say that people could smoke on Sunday but not on Monday because food would be served in the room in five days’ time. What would happen if the people changed or the groups changed as the week wore on? It would be too confusing for customers and for the people who were trying to organise it.

Mike Rumbles: The logic of that argument is that smoking should be banned in the establishment. I do not understand your response. You say that you would be quite happy with a full ban but not a halfway house; surely the bill seeks to make your life less restricted than it would be with a full ban.

Stephen Leckie: I am not sure that we are ready yet to propose a full ban. A consultation process needs to take place.

Mike Rumbles: So, have I got this right: you would not be in favour of a total ban on smoking in public places?

Stephen Leckie: Not at this stage.

Mike Rumbles: So you do not favour a total ban.

Stephen Leckie: It depends what happens with the consultation.

Mike Rumbles: May I pursue this with you? Your position does not strike me as being logical.

Stephen Leckie: If you start with the premise that we are trying to prevent people from being exposed to the effects of passive smoking in public areas where food is supplied—and I was interested to hear the arguments on that today—why not apply the ban to areas where food is not supplied? The consultation process will consider that. Meantime, we continue to believe that the voluntary approach is right just now.

Mike Rumbles: Right, so you do not want any legislation on this issue.

Stephen Leckie: Absolutely.

Mike Rumbles: That is fine. I just want to know what your position is, because it seemed to be different. Your position is that you do not want any legislation in this area at all.

Stephen Leckie: Not yet. There is not enough evidence to tell us that a total ban is conclusive and the right thing to do.

Mr McNeil: We have heard a lot about Ireland, in the debate generally and here today. It has been confirmed that compliance rates are particularly high. Anecdotal evidence from friends I recently visited in Dublin and outside Dublin is that their experience has been favourable, in that people have complied. Do you believe that that compliance has come about only over time—as David Davidson said, over a 14-year timeline? Do you believe that in Ireland they have been able to resolve and satisfy themselves of the arguments, and that only by doing that have they got such compliance rates?

I can give you another scenario. It would not be suggested that if England consulted, took
evidence and legislated that that would automatically be a model for Scotland. Why would we automatically apply the model from Ireland? In order to win the debate, is it not important for us to consult, rigorously examine the evidence and come to a conclusion that is satisfactory to the wider population? Also, would it not be helpful if the industry participated fully in that argument and examined a voluntary charter plus? We have heard today that much more can be done. Why is it not being done?

Arun Randev: In my opinion the bill does not go far enough. There needs to be more consultation. The bill emphasises the food element, but people who work in bars where no food is served are exposed to the same elements to which workers in the food industry are exposed. We need to be consulted more on a number of areas, because we work daily in the field.

I have 100 per cent no smoking in the restaurant and I have a smoking bar area. I am moving down the voluntary road and I exhibit what my policies are in my window. However, nobody has come along to ask me how it is working. It is about letting it work and giving people the choice. We always state in our advertising that ours is a non-smoking restaurant, in the way that people advertise their facilities for disabled people.

Mr McNeil: Can I have a response to my question?

Stephen Leckie: I am confused as to whether it was a long statement or a question.

Mr McNeil: It was a bit of a statement, I am afraid.

Is it not an integral part of the process to debate and win the argument in Scotland, rather than to overstate examples of the experiences in New York or Ireland? Do we not need to travel the same journey as those places had to travel?

Stephen Leckie: Scotland has voted for its Parliament, so it makes sense for Scotland to think about Scotland.

Helen Eadie: My question is for Stephen Leckie, but if anyone else wants to comment, that is okay. How does your trade association share information with places such as the Republic of Ireland?

Arun Randev: Every time that the main entrance door opens, smoke from outside travels into the premises. How would that be stopped?

Mike Rumbles: We are talking about an enclosed area.

Arun Randev: How hard would it be to control the smoke that enters from the street? People who work in the offices above my premises stand about outside my premises, where they drop litter and prevent customers from entering my premises. Twenty or 30 of those people congregate at a corner to smoke. What is to say that that smoke will not end up travelling into my bar, too?

The Convener: I will ask a brief question so that we can move along. What are the witnesses’ views on using the criminal law to reduce passive smoking? I take it that corporate liability or individual liability in the case of a sole proprietor or partner will apply.

Stephen Leckie: The BHA sets out its view on that in our submission, which says:

“The structure of some of our members businesses involves premises being leased from them or managed on their behalf. As currently drafted this section appears to
suggest that they will be proceeded against even in circumstances where they are not in day to day control of their business."

**The Convener:** A company might not know about breaches of the law, but absolute liability will apply.

**Stephen Leckie:** Yes.

**The Convener:** Is that not the position in other legislation?

**Stephen Leckie:** Possibly. I will need some time to think about that properly.

**The Convener:** Do you wish to say anything else about criminal penalties? I know that I am rushing somewhat, but I want to give Stewart Maxwell a chance to ask questions.

**Andy Matson:** We have come to the committee to give our view on possible employment implications. If criminal penalties are to be imposed for breaching provisions, I suspect that when the licence for an establishment needed to be renewed, the police would comment to the licensing board. After that, it would probably be in the licensing board’s remit to deny renewal of a licence, which could have knock-on effects on employment in an establishment.

**The Convener:** We have opened up that seam in our consideration of the Breastfeeding (Scotland) Bill, which proposes similar penalties and might lead to situations in which people come before the licensing boards.

If you want to add anything about criminal penalties, please write to the committee. I realise that I have skirted over the issue rather quickly, but I am trying to keep to the timetable. I will allow Stewart Maxwell five minutes to question the witnesses. I am sorry, Stewart; I must try to keep to the timetable, but you will have a chance to give evidence.

**Mr Maxwell:** I will start by asking Andy Matson about protecting jobs. Are you aware that Unison Scotland submitted evidence to the committee?

**Andy Matson:** No.

**Mr Maxwell:** The submission says:

"UNISON Scotland supports the general principles of this Bill."

The submission goes on to say that the bill would provide workers with "a healthier workplace" and continues:

"UNISON Scotland believes that all employees should enjoy a healthy and safe working environment."

Does Amicus agree that all workers deserve a healthy and safe working environment?

**Andy Matson:** In our written evidence we make the point that the health and safety of the work force is paramount.

I view the bill from a perspective that is different from that of Unison. We represent people who are employed in the sales forces of the major tobacco companies and people such as vending machine engineers who are employed in commissioning and maintaining the cigarette vending machines that are found in pubs, clubs and hotels. It is difficult to say how many are employed in the drinks retail industry. According to our information, the three major tobacco companies—Imperial Tobacco, Gallaher and British American Tobacco, which took over Rothmans—employ in the region of 114 salespersons in Scotland and the vending machine companies employ around 75 to 85 personnel. It does not logically follow that all those people service the areas that would be covered by the bill, but the bill could have an impact on some workers. As I said, other regulations are coming down the track, too.

**Mr Maxwell:** I am sure that you agree that the bill would not prevent people from smoking, so tobacco sales are neither here nor there. The bill would prevent people from using the product in certain premises.

**Andy Matson:** It might do in some places.

**Mr Maxwell:** I am sure that you also agree that it is reasonable to put workers’ health and public health before a possible risk to some jobs and employment prospects. People who worked in the asbestos industry lost their jobs when we discovered what asbestos did, for example.

**Andy Matson:** Asbestos is a very bad example. When industrial diseases such as pneumoconiosis were clearly identified, suitable and adequate measures were put in place to minimise the problem in particular areas.

In our submission we say that other solutions to the problem can be found. After all, there is a wealth of engineering ingenuity out there in Scotland and elsewhere that is capable of developing processes that would deal with tobacco smoke in pubs, clubs, restaurants and workplaces, as it has been capable of dealing with other situations.

**Mr Maxwell:** Do you agree that no system of ventilation provides adequate protection against environmental tobacco smoke? The UK Government, the Scottish Executive and the European Commission agree on that.

**Andy Matson:** I do not know—I am not a chemist. However, the Government has put in place systems to ensure that its troops are protected from chemical warfare. I assume that that technology could be applied.

**Mr Maxwell:** I am sure that you are not suggesting that we all wear chemical suits.
Andy Matson: No, but I am suggesting that somewhere in the Government—both national and local—there is the technology to provide adequate filtration systems that would deal with the problems that you outline in the policy memorandum to the bill.

Mr Maxwell: There is no research evidence to suggest that.

I have a question for Stephen Leckie. You talked about having either a full ban or none at all—in other words, a voluntary charter. Do you accept that much of the legislation that we implement in the Scottish Parliament and that is implemented around the world is progressive? For example, around the world, smoking was banned in restaurants and other places and then the authorities moved on to further bans. In the United Kingdom, we enforced the use of seat belts in the front of cars and moved on to enforcing their use in all car seats and then on buses. On drink driving, we set the level of alcohol in the blood at a certain amount and then reduced it. Do you agree that progressive legislation is a perfectly acceptable way to introduce laws so that the public accept and get used to them before moving on?

Stephen Leckie: Yes I do, but your bill leaves too many anomalies open for debate and interpretation, which, in our view, leaves us too exposed and makes it too difficult for us to follow the bill for the reasons that I have already outlined.

Mr Maxwell: I do not accept what you say and I am not sure that I understand what anomalies you are talking about.

I have a question for Mr Randev. Do you believe—I am sure that you do—that owners should have the right to choose whether to allow smoking on their own premises?

Arun Randev: That is decided through consultation with our customers and employees and then it is more or less left to the public to decide. We leave it to choice.

Mr Maxwell: In effect, you decide whether or not to allow smoking in your own premises.

Arun Randev: We work by consultation with our employees and customers.

Mr Maxwell: After consultation, do you decide what the policy will be in your own premises?

Arun Randev: We suffer or fall by our own decisions.

Mr Maxwell: Do you, by extension, believe that you should be allowed to decide the policy on other laws? For instance, on under-age drinking, should bar owners be allowed to decide at what age people are allowed to drink in their bars?

Arun Randev: Yes, we should, because we are active in the industry and face such questions daily. We are sensible and know our business well enough to know the problems that we face. I made a personal submission to the Nicholson committee based on my 25 years of experience. That experience in the trade is why I am here today, and it is enough to enable me to make such decisions.

Mr Maxwell: So your view is that bar owners should be allowed, in a laissez-faire way, to decide for themselves what laws they should implement or not on their own premises. Is that correct?

Arun Randev: It is not for me to decide; it is for the customer to do that. I first have to realise the economics of the matter.

Shona Robison: Andy Matson talked about his members who work in the tobacco industry. Do you not agree that all measures to reduce smoking levels could have an impact on their jobs, whether health warnings on fag packets, a ban on tobacco advertising or smoking cessation classes? All those measures potentially have an impact on your members’ jobs, but you are surely not going to oppose them.

Andy Matson: You are right. A raft of measures and issues could impact on employment prospects in the tobacco industry. I remember Dr Michael Kelly leading the smoke-free Glasgow campaign—I think that most of us here are old enough to remember that. I think that, at that time, Imperial Tobacco still had a facility in Glasgow, but nobody could say what alternative employment, with the same sort of employment package, they would put in place for the workers in the Imperial Tobacco factory if it was closed as a direct result of a ban on smoking. The answer to that question is still awaited.

Obviously, a whole raft of things can impact on employment in the industry, some more directly than others. Technology has had an impact on the levels of employment of our members in the tobacco production industry. It is naive to think that production capabilities and methods of production stand still, whether in the tobacco industry, the engineering industry or any other industry. The one thing that is constant is change and we are always moving on. Each time production methods become more sophisticated, somebody somewhere usually loses a job, whether a member of ours or of another trade union.

The Convener: I want to bring the item to an end. That point—economic impact and whether there should be compensation—is where we came in, so we have come round full circle. I thank the three witnesses for their evidence.

I suspend the meeting for 10 minutes. We will start again at 20 to five.
16:29

Meeting suspended.
8 June 2004 (15th Meeting, Session 2 (2004)) – Supplementary Evidence

SUPPLEMENTARY SUBMISSION FROM ASH

Early reports from Ireland are encouraging.

31st May 2004 - the Office of Tobacco Control in Ireland published its first report on compliance for one month after the smoke-free law came in (covering the period 29th March when the ban was introduced to 30th April 2004). The report comprises of data from three sources: the National Tobacco Control Inspection programme, the smoke-free workplace compliance line and market research on public attitudes and behaviours.

The report found that 97% of premises inspected under the smoke-free workplace legislation were compliant with the law (i.e. no one smoking and no evidence of smoking in contravention of the law) and indicated that levels of visits to pubs and restaurants remained constant, with one in five smokers choosing not to smoke at all when out socialising.

Prior to the introduction of the smoke free workplace law, 91% of the population stated they would be either more likely or just as likely to visit a restaurant to eat. Since the law was introduced, this figure is 92%.

The rate of smokers visiting pubs has remained steady at 74% since the legislation was introduced. The frequency of non-smokers visiting pubs has increased from 67% to 70%.

The full six page report is available on their website www.otc.ie under Publications.

Progress on smoke-free public places is being made elsewhere in Europe.

Tuesday 1 June 2004 - legislation in Norway to introduce smoke free public places is implemented.

May 12, 2004 - the Swedish parliament votes to ban smoking in bars and restaurants, starting on June 1, 2005.

Smoke free New York - one year review shows success.

The Smoke-Free Air Act took effect on March 30th 2003. On May 12, 2004 the New York City Department of Health and Mental Hygiene (DOHMH) announced an 11% decline in the number of smokers in New York City over the previous year - the fastest drop in smoking rates ever recorded nationally. This drop represented 100,000 fewer New Yorkers smoking in 2003 compared with 2002. Those who continued to smoke were also smoking less. The DOHMH attributed the fall in smoking rates to its program of tobacco control, including the ban on smoking in public places.

Concerns had been expressed about the potential economic impacts on business of a ban. Data from the DOHMH one year review showed that:

- Business tax receipts in restaurants and bars were up 8.7%
- Employment in restaurants and bars had increased by 10, 600 jobs (about 2,800 seasonally - adjusted jobs) since the law’s enactment
- 97% or restaurants and bars were smoke-free
- New Yorkers overwhelmingly supported the law
- Air quality in bars and restaurants had improved dramatically
• Levels of cotinine, a by product of the body's metabolising tobacco smoke, decreased by 85% in non-smoking workers in bars and restaurants
• 150,000 fewer New Yorkers were exposed to second-hand smoke at work

SUPPLEMENTARY SUBMISSION FROM TOBACCO MANUFACTURERS’ ASSOCIATION

Introduction
On 8th June 2004, the Tobacco Manufacturers’ Association (TMA) gave oral evidence to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. During the course of those proceedings the TMA undertook to provide the Committee with certain further information, hence this supplementary written evidence.

The whole debate about smoking in work and public places revolves around and is founded on the assertion that ETS is harmful to the health of the non-smoker. In particular, the Committee asked for further information: on the epidemiological studies which have been undertaken concerning ETS; about the balance of the findings of those studies; and effectively why the TMA did not believe that they justified or supported the popular perception that ETS causes serious diseases in non-smokers. Additionally, the TMA offered to provide further information on legal cases brought against employers.

In order to provide a comprehensive answer to those questions, and to enable the Committee to reach its own conclusions on the available evidence on an informed basis, it is not sufficient simply to list the ETS studies that have been published. The studies need to be put into a proper context, their design and terminology explained and a guide provided as to how their findings should be interpreted.

A chronology
In the US Surgeon General’s reports of 1972 and 1975, initial speculations were raised about the possible consequences of exposure to environmental tobacco smoke (ETS). The US Surgeon General’s 1979 report noted several adverse outcomes that appeared to have an association with ETS; but also that there was only a limited amount of systematic information available regarding the health effects of ETS. The Surgeon General’s 1982 report raised the concern that ETS might cause lung cancer. Following that report a number of epidemiological investigations were published which claimed to show a relationship between ETS and lung cancer.

Then in 1986, the US Surgeon General’s report, as well as reviews by the National Research Council and National Academy of Science (sponsored by the US Environmental Protection Agency (EPA)), concluded that ETS caused lung cancer and claimed an increase in risk of 30%, with the latter two reviews also associating ETS exposure with adverse respiratory outcomes in young children.

However, a review published in 1986 by the International Agency for Research on Cancer (IARC) of the World Health Organisation came to different conclusions. It did not produce estimates of risk but concluded that available studies:

“had to contend with substantial difficulties in determination of passive exposure to tobacco smoke and to other possible risk factors. The resulting errors could arguably have artefactually depressed or raised estimates of risk, and, as a
consequence, each is compatible either with an increase or with an absence of risk."\(^1\)

Nonetheless, in June 1989, the US EPA issued a public notice that stated categorically that ETS "is a known cause of lung cancer". However, the EPA did not provide an analysis of the data on which it had based its conclusion. It was pressed to do so but did not produce its analysis and risk assessment until 1992\(^2\). This took the form of a review of selected published studies. It was subjected to devastating criticism, not least by members of the US Congressional Research Service appearing before a Committee of the US Senate, who said:

"The EPA study analysed and summarised 30 studies of passive smoking lung cancer effects. Critics have questioned how a passive smoking effect can be discerned from a group of 30 studies of which 6 found a statistically significant (but small) effect, 24 found no statistically significant effect, and 6 of the 24 found a passive smoking effect opposite to the expected relationship."

"… our evaluation was that the statistical evidence does not appear to support a conclusion that there are substantial health effects of passive smoking."\(^3\)

The report was later also challenged in the courts\(^4\) where the EPA was found to have knowingly, wilfully and aggressively disseminated false information with far reaching regulatory implications in the US and worldwide. Judge Osteen found that the EPA had:

"changed its methodology to find a statistically significant association . . . In conducting the ETS Risk Assessment, EPA disregarded information and made findings on selective information; did not disseminate significant epidemiologic information; deviated from its Risk Assessment Guidelines; failed to disclose important findings and reasoning; and left significant questions without answers … Gathering all relevant information, researching, and disseminating findings were subordinate to EPA’s demonstrating ETS a Group A carcinogen."

Yet to this day, despite that judgement which vacated (annulled) the report after ‘forensic’ investigation of the EPA’s review and process, the report is used as a ‘gold standard’ by the authorities. It is the ultimate foundation of the estimates made by UK authorities of UK deaths resulting from exposure to ETS. The report and its methods have subsequently been used as a model for other reports by the Californian EPA\(^5\), the National Health & Medical Research Council of Australia\(^6\), and the UK’s Scientific Committee on Tobacco and Health (SCOTH)\(^7\). In 1998, the US National Toxicology Program accepted the EPA 1992 report and its twin from California as the basis for listing ETS as a known human carcinogen.

At the time the EPA prepared its 1992 report, there were only around 30 published studies seeking to determine lung cancer risks associated with exposure to ETS. There have now been well over 100 studies and reviews that have been published; a great many more are thought to have been undertaken but not been published.

**The significance of publication and publication bias**

Whilst, therefore, the total number of studies and reviews that have been undertaken is likely to be very much larger, only those that have been published form part of the accepted compendium of information on ETS. This means that every party has access to the same information upon which they may make their own judgements.
Unpublished studies are not concealed or used; publication is the determining factor. Such differences of opinion as do exist about ETS studies and reviews arise out of the critical examination and analysis to which they may then be subjected, and the interpretations and judgements which may then be made as to their data and findings.

Given this significance of publication, it is well recognised that what epidemiologists term ‘publication bias’ may arise:

“Publication bias occurs in two quite separate forms. Studies with positive results are more likely to be submitted for publication and more likely to be accepted; and significant findings, such as an association with a particular occupation or exposure, are often given prominence by the authors, particularly in case-control studies [explained at paragraph 21 et seq.], while other exposures that were analysed but were not significant may not be mentioned at all. Both types of bias tend systematically to exaggerate associations in the published literature.”

“Quite different conclusions might be drawn from a review of all published and unpublished studies.”

“The presence of even a modest degree of publication bias can lead to a substantial increase in the estimated risk.”

“The result is a biased understanding of the differences and similarities in the disease patterns of populations and an exaggerated view of the importance of associations between risk factors and disease outcomes.”

Publication bias is well recognised as existing particularly when a consensus develops among the ‘experts’ themselves – albeit that consensus opinion may not be correct. Once a large number of people believe something, it can be difficult and costly to argue to the contrary. For example, academics and researchers who then go against the grain can find it difficult to achieve publication of their opinions and research, or struggle to find posts or research funds.

An illustration of the reception that can be given to the publication of views which do not conform to the accepted wisdom – and which thereby illustrate the strong force that publication bias represents was provided by the reaction to the publication by the British Medical Journal in May 2003 of a major new ETS study, in respect of which the BMJ carried the front-page headline, “Passive smoking may not kill”. This prospective study measured the relationship between ETS, as estimated by smoking in spouses, and long-term mortality from tobacco related disease and was conducted on over 100,000 Californian adults between 1960 and 1998. The conclusions of the study stated:

“The results do not support a causal relation between environmental tobacco smoke and tobacco related mortality although they do not rule out a small effect. The association between exposure to environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed.”

The publication of the study by the BMJ gave rise to a violent storm of criticism from the medical community. In responding, the editor of the BMJ was minded to comment -

“Of course the study we published has flaws – all papers do – but it also has considerable strengths: long follow-up, large sample size, and more complete follow up
than many such studies. It’s too easy to dismiss studies like this as fatally flawed with the implication that the study means nothing . . . I found it disturbing that so many people and organisations referred to flaws in the study without specifying what they were. Indeed, this debate was much more remarkable for its passion than its precision.”

“We must be interested in whether passive smoking kills, and the question has not been definitively answered. It’s a hard question, and our methods are inadequate.”

The heterogeneity of studies and reviews
Whilst it is now common for the statistical findings of ETS epidemiological studies to be expressed in a common manner – in terms of a reported estimated relative risk [explained at paragraph 32 et seq] there is no accepted common study design and “few epidemiological studies satisfy the stringent methodological criteria that should ideally be applied.” Thus individual studies and reviews exhibit wide variations in design, methodology, data collection, country, population and study size. It is therefore not surprising that findings show little consistency. This makes interpretations and comparisons both difficult and contentious. This is particularly so as even where a positive association between ETS and a disease has been reported, it has been of a very low order of risk. It has been of a magnitude that might easily be accounted for by bias or confounding [explained at paragraphs 24 and 28 respectively], or by inadequate adjustment in the study of such bias and confounding. It has also been of a magnitude well below that normally regarded as being significant and appropriate as a guide for public policy.

Meta-analysis
Given the great variability of individual studies, in undertaking collective reviews of studies, a weight of evidence approach is frequently used. This involves considering the quality of individual studies, discarding some and including others in making an overall judgement. Inevitably, this approach involves a great many subjective judgements about the available studies.

Meta-analysis involves the quantitative synthesis of the results of separate studies, to provide a summary of the pooled results. However, for this to be a valid approach, the studies need to be similar and comparable in design and many other respects, otherwise the result is no better than mixing apples with oranges. Such inappropriate mixes may result from pooling studies of widely varying design and methodology; studies from different countries and populations in respect of which there may be significant and varying confounding variables; studies undertaken in significantly different time frames; and from the selective inclusion of studies based on the researcher’s impressions of study quality.

For example, almost all of the ETS studies that have been undertaken have been of populations outside the UK, particularly in the United States and Asia. They are very different populations to the UK in a great many respects. They have been undertaken over a time period since 1981 and there is a marked difference in the findings between those studies conducted before and after 1989. The difficulties of extrapolating data on one population and applying it to another on the basis that one group of people is broadly equivalent to another has been vividly illustrated by the extrapolation of risk scoring methods for coronary heart disease derived from the US Framingham heart study and its application to the UK. The Framingham study played a key role in quantifying risks such as smoking and high cholesterol. The UK researchers compared the Framingham results with the British regional heart study. They found that using
Framingham, there was an over-estimation of the risk of non-fatal coronary events of 57%, and also that 84% of British heart deaths occurred in the 93% of men classified as low risk by Framingham criteria. The fact is that substantial variations in coronary heart disease are found between different regions and different ethnic groups, socio-economic status and family history of coronary heart disease.

Nonetheless, in recent years, meta-analysis has been increasingly used to combine evidence from epidemiological ETS studies of quite different design. This can result in a combined relative risk estimate that has narrow confidence limits [explained at paragraph 35 et seq]; it may appear to be precise, but can in fact be an inaccurate estimate of the true association, if any.

**Understanding and interpreting the results of ETS epidemiological studies**

“In experimental animal research and in some situations in clinical medicine, for example testing the efficacy of a new drug, it is possible to carry out clinical ‘experiments’ comparing groups receiving different treatments. However, in epidemiological research requiring large populations for the evaluation of potentially harmful exposures, alternative approaches are needed. For example, to ‘prove’ that ETS causes cancer or heart disease would require the conduct of long term experiments (randomised controlled trials) involving hundreds of thousands of individuals half of whom would be randomly assigned to long term ETS exposure and the other half assigned to non exposure. But because it is not ethical to expose human subjects to a potentially harmful substance (in this case ETS), the only research approaches possible are those based on observational studies of non-smokers. Either disease rates in individuals exposed to ETS at home or at work are compared with rates in individuals not so exposed (cohort study); or past ETS exposures are compared in cases (those with the disease in question e.g. heart disease or lung cancer), and in those without these conditions (controls) (case control study). There is no certainty in either type of study that the two groups being compared are similar with respect to other relevant variables. Thus there is the possibility that any differences observed between the groups could be due to factors other than the ETS exposure. If such factors also affect the risk of disease, they are referred to as confounding variables. The consequence is that part or all of the observed association between ETS and the disease may be spurious.\(^\text{17}\)

A ‘cohort’ study follows a population group through a lengthy time period. It tracks the disease incidence in the cohort, and can assess possible lifestyle factors and calculate their relationship to the disease incidence. Cohort studies are larger and lengthier than case control studies, and hence are more costly. However, they are thought to be somewhat more reliable than case control studies, especially when multiple risk factors are involved.

However, the vast majority of the investigations that have been undertaken into ETS have been case-control studies. These have typically compared the incidence of certain diseases in non-smokers living with smoking spouses, as compared with non-smokers living with non-smokers. For chronic diseases, such investigations need to assess exposure over a period of thirty to forty years. This is usually achieved through questionnaires - obviously relying on the
personal recollections of people - of the intensity and duration of exposure to ETS over a lifetime. The uncertainty involved in this form of data collection makes such epidemiology a relatively imprecise tool.

Bias
In statistical terminology, ‘bias’ relates to deviations from the facts arising from such factors as flaws in study design, data collection or analysis. ETS studies are particularly susceptible to many forms of bias. Aside from the comparative unreliability of individuals’ memories – known by epidemiologists as recall bias - questionnaires are often administered not to the actual members of the populations being studied, but to surviving family members, so increasing recall unreliability and introducing or aggravating other possible sources of bias.

Smokers tend to marry smokers and non-smokers non-smokers and a proportion of people are known not to tell the full facts about their present or past smoking habits. Together, these facts are recognised to give rise to substantial misclassification bias.

Also there cannot be certainty about the precise cause of death, given both the difficulty of establishing that fact and also that “inaccuracies in the registered cause of death are recognised, especially with multiple causes”\textsuperscript{18}. In any event, death certificates do not record what caused the illness stated on the death certificate.

Publication bias is also possible – that is the likelihood that studies are published only if they produce positive results or results which conform to the accepted wisdom.

Confounding
Studies are also subject to confounding – distortion because there may be an association of disease with factors other than ETS, such as diet, alcohol consumption, socio-economic circumstances, the level of exercise, the history of disease in the family, that happens to correlate with being in a household with a smoker. While some ETS studies have attempted to collect information on some confounding factors, there has generally been an inconsistency and inadequacy of approach. Yet confounding is a most important consideration in ETS studies. Diseases in smokers that have been associated with smoking are well recognised to be multi-factorial. For example, cardiovascular disease has been associated with over 300 different factors.

There are methodological and statistical techniques to adjust for likely confounding and biases, but again they are not applied uniformly in each individual study, nor are they anything other than devices that may not reflect the true situation, and are themselves subject to limitations.

In reality, therefore, ETS epidemiological studies are statistical exercises, the measurements of which have limited credibility in terms of accuracy. That is not to say that they are irrelevant but it is to put them into a proper context. Epidemiology is “a crude and inexact science”\textsuperscript{19}; and “…until we know exactly how cancer is caused and how some factors are able to modify the effects of others, the need to observe imaginatively what happens to various different categories of people will remain.”\textsuperscript{20}

In other words, epidemiological findings are not incontrovertible, objective conclusions; the judgements made about epidemiological data which indicates a low level of risk, are inevitably subjective. And in the case of ETS, “the judgement as to whether the links observed are causal or not remains difficult.”\textsuperscript{21}
Relative Risk

Epidemiological studies generally express their findings in terms of reported estimates of relative risk (RR). This is the ratio of the incidence of the disease being studied in the group exposed to ETS (generally non-smokers living with smoking spouses), to the incidence of disease in the group not exposed to ETS (generally non-smokers living with non-smokers).

The RR reported has no direct bearing on the probability that an individual will acquire the disease in question. RR provides only an index of the strength of any association between exposure and a disease, and is always a relative term to the incidence of disease in the non-exposed group.

In case-control studies, relative risk (RR) is most often now expressed as an Odds Ratio, as in the following example:

1.26 (95% CI 1.06-1.47)

In this example, say the RR of 1.26 is the estimated risk of the disease in non-smokers living with a smoker, relative to the risk in non-smokers living with non-smokers. Were it to be less than 1.0, it would indicate that non-smokers living with smokers were less at risk of the disease than non-smokers living with non-smokers.

Confidence Interval

CI is the ‘Confidence Interval’, which is normally stated at the level of 95%. It does not mean that there is 95% certainty that the stated RR - in the above example, 1.26 – is correct. The 95% actually refers to the frequency with which the statistical test used will generate boundaries capturing the true figure. In other words, it relates to the reliability of the test, not to the parameter.

Interpreting Relative Risk

In interpreting what a RR figure means in terms of the population, it is necessary to know what the ratio or incidence of the disease is in the population not exposed to ETS: in other words what the rate of death or disease is in non-smokers living with non-smokers.

As explained in the 1988 report of the Independent Scientific Committee on Tobacco and Health, in the case of lung cancer in the UK population, the rate of death or disease amongst non-smokers living with non-smokers is generally taken to be 10 per 100,000 person-years of the population\textsuperscript{22}.

Thus, in the above example, a RR of 1.26 would then mean that amongst non-smokers with smoking spouses, the incidence of the disease would be 12.6 persons in every 100,000 person-years of the population, as opposed to 10 per 100,000 in the case of non-smokers living with non-smokers.

RR is sometimes expressed as a percentage. Most frequently is this the case when the purpose, either of researchers, publications or reporters, is to make the risk more easily comprehended by the public. The outcome is generally the reverse.

For example, when a RR of 1.26 is expressed as an increased risk of 26%, the entirely wrong impression acquired by the ordinary person is that out of every 100 non-smokers 26 will suffer from the disease. What a relative risk stated of 26% indicates is that the incidence of the disease will be 26% greater amongst non-smokers exposed to ETS by...
their smoking spouses than it would be had they lived with a non-smoker. Given that the rate of death from lung cancer amongst non-smokers living with non-smokers is 10 per 100,000 person years, the percentage increase in risk is from 0.010% (amongst non-smokers living with non-smokers) to 0.0126% a year (amongst non-smokers living with smoking spouses).

However, such a very small increment in risk – 0.0026% - would not make news that demands loud, clear and unequivocal headlines and sound bites. If that kind of message is not provided by the research itself, or by the professional journals publishing their work and wanting to promote their own publications, the danger is that it can then be generated by reporting that lacks thoroughness and concern for detail and accuracy.

A recent example of the misuse of science was provided by an estimate that claimed ETS exposure caused the death of 49 workers in UK pubs and bars each year. This figure was arrived at by using relative risks for lung cancer, heart disease and stroke for home and workplace exposure that were used in a New Zealand review paper; assuming a workforce in pubs and bars of 53,500 of which half were permanent staff; assuming that all of the workforce was exposed 100% of the time over a 6-hour shift to 3 times more smoke than would a non-smoker at home living with a smoker; and assuming that all the workers in those places were non-smokers. The review paper from which the relative risks were drawn did not claim precise predictions but only a guide dependent upon many assumptions and unknowns. The researcher’s assumptions were highly speculative, but the estimate suffers from a much larger flaw - the assumption that a relative risk for a chronic disease, which is the result of prolonged exposure over forty or so years, can be applied to a population group which is much younger (as well as one which also changes jobs frequently), with a consequently much smaller duration of exposure. The incidence of lung cancer, heart disease and stroke, below the age of 40 is very low and the age distribution of workers in the hospitality trade on average is very different from those exposed to ETS at home. As if that were not sufficient, an additional, fundamental error in the data used effectively destroys all possible credibility in the claim that was made.

Even though some may regard the public as being scientifically illiterate and mathematically innumerate, that is not a reason for the public to be misled, simply because of the perceived need to achieve headlines.

**How the magnitude of a relative risk should be interpreted**

In statistics, the words ‘statistical significance’, or ‘statistically significant’, have nothing to do with the magnitude of a measured difference. Statistical significance does not imply real life significance. It is a probability statement of the likelihood that the results did not occur by luck or chance if the groups were really alike; about how certain it is that the results are not a fluke.

Traditionally, conventionally and historically, a RR is considered to be statistically significant – not a fluke - when at a 95% CI it does not include 1.0, albeit that the choice of the value of 95% CI is arbitrary.

A RR finding of around 3.0 is generally considered necessary in order to establish cause. For example:

“The association between cancer occurrence and exposure to either extremely low frequency (ELF) or radiofrequency (RF) fields is not strong enough to constitute proven
causal relationship, largely because the relative risks in the published reports have seldom exceeded 3.0...25

A RR of 2.0 or less is generally regarded as being weak and not indicative of a causal association. The nearer the RR to 1.0, the more likely is this to be the case:

“...relative risks of less than 2.0 are considered small and are usually difficult to interpret ... Such increases may be due to chance, statistical bias, or effects of confounding factors that are sometimes not evident.”26.

“...when the relative risk lies between 1 and 2 ... problems of interpretation may become acute, and it may be extremely difficult to disentangle the various contributions of biased information, confounding of two or more factors, and cause and effect.27

“Until the 1980s, epidemiologists were concerned mainly with relative risks that exceeded about 1.5 and were often much higher. Many controversies now centre on much lower risks, a notable example being the effect of ‘passive smoking’ on lung cancer risk. The pooled data show a statistically significant effect, and all studies are consistent with a relative risk of about 1.3 (US National Research Council, 1986). In view of the many difficulties discussed above, however, it can plausibly be argued that such small effects are beyond the limits of reliable epidemiological inference (particularly for lung cancer, in which the major cause produces large relative risks), as smoking habits may be inaccurately recorded and are correlated with many other social and occupational factors, including the smoking habits of spouses. A number of spurious associations with relative risks for lung cancer of this order might thus be found in a large enough sample. The observations that short-service workers in various industries suffer elevated risks for lung cancer, which seem unlikely to be caused by their recorded occupational exposure, further illustrates the problem.28

Yet, in the case of lung cancer and ETS, a 1997 meta-analysis29 accepted by the UK authorities found a RR of 1.26 (95% CI 1.06 – 1.47), derived amongst non-smokers living and not living with smoking spouses. That has been claimed to be a "substantial" excess risk and one warranting bans on smoking in work and public places. That is simply not correct.

In 1992, the US EPA found a RR of 1.19 for lung cancer associated with ETS. However, that was only statistically significant at a 90% CI; it was not significant at 95% CI at which it included 1.0. Nonetheless, in 1998 that report was used as a basis for listing ETS as a known human carcinogen.

IARC’s 1998 report30 was a case-control study of lung cancer and exposure to ETS in 12 centres from 7 European countries that the researchers claimed provided “the most precise available estimate of the effect of ETS on lung cancer risk in Western European populations.” It reported no overall statistically significant increase in risk of lung cancer from ETS in any of the situations where people were exposed to ETS. The conclusions of the study stated:

“Our results indicate no association between childhood exposure to ETS and lung cancer risk (0.78 (95% CI 0.64-0.96)). We did find weak evidence of a dose-response relationship between risk of lung cancer and exposure to spousal (1.16 ( 95% CI 0.93-1.44)) and workplace ETS (1.17 (95% CI 0.94-1.45)). There was no detectable risk after cessation of exposure.”
In other words, not only were relative risks found to be low, but at the 95% Confidence Interval they included 1.0, indicating that they were not statistically significant. The following observation was also made in the report:

“The available literature on ETS exposure from the spouse and lung cancer is large. However, only six studies are available from Europe; two of them, conducted in Greece, showed a twofold increase in risk for women ever married to a smoker. Of the other studies, one from Scotland provided very unstable risk estimates of the same magnitude as the Greek studies and two – one from the UK and the other from Sweden – provided little evidence of an association.”

The results were within the range at which the IARC itself concluded that unequivocal results may be forever unachievable. Yet after negative reporting of the results by the media, IARC insisted that the findings “add substantially” to previous evidence of the risk between ETS and lung cancer. A WHO press release then implied that the results proved a link between ETS and lung cancer, a highly problematic conclusion given their own guidelines of epidemiological best practice31.

It is difficult to see how it could be claimed that the study adds substantially to the case against ETS and much less does it prove a link between ETS and lung cancer. The interpretation of such weak evidence is not in line with the official interpretation of very similar findings of other supposed health risks.

For example, a major study32 of the supposed link between electric power lines and childhood leukaemias produced a RR of 1.24, with a 95% Confidence Interval of 0.86 - 1.79. The researchers concluded that this provided “little evidence” of a link between power lines and leukaemia. The US National Cancer Institute went further, declaring that the study showed magnetic fields “do not raise children’s leukaemia risk”.

Another study33 of women with breast implants found a RR for hospitalisation for connective tissue disorders of 1.3 with a non-significant 95% CI of (0.7 – 2.2), again close to the IARC passive smoking study. But whereas the IARC findings were claimed to prove a link between ETS and lung cancer, in the breast implant study they were found not to be associated “with a meaningful excess risk of connective tissue disorder”34.

What is absent is an explanation as to why the low RRs that have been reported in respect of lung cancer and ETS - with 95% CIs often including 1.0 and any excess risk capable of being accounted for by only modest degrees of bias and confounding, or by inadequate statistical adjustment for such factors - are regarded by some as providing incontrovertible proof of a causal link. And also why the interpretations of ETS RRs are not in line with the general guidance provided in 1998 by the Government in answer to a Parliamentary question, albeit incorporating an incorrect explanation of a CI:

“Relative risk provides a measure of the strength of association between a factor and an illness. It is an important way of measuring increases or decreases of risk over time or between different groups by comparing the incidence of an illness or hazard within a population to some baseline (for example, if drinkers are twice as likely to suffer from a particular disease as compared with the general population, a factor of 2 may be cited). A stronger association of greater than 2 is more likely to reflect causation than is a weaker association of less than 2 as this is more likely to result from methodological biases or to reflect indirect associations which are not causal. The significance of any
such number does though need to be considered in context and from a number of viewpoints.

First, there is a statistical significance: in other words, what confidence is there in the number itself. This will depend on the quality and extent of the available data. Scientists usually express these by giving a confidence interval: rather than by saying that the relative risk factor is 2, they will say that (for example) one can be 95 per cent certain that it lies between 1.6 and 2.4.

Even when the strength of an association is precisely determined, it is insufficient in itself to confirm a direct causal link between possible cause and illness. The strength of an association is only one of several criteria which must be considered in the assessment of causation. Other criteria include:

- the cause must precede the effect;
- the biological plausibility of the association - is the association consistent with other knowledge e.g. experimental evidence?
- the consistency of the finding – is the same result obtained from different studies using different methodologies elsewhere?
- the presence of a “dose-response” relationship – an increased response to the possible cause being associated with an increased risk of developing the illness.

All these factors would be taken into account in trying to pinpoint cause.

The practical significance of risk factors, also needs to be considered and depends on how great is the underlying risk. Doubling a very small probability (risk), say 1 in 10,000,000, still results in only a very small risk of illness. Doubling a risk of, say, 1 in 100 could, depending on its nature, be more serious.

In practice, scientific judgments will be made and debated on a case-by-case basis. The Government can draw on the expertise of independent scientific advisory committees which are constituted to provide balanced judgment on the questions covered above.\textsuperscript{35}

The factors mentioned in that important Parliamentary answer are included in the criteria that were proposed by Bradford Hill\textsuperscript{36} to guide the evaluation of a body of evidence as to whether or not an association between an outcome and a putative risk factor is causal. In the case of ETS, the study findings do not come close to meeting the Bradford Hill criteria for causality. In particular, they are not consistent, generally produce very weak or no excess risks, and rarely show dose-responses.

The nature of ETS
ETS is a mixture of the smoke released from the burning end of a cigarette (termed “sidestream” smoke) and the smoke exhaled by the smoker between puffs\textsuperscript{37}. This smoke quickly mixes with the ambient air and becomes highly diluted and, as a result, there are important differences between the level and the chemical and physical composition of the “mainstream” smoke inhaled by the smoker and ETS.
In all normal circumstances, ambient air contains a large number of substances, whether or not smoking has taken place. Such substances can include dust, pollen, bacteria, fungi, trace chemicals from vehicle emissions and other sources of pollutants, as well as, in certain circumstances, emissions from cooking and heating appliances. Research suggests that the types of substances found in indoor air are generally similar, with or without the presence of ETS.

It is extremely difficult to measure real-life ETS. The concentrations of the various substances that make up ETS are generally extremely low and many of the chemicals present in ETS are, irrespective of ETS, likely to be present in the air anyway, emanating from other sources. Moreover, ETS is a complex and constantly changing mixture, making it difficult to extrapolate total ETS exposure from the measurement of an individual chemical marker.

Nonetheless, the results of studies seeking to quantify exposure suggest that concentrations of chemicals in ETS are typically much lower than permissible exposure limits to these chemicals approved by regulators. Studies have, not surprisingly, also reported that non-smoker exposure to ETS is a great deal lower than the smoker’s exposure to mainstream smoke. Generally such studies have looked at exposure to nicotine, not because airborne nicotine is widely thought to cause lung cancer, heart disease or respiratory disease, but because it is almost unique to tobacco smoke and can be measured even at low concentrations.

For example, one study reported that, on average, in the course of a year, non-smokers had an exposure to airborne nicotine which was less than the amount delivered to a smoker by just five cigarettes with a yield of 1mg per cigarette. Another study of British women exposed to ETS in various settings reported that on average a non-smoker would only be exposed to the equivalent nicotine of smoking a single cigarette over a period in excess of two years.

A variety of studies which have measured the biological metabolites of nicotine have suggested ETS exposures of an average of 0.2% to 0.4% of active smoking, while estimates of particulate exposure suggest a factor of around 0.05% to 0.1%.

Measuring uptake, as compared with exposure, of ETS by non-smokers presents its own problems. The most commonly used markers are nicotine and its metabolite cotinine, which can be analysed in body fluids. Subjects do vary, however, in the rate at which they metabolise nicotine. Nicotine and cotinine are also not quantitative markers for other components of ETS. Most scientists also accept that there is a threshold for carcinogenesis and other disease processes.

The findings on the nature of ETS suggest that no firm conclusions can be drawn on the possible health effects of ETS without adequate supporting evidence from clinical, experimental and epidemiological studies.

A listing of ETS epidemiological studies

In the tables that follow, there are listings of ETS epidemiological studies concerning lung cancer and ETS, prepared for the TMA by the epidemiologist, P N Lee. With regard to heart disease, studies relating to the work place are listed. Further details relating to the composition of these lists, and also further detailed listings regarding heart disease, are available on the website, www.pnlee.co.uk. The overviews of the findings of those studies given below have been prepared by the TMA.
Lung cancer
There have been over 60 epidemiological studies of lung cancer among life-long non-smokers. The overall evidence shows no statistically significant increased risk of lung cancer in relation to ETS exposure from parents in childhood, or in social situations or to non-spousal ETS exposure at home. The overall evidence shows that lung cancer risk among non-smoking women is associated with having a husband who smokes (and vice versa but an even weaker association). However, this excess risk of well below 2.0 may be accounted for by bias and failure to take account of confounding factors and misclassification. Those studies that reported stronger associations did not adjust for age, a standard procedure to avoid bias. 80% of the studies showed no statistically significant association with smoking by the spouse and lung cancer. The largest five studies (with over 400 lung cancer cases) produced inconsistent results; one reporting a small increase in risk, three no statistically significant increase and one a statistically significant decrease in risk.

Of those studies, around 50 have examined the incidence of lung cancer in women who claim never to have smoked, but who are married to smokers (“spousal” studies), or the nearest equivalent index, such as living with a smoker. Many have reported a small increase in risk, but a significant majority have not reported overall statistically significant increases. Where a statistically significant association was reported, the magnitude of relative risk reported was so small (below 2.0) that it would generally be regarded as being too weak by normally accepted epidemiological standards to form a basis for public health policy.

The small increase in risk reported by various studies could be accounted for by a number of factors. For example, non-smokers living with smokers tend to have different lifestyles and diets from those living in non-smoking households. It is also not possible to be certain that all studies made appropriate adjustments for misclassification – such as when self-reporting non-smokers are in fact former or current smokers. This is especially problematic because former and current smokers not only have an increased risk of lung cancer, they are also more likely to have married smokers and thus be included among those exposed to ETS in these studies.

The data on ETS exposure at work is even less conclusive than the spousal data. Only a very small minority of the studies on ETS and lung cancer have reported an overall statistically significant increase in risk. Similarly, most studies which have looked at ETS exposure in social settings and during childhood do not report an overall statistically significant increase in risk of lung cancer.

Coronary heart disease
There have been around 30 studies of heart disease and ETS among life-long non-smokers. The overall evidence does not indicate an increased risk of heart disease due to ETS exposure in the work place. Only one study out of 18 reported a statistically significant association. Again the weak associations found between spousal smoking are generally not statistically significant and could be accounted for by lifestyle confounding factors – of which over three hundred have been reported – study design, absence of confirmation of diagnosis, and misclassification. Two of the most substantial pools of data on this subject are the databases of the American Cancer Society’s Cancer Prevention Study and the database of the US National Mortality Followback Survey. Analyses of these data sets have reported no overall association between ETS and heart disease.
A further large study of ETS and heart disease was published in 2003 and also showed no increase in risk.

A report of the US Surgeon General noted “because smoking is but one of the many risk factors in the aetiology of heart disease, quantifying the precise relationship between ETS and this disease is difficult”.

**Children**

There is a large body of research on ETS exposure and respiratory disorders in children. These are difficult to analyse overall as there is great disparity in study design, age ranges and subjects, the symptoms measured and methods of diagnosis. There are quite a number of reports of statistically significantly increased risk of respiratory disorders in pre-school age children exposed to ETS. It is unclear to what extent this increase is influenced by other factors more statistically common in smoking households, such as poor diet, housing conditions and quality of pre-natal care. The pattern of increased risk is not consistently replicated for children of school age, suggesting that a real effect, if one exists, is short term and is age-related.

Although smoking by parents has been associated in some studies with an increased risk of “cot death” (sudden infant death syndrome), a long list of other factors has also been reported. Some recent studies have reported that incidence of ‘cot death’ has been reduced by up to 50% where parents have followed government advice not to put their children to sleep in a prone position. However, no one yet fully understands the reasons or mechanisms behind this syndrome. Some have suggested that there may be some residual effects of a mother’s smoking during pregnancy, in respect of which there is strong public health advice to women not to smoke during pregnancy.

**TABLE 1 – Relative risk of lung cancer among lifelong non-smoking women in relation to smoking by the husband**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author</th>
<th>Year</th>
<th>Location</th>
<th>No. of lung cancers</th>
<th>Relative Risk</th>
<th>Confidence Interval at 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Garfinkel 1</td>
<td>1981</td>
<td>USA</td>
<td>153*</td>
<td>1.17</td>
<td>0.85 – 1.61</td>
</tr>
<tr>
<td>2</td>
<td>Chan</td>
<td>1982</td>
<td>Hong Kong</td>
<td>84</td>
<td>0.75</td>
<td>0.43 – 1.30</td>
</tr>
<tr>
<td>3</td>
<td>Correa</td>
<td>1983</td>
<td>USA</td>
<td>25</td>
<td>2.07</td>
<td>0.81 – 5.25</td>
</tr>
<tr>
<td>4</td>
<td>Trichopoulou</td>
<td>1983</td>
<td>Greece</td>
<td>77</td>
<td>2.08</td>
<td>1.20 – 3.59</td>
</tr>
<tr>
<td>5</td>
<td>Buffler</td>
<td>1984</td>
<td>USA</td>
<td>41</td>
<td>0.80</td>
<td>0.34 – 1.90</td>
</tr>
<tr>
<td>6</td>
<td>Hirayama</td>
<td>1984</td>
<td>Japan</td>
<td>200*</td>
<td>1.45</td>
<td>1.02 – 2.08</td>
</tr>
<tr>
<td>7</td>
<td>Kabat</td>
<td>1984</td>
<td>USA</td>
<td>53</td>
<td>0.79</td>
<td>0.25 – 2.45</td>
</tr>
<tr>
<td>8</td>
<td>Garfinkel 2</td>
<td>1985</td>
<td>USA</td>
<td>134</td>
<td>1.23</td>
<td>0.81 – 1.87</td>
</tr>
<tr>
<td>9</td>
<td>Lam W</td>
<td>1985</td>
<td>Hong Kong</td>
<td>75</td>
<td>2.01</td>
<td>1.09 – 3.72</td>
</tr>
<tr>
<td>10</td>
<td>Wu</td>
<td>1985</td>
<td>USA</td>
<td>31</td>
<td>1.20</td>
<td>0.50 – 3.30</td>
</tr>
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Notes
* indicates a prospective study, all others being case-control studies.

The list excludes studies which have been superseded by later results or included in other studies, or where data or size of study is generally regarded as being inadequate.

A variety of indices of ETS exposure were used in these studies. Nearly all considered smoking by the spouse (or partner) as a measure of exposure, with a number of studies considering ETS exposure by other household members, in the workplace, in childhood or in social situations.

Where necessary, relative risks and 95% confidence limits were estimated from data presented.

The above studies should not be interpreted as indicating a causal effect of ETS:

- the association is weak and in the great majority of studies is not statistically significant; about 80% show no statistically significant association;
- the combined results vary over time, with the association being significantly weaker in studies published since 1989 than in those published in the 1980s; they also vary by region, study size, study quality and by the type of control group used (with no significant association evident in those studies using healthy population controls);
- some of the very largest studies show no association, including 4 of the 5 studies involving over 400 lung cancer cases: No 31 (Brownson 2) reported no statistically significant association between lung cancer and any index of ETS exposure; No. 29 (Wu-Williams) even reported a significantly reduced risk of lung cancer for non-smoking women married to smokers;
- about 20% of the studies did not adjust for age in the analysis, a standard procedure in epidemiology to avoid bias; those studies report much stronger associations with spousal exposure than those that did age-adjust;
- spousal studies are particularly susceptible to various biasing factors including failure to consider diet, lifestyle, family medical history, education, socio-economic status and other factors recognised as being different between smoking and non-smoking households; and the inappropriate inclusion of some misclassified current and former smokers among the life-long non-smokers;
- the studies also rely on reported, rather than objectively measured ETS exposure data; and
- publication bias must be taken into account - the studies are not representative of the totality of studies; those with results that are not positive may not be published.

**TABLE 2** - Relative risk of lung cancer among lifelong non-smoking men in relation to smoking by the wife

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Notes
* indicates a prospective study, all others being case-control studies.

The Notes at the foot of Table 1 are also relevant to this Table.

In these studies, the index of exposure is based on smoking by the spouse or, if not available, the nearest equivalent: otherwise exposed to ETS at home.

**TABLE 3 - Relative risk of lung cancer among lifelong non-smokers reportedly exposed to ETS exposure in the work place**

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<td>Layard</td>
<td>1994</td>
<td>USA</td>
<td>21</td>
<td>1.47</td>
<td>0.55 – 3.94</td>
</tr>
<tr>
<td>38</td>
<td>Kabat 2</td>
<td>1995</td>
<td>USA</td>
<td>41</td>
<td>1.60</td>
<td>0.67 – 3.82</td>
</tr>
<tr>
<td>39</td>
<td>Schwartz</td>
<td>1996</td>
<td>USA</td>
<td>72</td>
<td>1.10</td>
<td>0.60 – 2.03</td>
</tr>
<tr>
<td>43a</td>
<td>Cardenas</td>
<td>1987</td>
<td>USA</td>
<td>116</td>
<td>1.10</td>
<td>0.60 – 1.80</td>
</tr>
<tr>
<td>44</td>
<td>Kheng</td>
<td>1997</td>
<td>China</td>
<td>25</td>
<td>0.67</td>
<td>0.22 – 2.04</td>
</tr>
<tr>
<td>45</td>
<td>Auvinnen</td>
<td>1998</td>
<td>Finland</td>
<td>44</td>
<td>0.69</td>
<td>0.28 – 1.74</td>
</tr>
<tr>
<td>46</td>
<td>Boffetta 1</td>
<td>1998</td>
<td>Western Europe</td>
<td>141</td>
<td>1.47</td>
<td>0.81 – 2.66</td>
</tr>
<tr>
<td>55</td>
<td>Malats</td>
<td>2000</td>
<td>Europe/Brazil</td>
<td>17</td>
<td>1.50</td>
<td>0.41 – 5.43</td>
</tr>
<tr>
<td>56</td>
<td>Wang L</td>
<td>2000</td>
<td>China</td>
<td>33</td>
<td>0.56</td>
<td>0.20 – 1.40</td>
</tr>
<tr>
<td>58</td>
<td>Lagarde</td>
<td>2001</td>
<td>Sweden</td>
<td>191</td>
<td>1.15</td>
<td>0.81 – 1.63</td>
</tr>
<tr>
<td>63</td>
<td>Enstrom</td>
<td>2003</td>
<td>USA</td>
<td>79*</td>
<td>0.63</td>
<td>0.33 – 1.22</td>
</tr>
</tbody>
</table>
TABLE 4 - Relative risk of lung cancer among lifelong non-smokers in relation to ETS exposure in childhood

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author</th>
<th>Location</th>
<th>Sex</th>
<th>Relative Risk</th>
<th>Confidence Interval at 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Garfinkel 2</td>
<td>USA</td>
<td>F</td>
<td>0.91</td>
<td>0.58 – 1.42</td>
</tr>
<tr>
<td>10</td>
<td>Wu</td>
<td>USA</td>
<td>F</td>
<td>0.60</td>
<td>0.20 – 1.70</td>
</tr>
<tr>
<td>14</td>
<td>Gao</td>
<td>China</td>
<td>F</td>
<td>1.10</td>
<td>0.70 – 1.70</td>
</tr>
<tr>
<td>16a</td>
<td>Koo</td>
<td>Hong Kong</td>
<td>F</td>
<td>0.56</td>
<td>0.21 – 1.50</td>
</tr>
<tr>
<td>18</td>
<td>Pershagen</td>
<td>Sweden</td>
<td>F</td>
<td>1.00</td>
<td>0.40 – 2.30</td>
</tr>
<tr>
<td>25</td>
<td>Svensson</td>
<td>Sweden</td>
<td>F</td>
<td>3.30</td>
<td>0.50 – 18.80</td>
</tr>
<tr>
<td>26</td>
<td>Janerich</td>
<td>USA</td>
<td>Combined</td>
<td>1.33</td>
<td>0.86 – 2.06</td>
</tr>
<tr>
<td>28</td>
<td>Sobue</td>
<td>Japan</td>
<td>F</td>
<td>1.28</td>
<td>0.71 – 2.31</td>
</tr>
<tr>
<td>31</td>
<td>Brownson 2</td>
<td>USA</td>
<td>F</td>
<td>0.80</td>
<td>0.60 – 1.10</td>
</tr>
<tr>
<td>32</td>
<td>Stockwell</td>
<td>USA</td>
<td>F</td>
<td>1.66</td>
<td>0.80 – 3.44</td>
</tr>
<tr>
<td>35</td>
<td>Fontham</td>
<td>USA</td>
<td>F</td>
<td>0.89</td>
<td>0.72 – 1.10</td>
</tr>
<tr>
<td>38</td>
<td>Kabat 2</td>
<td>USA</td>
<td>M</td>
<td>0.90</td>
<td>0.43 – 1.89</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.63</td>
<td>0.91 – 2.92</td>
</tr>
<tr>
<td>40</td>
<td>Sun</td>
<td>China</td>
<td>F</td>
<td>2.29</td>
<td>1.56 – 3.37</td>
</tr>
<tr>
<td>42</td>
<td>Wang T-J</td>
<td>China</td>
<td>F</td>
<td>0.91</td>
<td>0.56 – 1.48</td>
</tr>
<tr>
<td>46</td>
<td>Boffetta 1</td>
<td>West Europe</td>
<td>M</td>
<td>0.79</td>
<td>0.52 – 1.21</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>0.77</td>
<td>0.61 – 0.98</td>
</tr>
<tr>
<td>48</td>
<td>Zaridze</td>
<td>Russia</td>
<td>F</td>
<td>0.92</td>
<td>0.64 – 1.32</td>
</tr>
<tr>
<td>49</td>
<td>Boffetta 2</td>
<td>Europe</td>
<td>Combined</td>
<td>0.60</td>
<td>0.30 – 1.20</td>
</tr>
<tr>
<td>51</td>
<td>Rapiti</td>
<td>India</td>
<td>M</td>
<td>1.09</td>
<td>0.38 – 3.18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>12.0</td>
<td>4.30 – 32.0</td>
</tr>
<tr>
<td>53</td>
<td>Zhong</td>
<td>China</td>
<td>F</td>
<td>0.93</td>
<td>0.72 – 1.20</td>
</tr>
<tr>
<td>54</td>
<td>Lee C-H</td>
<td>Taiwan</td>
<td>F</td>
<td>2.10</td>
<td>1.40 – 3.14</td>
</tr>
<tr>
<td>56</td>
<td>Wang L</td>
<td>China</td>
<td>M</td>
<td>1.46</td>
<td>0.60 – 3.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.51</td>
<td>1.00 – 2.20</td>
</tr>
<tr>
<td>57</td>
<td>Johnson</td>
<td>Canada</td>
<td>F</td>
<td>1.38</td>
<td>0.81 – 2.34</td>
</tr>
<tr>
<td>60</td>
<td>Ohno</td>
<td>Japan</td>
<td>F</td>
<td>1.00</td>
<td>0.51 – 1.98</td>
</tr>
<tr>
<td>61</td>
<td>Rachtan</td>
<td>Poland</td>
<td>F</td>
<td>3.31</td>
<td>1.26 – 8.69</td>
</tr>
<tr>
<td>64</td>
<td>Zatlopukal</td>
<td>Czech Republic</td>
<td>F</td>
<td>1.61</td>
<td>1.01 – 2.57</td>
</tr>
</tbody>
</table>

Note
Two other studies – Nos 3 and 11, reported finding no association but gave no detailed results.
TABLE 5 - Relative Risk of heart disease among lifelong non-smokers reportedly exposed to ETS in the work place

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author</th>
<th>Publication</th>
<th>Location</th>
<th>Sex</th>
<th>Relative Risk</th>
<th>Confidence Interval at 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Lee</td>
<td>1986</td>
<td>UK</td>
<td>M</td>
<td>0.66</td>
<td>0.26 - 1.66</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>0.69</td>
<td>0.26 - 1.87</td>
</tr>
<tr>
<td>5</td>
<td>Svendsen</td>
<td>1987</td>
<td>USA</td>
<td>M</td>
<td>1.40</td>
<td>0.80 – 2.50</td>
</tr>
<tr>
<td>9</td>
<td>Jackson</td>
<td>1989</td>
<td>New Zealand</td>
<td>M</td>
<td>1.80</td>
<td>0.94 – 3.46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.55</td>
<td>0.48 – 5.03</td>
</tr>
<tr>
<td>12</td>
<td>Dobson</td>
<td>1991</td>
<td>Australia</td>
<td>M</td>
<td>0.95</td>
<td>0.51 – 1.78</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>0.66</td>
<td>0.17 – 2.62</td>
</tr>
<tr>
<td>17</td>
<td>Muscat</td>
<td>1995</td>
<td>USA</td>
<td>M</td>
<td>1.20</td>
<td>0.60 – 2.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.00</td>
<td>0.40 – 2.50</td>
</tr>
<tr>
<td>19</td>
<td>Steenland</td>
<td>1996</td>
<td>USA</td>
<td>M</td>
<td>1.03</td>
<td>0.89 – 1.19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.06</td>
<td>0.84 – 1.34</td>
</tr>
<tr>
<td>21</td>
<td>Kawachi</td>
<td>1997</td>
<td>USA</td>
<td>F</td>
<td>1.68</td>
<td>0.81 – 3.47</td>
</tr>
<tr>
<td>24</td>
<td>Spencer</td>
<td>1999</td>
<td>Australia</td>
<td>M</td>
<td>No RR but no significant association</td>
<td></td>
</tr>
<tr>
<td>25b</td>
<td>He</td>
<td>2000</td>
<td>China</td>
<td>F</td>
<td>1.85</td>
<td>0.86 – 4.00</td>
</tr>
<tr>
<td>27</td>
<td>Rosenlund</td>
<td>2001</td>
<td>Sweden</td>
<td>M</td>
<td>1.14</td>
<td>0.78 - 1.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>0.94</td>
<td>0.59 – 1.50</td>
</tr>
<tr>
<td>28</td>
<td>Pitsavas</td>
<td>2002</td>
<td>Greece</td>
<td>M+F</td>
<td>1.97</td>
<td>1.16 – 3.34</td>
</tr>
<tr>
<td>29</td>
<td>Chen</td>
<td>2003</td>
<td>USA</td>
<td>M+F</td>
<td>1.70</td>
<td>0.90 – 3.20</td>
</tr>
</tbody>
</table>

Note
In study no. 21, the estimates were given by study No 32.

TABLE 6 – Meta-analysis : Lung Cancer

<table>
<thead>
<tr>
<th>Index of ETS Exposure</th>
<th>Estimates Combined</th>
<th>Fixed effects RR</th>
<th>95% CI</th>
<th>Random Effects RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking by husband</td>
<td>62</td>
<td>1.17</td>
<td>1.11-1.24</td>
<td>1.22</td>
<td>1.13 – 1.33</td>
</tr>
<tr>
<td>Smoking by wife</td>
<td>21</td>
<td>1.13</td>
<td>0.95 -1.35</td>
<td>1.13</td>
<td>0.95 – 1.35</td>
</tr>
<tr>
<td>Workplace exposure</td>
<td>30</td>
<td>1.21</td>
<td>1.11 – 1.31</td>
<td>1.21</td>
<td>1.11 – 1.31</td>
</tr>
<tr>
<td>Childhood exposure from any co-habitant</td>
<td>29</td>
<td>1.07</td>
<td>0.99 – 1.16</td>
<td>1.16</td>
<td>1.00 --1.40*</td>
</tr>
<tr>
<td>Childhood exposure from</td>
<td>9</td>
<td>0.96</td>
<td>0.77 – 1.20</td>
<td>0.98</td>
<td>0.77 – 1.25</td>
</tr>
</tbody>
</table>
Mother specifically

Social exposure | 12 | 1.04 | 0.92 - 1.17 | 1.02 | 0.80 – 1.28

Notes

Fixed effects meta-analysis assumes all the individual study estimates derive from a common mean, with their contribution to the overall estimate depending only on within-study variability, with large studies carrying more weight than small ones.

Random effects meta-analysis assumes that the individual study estimates derive from a distribution of effects, with the weighting of the individual estimates depending both on the within-study and between-study variability.

This estimate is inflated by one study (No 14, Gao – China) reporting an extremely high estimate of 12.0 (4.30 – 32.0)

TABLE 7 – Meta-analysis: Lung Cancer

Of studies of smoking by the husband, by publication date

<table>
<thead>
<tr>
<th>Studies published</th>
<th>Estimates Combined</th>
<th>Fixed Effects RR</th>
<th>95% CI</th>
<th>Random Effects RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981 – 1989</td>
<td>25</td>
<td>1.38</td>
<td>1.23 – 1.55</td>
<td>1.38</td>
<td>1.23 – 1.55</td>
</tr>
<tr>
<td>1990 – 2003</td>
<td>37</td>
<td>1.11</td>
<td>1.04 – 1.18</td>
<td>1.16</td>
<td>1.04 – 1.28</td>
</tr>
</tbody>
</table>

TABLE 8 – Meta-analysis: Heart disease

<table>
<thead>
<tr>
<th>Studies</th>
<th>Estimates Combined</th>
<th>Fixed Effects RR</th>
<th>95% CI</th>
<th>Random Effects RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse ever smoked</td>
<td>42</td>
<td>1.07</td>
<td>1.04 – 1.09</td>
<td>1.14</td>
<td>1.07 – 1.20</td>
</tr>
<tr>
<td>Spouse current smoker</td>
<td>42</td>
<td>1.08</td>
<td>1.05 – 1.11</td>
<td>1.16</td>
<td>1.09 – 1.23</td>
</tr>
<tr>
<td>Workplace exposure</td>
<td>17</td>
<td>1.11</td>
<td>1.01 – 1.23</td>
<td>1.13</td>
<td>1.01 – 1.27</td>
</tr>
</tbody>
</table>

Notes

Meta-analysis, its difficulties and shortcomings, are explained at paragraph 17 et seq.

In this table, ‘spouse ever smoked’ is used where a study also provides data for ‘spouse current smoker’, and estimates for ‘spouse current smoker’ are used where a study also provides data for ‘spouse ever smoked’.

As for lung cancer, heart disease studies published in recent years show a weaker relationship of risk to smoking by the spouse than previously published studies. It is notable that the relative risks from the two largest US studies, published in 1995 and 2003, were very close to 1.00 in each sex, and not statistically significant.
Again all the studies are subject to the same biases and confounding factors as are noted under Table 1.

ETS POSTSCRIPT

Whilst completing this supplementary evidence for the Committee, two reports have been published upon which comment is relevant.

The first is a report by IARC, published only at the end of May but a short report of the findings were made and publicised earlier, in 2002. The 222-page section entitled ‘involuntary smoking’ reports the ETS studies and reviews that have been undertaken. It reaches no substantially different conclusions as to the findings of those studies and reviews than is reported here and as was reported in the findings of the IARC study published in 1998.

IARC’s overall evaluation that exposure to ETS is carcinogenic to humans crucially depends on its evaluation that there is sufficient evidence that ETS causes lung cancer in humans, since IARC clearly considers the evidence that ETS causes other cancers in humans to be inconclusive. IARC considers that there is sufficient evidence of carcinogenicity of sidestream smoke condensates, but this finding on its own could not lead to ETS being classified as a Group 1 carcinogen. For the evidence that ETS causes lung cancer in humans to be considered sufficient, IARC requires that a positive association be observed for which “a causal interpretation is considered to be credible” and for which “chance, bias or confounding” can “be ruled out with reasonable confidence.”

Although IARC presents its own up-dated meta-analysis of the evidence relating ETS exposure to lung cancer risk in non-smokers, these analyses are not adjusted for bias or confounding. Instead, the conclusion that the excess risk “remains after controlling for some potential sources of bias and confounding” relies heavily on previously published meta-analyses of the evidence. The majority of the latter are old and based on limited data; of the only two citations by IARC in the last 10 years, IARC fails to address even adequately the substantial issues concerning misclassification, other biases and confounding that those citations raise, and fails to address the claim that the association of spousal smoking with lung cancer risk in non-smokers essentially disappears if proper adjustments are made. In this regard, the views of the eminent authorities quoted in paragraph 47 of this evidence to the Committee are also pertinent.

The second publication is that of a study examining levels of cotinine, a biomarker of exposure to ETS, with the risk of coronary heart disease and stroke. This study took data from the British regional heart study, which is a prospective study of cardiovascular disease in men aged 40-59 years that began in 1978-80. In 1978-80, research nurses administered a questionnaire on present and previous smoking habits – but not asking about ETS exposure - and blood samples were taken and frozen. In 2001-02, those samples were thawed and cotinine concentration (a nicotine metabolite and crude marker for ETS exposure) was measured. The cotinine values for each person were then compared with heart disease events over the period 1980 to 2000.

The study found no increase in risk of stroke associated with ETS exposure as measured by cotinine, a finding which contradicts results from an earlier retrospective case-control study. It found no increase in risks for coronary heart disease when
measured after 15 to 20 years. For life-time non-smokers, the study reports increases in risk that are not statistically significant for all adjustments apart from one.

As the study states, it was “modest in size with limited precision”. It also expressed concern as to possible misclassification arising from men in the higher cotinine groups smoking cigarettes on an intermittent basis. Such misclassification might account for the otherwise puzzling finding of a relative risk for non-smokers exposed to ETS being almost the same as that for active smokers of 1 to 9 cigarettes a day.

Contrary to the sensationalist headlines reporting the study in the popular press, the researchers’ conclusions were appropriately modest and prompt further questions about the nature of the association, if any, between ETS and heart disease, rather than provide any definitive answers.

ANNEX

Studies referred to in Tables 1 to 5


9 Lam WK. A clinical and epidemiological study of carcinoma of lung in Hong Kong [Thesis]. University of Hong Kong; 1985.


17 Lam TH, Kung ITM, Wong CM, Lam WK, Kleeves JWL, Saw D, et al. Smoking, passive smoking and histological types


43b Cardenas VM. Environmental tobacco smoke and lung cancer mortality in the American Cancer Society's Cancer Prevention Study II [Thesis]. Atlanta, Georgia: Emory University; 1994.


Note on judgments in employment cases involving ETS

The only cases of which the TMA is aware are those which there is an official court record, or where there has been a news report in the columns of the press.

The only case in which there has been full adjudication of the facts is the English case of *Silvia Sparrow v St Andrew's Homes Limited* that was heard in the Manchester High Court in 1998. In this case, the Plaintiff, who was a state-enrolled nurse in a nursing home, claimed that ETS had caused or aggravated her asthma. In May 1998, her claim was dismissed and the Judge found that her employers had done all that was reasonably practicable to take reasonable care of Mrs Sparrow's safety at work. In particular, the Judge concluded that there was insufficient scientific evidence relating to the causation of asthma in adults to be able to conclude that ETS caused her asthma. He said that what science there was, was “small in compass and speculative in weight”. The onus was on Mrs Sparrow to find other work, given that simple adjustments to the work place could not resolve the issue to her satisfaction.

In 1990, a case was heard by the Social Security Commission, *Clay v Adjudication Officer*. It is understood that Miss Clay worked as a social security officer and claimed that her asthma was aggravated by exposure to ETS. The Social Security Commissioner who decided her case, found that she had extreme sensitivity to the chemicals in tobacco smoke and that the case turned on its own special facts. He specifically stated that his decision was “no precedent for other cases where it may be alleged that there has been a deleterious effect from the gradual day-by-day process of employees being obliged to inhale other employees' tobacco smoke.” There may be other cases which have been brought in the UK, but these are the only two of which we are aware and for which we have any information.

The website of ASH makes reference to an award made in May 2000 in relation to Matthew Comstive, whose mother, Collette Comstive, was apparently exposed to ETS while working at Great Universal Stores during her pregnancy. ASH reported that a judge in chambers awarded the sum of £5,000. However, this may have been as a result of a settlement, rather than a court adjudication.

We are also aware that over the past 10 years there have been some 10 cases in respect of which legal proceedings were commenced but then settled, with the settlement details generally remaining confidential:

**In England and Wales**

*Veronica Bland v Stockport Borough Council* (1993) (reported settlement - £15,000)
*Beryl Roe v Stockport Borough Council* (1995) (reported settlement - £25,000)
In Northern Ireland
McGuirk v Southern Health & Social Services Board (1993)
McCalmont v Eastern Health & Social Services Board (1995)
Megarry v Police Authority for Northern Ireland (1998)
McClusky v Groby ex-Servicemen’s Social Club (2001)

In Scotland
Agnes Rae v Strathclyde Joint Police Board (1995)
Margaret Pacetta v Clydesdale Bank (1996)

We are also aware of several cases brought to the Employment Tribunal and Employment Appeals Tribunal in the context of constructive unfair dismissal claims:

In Waltons & Morse v Dorrington (1997), Mrs Dorrington lodged a claim for constructive and unfair dismissal on the grounds that she was forced to resign as a result of her employer’s failure to provide a smoke-free environment in which she could work. On appeal the Employment Appeals Tribunal held that:

“[I]t is an implied term of every contract of employment that the employer will provide and monitor for employees, so far as is reasonably practicable, a working environment which is reasonably suitable for the performance by them of their contractual duties. The starting point for the implication of such a term is the duty on an employer under s.2(2)(e) of the Health and Safety at Work Act to provide and maintain a working environment for employees that is reasonably safe and without risk to health and is adequate as regards facilities and arrangements for their welfare at work. The right of an employee not to be required to sit in a smoke-filled atmosphere affects the welfare of employees at work, even if it is not something which directly is concerned with their health or can be proved to be a risk to health.”

The Employment Appeals Tribunal concluded that it would have been reasonably practicable for the employers to have solved the problem by telling those who smoked that they would not be permitted to smoke in the building because it rendered the working conditions of other employees unacceptable. It was therefore reasonably practicable for the employers to have provided the employee with a working environment that was suitable for the performance by her of her contractual duties. The conditions in which they were requiring Mrs Dorrington to work therefore rendered them in breach of the implied term to provide a reasonably suitable working environment.

The Employment Appeal Tribunal has also considered the issue of ETS from the perspective of a smoker. In Dryden v Greater Glasgow Health Board (1992), Mrs Dryden, a nurse employed at the Western Infirmary in Glasgow, lodged a complaint of constructive dismissal following a ban on smoking on the employer’s premises. The Tribunal dismissed the complaint holding that there was no implied term to the effect that Mrs Dryden was entitled to be provided with a place to smoke at work. There was no basis for holding that there was any implied term to the effect that failure to provide such facilities was a breach of the implied term of trust and confidence.

1 IARC, 1986: p.308
2 Respiratory health effects of passive smoking: lung cancer and other disorders, EPA, Washington DC, 1992
3 Oral statement of Dr Jane Gravelle & Dr Dennis Zimmerman of the Congressional Research service, the Library of Congress, Washington DC, May 11 1994
4 Flue-cured Tobacco Stablization Corporation et al v United States Environmental Protection Agency and Carol Browner, District Court for the Middle District of North Carolina before District Judge Osteen, Order and Judgement, 17 July 1998
5 Californian EPA 1997
6 NHMRC 1998
7 SCOOTH 1998
9 The Lancet, April 23, 2004 on the research commissioned by the National Institute for Clinical Excellence into the prescribing of anti-depressants drugs to children; and The Independent, April 23 2004
11 Bhopal, R.S., Professor of Public Health, University of Edinburgh, Concepts of Epidemiology, p 91, OUP 2002
13 Richard Smith, editor BMJ, BMJ 2003;327:505
14 Peto, J (Institute of Cancer Research), Meta-analysis of epidemiological studies of carcinogenesis, in Mechanisms of Carcinogenesis in Risk Identifiation, p572, IARC 1992
23 Presented at the Royal College of Physicians’ conference on 17th May 2004.
24 Woodward A & Laugesen M, How many deaths are caused by second hand cigarette smoke, Tobacco Control, 2001;10: 383-388
26 National Cancer Institute, USA, Press Release, 26 October 1994
27 Doll, R and Peto, R, The causes of cancer, p 1219, OUP 1981,
31 Isabel dos Santos Silva. Cancer epidemiology: Principles and methods, IARC 1999
34 Cooper C, Dennison E. Do silicone breast implants cause connective tissue disorder? BMJ;1998;316:403
40 Gori G B and Mantel N, Mainstream and environmental tobacco smoke. Regulatory Pharmacology and Toxicology 1991;14: 88-105
44 Dirty Water. US National Cancer Institute, Reason 1996;28:1.52
SUPPLEMENTARY SUBMISSION FROM BRITISH HOSPITALITY ASSOCIATION SCOTLAND COMMITTEE

Thank you for the opportunity to submit supplementary evidence to the Committee for consideration. I hope the points outlined below help clarify our position and will aid the Committee's consideration of the Prohibition of Smoking in Regulated Areas (Scotland) Bill ('the Bill').

In the oral evidence session the Committee questioned the British Hospitality Association Scotland’s (BHA) position. The BHA supports the Voluntary Charter as long as it continues to have industry and government support. If the Voluntary Charter is no longer supported in this way a total ban on smoking in places of employment is viewed by the BHA as the only logical step open to government. A partial ban on smoking in certain public areas or a ban that is introduced at a local authority level are viewed by our organisation as the worst possible policy or legislative options.

If legislation is to be brought forward it must deliver clear health benefits, be Scotland-wide or in the case of Health and Safety legislation UK-wide. The legislation must also be straightforward to implement and enforce. Penalties must be focussed on those individuals who smoke in areas of employment rather than penalising operators for the offences of others. Legislation must be applied equitably across all areas to which the public have access and not just where food is served. The Bill as currently drafted does not meet this criterion.

The BHA believes that the Voluntary Charter has delivered tangible results; indeed, as the Committee has already heard it has met or exceeded almost all of its original targets. The Voluntary Charter provides consumer choice while extending the number of smoke free areas. However, we are fully aware that for the Charter to succeed it must have political, public and industry support. If the situation arises where the Voluntary Charter no longer has support, we would then support legislation in this area.

The BHA has a number of concerns with the Bill as currently drafted. These include:

- The Bill is not equitable, as the ability of an establishment to implement separate areas will depend on its physical characteristics. Thus it discriminates against smaller establishments, damaging their ability to compete.
- The '5 day' rule is complicated for the hospitality industry to implement. For example, contract caterers may supply food to a venue and not be aware, or able to
control, whether smoking was allowed within the previous 5 days. Nevertheless, they would be liable to prosecution under this Bill.

- The 5 day rule will be virtually impossible to enforce. It does not take into account the dynamic nature of the hospitality industry and will lead to both guest and staff confusion which will impact negatively upon guest satisfaction and staff recruitment.
- If the health impacts of passive smoking are as outlined in the Bill’s Policy memorandum then a total ban on smoking in public is the only realistic option.

The Committee inquired whether the Voluntary Charter Group had discussed ‘ratcheting’ up the Voluntary Charter in response to concerns that it was not delivering improvements at a rate which satisfied stakeholders. In a meeting with Tom McCabe MSP, Deputy Minister for Health on 20 May 2004, the Charter Group comprising the Scottish Licensed Trade Association, Scottish Beer and Pub Association and the BHA made a number of proposals which would ‘ratchet’ up the Voluntary Charter. These proposals would extend the Charter to include registered clubs within the Charter and that:

1. every licensed premise must have a written smoking policy for employees;
2. every licensed premise must have a written smoking policy for customers;
3. the smoking policy of every licensed premise must be clearly communicated to the public by signage or some other acceptable means;
4. in all licensed premise no smoking will be permitted within three feet of the bar counter or within three feet of other areas where staff are serving behind a counter; and,
5. no smoking will be permitted in licensed premises where and when food is served unless fully segregated areas are provided.

The Charter Group also suggested that under a revamped Voluntary Charter all licensed premises would be required to have a designated (but not segregated) non-smoking area in areas where food is not served and that the size of that area will be increased yearly as follows:

- Year 1 – minimum of 30% of public floor space
- Year 2 – minimum of 40% of public floor space
- Year 3 – minimum of 50% of public floor space

It was the view of the Voluntary Group that the three year period will allow the Scottish Executive to monitor the impact of the new regulations and gauge public opinion as to whether the percentages should be increased. However, the position of the Deputy Health Minister was that the Voluntary Charter Group should put these proposals forward during the Scottish Executive consultation on smoking in public.

The Committee requested further information on the BHA’s position on the economic impact of the Bill. Our position is that the Scottish Executive research (commissioned as part of the Scottish Executive consultation) on the economic impact of similar bans on smoking should be carried out and published before legislation in this area is considered.

I hope this additional clarification and information will be helpful and does not leave the Committee in doubt of our position that the only options are a continuation of the Voluntary Charter or a total ban on smoking in public.
SUBMISSION FROM FIRHILL HIGH SCHOOL

Petition to Ban Smoking in Public Places

We, the undersigned, declare that: In order to prevent ill health and disease caused by passive smoking and also in order to contribute to the improvement of public health, smoking should be banned from all public places in Scotland.

The petitioners therefore request that the Scottish Parliament: Introduce a relevant law or laws to make it an offence to pollute public places through the smoking of tobacco or cigarettes.

We, the petitioners present this request in the knowledge that there is much research available to the public supporting our claim that passive smoking can seriously damage health. The bodies which support our view include ASH and QUIT.

SUBMISSION FROM MILE END HIGH SCHOOL PUPILS

Submission by Beth Fiddes

If the bill is passed then a portion of the public will be very unhappy. It could and will start arguments among the public. It will not stop people from smoking, if they want to smoke they will. Most people smoke when they are upset or stressed, take the ability to smoke away from them and you’ll have a very depressed country on your hands.

The bill is to hard to enforce and if you want it to work then get your system sorted. You would need to hire a special team to enforce it. The bill is more trouble than it’s worth! Would you authorise shop keepers and teachers to hand out fines? You don’t have the officers to waste time asking “were you smoking?” all day every day.

To stop the passive smoking problem simply put a wall down the middle of the restaurant and make one half smoking and one half non-smoking. The bill will not go down well with the smoking half of the public. If you ban smoking you won’t get as much money from the cigarettes.

Submission by Shona McDonald

I am writing to you concerning the matter of the prohibition of smoking in regulated areas. I do support this bill and I think it is a good idea. Passive smoking is a dangerous thing and non-smokers shouldn’t be put at risk of the dangers and diseases of second-hand smoke. Banning this is a reasonable thing to do and it means non-smokers can enjoy a mean without smelling smoke.

I think the only other area that should be added is perhaps a supermarket because fresh food is being supplied. I also think it will be quite difficult to enforce but after a couple of months, smokers will hopefully see why this is being enforced. I personally don’t like people smoking around me because not only does it make me feel sick, it is also dangerous.

I think the only way to protect non-smokers from second-hand smoke is to ban smoking from all public places.
Thank you for taking the time to read my letter and I hope some of this will be taken into consideration.

Submission by Niall Rundle

I am writing to you in connection with the Prohibition of smoking in regulated areas (Scotland) bill. I personally am strongly supportive of the bill, as I believe that it will improve the quality of health in Scotland.

I am a strong believer that this bill should be passed. If the before mentioned bill is passed it is my belief that it will make the decline of smoking speed up. Though I agree with the bill I think it will be very difficult to enforce as there are too few police to deal with any slakers. And I also think there should also be a ban on smoking in shops, public parks and museums.

I would like to thank you for reading my letter.

Submission by Lisa-Ann Grant

I am writing to you to tell you about why I think that the bill should be passed. I think it should be passed for many reasons like it can cause many serious diseases like mouth cancer, lung cancer and emphysema. I also think it is the smokers choice to hurt themselves but it is unfair to hurt others through passive smoking. Passive smoking also hurts pregnant woman it can damage the unborn baby causing it to become ill or even die.

It should also be banned in all shopping centres because the cigarettes could cause fire and it would be hard to get a large amount of people out of the building. It may be hard to enforce this if it becomes law but every body will get something out of this.

I hope you will consider this letter and thank you for reading this letter.

Submission by Sofiane Kennouchie

I am writing to tell you that I am disappointed about the smoking problem. I am a child that would like a ban to be placed on public smoking. I am fed up having smoke blown into my face in restaurants. I think that a ban should be in place. It may be hard to enforce, but the end result would be well worth it. Also, if this ban was made law, more restaurants would have this ban, and the smoker might consider quitting because there is hardly anywhere else to go. I hope these points are taken into consideration.

Submission by Nial Holden

We have been learning about the non smoking bill and I am writing on to tell you my views on it. In school we debated it and in the end by the majority of us said yes including me so I am going to tell you some of the points I put forward.

I think it should be passed because if there is a smoking section in a bar or restaurants there is no point because the smoke just drifts through anyway but I think that my friend Findlay made a very good point when he said “I think that people should be able to choose if people can smoke in the club, bar etc.

Thank you for reading my letter.
Submission by Sean Harrower

I am writing to you to tell you that I hope that smoking in public places is stopped because the non-smokers should not suffer lung problems because of the people who smoke. I have been in restaurants where people smoke and my eyes go really sore so I think it should be stopped.

I do no think it will be easy to stop because people will just keep doing it in non-smoking places. So I think it will be hard to stop.

Submission by J Bruce

I am writing to you to tell you about the bill which is the prohibition of smoking in regulated areas in Scotland. I feel strongly about this bill and would like to share my views on it.

First of all I am supporting it because if you’re eating something and smoke drifts over it can make food taste bad, non-smokers should not have to breathe in other people’s smoke and germs. The smokers should smoke in their house or their gardens.

I think if you get the message across that smokers are not allowed to smoke in regulated areas they might give up smoking all together. I think it will be hard to enforce this but it is worth a try. For Scotland’s sake lets stop people smoking in regulated areas.

Submission by Elizabeth Butler

At school we had a debate about the bill being passed pr not, at the end we all voted and we decided yes.

Some of the points we made were “if the bill was passed children would live a more healthy life” and “it might help people quit.”

I think the bill might be a bit difficult to enforce it first but then it will get easier.

Submission by Joanne Wilson

I am writing to you to tell you about the bill and the problems of smoking in restaurants, bars and cafes.

Most of the public who don’t smoke don’t like sitting in restaurants and being surrounded by smoke all of the time and coming home smelling of smoke it also puts peoples lives in danger as well as their own.

I think people shouldn’t have to sit around smokers anymore and come home smelling of smoke I think it would make people more happy if smoking would be banned in regulated areas and it might cut down how much people smoke when they’re out. If someone wants to smoke I think they should have to go outside or smoke in their own homes.

I hope you look into this big problem and do something about it and have no more smoking in restaurants, bars or clubs. Thank you for taking the time to read this letter.

Submission by Richard P Duffy

Smoking is a horrible habit it gets in people’s eyes, nose and mouth even though they don’t want it to. I am in full support of the Bill. Any smoking areas should be banned because the smoke is inhaled from the non-smoking section anyway.
I think it will be difficult to enforce the Bill, many fights might break out because of people not being able to smoke in some places. The owners of bars/restaurants may object to the law because they want to smoke too.

By having non-smoking rooms instead of sections non-smokers would not have to suffer the dangers of passive smoking. Smoking in cars is a distraction from driving and should be banned as well. I hope you will take my views into consideration.

Submission by Zoé MacAndrew

I am writing to you concerning the matter of the Bill that is being passed around the Scottish Parliament. This Bill clearly states that smoking should be banned in public places. I personally don’t think that it should be passed. I have put forward a few points and I hope you will take them into consideration.

If this Bill is passed more people would start smoking in the street. This causes problems because more people would get into trouble from the police. This would annoy people and waste the police’s time when they could be doing something more important.

Most people blame people who smoke for setting off their asthma attacks. I don’t believe this because my mum smokes and my mum smokes and my brother has asthma and it never gives him an attack.

I hope you will read my points and take them into consideration.

Submission by Jack Hughes

I am writing to you about the Bill that is being passed around the Scottish Parliament about the smoking prohibition in regulated areas. I’m supporting to ban smoking in public places so I hope you should take it into account.

Here are some reasons why it should be banned:

1) If smokers smoke among others they could really damage their eyes, lungs, heart and many more or it could end up in death.

2) The people who smoke the cigarette only takes in 8% of it the other 92% is going up into the air.

3) If someone comes to have a meal. It’s not nice for the person to inhale the smoke.

After all this I hope you can take the banning of smoking to the next step.

Submission by Findlay Masson

If it was up to me I would say it would be a personal opinion. e.g. if you were a shop keeper or a bar owner it would really be up to them, if you were in that position you would have two sides one about smoking can get your clothes dirty and smelly and the smokers would not come back maybe.

If you were a smoker you might not go anywhere if all places were non-smoking and would have to smoke in there own time.
Submission by Claire Soutar

I am writing this letter to agree that I think the bill should be passed because people who don't smoke have to suffer. Smoking can cause diseases such as lung cancer, stomach cancer and mouth disease.

I think smoking should be banned altogether in public places because I have sat in a restaurant in a non-smoking area and the smoke from the smoking area still filters over. A majority of people, including smokers support smoking restrictions and that they are concerned about breathing in other people's smoke. If you are in any place where there are smokers your clothing will smell of smoke. Passive smoking hurts pregnant women it can damage that woman's unborn child.

I hope you will consider my points I have made and thank you for reading my letter.

Submission by Andrew Mudie

I am writing this letter to give my opinions on the bill that is going through Parliament.

First, I don't support the bill as I think tobacco manufacturers would make less money so jobs would be axed. Also, less tobacco would be sold and the tax on it would bring the Government less money.

The bill would be very hard to enforce. There is simply not enough policemen and police women to enforce a ban. They can't just go into every single day care centre in Scotland. Other than that I don't think there is any other problem with the bill.

I don't really know how to protect non-smokers but banning it not a step forward.

Submission by Claire Repper

I am writing for the consideration of the Prohibition of smoking in regulated areas (Scotland) bill. Let me first like to put to mind I am all in for the bill to be passed through, though this is a free country and anything which is legal is an odd thing to ban.

The problem is I believe that the government don't mind that the bill is not passed through because they like the taxes coming from the cigarettes. It is a problem for reputation of Scotland to have a lot of smokers in public areas. Also smoking creates a lot of waste from cigarette ends and ash. If smoking is banned in public place it would be much cleaner.

Thank you for taking these points into consideration, I hope this helps your research and good luck for the decision, I hope you get your bill pasted through!

Submission by Robbie Hartley

I am writing to you about the decision to ban smoking in public places. I strongly agree with the proposition to ban smoking and think that the bill should go through the Scottish Parliament and be carried.

I also think that smoking should be banned in public parks and public shops.

Smoking in public places can really affect people's health and can trigger asthma attacks.
Submission by Eleanor Beaumont-Smith

I have been learning about Prohibition of smoking in regulated areas bill and I would like to tell you my opinion.

I support all principles of the bill since I think it is unfair how non-smokers have to breath in other peoples smoke. I also think it is unfair how non-smokers will also get all the diseases that a smoker will get.

I would also be grateful if the government could encourage pregnant women not to smoke because if they do they are more likely to have a premature baby.

In think that it will be quite hard to promote the bill at first but if people refuse to go along with it then you could raise the fine.

Also bar tenders or waiters/waitresses could ask people that it they want to smoke they could do it outside.

Submission by Gordon Buchan

I am writing to tell you about the smoking ban. I think smoking in public or regulated places should be banned because not only does it affect people with asthma but if you go at lot to restaurants with a smoky environment you increase your chance of lung cancer and heart disease. It will a very tough assignment to enforce. This is my opinion on the matter. Thank you for reading this letter.

Submission by Bao Cong Xia

We have been discussing in school if smoking in regulated areas should be banned. I personally think so, because smoking in public affects the environment and the people around them. It especially affects people with asthma and lung problems.

Passive smoking is much more likely to cause cancer and heart disease than direct smoke. It also contains more poisonous chemicals than direct smoke.

These are my opinions on if smoking should be banned in regulated areas. Thank you.

Submission by Ebi Ibojie

I am writing to tell you my views on the banning of smoking in public places. I support the bill and I think that it will make Scotland a cleaner, happier place.

Seven out of ten people don’t smoke these people should not have to breathe in other peoples smoke when they go into a pub or restaurant. Banning smoking may encourage people to stop smoking.

I think the bill will be hard to enforce because some smokers will probably complain and maybe start fights.

I also think that you should ban smoking while people are driving because it can distract the person driving and can disturb the passengers.

I hope you will take my letter into account and thank you very much for reading it.
Submission by Sam Knudson

I am writing to you about the bill that is being passed round the Scottish Parliament about smoking. The bill is whether or not smoking should be banned in public places. I think you will have to put a lot of thought and consideration in to this subject so I have got some points that might sway your decision.

I think if you did ban it there would be a lot of fights about where you smoke and where you can’t but if you did ban it the public’s health would get better.

I hope you come to a good decision and I hope my points have helped.

Submission by Molly Gray

I am writing to tell you that I agree with The Health Committees bill to ban smoking in public places. I also think it’ll be hard to make happen and there should be a fine.

My reasons for wanting the bill to be passed is it’s harming the smokers health as well as non-smokers health. Also it can be irritating for non-smokers as the smell can get in your hair and clothes. Some people may not want to eat in a smoky and smell place. It will make Scotland more healthy and there will be less deaths. Also less for the doctors to do and more time for them to concentrate on other things.

Thank you for taking time out to read my letter. I hope you take it in to consideration.

Submission by Scott Blair

I am writing, to you today, to tell you what I think about the Prohibition of Smoking in Regulated Areas (Scotland) Bill. I am writing on behalf of Mile-End School, and Aberdeen.

I will start off by saying that I am totally for the general principles of the bill. It will be easy to enforce for non-smoking people, but maybe a bit more difficult for the smokers. Other ideas for protecting the non-smokers, would be that you could put signs up on public toilets, restaurants, and any public places that lots of people go to. Any other things that could help, would be maybe more billboards, adverts and posters about quitting smoking.

I will enclose this letter by saying (and asking) to take my advice and at least taking it into consideration.

Submission by Rachael Hadjitofi

At school we have been looking into the bill meaning if we should ban smoking in regulated areas altogether, and I would like to give a few of my opinions.

First of all I would like to say that I think smoking should be banned in regulated areas because if you were at a restaurant the smoke from the smoking area could drift over were some people don’t like it. And if people had asthma smoke again could drift over and it might cause the person to react. The other thing that I don’t think is very fair is that non-smokers don’t really have a choice and the smoke will affect them to a certain degree anyway.

If you weren’t going to ban smoking you could easily make the smoking area outside and if it rains you could put a shelter over them. And last but not least if the smoke drifts over the non-smokers could breath it in and not enjoy their food as much.
I hope you will take time to think about this and made a good decision.

Submission by Callum McPherson

I am writing to you to tell you about my views on the bill about smoking in regulated areas.

First of all, I have to say, I am completely behind the bill. Too long have we had itchy eyes and coughed because of smokers! The main reason I am behind the bill is due to the health risks that are too numerous to name. It is not fair that we are getting cancers and diseases because other people have chosen to smoke! If all the health risks that are thought to be true are true, then the future is pretty bleak unless we do something right now.

There is one factor which may sway people though, the thought of lost business in many pubs and other regulated areas. This may be a threat, however, in other countries who have implemented the same ban, there has been no loss of customers, and sometimes a rise.

Another is the problem of enforcement. You can’t have a police officer in every regulated area. This will be a problem but I’m sure it can be passed.

I hope you have listened to my views.

Submission by Kate Stephen

I am writing to you because I would really like the bill on smoking to be passed. I think that smoking is a disgusting habit, it gives people cancer and health problems. There is also pressure on non-smokers to smoke all the time which is against free will. When there is a smoking part of a restaurant, the smoke from the smoking point will eventually filter through the non-smoking part of the restaurant. It’s the same everywhere, the smoke will always reach you, therefore causing pollution and discomfort.

If the bill was passed then the tourist industry would benefit. babies have delicate lungs and if there are smokers around them in public places it can cause lung disease and reduced lung growth. Accidents can happen with cigarettes and people can get them in their eyes and they could burn people.

Please pass this ban as it would benefit Britain in more ways than one.

Submission by Naomi Watson

I am writing this letter to state my views on the “Prohibition of smoking regulated areas (Scotland)” bill. I think that smoking should be banned in “regulated areas.” Passive smoking is a big risk to everyone, even if they don’t smoke. It is unfair on non-smokers to give them the same risks as smokers through passive smoking when they don’t smoke themselves. I also think that it is unfair to make people work, eat etc in a smoky environment. Cigarette smoke can trigger asthma attacks and make any cough worse.

I think that this bill will be quite difficult to put into practice, but with a bit of determination, I think that it would be a very good move and it could work after a little while. It is not very pleasant to walk into a building that stinks of cigarette smoke. If this bill is passed, then it will greatly help this problem. Also even if there are smoking/non-smoking areas in restaurants/pubs etc, then that doesn’t necessarily mean that the smoke from the smoking area doesn’t drift through to the non-smoking area.
I think that if this bill is passed, then it would be a very positive action and I hope that you will read this letter and take my views into consideration.

Submission by Kirsty Cassie

I am writing this letter to you because of the bill banning smoking in public areas, I would really like it if it came into action in Scotland I also think that it would promote Scotland as a country.

When this bill comes into process I think there will be a bit of disruption with the smokers but in time I think that it will sink in. I also think we should build designated smoking areas for smokers that want to stop get the help they need to help them stop. Another place I think you should ban smoking in public parks for the enjoyment of others because smoke clings onto your clothes and hair.

I hope that this bill goes through and that it shall carry on through the UK. Thank you for reading my letter and I hope that it all goes well thank you again.

Submission by Jamie Gibbon

I am writing to you because I think that the bill is really, really unfair. In my opinion I think that non-smokers have the right to breathe clean and fresh air. It should be banned because there are more non-smokers than smokers.

One of the reasons is because 85% of the smoke goes into the air and only 15% goes in to the smoker. Smoking also causes lung disease, cancer etc. If people smoke near schools, colleges etc. they might set a craze to smoke. If restaurants are split into smoking areas and non-smoking the smoke still gets everywhere.

To be honest I will be happy if you just put a warning or picture on cigarette packets.

Submission by Sally E Casson

I think this bill should be passed because I get very put off some regulated areas if a lot of people smoke in them. I also think regulated areas will be more pleasant if no one smokes in them.

I don’t think anyone should be allowed to smoke anywhere apart from their own homes because if people can’t smoke in public places people might not smoke as much which means that some people might cut down on how many cigarettes they have a day and some people might even quit smoking which means we might end up as a healthier country!

I think it will take a while to get used to if the motion is passed but after a while it will be a big success!

If regulated areas have smoking and non smoking areas the smoke will still drift into the non smoking areas!

I think smokers are inconsiderate to non smokers because the non smokers breathe in smoke which is bad for them! Thank you very much for taking time to read this letter and take some of my points into consideration.
SUBMISSION FROM GREATER GLASGOW NHS BOARD

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Feedback from the Consultants in Public Health Medicine (Communicable Disease and Environmental Health) Working Group

Our group includes all Scottish health board-based public health doctors concerned with the prevention and control of outbreaks and environmental hazards. As such we strongly support any initiative aimed at reducing or eliminating indoor air pollution implicated in the cause of disease and premature death. The passive inhalation of environmental tobacco smoke (ETS) is now incontrovertibly linked to a wide range of diseases and causes of premature death. We feel that the Prohibition of Smoking in Regulated Areas (Scotland) Bill is a long overdue first step toward smoke-free public places by introducing the concept that it is unacceptable to allow smoking in restaurants when food is being consumed. In addition, limiting smoking in public places will have important knock-on effects on primary smoking in the general population, reducing smoking prevalence and per capita consumption of cigarettes, with the huge benefits that will result across the board (reduced morbidity, mortality, absenteeism, fires, etc.). Most critically, a ban in public places would reduce primary smoking in the home, alleviating some of the devastating effects on the health of children (including the unborn) who are unwilling victims of this dangerous addiction.

The following are all good reasons to move toward legislation-based controls of smoking in public places. They have all been endorsed by Glasgow-based Smoking Concerns.

There is increasing scientific evidence conclusively linking ETS and a wide range of diseases in adults including lung cancer, ischaemic heart disease, exacerbation of chronic obstructive lung disease, asthma attacks in those affected, and onset of symptoms of heart disease. There is substantial evidence linking ETS with strokes.

In addition, exposure to ETS during pregnancy has been conclusively linked to reduced foetal growth and premature birth. Almost one in three pregnant women are exposed to ETS in the workplace. Exposure of children to ETS has been conclusively linked to cot death, middle ear disease, respiratory infections, development of asthma in those previously unaffected and asthma attacks in those already affected. By allowing smoking in public places to go relatively unabated for decades we have silently endorsed primary smoking in the home and badly let down countless numbers of unborn babies and children.

Restaurants that attract families with children and allow or even encourage smoking is an unacceptable development that needs to be countered with reasoned, evidenced-based arguments on the dangers to children of the prolonged exposures that can take place in these environments.

The majority of the general public and, indeed, the majority of smokers want a ban on smoking in public places, including restaurants.

Control of smoking in the workplace has already been partially achieved through voluntary workplace restrictions. It is not just reasonable but mandatory to extend these voluntary codes of practice to legal requirements. The Health & Safety at Work Act 1974 already compels employers to protect the health of their staff, and the general public using the premises, as a general duty of care. It is only a matter of time before employees take legal action against their employers for passive smoking-related disease.
Extending a comprehensive workplace ban to a ban in all enclosed public places would be a natural progression, in that public places are also workplaces and their employees have a right to employment in a smoke-free environment.

Ventilation does not remove the carcinogenic gases from cigarette smoke in the air, only the particulate matter and smells. This is supported by American research that concludes that ETS “cannot be controlled to acceptable levels of risk by ventilation or air cleaning”. Ventilation provides false reassurance to passively inhaling unwary occupants of ventilated smoking areas, effectively neutralising what should be their natural objection to inhaling ETS.

Comprehensive workplace and public place bans involving an entire country have been found to reduce prevalence of smoking by 15% in relative terms (~10% when applied to a city or small region). Therefore, in addition to eliminating passive smoking in the workplace and in public places (assumed to be approximately 2/3 of the total passive exposure) it would also reduce primary smoking and therefore smoking related disease. It also reduces per capita consumption by smokers. By reducing the prevalence of primary smoking and the per capita consumption of smokers it would further reduce the passive smoking suffered by foetuses and children. Children born into less privileged homes in Scotland are affected by the combined effects of poverty and ETS because their parents are more like to smoke, predisposing them to a range of diseases in later life.

Comprehensive bans have been shown to work in some Canadian provinces, several American states, several countries (including New Zealand) and European cities. Why should Scotland, where large areas experience a combination of high smoking prevalence and social deprivation, be so reluctant to follow in the path of more privileged parts of the world where the need for a ban is less acute?

The evidence to date shows that banning smoking in public places does not harm the business of pubs and restaurants as predicted by the tobacco industry. The majority of the population is non-smoking and would be persuaded to return to the restaurant and pub if they could be assured of clean air to breathe. The smokers would learn to enjoy the pub in a new and more wholesome way.

Smelling other people’s second hand smoke is unpleasant and anti-social. It irritates the eyes and upper respiratory tract. It makes your clothes smell. The minority of smokers should not be allowed to diminish the quality of life for non-smokers.

It is difficult to justify bans on the use of mobile phones or compulsory use of seatbelts while driving and then accept smoking in the workplace or in public places. We legislate to defend civil liberties and save lives and we should be consistent and apply this to ETS which does infringe on one’s basic right to breathe fresh air and does cause disease and kill, even if it doesn’t tend to do this instantly. It is equally important to protect vulnerable members of society from ETS.

Both the previous and current Chief Medical Officers for Scotland have issued strong and clear calls for a ban on smoking in public places. On his retirement as CMO, Sir David Carter stated, “A ban on smoking in public places is the single most important initiative we need in Scotland to improve the public health”. He was right. Now Dr Mac Armstrong is echoing those words. If we refuse to take heed of advice on such an important public health matter from the most senior doctor in the land, who will we take advice from?

The NHS is straining to provide limited NHS services for an apparently limitless demand for healthcare. We simply can’t afford to provide the full range of prevention and treatment-based services to everyone in Scotland if 35% of the population is still smoking.
The above are all good reasons why we should support Stewart Maxwell's Bill and move toward the inevitable and desired goal: a smoke-free Scotland. In contrast, there is only one reason why we have allowed, and would continue to allow, smoking in enclosed public places in the face of evidence on the dangers of passive smoking, and that is to appease a powerful tobacco industry. It is time to put Scotland on the map and do the right thing.


SUBMISSION FROM NHS HIGHLAND

Thank you for allowing the opportunity to comment on the above mentioned legislation, to which you will find below NHS Highland's response.

NHS Highland welcomes the Prohibition of Smoking in Regulated Areas (Scotland) Bill and the principles of a ban on smoking in public areas where food is supplied and consumed, as a first step in legislating to restrict smoking in public places, a course of action central to addressing public health in Scotland. This issue was specifically discussed at the Highland NHS Board Meeting of 3 February 2004 in a debate around a recommendation in the Annual Report of the Director of Public Health (John Wrench, 2004) which called for such action, with item 139 of the minute recording that “the Board endorsed the support for a ban on smoking in public places”.

For more than a decade convincing scientific evidence has been available to demonstrate that exposure to second-hand smoke both harms health and worsens existing health problems. It is estimated that at least one thousand people die each year in the UK as the result of exposure to other people’s tobacco smoke and some studies put this figure much higher.

Second-hand smoke has been labelled "carcinogenic to humans" by the World Health Organisation’s International Agency for Research on Cancer. It has also been labelled a "class A human carcinogen" by the United States Environmental Protection Agency. Second-hand smoke increases the risk of an acute coronary heart disease event by 25-35% and increases the risk of cancer by 20-30% and stroke by 82%. Yet for the majority of the population, public places are the main source of exposure to second-hand smoke. Three million people in the UK are still exposed to tobacco smoke in the workplace. Currently Scotland has fewer smoke free workplaces than the rest of the UK and only half of all UK workplaces are smoke free. Those working on low incomes, or in small businesses and in the hospitality industry, both of which are key elements of the Highland economy, are at greatest risk.

Smoke free workplaces and public places are of significant help to smokers who are trying to quit. Over 70% of smokers want to quit and 50% have made a serious attempt to quit in the last 5 years. Spending time in places where smoking is not permitted helps prevent relapse in smokers who have recently quit and for those who continue to smoke, there is good evidence of the reduction in consumption.
One of the most important aspects of a ban on smoking in public places is the message it gives, especially to young people, that non-smoking is the norm in society, and there is clear evidence that in those areas which have introduced such a ban, smoking prevalence is falling at a rate faster than in those areas without restrictions.

To exemplify the impact such a ban would have here, a recent study using data from other countries showed that if all UK workplaces were smoke free, we could expect smoking rates to fall by 4% and overall tobacco consumption by 7.6%. Public support for smoke free provision has been growing steadily in recent years. Numerous surveys have shown a clear majority of people, including smokers, support smoking restrictions and are concerned about breathing in other people's smoke. In Highland, the most recent Adult Health and Lifestyle Survey (2001), which surveyed a 3% population sample, specifically asked about attitudes to smoking in public places, and key findings were:

A more than 6:1 majority in favour of a total ban in restaurants

An almost 2:1 majority in favour of a total ban in pubs

For these reasons, we believe the Bill is an excellent first step and Mr Stewart Maxwell, MSP, and the Scottish Executive should be congratulated for taking forward this important initiative. We would, however, call on the Scottish Executive to go further with all possible haste, and introduce legislation on smoking in all enclosed public places that will build upon the excellent foundations laid by the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

**SUBMISSION FROM NHS GRAMPIAN**

**1. Evidence in Support of the Bill**

NHS Grampian fully supports the introduction of The Prohibition of Smoking In Regulated Areas (Scotland) Bill.

**Improving the Health of People in Grampian**

The introduction of legislation to restrict smoking in public places is consistent with our objective of people in Grampian having longer, healthier and more fulfilling lives.\(^1\)

Exposure to environmental tobacco smoke (ETS) or passive smoking is a major public health risk. It is a cause of lung cancer, childhood respiratory disease and other conditions. It increases the risk of heart disease and exacerbates respiratory conditions such as asthma.

The British Medical Association estimates that at least 1000 people die each year in the UK as a result of exposure to other people's tobacco smoke.\(^2\)

Everyone who is exposed to tobacco smoke can be affected, including family members and work colleagues.

Encouraging and Helping People to Stop Smoking Restrictions on smoking in public places will lead to a reduction in smoking prevalence. They will help existing smokers to give up by creating a culture where it is no longer acceptable to smoke in certain public places. It will also present a strong and symbolic statement about the government stance
on tobacco use. Successful legislation has already had an impact in California, Massachusetts, New York, parts of Australia and now Ireland.

NHS Grampian has an evidence based smoking cessation service which is nationally recognised as an example of best practice. We have the resources available to offer support to an increasing number of people who seek help in stopping smoking.

**The Importance of Smoke-Free Workplaces**

Places where food is served are workplaces. Smoking restrictions in workplaces would protect people from the impacts of ETS and reduce smoking rates and tobacco consumption. (3)

A BMJ study used data from other countries to show that if all UK workplaces were smoke-free, we could see smoking rates fall by 4% and overall tobacco consumption by 7.6% (4)

**The Need for Legislation**

The UK Government has to date pursued a voluntary approach towards smoking in public places, working with business and others to put controls in place. However, this has not been adequate. (5) Legislation is the only truly effective way to protect people from the impact of passive smoking.

The voluntary approach of controlling environmental tobacco smoke has often included the use of ventilation, though evidence shows this does not provide adequate protection from the risks of it passive smoking. Ventilation may make a room feel more comfortable but it does not make it safe and healthy. There is no safe level of exposure to ETS. (6,7) Similarly, designated smoking areas often allow for the transfer of smoke to non-smoking areas.

It is therefore extremely important to implement effective legislation on smoking in public places.

**Public Opinion**

Restrictions on smoking in public places have widespread public support. Two thirds of the Grampian population feel that smoking should not be allowed in public places. In Grampian, 7 out of 10 people are non-smokers and of this group, 81.5% believe that smoking should not be allowed in public places. (6)

11% of people in Grampian report that they spend most of their day in the company of people who I smoke. A further 29% spend some of their day where people smoke. (9)

Issues of civil liberties are often expressed and this applies to all individuals, smokers and non-smokers. NHS Grampian believes that people who wish to smoke have the right to do so but also have a responsibility not to harm others. People have the right not to inhale other peoples tobacco smoke if they do not wish to. Given the lack of success from voluntary measures, this Bill is clearly required.

**2. Scope of the Legislation**

It is necessary for legislation to restrict smoking in a number of other public places, in addition to areas where food is served.
Exposure to environmental tobacco smoke is a significant issue in all workplace and it is important that legislation is introduced to take account of this.

Smoking in public places should also be prohibited through legislation in a number of other areas, for example, shopping centres, taxis, public transport, offices, and railway stations.

Further reaching legislation would be appropriate. This would offer equity in the protection offered to the public.

References


SUBMISSION FROM NHS TAYSIDE

Do you support the general principles of the Bill and the key provisions it sets out?

While there is support for the general principles, there is a strong belief that the Bill does not go far enough. However it is an important first step.

Are there any omissions from the Bill that you would like to see added?

There should be additional focus on the health of people who work in any "enclosed public space" and who are exposed to smoke. Also, for many publicans, there is a fear that they will suffer a loss of trade if smoking is banned. However they will feel more reassured if they know that the ban is applied to all hostelries – whether food is served or not. Therefore Clause 10 (Interpretation) in the Bill should ensure that the definition of food includes drink.

Also why does the Bill exempt health service hospitals – surely these catering areas would be automatic candidates for a smoking ban?

The exemption for vehicles in Schedule 1 should also be removed.
What are your views on the quality of consultation, and the implementation of key concerns?

The only consultation referred to in the Bill appears in Clause 5. Perhaps the Bill should be explicit in stating the persons and organisations who will be consulted regarding the general principles.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

A concentration on the health of people who, in the course of their work, may be exposed to smoke might provide a more effective route.

There will be enforcement complications regarding the fact that smokers will be allowed to congregate in non-regulated areas and smoke will therefore drift through connecting spaces to regulated areas.

Function rooms are used regularly for weddings. Meals are served before the same function room is altered to a dancing area with drinking of alcohol and smoking taking place. With the prescribed period of five days beforehand, difficulties of enforcement could arise.

If there is to be the possibility of court prosecution for an offence, the resources and abilities of the police and the procurator fiscal would have to be determined/assured. The ability of the police to enter an enclosed space, whatever the type of premise, whether or not an actual offence is being committed at that time would have to be ensured.

Consideration could be given to an offender automatically being given the opportunity to pay a Fixed Penalty in the first instance. If they do not, then prosecution could take place in the District Court.

Publicity/materials should be available to owners/managers etc. prior to implementation of the Act with a publicity drive taking place to highlight the requirements/offences created.

SUBMISSION FROM BMA SCOTLAND

BMA Scotland response for the Prohibition of Smoking in Regulated Areas (Scotland) Bill

The British Medical Association in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 128,000.

Do you support the general principles of the Bill and the key provisions it sets out?

The BMA supports the general principles of the Prohibition of Smoking in Regulated Areas (Scotland) Bill. Legislation is required, as voluntary measures currently in place have proved ineffective in protecting the 70% of the adult population that do not smoke.

Smoking kills 13,000 Scots each year from tobacco related diseases such as cancer and heart disease. Passive smoke also kills thousands of people each year, causes heart disease and asthma, aggravates asthma in adults and is known to cause middle ear and respiratory infections in children and is linked to cot deaths.
Smoking affects reproductive health and can also prevent people from having a family, while parental smoking can have long-term and serious consequences for child health. Exposure to second-hand smoke is a risk during pregnancy and harms infants and children. The BMA’s publication, *Towards Smoke-Free Public Places*, states that no safe level of exposure to second-hand smoke has been identified.

A recent UK wide YouGov poll showed that nearly 90% of those surveyed supported smoke free enclosed public places and workplaces and a similar survey conducted in Scotland by The Herald also revealed a majority in support of this move.

The BMA is not seeking to vilify smokers, but argues that smoke free regulated areas would not only protect non-smokers but also provide support for the 70% of smokers who wish to give up. If smoke free public places were introduced, it is estimated that smoking rates could drop by 4% and tobacco consumption would fall by 30%. This would save hundreds of lives each year and reduce the impact of chronic disease on individuals and the health service.

**Are there any omissions from the Bill that you would like to see added?**

Ideally the BMA would like to see the introduction of primary legislation to make all enclosed public places smoke free, however, we do welcome this Bill as a positive step.

**What are your views on the quality of consultation, and the implementation of key concerns?**

The BMA is satisfied with the level of consultation that accompanied this Bill. We would like to see all enclosed public places smoke free but welcome the insertion for the opportunity to extend the definition of regulated areas through subordinate legislation in the future. We see no reason to delay the progress of this Bill pending the outcome of the Scottish Executive’s consultation.

**Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?**

The BMA believes that the health benefits gained will greatly outweigh any initial difficulties monitoring the effective implementation of this proposed implementation. In Ireland, the new legislation has been introduced smoothly and is operating effectively.

Alternative approaches, such as voluntary agreements have proved to be ineffective in protecting the public from the harmful effects of smoking. For over 20 years, the UK has had a succession of voluntary agreements on smoking, yet not one has reached its targets.

A recent review of the hospitality industry revealed that despite repeated government support for voluntary measures, less than half of all businesses in Scotland surveyed even knew about the Voluntary Charter. This experience has been shared worldwide. In Australia, compliance with the Voluntary Code of Practice was also poor and played an insignificant part in the adoption of non-smoking policies.

Partial restrictions on smoking in public places and the use of ventilation are inadequate and do not protect the non-smoker from the harmful effects of second-hand smoke. There are 4,000 toxins and more than 50 cancer-causing substances in tobacco smoke and many of these are odourless, invisible gasses, which are not removed by ventilation systems.
Designated “no smoking” areas provide, at best only partial protection from second hand smoke and it is not comparable with the protection afforded by smoke free premises.\textsuperscript{5}

One potential difficulty in implementing this Bill is the likely opposition from the tobacco industry whose publicity machine will go into overdrive brandishing figures regarding losses in jobs and revenue in the hospitality industry. However, almost all (94\%) of tobacco industry supported studies claimed that smoke free places resulted in a negative economic impact, compared to none of the studies funded by sources other than the tobacco industry.\textsuperscript{6} Smoke free regulations also do not appear to adversely affect tourist business and may, in fact, increase it.\textsuperscript{7}

The tobacco industry has made substantial financial contributions to hospitality associations and funded the development of a number of information initiatives on smoking aimed at the hospitality trade. A recent review of the introduction of smoke free workplaces estimated that if all UK workplaces became smoke free, consumption would drop, costing the tobacco industry £310 million annually in loss of sales.\textsuperscript{2}

Policymakers can therefore act to protect hospitality industry workers and consumers from the toxins in second hand smoke, safe in the knowledge that claims of losses are fuelled by the tobacco industry, who are the ones facing the real business threat.

It is also interesting that the Scottish Licensing Trade Association are calling on their members to comply with the voluntary measures as they are under threat of being replaced by more substantial smoking restrictions.\textsuperscript{8}

**Conclusion**

Continuing delays in implementing smoke-free public places is not an option. Scottish people are suffering from the effects of tobacco smoke now and international experience shows that comprehensive tobacco control programmes, supported with national legislation, work.

The BMA strongly believes that the time has come to move ahead with primary legislation. We welcome the recent statement from the Chief Medical Officer of Scotland who said “it is my duty as CMO to speak out firmly on the motion that there should be a complete ban on smoking in public places in Scotland. That is my position and that is my advice and that is what I am advocating.” He also declared that he believes it is the Government’s duty to take a lead in this, regardless of whether the public is entirely in favour.\textsuperscript{9}

When the Westminster Parliament faltered under pressure from industry sources, Scotland led the way in establishing a ban on tobacco advertising within the UK. The Scottish Parliament should be congratulated for its key role in achieving success in Westminster on a UK advertising ban and should now lead the way once more to legislate for smoke free regulated areas.

\textsuperscript{1} BMA Board of Science and Education & Tobacco Control Resource Centre. *Smoking and reproductive life.* London: BMA, January 2004.

\textsuperscript{2} BMA Board of Science and Education & Tobacco Control Resource Centre. *Towards smoke-free public places.* London: BMA, November 2002.


SUBMISSION FROM THE FACULTY OF PUBLIC HEALTH IN SCOTLAND

I am responding on behalf of the Faculty of Public Health in Scotland. The Faculty has a multi-disciplinary membership of public health professionals. The great majority of Directors of Public Health, Academics in Public Health and Consultants in Public Health in Scotland are members of the Faculty.

We strongly support this draft Bill and the opportunity to comment on its content. We congratulate Mr Stewart Maxwell MSP, and the Scottish Parliament in taking this initiative forward. We strongly support this action to reduce the present unacceptable level of smoking related disease in Scotland. This is a very positive opportunity for the Scottish Parliament to lead and act for the benefit of the population of Scotland.

Scotland suffers from more ill-health than the rest of the UK. Relatively poorer socio-economic circumstances in Scotland contribute significantly but smoking puts a much greater burden of ill health on those who are already the poorest. Those who have least money smoke most.

Tobacco smoking is attributable to the 20 to 25% of all deaths in Scotland each year. It is the major cause of premature mortality and is one of the major drivers of the inequality in health between the affluent and the poor. Around two thirds of the social class difference in death rates in middle age is due to smoking.

NHS Scotland uses substantial resources in any single year on tobacco related disease. The draft Bill does not highlight the huge resource used to treat tobacco related disease such as coronary heart disease, lung cancer, chronic bronchitis, other vascular disease and many other disease. We would estimate that, at minimum, some £200 million will be used in the treatment of tobacco related disease in Scotland alone. We would suggest that current estimates underestimate the cost. For example many of the population are prescribed drugs (statins) to reduce their risk of coronary heart disease because the additional risk of their tobacco smoking brings their total risk of CHD to a level requiring treatment. If they did not smoke they would not need these drugs. We would also highlight that much more resource is used for tobacco cessation and prevention than that set out in the draft Bill papers. We would estimate that NHS Scotland uses at least £10 million each year on smoking cessation programmes, school programmes, support for “National No Smoking Day”, Nicotine Replacement therapy, and drop in smoking cessation services.

We welcome action that will reduce the acceptance of smoking as a norm. We particularly welcome action to reduce the level of passive smoking of workers in public places.

The draft Bill and its excellent associated papers provide very strong evidence of the level of harm of tobacco smoke to both smokers and non-smokers. The case for action is
overwhelming. The Faculty of Public Health strongly supports the action set out in this draft Bill.

However the evidence highlights a clear risk to all workers exposed to tobacco smoke. All workers are at risk and we do not see the basis for excluding a significantly large population of workers who work in public houses and premises where only drink is sold. The inclusion of restaurants and exclusion of public houses is not justified in the evidence provided in the report. We do not see how the Scottish Parliament can leave such a group of workers at risk. There is no justifiable basis for differentiating between where food is eaten and drink is consumed. Tobacco smoke may be a minor contaminant of food but its major effect is not through the ingestion of food but through the inhalation of smoke.

Taking action to include eating and drinking establishments will lead too much less ambiguity about what constitutes a place where food is consumed. The concept of a shared space that is smoking and non-smoking is no longer tenable. Cigarette smoke moves across boundaries and rooms.

We have no doubt that exclusion of workers in public houses would have to be revisited by the Scottish Parliament sooner rather than later. We would ask that the Parliament acts and tackles this now rather than later. There is substantial support for action to reduce smoking in public places including significant support from smokers. Population surveys across Scotland highlight the fact that exposure to smoke in the workplace and public places is a major problem for the many smokers working hard to stop smoking. Some 60% of smokers want to stop smoking. This measure can help them.

In summary the Faculty of Public Health in Scotland fully supports the action set out in this Bill and looks forward to the health, social and economic gain for the people of Scotland. We ask that the draft Bill be amended to recognise its own evidence and protect the health of all workers in public places.

SUBMISSION FROM RCN SCOTLAND

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

The Royal College of Nursing (RCN) is the UK’s largest professional association and union for nurses, with over 360,000 members. (over 35,000 in Scotland). Most RCN members work in the NHS, with around a quarter working in the independent sector. The RCN works locally, nationally, and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a major contributor to the development of nursing practice, standards of care and health policy.

The RCN supports credible measures aimed at promoting good public health and health improvement, including tightening controls on the sale, advertising and consumption of tobacco and tobacco-related products. Nurses are at the forefront of promoting smoking cessation projects and positive approaches to discouraging smoking and promoting healthy lifestyles. When the issue of smoking cessation was last discussed at the RCN’s Annual Congress in April 2001 it resolved by 360 votes to 54: “That this meeting of RCN Congress believes that smokers need more support to stop smoking than is currently available.” Further restrictions on smoking in public places are an important factor in improving support for smokers who want to quit. The issue will be debated again at the 2004 Congress.

RCN Scotland supports the view of ASH Scotland that the Voluntary Charter on Smoking in Public Places is failing to protect the health of employees or the public. More than two
thirds of Scottish pubs permit smoking throughout, and four in ten leisure businesses do not offer any smoke-free areas. Even where they are provided smoke-free areas do not provide adequate protection from second-hand smoke, while typical ventilation systems are also not effective. RCN Scotland also recognises the health inequality dimension of smoking, with those from lower socio-economic groups far more likely to smoke and suffer the health impact as a result, than those from higher socio-economic groups.

We believe that restricting smoking in public places would have a significant impact on reducing the 13,000 tobacco-related deaths which currently occur in Scotland each year. Reducing environmental tobacco smoke would also help to protect non-smokers, who as a result of second-hand or passive smoke inhalation have a 20-30 percent greater chance of developing lung cancer. This Bill represents an important step forward in this area.

In December 2003 the RCN’s Scottish Board discussed Stewart Maxwell MSP’s proposed Bill and supported the view that it is time to abandon the voluntary approach to smoking in public places and resolved to give its full support to the Bill once introduced. RCN Scotland believes that there is sufficient evidence, both on the harmful effects to health of tobacco smoke and on public attitudes towards restrictions on smoking in public places for the Scottish Parliament to confidently introduce the restrictions proposed in the Bill and indeed would support measures aimed at introducing wider restrictions to smoking in public places should these be brought forward in the future.

Smoking restrictions have been implemented effectively in other environments and we do not see why the provisions contained in the Bill could not be practically implemented should the Bill become law.

RCN Scotland would be pleased to provide further evidence, either written or oral, once the Committee starts its consideration of the Bill.
The Convener: I omitted to welcome to the committee Jamie Stone MSP, Nanette Milne MSP and Stewart Maxwell MSP, who is here for his bill. We cannot discuss the bill without Stewart in train. I welcome the three members to the meeting.

We move on to the first panel of witnesses, who will give evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. I welcome to the meeting Shona Hogg, Simon Hunter and Lea Tsui who attend Firrhill High School. I hope that I have pronounced that last name properly.

Lea Tsui (Firrhill High School): No. It is pronounced "Chu".

The Convener: I also welcome to the meeting Findlay Masson, Callum McPherson and Claire Repper, who are pupils at Mile-End School in Aberdeen. I refer members to the papers that accompany this item, which contain submissions from the two schools.

Perhaps it would be best if one pupil from either school answered members' questions. Others can respond if they feel that they want to say something different. Please do not feel that you have to say something.

Some of the pupils from Mile-End School said that the bill would be "more trouble than it's worth". That is a good way of putting it. Can you explain why they thought that?

Callum McPherson (Mile-End School): Some pupils thought that the bill would be pointless because many more policemen would have to be employed to find out whether people were smoking in bars and restaurants, or because it would give power to barmen, who might be a bit scared of telling big men to stop smoking. We cannot risk people in the catering industry being harmed.

The Convener: Is that the consensus of pupils in the school? What about the pupils at Firrhill High School?

Lea Tsui: If the measures were brought in, it would be like what happened when the euro was introduced. There might be some conflict at the beginning, but people would get used to this way of life as time went on.

The Convener: So you support the bill.

Lea Tsui: Yes.
Shona Robison (Dundee East) (SNP): Although most pupils appear to be in favour of the bill, I understand that some voted against it. Could you tell the committee some of the other reasons why pupils voted against the bill?

Claire Repper (Mile-End School): Some pupils thought that if the bill were passed people would waste more police time with complaints that someone had been smoking. There would also be less cash raised from tax on cigarettes. As a result, other taxes would have to be raised and the party that raised them would get fewer votes at elections.

Shona Robison: Do you think that those arguments are good?

Claire Repper: I thought that they were fairly good, but that the bill had more positive aspects.

Shona Robison: So the good things about the bill outweigh the problems that it might cause.

Claire Repper: Yes.

The Convener: Does anyone else want to comment? After all, you have come along so you might as well speak.

Lea Tsui: We thought that banning smoking in public places would benefit people’s health. As a result, the national health service would spend less money on treating lung, mouth and other cancers that come about because of passive smoking, which would make up for the smaller amounts of money that might be raised from tax on cigarettes.

Shona Robison: So, again, the positive outcomes would outweigh any potential problems.

Lea Tsui: Yes.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Do you agree that smoking kills people who smoke cigarettes and harms other people who breathe in that smoke? As a result, do we not have to protect people from the harmful effects of that smoke?

The Convener: I will start with Firrhill High School this time.

Lea Tsui: Passive smoking definitely kills people. We did research and we found out that being in a smoky environment for just half an hour can reduce the blood flow to the heart. That was quite a scary thing to read and it made us take a step back. If that is what happens to adults, what must it do to wee children and pregnant women? The smoke that pregnant women breathe in will go directly to their unborn baby. That does not sound right. It is unjust that someone should suffer for what someone else has done.

Mike Rumbles: Do we not have a duty to protect people?

Lea Tsui: Yes. We can always take actions to help to protect other people from illnesses.

Mr David Davidson (North East Scotland) (Con): Having listened to the comments from the Firrhill High School students, I want to ask about smoking at home. You have been very strong on the effects that smoking has on a range of people. Do you think that the bill goes far enough or should it cover other areas? Should people have some freedoms?

Lea Tsui: In private homes, people should make their own choice and it should be up to the family. In a public place, not everyone can get their say, whereas families in private households can make their own decision on whether to allow smoking in the house.

Mr Davidson: Does Mile-End School have any views on that?

Claire Repper: As the people from Firrhill said, it should be the family’s view. If the whole family smokes, that might be their choice. If they want to quit and other people are smoking, they have to fight back against other smokers in the house.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Would the bill lead to more people giving up smoking?

Claire Repper: It might not lead to more people giving up, but fewer people might start smoking because of the inconvenience that would be caused if the bill was passed in full. People who already smoke might also cut down on the amount that they smoke each day.

Lea Tsui: When our teacher and his wife went to California, where smoking in public has been banned, they found that finding somewhere to smoke was such an inconvenience that they stopped smoking.

The bill might also prevent peer pressure. If everyone is smoking on a work staff night out, you might feel a wee bit encouraged to smoke. As the girl from Mile-End said, if smoking was banned in public places, that might prevent people from starting to smoke.

The Convener: We wrote to Governor Arnold Schwarzenegger but he has not replied yet. When he does, I will keep the autograph.

Janis Hughes (Glasgow Ruther Glen) (Lab): If the bill as drafted becomes law, how should those who ignore it be punished?

Findlay Masson (Mile-End School): There should be a fine of £50. If people are caught breaking it several times, the fine should be higher—perhaps £200 or more.
Janis Hughes: Would that be sufficient to stop people doing it again?

Findlay Masson: Yes, probably.

Lea Tsui: I think that we agree with that.

Janis Hughes: Bearing it in mind that the bill talks about prohibiting smoking in areas where food is served, do you think that there are other areas in which smoking should be banned?

Claire Repper: Maybe in parks. Many people like to go out to the park for fresh air. That is also where people usually start smoking. Also, if there are animals about, they might get killed.

Shona Hogg (Firrhill High School): It should be banned in pubs and clubs. They are enclosed areas and that makes passive smoking worse.

Janis Hughes: You would like the ban to go further and to cover not just areas where food is served.

Shona Hogg: Yes.

Helen Eadie (Dunfermline East) (Lab): Some people have a different view to that which is expressed in Stewart Maxwell’s bill. They think that the provision of more non-smoking areas would be better than a ban on smoking. What is your view on that?

14:15

Lea Tsui: I do not think that that is sensible or that it would work. If an enclosed space has a non-smoking area and a smoking area, the air circulates into the non-smoking area. If the two areas are close and the division is not very effective, people who are near the border of the non-smoking area are affected just as much as they would be if they were in the smoking area.

Callum McPherson: If only 15 per cent of the smoke from a cigarette goes into the smoker’s lungs, 85 per cent of it goes into the air for the rest of us to breathe. In an enclosed restaurant, the circulation of the air means that that smoke will surely do us much more harm.

Dr Turner: Do you think that existing ventilation systems in the parts of public places where smoking is allowed work well enough?

Shona Hogg: I do not think that they do because in enclosed areas where many people are smoking, such as pubs and clubs, the smoke is all around. The smoke circulates and it is so thick that it is nearly impossible to breathe.

Helen Eadie: We have heard what you have said about passive smoking. What other effects do you think that people smoking in public places has on the people around them? Perhaps I can clarify my question by giving you a few clues. I am talking about runny eyes, the smell and the effect on people who are wearing contact lenses, for example. Apart from those suggestions, what are the other effects of people smoking in public places?

Shona Hogg: The smoke from someone who is smoking nearby can sometimes be so thick that people can choke on it.

Dr Turner: If people are fined for smoking in public places, what do you think that we should do with the money? Do you have any good ideas about that?

Callum McPherson: It would be good to use it to help people who were trying to stop smoking and to educate young people so that they would not smoke.

The Convener: Do you think that signs should be put up in places in which smoking is not allowed? If you think that they should be, what would you put on those signs?

Findlay Masson: There should be signs on all doors that say, underneath the no-smoking sign, “Smoking is prohibited here—that is the law”, for example. At our school, we have pupils of many different nationalities who might not be able to read English, so there should be clear signs on doors and in places where smokers would go, such as the corners of rooms.

The Convener: Are you saying that the signs should be in different languages?

Findlay Masson: Yes.

The Convener: That is interesting.

Simon Hunter (Firrhill High School): If there is a ban, I think that there should be signs that say where people are allowed to smoke rather than signs that say where they are not allowed to smoke. That would mean that smoking would be banned everywhere except in those places where signs allowed it. People who wanted to smoke would go to those places to smoke instead of smoking in public places.

The Convener: There is great concern that, once again, many young people are starting to smoke. Many people such as me have stopped smoking, but another generation is starting to smoke. Do you think that banning smoking in places where food is served would have any effect on young people starting to smoke?

Lea Tsui: I think that it would have an impact. If young kids who are out with their parents see people smoking in restaurants, they think that smoking is normal. However, if they do not get used to seeing people smoking around them as they grow up, it will become second nature for them not to smoke.
Claire Repper: I agree with the pupil from Firrhill: kids would not see cigarettes as much if there was a ban. My parents went to Ireland, where there is a ban, but they saw cigarettes on the ground where people had been smoking outside, so a ban might not have such an effect. Parents who smoke might stop smoking, so fewer children might copy their parents and start smoking.

Shona Robison: Why do young people start to smoke? If there is one thing that makes them start to smoke, what is it?

Lea Tsui: I do not think that we can narrow it down to one thing; many different things can make a young person want to smoke. It can come down to whether someone’s parents smoke, which would make them used to a smoky environment. There is peer pressure, too. The big thing is to be cool and to be like your friends; young people do not want to be the odd one out so they can be pressured into doing things that they do not really want to do.

Shona Robison: Will the bill help to reduce that pressure?

Lea Tsui: Yes.

The Convener: What do the Mile-End pupils think about that? Perhaps you know young people who smoke. Why do they start to smoke?

Callum McPherson: The biggest reason nowadays is probably peer pressure, but as Lea Tsui said, you cannot narrow it down.

The Convener: Members have run out of questions, so I invite Stewart Maxwell—who introduced the bill that we are discussing—to ask questions.

Mr Stewart Maxwell (West of Scotland) (SNP): I am responsible for the bill and I am pleased that Firrhill High School lodged a petition and that Mile-End School had a debate about smoking in public places. It is good news that young people are getting involved in the Parliament and its processes.

I will pick up on the question that Shona Robison asked. Is smoking viewed as cool by young people and children? Lea Tsui used the word “cool”. Do young people think that smoking makes them look more grown up?

Shona Hogg: I think that they do. We see celebrities smoking on television and lots of people look up to celebrities. If smoking was banned in public places, we would see that less and less, which might make people think.

Claire Repper: I think that smoking makes people look immature. There are so many chemicals in cigarettes—some contain stuff that is used to preserve dead people or to make weapons of mass destruction, toilet cleaner or nail varnish remover.

Mr Maxwell: Do young people think that smoking is cool because they see people smoking everywhere they go, so smoking is regarded as quite normal in our society in Scotland? If smoking was banned, it would be de-normalised—I hate to use that word—and it would no longer be a cultural norm to see smoking everywhere. Would that make children less likely to think that smoking was an adult thing to do and therefore make them less likely to start smoking?

Lea Tsui: It has been proved that Scotland has one of the worst rates of coronary heart disease, which can be caused by smoking. If we banned smoking in public places those rates would come down and the nation would be healthier. A ban might encourage healthier living.

In our school, a group in secondary 1 chose to find out other pupils’ views on smoking as part of a citizenship project. They did a survey among first and second years and found that 85 per cent support our campaign for a ban on smoking in public places. A huge majority in the school supports us.

Mr Maxwell: Is that support widespread among young people across Scotland or is it unique to Firrhill because of the petition that you submitted to the Parliament?

Lea Tsui: Not a lot of people in our school knew about the petition—perhaps only a couple of our friends. People chose to do what they did of their own accord. Given that when we started out on all of this, the S1 pupils had only just come up to the school, they did not really know what was going on. Support for the ban must be quite a big thing. There is support for it not only in our school, but—

Mr Maxwell: It is fairly widespread among young people.

Lea Tsui: Yes.

Mr Maxwell: I have a question for the pupils from Mile-End. You undertook a project, held a debate and wrote a number of letters on the subject. Did the pupils who took part in the debate have a vote on whether to ban smoking?

The Convener: The strong lady at the table—Claire Repper—is pointing at Findlay Masson. Do you want to say something, Claire?

Claire Repper: Almost everyone agreed that there should be a ban on smoking. When we held our debate, we did it almost in a parliamentary way—we had wanting-to-speak cards and so on. Pretty much all the class said, “Yes, I want the ban.”

The Convener: As Stewart Maxwell is satisfied on the point, I will bring in Nanette Milne.
Mrs Nanette Milne (North East Scotland) (Con): After a lot of campaigning, many people in my age group have given up smoking. It is now apparent that a lot of those who are taking up smoking are young people and, in particular, young girls. Do you have an idea why that is the case?

The Convener: Is it to stay slim? We are always being told that that is the reason—apart from looking cool, that is.

Simon Hunter: I do not think that it is to keep slim, although some people might use that as an excuse. I think that it is more the result of peer pressure. If someone’s friends do something, they just want to fit in and so they do the same things.

The Convener: I thank all the witnesses very much, not only for your petitions and submissions but for speaking out so well this morning. Your information was impressive—you have put us to shame. Thank goodness you are still too young to stand for Parliament or some of our coats would be on shoogly pegs.

The Deputy Minister for Health and Community Care is now available. I suggest that we return to item 1 after which we will resume our evidence taking. Are members content to do so?

Members indicated agreement.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

14:31

The Convener: We will take evidence from our next panel of witnesses. Their written submissions are included in members' papers after the schoolchildren's petition. I refer members to papers HC/S2/04/16/3 and following.

I welcome our witnesses: Gillian Lee is a programme manager for Grampian NHS Board; Garry Coutts is chairman of Highland NHS Board; Dr Helene Irvine is a consultant in public medicine for Greater Glasgow NHS Board; and Paul Ballard is a consultant in health promotion for Tayside NHS Board.

Shona Robison will ask the first question.

Shona Robison: Groups such as FOREST—the Freedom Organisation for the Right to Enjoy Smoking Tobacco—claim that the risk from second-hand smoke has been exaggerated. How do you answer that?

Garry Coutts (Highland NHS Board): I will kick off while the others think of a more substantive answer.

An extensive body of research shows that there is substantive risk from second-hand smoke. There are tolerances—research varies on how great the risk is—but there is no evidence that suggests that there is no risk from second-hand smoke. Health boards have a duty to protect and promote good health, so we need to try to curtail any risk from second-hand smoke.

My colleagues will speak to the specific evidence.

Paul Ballard (Tayside NHS Board): All the research papers that I have seen point markedly to the fact that passive smokers have an approximately 30 per cent increased chance of coronary heart disease and lung cancer. New evidence is emerging that suggests that there are also increased risks of type II diabetes.

Shona Robison: It would be useful if the committee could have that evidence, especially that on the link to type 2 diabetes.

Garry Coutts: The British Medical Journal published evidence in 1997, and the United States Environmental Protection Agency has published a lot of evidence. We can ensure that the committee has all the references. Many of them are cited in the policy memorandum to the bill, but we can provide any additional information that is required.

Dr Helene Irvine (Greater Glasgow NHS Board): When I examine the literature, my feeling is that dozens of studies refer to a wide range of conditions, such as an increased risk of cot death, of upper and lower respiratory infection, and the exacerbation and causation of asthma in children and an increased risk of lung cancer, ischaemic heart disease and stroke in adults.

None of the relative risks that are associated with those conditions is extremely high; they often do not exceed the magic number of 2. However, that does not suggest to me that we should ignore the risk from passive smoking. We see a consistent tendency towards elevated risks that are relatively small but are for a range of conditions that have biological plausibility. In other words, it makes sense that glue ear would be, and cot death might be, more common in the children of smokers because of the potent toxins, carcinogens and other substances in second-hand smoke. Several of the criteria of causality are satisfied, even though the relative risks as measured by the statisticians are not very impressive.

Statistical methods are extremely insensitive. Having worked in public health for almost 15 years, I am less impressed by the sensitivity of my own methods to pick up such links. We must bear it in mind that the methodology is not very strong. We need a range of different types of evidence to come together, one of which is statistical evidence of the type that people such as Mr Lee have denigrated in their submissions. Someone who is clever with statistics can easily find their weaknesses and denigrate the evidence, but I appeal to the committee to say, "Wait a minute—let's not throw out all that evidence when there is so much of it and it all points in one direction." The evidence is that a wide range of conditions are more common among the children of smokers, the colleagues of smokers at work and the spouses of smokers.

Shona Robison: I do not know whether you have had a chance to read the evidence that FOREST gave us last week. It dismissed the statistics as being so insignificant as to be irrelevant and said that they were propaganda. You say that we must take the evidence as a whole and consider the trends that are involved.

Dr Irvine: That is right. Many people are involved in undertaking, reviewing or criticising the research. In my experience, the vast majority of people conclude that a risk is present. It will always be possible to find an intelligent and educated professional who may be trained in medicine, statistics or epidemiology and who will denounce the evidence, especially when such huge incentives to do so exist, because the industry is powerful. I am not saying that all such
individuals are funded by the industry, but some of them are. There are reasons why people might use their knowledge to denigrate the evidence, but those people are in a tiny minority compared with the vast number of experts with other views.

All that the committee needs to do is to look at any of the reports. The bibliographies cite reports by the Department of Health, by the Independent Scientific Committee on Smoking and Health, by the Scientific Committee on Tobacco and Health and by the World Health Organisation’s international agency for research on cancer, including the report that it is about to publish. The documents are overwhelming and it could take years to read all that evidence. It is astounding that somebody from FOREST should denigrate that evidence. I am disappointed that people take such criticism seriously when so many committed professionals from around the world say consistently that an excess risk of a range of conditions is associated with being in a room with a smoker.

Just by being in a small room with someone who is smoking, you will feel the symptoms of irritation to your upper airway and eyes. You must ask yourself what happens when the same smoke that irritates external bits of your body—your eyes and nose—goes into your lungs and is immediately absorbed into your bloodstream. Within seconds, it comes into contact with every organ of your body. That cannot be completely benign. If that does not show up clearly in the statistics, that is because the methodologies are not very sensitive.

The Convener: I thank you for that exposition.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We all agree that smoking kills and we probably all agree about passive smoking when someone is locked in a room with a smoker or is in a smoker’s family, for example. However, we are not discussing that; we are discussing exposure to smoke for limited periods in social situations and in restaurants. I have read your submission and I know exactly where you are coming from. However, I worry that the debate is not just about a ban or a restriction, but about winning people over to the view that smoking is harmful. People are confused because both sides of the argument have been presented, although the truth is probably somewhere in the middle. As you have done, FOREST quoted the British Medical Journal, which claimed in a recent report that “the link between environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed.”

Quotes can be provided to support both sides of the argument. I worry that the argument is turning people off. Do you agree that simply banning and restricting smoking is only one tool that can be used in the programme?

Gillian Lee (Grampian NHS Board): I agree that banning smoking is only one element, but it is an important element. A comprehensive answer has been provided that addresses some of the issues about the mixed evidence. Given the wealth of independent evidence that is available, we must agree that smoking and exposure to environmental tobacco smoke is harmful and we must take measures to do something about that. Public places where food is served are workplaces as well as places for the public. You are right that we need to bring public opinion with us and that, because of the mixture of evidence that is promoted and the confusing messages, the public are not clear about whether environmental tobacco smoke is harmful, although the evidence is clear that it is. The Grampian NHS Board submission provides statistics on public opinion, which show that the tide is turning and that the public want premises to be smoke free. The Executive consultation that was launched last week will help to clarify some of those points.

In addition to restrictions on smoking, it is important that we provide smoking cessation services and other support and that we are clear in our messages to the public. A restriction would be part of a wider tobacco control strategy and an integral part of the tobacco control action plan.

Mr McNeil: Do you agree that the language that public health professionals use is the reason why we are here today? Health professionals have failed to communicate successfully to people a method for stopping smoking and have failed to get them not to smoke in public places, which means that we may have to legislate. Is that not caused by the failure of people such as you to get the message across?

Gillian Lee: A range of individuals other than health professionals have a responsibility to consider tobacco control and tobacco issues. The health service plays its part, but other mechanisms are available. However, the matter is difficult because of bodies such as FOREST and other agencies and the powerful advertising by the tobacco industry. That is why an overall tobacco control strategy is important. Such a strategy will have many elements and the health service must play its part. It is important that the public receives clear messages as part of the overall national tobacco action plan and any local work.

Paul Ballard: A recent survey by Action on Smoking and Health Scotland demonstrated that 75 per cent of the Scottish population supports a smoking ban, which shows that the information and education work is getting through. It is important to stress Gillian Lee’s point that banning smoking in public places is only one arm of the strategy. She rightly mentioned smoking cessation services, but a wide range of other work is done,
such as work with young people in schools and peer education. The initiatives, including the ban on smoking in public places, must work together; any one of the measures will not work by itself. A partnership approach between the NHS boards and local authorities is crucial, otherwise the initiatives will not work. We have extreme poverty in Tayside, particularly in Dundee, and we are conscious that we have to work with local communities to tackle poverty issues, which are closely linked to smoking. The agenda is complex.

In Tayside, particularly in Dundee, we are conscious that we have to work with local communities to tackle poverty issues, which are closely linked to smoking. The agenda is complex.

Mr Davidson: You talk about control, but what about choice? If an establishment had two physically distinct areas for smokers and non-smokers, would that satisfy what you want and balance it with civil liberties?

Dr Irvine: I have yet to see any evidence that suggests that it is possible to have one building with adequate separation of the two areas. There are other problems, such as when a party of six people consists of four non-smokers and two smokers. I had an evening like that last week. I was really keen to go out with friends of mine, two of whom are smokers. The rest of us are non-smokers and we suffered the whole evening—I had to cut the evening short because I could not cope with the smoking. Because there were smokers among us we ended up in the smoking section and it was really unpleasant. That is what happens in such situations.

One of those friends spends her day working with respiratory disease, but she still cannot give up smoking. If she had come into a no-smoking pub with us, she would have had to struggle without her cigarettes, but she would eventually have got used to it, as she did when she went to New York for five days and could not smoke—she almost gave up. Because of the way that human beings interact—smokers and non-smokers together—because we cannot physically prevent smoky air from wafting over into a no-smoking area and because ventilation systems apparently do not work to remove carcinogenic gases, I do not think that it is possible to live happily with smokers and non-smokers in the same building. I have yet to see any evidence that we can.

Kate Maclean (Dundee West) (Lab): If we agree to the bill, or go even further and introduce a total ban on smoking in public places, we will be preventing people from doing something that they want to do. Some have gone as far as to say that we would be interfering with their civil liberties. I was a smoker until quite recently, so I know that, to a certain extent, it is not something that people choose to do, because it is an addiction and it is difficult to cope with. Before we can decide, we must ensure that our decision is based on accurate information, but from the written and oral evidence that the committee has taken, it seems that there is contradictory evidence from scientific studies. Last week we heard from the Tobacco Manufacturers Association and from FOREST that they had studies that showed that the risk of lung cancer for a non-smoker who lived with a smoker was relatively small. In fact, it was insignificant enough for them to think that it was unnecessary to ban smoking in public places.

However, from the evidence that we have heard from you and others who work in the health field it seems that there are more scientific studies that
suggest that smoking-related conditions—but not necessarily lung cancer—are more prevalent in people who come into contact with second-hand smoke. Is that the case? Can you put a ball-park figure on the percentage of studies that prove there is an effect on non-smokers who come into contact with second-hand smoke, as opposed to the study that the tobacco industry likes to quote, which shows that there is no harmful effect? Before we make a decision on this important matter, it would be useful to have an idea of the percentage of the evidence on the effects of second-hand smoke on non-smokers that supports a ban.

Paul Ballard: It is interesting that you say that FOREST and the TMA provided evidence that contradicts the evidence that we have come up with.

Kate Maclean: Sorry. They did not provide evidence. As far as I am aware they did not provide us with the studies. They just said that the studies took place and quoted the results. I could not tell you what the studies were.

Paul Ballard: I have provided—as I am sure have my colleagues—a long list of evidence to support the points that we are making. It would be interesting to compare it with the list of evidence that FOREST and the TMA can come up with, and to see how much of that evidence is linked directly to funded surveys by the tobacco industry.

The Convener: I remind members that they told us that they would send that evidence. We have not received it.

Kate Maclean: That would be the tobacco industry’s own evidence.

The Convener: That is right.

Kate Maclean: It would be useful if we had a list, so that we could use it as a resource to do some research on the scientific studies that have taken place. I would find that useful.

Dr Irvine: My sources suggest that we have at least 50 studies on passive smoking and lung cancer alone. Many of them are small, and some of them are old. I notice that the submissions by the tobacco industry suggest that only five are large and worth looking at, of which three showed an increased risk that was not statistically significant, one showed an excess risk that was statistically significant, and one showed a decreased risk—it is implausible that someone would be safer if they were exposed to smoke than not exposed.

That is a beautiful example of selective reference to the literature. The literature on the subject is massive. If you want to prove your case, you choose those five studies, but if you want to show that passive smoking is dangerous, you pick the other 45. It should not surprise anybody in this room that there is a huge controversy on the subject. The tobacco industry is a multibillion pound industry. It is now targeting the developing world, because it is getting trouble from the western world. It is rightly looking for other markets.

We have had decades of evidence on what they have been up to, such as suppressing and concealing evidence when they knew that smoking was a deadly habit. It has all been documented. There have been television programmes on the subject. We should not be surprised that there are clever researchers selecting the literature that they want to use to try to prove the other argument. It is overwhelmingly obvious that smoking is a suspect habit, and that it must be dangerous for the people in the room if it is dangerous for the person who is puffing on the cigarette. You do not need to be a doctor to figure that out. The way that we have to go is overwhelmingly obvious.

Garry Coutts: If there were another 100 studies on the effects of passive smoking, and they all concluded the same thing, you would still find people arguing against the evidence. We would never have legislated on the use of seatbelts or mobile phones when driving if we had had to wait for the same weight of empirical evidence that there is on the effects of second-hand smoke. We have a very powerful lobby that is selectively using evidence to stop a piece of legislation that is overwhelmingly supported by the public.

Kate Maclean: The point is that we as MSPs and members of the committee must justify our decisions and it is useful for us to be able to present hard evidence to justify them. Obviously, if a person is involved in an accident while not wearing a seat belt and their head goes through the windscreen, there will be simple and straightforward evidence and a scientific study will not be needed. A list of studies that we could consider before we reached a decision would be useful.

Dr Irvine: We can make a point of getting that for the committee.

The Convener: Sending that to the committee clerk would be fine.

I want to move on. I have a list and am taking members in turn.

Dr Turner: I would love you to elaborate on what you think about the general duty of care. Dr Irvine’s submission deals with smoking in the workplace, and health and safety at work coming into play with the Health and Safety at Work etc Act 1974. Will you elaborate on that?

I have just thought of something else in relation to the previous question. There might be statistics
that I cannot draw to mind about the number of people who have to have redos in cardiac surgery and who continue to smoke after surgery. As I remember, their arteries fur up faster than those of people who do not smoke. There must be research figures on that matter, but I did not think about looking them up until now.

Dr Irvine: That is okay.

The Convener: Dr Irvine might have those figures at the tips of her fingers.

Dr Irvine: I do not, but we could certainly get hold of them.

I would like to dissect what you have asked about into two issues. The first question was about the Health and Safety at Work etc Act 1974. I am glad that you mentioned that, as I have looked at the act and it clearly states that an employer has a statutory obligation to protect the health of his employees and the health of all members of the public who use the premises. Therefore, a law exists that should prevent smoking in public places, but why is that law not enforced? That is the million dollar question that I have been unable to find anyone to answer. The answer probably relates to the fact that no precedent exists for environmental health officers and the Health and Safety Executive taking action and convincing a procurator fiscal to charge a restaurant or a pub for exposing its staff and the people using it to smoke. They have simply never tried to take action, and if there is no precedent, nobody will want to take the matter on—they will worry that the case will be thrown out. However, if we thought about the matter, there is nothing to stop an EHO from trying to prosecute at the moment on the ground that there is loads of evidence in the literature from a variety of sources throughout the world that suggests that smoking passively is a dangerous activity. Therefore, why are we encouraging it by selling cigarettes in vending machines in such places? The answer to what you ask is that the law exists, but it is not used.

Paul Ballard: There is also a—

The Convener: Please speak when the microphone comes on, if and when it comes on.

Paul Ballard: I am sorry. There is a linked issue that I have come across many times locally. Many people will use the fact that they have ventilation systems—they think that ventilation systems will get them off the hook in respect of the point that Dr Irvine made. However, we can clearly state that a considerable weight of evidence supports the fact that ventilation systems do not remove the carcinogens in the atmosphere that are caused by smoking. Many licensees say that they have ventilation systems and that they are therefore removing the risk, but the research evidence that I have come across does not point to that.

Considerable traces of carcinogens are left in the atmosphere. I understand that there must be a tornado-strength ventilation system to remove the whole risk. To link up to what Dr Irvine said, there is now significant evidence to point against ventilation systems as well.

The Convener: Again, we would be grateful if you would provide us with references for that research.

Shona Robison: I have a quick question. Is the denial of any health risk from passive smoking, such as that by the tobacco industry, reminiscent of that industry's denial of the impact on health of smoking itself that it used to propagate before it was evident that what it argued was not the case and it had to accept that smoking is indeed dangerous for people's health?

Dr Irvine: Definitely. It is amazing that anybody believes the arguments, given that we have heard them all before in the context of primary smoking.

The Convener: I ask you to wait until I call your name, because the microphone operator cannot see you. If you could wait until the light comes on, that would be helpful—otherwise, you will not be in the Official Report.

15:00

Dr Irvine: I do not usually need a microphone to get my point across.

The Convener: There is a rule that you get into the Official Report only if your microphone is on, and your answers are important to us. Shona Robison is content, so I call Duncan McNeil.

Mr McNeil: The debate that we have had illustrates the problem. There are people in the tobacco industry, and there are people on the other side. The people in between need support to use legislation to encourage compliance and to encourage people to stop smoking. We deal with perceptions all the time, and I suggest that the problem is that the messages need to be simpler. On your side of the argument, people claim that primary smoking has important knock-on effects and that the bill will reduce morbidity, mortality, absenteeism at work and the number of fires; it will also improve children's health—the list goes on and on. However, we are not communicating that and nobody believes you. Some 1.2 million people in Scotland continue to smoke despite the wealth of evidence. We are asked to legislate and to encourage compliance, using all the good arguments. Can we not get to the simple messages and effectively communicate them to people, rather than making extravagant claims on both sides of the argument?

Garry Coutts: In the Highlands, only 25 per cent of adults smoke, which is slightly lower than
the Scottish average. In our lifestyle survey of 3,000 of those folks, 65 per cent of smokers said that they wanted to stop. We have overwhelming evidence that the arguments about smoking cessation have got through to all but a tiny minority of people. The job is about helping those people to stop smoking—that is becoming very important. I do not see many people out there who seriously argue that smoking is not harmful.

**Mr McNeil**: What about passive smoking?

**Garry Coutts**: The vast majority of people, including the majority of smokers, already support a ban in restaurants—in Highland, 75 per cent of people support such a ban. The public are coming with us, but we need legislation to help to support the majority of the public. At the moment, the public are a step or two ahead of the legislation. If we can take a bold step forward, that will help people who run smoking cessation classes and assist folk who want to stop smoking. It is important to take that bold step to show that we take the issue seriously.

**Mr McNeil**: People clearly believe that smoking kills—I believe it and I do not know anybody who would argue against it. The job is to legislate to impact on passive smoking and I do not believe that we have won the argument about that. The chief medical officer in Scotland recently suggested that Scottish public opinion is not ready for it and there have been headlines in our newspapers about it. As legislators, we are trying to take people along with us, but I do not think that the same case has been made against passive smoking as was made against smoking.

**Dr Irvine**: I disagree. I think that people are ready for it. I asked my secretary to print the 318 submissions to the committee—I have them in my briefcase—and I was overwhelmed by the depth of feeling from people who implore the committee to support Mr Maxwell’s bill. I do not know what more you need. There were few submissions opposing the bill that did not express a fundamental conflict of interest. Even smokers have written in to ask the committee to take a ban forward. Depending on location, between a quarter and a third of the population still smokes, but that is not evidence that we must not do something about the problem, which is crippling the NHS. Should we believe that just because a lot of people still do it, we should throw in the towel and say, “On you go—keep doing it”?

The fact is that nicotine is a potent addictive agent and smokers cannot give it up, although most of them want to do so. They cannot give it up because it is addictive and because we live in a stressed society in which people rely on crutches such as cigarettes. It does not surprise me that people are having trouble giving up smoking and I think that we should be doing what we can to help people to give up. Setting an example by saying, “You don’t do it in public places,” is the best way forward. We have been waiting for that for decades.

**Mike Rumbles**: When the opponents of the bill gave evidence to us last week, they agreed that smoking kills. They also agreed that there is a danger from passive smoking, but where they disagreed was in saying that that risk was statistically insignificant. They also said that there was no evidence that passive smoking kills and I wondered whether there was indeed any evidence that passive smoking kills.

I have a question that follows on from what has just been asked. The submission from Grampian NHS Board mentions public opinion and states:

“Two thirds of the Grampian population feel that smoking should not be allowed in public places. In Grampian, 7 out of 10 people are non-smokers and of this group, 81.5% believe that smoking should not be allowed in public places.”

Could we have some more information on where that information on public opinion came from and more evidence as to its veracity?

**Gillian Lee**: The evidence came from the Grampian adult lifestyle surveys, which are conducted every three years among a sample of the population. It was from those surveys that we were able to get information about what restrictions people would welcome on smoking in public places.

Your first point has probably already been answered, but there is independent scientific evidence to show that exposure to environmental tobacco smoke contributes to coronary heart disease, stroke and cancers. Dr Irvine can probably provide more detail about that.

**Mike Rumbles**: The opponents of the bill were adamant in saying that passive smoking does not kill and that there is no evidence to show that it does. They were quite clear about that.

**Dr Irvine**: Lung cancer has a high case-fatality ratio. That means that, if you get lung cancer, you are probably going to die from it within a year or two. It is a nasty type of cancer and difficult to treat. As a passive smoker, you might have a 1.3 relative risk of developing lung cancer, but lung cancer is still a death sentence for you. According to the study that showed that relative risk, there is a greater risk of death if you have been passively exposed.

**Mr Davidson**: The witnesses have said that the statistics from their research indicate that people are ready to give up and that there is a willingness to ban smoking. Could they explain why each and every one of the four health boards does not ban smoking on its property?
Paul Ballard: Tayside NHS Board does ban smoking on all its premises.

Mr Davidson: That was not the question. I was asking about banning smoking on your property—in other words, on entering the hospital gates and from there on in.

Paul Ballard: Smoking is banned from all front entrances on all NHS sites in Tayside. The only exceptions that we have made, for humanitarian reasons, are for terminally ill patients, psychiatric in-patients and patients for whom the NHS has become their home. Other than where those exceptions apply, everywhere else is a totally smoke-free environment. If people wish to smoke within any NHS site in Tayside, they have to go to a designated area to do so.

Mr Davidson: So you provide designated areas.

Paul Ballard: We provide designated areas.

Mr Davidson: Where are they?

Paul Ballard: The criteria for a designated area are that it must be out of sight of the public and in a discreet location. Where possible, it should also be sheltered. At Ninewells hospital, for example, shelters have been constructed to the rear of the hospital where staff and patients can go to smoke. There is also an area away from the front entrance where patients only can smoke. Perth royal infirmary, Stracathro hospital and all the main hospitals have similar arrangements for designated areas. We are not able to provide shelters for all the health centres, because there are so many of them, but we are working towards identifying designated areas for all of them.

Mr Davidson: You are saying that smoking is not banned and that you have gone down the route of providing facilities to allow patients and staff to exercise choice.

Paul Ballard: My understanding is that smoking is banned in NHS buildings and their front entrances and that there are three exceptions to that, which have been identified for humanitarian reasons.

Mr Davidson: I am asking why, if the intention is to lead by example, the health boards do not have the courage to follow the evidence that they appear to have and ban smoking on their property. That would send a clear message; it would be more believable and, possibly, more effective than Mr Maxwell’s partial control system would be.

Paul Ballard: We did not ban smoking on all our property because some of the hospital sites are extremely large and have extensive grounds. It would be almost impossible to police such a ban. We had to be practical; we do not have security forces to patrol the grounds. We felt that the buildings were the most important aspect, particularly in relation to the issue of passive smoking and the good example that banning smoking in the buildings would set for patients and visitors.

At a recent meeting of the Tayside health improvement committee, the representatives of three local authorities congratulated Tayside NHS Board on taking the lead and said that, because of the lead that we had taken, they would now seek assurances in their areas that they were pursuing the lines that we were pursuing. That has helped in the work that Tayside is doing towards having a smoking ban across the region and is linked closely with the national agenda.

Shona Robison: A lot of the questions in this debate are, rightly, around passive smoking. However, your policies—and one of the main arguments in favour of the bill—relate to the impact on smokers of reducing the number of cigarettes that they smoke during their working day.

Paul Ballard: That is absolutely right. We have concentrated our discussion on passive smoking because of the severe risk but, as one of the school pupils pointed out earlier, if we are to help smokers, the importance of creating a non-smoking culture cannot be overstated. In our smoking policy, we state, as a point of principle, that the policy is designed not only to tackle the issue of passive smoking but to support smokers. To back that up, as well as creating a smoke-free environment, we have put in place smoking cessation services and advice to help smokers to give up.

Garry Coutts: I support everything that has been said. There is evidence to show that the ban on smoking in public places will not only help people to stop smoking—being unable to smoke in public places when I went to America certainly helped me to stop—but decrease the amount of cigarettes smoked by those who continue to smoke. That will have an impact on the health of smokers.

Dr Irvine: The literature suggests that we would have a reduction in smoking prevalence of between 10 per cent and 15 per cent in relative terms. That means that, in Glasgow, the number of smokers would decrease by between 4 per cent and 6 per cent. That would have huge ramifications for reduced morbidity and mortality rates among smokers. More important, their children and their unborn children would be less exposed to smoke. That group has been neglected because, in the past, we have endorsed the habit. We must bear in mind the fact that decades of children have had no choice. They have been exposed to a highly toxic substance in utero and once they were born, because we have said that smoking is okay. By providing so many...
public places in which people can smoke, we have
given out the wrong message.

15:15

Kate Maclean: Do you have any evidence that
cutting down smoking in the workplace reduces
the amount that people smoke overall? When I
smoked—I smoked about 20 a day—I found that,
when I was not able to smoke at work, I simply
smoked more at other times. I still smoked about
the same number of cigarettes. I smoked for 35
years and, despite the fact that during that time
there was a gradual reduction in the number of
places in which people could smoke, I found that
that did not mean that I smoked less.

Garry Coutts: I must admit that that was my
experience when I was a smoker.

The Convener: We are hearing about shared
experiences.

Garry Coutts: When I went through the
literature in preparation for my attendance at
today’s meeting, I found that there is evidence of
the benefits of smoke-free workplaces. A study in
the BMJ concluded:

“Smoke-free workplaces not only protect non-smokers
from the dangers of passive smoking, they also encourage
smokers to quit or to reduce consumption.”

That is the evidence of a BMJ study, which we will
make available. I must admit that that was not my
experience.

Mr McNeil: Last week, ASH said in its evidence
that results such as the 30 per cent reduction in
smoking that it was claimed had taken place in
Finland were produced not just by a ban; they
were helped by all the other measures that were
implemented on top of the ban. It is vital that bans
in the workplace such as that which Tayside NHS
Board has imposed are not applied on their own,
but that support such as patches and buddy
systems are provided.

The Convener: Helen, do you have a
supplementary?

Helen Eadie: I have a different question.

The Convener: I am trying to remember where I
am. Shona Robison has a supplementary.

Shona Robison: I have a quick question for
Paul Ballard from Tayside NHS Board on the point
that we have just discussed. As you proceed with
your policy on smoking, have you been monitoring
the number of smokers who have given up
smoking or who have reduced their smoking? If
so, can you make that information available to us?

Paul Ballard: The monitoring committee is
monitoring the effectiveness of the policy’s
implementation. There will eventually be feedback
from patients and staff. We had not intended to
assess the extent to which people have given up
smoking as a result of the policy; our intention was
to assess feedback on how effectively people felt
that the policy was being implemented.

We are conducting a piece of work to measure
the numbers of people who are attending smoking
cessation groups throughout Tayside. From that,
it should be possible to identify what motivated them
to come to those groups. In due course, that
information will be available.

Gillian Lee: An integral part of our tobacco
policy in NHS Grampian is that we have provided
smoking cessation services on site for staff and
patients, so we can provide the committee with
data on the number of people who have been
seen in the hospital setting and who are receiving
smoking cessation support through the link with
our community-based service. That will be part of
the ban and part of the care plan that those people
have in the hospital setting. We can give you that
information.

Helen Eadie: I have a different question
altogether. Today, we have heard on the news
that 140 deaths have been saved by the
Government’s measures to enforce speed
restrictions on roads using a variety of measures,
such as cameras. Do you know the cost of every
item of care that is used to treat patients who are
suffering from lung cancer or any of the variety of
cancers? My point is that, for each of the 140 road
deaths that are saved, £1 million is saved. That
means that the Exchequer is saving £140 million.
What would the Exchequer save for each person
who did not have to be treated for lung cancer or
any other cancer?

The Convener: I have a feeling that that is the
witnesses’ ink exercise for tonight, but if you feel
that you can comment just now—

Garry Coutts: The cost to Highland NHS Board
is £5.8 million, although I am not sure of the
source of that figure. Nonetheless, it is a
significant sum that could be invested in care
elsewhere.

Helen Eadie: Can that be broken down to
individual cases? We know what it costs when the
chancellor puts up the tax on a pint of beer, but
can we tell what the costs are for one individual to
be cared for? Have you discussed that with your
peer group?

Dr Irvine: I have not done that type of
calculation, but I point out that it is cheaper for the
NHS if someone drops dead from a heart attack
than if they live for 30 years with peripheral
vascular disease or ischaemic heart disease, for
example. We have to bear in mind the fact that the
morbidity is much more costly than the people who
die from disease.
Helen Eadie: We know that some say that a hip replacement costs £4,000 in the NHS and others say that it costs £7,000 in the private sector. I would like to have a ball-park figure of what it costs the NHS to treat people with a different variety of cancers.

Dr Irvine: I do not have that data to hand, but we can see whether the information exists somewhere.

Janis Hughes: The bill is about the prohibition of smoking in regulated areas. The committee has received some written evidence that argues that a blanket ban on smoking in all public places would be easier to enforce than a ban in specifically regulated areas. Would a blanket ban be more beneficial or would it place an undue demand on the enforcement agencies?

Paul Ballard: As we say in our submission, although we fully support the bill, our preference is for a wider ban than just in eating places. A wider ban would be easier to enforce, because the arrangements would be less complicated—with all due respect to the bill, we think that it would lead to certain complications for enforcement. As I said, local publicans have told me that they would prefer a total ban because it would make things a lot simpler for them. In economic terms, they would prefer a system whereby the public knew right away that there was to be no smoking where food or drink was being served. We would prefer a blanket ban, whether it comes from the bill or at a later date—and I hope that it is not too much later. Looking at the evidence from around the world, we can see that there are successes in New York and Ireland will be the same.

Janis Hughes: Would such a ban put an extra burden on the enforcement agencies?

Paul Ballard: No, it would make things simpler. Some provisions in the bill, such as the five-day rule, will be quite complex to enforce. There will also be questions about definitions, which might cause difficulties. A blanket ban would remove those problems and make it a lot simpler for enforcement agencies such as the police to define clearly when a breach has taken place.

The Convener: The term “public places” also applies to places such as parks. Would it be necessary to ban smoking in a large public park?

Dr Irvine: I find it annoying when I go into a park and someone sits beside me on a bench and lights up, but I think that imposing a ban to cover that situation would be going too far. We have to be reasonable and talk about enclosed public places.

The Convener: I did not know whether Paul Ballard had used that phrase—I thought that we were talking about “public places”, but you are talking about “enclosed public places”.

Paul Ballard: Yes. I meant places where food and drink are served.

Garry Coutts: It is interesting to note that members of the previous panel suggested that a ban on smoking in public parks might be appropriate. Indeed, in some places, a ban on smoking on beaches and in parks is being considered. However, we would be more than happy with a ban on smoking in enclosed public spaces at this time.

Shona Robison: Do you have a view on the requirement in the bill that next to a regulated area there should be an area called a “connecting space”, which would also be a non-smoking area?

Dr Irvine: I can understand why the bill addresses that issue, but it reinforces the argument made by Mr Ballard that it would be easier to ban the whole kit and caboodle. It is difficult to regulate only certain areas; it is easier to ban smoking in all enclosed places.

Paul Ballard: Tayside NHS Board raised the issue in its submission. The issue around smoke drift is difficult to sort out. I know that connecting spaces are meant to prevent smoke drift but, like Dr Irvine, we felt that the situation would become too complicated and that it would be simpler to ban smoking throughout an enclosed place.

Dr Irvine: I would like to go back to the point that Mr Davidson made about smoking policies in the NHS—I agree with him 100 per cent. I am disappointed with Greater Glasgow NHS Board’s history on the issue, as the line that it took was never strong enough for me. I can see why it gave in in certain areas, such as psychiatric wards and terminal care wards. The issue was made even more difficult because a lot of the porters, nurses and others smoked and, when staff do not want to comply, a ban is difficult. However, I agree with David Davidson and I think that we should insist on hospitals being 100 per cent smoke free if the policy is to have any credibility.

Mr Davidson: The point that I was trying to make was that the NHS seems to be happy to run to get legislation to deal with an issue on which it has not managed to change the culture, despite the medical knowledge and the reinforcement of the message by the various medical and health promotion professions. Do you believe that to go down the route of a partial ban would be an indictment of the fact that the health service has not been strong enough?

Dr Irvine: It is evidence that the Scots are compassionate. They say to somebody who is
dying of lung cancer and asks for a cigarette, “On you go.” Perhaps I would not be so compassionate, but the Scots are. If all that somebody with mental illness has in the way of pleasure is smoking cigarettes all day long, the Scots will say, “On you go.” The fact is that psychiatric nurses and psychiatrists—I was in psychiatry for six months and I had to inhale all that smoke for the duration—have to put up with smoking, because we are looking after mentally ill patients. However, that is the biggest cop-out. We are effectively saying, “You are mentally ill, you have schizophrenia—on you go, ruin your heart and lungs. Here is a pack of cigarettes.” In fact, there was a drawer in the nurses’ station full of cigarettes for that purpose. That must come to an end. I agree with David Davidson’s point, but it is not simply an indictment of the fact that we have failed—we have just not had enough courage. I am saying that we should all have courage and bite the bullet, not only in the NHS but everywhere else.

Mr Davidson: However, you still think that that can be done only through legislation.

Dr Irvine: Yes. The submissions that you have received overwhelmingly state the case. The best argument that I saw was from the Scottish Consumer Council. I do not know whether members have been able to read every submission—there are an awful lot of them—but they must read that one, as it is a beautifully articulated explanation of why we need legislation. The voluntary charter will never work; even the pub owners would tell you that. None of them will volunteer to restrict smoking unless everybody else is forced to do it at the same time.

Paul Ballard: We need to be clear about the issue. What we are saying—and NHS Tayside is not the only one—is that there will be specific designated areas for the three exception groups of patients, which I identified earlier, to smoke. As Dr Irvine pointed out, those exceptions are made for humanitarian reasons; it is not a question of failure. The point is that those are highly vulnerable people who have an addiction and have less choice and less opportunity than other groups to do anything about it. I fundamentally support the whole no-smoking policy agenda, but I also fundamentally defend the human rights of those three groups to have an area—specifically for them—where they can smoke. It would be a serious mistake for us to say to people who are in an institution for a considerable period, who may be dying and for whom whether they smoke or not will make no difference to the final outcome that smoking is not allowed anywhere, by anyone, and that the fact that they are in a vulnerable category is just hard luck.

Over time, the number of people who smoke, even in the groups to which the exception applies, will reduce. However, in these early days, as we start to roll out radical and important initiatives, we must remember the vulnerable in society. One or two points were made about choice. As I said earlier, vulnerable groups in our society live in areas of high deprivation and have little choice about many things. We must be sensitive to their needs. The smoking agenda does not mean saying that smoking should be banned in all circumstances. We should pursue a ban on smoking in public places, because of all the important points that have been made, but we must recognise that the smoking agenda is complex and that not every group is the same. Not every member of society can make the same choices as others. In the work that we do, we must take into account poverty and vulnerability.

15:30

Dr Turner: What are your views on using the criminal law partly to reduce passive smoking? Do you think that the penalties that would be faced by those convicted under the bill are appropriate? Have you thought about the fact that the bill will make smoking in public places a criminal offence?

The Convener: Paul Ballard’s light is on. I do not know whether that is involuntary, but now he will have to answer the question whether he likes it or not.

Paul Ballard: I have certainly thought about the fact that the bill would make smoking in public places a criminal offence. If the bill becomes law, that will happen automatically. A long time ago, drink driving was the norm. Now we would not think twice about saying that someone who knocks another person down with their car while they are drunk should be prosecuted. If we have legislation that recognises formally the dangers of passive smoking and the fact that it makes people ill and kills them, and an owner is irresponsible enough to allow passive smoking to continue on their premises, in spite of the law, of course that owner should be prosecuted. That is the issue. Without that sanction, we will not have the effective ban that we need.

The Convener: Does anyone else want to take up the cudgels, although perhaps that is the wrong word?

Garry Coutts: People are agonising over the issue of penalties and enforcement, but that is a secondary argument. Evidence from other parts of the world indicates that enforcement has not been a big issue once a ban has been put in place. We can sort out those matters over time. The only aspect of the bill about which I am concerned is that it relates both to the smoker and to the holder
of premises. In my view, owners of premises have the principal responsibility. There is also an equality issue, because whether people can afford to pay a fine depends on their income. However, the principal issue is the need for legislation. The number of prosecutions in other parts of the world is small. In the vast majority of cases, people obey the law. Rather than worrying about the detail, we should aim for that outcome.

Mr Maxwell: I am interested in your comments about enforcement. Do you know of any other law that was designed to protect the public and in which specific provision for enforcement, rather than the usual provision for enforcement through the police, was made?

Dr Irvine: I am sorry—whom are you asking?

Mr Maxwell: Anybody. Does anybody know of any laws to protect the public for which we use not the police but some kind of special force?

Garry Coutts: I cannot think of any special force.

Dr Irvine: Traffic wardens?

The Convener: I think that Mr Maxwell's question is for the Crown Office rather than for health professionals.

Mr Maxwell: The point about enforcement has been raised before. People have said that enforcement will be a problem and that we will need special smoke police, or whatever you want to call them. However, we do not use special drink-driving police or special other kinds of police; we just use the police.

Dr Irvine: Good point.

Mr Maxwell: Last week, FOREST tried to give the impression that the scientific evidence was balanced at 50:50. FOREST suggested that there was a reasonable debate to be had between the two sides of the argument—for and against. Do you agree that the evidence suggests a 50:50 split? If not, what is the split?

The Convener: I think that the witnesses have already answered that, but they may respond briefly if they want.

Dr Irvine: People can make it look as if the split is 50:50 when they select evidence to suit their argument. However, if you did a review of the literature on the subject, printed off every study and counted them all up, for and against, you would find that the vast majority of them suggest that there is an effect.

Mr Maxwell: I am trying to elicit an estimate from you. Is the split 50:50, or 90:10?

Dr Irvine: I would suggest that it is more like 90:10. However, the only way in which you could be sure would be by printing off all the pieces of evidence, of which there are hundreds. You would have to consider all the evidence.

The Convener: We must also consider the quality of the evidence, not just the quantity.

I wanted to ask one more thing about enforcement. Two of you have been to the United States. Have there been problems with prosecutions in New York?

Garry Coutts: I was not aware that enforcement was an issue. However, just before the law came into force in Ireland, the one issue that we heard about time and again—almost sneeringly—was that enforcement would be a nightmare. I do not hear a murmur about it now and I think that that is what will happen when the measures are introduced here.

Dr Irvine: I want to turn the argument on its head. My relatives live in British Columbia and, when I visit them, it is wonderful to be in all the places where there is no smoking. When they came to visit me last summer, they complained bitterly about the amount of smoking here. If you are worried about your tourism, you should worry about the amount of smoking in restaurants and pubs and about the fact that you cannot get away from it. Moreover, public toilets are non-existent, being closed down or in an appalling condition.

The Convener: I am not sure that that comes within the remit of the bill, but you have made your point.

That brings us to the end of what has been a most useful evidence session, for which I thank the witnesses very much. The session was quite long, so are members happy to take a 10-minute break now?

Members indicated agreement.

15:38

Meeting suspended.

15:53

On resuming—

The Convener: I reconvene the meeting. Before we move on to the next panel of witnesses, I have a question for members. I am aware of the pressure of business in what is a long agenda today. Would the committee agree to deal with item 4, on our work force planning inquiry, at next week's meeting? The issue is already on the agenda for then. I ask members to ensure that they have plenty of time for that meeting because we must also deal with stage 1 of the Breastfeeding etc (Scotland) Bill next week. Does the committee agree to my suggestion?
**Members indicated agreement.**

**The Convener:** That means that we will take our panel of witnesses and then move straight on to agenda item 5, which should not take too long.

I welcome to the committee Dr Peter Terry, deputy chairman of the Scottish council of the British Medical Association, and Dr Sinead Jones, director of the tobacco control resource centre of the BMA. May I ask you to turn your name-plates towards me? It is difficult to see them from where I am sitting. Thank you—you did that like ballroom dancers in formation.

I also welcome Geoff Earl, who is the Lothian member of the Scotland board of the Royal College of Nursing, and Dr Malcolm McWhirter, who is the convener of the Scottish affairs committee of the Faculty of Public Health.

**Shona Robison:** FOREST and others say that the risk from second-hand smoke has been exaggerated. Indeed, I think that they have gone as far as to say that the existence of such a risk has not been established. How do you answer that?

**Dr Peter Terry (British Medical Association):** Those sources are trying—not very effectively—to put up a smokescreen, if I may use that term.

**The Convener:** You have used it.

**Dr Terry:** I regret that now.

The evidence is overwhelming. I listened to the earlier part of the meeting and it seems that the committee is concerned about the evidence for and against the risk from passive smoking. There are fairly weighty tomes that are full of evidence and Sinead Jones might comment on a specific study, which concludes overwhelmingly that passive smoking has a harmful effect. There is no doubt about that in my mind or in that of most other health professionals.

FOREST clearly has a vested interest in its selection and presentation of evidence to the committee, because it is trying to protect an industry. However, that industry causes disease and death, not only in Scotland but throughout the world and we have a duty to meet it head on. The evidence that FOREST produces is overwhelmingly outweighed by the evidence that smoke is harmful.

**Dr Malcolm McWhirter (Faculty of Public Health):** It is wrong to portray the arguments as being split 50:50, as if there were two sides to the argument. Most health professionals consider public health in the population in Scotland as a whole and in the health board areas in which they work, whereas the tobacco industry and FOREST should be regarded as a marginal group, although it is a lobbying group.

I have passed to the official reporters a briefing paper from the Faculty of Public Health entitled "Tobacco Smoke: Pollution and Health", which was prepared in the past two weeks. It is a well-referenced document and I hope that the committee will find it useful.

**Shona Robison:** I put this question to the previous panel of witnesses: are the arguments that the tobacco industry puts forward about passive smoking similar to those that it used to make about the absence of proven health effects of direct smoking?

**Dr Sinead Jones (British Medical Association):** The record shows that that is the case. For many years, the tobacco industry denied that active smoking was harmful to health, although there was a mounting body of scientific evidence and a scientific consensus that smoking does indeed kill. The industry now knows that it cannot win the argument about active smoking, but it is desperately trying to instil insecurity in policy makers about the evidence base on passive smoking.

I strongly encourage the committee to read the International Agency for Research on Cancer monograph to which my colleague Dr Terry alluded. That United Nations agency is the scientific and technical body of the World Health Organisation and has a remit to consider cancer prevention. It considered the evidence on active and passive smoking by considering every published study—whether negative or positive—and it made a balanced judgment, not just on the basis of the statistics but on the basis of the biological evidence, animal studies and post mortem data. The agency concluded very clearly that passive smoking increases the risk of lung cancer by between 20 and 30 per cent. That is a significant increased risk. If there are high levels of exposure, the risk will be higher. When that exposure is removed, the risk goes down. The study has all the commonsense features of cause and effect. It is an excellent summary and I commend it to the committee.

**Mr McNeil:** Does the study refer to the danger of passive smoking in public areas, or to the danger of passive smoking in the home?

**Dr Jones:** It considers all the studies that have been published on passive smoking. It refers both to studies that have been carried out on passive smoking in the home, and studies of passive smoking in the workplace.

**Janis Hughes:** It has been argued in evidence to the committee that the relationship in the bill between food and a smoking ban reinforces the view that the bill is really more about comfort than
about health. I would be interested in your views on that.

Dr Terry: Scotland has one of the worst health records in the western world. Sure, there is a comfort issue but, as practising clinicians, we are overwhelmingly impressed less by the comfort issue than by the health issue. The health issue is what should be important to the committee.

Janis Hughes: But, in considering only the prohibition of smoking in areas where food is served, does the bill go far enough to enforce the health issue?

Dr Terry: No, of course not. What we would like, as suggested by the previous panel, is a ban in enclosed public places.

Dr McWhirter: Just to reinforce that, a ban that relates to places where food is eaten is not logical. We need to be more ambitious and make it a ban on public smoking places.

Mike Rumbles: I want to follow that up because I would not want your evidence to be misused. We have before us a bill to ban smoking where food is served. I understand that you all want to go further than that, but that is not a reason for opposing the bill. I want to clarify that. I can see three of the four of you nodding. Is that the case with you all?

Dr Terry: Yes.

The Convener: Nodding is not recorded.

Dr Jones: The people who are forced to be in bars and restaurants for the longest time are usually the staff. Bar and restaurant staff are among the workers who are most heavily exposed to second-hand smoke. Making bars and restaurants smoke free would have an immediate impact on the respiratory health of such staff. That has been shown in studies in California, where such a ban took place. The bill is a worthwhile measure—we would not want to let the best be the enemy of the good.

Mr McNeil: A lot of witnesses have told us that smoke goes from one area to another area.

Geoff Earl: Indeed.

Mr McNeil: How does that protect your members?

Geoff Earl: Members have the right not to work in the smoking area. If a patient decides that they want to smoke in a certain area, they have to accept that, although that is their right, they cannot force nursing staff to come in and treat them. Some of the arguments against the bill have centred on individual rights. If a person wishes to exercise an individual right to smoke, they can do so, but they cannot force somebody else to work in a smoky environment.

Mr McNeil: I am trying to understand the position of the RCN. You support the bill, but that practice—

Geoff Earl: The reality is that a number of nurses would go into a smoke-filled environment. As a community nurse, I go into homes where people smoke. I will enter that dangerous situation, and I do so through a duty of care but, where possible, I try to get the person to stop smoking and to ventilate the room before I enter. I make the personal choice to go into that room. I should have the right, of course, to be able to say, “I cannot come and treat you at home because it is a smoky environment that damages my health.” As long as I have the right to make the choice, I do not see that there is any contradiction in that position, and that is the RCN policy.

Dr McWhirter: Previous witnesses have mentioned the situation with regard to other health boards. I am the director of public health for Forth Valley NHS Board, which has a total ban on smoking on its premises. It used to be the case that places were set aside for staff to smoke, but now the only place to smoke is outside the front gates. There is an issue to do with long-stay patients because, in effect, the hospital is their home and I do not think that the bill is proposing that we should ban smoking in people’s homes. That is a natural tension and addressing the issue of people whose home is in hospital will be a continuing problem.

Kate Maclean: I would like to ask other members of the panel the question that Duncan McNeil raised about certain patients being allowed to smoke for humanitarian reasons. In Tayside, for example, somebody who is terminally ill is able to have a cigarette. Although I am in favour of a total ban, I would find it difficult to refuse somebody who was in the last few hours of their life a cigarette if that was what they wanted. What do industry have a right to work in a smoke-free environment.

Mr McNeil: A lot of witnesses have told us that that smoke goes from one area to another area.
the witnesses think about humanitarian exemptions for terminally ill patients or for long-stay psychiatric patients for whom the hospital is their home?

Dr Terry: I am persuaded by the humanitarian argument. We really have to introduce the smoking ban in a way that is reasonable and balanced, but I see those exemptions as a small side issue. The main issue concerns the vast majority of people who want to go out and eat in a restaurant without having their health put at additional risk. There may be a need for new sections to be introduced to the bill to cope with specific situations, but I think that members are more than capable of doing that.

The Convener: What kind of situation do you have in mind?

Dr Terry: For people who are terminally ill and in psychiatric wards.

The Convener: This is a bill about a ban in places where food is served.

Dr Terry: I know, and some people are served food on the ward.

Mr McNeil: Other witnesses have said that the bill does not go far enough and that they would like it to go further. In that context, it is relevant to have this discussion.

Shona Robison: As far as I am aware, the bill has exemptions for areas of hospitals, hospital wards or institutions that could be considered someone’s home.

The Convener: I can confirm that.

Dr McWhirter: There are times when health service staff expose themselves to known risks because that is their job, whether in caring for patients with communicable diseases or in other circumstances. As long as they know the risks that they are taking, they may need to accept some risk as part of the job, as other professionals do.

Dr Turner: Could you comment on the recruitment of psychiatric nurses? Has there ever been a problem in recruiting nurses because there is more smoking going on in psychiatric wards?

Geoff Earl: I am not aware of any statistics, but I know from personal experience that some students will not train on psychiatric wards because of the smoke. From personal observation, I would say that nurses can do a great deal of work with people who have psychiatric illnesses when they are sitting in the rest area, where communication between the nurse and the patient can take place in more of a social atmosphere. Unfortunately, students who refuse to go into that area because of the smoke do not get that learning experience.

That said, a number of psychiatric patients do not smoke. We should perhaps be careful about saying that nothing can be done to help psychiatric patients to overcome their addiction just because a large number of them smoke. On the contrary, there is strong evidence to suggest that cessation clinics have good success rates when nurses are involved. For some reason, we seem to assume that does not necessarily apply to psychiatric patients, but I am not sure that the evidence for that stands up. Just because many people in psychiatric hospitals smoke, we should not say that they will all do so.

Dr Turner: I accept that. Thank you for those comments.

The Convener: We may have drifted slightly from the subject after this thing about hospitals was thrown in. Schedule 1 provides for exempt spaces, which include "any health service hospital within the meaning of section 108(1) of the National Health Service (Scotland) Act 1978".

Kate Maclean: It was the witnesses who mentioned hospitals.

The Convener: I understand that. I think that Dr Terry raised the issue whether the ban would apply in wards where food is served.

Dr Terry: It is not wrong that the ban should not apply there. From a moderately careful reading of the bill, my interpretation is that it would ban smoking in public places where food is being served but that there would be special exemptions for people in certain circumstances. I endorse that.

The Convener: Schedule 1 lists some exemptions. Whether the list is conclusive is perhaps another matter.

Dr Terry: I was talking about reinforcing what is in the bill.

The Convener: According to some evidence that we have received, banning smoking in certain public places where food is served would have an impact not just on passive smoking but on smokers themselves by deterring them from smoking and by encouraging them to cut down or even stop smoking. However, one previous witness said that the ban on smoking in New York just made him stop going there. What are your views on that?

Geoff Earl: As I said earlier, nurses can play a large role in cessation clinics. One striking piece of evidence that nurses have pointed out to me is that smoking rates in New York have dropped by 11 per cent in one year. If anybody can come up with another method that produces better figures, I would like to see it. A drop of 11 per cent in one year is massive compared with the cessation rates that education and other programmes achieve.
The Executive is considering how to reduce smoking rates. I think that it would love to see a drop of 11 per cent even over 10 years.

**Dr McWhirter:** Most people do not stop smoking at the first attempt. They can sometimes take five or even 10 attempts before they achieve that. Like Tayside NHS Board, Forth Valley NHS Board monitors smoking rates in the population because smoking is a major cause of ill health. We have carried out a survey every three years since 1989. Although a major reason why people find it difficult to stop smoking is that other people in their family smoke, smoking at work is also a problem. People who try to stop smoking crave nicotine, so it is very difficult when they go into the workplace and smell smoke. The other place that people find difficult is the pub. That is where many people socialise and it can be very important to them. The pub is often the place where people break their commitment to stop smoking. That is why those places must be an important part of the overall commitment to stop smoking. That is why those places must be an important part of the overall theme in our attempts to control tobacco, which is the major cause of health inequalities in Scotland.

**Dr Terry:** Clearly, the primary purpose of the bill is to protect the non-smoking public when they are in public places. That does not mean that we cannot welcome all the other spin-offs from it. Those benefits include comfort, the fact that people may smoke less and possibly even stop and the fact that the bill may make smoking less socially acceptable than it is at the moment and encourage people to give up. However, we should be clear about the primary purpose of the bill.

**Dr Jones:** I will summarise some of the international evidence. When workplaces become smoke free, there is a reduction of about 30 per cent in overall tobacco consumption. On average, people who continue to smoke smoke three cigarettes fewer per day and the overall rate of smoking drops by about 4 per cent. Obviously, there is a significant gain to be had. Making workplaces smoke free encourages people to give up and supports them if they are trying to do so. It cuts their tobacco consumption, even if they continue to smoke. Besides protecting non-smokers, which is the principal purpose of the measure, it is helpful to smokers. Let us not forget that 70 per cent of smokers want to stop smoking and find that hard to do.

16:15

**The Convener:** A few members of the committee have succeeded, some quite recently.

**Dr Jones:** Congratulations.

**The Convener:** We are all coming out the closet.

**Helen Eadie:** I have never been a smoker. It has been suggested in written evidence from ASH and in the great volume of submissions that have been made to the committee that a blanket ban on smoking in all public places would be easier to enforce than the proposed ban on smoking in regulated areas. Do you think that a blanket ban would place an undue demand on the enforcement agencies?

**Dr Jones:** The evidence from countries that have introduced blanket bans is that they are relatively easy to enforce, provided that certain conditions are in place. First, there needs to be a reasonable level of public acceptance that passive smoking is a health risk. In the UK, we already have that. About 80 per cent of adults accept that passive smoking is a cause of lung cancer, so we have a sound body of evidence on which to build.

Secondly, there need to be meaningful regulations that are properly enforced. If the regulations can be coupled with measures to help smokers to stop smoking, that is so much the better. If nicotine replacement programmes and the associated health services are introduced, there is a real improvement. In Ireland, smoking prevalence dropped by 4 per cent in four years during the preparation phase, after the legislation was announced. In Scotland, the target is a drop of 4 per cent over 14 years. That gives the committee some idea of the progress that can be made.

**Dr McWhirter:** I came here today from Stirling by train—I use the train regularly. No one was smoking in the carriage and no police were present. That is a good example of people accepting that they should not smoke. The bill would act as a deterrent, but I do not see why the situation that I have described cannot apply across the board, as long as there is clarity. Everyone knows that on ScotRail trains the whole train is a no-smoking zone. If in public places people are not sure in which rooms or corridors smoking is not permitted, the situation becomes difficult. If someone had lit up on the train on which I was travelling today, the enforcer would probably have been me—I would have told them that they were not supposed to smoke on the train. Enforcement is not just about the police—we can all enforce legislation and remind others of the law.

**Helen Eadie:** I will put the same question to you that I put to the previous witnesses. Do you know the cost to the NHS of caring for an individual patient with a form of cancer? Can you provide us with that figure?

**Dr Jones:** I have only a global figure for the treatment of tobacco-related illnesses by the NHS in Scotland, which is about £200 million a year.
Mr Davidson: In the bottom paragraph on page 1 of its submission, the Faculty of Public Health cites the fact that

“£200 million will be used in the treatment of tobacco related disease in Scotland alone.”

The submission goes on to give evidence about the use of statins and suggests that people are prescribed those drugs

“because the additional risk of their tobacco smoking brings their total risk of CHD to a level requiring treatment.”

Can you give us the statistics please? What percentage of statins use at the moment is for other reasons? I am thinking of the treatment of long-term diabetics over 50 and so on. The situation is not as simple as has been described. Could you firm up on the evidence please?

Dr McWhirter: Statins are used for cardiovascular disease including stroke or coronary heart disease. Several different factors can produce the effect of furring up of the arteries. Those factors include tobacco smoking, high blood pressure, high blood sugar—for example, in cases of diabetes—and diet. There is no single cause; all the causes come together.

In respect of coronary heart disease, the causes do not add up; they multiply. That is why Scotland has a particular problem in this regard: the diet is poor and blood fats are high and smoking and high blood pressure are also involved. The point that I was trying to make is that it is not possible to look at one cause in isolation from another. We have a tendency to look at some of those diseases and think that a drug is the treatment when in fact one of the treatments is to stop smoking. That is a very effective and—dare I say it—a very cheap treatment.

Mr Davidson: I just wanted clarification on your evidence, as your submission does not quite read like that.

Shona Robison: Does any member of the panel have a view on the requirement in the bill that next to a regulated area there should be an area called a “connecting space”, which would also be a non-smoking area?

Dr Terry: As we suggested earlier, those areas make the situation a little bit more complicated. As my colleague Dr Jones mentioned, the legislation needs to be as clear as possible. If signage is also clear, everybody will know where they can and cannot smoke and that will make things easier. We would prefer to see a ban on smoking in all enclosed public spaces. The proposal for the “connecting space” areas is confusing. I can see exactly why one would want to remove the smokers from the non-smokers, which is presumably the reason for having the connecting spaces, but I agree that the provision will confuse more than it will help the situation.

Geoff Earl: Notwithstanding what has been said, I can see the logic in the provision. The problem in not going for a prohibition on smoking in enclosed public spaces is that we are getting into these difficult areas. I understand that a barrier is needed between the smoking and the non-smoking areas as smoke would otherwise drift between them.

Dr Turner: Apart from the question that I asked the last lot, if—

The Convener: “The last lot” is a bit of a casual remark. I am sure that Dr Turner does not wish to leave it at that for the Official Report.

Dr Turner: Yes. I did not mean it that way; I should have said “the last panel”. I have been thinking about all the experience that the panel members have. If you had a magic wand, what would you do to save the health of the public of Scotland and save money for the health service? What is the biggest single thing that you could do in relation to the discussion that we have just had on the bill? Are there any doubts in your mind about what would save the most money and, at the same time, save the nation’s health?

Dr Jones: Again, if one looks at the research evidence on the tobacco control measures that work, one can see clearly that the measure that we have not taken as yet in this country is to make indoor public places smoke free. There is now a good body of evidence that smoking in those places is harmful to health.

A ban on smoking in enclosed public spaces works in a number of ways, the first of which is the important fact that it protects non-smokers. At the moment in this country, the only substance that has been proven to cause human cancer and that is not regulated in the workplace is second-hand smoke. We are the only country in Europe not to have any such legislation, which is rather shameful.

We also know that a ban works—it helps smokers to give up. When smokers give up, fewer parents smoke and that means that fewer children are exposed to second-hand smoke. We are the only country in Europe not to have any such legislation, which is rather shameful.

Smoking has affected generation upon generation of people in Scotland. Enacting the bill
is one thing that we could do to start to break the cycle of tobacco dependence in communities in which, unfortunately, smoking rates have not budged for years, despite our best efforts. I feel strongly that legislating for smoke-free public places would make a real and lasting difference in Scotland.

**Dr Turner:** Does anybody else on the panel want to add to that?

**Geoff Earl:** From a nursing perspective and given the spirit in which the question was asked, I know that nurses would want to take all the people who are against a restriction on smoking in public places to meet people who suffer from the effects of smoking tobacco and to see the pain that they and their families go through. Nurses would say that although a person might have made the personal choice to smoke an addictive substance, they should not be allowed to force that killer on non-smokers. I would like to think that, once they had seen the effects of smoking tobacco, all those who oppose restrictions on smoking tobacco in public places would understand why we need them. The issue is about the choice of non-smokers not to develop smoking-related illnesses.

**Dr McWhirter:** Reducing tobacco smoking in the Scottish population is the one thing that will have a major impact on Scotland’s health. Smoking is one of the reasons why Scotland’s health is worse than that of the rest of the United Kingdom and why inequalities in Scotland are so much greater. The poorer someone is, the more they are likely to smoke and the more that impacts on their income. The bill is just one element of addressing the problem. We should also try to ensure that young people do not start smoking. Certainly, the young people who gave evidence earlier made their views very clear. We do work with schools within Forth valley and there have been many positive initiatives.

The proposed act would be only one arm in managing smoking, but it would be an important one. Over the past 15 years, smoking rates in Forth valley have gone down from 44 per cent to 29 per cent, but it is getting more difficult to get the rate down further. The 29 per cent of people who still smoke are finding it harder to stop. We must do everything that we can to make it easier for them.

**Dr Terry:** We can use all sorts of mechanisms to reduce smoking—for example, education, banning tobacco advertising and providing support for people who are trying to give up smoking. The bill is an aspect that we need to get in place, but other mechanisms are also important and will have an effect. I do not want the committee to think that enacting the bill is the only thing that has to be done and that things will then suddenly get better—that is far from being the case. We need to do all the other things as well.

**Dr Turner:** So you do not have any difficulty with the fact that we would be using a measure in criminal law to reduce passive smoking. Do you have any difficulties with that? That was the question that I was supposed to ask.

**The Convener:** No, you are not supposed to ask any question; you ask what you want.

**Dr Turner:** So many questions go through one’s mind when one listens to others. Does the panel have any difficulty with the penalties that people who would be convicted under the bill would face?

**The Convener:** I may be wrong, but the smile on Dr Terry’s face seems to say no. Perhaps he will tell us.

**Dr Terry:** You are absolutely right—I have no problem with people facing penalties. That is the only way in which the proposed act will work. There is not much point in having legislation and then allowing people to carry on smoking in restaurants because we will not do anything about it. That would send completely the wrong message. I thought that the whole point of legislation was to outlaw something and change the rules within society.

**Geoff Earl:** We use legislation to control different types of behaviour all the time. The speed controls that are being introduced in built-up areas—the speed limit has been reduced to 20mph on a number of estates—has nothing to do with controlling speed on the roads; it is about the fact that a child who is hit by the bumper of a car travelling at 20mph may well survive, but they will not survive if they are hit by the bumper of a car travelling at 30mph. In that case, criminal law has been introduced purely as a protective measure and not as something to outlaw behaviour. Banning smoking in public places is also a protective measure, for which we need legislation.

**Dr Jones:** The other thing to point out is that the evidence from throughout the world shows that voluntary approaches are worth trying, but they do not work. We have had 15 years of voluntary approaches in this country, the last one being the public places charter. After five years of that charter, less than 1 per cent of pubs in Scotland are smoke free. Three months after bringing in legislation in Ireland, 96 per cent of pubs are smoke free. Where laws are cleverly designed and carefully enforced, they make a difference.
Mr Davidson: I have a couple of points. Dr Jones accepts, of course, that Ireland had 14 years to develop legislation, which allowed for a fair amount of culture change and acceptance. The evidence on voluntary bans is not quite as stark. Does she think that the voluntary ban system that we have used has not set the right targets and has not been progressive, because of which people are simply ticking boxes and saying, “We’ve done enough”? Is that what she suggests has happened, or should we just abandon any notion of a voluntary ban?

Dr Jones: The problem with the voluntary charter is that it was not designed to protect health. There can be smoking areas beside non-smoking areas, so that smoke drifts between them. There is a reliance on ventilation, which we know is flawed, because it does not protect health. The charter is based on the concept of comfort, but that is an outdated concept when you look at the weight of evidence on passive smoking. We regulate things in the workplace all the time, and regulatory agencies define acceptable levels of risk. The risk of contracting lung cancer from passive smoking in the workplace actually exceeds the regulatory acceptable level by 200 times, and the risk of heart disease exceeds it by 2,000 times. We cannot have a voluntary approach to that because, unfortunately, the evidence shows that it does not work. It is now time to move on. Ireland has done that in one fell swoop, and it has been an outstanding success. The ban has been well accepted. The industry is running out of arguments for not acting.

Mr Davidson: This is not a case of my arguing on behalf of the industry, as I have never smoked in my life, and it is not a habit that I recommend to anybody, but the issue is how we deal with private places—which is what restaurants and pubs are—if we suggest to them that there will be a legal requirement. Would they have a level licence, buy even more drink for the same money, and stay at home and drink and smoke? Is that the full answer?

Geoff Earl: It is highly unlikely that a ban would blunderbuss anybody because the evidence on the number of people who do not wish to enter smoky environments cuts across all areas. The figures might be slightly different in urban working-class areas, but most surveys suggest that a steady 75 to 85 per cent of people would rather have no smoking in public places. The bill would not force the ban on any community.

Shona Robison: Dr McWhirter mentioned the higher rates of smoking in areas of high deprivation. What do you think about the recently expressed view that smoking is the only pleasure in life for folk who live in such areas?

Dr McWhirter: I heard John Reid speaking at the Faculty of Public Health conference in Edinburgh last week, which was two days after he was—as he put it—misquoted on the issue. His interpretation was that smoking is a broad issue and that, to understand why people smoke, we must understand the circumstances in which they live. That was the key point that he was trying to make, not that smoking is people’s only pleasure. He seemed to feel quite sore about the way in which his comments had been interpreted.

The broader challenge is to tackle life circumstances and to improve the life of communities. The use of many other substances, such as illegal drugs and alcohol, must also be tackled more broadly. The broad challenges must be addressed in tackling smoking, but passive smoking, which has an impact on other individuals, must also be addressed. A MORI poll that I saw a couple of weeks ago showed that people in the more deprived sections of the population are supportive of a ban and want to stop smoking. There does not seem to be a strong social-class effect.
Shona Robison: Does Dr Jones have evidence on whether the ban in Ireland has been effective for all socioeconomic groups?

Dr Jones: Evidence is not yet available for the period after the implementation of the smoke-free public places policy, although evidence has been gathered on the support for the ban across social groups. Now that the legislation has been introduced, support for it is more than 90 per cent. The 4 per cent decrease in the prevalence of smoking that took place in the run-up to the ban was consistent throughout all social groups.

Shona Robison: Can you give us evidence on that?

Dr Jones: I can make available the report from the Office of Tobacco Control in Ireland.

Mr Maxwell: I seek the witnesses’ opinion on the question of market forces and voluntary charters. If we had left the issue of drink driving up to market forces and a voluntary charter, would we have achieved the change in cultural attitudes to drink driving that we achieved through legislation?

Dr Terry: No—some of the committee’s questions are really very easy to answer. I will go on a little bit about voluntary charters. Health professionals and politicians are trying hard to persuade the population that smoking is not good for people’s health or the health of their families—we have heard about the effects. On the opposite side, a powerful industry is selling the product to young people. The tobacco industry spends billions of pounds advertising its products; it does so not simply because it wants to sponsor a few motor races or snooker competitions, but to persuade people, particularly young people, to start smoking and to keep smoking. Given that we are faced with such resources, only legislation will do.

Mr Maxwell: I have one more question. We touched earlier on the idea of ventilation. When the British Hospitality Association gave evidence, it said that it uses ventilation; the witness from the association said that he uses ventilation in his hotel bar. What is your view on the use of ventilation? How effective is it? Does it have any impact on the health risk and, if so, how small or large is that impact?

Dr Jones: A number of international bodies have examined the evidence on ventilation, particularly in relation to second-hand smoke. The studies that they examined show that ventilation is not a strategy to protect against the health risks of passive smoking. That makes sense when we recognise that a lot of the toxins in smoke are present as gases and vapours and, of course, air-filtration systems cannot get rid of those. What such systems can do is to spread gaseous toxins around, so in a large area that is ventilated, the gases will be spread around by the air-conditioning system. For that reason, the World Health Organisation says that ventilation is not an effective strategy against the health risks of second-hand smoke. There is probably quite a lot of money to be made from selling ventilation systems to licensed premises, and a lot of licensed premises buy such systems in an earnest effort to protect the health of their staff, but unfortunately they are not doing so.

The Convener: That concludes the evidence session. Thank you all very much indeed.
SUPPLEMENTARY SUBMISSION FROM GREATER GLASGOW NHS BOARD

The collection of papers I was referring to in my evidence to the health committee are summarised in the following monograph which is available on the web having just been published: [http://monographs.iarc.fr/monoeval/refs.html](http://monographs.iarc.fr/monoeval/refs.html)

Also a link to the IARC monograph on involuntary smoking: [http://monographs.iarc.fr/htdocs/monographs/vol83/02-involuntary.html](http://monographs.iarc.fr/htdocs/monographs/vol83/02-involuntary.html) is worth looking at.

SUPPLEMENTARY SUBMISSION FROM NHS GRAMPIAN

Supplementary Evidence Grampian NHS

Further to the evidence given to the Health Committee, please find attached information from the Smoking Advice Service (SAS - the smoking cessation service for Grampian). The SAS is part of a strategic approach to tobacco control in Grampian and therefore I have enclosed a brief overview of our overall approach including the NHS Grampian Tobacco Policy.

In addition, in response to the Committees questioning with regard to the strength of evidence on the health impact of ETS, I would refer the Committee to the report from the Scientific Committee on Tobacco and Health (SCOTH) published in 1998. Professor James Friend who is a member of the newly formed Ministerial Working Group on Tobacco currently chairs SCOTH. An updated report is pending. The 1998 report focused on the impact of ETS and received evidence from the Tobacco Manufacturers Association among other sources and dedicated the entirety of section two to a review of the evidence.

In summary the SCOTH report made the following conclusion:

Exposure to environmental tobacco smoke is a cause of lung cancer and, in those with long term exposure, the increased risk is in the order of 20-30%.

Exposure to environmental tobacco smoke is a cause of ischaemic heart diseases and if current published estimates of magnitude of relative risk are validated, such exposure represents a substantial public health hazard.

Smoking in the presence of infants and children is a cause of serious respiratory illness and asthmatic attacks.

Sudden infant death syndrome, the main cause of post-neonatal death in the first year of life, is associated with exposure to environmental tobacco smoke. The association is judged to be one of cause and effect.

Middle ear disease in children is linked with parental smoking and this association is likely to be causal.


In response to questions posed by the Committee with regard to increased risk of mortality in non-smokers exposed to ETS the SCOTH report provides the following explanation in relation to lung cancer:

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In response to questions posed by the Committee with regard to increased risk of mortality in non-smokers exposed to ETS the SCOTH report provides the following explanation in relation to lung cancer:
"If the risk of lung cancer in non-exposed non-smokers is 10 per 100,000, based on rates in non-smokers in the 35+ age group, a 20-30% increased risk in exposed non-smokers would be a rate of 12-13 per 100,000 per year. Thus we would expect an additional 2-3 lung cancer cases a year per 100,000 non-smokers regularly exposed to ETS. The numbers of people so exposed are not known precisely but an estimate would suggest about several hundred extra lung cancer deaths a year is caused by exposure to passive smoking. There are about 35,000 lung cancer deaths in the United Kingdom per year: it is estimated that 30,000 of these are directly attributable to active smoking."

A recent review (May 2004) of the evidence on passive smoking has been produced by ASH (London) and provides a helpful summary. A copy of the report is attached for reference. It is worth highlighting given the Committee’s role in considering all the evidence it has received and reiterating a point made in evidence, that the ASH report concludes by stating;

“The tobacco companies have a vested interest in challenging and undermining the findings on ETS and studies published by them or their affiliates should be treated with caution.”

This report also highlights research from Barnes and Bero (1998) which found that at that time from a total of 106 reviews of the evidence of ETS 31 have been written by those with some affiliation to the tobacco industry. Of the 31, 29 (94%) reported that passive smoking was not harmful in direct contrast to the 13% (10/75) reviews written by those with no tobacco industry connections.

As has been indicated above, there have been many National and International scientific studies on the health impact of ETS with a clear consensus of evidence which confirms that being exposed to a hazardous substance is a cause of several diseases. The impact of exposure also increases in magnitude of effect dependent upon duration of exposure and other factors such as number of cigarettes smoked.

Hopefully the attachments and subsequent references will reassure the Committee of the strength of evidence confirming the negative impact on the public’s health of exposure to ETS and the importance of measures to eliminate exposure.

Passive Smoking: A summary of the evidence

May 2004

Principal health effects

Breathing other people's smoke is called passive, involuntary or second-hand smoking. The non-smoker breathes "sidestream" smoke from the burning tip of the cigarette and "mainstream" smoke that has been inhaled and then exhaled by the smoker. Environmental tobacco smoke (ETS) is a major source of indoor air pollution. Tobacco smoke contains over 4000 chemicals, some of which have marked irritant properties and some 60 are known or suspected carcinogens (cancer causing substances).

Evidence of the health impact of passive smoking has been building up over the past two decades. During the 1980s, a number of comprehensive reviews of the effects of passive smoking were published. These include reports by the US National Research Council, 2 the 1986 Report of the US Surgeon General, 3 the National Health and Medical Research Council of Australia 4 and the UK Independent Scientific Committee on Smoking and Health 5. This culminated in a major review by the US Environmental Protection Agency 6 published in 1992 which classified ETS as a class A (known human carcinogen).
More recently, further major reviews on passive smoking have been published. These include studies by the UK Government-appointed Scientific Committee on Tobacco and Health\(^7\) (SCOTH), a World Health Organization (WHO) consultation report on Environmental Tobacco Smoke and Child Health,\(^8\) a report by the California Environmental Protection Agency\(^9\) (EPA) and a review by the International Agency for Research on Cancer (IARC).\(^{10}\)

The California EPA identified passive smoking as a risk factor for the following:

**Childbirth and infancy**
- Low birthweight
- Cot death (SIDS)

**Illnesses in children**
- Middle ear infection
- Asthma (induction & exacerbation)
- Bronchitis (induction & exacerbation)
- Pneumonia (induction & exacerbation)

**Illnesses in adults**
- Heart disease
- Stroke
- Lung cancer
- Nasal cancer

The California EPA report also identified a link between passive smoking and the following:
- Spontaneous abortion (miscarriage)
- Adverse impact on learning and behavioural development in children
- Meningococcal infections in children
- Cancers and leukaemia in children
- Asthma exacerbation in adults
- Exacerbation of cystic fibrosis
- Decreased lung function
- Cervical cancer

**Passive smoking and lung cancer**

More than 50 studies of passive smoking and lung cancer risk in never smokers have been published over the past 25 years. Most show an increased risk, especially among people with a high level of exposure. To evaluate this information, meta-analyses have been conducted whereby the relative risks from the individual studies are pooled together. These meta-analyses show that there is a statistically significant risk of lung cancer risk among non-smokers living with smokers. The risk is in the order of 20% for women and 30% for men. Furthermore, studies of non-smokers exposed to environmental tobacco smoke at work show an increased risk of lung cancer of the order of 16 to 19 per cent. The IARC review led the authors to conclude that “This evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in never smokers.”\(^{10}\)

Hackshaw et al\(^{11}\) analysed 37 published epidemiological studies of the risk of lung cancer (4626 cases) in non-smokers. The review found that the excess risk of lung cancer in lifelong non-smokers who lived with a smoker was 24 per cent (95% confidence interval: 13% to 36%). Adjustment for factors such as diet had little overall effect. Tobacco specific carcinogens in the blood of the non-smokers provided clear evidence of the effect of
passive smoking. In addition, the study found a dose-response relationship between a non-smoker’s risk of lung cancer and the number of cigarettes and years of exposure to the smoker. The authors concluded that “The epidemiological and biochemical evidence on exposure to environmental tobacco smoke, with the supporting evidence of tobacco specific carcinogens in the blood and urine of non-smokers exposed to environmental tobacco smoke, provides compelling confirmation that breathing other people’s tobacco smoke is a cause of lung cancer.”

A major European study of non-smokers’ exposure to ETS also found a small increased risk of lung cancer in non-smokers who work in a smoky environment or live with a spouse who smokes. The study by Boffetta et al12 was conducted in 12 centres from seven European countries. A total of 650 patients with lung cancer and 1542 control subjects up to 74 years of age were asked about their exposure to ETS during childhood, adulthood, at home, in the workplace, in vehicles and in public places. The study found that exposure during childhood was not associated with an increased risk of lung cancer: odds ratio (OR) for ever exposure = 0.78 (95% confidence interval: 0.64 - 0.96). The OR for exposure to spousal ETS was 1.16 (95% CI: 0.93 - 1.44). No clear dose response relationship could be demonstrated for cumulative spousal ETS exposure. The OR for workplace exposure was 1.17 (95% CI: 0.94 - 1.45) with possible evidence of increasing risk of duration of exposure. Although the increased risk of lung cancer is small, the findings are within the range of a 10-30% increase in risk found in other major studies of lung cancer and ETS exposure.

A review of the evidence to date on passive smoking and lung cancer risk, including the above studies, by the UK’s Scientific Committee on Tobacco and Health (SCOTH) concluded: “that long term exposure of non-smokers to ETS caused an increase risk of lung cancer which, in those living with smokers, is in the region of 20-30%”.

The report of the California EPA drew similar conclusions after reviewing evidence from major US studies. The reports states: “Taken together, the recent studies provide additional evidence that ETS exposure is causally associated with lung cancer. The consistency of the findings in the five recent studies and the meta-analysis result of the US EPA indicate about a 20 per cent increase risk of lung cancer in non-smokers.”

**Passive smoking and heart disease**

Evidence of a link between passive smoking and heart disease began to be established in the mid 1980’s. The first qualitative reviews were included in the Report of the US Surgeon General, 1986 and the report of the US National Research Council, 1986. Both reviews concluded that an association between ETS and coronary heart disease (CHD) was biologically plausible but the epidemiological evidence was inconclusive.

Studies by Glantz and Parmley13 14 in the early 1990s estimated that heart disease caused by passive smoking was the third leading preventable cause of death in the United States, ranking behind active smoking and alcohol abuse, and that non-smokers living with smokers had an increased risk of heart disease of around 30%.

Analysis of a large sample in the United States also showed an elevated heart disease risk of around 20%15. Given how widespread heart disease is in non-smokers, a 20% additional risk is very significant. The authors concluded:

If true, ETS might account for an estimated 35 000 to 40 000 heart disease deaths per year in the United States.
Since then, studies have shown conclusively that not only does exposure to ETS increase the risk of heart disease in non-smokers but that the risks are non-linear. It would appear that even a small exposure to tobacco has a large effect on heart disease, with further exposure having a relatively small additional effect. This may be explained by the fact that exposure to ETS causes the blood to thicken - a phenomenon known as platelet aggregation. New research has shown that even half an hour's exposure to environmental tobacco smoke by non-smokers is enough to adversely affect cells lining the coronary arteries. The dysfunction of these endothelial cells contributes towards the narrowing of arteries and a reduction in blood flow.\textsuperscript{16}

Unlike the risk for lung cancer, where the risk is roughly in proportion to smoke exposure, passive smokers' risk of heart disease may be as much as half that of someone smoking 20 cigarettes a day even though they only inhale about 1% of the smoke.

A review of 19 published studies of the risk of heart disease by Law et al\textsuperscript{17} found that nonsmokers have an overall 23 per cent increased risk of heart disease when living with a smoker, after adjusting for confounding factors such as diet. The authors also found that the immediate effect of a single environmental exposure was to increase risk by an estimated 34%. This compares with a risk of 39% from smoking one cigarette per day.

In a study by He et al\textsuperscript{18} the authors reviewed 18 epidemiological studies and found that, overall, nonsmokers exposed to environmental tobacco smoke had a relative risk of coronary heart disease of 1.25 (ie a 25 per cent increased risk compared with nonsmokers not exposed). The relative risk for men was 1.22 and women 1.24. Non-smokers exposed to tobacco smoke at home had an overall risk of 1.17, while at work the risk was found to be 1.11.

While the risk of heart disease in non-smokers exposed to ETS is proportionally large, it would appear that some of the early damage to arteries caused by smoking may be reversible in healthy adults if further tobacco smoke exposure is avoided for at least a year.\textsuperscript{19} The study by Raitakari et al in Australia found that most improvement in the former passive smokers was evident after 2 years of cessation of passive smoking.

Other circulatory diseases

Research in New Zealand by Bonita et al revealed that passive smoking as well as active smoking increases the risk of stroke.\textsuperscript{20} The study found passive smoking exposure increased the risk of stroke in non-smokers by 82% (odds ratio = 1.82; 95% confidence interval = 1.34-2.49). The risk was significant in men (OR = 2.10; 95% CI 1.33-3.32) and in women (OR = 1.66; 95% CI: 1.07-2.57). By comparison, active smokers had a fourfold risk of stroke compared with people who had never smoked or had stopped smoking more than 10 years earlier and who were not exposed to ETS (OR = 4.14; 95% CI 3.04-6.63.) Given that stroke is a common condition, this means that passive smoking is having a serious health impact on non-smokers.

Passive smoking and respiratory diseases

Passive smoking has subtle but significant effects on the respiratory health of non-smoking adults, including increased coughing, phlegm production, chest discomfort and reduced lung function. For people with asthma, ETS can cause serious problems as cigarette smoke is a common trigger for asthma attacks. There are 3.5 million people with asthma in the UK and ETS causes difficulties for up to 80% of them.\textsuperscript{21}
Adults exposed to ETS at home or in the workplace have a 40-60% increase in the risk of asthma compared with adults who are not exposed in these places. Passive smoking as a cause of chronic obstructive pulmonary disease (COPD) in non-smokers has been demonstrated in a number of studies, although the magnitude of the association is small. This may be a reflection of the lack of data and complexity of designing studies to measure the effects of non-malignant respiratory diseases. The review by the California EPA notes that recent studies suggest that ETS may make a significant contribution to the development of chronic respiratory symptoms in non-smoking adults.

The impact of passive smoking on children

According to the World Health Organization, almost half the world’s children (700 million) are exposed to tobacco smoke by the 1.2 billion adults who smoke. A consultation document issued by the WHO concluded that passive smoking is a cause of bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection, cot death, and possibly cardiovascular and neurobiological impairment in children.

Approximately half of all children in the UK are exposed to tobacco smoke in the home. Young children are particularly vulnerable to the health impact of passive smoking. In its 1992 report, “Smoking and the Young”, the Royal College of Physicians estimated that 17,000 children under the age of five are admitted to hospital every year in the UK as a result of illnesses resulting from passive smoking.

For young children, the major source of tobacco smoke is smoking by parents and other household members. Maternal smoking is usually the largest source of ETS because of the cumulative effect of exposure during pregnancy and close proximity to the mother during early life. Results from more than 40 studies of the impact of parental smoking on lower respiratory tract illnesses in children have shown that children whose mothers smoke are estimated to have a 1.7-fold (95% CI = 1.6 – 1.9) higher risk of respiratory illnesses than children of non-smoking mothers. Paternal smoking alone causes a 1.3-fold (95% CI = 1.2 - 1.4) increase in risk. Maternal smoking during pregnancy is a major cause of sudden infant death syndrome (SIDS) as well as other health effects including low birth weight and reduced lung function. In addition, the WHO consultation document notes that ETS exposure among non-smoking pregnant women can cause a decrease in birth weight and that infant exposure to ETS may contribute to the risk of SIDS.

Asthma is the most common chronic disease of childhood. Both asthma and respiratory symptoms (wheeze, breathlessness and phlegm) are increased among children whose parents smoke.

The California EPA report shows that there is now compelling evidence that ETS is a risk factor for induction of new cases of asthma as well as for increasing the severity of disease among children with established asthma. In the UK, this means that between 1,600 and 5,400 new cases of asthma occur every year in children as a result of parental smoking.

Childhood exposure to ETS is also causally associated with acute and chronic middle ear disease. Over 40 studies investigating the effects of parental smoking on ear disease in their children have revealed relative risks ranging from 1.2 to 1.4, and are statistically significant. For further evidence of the health effects of passive smoking on children, see ASH briefing:

Passive smoking: The impact on children
Other effects of passive smoking

The California EPA report has identified consistent associations between passive smoking and nasal sinus cancer, presenting strong evidence that ETS exposure increases the risk of nasal sinus cancer in non-smoking adults.

Existing studies have demonstrated a risk ranging from 1.7 to 3.0 although further study is needed to determine the magnitude of the risk across wider populations. Other diseases associated with passive smoking for which further study is required include: spontaneous abortion, adverse impact on learning and behavioural development in children, meningococcal infections in children, cancers and leukaemia in children, asthma exacerbation in adults, exacerbation of cystic fibrosis, decreased lung function and cervical cancer. (See table at the end of this document.)

Many people exposed to ETS experience relatively minor discomfort such as eye irritation, headache, cough, sore throat, dizziness and nausea. While not life-threatening, discomfort caused by persistent exposure to ETS can affect productivity levels in the workplace and lead to tension between smokers and non-smokers.

Policy Implications

Public Places

As part of its tobacco control policy, as set out in the White Paper, “Smoking Kills”, the UK Government launched a Public Places Charter in conjunction with the hospitality industry. This is designed to increase the provision of smoke-free areas in pubs, restaurants, etc. by voluntary means rather than through legislation. However, progress in this area has been slow and there is now increasing pressure for legislation to ban smoking in public places. At the forefront is the British Medical Association whose new report, “Towards Smoke-free Public Places” recommends legislation be introduced as soon as possible. The report notes that there is no safe level of exposure to second-hand smoke. (For further information on smoking in public places see: ASH briefings on smoking in public places)

Workplace

A survey by ASH in April 1999 revealed that approximately 3 million people in the UK are regularly exposed to ETS at work. In July 1999, the Health and Safety Commission issued a draft Approved Code of Practice (AcoP) to clarify the implementation of the Health and Safety at Work Act as it applies to passive smoking in the workplace. However, this was not adopted by the government. ASH and other health organisations are now campaigning for legislation that will outlaw smoking in the workplace.

Children

The severity of the health impact of ETS exposure on children has led the WHO to call for the right of every child to grow up in an environment free of tobacco smoke. To achieve this goal, greater efforts will be needed to encourage pregnant women and their partners to stop smoking; and by reducing overall consumption of tobacco products. In a review of the impact of parental smoking on child health, Cook and Strachan argued that “substantial benefits to children would arise if parents stopped smoking after birth, even if the mother smoked during pregnancy”. They too argue that policies need to be developed which reduce smoking among parents and protect children from exposure to ETS.
Estimate of UK impact of passive smoking

Whilst the relative health risks from passive smoking are small in comparison with those from active smoking, because the diseases are common, the overall health impact is large. The British Medical Association has conservatively estimated that secondhand smoke causes at least 1,000 deaths a year in the UK. However, the true figure is likely to be much higher. Professor Konrad Jamrozik of Imperial College London found estimated that domestic exposure to secondhand smoke causes at least 3,600 deaths annually from lung cancer, heart disease and stroke combined, while exposure at work leads to approximately 700 deaths from these causes. Jamrozik also estimates 49 deaths – or about 1 a week – from exposure at work in the hospitality trades. In the population aged 65 or older, passive smoking is estimated to account for 16,900 deaths annually. 9,700 are due to stroke, where current evidence of health effects is weakest.

Tobacco Industry Approach

The tobacco industry has consistently denied that non-smokers’ exposure to environmental tobacco smoke is harmful to health. Despite the strength of the evidence outlined above, the tobacco companies have steadfastly refused to acknowledge the dangers. This is because, to do so, would undermine what they perceive to be a "right" to smoke. The industry approach has been to try to spread doubt and confusion about the health effects of passive smoking and to recruit supportive scientists to promote their point of view. One tobacco industry executive stated: “Doubt is our product since it is the best means of competing with the ‘body of fact’ that exists in the mind of the general public. It is also the means of establishing a controversy. If we are successful at establishing a controversy at the public level then there is an opportunity to put forward the real facts about smoking and health.”

According to the Tobacco Manufacturers’ Association, “the health risk claims are all too often based on a selective view of the evidence.”

There have been several notable attempts by the tobacco industry to challenge sound research on the effects of passive smoking. See also ASH’s document, “Tobacco Explained” and “TRUST US – WE ARE THE TOBACCO INDUSTRY” for examples of what the tobacco industry has said and how it has responded to the issue of passive smoking.

A series of press advertisements by Philip Morris in 1996 compared the risk of lung cancer from passive smoking with a variety of other everyday activities, including eating biscuits or drinking milk. The implication was that the increased risk of lung cancer among those exposed to other people’s smoke of around 20% is tiny in comparison with the risks of eating foods high in saturated fat. The advertisements were eventually withdrawn after the Advertising Standards Authority ruled that they were misleading but by that time the campaign had already run its course.

A decade earlier, Philip Morris began a campaign dubbed ‘Project Whitecoat’ to “coordinate and pay so many scientists on an international basis to keep the environmental tobacco smoke controversy alive.” A memo dated February 1988 set out Philip Morris’ plans to headhunt consultants who should “ideally be scientists who have no previous associations with tobacco companies and who have no previous record on the primary issues.”

In March 1998, BAT orchestrated a campaign to undermine the Boffetta study on passive smoking and to cast doubt on the SCOTH report which was published at that time. The findings of the Boffetta study were misreported by the Sunday Telegraph which had accepted uncritically BAT’s interpretation of the results. The newspaper claimed that the
study found that not only might there be no link between passive smoking and cancer but that there could even be a protective effect. For an analysis of how the Sunday Telegraph mis-interpreted these results see the ASH briefing dated 11 March: “How the Sunday Telegraph and BAT got it badly wrong on passive smoking and why SCOTH and WHO agree.

The fact that tobacco companies have set out to recruit scientists and others to present their views on passive smoking has been borne out by a literature review which examined the affiliations of authors of studies on ETS. Out of a total of 106 reviews, 31 had been written by authors with tobacco industry affiliations. Of these 94% (29/31) concluded that passive smoking was not harmful, compared with 13% (10/75) of the reviews written by people with no industry connections.

**Conclusion**

The above research provides the most definitive evidence to date of the health effects of ETS or passive smoking on non-smokers. It is now known that exposure to ETS causes a number of fatal and non-fatal health effects. Heart disease mortality, sudden infant death syndrome, and lung and nasal sinus cancer have been causally linked to ETS exposure. Serious effects on the young include childhood induction and exacerbation of asthma, bronchitis and pneumonia, middle ear infection, chronic respiratory symptoms, and low birth weight. In adults, passive smoking causes acute and chronic heart disease and lung cancer. While the relative health risks are small compared to those from active smoking, because the diseases are common the overall health impact is large. The tobacco companies have a vested interest in challenging and undermining the findings on ETS and studies published by them or their affiliates should therefore be treated with caution. In view of the considerable health impact of passive smoking, particularly on the young, measures to restrict smoking in indoor environments should be a major public health objective.

**Health Effects of Environmental Tobacco Smoke**

**Tobacco Smoke**

US California

Population (million) 265 32

**Low birthweight**

(\text{max}) 18,600 2,200

(\text{min}) 9,700 1,200

**Cot death - SIDS**

(\text{max}) 2,700 120

(\text{min}) 1,900 -

**Middle ear infection**

(\text{max}) 1,600,000 188,700

(\text{min}) 700,000 78,600

**Asthma induction –new cases**

(\text{max}) 26,000 3,120

(\text{min}) 8,000 960
Asthma exacerbation
(max) 1,000,000 120,000
(min) 400,000 48,000

Bronchitis or pneumonia in infants - cases
(max) 300,000 36,000
(min) 150,000 18,000

Bronchitis or pneumonia in infants - hospitalisations
(max) 15,000 1,800
(min) 7,500 900

Bronchitis or pneumonia in infants - deaths
(max) 212 25
(min) 136 16

Lung Cancer
3,000 360

Cardiovascular Ischaemic heart disease
(max) 62,000 7,440
(min) 35,000 4,200

Column 1 & 2 (US and California) are from the California EPA report. The figures for California were derived from US figures multiplied by 12%, which is the California share of the US population. Exceptions are low infant birth weight and SIDS which are figures for California. This approach includes an implicit assumption that smoking behaviour, exposure and susceptibility in California are similar to US. This assumption was made by the authors of the California EPA report.

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SUPPLEMENTARY SUBMISSION FROM BMA

Thank you for inviting the BMA to give evidence as part of the Health Committee’s stage one inquiry into the above legislation. I would particularly like to thank you for extending the invitation to allow us to have two representatives present at the meeting on the 15th of June. I hope the Committee found our evidence useful.

In response to questions raised by Shona Robison during our evidence session, Dr Sinead Jones offered to send the committee the report on the Office of Tobacco Control in Ireland. Below is the relevant section from this report highlighting the prevalence of smoking that took place in the run up to a ban (across all social groups) in Ireland.

Should you, or Committee members, require any further information form the BMA on this matter do not hesitate to contact me.
There is also a clear gradient according to educational level, with both men and women in keeping with the International literature. Again, there is a consistent downward trend in reported rates in those with highest level of education, though this is not true of younger respondents with completed second level education, the only group where the trend appears upwards.
SUBMISSION FROM DUNDEE CITY COUNCIL

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Thank you for inviting Dundee City Council to give a local authority view on the above.

In respect of the four specific questions posed by the Health Committee, the comments from Dundee City Council are outlined below:-

Do you support the general principles of the Bill and the key provision it sets out?

Overall views are that the Bill is too limited in its scope. Nevertheless, there is support for the general principles of the Bill and key provisions and recognition that this is a step in the right direction.

Are there any omissions from the Bill that you would like to see added?

There is a strong view that the prohibition of smoking in regulated areas should also specify alcohol. This would provide an opportunity to protect the health of customers and staff in both the food and drink industry. It would also provide more of a 'level playing field' for businesses as food and drink have a combined association with each other, and with smoking.

What are your views on the quality of consultation and the implementation of key concerns?

It would appear that the only consultation mentioned in the Bill appears in clause 5 (offence to fail to display signs). Perhaps the Bill should be explicit in stating the persons and organisations who will be consulted regarding the general principles (or is this process covered by some other means)?

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Regulating areas, as described in the Bill, provides for unnecessary enforcement complications particularly as smokers are permitted to congregate in non-regulated areas. There is little doubt that there will be complaints from non-smokers of environmental tobacco smoke drifting through openings and connecting spaces into a regulated area. Despite the interpretation of 'connecting space', 'enclosed' and 'opening', in practice this could on occasion be awkward to enforce as it is difficult to legislate for every possible type of premises layout.

In terms of liquor licensing, some premises may not serve food ordinarily but on occasions such as the World Cup, patrons are given food whilst watching the match. In order to continue this practice, these premises would need to be smoke free for five days in advance of the event. In these circumstances it is not clear who would check for compliance.
SUBMISSION FROM EDINBURGH CITY COUNCIL

Introduction

The City of Edinburgh Council welcomes the opportunity to submit written evidence on the Prohibition of Smoking in Regulated Areas Bill to the Health Committee of the Scottish Parliament. The Bill is seen as a positive development that will take forward established policy and operating standards within The City of Edinburgh Council.

Background

The increasing medical evidence that environmental tobacco smoke is a cause of ill-health and death is a key basis for City of Edinburgh Council policies.

Reflecting the Scottish Executive’s priorities to improve health and reduce health inequalities, Edinburgh’s Joint Health Improvement Plan identifies reducing smoking and tobacco-related harm as a priority for health improvement.

The Council implements a wide range of health-improving activities, both in the role of employer and that of enforcer of legislation. Initiatives that specifically target issues related to smoking include:

- Protecting children and young people by placing conditions on licensed premises through the use of Children’s Certificates.
- Promotion of workplace-based health improvement. For example, via the Scotland’s Health at Work (SHAW) initiative and the implementation of a specific control of smoking at work policy.
- The Local Government in Scotland Act includes a power of ‘community well-being’. The Council’s work to improve health relates strongly to this power, and legislation to prohibit smoking in regulated areas would re-enforce these initiatives.

General principles

The general principles of the proposed legislation are welcomed, and are viewed as a natural development of existing policies and practices.

The recent implementation of legislation in Ireland, and anticipated legislation in Norway, will provide useful points of reference for Scotland.

The proposed legislation is welcomed as a way of improving the working conditions of those employed in the catering and hospitality sectors. It provides an opportunity to enforce existing legislation and resolve potential difficulties, where, for example, any employee is able to demonstrate that exposure to tobacco smoke at a Council venue had been detrimental to their health.

Environmental tobacco smoke is a known carcinogen; therefore the Bill should refer to the duties given by health and safety legislation. Most notable being sections 2 and 3 of the Health and Safety at Work etc Act 1974. In conjunction, the Bill should also refer to the duty given to the employer by regulations 11(1) and 11(2)(b) of the Control of Substances Hazardous to Health Regulations 1999 (COSHH). These particular regulations require that the employer shall ensure that employees, exposed to a substance hazardous to health are under suitable health surveillance. Such monitoring of the health condition will
be of increasing importance where the flexibility offered to operators by the five-day rule is taken advantage of.

The City of Edinburgh Council pioneered Children’s Certificates in licensed premises, introducing them in 1990. Certificates included the condition that smoking would not be permitted in areas covered by the Children’s Certificate during the Certificate’s hours of operation. The stringencies of this condition were believed to have affected uptake initially, but is now seen as acceptable regulation, with uptake increasing from 5 in 1994 to 62 premises holding certificates at present. It is anticipated that the same perception will apply to legislation prohibiting smoking in regulated areas.

The City of Edinburgh Council has an overall policy of no smoking in any Council workplace for all employees.

In addition the Council’s control of smoking at work policy states that ‘Where practicable, any organisation or person granted use of Council premises for meetings or events is informed that as part of the let, they will be required to conform to arrangements which seek to protect non-smokers from environmental tobacco smoke.’

This policy has been implemented in a variety of different ways. For example there has been a no smoking policy for all events at the City Chambers since the beginning of 2004. This policy has not resulted in income loss. Meadowbank Stadium is another example of a venue that does not permit smoking. Other venues across the city have differing policies, and the decision as to whether or not to allow smoking is, in some cases, left to the client hiring the facility. Concern about a potential loss of income has been noted, although this appears to be an assumption, rather than a statement of fact.

Support for key provisions set out in the Bill

The key provisions set out in the Bill are supported with concerns in the following areas:

Regulated areas
There are concerns about the practicalities of defining, segregating and ventilating regulated areas where their creation could conflict with planning regulations, or where these would not be practical. The examples provided in paragraph 38 of the Policy Memorandum have identified certain areas, such as large spaces, where this type of difficulty could arise.

In the current proposals, beer gardens or outdoor tables are not included as regulated areas (Policy Memorandum paragraph 40). However, the risk to health from inhaling environmental tobacco smoke also exists in outdoor areas and the Bill should consider whether these should be included as regulated areas.

Five day rule
Although this provision would allow flexibility in how premises are used, which could be welcomed by operators, potential difficulties in successfully enforcing this rule are anticipated. For example, providing proof of the time that has lapsed since the area was used for smoking could present problems.

The provision of research based evidence in relation to the stipulated five-day time period would be particularly welcome.

No smoking sign.
The principle of requiring appropriate signage is fully endorsed but further detail about the definition of ‘reasonable’ signage is sought. Consideration should also be given to cases
where an unauthorised person has removed a sign, and the subsequent implications for those required to place signs, and those who have chosen to ignore the signs. It should be noted that some signage will be of a temporary nature if the premises are being used flexibly.

**Support for the provision to make it an offence to smoke in a regulated area, and an offence to permit smoking in a regulated area**

The provisions of the proposed offences are supported.

The emphasis should be on the responsibility of the person in charge of the premises, in line with current responsibilities for health and safety and food provision. It would be in extreme circumstances where the owner has taken adequate steps that enforcement would be taken against a member of the public.

It may be worth considering that Section 3 offence by the smoker could be a fixed penalty.

Enforcement, to be effective, requires a clear duty to enforce the legislation. This duty is not included in the current proposals. It is suggested that local authorities should be the lead enforcers, with the police service providing support where necessary. Further comments are provided in paragraph 19 relating to the Financial Memorandum.

**Support for the provision of penalties on summary conviction**

There is support for the provision of penalties on summary conviction. However, consideration of whether there should be a distinction between offences by individuals (smoking in a regulated area) and business/organisations (allowing smoking in related areas) would be welcome.

**Support the provision for corporate bodies (including local authorities)**

There is support for the provision relating to corporate bodies and local authorities.

**Definitions**

Hotels and other similar establishments (Draft Bill, Schedule 2, paragraph 4). This definition is considered insufficiently rigorous, and should explicitly include, for example, bed and breakfast establishments and backpackers hostels.

**Commencement**

The implementation period is reasonable. However, it suggested that widespread and effective publicity and information about the new legislation is required in order to encourage compliance.

**Financial Memorandum**

Paragraph 62 states that ‘it is not anticipated that the provision should impose any direct costs on local authorities’. If Environmental Health Departments are to enforce the legislation, costs will be incurred in order to provide advice, undertake additional inspections, investigate complaints of non-compliance and prepare for any legal action.

There should be an appropriate assessment of the impact of this legislation on workloads (with approximately 3,000 food premises in Edinburgh that will be affected by the
proposed legislation). It will be important not to underestimate the additional workload and ensure that there is provision of appropriate funding.

**SUBMISSION FROM DUMFRIES AND GALLOWAY COUNCIL**

Do you support the general principles of the Bill and the key provisions it sets out?

Agree with:

1. Prevention of exposure to secondary smoke in certain public places, particularly the strong emphasis on protecting children
2. Focus on where food is supplied and consumed
3. Raising awareness and safeguarding the health of Scotland
4. Cessation aspects of the Bill, but some expansion is required on what follow up support is provided

However, the 5-day rule for premises where smoking is allowed seems reasonable until you work through the practicalities of enforcement and also what evidence is there that the harmful chemicals have actually dispersed and are no longer evident after 5 days.

It is noted that in relation to corporate bodies and local authorities individual officers could be prosecuted. Whilst this at first glance might seem harsh it is inevitable if the Bill is to be taken seriously.

**Are there any omissions from the Bill that you would like to see added?**

There is a question over the enforcement of the 5-day rule and how this will work in practice

The focus of the Bill is fairly narrow and does not tackle public places in general. While the Bill is viewed as being a positive step in tackling smoking issues there surely needs to be more far reaching legislation in terms of the public areas covered if the health of communities is to be improved

Only the eating areas appear to be covered in school/educational establishments, however as national policy focuses on reducing the rate of children smoking would it not be prudent to include the whole of these types of enclosed establishments within this section

It appears that the emphasis has been directed towards larger buildings/places. Is this because it will be easier to achieve, dilution of the air is greater etc. What help/encouragement would therefore be given to the smaller premises?

There needs to be some more thought given to hospitals, nursing/residential homes. These are always sensitive premises to dwell upon, but there is the occupational exposure and in certain areas such as maternity etc should we not be encouraging cessation, especially in the earlier stages of pregnancy

There needs to be more mention of the protection required for employees from the occupational exposure to Environmental Tobacco Smoke
Ventilation/Filtration – with the varying interpretations of the effectiveness or not of mechanical ventilation/filtration, there needs to be some guidance of what is acceptable etc in this area. The Bill is looking towards smoke free areas without the assistance of mechanical ventilation, but this is just not clear.

**What are your views on the quality of consultation and the implementation of key concerns?**

What are the costs of implementation and how is this to be carried out and by whom?

Will the police have the resources to respond to complaints etc, and how high will it be listed on their priorities? Would it therefore be prudent to also have the back up of another enforcement agency, but not as an absolute alternative?

Agree with the fixed penalty fine in principle, but could be issues with those who are under the influences of alcohol etc.

What are the transitional arrangements, if any? i.e. lead in period

**Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?**

What training if any will be available to enforcement staff, businesses and who will be giving this advice?

How quickly will this be rolled out? Will there be a lead in period for businesses?

Guidance for Licensing Boards: re: consideration of applications with regards to complaints or prosecutions against the premises, on renewal etc of their licences. Could smoking issues be considered as competent objections?

In essence the Council’s Health Improvement Officer Group support the introduction of this Bill and consider it to hopefully be a first step in addressing the problem of smoking in the wider community.

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**SUBMISSION FROM SCOTLAND CAN (CLEANER AIR NOW!)**

**Introduction**

Scotland CAN (Cleaner Air Now!) is a broad-based coalition of organisations that lobby for smoke-free places in Scotland. This submission is on behalf of Scotland CAN, but does not necessarily reflect the views of individual member organisations (see end of document for full list). Given our focus on campaigning for smoke-free public places, we are delighted that the Scottish Executive are considering legislation on this issue, and we ask to be called to give oral evidence to the committee.

The thrust of the proposed regulation is to be welcomed, and while Scotland CAN supports the notion behind the Bill, we also believe that the proposed regulations must be tightened and expanded upon to ensure that they are as effective as possible.
Environmental Tobacco Smoke – A Hazardous Substance

Scotland CAN’s primary concern is that the health issues concerning environmental tobacco smoke (ETS) are not made clear enough, as the proposed bill, with its focus on food and smoke-free places, reinforces the misleading view that ETS is primarily an issue of comfort. A recent study showed that this was the predominant perception in Scotland. However, the predominant problem is that ETS is a hazardous substance that causes a range of serious health conditions, not that it is irritating or uncomfortable. ETS has been labelled as “cancerogenic to humans” by the WHO’s International Agency for Research on Cancer (IARC). It has also been labelled a “class A human carcinogen” by the US Environmental Protection Agency, along with asbestos, arsenic, benzene and radon gas.

Smoking in the Workplace in Scotland

While exposure to other toxins at work is regulated by law, there is no mandatory right to protection from ETS in the UK and Scotland. Even though there is no evidence that there is a safe level of exposure to ETS, many workers and members of the public continue to be affected by the health risks associated with ETS. Scotland has fewer smoke-free workplaces than the rest of the UK, with less than half of them currently smoke-free. Thirty-one percent of working women and 21% of working men had been exposed to other people’s smoke at work in the week preceding the most recent Scottish Health Survey.

Scotland CAN is also concerned that, if the Bill is passed, it will not apply in the majority of public places where passive smoking causes harm. Those working on low incomes, or in small businesses and in the hospitality industry will be at greatest risk. Among the estimated 53,000 UK bar workers, approximately 17% will die from passive smoking during their working lifetime, amounting to 165 deaths per year among non-smokers. For UK non-smoking office workers, it is estimated that approximately 900 deaths per year are caused by ETS, based on an extrapolation from US estimates, adjusting for relative population size. For UK manufacturing workers, it is estimated that about 146 deaths per year among non-smokers are caused by ETS. While this is a preliminary estimate, it is triple the annual number of fatal occupational injuries among UK manufacturing workers.

Health Risks Associated with ETS

Exposure to ETS has been established as a cause of heart disease, lung cancer, and stroke. Research has demonstrated an 82% increased risk of stroke; a 25-35% increased risk of heart disease; and a 20-30% increased risk of lung cancer associated with ETS in both men and women. A recent Scottish study demonstrated that non-smokers exposed to ETS in the workplace may have their lung function reduced by up to 10%. It has also been estimated that ETS in the workplace poses 200 times the acceptable risk for lung cancer and 2000 times the acceptable risk for heart disease.

ETS is also a cause of asthma in children, and it is cited by up to 80% of people with asthma as a trigger for further attacks. Each year, more than 17,000 children aged under five are admitted to UK hospitals because of exposure to other people’s cigarette smoke. ETS is also known to cause lower respiratory illness in children such as pneumonia, bronchitis, coughing and wheezing. It is also a cause of reduced lung function and middle ear disease, including recurrent ear infections, and it has been demonstrated to be a cause of cot death (sudden infant death syndrome (SIDS)). Studies of families where fathers smoke and mothers do not have reported an increased risk of SIDS.

Furthermore, despite the many associated health risks, almost one in three pregnant women in the UK is exposed to ETS in the workplace. ETS exposure is linked to low birth weight; the greater the exposure, the greater the risk of having a low birth-weight baby. While a
reduced birth weight is not in itself a risk for most babies, it could compound health problems for those with additional health problems or risk factors. ETS has also been found to increase the risk of giving birth prematurely, and research evidence also demonstrates that exposing children to ETS in utero affects their lung function during the first year of life.

**Economic Issues**

Current smoke-free legislation in many other countries applies in all public places, for example in New Zealand, Italy, Malta, Uganda, Romania, and in parts of the US and Australia. Whilst some UK businesses have concerns that a total ban on smoking in public places would have a negative impact on business, international experiences demonstrate that this is not the case. A recent report from Ireland suggests that, overall, the evidence is that smoking bans do not have an adverse effect on sales in the hospitality sector, and may, in fact, have a positive effect. Similar conclusions have been reached in the US, following an assessment of 97 studies of restaurants and bars after no-smoking policies have been introduced. Again, many businesses have been shown to profit from such a ban. Further US and Canadian studies suggest that ETS causes a net loss of trade for the hospitality industry by causing offence to non-smokers from odour, irritation and health concerns.

The health benefits of introducing no-smoking policies are also clearly documented. The California ban on smoking in bars has provided both immediate and longer-term respiratory health-benefits for both smoking and non-smoking bartenders. A recent calculation of the possible impact of a smoking ban in workplaces in Glasgow alone suggested that up to 1,000 fewer people a year would die of heart disease, respiratory disease and cancer. UK public opinion also clearly demonstrates that it is time for a ban on smoking in the workplace and in public places. The recent UK-wide ‘Your NHS’ survey found that 77% of Scottish respondents want a ban on smoking in all public places, slightly higher than the UK average of 73%. Similar statistics were obtained in the 2002 Office of National Statistics survey, where over four-fifths of UK respondents agreed there should be restrictions on smoking at work (86%), in restaurants (88%) and in other public places such as banks and post offices (87%).

**Ventilation**

Current measures proposed to address smoking in public places in the white paper *Smoking Kills* are clearly not providing effective smoke free public places. Although ventilation systems can increase comfort in the short-term by removing particle matter, they don't remove harmful gases that are present in second-hand smoke. Therefore ventilation does very little to reduce the significant health-risks associated with passive smoking.

AIR (Atmosphere Improves Results) have promoted ventilation standards which state that a minimum of 12 air changes per hour are required for an average sized room, in order to judge ventilated air as ‘safe’. However, based on this recommended ventilation rate for a pub at full occupancy, it is estimated that 5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer during his or her working life. There simply is no safe level of exposure to second-hand smoke. In fact, it has been estimated that it would require tornado-like quantities of ventilation, in excess of 10,000 air changes per hour, to produce levels of risk acceptable to bar staff from ETS.

**The Voluntary Charter**

Under the current Voluntary Charter, businesses can choose the level of smoking restriction that they wish to impose, if any. For example, it is possible to comply with the Charter by using clear signage that reads ‘smoking permitted throughout’, without doing anything to provide smoke-free areas. Even where designated smoking areas are provided, they
increase exposure to workers and occupants within the smoking area by concentrating smokers in the one place. Recent research has demonstrated that the voluntary approach does not work in Scotland. More than 7 in 10 pubs still permit smoking throughout, as do nearly 4 in every 10 leisure industry sites. Seventy percent of the public do not smoke, and yet only 18% of public places are currently smoke free.

Concluding Comments

Scotland CAN agree that legislation on smoke-free public places is needed in Scotland, and we welcome support the Bill as a positive first step in the right direction. As outlined however, the Bill is partial in its current form, as it will not apply in the majority of public places where passive smoking causes harm. If the current ban is implemented, individuals will be no closer to obtaining freedom of choice concerning exposure to environmental tobacco smoke, and nor will they be protected from the harmful health-effects of ETS. It is estimated that 1,000 lives each year would be saved if workplaces were smoke-free. Exposure to ETS presents a significant health risk for every Scot, and pregnant women, hospitality workers, children and many individuals with existing health problems face an even greater risk associated with exposure to ETS. The wealth of existing research literature, combined with public opinion clearly demonstrate that it is now time to increase efforts to protect the Scottish workforce and members of the general public, from the hazardous effects of ETS.

Scotland CAN involves the following member organisations:

ASH Scotland  
Beatson Oncology Centre  
British Lung Foundation  
Department of Public Health Fast Forward  
Smoking Concerns  
Cancer BACUP  
Cancer Research UK  
Chest, Heart and Stroke Centre of Tobacco Control  
Children in Scotland  
Health at Work  
Macmillan Cancer Relief  
Marie Curie Cancer Care  
National Asthma Campaign  
NHS Health Scotland  
Path House Medical Practice  
Roy Castle Lung Cancer Foundation  
Royal College of Nursing  
Royal College of Physicians  
Royal College of Physicians & Surgeons  
Royal College of Surgeons  
Royal Environmental Health  
Scottish Tobacco Control Alliance  
STUC  
West Lothian Drug & Alcohol Service

SUBMISSION FROM CANCER RESEARCH UK SCOTLAND

Introduction

Cancer Research UK is the major funder of cancer research in Scotland. Smoking remains by far the single biggest preventable cause of cancer and premature death and thus one of the charity’s key concerns. In addition to research around Scotland on all aspects of cancer, we fund the Centre for Tobacco Control Research at the University of Strathclyde directed by Professor Gerard Hastings. An integral part of the centre's research is into the marketing activities of the tobacco industry as well as new ways to encourage people to stop smoking. The researchers are also evaluating tobacco control policies and identifying those that most successfully change smoking behaviour.

Our lead researchers have commented that the evidence marshalled in the Policy Memorandum of this Bill represents a very fair evaluation of the state of the evidence and of the likely practicability of the measures proposed.

Cancer Research UK Scotland’s position

- The scientific evidence that breathing in second hand smoke is harmful has never been stronger.
• Cancer Research UK Scotland supports a ban on smoking in workplaces and enclosed public places.
• Cancer Research UK Scotland therefore supports the Prohibition of Smoking in Regulated Areas (Scotland) Bill, but sees it as an incremental step towards a ban on smoking in all workplaces and enclosed public places.
• Cancer Research UK Scotland would be welcome an opportunity to provide expert oral evidence to the Health Committee on the Bill

The risks of second hand smoke

There is abundant evidence that breathing in other people’s tobacco smoke carries serious heath risks, especially for children or those who are chronically exposed.

An IARC study in June 2002 analysed all significant published evidence relating to tobacco smoking and cancer, across 12 European countries. The IARC panel of experts – which included eminent British researchers Sir Richard Peto and Sir Richard Doll - concluded that second-hand smoke is indeed carcinogenic to humans. They estimated that non-smokers living with a smoker run a 20-30 percent greater risk of lung cancer than those living in non-smoking households. For non-smokers exposed in the workplace the risk of lung cancer is increased by 16-19 percent.

There is also strong evidence that passive smoking is an important and avoidable cause of ischaemic heart disease, and significantly increases the risk of sudden infant death syndrome, respiratory illnesses such as asthma and middle ear disease.

In July 2003 the Chief Medical Officer for England, Sir Liam Donaldson, published his annual report: Health Check: On the State of the Public Health and identified second-hand smoke as a ‘direct hazard to health’. In November 2003, the leaders of the 13 Royal Colleges of Medicine called for legislation to ban smoking in public places.

The Chief Medical Officer for Scotland, Dr Mac Armstrong, reinforced these views in an interview with BBC Radio Scotland on 7 April 2004. Dr Armstrong said: “I am speaking very firmly - it is my duty, it is my duty as Chief Medical Officer to speak out very firmly and very vocally on the motion that there should be a complete ban on smoking in public places in Scotland.”

In his annual report he had calculated that the possible impact of a smoking ban in workplaces in Glasgow alone could be to save 1,000 lives from heart disease, respiratory disease and cancer.

Smoking prevalence in Scotland – helping smokers to quit

Scotland has an estimated 1.4 million adult smokers. A third (33 percent) of both men (34 percent) and women (32 percent) aged 16-74 smoke cigarettes according to the Scottish Health Survey 1998. The 1995 Scottish Health Survey found that 35 percent of Scots (34 percent men and 36 percent women) smoked cigarettes.

Rather than punishing smokers, restricting smoking in public places is part of the strategy to ‘denormalise’ smoking. Non-smoking is the norm – the vast majority (73 percent) of British adults are non-smokers. Limiting the number of places in which smokers can light up not only protects non-smokers but is also effective in helping would-be quitters to give up smoking. Surveys suggest that around 70 percent of smokers would like to quit.
International legislation - Ireland leads by example

On March 29th 2004, Ireland joined a growing list of countries to pass legislation banning smoking in public places including restaurants, bars and pubs. In this important move, Ireland has set an example for the UK to follow. Reactions to the ban have been varied but there has been strong support from the Irish public, over seventy per cent of whom are non-smokers. Cancer Research UK Scotland welcomes the ban; we hope that it will mark the start of a domino effect in the UK and throughout Europe.

Other countries to have banned smoking in public places include New Zealand, Uganda, Tanzania, Bhutan and Romania, as well as states and cities in North America.

In Westminster, the Government is currently examining two Private Members Bills concerning second-hand smoke: The Second Reading of Lord Faulkner of Worcester’s Bill, Tobacco Smoking (Public Places and Workplaces), is to be held on Friday 23 April. Also on that day, Baroness Ilora Finlay’s Bill on Smoking in Public Places (Wales) will be debated in a Committee of the Whole House.

Public support

The majority of people in the UK support smoking restrictions in pubs (54 percent), restaurants (86 percent) and other enclosed public places (88 percent). In late 2003, the London Health Commission conducted a poll to benchmark opinion on smoke free public places in London. Over three quarters (78 percent) of the 34,446 Londoners who took part in the Big Smoke Debate stated that they would prefer enclosed public places in London to be completely smokefree.

The results also showed that people were keen to see proper protection for those who work in public places. Nearly three quarters (74 percent) stated they would back a law to make all workplaces smokefree. Although many workplaces now operate smoking bans, some three million people are still exposed to tobacco smoke in their workplaces. The consultation for the Your NHS programme on BBC One surveyed views of more than 600 people on issues such as obesity, smoking and sexual health. In Scotland, 77% of those surveyed supported the idea of a ban on smoking in public places, slightly higher than the UK average of 73%.

The hospitality industry

The Big Smoke Debate results also demonstrated a strong public desire for change, particularly in venues within the hospitality industry, with more than six in ten (64 percent) respondents wanting the capital’s restaurants to be completely smokefree and over four in ten (43 percent) wanting pubs and bars to be entirely free of smoke. Adding weight to the debate, a recent survey of 1,700 people found that 64 percent of people working in pubs and bars said they would prefer to work in a smoke-free environment. Yet currently, only a tiny percentage of London’s pubs and restaurants are smokefree, despite a voluntary agreement signed up to by the hospitality industry in 1998 to increase smokefree provision.

One of the main arguments of the hospitality sector against introducing no smoking policies is that it would lead to a fall in income and would jeopardise the viability of bars, restaurants and pubs. However, a year after New York City passed legislation to ban smoking in all its bars and restaurants figures have shown that contrary to these assertions business tax receipts are up 8.7 percent and employment in the sector is the highest in over a decade.
At present there are few options available for consumers who want to eat in smoke-free venues and employees who want to work in them. Encouragingly attitudes within the industry are beginning to change. In March this year two leading pub chains expressed support for a ban on smoking in all public places. The Laurel pub chain (including the former Whitbread chain) has already introduced no smoking policies into sixty of its pubs, while Wetherspoons, although not yet smokefree, has publicly backed a universal ban on smoking in all public places including pubs: Chief Executive John Hudson describing it as “the simplest and easiest step to take now”.

Is there an alternative to a complete ban?

Although workplace health regulations are a reserved matter for Westminster, we see this Bill as a step towards Cancer Research UK’s preferred measures of a complete ban on smoking in every workplace. Despite efforts to put in place voluntary codes of practice such as the Voluntary Charter agreed between the Scottish Executive and the hospitality industry, these have been unsuccessful in increasing greatly the number of smoke-free pubs and restaurants. The audit of the Voluntary Charter found that more than seven in every ten pubs and four in every ten leisure centres still permit smoking throughout. Nevertheless, employers such as pub landlords and restaurant owners, who do not want to ban their customers from smoking, have a duty protect their employees from the dangers of second-hand smoke.

Therefore, while we welcome the measures within the Prohibition of Smoking in Regulated Areas (Scotland) Bill to ban smoking in restaurants and pubs that serve food, we note that it will not afford protection to employees or customers in pubs which do not serve food or only provide snacks. We therefore see the Bill as part of an incremental move towards all workplaces being smoke-free.

It is clear that ventilation is an inadequate method of dealing with the problem of second-hand smoke. While it may improve comfort levels, it does not reduce the health risk of second-hand smoke to employees or customers. The cheapest and most effective method of dealing with second-hand smoke is to go smoke-free.

Tobacco industry spin

The tobacco industry recognises the threat to its profits from restrictions on smoking in public places and is marshalling its defences to prevent bans being put in place. Its tactics have included:

- Seeking to discredit the scientific facts on the risks associated with second-hand smoke.
- Implying that ventilation offers a solution to the health risks of second-hand smoke.
- Positioning smoking as a ‘human right’, though it is the non-smokers’ right that must take precedence (i.e. not to breathe in the carcinogens contained in other people’s smoke).
- Claiming that the economic effects of a ban on smoking in public would lead to devastating job losses, when evidence from countries where bans have been implemented suggests otherwise.

We urge the Scottish Executive to take the first step towards smoke-free public places by supporting the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

Further information about the economics of introducing smoke-free public places can be found on the ASH website: http://www.ash.org.uk. Of particular interest is the ASH

References:

5. Dr Mac Armstrong speaking on Good Morning Scotland, BBC Radio Scotland, Thursday 7 April 2004
6. Health in Scotland 2003, 7 April 2004, Chief Medical Officer for Scotland’s annual report, HMSO.
10. As above
14. BBC Scotland News Online, 24 March 2004 “Support for Scottish Smoking Ban”
16. Source: Joe Cherner. Smokefree.net

SUBMISSION FROM ROY CASTLE LUNG CANCER FOUNDATION

Prohibition of Smoking in Regulated Areas (Scotland) Bill

As the UK’s only charity dedicated to defeating lung cancer, the Roy Castle Lung Cancer Foundation firmly supports the Prohibition of Smoking in Regulated Areas (Scotland) Bill in order to protect the people in Scotland from the effects of second-hand smoke.

A restriction in areas where people can smoke can only be positive – protecting the health of approx. 70% of the population in Scotland who have chosen not to smoke, encouraging those addicted to tobacco smoke to “give up” and protecting those exposed to a smoke filled environment in their place of work.

The evidence

Tobacco smoke contains 4,000 toxic chemicals and at least 40 known carcinogens. Smoking is the single greatest preventable risk to health and is responsible for 120,000 deaths in the UK annually.

Smoking is not only a threat to smokers, passive or secondhand smoking (involuntarily breathing in the smoke of others sometimes called exposure to environmental tobacco smoke) is established beyond doubt as a cause of serious disease in non-smokers -
including cancer, cardiovascular disease and numerous respiratory conditions. Children, pregnant women and those with established disease processes such as asthma are particularly vulnerable³.

Short-term exposure to passive smoking leads to effects ranging from headache, sore throat, dizziness and nausea, increased cough, wheeze and phlegm production, to irritation of the eyes and the nuisance of foul smelling clothes and hair – interestingly many who suffer this ‘inconvenience’ will not ask a smoker to stop for fear of causing offence! Research indicates that 5-minutes exposure to secondhand smoke significantly reduces the coronary blood supply in a fit and healthy adult⁴.

3 million people in the UK are exposed to environmental tobacco smoke in the work place⁵ and latest estimates suggest that 12,000 U.K. non-smokers die annually as a result of exposure to secondhand smoke⁶.

Employers have a legal responsibility to protect the health of their employees. Creating a smoke-free workplace can reduce employers’ legal liability, create a safer working environment, improve workers’ health and enhances corporate image. Introducing a workplace smoking policy removes the risk of exposure to passive smoking. In addition research has shown that smoking prevalence is reduced by the implementation of a policy and that those who continue to smoke, smoke less⁷.

However attitudes toward smoking, even amongst smokers themselves, are changing:

- Smoking is a minority activity – more than 70% of the population are non-smokers
- 86% of all adults agree there should be restrictions on smoking at work
- 88% of all adults agree there should be restrictions on smoking in restaurants
- 53% of all adults agree there should be restrictions on smoking in pubs
- Smokers are increasingly considerate towards others in their smoking behaviour
- 57% of smokers say they would not smoke at all if they are in a room with children
- 45% of adult smokers say they would not smoke at all in the company of adult non-smokers⁸

The way forward

As more and more cities around the world take sight of the dangers of second-hand smoke and ban smoking in workplaces, the Roy Castle Lung Cancer Foundation would urge the Scottish Parliament to follow suit & protect the health of the people in Scotland.

In his annual report (April 2004), Scotland’s Chief Medical Officer Dr Mac Armstrong estimated that a ban on smoking at work in Glasgow alone could save around 1,000 lives each year.

Although the Prohibition of Smoking in Regulated Areas (Scotland) does not completely ban smoking in public places, and focuses on areas where food is supplied & consumed, the Roy Castle Foundation supports this legislation as a positive first step to a ban on smoking in public places.

A recent BMJ study using data from other countries showed that if all UK workplaces were smoke-free, we could expect smoking rates to fall by 4% and overall tobacco consumption by 7.6%⁹. Around 90% of lung cancers are caused by tobacco smoke; The Roy Castle Lung Cancer Foundation would be delighted to see any measures taken to help the public to quit smoking and eliminate this devastating disease.
The Roy Castle Lung Cancer Foundation is the only UK charity dedicated to defeating lung cancer. Our work focuses on Lung Cancer Research, Patient Care; Information, Support & Advocacy initiatives and Tobacco Control.

4 Otsuka et al. Acute Effects of Passive Smoking on Coronary Circulation in Healthy Young Adults. JAMA 2001; 286436-41
5 MORI (March 1999) Smoking in the Workplace
6 ASH. A Killer on the Loose: special investigation into the threat of passive smoking on the UK workforce 2003.
8 Lader, D and Meltzer, H Smoking related behaviour and attitudes, 1999. ONS 2000
9 Fichtenberg, CM; Glantz, S. Effect of Smoke-free workplaces on smoking behaviour. systematic review. BMJ 325 (7357), 2002, 188-191

SUBMISSION FROM BRITISH THORACIC SOCIETY

The British Thoracic Society was formed in 1982 and has grown over the last few years to include medical practitioners, nurses, scientists and any professional with an interest in respiratory disease. There are currently 2350 members. Its core functions are:

i. The relief of sickness of people with respiratory and associated disorders by the promotion of the highest standards of clinical care and the undertaking of research into the causes, prevention and treatment of respiratory and associated disorders, and disseminating the results of such research.

ii. The preservation and protection of public health by the provision of information in matters concerning respiratory and associated disorders and how they might be prevented.

Based on the experiences of the USA, Australia, Canada and Germany, for smokers, a change in the law is likely to result in:

- 10 per cent decrease in the number of smokers
- 30 per cent reduction in the overall tobacco consumption among those who continue to smoke
- motivational help for smokers who wish to quit, in helping those attempting to stop smoking to persevere

Second-hand tobacco smoke is undeniably harmful to non-smokers, it causes:

- up to 600 lung cancer deaths and 12,000 cases of heart disease in non-smokers each year in the UK
- 26% increased risk of lung cancer in adults
- 23% increased risk of heart disease in adults
- respiratory disease in childhood (such as cot death, middle ear disease and asthma) iv
- harm to non-smokers even in small amounts and short durations - particularly to a substantial proportion of the population (more than 10m people) who are known to be especially vulnerable to adverse effects, such as pregnant women, children,
people with lung disease, people with angina and people who have had a heart attack or a stroke

- immediate effects on adults including eye irritation, headache, cough, sore throat, dizziness and nausea

Alongside supra-inflationary increases in the tax on cigarettes, a complete ban on advertising tobacco products and increased funding of smoking cessation programmes/counsellors, a ban on smoking in public places is the logical next step in protecting the population's health from the harm that smoking causes.

Based on the huge amount of evidence that smoke-free public places will bring major health benefits to both smokers and non-smokers, the British Thoracic Society gives its full support to the proposed Prohibition of Smoking in Regulated Areas (Scotland) Bill.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

14:04

The Convener: We move on to item 3 and paper HC/S2/04/17/1, which has been circulated to all members. I welcome our first panel of witnesses. Gordon Greenhill is environmental health manager, regulatory services department, City of Edinburgh Council—this is a long title—and representative of the Society of Chief Officers of Environmental Health in Scotland. We need an acronym for that. Liz Manson is operations manager in the policy and performance unit of Dumfries and Galloway Council. Peter Allan is policy planning manager at Dundee City Council.

Kate Maclean (Dundee West) (Lab): Obviously, for the committee to agree the bill’s principles, members would have to feel that it would have a direct benefit for health. I know that the City of Edinburgh Council and Dundee City Council have banned smoking in the workplace. I wonder whether you have found any evidence that employees have stopped smoking because of the ban. Do you think that there is any direct link between banning smoking in the workplace and people giving up smoking?

Some of the medical evidence that we heard last week seemed to suggest that people at least reduce the amount that they smoke if there is a ban in the workplace. My experience of a workplace smoking ban was that I smoked just as much over the course of a day but in more concentrated pockets, when I was able to. Do you have any evidence of the benefits of workplace bans for the cessation of smoking?

Gordon Greenhill (City of Edinburgh Council): We ran quite an intensive campaign that included smoking cessation classes that had a good take-up. I do not know whether figures were produced to show how many people continued to smoke after they had attended the classes. I would be grateful if we could get back to you with a written submission on that.

Kate Maclean: That would be useful.

Peter Allan (Dundee City Council): We do not have evidence of the reduction of smoking among smokers either.

The Convener: Can I ask you to move your microphones a little closer to you? I am fighting against fans, here—not fans of me personally, unfortunately, but fans of the electronic variety.

Peter Allan: We believed that it was important for us, as employers, to protect the health of our employees, customers and service users. We believed that there would be spin-offs from our workplace ban in the lives of individuals and families and in society as a whole. We felt that it was important to protect non-smokers by reducing the opportunity for people to smoke. We have heard that smokers welcome that, as it helps them to quit if the opportunity or the time that is available to them to smoke at work is reduced. Most of all, we wanted to contribute to the denormalisation of smoking to demonstrate that workplaces—like so many other places, including trains, buses and cinemas—are becoming places where it is unacceptable to smoke. We wanted to be part of that change in culture across the board.

The Convener: You are going to write to us. Do you have any statistics? Anecdotally, we are hearing that banning smoking in workplaces will deter people from smoking or reduce their smoking. Did you measure that in your council areas?

Liz Manson (Dumfries and Galloway Council): Dumfries and Galloway Council is about to undertake a baseline survey of staff as part of the Scotland’s health at work scheme. However, we do not have any statistics to confirm the smoking levels across the council.

Janis Hughes (Glasgow Rutherglen) (Lab): As you know, the bill currently seeks to ban smoking only in regulated areas. However, Dundee City Council’s submission states:

“There is a strong view that the prohibition of smoking in regulated areas should also specify alcohol.”

Can you give me some explanation of that statement? I would also welcome comments from the other witnesses.

Peter Allan: It is our view that we need to extend the measure to all public places. We believe that that was the best option to emerge from the Scottish Executive’s consultation exercise and we would support it. As it stands, the bill is positive about creating a comfortable environment for people when they are eating, but we think that it should go beyond that to protect employees and customers from passive smoking in places such as bars where alcohol is served. The council has not yet made a decision on the consultation, but all the discussions that we have had about health improvement and health inequalities suggest that we would support a total ban because of the benefits to employees and non-smokers.

Gordon Greenhill: The concept that I ask you to consider is the effecting of cultural change by enforcement. As an enforcer, we ensure that people comply with something or not, whether it is a good law or a poor law. On the whole, the bill is to be welcomed as good law.
People did not stop drink driving or put on their seat belts as a matter of course until legislation was introduced. At the moment, we are effecting a cultural change in Edinburgh in relation to littering through the use of fixed-penalty notices, more than 1,700 of which have been served and paid.

The Convener: It is more important that they are paid.

Gordon Greenhill: With the co-operation of the local media in publicising them, fixed-penalty notices have had a good effect in changing people’s attitudes. If we want to use the law as a method for controlling and changing people’s attitudes, the bill probably does not go far enough or range widely enough to address the problem of smoking in public places.

The Convener: In my haste, I have not passed on apologies from Mike Rumbles or welcomed Stewart Maxwell back to the committee. I do so now.

Mr David Davidson (North East Scotland) (Con): I return to a comment made by Peter Allan. I think that he referred to the right of employees to work in a smoke-free area. Is he suggesting that Dundee City Council supports the introduction of a statutory right for people to work in a smoke-free area, or does it take the more flexible position that people should have the choice to work in such an area?

Peter Allan: We respect the right of our employees to work in a smoke-free environment. However, that causes us problems in respect of people who provide services in the homes of individuals who may be smokers. We are conscious that there is a tension between the right of an individual to smoke, which is a legal activity, in their home, and the right of our employees to work in a smoke-free environment. In our view, all employees should have the right to work in a smoke-free environment, which has implications for the hospitality sector. We like to bear in mind the fact that, from an inequalities perspective, people who work in the hospitality sector are likely to be on low wages and to have poor quality of life. We think that the measure is important to protect a vulnerable section of the work force.

Mr Davidson: I am not agreeing or disagreeing with you, but if we follow your argument to its conclusion, the bill would remove any choice from the owner or manager of a business who wants to provide choice for customers. If there were a separate smoking zone, staff would have the right not to serve people there, but would you allow a member of staff who was prepared to serve there to do so? I am trying to tease out the practicalities of what you are saying about the bill.

Peter Allan: In our view, the situation could be simplified if there were a comprehensive ban on smoking in public places. As health improvement organisations, local authorities have a responsibility to protect the health of their citizens. In some instances, the protection of health is a greater good than the provision of choice.

Gordon Greenhill: The situation that the member describes does not apply, because the employer has a duty of care to the individual concerned. It is not a case of someone choosing to go into a smoky atmosphere to serve people. The employer should make a risk assessment to determine whether that person should go into the area, so that the choice is not left to the individual employee.

Mr Davidson: Is that the position under current legislation?

Gordon Greenhill: Yes.

Mr Davidson: You are talking about the application of current legislation, rather than an effect that the bill would produce.

Gordon Greenhill: Yes. The member is suggesting that the provisions of the bill would be applied and that there would be clear delineation of areas in establishments in which people could smoke. You are also suggesting that proprietors could decide whether they wished to have such areas and that employees could decide whether they wished to enter them to serve people. I do not think that that situation applies because, as part of their duty of care, proprietors must protect all their staff.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Are employers required under the duty of care and health and safety regulations to monitor the length of time that any one worker must work in a smoke-filled atmosphere, whether in a restaurant or pub or in someone’s home? I am thinking of a home help who might have to be in someone’s home for longer than normal.

Gordon Greenhill: In that situation, each set of premises would have to undergo a risk assessment. That is the norm in any case—a risk assessment should be made of each working situation in all businesses. The situation of each employee would have to be considered individually, which would make the process more onerous than it is at present.

Dr Turner: Would a length of time be stipulated?

Gordon Greenhill: I am not medically qualified to say how long someone has to be in a smoky atmosphere before they are affected; that is a question for the medical profession. However, we would monitor the time and the intensity. If someone is in a room where 40 people are smoking, the effect is more intense.
Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We have asked employers in the health service about how they apply the current legislation. From what I have just heard, it seems that councils are not complying with their duty of care. You allow your employees to go to areas where they will be subjected to second-hand smoke. Is there not a contradiction there? It is difficult enough to comply with the current legislation, but now we are talking about legislating again, which will cause further difficulties with compliance.

Gordon Greenhill: The bill contains exemptions.

Mr McNeil: We have heard evidence, week after week, that no level of second-hand smoke is acceptable. We have heard that being subjected to second-hand smoke for very short periods harms a person. I presume that you are here to give evidence because you are in favour of the proposed legislation, but you do not comply with the existing legislation.

Peter Allan: You will find that such tensions often exist when public services are provided for individuals who are vulnerable because of their health—for example, people who are in long-term care in hospitals or who are housebound. Organisations have to balance the responsibility to deliver services to people in need and the responsibility to protect their staff. We have reached a compromise in Dundee in our commitment to staff. We recognise people’s right to work in a smoke-free environment, but we accept that, on occasion, they will have to go into smokers’ homes. When that happens, we try to support staff. We make individuals aware that our staff are coming and we ask them not to smoke while our staff are there and, if possible, to clear the environment of smoke that has been there. We have to balance those needs.

If a home-care worker has a list of service users, we try to ensure that they do not have days when all the people they visit are smokers. We try—

The Convener: That is not relevant to the bill.

Peter Allan: No, but I am answering the question that I was asked.

The Convener: I understand, but I have to make it clear that some things might not be relevant to the bill.

Mr McNeil: It is relevant. Organisations are coming here and asking us to legislate. Many of their arguments are based on the effect of passive smoking on bar staff, for example. It is contradictory for organisations that have not resolved such issues for their own staff to come here and ask us to pass legislation that will impact on someone else’s staff. Therefore, I would argue that my question was relevant.

The Convener: Sometimes our questions get into wider areas of banning smoking in all kinds of public place, but we are trying to take evidence on this particular bill. It is quite legitimate to go a certain distance into other areas, but the bill is limited and we must write our report based on evidence that relates to it.

Peter Allan: The comparison that Mr McNeil makes might be fair in relation to employment law, but the situation of a person who serves drink to a person who has chosen to go into a bar is fundamentally different from that of a person who gives a service to someone who, because of their health, has no choice in the matter. People who are in long-term care in hospital and who may be terminally ill, and people who are housebound, have been deprived of choice. How we accommodate their needs is important.

Mr Davidson: If I could bring the discussion back to the bill, does each of your councils operate totally smoke-free cafes and so on that are open to the public?

Gordon Greenhill: I think that the answer is yes, but I would like to check that. I cannot think of any premises that the council runs where people are allowed to smoke. That includes the City Chambers for the purposes of wedding functions and so on. I would need to check whether, when we subcontract, we have that condition in the terms of leases for all premises. Generally, we do apply such a policy, but I would have to check the detail.

The Convener: That is fine—you can give us supplementary written information on that.

Liz Manson: Dumfries and Galloway Council’s policy is for a complete ban on smoking other than in designated areas. Designated areas do exist in certain facilities, for example in our film theatre and arts centre. Some buildings are completely smoke free. It depends on the nature of the facility, and it is up to the manager to determine the policy.

Peter Allan: The most complicated areas for Dundee City Council are where we have franchised out parts of buildings to licensed premises. I think that, in those instances, smoking is still allowed. There is a bar in the Dundee Contemporary Arts centre, which is a popular social facility, where smoking is allowed. As a council, we are faced with the challenge of how to apply some of the principles of what we are discussing today to such facilities.

Helen Eadie (Dunfermline East) (Lab): What are your views on using the criminal law to reduce passive smoking?
Gordon Greenhill: We have a problem with the concept. As you are probably well aware, the criminal courts are busy as it is. We would like there to be a split between two means of enforcement. First, the person who is causing the offence, that is the smoker, should be subject to a fixed penalty, which is a quick, effective method of getting across the message that they have perpetrated an offence. Much of the experience of applying such legislation suggests that it does not clog up the courts. For the very few people who do not pay their fixed penalty, the matter should become criminal and go before the procurator fiscal.

Secondly, there should be a criminal element to not showing signs and not properly enforcing the legislation where people are allowed to smoke in regulated areas. Proprietors protect a large number of people and should comply with the law, so the criminal element should apply. Unfortunately, two officers would be required to enforce the bill because, under Scots law, there must be corroboration.

Liz Manson: I agree with that.

Helen Eadie: Does—

The Convener: Is the proposed law more likely to be obeyed in the observance than by having to be enforced? In other words, do you think that the penalties will not need to be imposed and that, because people know that they exist, they will not breach the law?

Peter Allan: We are looking for compliance, not punishment.

The Convener: That is what I was seeking to say—thank you.

Peter Allan: We are looking for a deterrent. Sometimes we need legislation to create a new norm and to advise people of their rights and of which rights they may exercise with other members of the community. It is important that, whatever model of penalty we agree on, communities are convinced that we will take the matter seriously. There is no point introducing legislation and telling communities that we have adopted its provisions if we do not enforce them. If we did that, we would start to lack credibility and any momentum that had been developed would be lost.

Helen Eadie: Could I finish off my question, convener?

The Convener: I am so sorry, Helen—I thought that you had already done so.

Helen Eadie: That is all right. Would a voluntary approach or action to promote better ventilation be a better alternative?

Gordon Greenhill: No—emphatically no. That approach has been tried by other local authorities, notably Birmingham City Council, but it does not work.

Ventilation systems are variable: a system is brand spanking new on the day that it is installed; it works well and makes the air changes that it was designed to make. However, it gets dirty and thumped about—people put things into it that they should not and so on—which means that by day two it is not so effective. By the time that day 102 is reached, the system does not shift the air as it should.

I have come across voluntary schemes in my 30 years in local government. I am clear that enforcement works and voluntary schemes do not work.

Liz Manson: We have some experience of voluntary schemes because of the schemes that the licensing boards are running in our area. A number of premises across the region are picking up on the issue and, generally speaking, the voluntary bans are being observed. We support a legislative proposal that has the same basis as the seat-belt argument, which is that, generally speaking, people want to comply with the law. Legislation raises the profile and gives an added seriousness to the issue.

Mr Davidson: I want to return to the issue of enforcement on which all of you submitted detail, in particular City of Edinburgh Council, which included evidence about the five-day rule and so on. As the bill is drafted, is it likely that it would place an undue demand on enforcement agencies? How will enforcement be run?

Gordon Greenhill: It is optimistic to suggest that the bill, as currently drafted, would be cost neutral for local authorities, as the explanatory notes that accompany the bill, which include the financial memorandum, suggest. Complaints would be made and an extra burden would be placed on authorities during inspections. It would be another piece of work that would have to be done. There are 17,000 premises in Edinburgh alone in which we enforce the health and safety at work regulations. If legislation adds another factor, the time that inspections take would increase and the frequency of inspections would reduce.

From the point of view of how enforcement would work, the bill is quite well framed. I am referring to the provisions for both the proprietor and the offender—the person who has lit up. However, it is not clear who would do the enforcement. It is optimistic to suggest that the police would do it, as it would not be high on their list of priorities. I am not sure whether the Association of Chief Police Officers in Scotland will give evidence to the committee, but enforcement would be well placed within the local authorities. A minimal input of finance would address the proper enforcement of the bill.
Mr Davidson: Would the City of Edinburgh Council put on a special team that would be available to answer calls and queries during restaurant opening hours?

Gordon Greenhill: That is a good question. We should take a look at what is happening in enforcement at the moment. It is a wonderfully active field, which in the main is due to the Scottish Parliament.

The Convener: I am not sure whether that is a compliment.

Gordon Greenhill: In the field of local government, it was a compliment. A number of areas that were poorly enforced have been addressed. The Antisocial Behaviour etc (Scotland) Bill will introduce the need for councils to have teams in place to address various forms of antisocial behaviour. The noise component of the environmental health provisions allows for fixed-penalty notices and the Scottish Parliament has wisely funded the bill to ensure that local authorities have teams in place to issue the FPNs.

It would not be a great burden on authorities if complaints were added to the remit of their teams. Given that they are on call or out and about in the area doing inspections on a 24-hour basis and not in a 9-to-5 scenario, complaints about smoking in public places could be added to their remit.

We also need to consider the recommendation of the Nicholson report for licensing officers. A large number of the premises that would be covered by the bill would fall under the umbrella of licensed premises. Any licensing enforcement people who would be put in place would be funded from the liquor licence. A picture is beginning to emerge of a number of funds under which enforcement of the bill's provisions could be financed. Councils should address the issue from a best-value perspective and consider how best to address all the different crossovers that relate to such premises.

I would envisage a team that addresses some forms of antisocial behaviour, including noise complaints and the like, liquor licensing enforcement and complaints about someone lighting up in a premises, all of which would need immediate action. If we do not respond to complaints, the public become disillusioned. If that happened, we would end up with just another piece of law on the statute book that is not enforced.

A multitude of different pieces of legislation that are coming to fruition will be greatly beneficial if local authorities use wisely the skills and moneys that are available. I think that the bill will be effective, but I still think that further funding would be required for the core daily inspections that would take place.

Mr Davidson: Can you send us a note to say how much extra funding would be required for City of Edinburgh Council?

Gordon Greenhill: Yes.

14:30

Liz Manson: We agree that the enforcement arrangements need to be clarified. Environmental health officers would be happy to assume the additional responsibility, provided that resources were made available.

Members will not be surprised if I point out that rural authorities have facilities that are spread across a wide geographical area. It could be difficult to respond to a complaint that was 20 or 30 miles away from where the dedicated 24-hour team was situated. Our teams would be able to respond quickly in our urban locations, such as Dumfries and Stranraer, but we would have an issue about responding quickly in some of the more remote areas.

Peter Allan: On the issue of costs, although providing local authorities with the resources necessary to carry out the task might be viewed as an increased call on the public purse, we should bear in mind the fact that long-term savings could accrue for the health service from the improvements in people's health and quality of life.

The Convener: In addition, if the culture change that you mentioned happened, there would not be the need for so much enforcement.

Mr McNeil: The bill's supporters claim that enforcement and compliance should not worry us too much because the experience in Ireland suggests that everyone will comply. To be fair, anecdotal evidence suggests that there has been a high degree of compliance with the Irish smoking ban. However, rather than consider what has happened in Ireland, do we have information on compliance in council workplaces and public buildings in Scotland? I receive a lot of traffic from people who complain about people smoking on buses despite the fact that smoking on public transport has been banned for some considerable time. Does that tell us anything about likely compliance with a smoking ban? Is information available on how many complaints local authorities receive? Are local authorities confident that their smoking bans consist of more than just tokenistic no-smoking signs? For example, are you sure that the school janitor does not have a fag in the boiler room? How do councils establish whether the level of compliance is acceptable? Such information might indicate what compliance would be like in Scotland rather than in New York or Ireland.

Gordon Greenhill: There are two elements to that. In the City of Edinburgh Council, it is a disciplinary offence for employees to light up in an
area where they are not meant to do so. I think that the compliance rate is almost 100 per cent. People would be able to tell pretty quickly as they went through the school building whether the janny had had a fag in the boiler room—the smell would be very noticeable. I can find out whether figures are available, but I think that there is almost 100 per cent compliance in the council workplace.

Compliance by the public will not be 100 per cent. We would not need any police officers or environmental health officers if everybody complied with the laws of the land. If all that we had to do was pass a law, that would be great, but things do not work like that in my experience. As with antisocial behaviour, a certain element will flout the law, so the law needs to be enforced. I cannot say what percentage of people do not comply with our current smoking bans, but I imagine that a small hard core of refuseniks might not comply just to test the system. That is why we need the back-up of a good law that is well enforced by the courts.

Liz Manson: Dumfries and Galloway Council has introduced designated smoking areas in a number of its premises, so staff and customers have somewhere to go if they want to smoke. In certain buildings, a ban has been put in place with the approval of the staff in the building. I know of only one disciplinary incident, in which an employee was disciplined for smoking in a council vehicle. I have no other information about breaches of the policy.

The Convener: Do you want to add something, Mr Allan? You do not have to do so.

Peter Allan: I would be surprised if there were many cultural differences between ourselves and the Irish and New Yorkers.

The Convener: We will take evidence from New York next week by video link. That will be a bit glamorous for us. Unfortunately, Arnold Schwarzenegger still has not replied to our letter—I live in hope.

Dr Turner: In its written evidence, the City of Edinburgh Council said that the no-smoking policy in the City Chambers had not resulted in loss of income. The submission goes on to say:

“Concern about a potential loss of income has been noted, although this appears to be an assumption, rather than a statement of fact.”

The evidence from New York, Ireland and various other places is mixed. Do you expect that the income of establishments would be affected by the bill? We have had a lot of anecdotal feedback that suggests that income would not be affected.

Gordon Greenhill: No, I would not expect there to be a loss of income, although I am not an expert in the trade. There are a number of smoke-free restaurants in Edinburgh that do a very good trade and are well attended by the public. The City of Edinburgh Council’s strict no-smoking policy for wedding and other receptions that take place in the City Chambers has not led to a fall-off in income. People are desperate to book our facilities.

People adjust to the requirements that are placed on them. If they need to go outside to have a cigarette—as they do in Ireland—they do so, or they say, “Okay, I won’t smoke tonight.” There is no indication from establishments that currently operate a no-smoking policy that that leads to a loss in income.

Dr Turner: That is interesting.

Do you have any figures for the costs of repairs to carpets and toilet facilities on your premises that are damaged by smokers? I have noticed such damage and I am sure that councils incur costs. Have you noticed any reduction in damage in areas where a no-smoking policy operates?

Gordon Greenhill: You make a good point. The grand ceiling in the City Chambers used to be yellow by the end of each year.

The Convener: I did not realise that Jean Turner’s role in life was to scrutinise carpets and toilets.

Dr Turner: I am a non-smoker and I notice that carpets and toilet equipment in hotels and other places where people smoke are often ruined.

Gordon Greenhill: I can find out whether our facilities manager has the figures. From a purely subjective point of view, I think that we no longer have those yellow stained ceilings or burned carpets in the City Chambers. Equipment might well be lasting much longer and probably costs have been cut somewhere in the council.

Peter Allan: Dr Turner asked about the economic impact of the bill. Traders in Dundee tell us that they would prefer smoking to be dealt with through a voluntary arrangement, but that if there were to be legislation they would like it to be applied consistently across the trade. Traders want a level playing field. Dundee City Council attaches a condition banning smoking when issuing children’s certificates, but it can do so only when a licence comes up for renewal. Because of that, some premises will not have to accept the new condition for nearly two years. Traders think that is unfair, but the licensing board cannot do more to introduce the condition in children’s certificates. Traders would like any legislation to apply consistently to everyone so that it would not affect competition.

The Convener: Would it be simpler to amend licensing legislation than to pass a stand-alone
bill? I am pretty ignorant of licensing law—apart from the licensing of taxi drivers, which I know about for some obscure reason.

**Peter Allan:** I am no expert, either, but I have been advised that, at the moment, the licensing regulations do not even extend to restaurants unless they have a bar. If the ban on smoking in public places were to be extended to all premises that served food, I do not believe that the licensing regulations would cover them all.

**Liz Manson:** We have been taking the opportunity to change smoking facilities into other, more positive facilities, such as staffrooms or rooms with nappy-changing facilities, because space is at a premium in many offices and in other premises. In workplaces in which there is a smoking staffroom and a non-smoking staffroom, the imposition of a smoking ban would mean that the smoking staffroom could be used for something that staff would consider as an additional benefit. That opportunity exists.

**Shona Robison (Dundee East) (SNP):** I have a question about signage. Do any of the witnesses have views on the requirement in the bill that signs should be put up to indicate where smoking is not permitted? In particular, what are your thoughts on the size, shape or wording of those signs? I think that the City of Edinburgh Council had something to say about that.

**Gordon Greenhill:** It seems that the signs’ size—and, in the case of a city that gets a large number of visitors, the languages that are used—will be defined by regulation. It is standard practice for such matters to be defined in legislation and we would expect that to be the case, so that enforcement is easy and practice is uniform across the country.

**Liz Manson:** We would be happy for local authorities to be included in the list of consultees.

**Shona Robison:** I want to move on to consider connecting spaces. Do you have a view on the requirement in the bill that, next to regulated areas, there should be areas called connecting spaces, which should also be non-smoking areas? I know that the issue was mentioned in your submissions, but I would like to hear your views.

**Gordon Greenhill:** There needs to be clarity on what is being enforced. If the bill defined a connecting space as a box with four walls, a roof and a door, that would be wonderful, but many buildings in Scotland are not designed in that way. We should be thankful that that is the case, because variety adds to architectural beauty.

The issue comes down to experience in enforcement and interpretation of design. The space that we are talking about is similar to the intervening ventilated space next to a toilet. I am afraid that we have returned to discussion of toilets, which is unfortunate. Someone who goes to the toilet in a pub goes through one door and, before they go through the other door into the toilet, there is a wee space. That is for hygiene reasons, such as preventing the spread of germs. That is the concept that the bill is working on. The connecting space could almost be called an intervening ventilated space, because it acts as a buffer zone.

In the design of buildings, it is standard practice to incorporate buffer zones or ventilated spaces between different areas. Although the proposal is not ideal—it would probably be better to prohibit smoking throughout the premises—the design of buildings that are as grand as the one that we are in means that it would be difficult to define the space without going down the road of having a buffer zone.

**The Convener:** Do you agree, Ms Manson?

**Liz Manson:** Yes.

**The Convener:** Stewart Maxwell, the bill’s proponent, has his regulatory five minutes to ask questions.

**Mr Stewart Maxwell (West of Scotland) (SNP):** Good afternoon. I was interested in your discussion of fixed-penalty notices. Do you have any thoughts on the idea of fiscals imposing fiscal fines? Would that not be, in effect, the same thing? Would fiscal fines clog up the courts? I think that that was the phrase that you used.

**Gordon Greenhill:** Fiscal fines would still have an impact on the fiscals’ time and on councils’ time, because a report would have to be done. As you are probably aware, non-police reporting procedures are quite lengthy for the officers involved. In many cases, the fixed penalty is one and done. At the moment, 98 per cent of the fixed penalties in Edinburgh are being paid. The remaining 2 per cent must then go to the fiscals, who deal with the majority of them through fiscal fines. Obviously, those cases are not publicised, because they have not been through the courts. The small percentage that is left goes for trial. I do not see how using fiscal fines would free up fiscal time. A junior fiscal would still have to read a report, write letters, send them out and so on. Therefore, there would be an impact on the fiscal service.

**Mr Maxwell:** An extra burden on environmental health officers and local authorities has been mentioned, about which all the witnesses seemed to agree. Do you accept that the bill would not place a burden on environmental health officers to enforce its provisions?

**Gordon Greenhill:** Absolutely—you are right. The bill does not enable anybody to enforce its
provisions because it does not state what the enforcing body would be. That needs to be clarified.

Mr Maxwell: I will clarify that for you now, if you want. The enforcing body would be the police. I think that it said that in the policy memorandum and in the explanatory notes. If the bill is passed, it will become a crime to smoke in regulated areas. Do you accept that the police are the normal route for the purposes of reporting such criminal activities?

Gordon Greenhill: No. The local authority undertakes the majority of prosecutions in Edinburgh. The local authority is the enforcing body for incidents that relate to health or health and safety and has dual responsibility for fixed penalties for littering, dog fouling and so on.

Mr Maxwell: Yes, but if an individual in a pub broke the law in that pub, would the staff phone the local authority or the police?

Gordon Greenhill: The Nicholson report suggests that they would phone the local authority.

14:45

Mr Maxwell: That is not where we are just now, is it?

Gordon Greenhill: At this moment in time, they would phone the police, but that is a different concept entirely. We are talking about legislation that deals with, for example, someone sitting in a restaurant who lights up a cigarette. Such situations are akin to those covered by legislation that deals with the dropping of litter and dog fouling. The police would not readily respond to, or prioritise, such a smoking incident. The police prioritise calls and, as someone who works in daily, close partnership with the police, if I were to give that incident a ranking, I suggest that it would come in at about a four, which means a four-hour response. Therefore, there would be no enforcement in relation to such incidents.

Mr Maxwell: Do you accept that calling the police would be a last resort anyway? Effectively, the owner or manager of the premises would deal with the problem on site at the time, as they do with incidents such as those that involve people who are under-age trying to buy drink or people causing trouble, or with any other kind of problem on their premises.

Gordon Greenhill: Absolutely—I agree with that entirely. Such confrontational situations can flare up occasionally. However, we very rarely call the police for back-up in relation to fixed penalties. You are saying that the police would inspect premises for the relevant signs and compliance.

Mr Maxwell: No. I did not say that at all.

Gordon Greenhill: So only one half of the bill would be enforced. You said that only the police would be empowered.

Mr Maxwell: I am sorry, but I think that you are misunderstanding me and, perhaps, the bill. The bill says that people such as environmental health officers, who have a locus to go into premises for normal inspections, would have an additional duty—I accept that it would be an additional duty—to inspect premises for evidence of smoking. That would be part of their work load. I am trying to distinguish between their normal duties of going into premises—an extra visit would not be required—and the idea that you mentioned earlier of having special teams, which I find rather strange.

Gordon Greenhill: No, that task would be added on; it would not be a major part of the officers’ work. In fact, it would be a tiny part of their work. However, we are talking about meeting the public’s needs. The police would not respond to a report of someone lighting up in premises that served food, but if the public believed that nothing was happening about such incidents because those in charge of the premises were doing nothing, they would need to be able to phone someone who would respond. If officers were walking past premises and saw someone smoking there, they would go in and serve a fixed-penalty notice. That is how good legislation works and how cultural change is effected—action is taken there and then.

Mr Maxwell: You accept that environmental health officers and others, including the police, make regular and on-going visits to premises.

Gordon Greenhill: The police do not make such visits to non-licensed premises that sell food.

Mr Maxwell: As far as I am aware, environmental health officers visit all premises that sell food. The police also visit a number of premises—especially licensed premises—regularly. Would the task not become a tiny part—as you said—of the role of those groups and others who make regular visits? I am trying to understand where the idea of special teams and an extra burden comes from.

Gordon Greenhill: No—the special teams would not be an extra burden. I said that an amalgam of legislation is going about in relation to antisocial behaviour and the Nicholson report. If the bill was passed, it would be common sense to add the duties that it creates to those of the teams that are in place.

If one of my officers was undertaking a health and safety inspection and had to add to his checklist a check of the regulated areas and the buffer zones, that would add to the time that the inspection took. If that time was added up for the
17,000 premises in Edinburgh, it would equate to an extra burden.

**Mr Maxwell:** What does the panel think of the police enforcing the legislation in the same way as it has enforced other legislation—through blitzes? The police could suddenly target and check some premises, just as they target areas for speeding. They respond to public demand when people complain about a matter in their area. Would enforcement be driven by public demand? The police could take action in that way, rather than in the way that Gordon Greenhill talked about.

**Gordon Greenhill:** That is a standard procedure that we use with the police regularly for many of the pieces of legislation that we enforce. However, it does not effect cultural change or make something the norm if we let matters deteriorate and then undertake a blitz, for which we depend on available police time. I can speak only about the situation in Edinburgh, where the police have extra resource away from their normal duties only one day a week, which is allocated to various tasks throughout the year.

I do not see from where the extra resources will become available to the police to undertake blitzes, which would definitely be an extra burden. Why would we want to have blitzes when we are trying to change people’s attitudes to smoking and their attitudes to other people as part of how we interface in the culture of Scotland? We will do that by changing the culture permanently, rather than by having a blitz because it is Christmas and everybody is out drinking and smoking.

**Mr Maxwell:** I was not suggesting that.

**The Convener:** Does either of the other witnesses want to comment on the matter?

**Liz Manson:** I said that our environmental health staff would be happy to accept appropriate responsibilities as part of their regular inspection services but, as Gordon Greenhill said, that would add something to their checklist, which would have a resource implication. We would expect the police to be alert to the matter as they make their normal visits to establishments. As for the idea of blitzes, in some of our towns and villages in Dumfries and Galloway, a blitz would be on one establishment, which would take a journey of 40 miles to reach.

**The Convener:** That would be the case in the Borders, too.

**Liz Manson:** The same concept would apply in the Highlands and Islands. I accept that such measures may be appropriate in urban settings, but that would not necessarily apply everywhere. We would expect the police to pick up the matter as part of their normal visits.

Teams were mentioned because they might respond to a complaint when a proprietor had not been able to persuade a person to comply with the arrangement.

**Peter Allan:** Blitzes might be the most efficient way in which the police could respond. They would be less likely to respond to individual cases. If blitzes were the most efficient method, we would support them.

**The Convener:** I thank all the witnesses for attending.

Committee, we are on schedule, which is commendable. We will move on to our second panel of witnesses. Due to time pressures, Professor Andrew Peacock of the British Thoracic Society cannot participate in the evidence session. The society would like the committee to note that it was keen to give oral evidence and that it made every effort to find a replacement for Professor Peacock. As an alternative to giving oral evidence, the society has offered to submit supplementary written evidence in response to the questions that are asked of the voluntary sector panel. I am grateful to the society for that offer, as I am sure committee members are. We look forward to reading its answers.

I welcome the next group of witnesses. Christine Owens is head of tobacco control at the Roy Castle Lung Cancer Foundation; Professor Gerard Hastings is the director of the Cancer Research UK centre for tobacco control research at the University of Strathclyde; and Marjory Burns is the representative of Asthma UK Scotland on Scotland CAN, which stands for cleaner air now. I know that you sat through the previous evidence. Thank you for doing so. I do not suppose that we will mention toilets any more. Perhaps that will be an end to them. Who knows?

**Janis Hughes:** Good afternoon. How would you answer the criticism that is advanced mainly by the pro-tobacco lobby—some of whom we have heard evidence from—and which is also supported in some sections of the medical press, that the risk from second-hand smoke has been exaggerated?

**Marjory Burns (Scotland CAN):** Scotland CAN contends that there is ample evidence of the hazardous effect of second-hand smoke on health. Numerous studies that have been conducted over many years are very persuasive that environmental tobacco smoke is hazardous to health. Indeed, our own chief medical officer agrees with that contention.

**Professor Gerard Hastings (Centre for Tobacco Control Research):** I reinforce that. Examining the evidence base in this area is fiendishly difficult, because there are so many contentious issues and people come at it from so many different angles. However, ultimately, you have to take the word and the work of serious professional organisations that have examined the
issue and come to a determination. Organisations such as the World Health Organisation, the British Medical Association and the International Agency for Research on Cancer have all agreed that second-hand smoke is a hazard to public health. We have to accept that.

**Christine Owens (Roy Castle Lung Cancer Foundation):** The Environmental Protection Agency in the United States has classed second-hand smoke as a carcinogen. The BMA tells us—and there is masses of evidence to support it—that there is a need to do something about second-hand smoke. Few reports dispute that. There is a body of evidence that is widely accepted.

**Janis Hughes:** Professor Hastings, in your written submission you refer to a study in 2002—

**The Convener:** I am sorry, but I have just received a note to ask Marjory Burns to move her microphone closer. It is a mystery note that is not signed. I am just obeying it.

**Janis Hughes:** Professor Hastings, in your submission, you refer to an International Agency for Research on Cancer study in 2002, in relation to which you say:

“For non-smokers exposed in the workplace the risk of lung cancer is increased by 16-19 percent.”

Is that study representative or, in your opinion, is the risk greater or lesser?

**Professor Hastings:** Are you sure that you have my paper?

**Janis Hughes:** Yes, we have the Cancer Research UK paper.

**Professor Hastings:** I am sorry, but there are two bits of evidence. There is also the evidence that I submitted last week, which is different.

Many studies have confirmed that second-hand smoke is a problem and the IARC report is typical of such studies.

**The Convener:** I am trying to find the additional submission from Cancer Research UK Scotland among our papers, but the pages are not numbered. [Interruption.] I have now found it; excuse my confusion.

15:00

**Dr Turner:** In much of the evidence—for example, the Roy Castle Lung Cancer Foundation cited a study from 2002 in Tobacco Control—there is a hint that a ban on smoking in the workplace leads to people reducing their smoking habit. Is there evidence of a direct causal link between the two? I know of people in California who stopped smoking because of the ban on smoking. What do the figures demonstrate?

**Christine Owens:** Several studies demonstrate that link where smoking has been banned, not only in individual workplaces but more generally. There is evidence that, if we had a complete ban on smoking in workplaces, we could hit all the targets required to help people to stop smoking without taking any further action.

I know from some of the work that I have done that, when workplaces introduce smoking bans and support is provided for workers, people quit smoking. When people are giving up smoking, they struggle with going to public places where people are allowed to smoke. People are calling for a bill such as the Prohibition of Smoking in Regulated Areas (Scotland) Bill—smokers are asking for smoking to be regulated.

**Professor Hastings:** A study, or rather a systematic review of all the studies that had been done previously, was cited in the British Medical Journal in 2002. The review came to the conclusion that a ban on smoking increased quit rates by something like 3.8 per cent. Another study is about to be published that is slightly more conservative, but it still reckons that such a ban would double the quit rate. A ban would have an immense public health benefit in that sense, as well as preventing people from ingesting involuntarily a cocktail of rather nasty chemicals.

**Janis Hughes:** It has been argued in some written evidence that the relationship in the bill between food and a smoking ban reinforces the view that the bill is more about comfort than health. Do you support that view?

**The Convener:** Do not be paranoid about the microphone, Miss Burns; it is working.

**Marjory Burns:** No, I do not support that view. It is clear to many people.

**Dr Turner:** Concerning employment law. Do you have any concerns concerning employment law and would therefore be reserved to Westminster. We are thinking about what powers the Scottish Parliament has to ban smoking and we cannot deal with matters concerning employment law. Do you have any views on that?

**Marjory Burns:** Scotland CAN supports the bill, but we see it as the first in a chain of steps that have to be taken to regulate environmental
tobacco smoke in all public places. That is the ultimate position that we want to reach, but we will support the bill as a step in the right direction.

**Professor Hastings:** If we took a step further in Scotland than the measures proposed in the bill and prohibited smoking in all public places, effectively we would achieve the same end. In achieving that end, the issue of banning smoking in workplaces is a technical one. Scotland is perfectly capable of taking a lead on the matter if it wishes to do so.

**Shona Robison:** This issue has been touched on already, but what amendments, if any, should be made to the bill?

**Professor Hastings:** My principal amendment would be to extend its scope. I cannot see the justification for banning smoking simply in places where food is served; such a ban would be a great first step, but only a first step.

**Marjory Burns:** I agree. As I understand it, the bill makes provision for incremental progress in regulated areas as time goes on.

**Christine Owens:** The bill is a first stage, but our ultimate aim is for a ban on smoking in all public places. The line should not be drawn at places in which food is served.

**Shona Robison:** The exempt spaces that the bill would create—previous witnesses have supported them—are areas of hospitals and care homes that are, in effect, a person’s home. Would you go as far as to say that smoking should not be allowed in such areas?

**Christine Owens:** We need to be careful when we talk about that issue. The reasons for banning smoking in such places would definitely be about worker health and safety. The committee should consider other places that have banned smoking to see what has happened there. In New York, smoking was banned in prisons and in public places that were considered to be people’s homes. That was done overnight.

**The Convener:** And there were no riots?

**Christine Owens:** No.

**The Convener:** Were the prisoners still getting other drugs? I find that astonishing.

**Christine Owens:** One of the reasons for my going to New York to ask questions was that I was amazed that that had been done. However, I know from the work that my organisation has done in prisons that massive numbers of inmates ask for support to quit smoking.

**The Convener:** We will ask about that astonishing fact in New York next week.

**Professor Hastings:** It is worth noting that Ireland has not chosen the American solution. The law in Ireland has certain specific exemptions that cover places where, in effect, people’s homes are involved. The issue must be dealt with carefully. The Parliament should take advice on the best way forward from people who work in such areas—I do not feel qualified to make a judgment on that.

We should bear it in mind that the great majority of smokers want to stop. We have just completed a survey of adult smokers in the UK, which revealed the horrifying statistic that more than 80 per cent of them regret starting smoking. Smokers often want radical action to ban smoking, because it puts a little strength in their backbone to help them quit.

**Shona Robison:** Given what you have just said, do you think that the tobacco industry’s recent advertising campaign will have little effect? I do not know whether you have seen the advertisements.

**Professor Hastings:** Tell me more about them.

**Shona Robison:** They try to promote freedom of choice for people to smoke in public places.

**Professor Hastings:** Freedom of choice is the ultimate specious argument, when we are talking about a habit that is taken up by kids before they are old enough to make a decision. By the time that they are old enough to decide, they are fiendishly addicted to tobacco.

**Shona Robison:** Do you have a view on the bill’s requirement for areas called connecting spaces—in effect, they would be buffer zones—next to regulated areas?

**Professor Hastings:** I will broaden out the issue and talk about ventilation, which was discussed in the previous evidence session, and how to cope with the problematic fact that the bill would not introduce a complete ban.

I have just come back from a conference in Ireland, at which the latest evidence on ventilation was presented. The fundamental problem with ventilation is that using it is like trying to empty a bath while the taps are still on. Smokers are still smoking while the ventilator is going. People do not simply smoke for half an hour then stop to let the air clear. As a result, toxins are always present and, unless the ventilators are working at wind tunnel strength, they cannot remove all the toxins. Ventilation just does not work. Buffer zones are required because, as someone put it, crudely, having a no-smoking area in a pub is like having a no-peeing area in a swimming pool. That approach really does not work.

**The Convener:** That was nearly another reference to toilets. Do any of the other witnesses wish to comment—not on swimming pools, but on connecting spaces?
Marjory Burns: Perhaps I could bowdlerise Professor Hastings’s comment. We tend to say that having a no-smoking area is like having a chlorine-free end in a swimming pool; it is physically impossible for such a thing to exist. Scotland CAN accepts that ventilation is not the answer and that, if there are going to be separate smoking and non-smoking areas in pubs and restaurants, there must be buffer zones between them.

Christine Owens: The small print of the manufacturers’ guidelines does not guarantee that ventilation equipment will take away carcinogens; it simply says that it will make the air slightly more pleasant for those who are sitting in it.

Mr Davidson: What are your views on using criminal law to reduce the incidence of passive smoking and on the fact that many people could end up with a criminal record? That could affect other aspects of their lives, such as their ability to get insurance.

Marjory Burns: Scotland CAN has been trying for many years to get smoke-free public places through voluntary arrangements. However, that approach has been ineffectual and it is time for statutory regulation. Although we might regret such a move, we see no other way of protecting people’s health from the effects of second-hand smoke.

Mr Davidson: Were the voluntary arrangements that you mentioned onerous enough? Should such an approach have been taken in stages, one of which would have been a requirement for separate, distinct smoking and non-smoking spaces to be provided if premises were physically capable of being arranged in that way?

Marjory Burns: With all due respect, that is water under the bridge. The voluntary charter has been shown to be ineffectual. At the time, we agreed to the charter—albeit with some reluctance—because we felt that it would be a step in the right direction and that it was the best that we were going to get. As far as people with asthma, for example, were concerned, even their being able to rely on information at the entrance of premises that told them whether smoking was permitted would be an improvement on their having absolutely no information about whether they were about to enter a smoky zone.

Society has moved on since then. As many polls have indicated—I could quote statistics all day—the majority of people, including smokers, want smoke-free public places. The Office for National Statistics has pointed out that, every time it surveys people on this matter, the trend towards wanting smoke-free public places keeps increasing. As a result, the voluntary charter is no longer a subject for discussion.

Mr Davidson: It took 14 years to establish the Irish model; we are trying to do it overnight. Will the legislation be enforceable? The provisions will create offences under criminal law, so the police will have to enforce them.

Professor Hastings: As far as the Irish example is concerned, a minuscule number of people now have a criminal record as a result of the legislation. The vast majority are perfectly happy to obey the rules. For example, I heard a lovely story from the west coast of Ireland. Guys who were drinking in a pub that was having a lock-in were going outside at 2 am to have a smoke. That speaks to the fact—[Interruption.]

The Convener: I hear some disgruntled murmurings. Do you disagree with that, Duncan?

Mr McNeil: No, but last week when we asked experts about Ireland, they said that they could not comment on facts and figures because the legislation had not yet been in place for a year. There is a lot of anecdotal evidence—

Professor Hastings: The evidence is more than anecdotal. The Office of Tobacco Control—

Mr McNeil: You are giving information that someone could not give us last week about the statistics in Ireland, the level of compliance and so on.

Professor Hastings: I am sorry, but that evidence is available.

Mr McNeil: How long has the ban been in place?

Professor Hastings: Three months, but the Office of Tobacco Control has just produced a report on where it has got to so far. The committee should have that report, which appeared about a week ago.

15:15

Mr Davidson: We have not heard from Ms Owens.

Christine Owens: As you might know, our head office is in Liverpool. A delegation of environmental health officers from Liverpool was sent to Ireland to talk to their counterparts about enforcement because they were worried about what would happen if we get legislation on this side of the Irish sea. They came back absolutely delighted because their counterparts in Ireland had reassured them that the work is not that onerous. I have seen the adverts; people do not have to walk around being the smoking police in outfits like traffic wardens. The New York Bureau of Tobacco Control, to which the committee will speak next week, has a high level of compliance. It has a three-strikes-and-you’re-out system for removing people’s licences—obviously, that system applies only if licences are in place.
In general, the public want to comply with the law. There will always be people who break the law, but if they do not break this law they will break another law—that is the way things are. The work will not be as onerous as people think. We must examine other people’s experiences, including those in New York, which is more than a year down the line. We must also talk to the people who enforce the law and examine the problems that they have.

Mr Davidson: You describe a situation in which a local authority is the enforcement agency, but the bill suggests that the police and the procurator fiscal should have that role.

Christine Owens: I understand it to be a joint arrangement; environmental health departments will examine evidence of smoking and signage and the police will respond to actual incidents of smoking. The police are placed to respond quickly to such incidents, but in the main I would expect the proprietor to ask the person to either put out their cigarette or leave the premises. The proprietor would take that action and deal with the situation there and then, as they do with other things that people might do in their premises that are not within the law. Proprietors want to comply with the law. They would call the police in the normal way only if someone were to behave in an antisocial manner and cause trouble.

The ban will not be that difficult to enforce, even for the police. I am not saying that there will be no violations, but the number of cases will not increase simply because the police are enforcing the ban, as long as someone is enforcing it and there is a public awareness campaign. Ireland made a good job of letting people know about the law so that they were ready for it.

The Convener: We will obtain a copy of the Office of Tobacco Control report that was referred to, for Duncan McNeil and the rest of the committee.

Helen Eadie: I turn to the practicalities of enforcement and implementation. The written evidence argues that a ban might have a positive economic impact, as demonstrated in Ireland and New York, but some studies record the opposite effect. In particular, an independent review that was conducted by Ridgewood Economic Associates and cited by the New York Nightlife Association records a negative economic impact. Do you have views on that?

Professor Hastings: A large number of studies have been done on the economic impact of bans and an excellent review of those studies was published last year in the journal Tobacco Control. The review examined the quality and funding of the studies and found that the 21 studies that were judged to be of high quality—on the basis that they had objective outcomes and were published in peer-reviewed journals—found that there was no economic impact.

The studies that found an economic impact were either flawed or not published in peer-reviewed journals, and all were funded by the tobacco industry. I recommend that the committee looks at that short paper if it has anxieties about the economic impact of a ban. It is listed in my evidence, and it takes all the papers, considers them objectively and comes to that determination.

The Convener: That is fine; we have got a note of that.

Stewart Maxwell has his regulation five minutes.

Mr Maxwell: I have one question.

Mr Maxwell: Much of the evidence has been covered by the questions that have been asked by the committee. David Davidson asked you about the Irish taking 14 years to introduce a ban. What steps have been taken in Scotland and throughout the UK? David Davidson seemed to suggest that we are going to act overnight; I assume that you would not agree with that. I can think of many different attempts that have been made over many years to reduce the smoking rates.

Christine Owens: We have probably spent more than 14 years working towards this point. On a recent study visit to New York, I was delighted to find that we are ahead of the game because we have a ban on advertising whereas the legislation there still has to provide for the tobacco industry’s promotional activities in the state. The fact that we have been preparing for a long time is also demonstrated by the availability of smoking cessation support and lots of awareness-raising campaigns. MORI polls show a year-on-year increase in the number of people who support such action.

Mr McNeil: Action has been taken on smoking, but my focus is on the 1.2 million people who smoke and who will have to be encouraged to comply with the legislation. Rightly or wrongly, those people are unconvinced by the passive smoking argument. Smoking kills and we accept that, but all the efforts that you mentioned are focused on stopping people smoking, not on passive smoking, which is still a contentious subject.

Professor Hastings: I am somewhere between the two points of view. We have progressed a long way and it would be wrong to say that we are starting from zero. However, if the bill is to get on to the statute book and be good law, we need to ensure that we take people with us. It is a matter of the legislators recognising that they have to have courage.
The situation in Ireland has been greatly enhanced by the fact that Micheál Martin, the Minister for Health and Children, was prepared to stand up and fight to get the legislation through, despite a lot of opposition and political in-fighting. He had the courage to do that, and he has shown that such courage bears fruit—it is remarkable to go to Ireland and see how easily the ban has been implemented and how pleasant the pubs are. While I was there, I made it my onerous duty to visit some pubs—

Mr McNeil: I tried to do that, too.

Everyone who has given evidence to the committee has said that there could be a better bill.

Professor Hastings: Better than this bill or better than the Irish one?

Mr McNeil: Better than this bill.

Professor Hastings: As I said, I would improve the bill by extending its powers, as has been done in Ireland.

Marjory Burns: I have a couple of things to say to Duncan McNeil. If the choice is the bill or no bill, there is no doubt that it has to be the bill. If you bear in mind the fact that there are 800,000 people in Scotland with lung disease—

Mr McNeil: From smoking, not from passive smoking.

Marjory Burns: No, they have lung disease.

The Convener: Please let the witness finish, Duncan.

Marjory Burns: They have lung disease, which can be caused by a variety of things. Approximately half of those 800,000 people have asthma, and 80 per cent of those people will tell you that environmental tobacco smoke makes their asthma worse. You asked the earlier panel of witnesses about health effects and I assure you that people with asthma suffer immediate effects from being in a smoky environment. They are involuntarily breathing in something that is hazardous to their health and which could send them to hospital, or cause them to have attacks. It can cause people to develop asthma when they would not otherwise have it, whether they are adults or children. The health benefits and health damage are very clear and we support the bill as a way of protecting people's health.

Mr McNeil: The bill deals with passive smoking in public spaces. If I am frustrated with the evidence that has been led so far, it is because the people who have come to the committee have argued about the harmful effects of smoking and passive smoking but they have not reduced their arguments down to passive smoking in public spaces. They still claim that passive smoking in public spaces contributes to all those effects on health, but passive smoking is only a small part of that. An extreme example of a person who suffers from passive smoking would be someone who shares a house with someone who smokes 60 a day. Is that equal to someone who occasionally goes into a pub?

Professor Hastings: If you are talking about a restaurant, for example, I agree that some people come in and visit it, but other people have to work there. Those people ingest as much smoke as someone who lives with a smoker. There are real issues. If someone lives with a smoker, they can at least negotiate with them and perhaps the smoker will go outside to smoke; I think that a lot of people do that now, particularly if they have children. However, in a restaurant or other place of work, people cannot do that.

The people of Scotland will look back and ask why we did not do something sooner. If the chemicals were coming out of the ceiling tiles, the building would be condemned, but because they are coming out of a tube of paper, we seem to think that that is not a problem.

Mr McNeil: I am not suggesting that it is not a problem; we just have to evaluate the extent of the problem.

The Convener: We will conclude the discussion with Professor Hastings’s very interesting metaphor. I thank the members of the final witness panel.

15:26

Meeting suspended until 15:36 and thereafter continued in private until 16:42.
SUPPLEMENTARY SUBMISSION FROM BRITISH THORACIC SOCIETY

How would you answer the criticism, advanced by the pro-tobacco lobby and supported in some sections in the medical press that the risk from second hand smoke has been exaggerated?

The medical facts about passive smoking underpin the recent moves to limit smoking in public places, so it comes as no surprise that opponents of the proposed Bill are seeking to undermine them.

The evidence is clear: second-hand tobacco smoke is harmful, it causes:

- up to 60 lung cancer deaths and 1,200 cases of heart disease in non-smokers each year in Scotland
- 26% increased risk of lung cancer in adults
- 23% increased risk of heart disease in adults
- respiratory disease in childhood (such as cot death, middle ear disease and asthma)
- harm to non-smokers even in small amounts and short durations - particularly to a substantial proportion of the population of Scotland (more than one million people) who are known to be especially vulnerable to adverse effects, such as pregnant women, children, people with lung disease, people with angina and people who have had a heart attack or a stroke
- immediate negative effects on adults including eye irritation, headache, cough, sore throat, dizziness and nausea

Passive smoking is an easily preventable health and safety risk. Obviously this risk increases for workers who are exposed to second-hand tobacco smoke day after day and over long shifts.

Are you aware of any empirical evidence that has found bans on smoking - in the workplace, for example - have led to higher rates of smoking cessation? Is there evidence of a direct causal link between the two?

The BTS supports the view that banning smoking in public places, such as the workplace, leads to higher rate of smoking cessation. There is considerable empirical evidence:

- Research published in the British Medical Journal shows that complete smokefree policies in the workplace typically reduce the absolute prevalence of smoking by about four percent, and partial policies by about two percent. In addition, a review of smokefree workplaces in the USA, Australia, Canada and Germany estimated that bans had reduced overall tobacco consumption by 30 percent.

- A study by the Royal College of Physicians estimated that if all UK workplaces and public places that currently permit smoking were to become smokefree, at least 320,000 current smokers would quit. Taking 10% of the UK figure to be representative of Scotland’s population, this amounts to 32,000 current smokers in Scotland quitting.

- A report by the US National Center for Chronic Disease Prevention and Health found that:
“[smoke-free environments] have been shown to decrease daily tobacco consumption and to increase smoking cessation in smokers.”

- Research published in the American Journal of Public Health on the impact of California’s clean indoor air laws on cessation efforts found that:

  “Multiple workplace observations have demonstrated that instituting a change in workplace smoking restrictions is accompanied by an increase in cessation attempts and a reduction in number of cigarettes smoked per day by continuing smokers. Once restrictions on smoking in the workplace have been successfully implemented, they continue to have effects. Observations… demonstrate that being employed in a workplace where smoking is banned is associated with a reduction in the number of cigarettes smoked per day and an increase in the success rate of smokers who are attempting to quit.”

- The World Bank has concluded that smoking restrictions can reduce overall tobacco consumption by between four and ten per cent.

It has been argued in written evidence that the relationship in the Bill between food and a smoking ban reinforces the view that the Bill is more about comfort than health. Can you elaborate on this position?

The BTS supports taking legislative action on smoking in public places because of the major health benefits that it would bring, as detailed in our answers to questions 1 and 2 above. As stated below, in answer to the question about what changes would we like to see made to the Bill by amendment, the BTS takes the view that the proposed Bill should not be restricted to prohibition of smoking in public places where food is supplied and consumed, and that the Bill should be amended so that it covers all workplaces.

Nonetheless, the BTS still gives its full support to this Bill in its current form because it will bring significant public health benefits, even though extending the scope of the ban to all workplaces would increase these benefits. The Society would also like to think that this Bill is the first step in Scotland on a path that will eventually lead to a ban on smoking in all public places.

As an impartial medical Society, the BTS recognises that it has a particularly important role to play in providing an opinion on public health issues. Over the years, the Society has expended considerable resources in its support for the movement to ban smoking in public places because of the health issues at stake - a core function of the BTS is the preservation and protection of public health in matters concerning respiratory disorders and how they might be prevented. The BTS as an organisation recognises that it has a less important role to play when it comes to providing an opinion on personal comfort issues compared to health issues, even though for many individual BTS members comfort will also be a factor in their support for this Bill. However, this is inconsequential in this instance because this Bill is, from a BTS point of view, more about protecting health than personal comfort.

It is worth noting that the 2000 Office for National Statistics survey into attitudes to smoking found that 55% of nonsmokers ‘would mind’ if people smoked near them. The reasons given included perceived health impacts:

- Bad for health 51%
- Affected breathing or asthma 23%
What changes would you suggest should be made to the bill by amendment?

The British Thoracic Society strongly supports the general principles and the key provisions of this Bill but would ask that the Scottish Parliament consider removing the exemptions specified in Schedule 1 (1), 2 (a), (b), (c) and (d).

Do you have a view on what the bill says about requiring that next to 'regulated areas' there should be areas called 'connecting spaces' which should also be non-smoking areas?

As stated above, in answer to question 1 about what changes would we like to see made to the Bill by amendment, the BTS takes the view that the proposed Bill should not be restricted to prohibition of smoking in public places where food is supplied and consumed, and that the Bill should be amended so that it covers all enclosed public places.

Segregation of smoking and non-smoking areas may appear to reduce the problem, but doesn’t stop tobacco smoke from drifting into non-smoking areas11.

The general principle is that the BTS supports as many non-smoking indoor areas as possible. Therefore, if there were to be ‘regulated’ areas where smoking is permitted adjoined by ‘connecting spaces’, then the BTS would support that these ‘connecting spaces’ be made non-smoking areas.

What are your views on using the criminal law as a measure to reduce passive smoking perhaps leading to more people having criminal records?

Based on the experiences of other countries that have managed to successfully bring about a smoking ban without it leading to high levels of civil disobedience (e.g. Ireland, New York, etc.), the BTS expects that the proposed Bill would be relatively easy to enforce if it were to become law in Scotland without it leading to significant numbers of people having criminal records.

Clearly there is a lot to be learned from the experiences of other countries in terms of how best to implement an effective public relations campaign to inform people how and why the changes are being made. But this would not be a hard sell, as in the UK the great majority of people, both smokers and non-smokers, prefer public places to be smokefree – over 70% of smokers and over 80% of non-smokers support restrictions on smoking at work and in public places such as restaurants, and one in three current smokers and two in three never smokers support restrictions in pubs [Office of National Statistics]12. Based on these statistics, it is difficult to see how large numbers of people would risk a criminal record for the privilege of lighting up in a restricted place as specified in this Bill.

Being a medical Society rather than a Society that deals with the justice system, the BTS is not in a position to present a detailed view on how best to go about the legal enforcement process, other than to say that the BTS supports whatever measures are necessary to uphold the law.
It has been argued in written evidence that a ban may have a positive economic effect, as demonstrated in Ireland and in New York, but some studies record the opposite impact. Do you have a view on this?

The BTS agrees with the findings of a comprehensive 2003 review, published in BMJ/BTS medical journal *Thorax*, of the quality of 97 separate studies on the economic effects of smoke-free policies on the hospitality industry, which concluded that:

"All of the best designed studies report no impact or a positive impact of smoke-free restaurant and bar laws on sales or employment."

With regard to the conflicting evidence on this issue that the Scottish Parliament has received, it is worth noting that policy makers in Ireland and New York were also presented with a huge amount of conflicting evidence about the economic effect of a smoking ban. The BTS urges the Scottish Parliament to look closely at the quality of the evidence it is presented with, rather than the quantity. (In their case study of deliberations by the Maryland Occupational Safety and Advisory Board, Montani *et al* demonstrate that those opposing proposed smokefree workplace regulations lodged twice the number of submissions as those supporting it, but that evidence from opponents was substantially less scientifically rigorous than evidence provided by supporters of workplace smoking regulations.13)

The BTS offers the following advice to policy makers on how to make a preliminary assessment of study quality by asking three questions:

i. Was the study funded by a source clearly independent of the tobacco industry?
ii. Did the study objectively measure what actually happened, or was it based on subjective predictions or assessments?
iii. Was it published in a peer reviewed journal?

The aforementioned 2003 review went on to say that of the 35 studies on this topic published that concluded a smoking ban would have a negative economic impact, 80% of these studies passed none of these basic tests of quality - and none had been funded by a source clearly independent of the tobacco industry.

**In light of some views on the inappropriateness of using the criminal law, do you have any comment to make on the suggested alternatives such as better ventilation systems or reliance on the Voluntary Charter?**

*Ventilation systems*

The only way to protect staff properly is for people to smoke outside. The Irish experience shows us that most smokers don't have a problem with that.

Because only the particulate matter in smoke is visible, ventilation filtration systems can give the non-smoker the impression that they are safe from exposure to Environmental Tobacco Smoke [ETS]. However, the evidence shows that conventional ventilation and air-cleaning systems, where the smoky air is partially diluted and filtered then re-circulated, do not provide effective protection against the health hazards of second-hand smoke.14 15 16

Most recently, an industrial hygienist at Rolls-Royce17 was asked for his view on whether ventilation works as a means for dealing with ETS, his reply was:

"[Ventilation systems are] unlikely to be effective unless you are dealing with a small enclosed space and have a well balanced, high air change rate, input/output extraction
system. Even then it will depend on the number of smokers, i.e. smoke emitted. It is unlikely that any extraction system could completely eliminate exposure to ETS."

No safe level of exposure to second-hand smoke has been identified, below which no adverse effects are seen. Moreover, exposure to levels of tobacco smoke that may result in minor health effects in one individual may precipitate more severe effects in another person.18

ETS causes harm to non-smokers even in small amounts and short durations - particularly to a substantial proportion of the population of Scotland (more than 1m people) who are known to be especially vulnerable to adverse effects, such as pregnant women, children, people with lung disease, people with angina and people who have had a heart attack or a stroke19.

The BTS agrees with the World Health Organisation’s conclusion that:

“Since there is no evidence of a safe exposure level to ETS, legislation limited to ventilation design and standards cannot achieve smoke-free workplaces and public places.’

Therefore, the BTS is opposed to the use of ventilation systems as an alternative to having people smoke outside, as would happen should the proposed Bill become law.

Voluntary Charter
The current voluntary system of self-regulation in pubs has failed to protect the majority of staff or customers. Since its introduction, the proportion of smokefree premises has increased from 1% to only 2%20.

The Charter was agreed by the hospitality trade associations and mostly promotes signage indicating the smoking status in the premises as a means of protecting workers. The BTS believes this to be insufficient protection against the negative health affects of ETS for workers and customers, and supports the legislative approach as provided by this Bill.

References

1 'Passive smoking: summary of new findings. ASH November 1997; uses 10% of the figure that is given for the UK as being representative of Scotland’s population, although the number of people suffering illness from passive smoking in public places is likely to be higher because of Scotland’s relatively high incidence of smokers compared to the rest of the UK
5 Fichtenberg, British Medical Journal; 2002; 325:188-91
6 Nicotine Addiction in Britain, Royal College of Physicians, London 2000
11 Carrington et al, Atmospheric Environment 2003; 37:3255-66
17 2003 email correspondence with BTS Tobacco Committee member Doctor John Britton, consultant respiratory physician at Nottingham City Hospital.

**SUPPLEMENTARY SUBMISSION FROM CANCER RESEARCH UK**

Introducing a ban on smoking in public places will be good for business, good for Scotland and good for public health. It will also be extremely popular.

**Good for business**

A recent review of the evidence (Scollo et al 2003) shows that of the 21 high quality, published studies examining the financial impact that going smoke-free has on pubs and restaurants, none have shown any negative impact. Scollo et al point out that there are studies showing the reverse, but these are all low quality - none for example has been published in a respectable scientific journal. They have also all been funded by the tobacco industry.

**Good for Scotland**

Michael Martin has led the introduction of a ban in Ireland. Three months in this has already proved a success, and, incidentally confirmed Michael Martin’s reputation as a courageous and forward thinking statesman. Compliance is virtually universal, the licensed trade is running a powerful campaign to capitalise on the fact that in Irish pubs “The Atmosphere’s Got Even Better” and the public are enthusiastically supportive (OTC 2004, LVA 2004). The result, somewhat to England’s chagrin, is that Ireland is taking an enlightened lead joining New York, California and Scandinavia. Scotland now has the chance to show the same initiative.

**Good for Public Health**

Going smoke-free would have two major benefits for public health. First of all Scots would no longer have to involuntarily ingest a cocktail of poisons when they socialise or – crucially for those in the hospitality trade – go to their place of work. The latest (very conservative estimate) is that secondhand smoke in the workplace causes 700 premature deaths every year in the UK (Jamrozik 2004).

A ban would also help the two thirds of smokers who want to quit to do so - partly by reinforcing non-smoking norms and also by reducing the temptation to smoke during the average day. Evidence from the US COMMIT study shows that smokers in smoke-free work places are nearly twice as likely to give up as are other workers and those who do not quit reduce their consumption by 2-3 cigarettes a day (Bauer et al forthcoming). These figures increase the longer the policy is in place. In this way a smoke-free Scotland would save many thousands of lives.
Popular

Opinion polls show a large majority of Scots (77%) favour smoke-free public places (Ash Scotland 2004a). Similar numbers (75%) support smoke-free enclosed workplaces (Ash Scotland 2004b). This is not surprising: if the poisons that come from involuntary smoking were being emitted from machinery or ceiling tiles, action would be taken immediately. It is only a historical anomaly that leads us to turn a blind eye when they come from tobacco.

References


SUBMISSION FROM NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

I am writing to support your decision to prohibit smoking in public areas in Scotland. This is one of the most important public health actions Scotland can take. The evidence that second-hand smoke kills is clear and consistent. Second-hand smoke increases the risk of heart disease; even 30 minutes of exposure can increase the risk of a heart attack. Second-hand smoke also increases the risk of lung cancer. Workers in the hospitality industry breathe more second-hand smoke than any other occupational group in the United States and, as a result, are more likely to die from lung cancer.

To help curb this public health threat, our City Council passed the New York City Smoke-Free Air Act (SFAA). This law went into effect on March 30, 2003, making virtually all workplaces smoke-free, including restaurants and bars. A similar law, the New York State Clean Indoor Air Act (CIM) went into effect state wide on July 24, 2003, protecting virtually all workers throughout New York State from the dangers of second-hand smoke. Similar laws are being passed across the United States and worldwide.

In New York, movie theatres, concert halls, museums, airports and train stations, and sports stadiums and arenas were already smoke-free. There is no evidence that going smoke-free has reduced attendance or income at any of these venues.

Economic data for the restaurant and bar industry suggests that the New York City Smoke-Free Air Act of 2002 did not hurt business and may have even helped the industry overall. The New York State Department of Labor reports that overall employment in New York City’s restaurants and bars has increased by about 2,800 seasonally adjusted jobs, amounting to an absolute gain of about 10,600 jobs as of December 2003. In addition, data from the Department of Finance show that New York City bars and restaurants paid the City 8.7% more in business taxes from April 2003 to January 2004, than they did in the corresponding period in 2002-2003.

Other research has found that the public strongly supports clear air legislation. Most people, even those who smoke, prefer to breathe clean air. Some public opinion surveys have suggested that many more New Yorkers go out more often now that bars and nightclubs have become smoke-free.

Our agency and the New York State Department of Health have been monitoring the health impact of the SFAA and the CIM. In New York City, the Department measured indoor air quality in bars before and after the SFA went into effect. We found significant improvement in air quality with a six-fold decrease in pollution levels. The New York State Department of Health recently conducted a study in which researchers collected biological samples from non-smoking bar and restaurant employees during the month before the State CIAA was effective and again, three months later. They found that cotinine levels, a by-product of tobacco smoke, declined by 85% after the state law went into effect.

Smoke-free workplaces protect employees and the public alike from the dangers of second-hand smoke and ensures that everyone has the right to breathe cleaner, safer air.
SUBMISSION FROM THE SCOTTISH EXECUTIVE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Introduction

This Memorandum has been prepared by the Scottish Executive to assist consideration by the Health and Community Care Committee (as lead committee) of the Prohibition of Smoking in Regulated Areas (Scotland) Bill which was introduced by Stewart Maxwell MSP on 4 February 2004. It reiterates the Executive’s commitment to achieving a substantial increase in smoke-free environments in Scotland and refers to the wide-ranging consultation and evidence gathering process it launched on 7 June to inform future policy in this respect. It also confirms that, while the Executive does not rule out Scottish legislation to restrict smoking in public places at some point, it considers it would be premature to reach a decision on legislation in advance of hearing the views of the Scottish people and of consideration of the evidence being gathered.

Background

The health risks posed to non-smokers by exposure to second-hand smoke –also known as environmental tobacco smoke (ETS) or passive smoking- are clear. Tobacco smoke contains about 4000 different chemicals, including over 50 that can cause cancer. Long term exposure to second-hand smoke increases a non-smoker’s risk of lung cancer and heart disease by about 20-30%. Babies and children exposed to second-hand smoke are at particular risk for example it is linked to asthma and other respiratory disorders. The case for protecting employees and members of the public from breathing tobacco smoke in enclosed public places and workplaces is strong.

At present no legislative ban has been introduced to restrict smoking in the workplace or public places. However, much progress has been made in the provision of smoke-free environments through voluntary action. Smoke-filled buses, trains and cinemas are a thing of the past and an increasing number of shopping and sports centres, restaurants and other public places have adopted sound smoking policies. In spite of the in-roads made through initiatives such as the Scottish Voluntary Charter on Smoking in Public Places, progress has been much slower in the licensed hospitality sector, particularly pubs, leading many to believe that statutory controls are the only way to make real progress.

The Bill seeks to ban smoking in public areas where food is sold, supplied and consumed to prevent people being exposed to second-hand smoke.

The Scottish Executive’s view

In January 2004, the Scottish Executive published the first ever action plan on tobacco control designed specifically for Scotland “A Breath of Fresh Air for Scotland”. The action plan sets out proposals for reducing tobacco related harm. It indicated the need for:-

- more public education on the health risks associated with second-hand smoke;
- firm action to extend smoke-free zones in enclosed public places; and
- an open debate on the dangers of involved in passive smoking.
Since January, through NHS Health Scotland, awareness raising about the health impact of second-hand smoke has been substantially increased. This was in preparation for the launch on 7 June of wide-ranging consultations to inform future policy which will run until 30 September. The consultation aims to provide individuals, businesses, representative groups and other organisations with the opportunity to air their views on the topic. As part of the consultation there will be a number of regional seminars organised in conjunction with Scottish Civic Forum and focus group work with targeted groups to allow people to air their views. In addition Young Scot is undertaking a number of activities to ensure the involvement of children and young people in the consultation. All of this is being undertaken as part of a wider evidence gathering process involving a number of pieces of research. This includes an assessment of international experience and evidence about the health and economic impact of action to reduce exposure to second-hand smoke and existing workplace policies in Scotland.

The consultation floats a number of possible options to reduce exposure to second-hand smoke:-

Continuing to work with the business sector to accelerate smoke-free provision through voluntary action.

New public health laws in Scotland which restrict or prohibit smoking in enclosed public places. These could take the form of:

- a total Scotland-wide ban with certain exemptions;
- a targeted Scotland-wide ban on smoking in specific places (e.g. hospitals, schools etc)
- giving powers to local authorities to regulate smoking in public places in their areas; or
- a combination of targeted statutory controls and voluntary action in other areas.

The process of reaching entirely smoke-free public places and workplaces requires broad-based public support and increased awareness of the dangers of passive smoking. The consultation will provide us with a strong indication of public opinion and place a vast amount of evidence at the Scottish Executive’s disposal. We believe it is premature to reach a decision on legislation until we have time to review and consider all the evidence from the consultation in its entirety. For this reason, we are reserving our position in relation to the Bill.

**Specific comments on the draft Bill**

Whilst reserving our position on the Bill, the Scottish Executive has a number of comments on the Bill’s provisions, particularly in relation to offences, penalties and enforcement implications of the Bill and the assumptions made in the financial memorandum:-
Offences/ penalties/enforcement

General

Officials from the Crown Office Procurators Fiscal Service (COPFs) recently submitted written evidence to the Committee on the Bill’s provisions in respect of that department’s responsibility for the investigation and prosecution of crime in Scotland. A copy of the written submission is attached for information. You will note this highlights a number of perceived difficulties in this respect.

Section 4

The first word ‘the’ in the third line of subsection 3 should be changed to ‘a’.

Section 6

Further careful consideration will require to be given to whether the penalty is pitched at the appropriate level.

Enforcement

The assumption made is that compliance with the Bill’s provisions will be high. It is anticipated that venue operators or concerned members of the public will be responsible for reporting breaches to the police for investigation or offences will be identified in the normal course of police duties. This assumption is made on the basis of high compliance rates elsewhere in the world. However, in most instances there has been high profile enforcement activity in the immediate period after the introduction of a ban. For example, in Ireland an additional 41 people were hired with a specific remit to deal with tobacco, including the enforcement of the ban. It could be argued, therefore, that high compliance rates are a direct result of high profile enforcement activity.

Financial assumptions

Executive officials recently gave evidence to the Finance Committee on the assumptions in the financial Memorandum regarding costs that will fall as a consequence of the Bill to the Scottish Executive and on the overall figures and assumptions contained in the financial memorandum. A copy of the written submission made to the Finance Committee is attached for information. You will note this questions a number of the assumptions made including in relation to enforcement costs.

Prohibition of Smoking in Regulated Areas (Scotland) Bill: Financial Memorandum

Written Submission from Substance Misuse Division, Scottish Executive Health Department

Introduction

The Finance Committee has invited officials for views on the assumptions in the Financial Memorandum regarding the costs that will fall as a consequence of the Bill to the Scottish Executive and for any views on the overall figures and assumptions contained in the Financial Memorandum. A full Regulatory Impact Assessment has not been prepared on the Bill but this paper outlines officials’ preliminary views on the assumptions made within the Financial Memorandum.
It should be noted that, to inform future policy on smoking in public places, the Scottish Executive is shortly to undertake a wide-ranging consultation and evidence gathering process. While legislative action is clearly an option, the Scottish Executive is currently adopting a neutral position in relation to the Bill on the basis that it is premature to reach a decision on legislation until we have time to review and consider all the evidence from the consultation in its entirety.

**Costs on the Scottish Administration**

**Compliance, prosecution and smoking prevention**

The Financial Memorandum assumes compliance rates based on evidence from New York and prosecution rates from prosecutions in respect of seat belt offences. It also refers to current expenditure devoted to smoking prevention activity which includes passive smoking although makes no assumptions about future expenditure.

Financial assumptions made in the memorandum are based on a 98% compliance rate, a 1.52% annual prosecution rate and prosecution costs of £260 per hearing. On this basis it estimates that 640 licensed premises may not comply initially and, with the applied prosecution rate assumption, 10 prosecutions of proprietors/owners each year at a cost of £2600. It concludes that these costs are low and, therefore, could reasonably be absorbed within existing budgets.

More recent evidence from New York suggests that the compliance rate may be slightly lower at 97%. The more complex nature of the measures contained in the Bill would also suggest a higher rate of non-compliance initially. Moreover, it could be argued that prosecution rates could also be higher than assumed because it may be easier to catch non-compliance with a smoking ban than non-compliance with the seatbelt law.

With this in mind and for illustrative purposes only if we assume a compliance rate of between 90 and 98% and an assumed prosecution rate of between 1 and 5% per annum this would produce prosecution costs ranging from £1560 to £41,600. Again this range of costs is comparatively small and could reasonably be absorbed within existing budgets.

**Costs to Local Authorities**

The Financial Memorandum assumes no additional enforcement officers would be required to enforce the Bill. However, in Ireland, primarily as a result of the newly introduced blanket ban on smoking in the workplace with only few exemptions, an additional 41 people have been hired with a specific remit to deal with tobacco control. It could be argued, therefore, that the more complex nature of the proposals contained in the Bill would present much more of an enforcement challenge than is the case in Ireland. It would seem not unreasonable to assume, therefore, 1 fulltime environmental health officer in Scotland per local authority would be necessary, this would add an additional burden of £1.156m pa. Additional costs could also be incurred to “police” the ban outwith core working hours.

Another potential cost (highlighted in a number of the local authority submissions on the Bill) is the resource requirement for information provision in support of novel legislation of this type. In Ireland, for example, a compliance help-line has been set up which allows customers to phone and report alleged breaches of the ban. A very rough estimate might suggest a cost of £50-100K for the first year based on the Irish experience.
Costs on Individuals, Companies and Other Bodies

The Financial Memorandum suggests that compliance costs for businesses would be minimal -£25-50 each. However, this only takes into account the estimated cost of new signage. Account is not taken of the cost of structural alterations which would be necessary if an operator wishes to allow smoking to continue in some parts of the premises while food is served elsewhere. To avoid this burden, some venue operators might opt either to ban smoking completely or to stop serving food altogether.

In terms of impact on income, the Financial Memorandum assumes there will be no loss of trade/income to businesses and points to evidence (in the policy memorandum) that laws banning smoking in restaurants and bars in other countries had no negative impact either on revenue or jobs. While, there is evidence from New York –where a complete ban is in place- of an increase in business for bars and restaurants, with tax revenues up by 8.7% (April 2003-January 2004), it is impossible to tell from the available information to date the extent to which this is due to the smoking ban as opposed to other relevant factors.

1 The state of a smoke-free New York City: A one year review.

SUBMISSION FROM THE CROWN OFFICE AND PROCURATOR FISCAL SERVICE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

COPFs has been asked to provide a submission in relation to the Prohibition of Smoking on Regulated Areas (Scotland) Bill which was introduced by Stewart Maxwell MSP on 4 February 2004. The Bill links the smoking ban to the sale and consumption of food. As this department is responsible for the investigation and prosecution of crime in Scotland, the following comments on the Bill's provisions are given from this perspective and should not be taken as any comment on the policy objectives of the Bill as a whole.

Section 1

Section 1 of the Bill is complex in its terms, and as a result could be very difficult to prove. It is important that statutory crimes are clearly defined, particularly where offences prohibit a certain type of behaviour. In prosecuting such offences, the Crown will need to lead evidence to prove the accused engaged in prohibited behaviour, and this is naturally made more difficult if the offence does not precisely define what that behaviour is.

An essential element of the suggested offence is that the space concerned is a “regulated area”, and so the Crown would require to prove this by corroborated evidence. As drafted, the provisions mean the Crown would have to lead evidence to show the space was:-

- Enclosed: the space is completely enclosed on all sides, permanently or temporarily, or
- An enclosed connecting space: the space is directly connected to a space that is completely enclosed as above, and both spaces are under the same ownership or control;
- A public space; and
- A regulated area: food is at the relevant time being supplied and also consumed, or food will be supplied and consumed within 5 days.
Witnesses would require to speak to each of these elements, and this could cause difficulties. In particular, it may be hard to prove that a connecting space was under the same ownership as an enclosed space. Further, the definition of a regulated area includes somewhere that food would be supplied and consumed in 5 days’ time. There could be difficulties with regard to notice to the accused. It may need to be made clear in any such establishment that food was to be supplied and consumed within 5 days.

‘Public space’ is defined widely. Other statues define such a term, but the definition in the Smoking Bill one goes much further than, for example sections 47/49 of the Criminal Law (Consolidation) Act 1995. A public space is defined as somewhere that ‘sections’ of the public have access to, but this is ambiguous – there is no suggestion of the minimum size of a section. For example, it could be argued that a ‘section’ may include individuals at a private party or a gathering in a private house. Also, the inclusion of such institutions as Universities and schools, which are often multi-site, is very wide.

The definition of enclosed space is vague, and, again potentially very wide-ranging. A very large building may be taken to be an enclosed space in its entirety – such as, for example, the Royal Museum of Scotland or the Law Faculty of Edinburgh University. At present, this section could prohibit smoking in a private office in the top floor of the building, because food was being served from a cafeteria on the ground floor.

Section 3

Section 3 provides that it is an offence for any person to smoke in a regulated area. Taken together with the definition of ‘smoke’ and ‘smoking product’ in section 10, this provision would have a wide application. This could mean that any person holding a cigarette, for however short a period, or even sitting beside a cigarette in an ashtray, could be convicted of this offence.

Section 7

This section introduces the possibility of committing an offence by negligent action of an officer of a corporate body. Presently, to be guilty of ‘criminal negligence’, the conduct has to have a very serious degree of negligent conduct, and our criminal courts do not consider the civil common law and statutory duties of care. To criminalise negligent conduct is a significant extension to criminal liability in Scotland and certainly merits very careful consideration.

Section 8

Subsection 2 provides that while the Crown may not be found criminally liable, any ‘public body or office-holder having responsibility for enforcing that provision’ may apply to the Court of Session for a declaration of unlawfulness. There will be no consequent element of sanction or compulsion. It is unclear who should be applying to the Court of Session. While this would depend on the definition of ‘enforcing’ it would appear that this refers to the police and COPFS. This department is responsible for the investigation and prosecution of crime, and to ask Procurators Fiscal to apply to the Court for a declaration of unlawfulness in such circumstances would be a significant, and perhaps inappropriate, extension to their role.
15:09

On resuming—

Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

The Convener: Agenda item 4 is the taking of further evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. We begin with evidence by videolink, for which I welcome Dr Nancy Miller, who is assistant commissioner of the New York City Department of Health and Mental Hygiene’s bureau of tobacco control. Good morning from the Scottish Parliament.

Dr Nancy Miller (New York City Department of Health and Mental Hygiene): Good morning to you, too.

The Convener: I hope that it is a nice day.

Dr Miller: It is lovely here.

The Convener: It is fine in Scotland as well.

New York city’s written submission to the committee suggests that the New York City Smoke-Free Air Act of 2002 was passed to curb the public health threat from second-hand smoke. How do you answer the criticism that has been advanced by the pro-tobacco lobby and by some in the medical press that the risk from second-hand smoke has been exaggerated?

Dr Miller: We strongly disagree with that criticism. The United States Environmental Protection Agency, the surgeon general of the United States and numerous international and US reports have unequivocally determined second-hand smoke to be a class A carcinogen and a major risk factor for lung cancer, heart disease, asthma and numerous other conditions. In New York, we estimate that second-hand smoke is the third leading preventable cause of death and that 1,000 deaths are attributable to it in New York city each year.

The Convener: Thank you. I welcome to the committee Stewart Maxwell, whose member’s bill we are discussing.

Dr Turner: Before legislation was introduced in New York, what alternatives were considered, and why were they discounted in favour of a ban?

Dr Miller: That is a good question. In 1995, we introduced a smoke-free air law in New York city. That law regulated smoking in large restaurants that could accommodate more than 35 patrons and established separate smoking areas in office buildings and other places throughout the city; it did not regulate smoking in bars.
The volume of information about the effects of second-hand smoke has grown over time. We found through a community-based survey that many New Yorkers worked in jobs in which they had no protection from second-hand smoke—especially in the hospitality industry—and that many of those people were minority or low-income workers. We felt that we had an obligation to protect their health, because they were in jobs in which they were exposed without protection to very high levels of second-hand smoke for eight hours a day or more.

We felt that the 1995 law was not protecting those individuals, and it became apparent that we had to strengthen that law. That is why we worked hard to craft the 2002 law, which makes virtually all establishments in New York city smoke free. The law applies to all restaurants, bars, stores and office buildings. It covers any place that has workers, to provide them with what is needed to protect their health.

**Dr Turner:** What is the general public attitude to the ban? What work was undertaken to encourage the public to support the ban?

**Dr Miller:** From the beginning, public support has grown. Right now, more than 70 per cent of New Yorkers are in favour of the law. We have worked hard over time to increase public support. When the law was introduced, we ensured that lots of educational information and sessions were provided throughout the city, so that city council members, communities, bar and restaurant workers and others around the city knew what the law proposed, what protection we felt workers needed from second-hand smoke, what the health effects were and why the law was needed.

During consideration of the law, our city council held a series of public hearings at which opponents and proponents of the law spoke vigorously pro and con in relation to their concerns about the law and its health benefits. As a result of the work that we did in communities and through the public hearings, the city council voted in favour of the New York City Smoke-Free Air Act of 2002 by a very wide majority.

The law became effective on 30 March last year, and since then, public opinion has continued to grow in favour of it, even among smokers, such that it is probably at least 70 per cent in favour. The compliance rates also show that support: we have nearly 30,000 restaurants and bars in the city, and our compliance rates are extraordinarily high at 97 per cent; there are extremely few violations. We worked hard to educate the owners of hospitality businesses and others by, for example, sending them letters and providing them with materials—we put lots of materials on our website—such as signs and draft policies so that they were well aware of what the law was about, the reason for it and what they needed to do to comply with it.

15:15

**Mr Davidson:** In your preparations for the ban, did you consider any form of voluntary agreement from the bar trade? Did the trade offer anything along those lines? Did you consider the idea that smoke-free bars could be created voluntarily?

**Dr Miller:** There were many smoke-free bars in the city already. Some bars had determined to be smoke-free on their own, but we had the responsibility to consider the health of New Yorkers and the health effects of second-hand smoke. We felt that we needed to provide a level playing field of protection for all workers, all areas of the economy and all establishments, as well as providing business with a level playing field. We cannot have some establishments voluntarily comply with fire codes or other occupational laws that regulate businesses or protect workers, so we felt that we had to make the law on smoking apply uniformly throughout the city so that all workers would be protected.

**Mr Davidson:** Did the bar owners and their federations ask for the level playing field of a total ban or nothing? Was that their approach?

**Dr Miller:** That is pretty much the case. They were concerned about having a level playing field, which is why the New York City Smoke-Free Air Act of 2002 was written in the way that it was. If we make the case that second-hand smoke is unhealthy and that all workers need to be protected from it, we cannot simultaneously say that certain workers do not need to be protected for whatever reason. We felt that that was the case from a health standpoint, and the trade associations were concerned from an economic standpoint that there be one law that would affect everyone uniformly throughout the city. That is why our law is so effective. It provides protection, everyone has the same regulations and compliance is easy because everyone is following the same law. That is also well accepted by the public.

**Janis Hughes:** In New York, you are way ahead of us. You said that, in 1965—or was it 1985—there was a piece of legislation—

**Dr Miller:** It was 1995.

**Janis Hughes:** That legislation introduced a prohibition on smoking in larger restaurants and other areas. You are aware that the bill that we are considering proposes to prohibit smoking only in places where food is served. In your experience, is it easier to go for a partial ban first, followed by a wider ban, or would it be easier to go for a blanket ban in the first place?
Dr Miller: A total ban provides the best health protection to employees and the public. It makes it easier for all establishments to comply with the law, because they are all doing the same thing. We would suggest a total ban, but you would need to consider how best to achieve that through your political process.

Shona Robison: In 1995, when the partial ban was introduced, why did you not want to go for a total ban?

Dr Miller: I was not in New York city at the time, so I am not sure about all the conversations. What we did in New York city was comparable with what had been done in smoke-free air laws throughout the United States. We were tightening up regulations and trying to provide more protection. The focus at that time was more on the public at large than on employees, particularly in hospitality. Our knowledge of the effects of second-hand smoke has grown since then, and we have come to understand that hospitality workers, in particular bartenders, have virtually no protection. They work eight to 10 hours a day in environments in which, after a few hours, they have breathed in as much second-hand smoke as if they had actively smoked half a pack of cigarettes. We were very concerned about that.

We conducted a community-based survey and found that a large number—about 15 per cent—of workers in New York city had no protection under the existing law. Knowing the health effects and the danger of second-hand smoke, we felt that we had to take stronger action to provide protection, particularly to workers. The New York City Smoke-Free Air Act of 2002 is really a worker protection law, which is designed to ensure that, just to hold a job, individuals do not have to work in an environment in which they are exposed to cancer-causing substances.

Shona Robison: Thank you—that is helpful evidence. You said that the bill had the support of a wide majority on the city council. What was that majority? Did a number of people change their view during the process of the evidence and the public hearings?

Dr Miller: The bill was introduced in August 2002, and the city council started working on it in October 2002. Between October and 30 December 2002, when the bill was signed by the mayor, our agency conducted many educational sessions. The New York city coalition for a smoke-free city worked hard to educate the public, city council members, and the hospitality and other trade associations, about the need for the law. The effect of that was that, when the law was voted on, it was passed by a majority of 42 votes for and seven against. It was approved overwhelmingly. We had extensive public hearings so that the public could understand that the bill was not really an anti-smoking bill but a pro-worker, health protection bill.

Helen Eadie: Do you have any empirical evidence that the smoking ban has led to higher rates of smoking cessation?

Dr Miller: We are considering that carefully, and we have been conducting extensive cessation programmes in the city. The literature shows that smoke-free legislation encourages smokers to quit.

Two days after our law was implemented last year, we commenced a project to provide free nicotine patches to 35,000 New Yorkers who were interested in quitting. On the first day, more than 235,000 people tried to call that programme. It was a little overwhelming. We have implemented numerous other projects since then. Within one year of the implementation of the strong smoke-free air law and other tobacco control efforts—raising the price, promoting cessation, having strong education and media programmes and so on—New York city, which had had a 22 per cent smoking rate for the past 10 years, was able to reduce the prevalence of smoking by 11 per cent, down to 19 per cent. We think that the concerted effort, which combined smoke-free air legislation, more expensive tobacco and cessation promotion, has resulted in that achievement.

Helen Eadie: This committee has received evidence to the effect that enforcement will be a resource-intensive issue. What has been New York’s experience of enforcing the legislation?

Dr Miller: We already had a staff of inspectors who inspect every restaurant, bar, swimming pool and almost every other site that is covered by our smoke-free air law in the city. As part of their inspection process, those inspectors now check for compliance with the new law. To be compliant with the law, the establishment has to ensure that it has no-smoking signs, has no ashtrays and allows no smoking. Further, the employer must have a workplace policy for its staff. As I mentioned earlier, we have found a compliance level of about 97 per cent.

However, some establishments that are covered by the law are not within the remit of our inspectors. Further, because we have bars, restaurants and night clubs that are open until the wee hours of the morning, inspectors who work nine-to-five days would not be out there to see what was happening. We wanted to ensure that we got the message across that we were going to enforce the law actively, day or night, so the department hired about a dozen additional inspectors to help out, particularly during the night. That meant that those establishments that were open late understood that we were serious about enforcing the law.
The Convener: How many enforcers—if I may use that shorthand to refer to them—do you have? Do you think that they will be in place on a temporary basis and that, eventually, you will cut back on the numbers?

What are the penalties? I think that there is a civil penalty of $200, with a maximum of $400. How many fines have been levied? We have received evidence that smoke-free air legislation would be preventive and that we would not need to fine people—the procedure would come under criminal law in Scotland.

15:30

Dr Miller: Our health inspectors, who have done their job for a long time, inspect a host of establishments to enforce the health code. Many of them inspect food establishments. As part of their job, they also enforce the New York City Smoke-Free Air Act of 2002. There are around 25 inspectors across the city. We felt that we needed to add a small number of additional staff to that number—like I said, about a dozen—to help with night-time inspections. We felt early on that that was necessary to help establishments know what they needed to do to comply with the law and also to get the message out that we were serious about enforcing the law. There have been very few violations.

I keep mentioning that our enforcement rate is 97 per cent following the inspection of more than 20,000 establishments. There are always a few who will choose to go their own way, which is why we have a series of penalties. As was said, the first penalty is a fine of $200 to $400; the second is $500 to $1,000; and the third is a civil penalty of not less than $1,000 but not more than $2,000. After the third violation, an establishment can lose its licence.

The Convener: It is interesting that you are using licensing law and not the criminal law. You may not be able to answer the question, but why was the decision taken to use licensing law and civil fines rather than the criminal law?

Dr Miller: We felt that the law would, in essence, be self-enforcing. The public at large are widely in favour of it. We felt that simple civil penalties would be sufficient to help people to understand what the law was so that they would comply with it. I repeat that we have had to be concerned with very few violations, so the law is working.

Shona Robison: Your one-year review of the New York City Smoke-Free Air Act of 2002 in March 2004 found that both tax receipts and employment levels had grown. On the other hand, you will be aware of the report by Ridgewood Economic Associates, which was cited by the New York Nightlife Association, which came to the opposite conclusion about the economic impact. Can you comment on the difference of opinion?

Dr Miller: I would be happy to. The report that was issued on the one-year anniversary of the smoke-free air law was issued by the New York City Department of Health and Mental Hygiene, the New York City Department of Finance, the New York City Department of Small Business Services and the New York City Economic Development Corporation. Those are four major city agencies, which all worked together to examine all the data that were available at city level and the appropriate state-wide data to examine whether the law had had an economic impact.

We looked at hirings, employment levels, tax receipts, corporate tax receipts, the numbers of restaurants opening and closing and the number of establishments that have liquor licences—all factors that provide hard evidence to show the effect of the law. The data were analysed seriously over a long period. We even went back to 1980 to look at trends over time and at seasonal adjustments, because we know that in some months trends can go up or down, even due to the weather.

Using published data, the four agencies found that, over time, tax receipts were up, employment was up, openings increased and the number of liquor licences went up. Every published economic indicator that one could put one’s hand on was positive in relation to the law. Other studies have been published, but we have not been able to locate their sources or understand their methods. We certainly disagree with their conclusions. Those studies did not use established economic indicators.

Shona Robison: The Ridgewood Economic Associates report claims that the ban has led to 2,000 lost jobs, but the author of the report—Brian O’Connor—has said that the numbers were derived from projections and that actual employment data for 2004 were not yet available. Would you therefore conclude that the quality of the evidence in that report is—how can I say it—perhaps not the most reliable?

Dr Miller: I think that that would be a good way of putting it. It would be nice if we could project how we would like life to be, but we have to live with how life really is.

As I said, we used hard data from four major city agencies. Those agencies considered all the available data from all sources, and they reported on what actually occurred and not on what they projected should have occurred or what they wished would have occurred. When we consider what actually occurred, we see that all the results
were positive. The results for tax receipts, employment, openings, liquor licences and so on, were all positive. That is not only a New York phenomenon; if we consider data from California and numerous other states or cities, we see that it is a phenomenon across the United States. Studies from all over the country show that smoke-free air laws do not hurt business. In general, the result of such a law is either neutral or slightly positive. That is what we have found here in New York and we would expect that your bill would lead to similar results in Scotland.

**Mike Rumbles:** You said that your views are based on “hard data” from four main city agencies but how do you know that the impacts can be related to the smoking ban? In New York, you had a terrible terrorist attack in 2001. After that, business plummeted, but obviously it will rebound. How do you know that you are not seeing the effects of that rebound, rather the effects of the smoking ban?

**Dr Miller:** That is an excellent question. I work in health and we know a little bit about that, but we had to ask for help from people who were more familiar with economics and business. The four city agencies worked together to consider long-term trends. As I mentioned, we considered data from the mid-1980s up to the present. We considered good times and bad times. We considered the 1995 law and saw that its effects were positive, and we considered the impact of the 9/11 terrorist attack here in New York, after which everything plummeted. The economy of the city went down very low after the attack, and the city is only now recovering. However, in spite of those effects, when we consider the hospitality industry in particular, as opposed to the economy in general, we see that it is doing even better than everyone else, especially since the law was implemented.

We considered hard data and we considered some projections for the economy over the various seasons of the year over the long term. The results were very positive and were based on hard evidence, not projections.

**Janis Hughes:** Still on the economic impact of the legislation, how have the authorities sought to deal with those such as lobby groups who would like to scrap the legislation, or those who seek to enact the Destito-Meier bill?

**Dr Miller:** That bill failed resoundingly in committee last week by 16 votes to eight.

We are working against an industry whose intention is to make people addicted all over the world for large profits, resulting in 5 million deaths per year. It will work hard against anything that impinges on or threatens it. We know that the tobacco industry is working hard against state laws and the city laws in New York city and worldwide. It is against anything that will hurt its business. Unfortunately, it is able to find sponsors and others who will promote those ideas.

Nevertheless, public opinion polls and health surveys tell us that the general public are overwhelmingly in favour of the law: they like it, they comply with it and they think that it is terrific. Tourism is up in New York city; people are coming there from all over the world and saying how wonderful it is to be able to go into a restaurant and come out without smelling like they have to run and take a shower and wash their clothes and hair. Workers also feel that they are protected.

However, this is not just about a feeling and about economics. We did this for health reasons, and we have examined health surveys since the legislation. We have worked with the state health department and have conducted observational surveys to ensure that the law is complied with. We conducted air sampling in restaurants and bars and compared the results with those from other sites. We did that before the law came in to show that the air inside a smoky bar was 50 times worse than the air at the entrance to the Holland tunnel. Thankfully, since the law has been enacted, the air quality in that smoky bar has improved tremendously.

We also have data that show that non-smoking hospitality workers, particularly those who work in bars, had very high blood cotinine levels before the law was introduced. Cotinine is a biomarker of exposure to nicotine. Since the law was implemented, those cotinine levels have dropped by 85 per cent. We are examining the effects on health of a law that was enacted to protect the health of workers. Air quality is improving and exposure to tobacco is decreasing substantially. We will continue to study the health effects to see whether other health markers can also be shown.

**The Convener:** As you are aware, this is not a Government bill but a member’s bill. The member who is promoting the bill is at the committee today. Stewart Maxwell will ask you some questions.

**Mr Stewart Maxwell (West of Scotland) (SNP):** Good afternoon—or should I say “Good morning”. Thank you for your evidence so far; it has been very enlightening.

I have one question that does not appear to have been touched on yet. Many of the groups and individuals who oppose anti-smoking legislation say that we should bring in better ventilation to restaurants and bars. Why did New York city not take that route instead of going for a ban?

**Dr Miller:** Experience has shown that the ventilation idea comes from the tobacco industry. The idea is that when this nifty little device is put
Mr Maxwell: It has been argued by those who oppose such laws that they remove choice from those who wish to smoke. Do you have anything to say about the idea of free choice when it comes to smoking and passive smoking?

Dr Miller: My duty is to encourage all New Yorkers to be healthy. Therefore, I encourage them not to start to smoke and, if they smoke, to quit—our office exists to help them with that. The legislation is not anti-choice; it is legislation to protect workers and the public at large. It applies where other people are being injured involuntarily, against their will, by a substance that causes cancer—among other diseases. That is what the legislation is about.

Smokers can choose to smoke, but I cannot choose to breathe. I must breathe for my continuance, as we all must do. There is an adage that you can swing your fist and, as long as it does not hit my nose, you can do whatever you want. Unfortunately, second-hand smoke gets not only into my nose but into my lungs and into other parts of my body. If I choose not to smoke, I also choose not to breathe in second-hand smoke. The law ensures that workers and those who are most affected by the harmful effects of second-hand smoke also have choice.

The Convener: Thank you very much, Dr Miller. Personally, I think that the only way that we could have taken evidence was by visiting New York—I think that the whole committee would have endorsed that—but unfortunately, being mean-spirited Scots, we were not allowed to do that and we only got a video link.

Dr Miller: We just entertained a group of 17 people from Liverpool—you are welcome anytime.

The Convener: I hope that somebody who has their hands on the purse-strings is listening. We will endorse that idea and might put that on the agenda.

Thank you very much for your helpful and thorough evidence. Have a good day.

Dr Miller: Thank you. If there is anything further that I can assist with, I will be happy to do so.

The Convener: I am much obliged. Thank you.

We move on to the next panel. I do not want to impugn Mr McCabe's talents, but it is perhaps not quite so glamorous to come from the back row. I shall give the minister and his officials some time to take their seats.

If everybody is sitting comfortably—some of you may remember the phrase—then we shall begin. I welcome Tom McCabe, Deputy Minister for Health and Community Care; Dr Mac Armstrong, chief medical officer; and Amber Galbraith, principal procurator fiscal depute at the Crown Office. I know that they sat through the interesting evidence that we heard earlier. I am sure that they will be able to allocate among themselves responsibility for addressing members' questions.

The Executive's written submission says:

"Long term exposure to second-hand smoke increases a non-smoker's risk of lung cancer and heart disease by about 20-30%.

Where does that statistic come from? Is there any distinction between exposure to smoke in public places and exposure to smoke in a domestic setting?"

The Deputy Minister for Health and Community Care (Mr Tom McCabe): If you do not mind, I will deal with that question at the end, but I would like to set the Executive's memorandum in context before I answer specific questions.

The Convener: If you make a statement, please keep it short. You have sprung that on me, you see. We have a no statements rule, but you have been so charming that you caught me off balance, and it is the end of term.

Mr McCabe: Thank you very much for the opportunity to provide oral evidence and to answer the committee's questions on Stewart Maxwell's Prohibition of Smoking in Regulated Areas (Scotland) Bill. My intention is to augment the
Executive’s memorandum and to set the Executive’s position in context.

The bill’s policy intention is to restrict the number of public places where people can smoke and to reduce the health impacts of second-hand smoke, and the Executive commends those objectives. However, we have decided that a more robust and comprehensive approach is required both in making those objectives a reality and in garnering a level of public support that will ensure that they are sustainable.

Earlier this year, we launched our action plan on tobacco control, which contained a wide range of actions to reduce the prevalence of smoking in Scotland. At the same time, we launched a substantial public information campaign on the dangers of passive smoking, and we have made no secret of the fact that we wish to see substantial reductions in rates of smoking prevalence. With specific regard to passive smoking, earlier this month we launched a major consultation on smoking in public places. The Executive firmly believes that, if we are to achieve sustainable change, the driving force must be a well-informed Scottish population that expresses a wide view on the options for the future.

The nature and breadth of that consultation are important. I understand that Mr Maxwell’s consultation received 39 responses from 43 organisations, and the Health Committee’s own consultation has elicited around 350 responses. The consultation that the Executive launched on 7 June this year elicited 950 responses on the first day. So far, we have issued 210,000 freepost response forms and 6,500 consultation packs. The consultation runs until the end of September this year. As members are aware, people can respond in a variety of ways, including via freephone numbers and the internet.

The consultation is complemented by a number of regional seminars—14 in total—the first of which was held in Dundee today. It is further complemented by comprehensive research into international experience, by a separate and specific public opinion survey and through focus group work. We have also made it clear that all options, from a voluntary approach to a legislative approach, are within our consideration.

I hope that I have demonstrated our belief that to have the backing of the Scottish people for any action is absolutely critical. It is the Executive’s firm belief that we shall revolutionise health outcomes in Scotland by helping people to make their own changes to lifestyle choices.

We have reserved our position on Mr Maxwell’s bill because we think that it is premature to reach a decision before completing this very substantial piece of work. Indeed, we are picking up evidence of confusion among the general public, some of whom—quite understandably—have little understanding of the distinction between Executive and members’ bills.

I am happy to try to answer any questions, with assistance from my colleagues. I hope that my comments so far and our responses to your questions will help the committee to determine how to progress the bill.

The Convener: Will you now answer my question and tell me the source of the statistic that long-term exposure to second-hand smoke increases a non-smoker’s chances of lung cancer by 20 to 30 per cent?

Mr McCabe: I will hand you over to the chief medical officer.

Dr Mac Armstrong (Chief Medical Officer): The statistic was quoted in the report that Action on Smoking and Health Scotland and NHS Health Scotland prepared at the Executive’s request.

The Convener: Do you make any distinction between exposure to smoking in public places and exposure to smoking in a domestic setting?

Dr Armstrong: No.

The Convener: So there is no greater danger from or higher degree of safety in being exposed to smoke in one or the other setting.

Dr Armstrong: Absolutely not. As my colleague in New York pointed out, environmental tobacco smoke is a health hazard. There is no safe level of exposure. It is a highly carcinogenic substance that contains class A carcinogens. No matter where you come into contact with it, it is always dangerous.

The Convener: I might ask a few supplementary questions later.

Janis Hughes: Although the Executive acknowledges the negative health effects of environmental tobacco smoke, it argues in its written submission that the bill is premature. Given that the Executive regularly argues for immediate action in other areas of health improvement, do you not concede that the bill is quite timely?

Mr McCabe: No. Although we are involved in a programme to reduce the prevalence of smoking in Scotland, we are also involved in a wider programme to revolutionise people’s health outcomes through their diet, their alcohol intake, their levels of physical activity and so on. Earlier this year, I launched constituency health profiles that demonstrated the stark differences in life expectancy and life journeys in different parts of Scotland. Although there are many reasons for those differences, the biggest single reason was smoking. As a result, we are interested in reducing...
the prevalence of smoking, but want to do so in a sustainable way.

We believe that we will sustain that reduction by providing comprehensive information to the Scottish public that will improve their understanding of just how negatively smoking and passive smoking impact on society and our health outcomes. With such a sustainable approach, we will revolutionise the health outcomes of people in Scotland.

The message that we have received from the people in Scotland is that if we are to make this change meaningful, long term and sustainable, it should not be made by Government diktat. We have to convince people of the reasons for our approach to smoking and take them with us. That is why we have embarked on the comprehensive programme of actions that I outlined a few moments ago and why we think that it would be counterproductive to consider more narrow legislation at this time.

Janis Hughes: Previous voluntary bans have had minimal impact, and there is a general consensus that we need some form of legislation that makes it an offence one way or the other to smoke in public places. Does the bill not represent a step towards doing something about the situation?

16:00

Mr McCabe: It would. However, any measure that reduces people's exposure to second-hand smoke would be progress. My point is that we are interested in a wider goal and in taking a far more comprehensive approach in Scotland. Although public houses and restaurants are an important part of our social life, the public also gather in many other places and we believe that they should also be protected in those places.

We are convinced that the mood has changed in Scotland, that there is a strong notion for change—you are right to say that—and that people recognise more than ever before the dangers of smoking and passive smoking. We hope that the Executive has played a part in promoting that understanding. However, if the proposed changes are to be sustainable, we should test public opinion and, in so doing, give a firm commitment that we will listen to the opinions expressed. When I launched the consultation on behalf of the Executive on 7 June, I made it clear that if the Scottish public spoke to us in large enough numbers and in a loud enough voice, we would not shrink from taking appropriate action. I repeat that again today.

I said that we are picking up evidence of some confusion among the public who, understandably, little understand the distinction between a member's bill and Executive legislation. We are picking up some concerns from the licensed trade about market distortion and its inability to put in place some of the aspects of the bill. My colleague from the Crown Office will speak in more detail about that.

When I spoke before, I chose deliberately to mention as one of my first points the fact that we concur with the policy intention of Mr Maxwell's bill. However, as the mood has changed in Scotland, we believe that taking a more comprehensive approach could secure a bigger gain.

Shona Robison: My first question concerns the timing of the consultation. Why did you decide to have the consultation now and not last year or in the years before that?

Mr McCabe: In simple terms, I was not Deputy Minister for Health and Community Care then.

Shona Robison: Then why did your department or predecessor not have the consultation then?

Mr McCabe: I feel more comfortable answering for myself and find it more difficult to do so for others. However, as members know, there has been a series of moves since 1995 to reduce smoking prevalence in Scotland, right from the white paper, which I think was in 1997, to the increase in smoking cessation services to the provision of nicotine patches on prescription. A range of measures has gradually moved the agenda on in Scotland. That has been very important. Any attempt to go from a stark position to a greatly different one would have failed. We can demonstrate that a range of actions has been taken over time and has contributed to our arrival at the current position in Scotland.

In our partnership agreement, we made a commitment to produce a tobacco control action plan, which we launched earlier this year. That was the first time that a plan for the control of tobacco had been designed specifically for the circumstances that we face here in Scotland. That in itself was substantial progress.

We firmly believe that an integral part of that plan is the on-going consultation. We embarked on a substantial public information campaign, which has been going on since January this year—I watched one of the adverts on television just last night. We have secured a number of advertising slots during the coverage of Euro 2004 and we will continue to use them. We have also had a number of slots during peak viewing events on television in previous months and we will continue to secure them through NHS Health Scotland.

We took a firm view that we had to engage with the people of Scotland in a way that we had never
done before if we were to raise the level of understanding and garner the appropriate level of support. That is what we are doing.

Shona Robison: Would it not be fair to say that the introduction of Stewart Maxwell’s bill focused the Executive’s minds on the matter and that it was largely what led to the announcement of the consultation?

Mr McCabe: That is not true. Evidence from the mid-1990s contradicts that view. I said earlier that it was hard for me to respond to events that happened before I became a health minister—I became a minister for health last year—but I have had a lifelong commitment to the drive to reduce smoking prevalence in Scotland. I have been aware for a long time of how negatively smoking had a lifelong commitment to the drive to reduce smoking impacts on our society. With the greatest respect to Mr Maxwell—I have already said that there is no difference between us on the policy intention—considerable work was going on in the Scottish Executive and before its time to move on the smoking agenda in Scotland.

Mike Rumbles: Even some of those who support Stewart Maxwell’s bill have given evidence to suggest that the bill does not go far enough and is not sufficiently comprehensive, whereas the minister has just said that there is no policy divergence between the bill and the proposals on which the Executive is consulting. Obviously, the committee will produce its stage 1 report on the bill before that consultation is closed, but the stage 1 parliamentary debate will not take place until about the beginning of November. Rather than introduce an Executive bill, which would need to go through the whole process again from the start, could the Executive amend Stewart Maxwell’s bill at stage 2 to take into account the results of the consultation? Hypothetically, and without pre-empting the committee’s stage 1 report, would it be possible and practical for the Executive to do that?

Mr McCabe: I must be careful to preceed my remarks by explaining that it is not my business to tell the committee how to deal with this bill or any other. Obviously, the decision is for the committee. However, with the greatest of respect, I suggest that the committee could decide to produce its stage 1 report on the bill after the Executive’s consultation has concluded. For instance, the committee could decide to suspend consideration of the bill while it awaits the outcome of the consultation. If the committee was then unhappy with the Executive’s proposals, it could restart consideration of Stewart Maxwell’s bill. I stress that my remarks should not be interpreted as the Executive trying to tell the committee what to do, but I think that the scenario that was suggested in the question is perfectly feasible. My colleague from the Crown Office is likely to suggest that it would be difficult to amend the bill appropriately at stage 2, but I will leave that to her to explain.

The Convener: When will the consultation conclude?

Mr McCabe: I think that it will conclude in the third week of September. We have committed ourselves to do our very best to announce our thoughts on the outcome before the end of this year, although such commitments always have caveats. In this case, we are trying hard to break the record by eliciting the most responses to any consultation ever in Scotland.

The Convener: Of course, the evidence that the committee has taken is also pertinent. We will discuss this later, but the deadline for our report is 2 November. That is just a point of information.

Mike Rumbles: Are we under instruction to complete our report by 2 November?

The Convener: Yes. As I understand it, that is the current timescale for the submission of our report. Let us leave the procedural matters to the side at the moment. That was just a point of information.

Mr McCabe: May I offer a point of clarification? Having had some involvement in the Parliamentary Bureau in a previous life, I know that it is open to the committee to explain the circumstances to the bureau and to ask for the timetable to be altered.

The Convener: Yes. As I said, 2 November is the current situation, but I am obliged to the minister for that clarification.

Helen Eadie: Minister, everything that you have said this afternoon points to the need to win public support for the arguments. Politicians must lead the country, but they must not run too far ahead of their constituents. In your opening statement, you referred to the policy memorandum to Stewart Maxwell’s bill. My recollection is that Kenny Gibson received 39 responses from 43 organisations throughout Scotland to his bill, but Stewart Maxwell’s policy memorandum is silent on how many responses he received. When Malcolm Chisholm made the announcement in the chamber two or three weeks ago, he said that the Executive had received some 700 responses on the first day following the launch—[Interruption.]

The Convener: Excuse me. Unfortunately, I must embarrass someone whose mobile phone is still switched on. Thank you for switching it off.

Helen Eadie: I wondered whether there was an update on the feedback to the Executive. Can the minister update us on the number of responses to the consultation?

Mr McCabe: My information was that there had been 39 responses to Mr Maxwell’s consultation
from about 43 organisations. That was my understanding. Although the figures may relate to Mr Gibson’s consultation, the point remains the same. The piece of work that the Executive is involved in has the full force of the Executive behind it and is eliciting extremely large numbers of responses. On the first day, there were 950 responses to the consultation. We continue to enjoy significant levels of response.

I must be honest and admit that I am somewhat wary of inducing what may be called Scottish apathy by mentioning figures that indicate that the proposal is a done deal and that enough people are responding. There are different forces at work. This morning in Dundee I attended the first of our regional seminars. It is fair to say that the licensed trade’s representation was more than reasonable and that its members were fairly vocal. It is part of my job to ensure that the responses are balanced. We are enjoying a significant level of response to the consultation.

Mr McNeil: Previous evidence has suggested that whatever proposals are produced need to have the backing of the Scottish people. That position has been supported by the evidence that we have received today from New York and from you, minister. You also said that the mood had changed. What has changed since Dr Armstrong said publicly a couple of months ago that there was no public support for such a ban in Scotland?

Mr McCabe: With the greatest respect to our friends in the press, I think that we sometimes need to take rather lightly some of the comments that we read. A few weeks after the occasion to which you referred, Dr Armstrong made a very different range of comments.

The Convener: I would like to hear what Dr Armstrong has to say.

Mr McCabe: From time to time, we have all had experience of how easy it is to be misinterpreted when we engage with our friends in the press. Dr Armstrong might want to say a few words on that.

Dr Armstrong: I welcome the opportunity to do so. It is true that the way in which the questioning in the first interview was phrased led me to give a cautious response, because the interviewer was attempting to make me pre-empt the public consultation, which I regard as a very important part of the process. Subsequently, I have been offered the opportunity to state my personal opinion—I have not resiled from giving a clear statement of my personal and professional opinion on the matter, because I think that it is important that the public should have from me, as chief medical officer, a clear professional lead.

Mr McNeil: You would both agree that, as the minister suggested, we need the backing of the Scottish people. Today we have heard about some great examples that highlight the weaknesses of the bill. It is not comprehensive. To obtain the health gains that we seek, we need to give support through measures such as free patches, counselling and education.

Dr Armstrong: That is true.

Mr McCabe: Absolutely. We cannot stress that too strongly. I firmly believe that a top-down approach simply will not work. Supplying the people of Scotland with the appropriate information and allowing them to come to a decision will mean that any changes that we make will be sustainable. That is the only way forward. I make no secret of the fact that those changes as regards smoking prevalence will be sustainable. When we better inform people about the lifestyle choices that have such a negative impact on our life journeys and our life outcomes, we will revolutionise our experiences across a range of issues.

Mr McNeil: You have discussed your involvement in Dundee. Do you have any plans to learn from the New York experience by setting up public hearings and information sessions throughout the country? If you do, is there a budget to fund that?

16:15

Mr McCabe: There is a difference in terminology. Our friends across the pond speak of public hearings; we have arranged 14 regional seminars, which are effectively the same thing. The seminars will have a panel of four, including the director of public health in the area, a representative from the Scottish Licensed Trade Association and a representative from ASH Scotland. A broad range of interest groups and members of the public will attend the seminars. There was a seminar this morning, at which I was on the panel. I intend to attend at least three of the remaining 13 seminars. The consultation, which is wide ranging, started on 7 June—we have already issued 210,000 response forms and 6,500 consultation packs. The seminars are complemented by a separate and specific public opinion survey and by specific focus group work. The overall consultation will be informed by research into international experience of restricting smoking in public places. The Executive considers that its approach is as comprehensive as it could be.

Shona Robison: Will Dr Armstrong tell us for the record his view on a smoking ban in public places? If the choice was between Stewart Maxwell’s bill and no change, what would his position be?

Dr Armstrong: I have no difficulty with that. I am already on record as saying that I fully support
a ban on smoking in public places. I also say for the record that I do not believe that that should be the end of the affair. We are progressing on a journey towards a healthier, smoke-free Scotland. A ban on smoking in public places should be seen not as an end in itself, but simply as the logical next step on that journey.

A ban is important for four straightforward reasons. First, as committee members have already said, it is in line with public opinion. Attitudes are shifting: 70 per cent of the population does not smoke; more than two out of three smokers want to quit; and almost 90 per cent of a random sample of the Scottish public—smokers and non-smokers alike—appears to support a ban. Secondly, worldwide evidence shows that a ban helps to drive down the level of smoking among the public, as the committee has heard this afternoon. That is the goal on which we should be fixing our thoughts.

Thirdly, a ban protects not only non-smokers in otherwise hazardous environments from the effects of environmental tobacco smoke, but those who cannot choose. My principal concern in that regard is the unborn and children. Lastly, a ban sends a clear signal that smoking is not acceptable, for all the reasons that the committee has heard. The question is the degree to which tobacco and smoking-related harm is a social justice issue—the burden of the harm is borne by the poorest and most vulnerable in society, to whom we owe our protection.

**Shona Robison:** What about if the choice was between the bill and no change?

**Dr Armstrong:** That is like a controlled experiment in which I offer you a medieval treatment versus no treatment at all. In other words, if the choice is nothing or the bill, I would choose the bill, but we are not in a position to say whether the choice is between nothing and the bill. At the current rate of response, and from what I have heard so far this month, I believe that the consultation will show that the bill falls far short of what the Scottish population expects from its legislature.

**The Convener:** You are clearly saying that the public support a ban, so, against that background, why consult? There seems little doubt that the public want a ban in public places—appears to support a ban. However, if the Executive’s consultation comes out with a rich sample of the public in favour of a ban in all public places, such as the sample that Dr Armstrong has demonstrated for us, when will a bill that the minister considers to be in an appropriate form—rather than the current one, which he says is imperfect—be before the committee?

**Mr McCabe:** Representatives of the media have said to me on many occasions, “Why not just ban smoking? You know that the evidence exists, so you should just go ahead and do it. You are wasting time.” Let us take a snapshot of this morning’s discussion in Dundee. At one end of the spectrum we were being accused of already having reached a conclusion and were told that the consultation was a sham, whereas at the other end of the spectrum people were saying that the consultation was clear, that we should act now and that there was no need for a consultation. We are always caught in that dilemma, but, if I hear voices from two ends of the spectrum, that gives me a reasonable indication that we are on the right track.

It is difficult to be precise about when a parliamentary slot would be available for a bill and it would be dangerous to identify such a slot lest it give weight to the view that we have already made up our minds and the consultation is a sham. I would not want to give weight to anyone who expresses such a view.

**The Convener:** I am not suggesting that. Let us say that the consultation runs its course and, at the end of December, you have a view—I accept your stated commitment to be anti-smoking. Broadly speaking, when would you envisage that a bill would be before the committee? Would the Health Committee be considering stage 1 of an Executive bill on banning smoking in public places next year or the year after that?

**Mr McCabe:** The best that I can say is that I envisage no unnecessary delay. Those matters are not entirely in my control, but I repeat that I envisage no unnecessary delay and I give a personal commitment that, as the Deputy Minister for Health and Community Care, I would advocate strongly that we act sooner rather than later.

**The Convener:** I have a feeling that that was a civil servant’s answer. You said “sooner rather
than later", but can I read into that that we would see the bill next year?

**Mr McCabe:** No. It would be sooner rather than later.

**Shona Robison:** Still speaking hypothetically, I would argue that, if the consultation comes out in favour of a complete ban on smoking in public places, the quickest way of introducing such a ban would be to amend the bill that is before us. Will you give me some reasons why that would not be the best way forward?

**Mr McCabe:** I will follow your guidance on whether to answer that question, convener. You indicated that you wanted to deal with the issue later, but my colleague from the Crown Office and Procurator Fiscal Service is here and we can deal with the issue now, if you want.

**The Convener:** We were focusing on the question of expanding the ban to all public places, although I am happy to come to the issue of enforcement. The Executive will have the same enforcement problems whether Stewart Maxwell’s bill is amended or it introduces its own bill.

**Mr McCabe:** The issue is not as straightforward as that. My colleague from the Crown Office and Procurator Fiscal Service might have a view on that.

**The Convener:** Shona, can we come back to your question when we deal with enforcement? You can also deal then with amending the bill to broaden its scope.

**Shona Robison:** Okay.

**Helen Eadie:** Minister, are you aware of any empirical evidence that has found that limited bans on smoking—in the workplace, for example—have led to higher rates of smoking cessation?

**Mr McCabe:** There is such evidence. I will refer the question to the chief medical officer, but there is evidence that, where there is a restriction on smoking in whatever location, it helps to drive down the prevalence of smoking and that the more comprehensive the restriction is, the more the incidence of smoking drops. The committee heard evidence from New York suggesting that rates of smoking have dropped substantially in a remarkably short period of time. There are also indications from Ireland, but I think that it is too early to draw any conclusions from them as yet. An important part of our work will be to conduct research into the international experience, by which I mean the impact that a restriction on smoking in public places has had on rates of smoking and on economic and other factors.

**Janis Hughes:** As you said, minister, we heard evidence earlier from New York about the economic impact of such legislation—indeed, the reports from New York show conflicting views on the issue. You talked about the evidence that you heard this morning from the licensed trade about its obvious concerns. What will the effect be on the income and revenues of the establishments that are affected by the legislation? I am thinking in particular about the different views in the licensed trade about the impacts of a partial or blanket ban.

**Mr McCabe:** I fully understand why the licensed trade might have reservations about the proposed restriction. Clearly, any new situation is indeterminate to some degree. It is therefore natural that the people who have invested in licensed trade premises would be nervous. Sometimes I find it difficult to understand why people do not talk more about the 70 per cent of the Scottish population who do not smoke. If I was in business, I would want to appeal to and attract such a large market. At the very least, there is the strong possibility that the market is to be gained is at least as big as, if not bigger than, the market that could be lost.

I recognise that it is difficult for people in the business to express that view, but we are beginning to see evidence from around the world of the economic benefits as well as the disbenefits. In any market, there will always be a difference of views. Again, I will have to qualify what I am saying—I am before the committee as the Deputy Minister for Health and Community Care and not as a minister for enterprise. That said, most people recognise that in any market there will be a range of gainers and losers. In this case, the exact balance remains to be seen, although some of our research will help to clarify things.

It is worth saying that, whatever the eventual balance of the calculation, we believe that we have firm and irrefutable evidence that second-hand smoke is responsible for around 1,000 deaths each year in Scotland. That fact also has to be factored into the balance sheet. It is legitimate to ask what kind of financial price we place on 1,000 deaths each year in Scotland.

**Janis Hughes:** I have heard anecdotal evidence from licensees that they would prefer a blanket ban, as that would put everyone on a level playing field, whereas, if there was a partial ban, they might have to make fairly extensive modifications to their premises. What is your view on that? Have you heard similar evidence?

**Mr McCabe:** I am sorry, are you talking about alterations to premises?

**Janis Hughes:** Yes. Some licensees who serve food in one part of their premises claim that a partial ban such as the bill proposes would mean that they would have to make fairly major modifications to their premises in order to comply
with the law. They say that a partial ban could put them at a disadvantage and that they would prefer a blanket ban, because that would put all licensees on a level playing field.

Mr McCabe: From the discussions that we have had with the Scottish Licensed Trade Association, we know that licensees would like consistency. Whatever we do, we should avoid market distortion. Licensees are greatly concerned that the power to make laws might pass to the local government level. Their great fear is that neighbouring authorities could take different approaches. That could result in movements of people, which, in turn, could lead to market distortion.

I have certainly heard concerns expressed about the costs of modifications to accommodate the bill. That is part of the confusion between consideration of Stewart Maxwell’s bill and the direction in which the Executive is travelling. If, for instance, a business had to incur substantial costs—I have heard the figure of £3,000 or more quoted—only to find that, hard on the heels of the bill, the Executive took more comprehensive action, the business would undoubtedly consider that that money was not well spent. We want to do everything that we can to avoid such a situation.

16:30

The Convener: We will move on to enforcement, which you refer to as one of the difficult features of the bill that cannot be amended. I also ask you to address broadening the bill’s scope.

The Crown Office and Procurator Fiscal Service’s submission says of section 7:

“To criminalise negligent conduct is a significant extension to criminal liability in Scotland and certainly merits very careful consideration.”

That section deals with bodies corporate, partnerships and voluntary unincorporated associations. I ask the Crown Office representative why that would be a significant extension. Does no other legislation have a similar provision?

Amber Galbraith (Crown Office and Procurator Fiscal Service): Not that I am aware of. To a degree, criminal liability in Scotland is obviously of a necessarily high level. To be libelled as criminal conduct, conduct must be severe and very culpable. For that reason, negligent conduct can be criminal only if it is very severe, such as gross or wicked negligence. Under the bill, mere negligence on the part of an employee would be libelled as criminal conduct. That would take the level of negligence down a step and would not attach a criminal or serious element.

The Convener: I say with respect that that does not seem to be what section 7 says. We understand the situation of a negligent employee acting on their own, but section 7(1) refers to

“an offence under section 4 or 5”—

the offence of permitting smoking in a regulated area or of failing to display signs—

“which has been committed by a body corporate other than a local authority”

and

“is proved to have been committed with … consent or connivance”.

That is more than simply neutral—a body corporate must have consented or connived. The section also covers an offence that

“is attributable to, any neglect on the part of—

(a) a director … or

(b) any person who was purporting to act in any such capacity”.

That would mean that senior management—directors who knew that the law was being broken and who consented to or connived in that—became criminally liable. It is not simply a case of some naughty employee doing something of which directors were unaware—the directors would be part of that. To take it further, the employee might be unaware of the law because the owner, proprietor or body corporate operated in that fashion.

Amber Galbraith: I am sorry; I did not mean to confuse the issue by referring to an employee. It would not matter what the nature of the accused person was; what would be important would be the mens rea that was involved.

The Convener: Is there not mens rea in consent or connivance?

Amber Galbraith: Indeed, but in general what the bill is talking about is art-and-part liability. If people were so involved in the offence, they could be prosecuted in any event.

The Convener: The provision seems to be perfectly sound. If I were a proprietor or a company director and I wilfully, with consent or connivance, broke the law by failing to display signs or by allowing smoking to take place, I should be prosecuted.

Amber Galbraith: Perhaps that is a separate issue. The body corporate is found guilty of such an offence, but it is referable to neglect on the part of a manager. The bill would criminalise neglectful conduct.

The Convener: Yes, but the conduct would be knowingly undertaken. It would not be undertaken in a neutral state or in absence. The important
words are “consent” and “connivance”. I understand that section 7 would prevent individuals from hiding behind the corporate veil. It would put them on the same footing as that of members of a partnership or a voluntary association. In other words, the important thing, as you point out, is mens rea—doing it knowingly. That is the important issue in establishing criminal liability. I did not understand the points that you raised in objection to that.

Amber Galbraith: Perhaps we have a difference of view. My reading of the section is that where an offence is attributable to neglect on the part of a director, the director—as well as the company—could be found liable. The issue is not about a director or a particular individual separately committing the offence, which could happen anyway. There is arguably no need for a separate provision.

The Convener: We will tease that out. I disagree entirely. I can see the import of the section, which is not to protect company directors, members of partnerships or the chair of a voluntary organisation from being held personally responsible for wilfully ignoring the law.

I do not understand what the Crown Office and Procurator Fiscal Service submission says about section 8. It states:

“Subsection 2 provides that while the Crown may not be found criminally liable, any ‘public body or office-holder having responsibility for enforcing that provision’ may apply to the Court of Session for a declaration of unlawfulness. There will be no consequent element of sanction or compulsion. It is unclear who should be applying to the Court of Session. While this would depend on the definition of ‘enforcing’ it would appear that this refers to the police and COPFS.”

The explanatory notes on section 8, which I meant to quote first, state:

“Many public spaces where food is supplied and consumed will be operated and controlled by the Crown … Section 8(1) applies the provisions of the Bill, including any orders or regulations made under it, to places operated by the Crown.”

I am not quite sure why Edinburgh Castle is operated by the Crown. Is the Palace of Holyroodhouse operated by the Crown? What if the Queen broke the rules and allowed smoking in a public area where food was served?

The explanatory notes continue:

“under subsection (2) the Crown itself cannot be held criminally liable for committing an offence under the provisions of this Bill. A public body or office holder who has responsibility for enforcing any of the provisions in the Bill”—

which I take to mean an environmental health officer, for example—

“can make an application to the Court of Session, to declare that any specific breach of the provisions of the Bill by the Crown is unlawful.”

Is not that unfair? Why should the Crown be different from anyone else?

Amber Galbraith: I agree, but that was not the point of the submission. The arrangement reflects similar provisions in health and safety legislation. There is a difficulty with Crown immunity. In particular legislation it is perhaps right that the policy should be that the Crown is not exempted from its application. Where the Crown cannot be held criminally liable, the provisions provide a mechanism for some kind of sanction. Put simply, the enforcement mechanism for the sanction was not clear. In England and Wales, the Health and Safety Executive petitions the court for a Crown notice.

The Convener: When Stewart Maxwell answers his questions, I will get him to say whom he expected to make applications for a declaration of unlawfulness. The problem is only about who will make the application; there is no other problem with that procedure.

Amber Galbraith: No.

The Convener: My lawyer’s horns are beginning to come out.

Minister, aside from the amendments on enforcement that you may have to deal with, what difficulties arise from the point that Shona Robison made? Let us say that the response to your consultation is, “Absolutely. We’re with the chief medical officer on this. We should bring in a ban in public places.” Why could the bill not be amended? Let us say that we sort out the penalties. Why cannot the other bits be amended?

Mr McCabe: In theory, it is possible to amend any bill. However, as the Executive’s consultation has not been concluded, and given the time that it will take for the Executive to consider the responses and to make an announcement, we are not convinced that amending the bill is the best way forward. As I have said, work on the bill is going on at the same time as a high-profile piece of work on behalf of the Executive. That is causing confusion and is allowing people—especially people in the licensed trade—to say that elements of the bill could result in considerable expenditure that might be negated shortly afterwards if the Executive decides to take a different course of action. In theory, any bill could be amended. However, I have to put a caveat on that comment: I am not a lawyer and we would have to take considerable advice from our legal advisers.

The Convener: That is not an absolute no, then.

Mr McCabe: I have been asked some hypothetical questions and I have given committee members a theoretical example.

Shona Robison: Is it not the case that if you put three lawyers in a room they will disagree with one
another? Legal advice could argue for both sides of the argument, but where there is a political will, there is always a way. If the weight of evidence that we hear in relation to this bill is in favour of a complete ban, and if the evidence that the Executive hears through its comprehensive consultation is in favour of a complete ban, then is there not a better solution than the Executive trying to find room in its legislative program? If that happened, I fear that there would be a big delay. Would it not be better to pick up on where we are with this bill, fix it where you feel it needs to be fixed, and get the bill on to the statute book?

Mr McCabe: I would make a distinction between different legal advice and sound legal advice. I hope that the Executive will move on the basis of sound legal advice.

Shona Robison seems to assume that there could be considerable delay. I had not intended to give that idea to the committee this afternoon, and I do not think that I did. I am here to give evidence as the Deputy Minister for Health and Community Care. I do not have specific responsibility for the progress of the legislative programme. If I gave a specific time commitment now, those who have a different view of the need to take action on smoking in public places would be able to take that time commitment as evidence that we had already reached a conclusion in advance of the consultation. I want to avoid that. However, I do not see why there would be any considerable delay if, as a result of the consultation, the Executive announced a specific course of action.

We are not in this for the sake of going through the motions. As I have said time and again, we are convinced of the impact that smoking and passive smoking have on our communities in Scotland. We are absolutely convinced that we need to take action on smoking in public places. If people speak in large enough numbers and in a loud enough voice, we will not shrink from taking action. I do not think that there is anything to indicate that, in taking that action, we would introduce any unnecessary delay.

Dr Turner: I remind everybody here that the medical profession has known since the 1960s how detrimental smoking is to health and its costs in human life and misery. Throughout my 35 years in medicine, we have known those things. The evidence that we are gathering now is the icing on the cake of public opinion. The evidence that we have heard has convinced me that the public are way ahead of us and are desperate for help.

If the Executive were to act now, I do not think that it would be regarded as having cut short consultation. I think that it would be admired. For 35 years, the medical profession has been desperate for a government to take a lead. However, financial considerations and the cigarette companies seem to have had the upper hand.

You should not be afraid. If your consultation is over by the end of September, you would be applauded if you made a decision then.

Mr McCabe: That is a point of view—

Dr Turner: It is the view of many doctors who have written, believe it or not.

Mr McCabe: The medical profession has been convinced for many years of the negative impact of smoking. The difficulty is that the general public in Scotland have continued to adhere to the habit and smoking continues to take 13,000 lives in Scotland every year and to result in 33,000 admissions to hospitals.

Dr Turner: What does that tell you?

16:45

Mr McCabe: It tells us that there is a serious problem. The Executive is determined to take action on it, which is why we are engaged in a comprehensive piece of work and why we have a tobacco control action plan, which is the first such plan designed to tackle the problem in Scotland. We have issued 210,000 response forms and 6,500 consultation packs and we are holding 14 regional seminars as well as focus groups and public opinion forums. We firmly believe that there is a change in the public mood. Measures will be sustainable if people express their view and believe that they have made a contribution to the formulation of public policy. One thing that I hear time and again in politics—I have heard it for a considerable number of years—is that there is a disconnection between the legislators and the people whom we try to represent. We have an opportunity to get the biggest ever response to a consultation and to allow people to be convinced that the views that they expressed genuinely helped to form public policy.

The difference between us is perhaps a matter of five months at the most. The consultation ends at the end of September and we hope to make an announcement before the end of the year. There are big gains to be made by adopting the Executive’s approach, which is why I advocate that that approach is the right one. I genuinely believe that confusion has been caused, which disappoints me, given our commitment to and determination on the issue.

I agree with Jean Turner about the determination in the medical community and the length of time that the knowledge has existed. However, even though that knowledge has been available, smoking has continued seriously to damage health and people’s life journeys in Scotland. For the first time, the people of Scotland will have an opportunity to say clearly that they have had enough and then to ask us what we will
do to ensure that that does not happen in the future.

The Convener: Perhaps we are exasperated because we are into the fifth year of the Parliament—it would have been good if we had done the work in the first year. I realise that your heart is in the right place, minister, but urgency is sometimes not the hallmark of the Parliament. That is my personal view.

Mr McCabe: We are all experienced politicians. Despite some of the trials and tribulations, we are all in the job for the right reasons. We know that we cannot cure the ills of the world overnight and that we cannot do everything at once. We are five years into a Parliament for which we waited 300 years and we are on the verge of making significant breakthroughs to tackle the single biggest cause of preventable death in Scotland. That is significant progress.

Mr McNeil: The other view needs to be presented for the record that if we legislate in haste, we repent at leisure. It is better to get any measures right, certainly given the evidence that we heard today from New York about how to get people to comply and how we deliver on the legislation. While we have the comfort of hours and hours of evidence from campaigning organisations, we have not heard from people from bowling clubs, bingo halls and social clubs, who will provide severe opposition to any proposed legislation. The 1.2 million people who smoke in Scotland have to be won round to the idea. My regret about all the hours that we have spent on the bill is that we have not focused on those 1.2 million people. The minister should take time and should not rush the matter because it is more important to get it right.

The Convener: The witnesses whom we called reflected the balance of evidence that we received. We put out a call for evidence and we can do no more than that.

Mr McNeill: The people I was talking about do not respond to that sort of call.

Mr McCabe: I agree with Mr McNeill’s sentiments. At our meeting this morning in Dundee, it was related to me that community halls in Dundee are under community management—they are owned by the council but leased to and managed by community management groups. Smoking in the halls is generally restricted, although it is allowed on specific occasions for functions such as funerals, weddings and others. The council decided to consult those management groups about restricting smoking completely. The council was aware that the majority of the members of the management groups were smokers and it was stunned that all but one group came back and agreed with a restriction on smoking in those halls.

Yes, we need to engage with a variety of groups in Scotland, but as the chief medical officer has rightly said, all our evidence suggests that the vast majority of people who smoke are anxious to kick the habit. Whatever we can do to assist them will be warmly welcomed, whether it be restricting smoking in public or expanding smoking cessation services.

The Convener: I will bring in Stewart Maxwell very briefly. You two seem to be having a meeting on your own now and I am conscious of the time.

Mr Maxwell: I pick up on the point about the Executive’s intentions versus the bill, but I am struggling with your logic. I am not sure that I understand what the conflict is between all the robust action that you are taking, minister—I have commended you for taking that action and I do so again—and the passage of this bill when it is amended as the committee and other members might see fit. It seems to me that the two timetables could merge quite easily. The advantage would be that we would get the bill that we want, there would not be a five-month delay, and this very busy committee of the Parliament—one of the busiest, if not the busiest—will not have to go through the process twice by having to consider an Executive bill sometime next year or perhaps the year after. What is the conflict?

Mr McCabe: Again, I have to say that it is not for me to tell the committee how to do its business. I do not think that the committee would have to repeat the process if, for example, it suspended consideration of this bill.

As I have said umpteen times, we will conclude the consultation at the end of September. I give a commitment to do my very best to be in a position to make an Executive announcement before the end of the year. The caveat is always that the response to the consultation might be so huge that the analysis takes longer than we anticipate. The outcome of that consultation might well see far more robust proposals for a way forward.

If that is not that case or if, for example, the consultation has a disappointing response, or if the committee and Mr Maxwell are disappointed by the Executive’s proposals, there is nothing to stop consideration of the bill restarting after we have made our intentions clear.

We do not differ in our policy intention. I do not want this to turn into a mutual admiration society, but I have also made it quite clear that we have no difference with the work that you have done, Mr Maxwell, and we commend you for advancing the agenda and bringing it to the notice of the general public in Scotland. The fact that you introduced a member’s bill has contributed to the level of awareness in Scotland and I am happy to acknowledge that.
However, if we are legislating responsibly, and we are taking the opportunity of adhering to the founding principles of the Parliament, it makes sense to await the outcome of one of the biggest questionnaires that has ever been placed before the people of Scotland, to assess those responses and then to decide on the appropriate way forward.

This is a fundamental issue for Scotland. I have said before and I will say again that it is about more than smoking in public places and more than driving down the rates of smoking that are prevalent in Scotland. It is about engaging with the people of Scotland and asking them to think differently about their lifestyle choices in smoking, in diet and physical activity, and in how they interface with alcohol.

For all those reasons, it is important that we do this properly and comprehensively, and that we avoid anything that allows confusion and that allows people who take a different view and want to maintain the status quo to make the charge that our minds are already made up and we are only going through the motions.

That is the conflict. At this time, we are in danger of introducing a degree of confusion, and I stress that it is just a degree of confusion; I do not want to overstate the point. Irrespective of where we stand in the debate, if someone steps back and assesses the work that is going on—although I am not going to go through all the aspects of the consultation again—they will conclude that we will arrive at a very firm indicator of the direction of travel of the Scottish people. That is extremely important to me, particularly in this debate.

Mr Maxwell: I have a question for the Crown Office. I was left a little confused by your response on Crown liability. Perhaps you could tell me who is responsible, under section 67 of the Water Industry (Scotland) Act 2002 and section 66 of the Transport (Scotland) Act 2001, for the very same actions, in relation to the Crown?

Amber Galbraith: I am sorry; I do not have the answer to that. However, I assume from the question that it is the Crown Office.

Mr Maxwell: It is the Crown Office. The provision in the bill that we are discussing is exactly the same as in those acts. Why do you have a problem with a power being in the Smoking in Regulated Areas (Scotland) Bill that is already in those acts? You have that power already.

Amber Galbraith: Is the wording exactly the same in those acts?

Mr Maxwell: It is exactly the same. I think that that answers my question.

The Convener: We can perhaps consider that. I thank our panel for their help.
Mr Maxwell: I will answer a question quickly if I may. I was asked about the link between smoking and food, rather than alcohol. The bill is a progressive measure. We must reflect on the fact that, when the bill was originally proposed a year ago, the situation was different to where we are now; the argument has moved on quickly since then.

The reason why the bill connects smoking with food is that that mirrors approaches taken in other jurisdictions. You heard the representative in New York say that they had a ban on smoking in restaurants before they had a full ban elsewhere. It was also clear at that time that there was public support for introducing a ban in restaurants and other places where food is served. I agree with the minister about taking the public with us to make legislation effective.

I have outlined the original reasons why we plumped for going as far as we did with the bill. However, as I said a moment ago, we left scope in the bill for any possible amendment to go much further—or indeed to go for a full ban. Having sat through all the evidence sessions with other committee members over the past four weeks and having read all the written submissions as well as the enormous amount of scientific evidence, other surveys, reports and evidence from around the world, I am of the opinion that the bill does not go far enough. I now think that we need a full ban on smoking in public places. I am glad that we left scope in the bill for introducing an amendment that would remove section 1 and replace it with a new section 1 that would allow us to have a full ban. I would certainly support such an amendment at this point.

The Convener: Both the Crown Office and I were partly confused about section 7. Section 7(1) refers to

"the consent or connivance of, or is attributable to, any neglect on the part of—"

(a) a director, manager or secretary, member or other similar officer of the body corporate".

I ask the legal team whether they should remove the phrase

"any neglect on the part of".

Does that phrase add confusion? I want to know why it is there. If a manager consents or connives to break the law, it seems that you want to make them criminally liable. I do not quite understand the need for that phrase.

Mr Maxwell: The intention was clear and your questions to the Crown Office followed exactly the intention of the bill, which was to prevent corporations or businesses from hiding behind the corporate veil, as you put it. Perhaps Catherine Scott will respond.

Catherine Scott: That type of provision is common in statute law. It is common in regard to regulatory offences that might be committed by businesses. We see examples in the Trade Descriptions Act 1968 and the Food Safety Act 1990 and there are some examples in acts of the Scottish Parliament. The provision was modelled on a similar provision in the Building (Scotland) Act 2003.

The Convener: I seem to remember asking the representative of the Crown about that and was told that the provision was not statutory—was that not correct? The representative of the Crown said that it was not, but you tell me that it is.

Catherine Scott: I think I know where the Crown might be coming from on the matter. It is unusual for a common-law crime in Scotland to be committed through negligence, but the same considerations do not apply where it is a statutory offence. That type of provision for bodies corporate is common.

The Convener: That is fine—you have cleared up that the situation is not unusual and that the provision seems to be enforceable.

Dr Turner: We heard from witnesses that it would be impractical to require that there should be connecting spaces and non-smoking areas next to regulated areas. Even where there is a buffer zone, the practicalities would be quite difficult because such a zone would not prevent the smoke getting to the people on the other side; it would drift regardless of the barrier. Such an area would have to be at quite a distance. What do you think of that?

Mr Maxwell: I should make a couple of points in response to that question. First, as I said earlier, the evidence is clear that a full ban is the obvious answer to the problem.

Dr Turner: That would cover both aspects.

Mr Maxwell: Scientific evidence clearly shows that smoke drift occurs even when there is a single barrier or door. If we had connected spaces, the places that connect to a smoke-free enclosed place—even through a door—must also be smoke-free to avoid the problem of smoke drift from immediately adjacent spaces. As a result, we would have a double barrier, because the enclosed place and the connected space—or what you call the buffer zone—would be smoke free. I do not want to go back to last week’s evidence about having toilets with two doors and a connecting space, but it is the same kind of zone. That said, I think that a full ban is the right approach.

Dr Turner: That would exclude the need both for connecting spaces and for the five-day rule, which could also raise difficulties.
Mr Maxwell: As the unamended bill sets out a partial ban on smoking in public places, the five-day rule was supposed to address scientific research on the length of time that carcinogens, gases and other chemicals remain in the atmosphere or re-emerge into the atmosphere from furnishings. As we all know, people who have been in a smoky atmosphere can smell the smoke on their clothes the following day or even several days later.

Dr Turner: I understand the reasoning behind it.

Mr Maxwell: The five-day rule simply creates enough time for people to remove smoke from the atmosphere and furnishings in a room. Within this unamended bill's framework, such a measure is valid to ensure that carcinogens from smoke are not present for customers and the people who work in a particular place. However, you are right; a full ban would remove the necessity for such a rule.

The Convener: The Crown Office has said that phrases such as "regulated area", "enclosed space", "connecting space" and so on are badly defined in the bill and its written submission cites certain examples. What is your response to those criticisms and to the comment that, as it stands, the proposed legislation will result in many failed prosecutions?

Mr Maxwell: I must be honest and say that I have some difficulty with the whole of the Crown Office's evidence. I will certainly answer its criticisms, if you wish; however, instead of going through all of them here, it might be better if I wrote to the committee with a point-by-point explanation of where I disagree with the Crown evidence. Is that acceptable?

The Convener: Is the committee content with that?

Members indicated agreement.

The Convener: That would be very useful. After all, this area is a bit too technical to go into at this time of the day. However, it must be addressed.

Mr Maxwell: I also disagree with the Crown's evidence given during the meeting on the points that have been raised and the questions that have been asked. It has either accidentally or deliberately misinterpreted what is in the bill.

The Convener: I do not think that we should say that the Crown's evidence was deliberately misleading.

Mr Maxwell: Well, there has been accidental misinterpretation.

The Convener: Perhaps we should say that there might have been some differences in legal views.

Janis Hughes: On enforcement, is the bill not likely to place undue demands on enforcement agencies, such as the police? I think that the financial memorandum underestimates the impact on local government of, for example, the complexities of enforcing the five-day rule.

Mr Maxwell: Perhaps I should respond to that question by referring to enforcement in its broadest sense instead of to the five-day rule. After all, I have conceded that, given the evidence that the committee has received, a full ban—or what you have called a level playing field—is probably a much more sensible option. However, no matter whether we are talking about this bill as it stands, an amended bill or an Executive bill, the enforcement issue will remain. It is not exclusive to this bill.

That said, after considering evidence from Ireland, Norway, New York, California and elsewhere, I feel that enforcement has not been an issue. For example, Dr Nancy Miller mentioned that, after one year, the compliance rate was 97 per cent. Such an exceptionally high figure suggests that enforcement has not been a problem. If I recall correctly, I think that she said that an additional 12 enforcement officers or whatever they were called—they sounded like environmental health officers to me—had been needed. That does not seem that many for New York. I do not know how many premises there are in New York city, but Dr Miller said that more than 20,000 premises have been inspected so far, so there does not seem to be much of a problem.

The Office of Tobacco Control in Ireland has said clearly that there does not appear to be a problem with the enforcement of the ban in Ireland and the committee heard similar evidence last week and in other weeks. I have difficulty in understanding why enforcement might be an issue, given that wherever a ban has been introduced it has been enforced by the public themselves and there has been no need for draconian enforcement measures.

It would be incumbent on owners and proprietors to enforce the ban, so we would not need smoke police, as the pro-tobacco lobby suggests. Owners and managers would have a legal as well as a moral incentive to enforce the law. The ban would be enforced not only by the public, but by the owners of the establishments that were involved.

Shona Robison: You heard that there are opposing views on the impact of a smoking ban on jobs and businesses. What is your view on that? The Finance Committee's report on the financial memorandum to the bill rightly recommended that the Health Committee consider the bill’s effect on businesses. The report said:
“the Committee has concerns that greater costs may fall to on-premises licensed outlets”.

What is your view on the Finance Committee’s interpretation of the evidence on the economic impact of a ban?

Mr Maxwell: The best word to describe my reaction to the Finance Committee’s report is “disappointed”, because the report does not truly reflect all the evidence that was taken. To a great extent, the report’s conclusion hangs on paragraph 22, which states that the Scottish Licensed Trade Association mentioned a report from New York that said that the ban there had led to a loss of trade. The New York report is not referenced in the Finance Committee’s report and Finance Committee members obviously did not see it.

Dr Nancy Miller debunked the evidence from the New York report, which was based on assumptions, guesses, projections and the wishes of those who oppose the ban—I am not surprised that it arrived at the figures that it stated. Moreover, the report’s author has admitted that he based the report on projections rather than on real figures and he has accepted that it is not the case that there have been 2,000 job losses, as the report suggests. He has admitted that that figure was based on a projection of a hoped-for increase in jobs that did not happen. Frankly, Dr Miller answered the question clearly. That single report does not reflect the situation in New York. The New York City Department of Health and Mental Hygiene and other departments—I think that Nancy Miller mentioned four separate departments—have produced evidence that jobs are up, tax takes are up and the number of licenses is up. We should accept the evidence from the facts that those departments have supplied, rather than the projections of people who oppose the ban.

The Finance Committee rather underplayed some of the other effects of the bill. Productivity loss and figures on absenteeism were not considered in the report, although the figures suggest that non-smoking employees take between 2.5 and 6.5 fewer days’ absence per year than smoking employees—so there would be productivity gains to be made for businesses. There would also be massive gains for the health service, which estimates that smoking-related illness and death cost the service about £200 million per year. Such costs should have been mentioned in the Finance Committee’s report. The Executive is keen on talking about balance and offsetting costs; I have often seen bills that suggest that costs would be neutral because savings could be offset against the costs that would be incurred.

The Finance Committee’s report did not mention ventilation costs, either. However, if the ventilation route is chosen, the evidence even from the SLTA is that the cost to premises of installing a system would be between £5,000 and £20,000—perhaps even more for large premises. There are a lot of savings to be made through the bill, but the Finance Committee’s report hangs on a comment from the SLTA about the report that Dr Miller debunked. All the surveys that have been carried out around the world into the economic effect of smoking bans on businesses report that the effect is either neutral or positive.

The Convener: The Health Committee has been sitting for three and a quarter hours with scant ventilation. Before we expire, I thank witnesses for their evidence and—before I expire—I advise that the first draft of our stage 1 report should be available on 21 September and the final draft should be ready on 28 September. I thank the clerks for their work this year, and members who have managed today’s endurance test and I wish them and everyone else a happy recess. I hope that you come back bright, brisk and ready for another year.

Meeting closed at 17:15.
SUPPLEMENTARY SUBMISSION FROM STEWART MAXWELL MSP

Prohibition of Smoking in Regulated Areas (Scotland) Bill

During the Committee evidence taking session I undertook to respond to the written evidence from the Crown Office. My comments on each of their observations are as follows. I have commented in relation to the Bill as presently drafted although I would repeat that at stage 2 it would be my intention to lodge amendments to extend the Bill to cover all enclosed public spaces. That alone would cover the suggested difficulties with some of the definitions.

Section 1

It is a credit to the clear drafting of the Bill that most of the respondents to the Committee’s consultation appear to have understood what a regulated area is (including the connecting space concept). The behaviour that constitutes each offence is straightforward and has been clearly defined in sections 3(1), 4(1) and 5(2).

I disagree with a number of the Crown Office’s specific comments on the various definitions in this section.

Enclosed

The Crown Office appear to have misread the definition of “enclosed”: they say it means “the space is completely enclosed on all sides, permanently or temporarily”. In fact, the definition refers to “... a single space which, except for any opening, is completely enclosed on all sides whether temporarily or permanently”. The Bill defines “opening” as “a door, sliding partition, window, hatch or other similar opening that is capable of being closed”.

I do not agree with the Crown Office’s remark that the definition of enclosed is vague. This is a very clear and precise definition. Whether or not a room is enclosed for the purposes of the Bill is a simple matter of fact, capable of proof by inspection of the site and witness testimony.

I do not agree that the definition could encompass a large building in its entirety. Most buildings consist of a series of rooms (“single spaces”) separated by doors. In such a building, only the rooms where food is served, and any connecting rooms, would be regulated. Admittedly, some modern buildings, such as the New Museum of Scotland, consist of a series of interconnecting rooms with no doors between. In such a building, the large interconnected area would be considered a “single space” for the purposes of the Bill, and would be regulated if food was served anywhere within it, as would any connecting spaces. I imagine that any offices in such a building would be at least two doors away from the interconnected area, and so would not be regulated. Only an office accessed directly off the interconnected area would be caught by the Bill, because it would be a connecting space.

Connecting Space

The Crown Office is correct in its interpretation of the connecting space concept. A connecting space is a space directly connected to an enclosed public space, provided that both spaces are under the same ownership or control. Again, this is a simple matter of fact provable by inspection of the premises and reference to the Bill’s definition.
Ownership or control of the connecting space would be provable by reference to the title deeds or lease to a property, perhaps combined with witness testimony.

Public Space

I agree that “public space” is defined widely and goes further than, for example, sections 47 and 49 of the Criminal Law (Consolidation) Act 1995. This was deliberate policy, in order to catch a lot of public places and protect as many people as possible from the dangers of passive smoking. There are statutory precedents for including places that “sections of the public” can access: see the Dog Fouling (Scotland) Act 2003 (section 2); the Public Order Act 1986 (section 16); and the Criminal Justice and Police Act 2001 (section 16).

The courts have considered the phrase “sections of the public” in relation to other statutory references to public places: Vannet v Burns 1999 SLT 340; Paterson v Ogilvy 1957 SLT 354. I do not agree that a gathering at a private house would bring that house within the definition of public space. This would be wholly inconsistent with the findings in these cases.

The Bill acknowledges that the wide definition will catch certain places that might otherwise be thought private. Schedule 2 to the Bill is a list of places specifically included in the definition of public place, for example membership clubs, hotel function suites, places of work, colleges and universities. Notably, that list does not include private residences. In fact, paragraphs 3 and 5 of schedule 2 specifically exclude private dwellings from being considered as public places. At the Subordinate Legislation Committee I was questioned closely on this aspect and confirmed that it was not the policy intention to stray into people’s homes.

The definition of public space is wide, but care has been taken to make that definition as clear as possible.

5 Day Rule

I do not accept the Crown Office’s comment that “There could be difficulties with regard to notice to the accused. It may need to be made clear in any such establishment that food was to be supplied and consumed within 5 days.” That comment does not take account of the signage requirements at section 5 of the Bill.

Persons charged with the section 3 smoking offence should have had notice that they were in a regulated area because, under section 5, proprietors are required to display signs inside and outside regulated areas indicating that smoking is not permitted. An area is a regulated area during the 5 days before food is to be served, and signs should be displayed throughout this period. If signs are not displayed during the 5 days, the proprietor is guilty of an offence under section 5(2), and the accused may be able to rely on the defence at section 3(2).

Whether or not the area is to be used for food service within the next 5 days is a matter of fact that should be known to the proprietor. If smoking has been permitted in a room today, the earliest food function booking that a proprietor can accept will be in 5 days time, and no smoking signs should be placed inside and outside the area during the 5 days prior to the food function.
Proving the Offence

I agree that in the worst case it would be necessary for witnesses to require to speak to each of the elements, but I do not accept this would cause the difficulties suggested by the Crown Office. Each of the elements has been clearly drafted and is capable of proof.

In addition, the law of criminal procedure encourages parties to agree any evidence that is not contested. Most matters before the courts are complicated to prove, but can be proved by a combination of agreed evidence and witness testimony.

Comparison with other legislation might be useful to the Committee. For example, if the Crown had to prove all aspects of a speeding charge it would have to prove the calibration of the camera back to the check on the speedometer of the police cars used for that and the watches used to check the timings of the police car and the measured mile they use. In each case the relevant officers involved would potentially need to attend court and give evidence in person. In practice, this technical evidence is often agreed between the Crown and the accused, and does not need to be proved in court.

Section 3

The Crown Office note in relation to section 3 that it “provides that it is an offence for any person to smoke in a regulated area. Taken together with the definition of ‘smoke’ and ‘smoking product’ in section 10, this provision would have a wide application. This could mean that any person holding a cigarette, for however short a period, or even sitting beside a cigarette in an ashtray, could be convicted of this offence.”

Again I do not agree with their conclusion on this section. The definition of “smoke” actually says that this means “smoke, hold or otherwise have control over ...”. Although this is a strict liability offence, the prosecution still has to prove the key element of control. A person merely sitting at a table where a cigarette is burning in the ashtray is unlikely to be considered to have control over the lighted cigarette, unless they put it there. However a person asked to hold a cigarette for a friend, even for a short time, could, for that period, be considered to be in control of the cigarette. In exercising its prosecutorial discretion regarding this offence, I would expect that the Fiscal Service will bear in mind the public interest and not prosecute individuals who had no real control over the smoking product.

Section 7

There was direct questioning of the Crown Office at the Committee in relation to their comments on this section, when some of the apparent confusion appeared to be resolved. As the Crown Office say, this section introduces the possibility of committing an offence by negligent action of an officer of a corporate body.

I do not agree with their comment that “To criminalise negligent conduct is a significant extension to criminal liability in Scotland and certainly merits very careful consideration.” That comment may be of some relevance in relation to the development of common law crimes in Scotland, but it is not applicable to statutory offences. Statute law contains many examples of offences that may be committed with no mens rea at all: offences of strict liability. As Sir Gerald Gordon remarks in his leading textbook “Criminal Law”:

“Indeed, so many statutory offences can be committed without any mens rea at all that when punishment is made to depend on negligence the law appears to be making a gracious concession to the requirements of morality.”
Bodies corporate provisions in similar terms to section 7 are commonly applied to regulatory offences that may be committed by businesses as well as by individuals. Such provisions encourage compliance with the law by management, and can be found throughout the statute book: see, for example, the Trade Description Act 1968 (section 20); the Health and Safety at Work etc. Act 1974 (section 37); and the Food Safety Act 1990 (section 36).

Over the last few years, the Executive has included similar provisions in a number of Bills which have become Acts of the Scottish Parliament: see, for example, the Regulation of Care (Scotland) Act 2001 (section 23); the Water Industry (Scotland) Act 2002 (section 66); the Protection of Children (Scotland) Act 2003 (section 20) and the Building (Scotland) Act 2003 (section 49) on which the provision at section 7 is, in fact, modelled.

Section 8

I think that in relation to their section 8 comments the Crown Office would now accept that this is not a new role for the Procurator Fiscal service. The provision was included so that the Bill would comply with what I understand to be Executive policy: that the Crown should normally be subject to any Bill in the same way as any other person, except with regard to criminal liability for contravention of any regulatory measure. The provision follows the approach first adopted in section 54 of the Food Safety Act 1990, which is, I understand, the same approach that would be taken by the Executive in the introduction of any new regulatory measure such as this and can be seen in a number of Acts of the Scottish Parliament.

The Crown Office representative was apparently unaware of existing powers in this respect: see, for example, Transport (Scotland) Act 2001 (section 66); the Water Industry (Scotland) Act 2002 (section 67); the Building (Scotland) Act 2003 (section 53); as well as section 54 of the Food Safety Act 1990. That the Fiscal service has not been called on to use its existing powers is perhaps a measure of the care taken by the Crown to comply with regulatory measures.
SUBMISSION FROM STEWART MAXWELL MSP

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Thank you for your letter of 22 September and I now write to provide the detail of the legal advice I have received on the scope of my Bill and in particular confirmation that the areas presently covered could be extended at Stage 2.

During my evidence to the committee on 29 June I was asked by Dr. Jean Turner whether the Bill could be extended to provide a “blanket ban”. The answer I gave then (at column 1134) was that

“There is no doubt that a full ban on smoking in public places can be achieved through the bill. ….. The scope of the bill is clear and unequivocal: it is to prevent people from smoking in regulated areas, hence both the short and the long title. There is no problem in extending the definition of regulated areas to cover all enclosed public places. The only thing that the bill cannot do is ban smoking everywhere, which is not the intention.”

Catherine Scott from the Parliament’s Directorate of Legal Services who was accompanying me when I gave that evidence then confirmed the position to the committee.

Following receipt of your letter I have again sought advice on this matter from the legal advisers. They confirm the evidence I gave that the scope of the Bill is wide indicating that

“amendments which made all enclosed public spaces regulated areas (removing the linkage with food) would appear to be within scope.” I attach the full advice I have received.

During my evidence I also indicated that I thought the evidence justified a full ban on smoking in public places. I have been giving this further consideration and it is my current intention at stage 2, based on the evidence that the committee has received, to seek to widen the Bill by extending the areas covered and in particular break the linkage with food. Amendments have not yet been instructed, in general terms only they are likely to be along the following lines:

Delete sections 1(1) (a) and (b) (removing food)
Delete section 1(4) (removing prescribed period as unnecessary given extent of new areas)
Possibly delete section 2 (as being unnecessary with the other changes)
Amend section 4(2)(a) and delete 4(2) (ii) and (b) (food and prescribed period references)
Delete definitions in 10 of food, food operation, prescribed period and supplied
Amend schedule 1 paragraph 2 by removing references to food.

I hope this is helpful and look forward to answering any further questions for the committee on Tuesday.
To: David Cullum  
cc: Catherine Scott, Alison Campbell  
From: Mark Richards  
Office: Directorate of Legal Services  
Date: 24 September 2004

Prohibition of Smoking in Regulated Areas (Scotland) Bill Scope

1. You have asked for advice in order to assist Stewart Maxwell MSP in relation to is further evidence to the Health Committee on Tuesday 28 September. A question has been asked about whether the scope of the Bill can be extended.

2. Scope is determined by the entire contents of the Bill at introduction. The concept of scope is used by the Parliament to assist with the determination of the relevance of amendments. The Standing Orders provide at Rule 9.10.5(b) that amendments to a Bill are only admissible if they are relevant to the Bill. In other words, if an amendment is within the scope of the Bill it will be admissible.

3. The Bill is to prohibit smoking in regulated areas. These regulated areas are currently defined in the Bill as enclosed public spaces where food is either currently being, or within five days will be, supplied and consumed. It is important to note that section 2(1) enables the definition to be amended in order to extend the places to which the Bill has application. This power is itself very wide and can be used to add places which have no food connection. The Subordinate Legislation Committee has commented that it seems possible that the Bill would be open to amendment making any area a regulated area for the purposes of the Bill.

4. It is clear, therefore, that the scope of the Prohibition of Smoking in Regulated Areas (Scotland) Bill is not limited to prohibition of smoking in public spaces where food is sold and consumed. If that were the case the Bill would simply have prohibited smoking in those spaces and the concept of regulated areas would have been unnecessary.

5. The scope of the Bill is, in fact, quite wide. Amendments to widen the areas covered by the Bill would be within scope provided that the regulated areas concept is not abandoned. For example, an amendment which added other types of public premises to the regulated areas would be within scope. Similarly amendments which made all enclosed public spaces regulated areas (removing the linkage with food) would appear to be within scope.

Mark Richards  
Senior Assistant Legal Adviser
SUBMISSION FROM THE DEPUTY MINISTER FOR HEALTH AND COMMUNITY CARE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Thank you for your letter of 22 September seeking further information to inform The Committee's consideration of Stewart Maxwell's Prohibition of Smoking in Regulated Areas (Scotland) Bill.

As the Committee is aware, the wide-ranging consultation we launched on 7 June to inform future policy on smoking in public places comes to an end on 30 September. The aim has been to provide individuals, businesses, representative groups and other organisations the opportunity to air their views both through written and on-line consultation responses and the regional seminars which have taken place across Scotland. The consultation has attracted an unprecedented number of responses and this, together with the wider evidence being gathered through, for example, commissioned research, will place a wealth of information at our disposal in order to inform future policy.

The Scottish Executive's position in relation to the Stewart's Bill is unaltered. We still believe that it is premature to reach a decision on legislation until we have had the opportunity to review and consider all the evidence from the consultation in its entirety. While the exceptional level of interest in the consultation does present a huge challenge in analytical terms, we still hope to be in a position to announce our future policy intentions before the end of this year. For this reason, I would repeat the suggestion I made when I gave evidence to the Committee on 29 June for consideration of Stewart's Bill to be suspended meantime.

I hope this information is helpful.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

14:25

The Convener: Item 4 concerns the Prohibition of Smoking in Regulated Areas (Scotland) Bill. We will take evidence from Stewart Maxwell, who will be accompanied by David Cullum from the Scottish Parliament non-executive bills unit and Mark Richards from the Scottish Parliament directorate of legal services.

Do all committee members have copies of the correspondence? There should be an additional letter from Stewart Maxwell and a letter from the Deputy Minister for Health and Community Care.

I thank Stewart Maxwell for coming along and for his letter and its attachment. We have not discussed any lines of questioning, but we hope that we will not keep him terribly long. Stewart’s letter and its attachment are relatively clear on the potential future remit of the bill and its ability to be amended to widen its provisions. Does any committee member have a question about that aspect?

Shona Robison: The letter and the advice are helpful, but it might be useful for the record if Stewart Maxwell were to say whether he feels that the scope of his bill could be extended to cover a ban on smoking in all public places and if he could suggest the number of amendments that would be required to do that.

Mr Stewart Maxwell (West of Scotland) (SNP): As I said in my evidence on 29 June, the bill’s scope allows it to be amended to include a wider area of Scotland in any ban. The letter that the committee has received contains a quote from my evidence session and a legal opinion from the directorate of legal services about the fact that the parliamentary authorities clarified and cleared the bill’s scope before it was published.

The letter describes the amendments that would be required, but not in detail. We estimate that only six amendments would be required to take the bill from its current position to a full ban on smoking in enclosed places in Scotland. I presume that you do not want me to go through the six amendments. If an intermediate ban that covered some areas but not others was required, that would have to be considered, but to go from where we are to a complete ban would take only six amendments.

Dr Turner: That more or less covers what I wanted to ask about. I would like the bill to be extended.
**The Convener:** We will not go into that at the moment. We are just dealing with whether, according to the legal advice, the bill can be extended, because that is germane to our consideration. We all have our different views about whether the bill should be extended, but we do not want to go there.

**Dr Turner:** I assume that the bill can be extended. I accept that.

**Mike Rumbles:** I would like to know Stewart Maxwell's view; I do not know whether to make my point into a question. He says that the legal advice is that the bill could be extended by stage 2 amendments. However, the point is that the committee has spent much time taking written and verbal evidence at stage 1 on the bill's general principles, which do not relate to an outright ban on smoking in public places—the bill concerns a ban on smoking in places where food is served. If the proposed amendments are lodged at stage 2, how should the committee proceed? Should we take more evidence, or will the Executive's evidence be sufficient?

**Mr Maxwell:** The bill's purpose is not just to ban smoking in places where food is consumed. Its singular purpose is to ban smoking in regulated areas. The definition of those areas can be as narrow or wide as the Parliament decides, and the bill defines one type of area. The bill's purpose—to create regulated areas—has always been clear.

It is up to the committee to decide how to proceed. If the committee thought that further evidence was required, I am sure that the parliamentary authorities would be happy to allow it to take evidence at stage 2. It is quite usual for that to happen. I was a member of the Justice 1 Committee, which is about to take stage 2 evidence on the Emergency Workers (Scotland) Bill. Taking evidence at stage 2 on my bill might be appropriate.

The Executive's consultation is producing much evidence. In addition to submissions from the public, the Executive has told us about research that has been undertaken and about an international conference that it has held. It is not for me to say how the committee should deal with that evidence.

Mike Rumbles mentioned the written and oral evidence that was submitted to the committee in the run-up to the end of June. I wondered about an issue in which I thought members might be interested and I spent some time studying all the evidence that was submitted to the committee. My analysis, which I am sure that members could confirm if they did it themselves, is that every committee member at some stage and sometimes several times in the four evidence sessions discussed a full ban. All but two witnesses discussed a full ban. Therefore, it is not correct to say that the discussions were about a ban only in certain places. The evidence shows clearly that a full ban was discussed widely in every evidence-taking session by every committee member and by almost every witness.

**The Convener:** Do either of your officials wish to comment at this stage? No.

**Kate Maclean:** There was never a question about whether the bill could be amended; it is obvious that any bill can be amended. If Parliament agrees amendments to a bill, that is how the bill progresses. However, I was under the impression that the bill was put together in the way that it was because that would make it less open to possible legal challenge. Is that the case? Or am I remembering wrongly evidence from some time ago? I thought that, if the bill was amended to include all public places rather than just places in which food was served, it would be more open to legal challenge.

**Mr Maxwell:** I will answer that briefly and perhaps the lawyer from the legal directorate can help. What you said is not the case. Before the bill’s publication, we were careful to ensure that its scope would include the possibility of amending it to include a ban in all public places, if Parliament decided that it wanted that. The evidence was that Parliament wanted that. We checked the bill closely and clarified its scope with the parliamentary authorities prior to its publication.

There was never any doubt in my mind about the bill’s scope. I have now given you the legal advice about that and information about the amendments that would be required to widen a ban. I do not think that the bill has ever been open to legal challenge on that basis. It is very much within the bill’s scope to extend a ban to all public places. There may have been discussion previously in the committee about whether the bill’s scope included such a ban, but the committee obviously did not have the evidence before it early on that it now has about the legal opinion and the documents about what amendments would be required, which have recently been supplied. The bill team, the legal advisers and I have been clear about the bill’s scope from the beginning. Mark Richards may be able to help on that.

**Mark Richards (Scottish Parliament Directorate of Legal Services):** The decision to include the initial limitations to the bill’s scope was a policy one rather than a legal one. However, there is a power in section 2(1) to enable the defined areas to be amended to include other areas. Therefore, the legal advice on that provision’s width is that a ban can be extended to include all enclosed public places.
Dr Turner: I thought that, except in a few exceptional circumstances, all the evidence that we gathered—particularly the medical evidence, including Mac Armstrong’s—pointed to the fact that everybody wanted the bill to go for a complete ban. From the point of view of people who may have to go to the expense of ventilation systems, it would be fairer if we could extend a ban.

The Convener: You are straying into stage 2 again, Jean.

Dr Turner: It is just that the evidence that was gathered—

The Convener: I appreciate that.

Dr Turner: Is that not relevant at this stage?

The Convener: No. The issue is whether, within the context of the current bill, we could accept amendments that would extend the ban to a full ban. The policy argument about whether we should or should not do that is a different issue.

Dr Turner: We have legal evidence that says that the bill can go to a full ban and we took evidence that pushed us towards considering making such amendments. I thought that that was relevant at this stage.

The Convener: Strictly speaking, it is not.

Dr Turner: I am a learner—sorry.

The Convener: We will decide on the amendments issue. This discussion is part of the process of informing us how to deal with the stage 1 report. We must clarify this important issue, about which we have had clear legal advice.

Mr McNeil: The matter is confusing. We are all learners in this process because we are dealing with something that does not happen every day of the week. It is not only the politicians round the table who are confused; the private briefing paper that we have states:

“The Prohibition of Smoking in Regulated Areas (Scotland) Bill seeks to prevent people from smoking in public places where food is supplied”.

It is not a case of our being mistaken or confused—that is what we took evidence on. Going by some of the public statements that Stewart Maxwell made at the time, he did not seem to be pursuing a total ban. To return to Mike Rumbles’s point, what do we need to do now in terms of evidence taking to broaden a ban to include all public areas?

The Convener: That is not in Stewart Maxwell’s gift; how we deal with any such amendment at stage 2 is a matter for the committee. If we consider it appropriate to take evidence at stage 2 on specific amendments, we can do so, but that is not a decision for Stewart Maxwell to make; it is for us.

Mr McNeil: I accept that, but I am genuinely confused about where we are going and what we took evidence on. People who came to give us evidence would have given different evidence if we had been talking about a total ban. There is a wee bit of shifting sand here and the committee has to be very careful.

Mr Maxwell: The long title of the bill is:

“An Act of the Scottish Parliament to prohibit persons from smoking in regulated areas; and for connected purposes.”

That is the scope of the bill. Part 1 of the bill talks about particular regulated areas where food is served, but the purpose of the bill is given in the long title. There has never been any doubt about that.

Shona Robison: I understood from Stewart Maxwell’s analysis of the evidence that we took—perhaps we should also analyse that evidence—that almost every witness expressed the view that there should be a ban on smoking in all enclosed public places. Is that what you said?

Mr Maxwell: It is. I did the analysis because I wondered whether that matter would be raised as a problem. If members also want to do that, please go ahead. You will find that that was the view of all but two witnesses, I think. A couple of witnesses did not speak; for example, Mr Cullum from the non-Executive bills unit, who accompanied me when I gave evidence, did not speak. However, of all the witnesses who gave oral evidence, only two did not discuss introducing a full ban; all the rest did.

Mike Rumbles: Who were they?

The Convener: Sorry, Mike, Helen Eadie is next after Shona Robison.

Helen Eadie: The main issue for me concerns the call for evidence and the policy memorandum that was published when the bill was introduced. We received evidence from those people who wanted to give evidence on the basis of the policy memorandum as it stood at that time. Now that the sands have shifted in that regard, I am left feeling uncomfortable until we can have more consultation with the public to find out their views about whether we should go to the next stage.

The Convener: That is a reasonable point to make, although it might have more strength had it not been standard procedure over the past five years to introduce quite major changes to bills at stage 2 that have not been part of the stage 1 evidence-taking process. It comes back to whether, if such amendments were to be lodged, the committee would want to take further evidence. We could do that.
Helen Eadie: With respect, convener, two wrongs do not make a right. I feel strongly that, if we are to have consultation, it has to be meaningful and we have to be clear about what the consultation proposals are. If, in fact, the ground has shifted in that regard, that gives me a problem.

The Convener: I look forward to discussions on future legislation when substantive issues are introduced at stage 2. What we have at the moment is a clear indication on the key point that it is perfectly possible to amend the Prohibition of Smoking in Regulated Areas (Scotland) Bill at stage 2.

Mr Davidson: I do not argue with the technical point. One can change anything one likes apart from the long title of the bill—I am not even sure that one cannot change that. However, I find it strange that we are encouraging people not to use subterfuge—I would not go as far as to say that—but to test the water with a member’s bill and then to change tack after they have introduced it. If we were to do that, we would have to go back and invite all those who gave evidence to confirm what they said or ask them whether they now have a different view. It is almost as though Stewart Maxwell is starting the bill again. It is not that we have not had chats about that, but I felt that he was a little disingenuous at the introduction of the bill.

Janis Hughes: I accept David Davidson’s point, but I return to a point that Kate Maclean made earlier. It was my understanding, too, that it was because of a technicality that the bill was introduced to propose a ban in regulated areas. Stewart Maxwell looks puzzled, so perhaps I should ask a direct question. Why did you draft a bill that would prohibit smoking only in regulated areas, rather than introduce a total ban? I take David Davidson’s point: we took evidence on the proposal to ban smoking in regulated areas in which food is served, but now you want to change the substance of the bill...

Mr Maxwell: A number of points have been raised. As far as I am aware, the committee took evidence on the bill, rather than just on the specific provisions about food. Section 2(2) would require Scottish ministers to consult before amending the meaning of “regulated area”, so consultation in the event of an extension of the bill’s scope was built into the bill.

Janis Hughes asked why we did not call for a full ban in the first place. Members should remember that I indicated my intention to introduce a member’s bill well over a year ago and I think that everyone would agree that since then there has been a tremendous amount of debate and argument and a tremendous amount of evidence has come forward. Things have moved on considerably and at quite a pace. The bill was drafted on the basis of the evidence and public opinion at the time, but I understood that the situation might move on; that is why we drafted the bill in a way that would leave its scope open to amendment if the evidence indicated that that would be necessary.

I have copies of all the written submissions that the committee received and I attended all the evidence sessions that the committee held, as did members. It was clear that the debate had moved on and that the evidence showed a move towards support for a full, rather than a partial, ban. I do not refer only to witnesses who supported anti-smoking measures; the representative from the British Hospitality Association stated clearly that the association would prefer there to be a level playing field, so it would prefer a full ban. When I gave evidence to the committee on 29 June, I said that given the evidence that had been received at stage 1, it seemed reasonable to conclude that a full ban would offer a simpler approach and would be supported not only by those who gave evidence to the committee but by the wider public.

Janis Hughes: I accept what you say about the evidence that we received and I am pleased to hear you say that, as time has passed since you introduced the bill, much more evidence has come to the fore. That is why there has been such a response to the Executive’s consultation on a total ban on smoking in public places. You acknowledge that a lot of new evidence is being received, so would it make sense to wait and hear that evidence, which is being received in response to proposals for a total ban?

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Mr Maxwell: This might be a semantic point, but for clarification, when you say “suspend”, do you mean “extend” consideration of the bill?

The Convener: Janis Hughes’s point really belongs to the next item on the agenda. It is for the committee, not Stewart Maxwell, to decide how to proceed.

Mike Rumbles: I do not know whether my question to Stewart Maxwell is appropriate, but his answer might inform the decision that we make under the next agenda item. What would you think if the committee were to decide today to recommend that the Parliament suspend consideration of the bill until the Executive comes forward with the material that it receives, on the ground that the committee and the Executive should not do the same work at the same time?

Mr Maxwell: This might be a semantic point, but for clarification, when you say “suspend”, do you mean “extend” consideration of the bill?

The Convener: We cannot suspend consideration; we can only extend consideration.

Mr Maxwell: I am open minded on the matter. I understand that the Executive’s consultation has
attracted something like 10 times as many responses as any other consultation has received and that the Executive has conducted research and held an international conference. It is for the committee to decide what to do, but I can understand why the committee might decide to extend stage 1 consideration, and I would not throw up my hands in horror at that prospect. The most important point is that we should have a clear, transparent parliamentary process that is open to all and accountable.

Throughout Scotland, there is a huge amount of interest in this issue. People on both sides of the debate have strong opinions. It would be better for the committee to dot all the i's and cross all the t's than simply to jump in while it is unsure about the position. It would be preferable for us to go through the stage 1 process and to take evidence from all the sources, as that would allow us to take a solid decision at the appropriate time. The Executive has said that it will take a decision by the end of the year. If that means the committee delaying stage 1 consideration of the bill until January, I can understand why it might decide to do so. That would not be an unreasonable decision to take.

The Convener: That is clear. As members have no other questions, I thank Stewart Maxwell and the two other witnesses for their attendance. We will let you know what our decision is.

That ends our business in public. I ask all those who are not members of the committee to leave.

14:48

Meeting continued in private until 15:07.
ANNEX D – OTHER WRITTEN EVIDENCE

SUBMISSION FROM M M ATKINSON

Dear Mr Reid

Although a "smoker" I have no problem with "designated" areas for people who smoke which are properly ventilated and subject to the same standard of cleanliness as a non-smoking area - and not a converted broom cupboard. I would however, hope that smokers are all treated to the same level of care and consideration by the N.H.S as non-smokers and not subjected to puritanical measures by doctors putting their personal opinions before their Hippocratic oaths. I have heard of this happening.

In my experience excessive drinking and the effects on Family, N.H.S, Social Services, Local Councils and Community at large has a much more devastating and costly effect.

As for total bans in social areas I feel is treating us like "lepers".

Yours sincerely

Mrs M M Atkinson

SUBMISSION FROM KAREN ALLAN

I have three children whom I try to protect from passive smoking, and also from taking up smoking. It can be difficult enough taking them places to eat, without having to worry about smoking.

In fact, I would go further and ban smoking from all public places. My daughter goes to a dance club at a local hall, which also has a bar. When they give public performances to parents etc, the place is full of smoke, and yet the children are obviously breathing heavily. If I complained, people would think I was mad, but if withdraw her from the class we are withdrawing from the community.

There is still a long way to go with regard to public information, and I fully support Tayside Health's proposal to ban smoking in public places.

Regards,

Karen Allan BSc
Dundee

SUBMISSION FROM HELEN ARTHUR

Sorry I have not contacted you sooner. I am just back from a bus trip which was a non smoker you must be joking I had a very uncomfortable journey why? Well some of the smokers went down to the toilet for a smoke, when I complained to the driver he informed me he couldn't do anything. So I ask you why do they make it a non smoking bus? Yes I do support your campaign for a no smoking policy. You may use my submission to where or whomsoever it should go. I would even like cigarette sales banned so you will know how uncomfortable my journey was.

Yours sincerely

Miss Helen Arthur
SUBMISSION FROM AVRIL AUCHTERLONIE

I am writing to support Mr Stewart Maxwell's Prohibition of Smoking in Regulated Areas (Scotland) Bill, shortly to be considered by the Scottish Parliament.

The detrimental health effects of passive smoking are now beyond debate, and the evidence is particularly strong that young children are especially vulnerable to the harmful effects of environmental tobacco smoke (ETS).

Many Scottish pubs and restaurants have attempted to attract new business by promoting themselves as "family friendly", but there are almost no cases of pubs and only a minority of restaurants that are genuinely smoke-free. When a pub or restaurant has a partial smoking ban, smoke typically diffuses freely into non smoking areas. Although new pubs and restaurants are addressing this problem by improved ventilation systems this increases energy usage and could be avoided by a no smoking policy.

At the present time it is therefore impossible to have a normal social life with children without exposing them to the harmful effects of ETS. Young people will see smoking as an acceptable habit and possibly associate with "maturity and looking cool". This will encourage more youngsters to take up smoking and thus create even more problems for the NHS in future years. For people who do not want to expose their children to ETS, the result is social exclusion, and a damaging effect on the fabric of Scottish society. Only a complete ban on smoking in public places would fully protect Scotland's children from the dangers of ETS.

Yours sincerely

Avril Auchterlonie

SUBMISSION FROM WILLIAM AND MURIEL BARLOW

With regard to the above-mentioned Bill we would like to respond in support of it. There is significant evidence from the Health Services to prove the dangers of passive smoking and smoking. To have half a restaurant supposedly a "non-smoking area" when there are no partitions is an absolute nonsense and basically the proprietor is paying only lip-service to public demands. Many people, in fact often the majority of people, would prefer that a public place, especially where food is to be consumed, should be smoke-free.

On a personal basis, I have home-tutored a ten-year old child, suffering from Leukaemia and although I am glad to report today that he is alive, he was "sent to Hell and back" with the horrendous treatment he had to endure as a primary schoolchild. In his case he was certainly a product of his environment and we feel that a lot more publicity should be given to the facts and statistics to see if people can change habits of a lifetime.

My aunt suffered and died, no doubt, as a result of passive smoking. My uncle gave up, instantaneously sixty cigarettes a day, when he developed mouth cancer and he is still alive over thirty years later.

At present we are visiting a very dear friend in the Beatson Oncology ward at the Western who is suffering from cancer and has just started his chemotherapy treatment this weekend. Cancer is so prevalent in Scotland that perhaps we are accepting it all too easily, instead of making a firm attempt to combat it.

We believe that The Prohibition of Smoking in Regulated Areas (Scotland) Bill would certainly be a positive step in the right direction. We are aware it takes generations to educate people but we must take measures now to remedy our present standards.
Obviously this Bill would involve expense for hoteliers, proprietors etc. but through time we are sure more customers will be encouraged to use their facilities. Our young people/ students who work in low-paid catering and bar work will also benefit from this Bill, as often they work long hours within these establishments and will therefore not be putting their own health in jeopardy.

SUBMISSION FROM M BEATON

I support the general principles of the above Bill and the key provisions it sets out.

M Beaton

SUBMISSION FROM DR JENNY BENNISON

1. Background

1.1 RCGP Scotland is the Scottish Council of the Royal College of General Practitioners (RCGP). The College’s aim is to encourage, foster and maintain the highest possible standards in general medical practice by providing leadership and support to GP members in relation to clinical standards and professional development; as well as to provide personal support to members and to promote general practice as a profession.

1.2 RCGP Scotland welcomes the opportunity to comment on this Bill, which will protect individuals, including children, from the harmful effects of passive smoking in areas where food is served. RCGP Scotland lent its support to this legislation in a letter from the medical organisations in Scotland to Mr Maxwell, sent on 4 February 2004.

1.3 The Royal College of General Practitioners, at a UK level, is in favour of a ban on smoking in all public places. In November 2003, the College, in partnership with the other medical royal Colleges and Faculties, wrote a letter to The Times calling for legislation at the earliest opportunity for a ban on smoking in all public areas. We are pleased to note the introduction of a House of Lords Bill, Tobacco Smoking (Public Places and Workplaces) Bill, which seeks to achieve this, although do not feel that we should wait for UK legislation to take action on this important public health issue in Scotland.

1.4 As doctors, seeing the daily consequences of smoking and passive smoking, we are in complete support of any effective measure that will help reduce the effects of tobacco in Scotland. This includes primary prevention (measures to stop people starting in the first place), giving support to those who are trying to give up smoking and providing protection for non-smokers from the effects of second hand smoke.

1.5 We believe that the current voluntary measures have not done enough to protect the public from the harmful effects of second hand smoke. A review of the Voluntary Charter last year showed that only 11 per cent of businesses in the Food and Entertainment sector were completely smoke-free. When respondents without smoking restrictions were asked why they had no policy to ban or restrict smoking, 31 per cent said ‘there is no need for one’.

1.6 The World Health Organisation’s Agency for Research on Cancer has concluded that environmental tobacco smoke (second hand smoke) causes lung cancer, increasing the risk by 20-30 per cent. Prolonged exposure to second hand smoke also increases the risk of coronary heart disease by 25-30 per cent, and has been linked to an increased risk of stroke and other serious illnesses. According to the Chief Medical Officer, smoking itself is the biggest single cause of preventable premature death and ill-health in Scotland, accounting for 13,000 deaths each year from smoking-related illness.
2. General Principles of the Bill

2.1 We support the Bill's objective of protecting individuals from the harmful effects of second hand smoke. We further support the aims of the bill to raise awareness of the dangers of second hand smoke and to encourage individuals to change their attitudes towards smoking in general.

2.2 Fifty years ago, most men and half of all women smoked and smoking in public places was the accepted norm. Today, smokers are in the minority but continue to subject the now non-smoking majority to the harmful effects of tobacco smoke. We firmly support the principle that people should have the right to a smoke free environment, just as employees should have the right to work in a safe environment.

3. The Extent of the Bill

3.1 We believe that this legislation will reduce tobacco use in public and therefore non-smokers' exposure to second hand smoke. We also know that smoke free policies can help smokers give up, with complete smoke free policies typically reduce the prevalence of smoking by 4 per cent, while partial policies reduce the prevalence by 2 per cent. It is further estimated that if all workplaces that currently permit smoking in Britain became smoke free, more than 300,000 people would quit smoking and in the longer term more than 150,000 lives would be saved.

3.2 As the Bill stands, its remit is limited to enclosed areas where food is being served. We welcome the provisions in the legislation for Scottish Ministers to extend the definition of enclosed public places as a means of broadening the remit of this legislation over time.

4. The Consultation Process

4.1 We feel the consultation process has been appropriate and inclusive.

5. Implementation of the Bill

5.1 Legislation is an important tool in changing behaviour and, as experiences in America and Finland have shown, is more effective than voluntary action. However, legislation alone cannot change the public's attitude towards smoking. The launch of this Bill should be accompanied by a strong anti-tobacco campaign to raise public awareness of the dangers of smoking and second hand smoke.

5.2 Those working in the NHS, particularly in primary care, are at the forefront of measures to reduce the effects of tobacco on the nation's health. Smoking cessation is a priority for Health Boards and recent developments such as the availability of Nicotine Replacement Therapy (NRT) on prescription have helped lower the smoking rates in Scotland. We feel however that more can be done, and that the apparent political unwillingness to act on smoking in public areas undermines efforts to persuade the public to change their behaviour. The message has to be consistent - smoking is bad for you and for those around you. If we believe this, everything that can be done to tackle this issue should be done. As health professionals we feel exposed and unsupported in our current efforts to encourage patients to give up smoking.

6. Conclusion

6.1 A ban on smoking in public places would be the most significant single action to improve the nation's health in Scotland and we congratulate Mr Maxwell for introducing this private members' bill. The consistent reluctance of Westminster and Holyrood administrations to tackle this issue casts doubt on their commitment to improving public health.
6.2 This legislation will succeed where voluntary action has failed, and will have a positive effect in reducing the effects of second hand smoke in Scotland. It is a vital part of the campaign to change public attitudes towards smoking in public places, and a significant step towards our ultimate goal - a smoke free Scotland.

Dr Jenny Bennison
Deputy Chair (Policy)

1 Smoking in Public Places: A Follow-up Survey of the Scottish Leisure Industry, Ash Scotland, 2003
2 ‘Tobacco Smoke Pollution: The Hard Facts; Ten reasons to make public places smoke free’, Royal College of Physicians, 2003
3 Health in Scotland 2003, Scottish Executive 2004
4 The majority of smokers (70%) want to quit; Ash Scotland, 2004
5 ‘Tobacco Smoke Pollution: The Hard Facts; Ten reasons to make public places smoke free’, Royal College of Physicians, 2003
6 There has been a slight decrease in smoking prevalence in Scotland in recent years with an average of 31% of Scots (1.2 million) who smoke. This is still 5% higher than the UK average. Health in Scotland, Scottish Executive 2004

SUBMISSION FROM JOHN BOGLE

Dear Sirs

I write to express my personal opinion on the above bill. I fully support the introduction of this bill, my only criticism is that it does not go far enough, with all the evidence that is available to us of the harm done by smoking I firmly believe that you as our Parliamentarians should do all in your power to stamp the practice out. I do not agree with the argument that it is an infringement of human rights to ban smoking - what about the human rights of non-smokers who are forced to suffer from passive or rather enforced smoking? Personally I think that if someone wishes to smoke themselves to death then that is their right but they should not be free to inflict it on the rest of us, an extension of this argument is of course that suicide should be legal!

My own experiences of smoking in places where food is served is that segregation does not work. Invariably when smokers are in a designated area in the same room as non smokers their smoke drifts over to where the non smokers are. Even if there is a completely separate room, waiting staff moving between the areas bring the stench of smoke through with them on their clothes. Surely it is not too much to ask smokers to wait until they are outside before lighting up? In Wick my family always prefer to go to a non-smoking café.

I am secretary of Wick RBLs Pipe Band and we have some experience of introducing a smoking ban. Each Summer we stage Variety Shows in our Pipe Band Hall, during the interval we serve tea/coffee and biscuits, up until 2 or 3 years ago we used to put ash trays out on the table, only a few guests smoked (some already went outside to indulge) but by the end of the night everyone went home with their clothes stinking of smoke. We decided to introduce a smoking ban, only one of our regular guests complained and said he would not come back everyone else accepted it and the shows are now much more enjoyable, we witnessed no reduction in our income (even the objector returned after a few weeks and accepts the ban). If our experience is anything to go by then proprietors of establishments should have nothing to fear from a ban especially if all premises are in the same boat.

Yours faithfully

John Bogle
Caithness
SUBMISSION FROM ANN BOYLE

There was a letter handed round our church on Sunday 11\textsuperscript{th} April. The Church of Jesus Christ of Latter Day Saints Johnstone Renfrewshire about banning smoking in Public places especially in restaurants and anywhere where food is on display. Cigarette goes up fills the air in clouds of smoke then comes back down onto the food then the public eat the food no wonder so many get cancer eating cigarette smoke after a while the cigarette smoke blackens the tables or work tops as if the tables had never been washed. I was in British Home Stores Restaurant Saturday 10\textsuperscript{th} at Sauchiehall Street Glasgow there where no smoking signs up in the restaurant but people were still smoking. I think the staff should be pointing out that it is a no smoking zone not just ignoring the people smoking they should be told to put out their cigarettes. I have never smoked myself and breathing in cigarettes is sickening never mind having to sit and eat cigarette smoke it should be banned.

Ann Boyle

SUBMISSION FROM BARBARA BOYLE (MRS)

I support whole-heartedly the prohibition of smoking in public places.

Cafes, restaurants and bars where segregated areas are on offer simply do not work, especially when only one or two tables are available. Fitted rotary-type circulation fans overhead merely distribute the smoky air around the whole of the premises! Proper extractor fans are usually more effective. Any movement of air from an open window or door, however, renders their effect almost useless.

Another bone of contention of mine is the non-smoking policy some bus companies operate. Smokers simply sit upstairs (or at the rear of single-deckers) where their smoking goes unnoticed or ignored by the driver, leaving the passengers to get abused if they ask for the smoker to stop - and what if the driver smokes?

No - for me only a total ban is good enough. All power to your Bill.

SUBMISSION FROM SUSAN BRADLEY

This email is for me to voice my opinion on the subject of smoking in public places in Scotland.

I think that smoking should be prohibited in all public places as being a non smoker I feel I do not have a choice to smoke or not as I am breathing in the smoke from other members of the publics cigarettes etc. I also think that it is unfair for me to have to put up with the smell and have the smoke cause my clothes to smell awful for days. If smoking was prohibited then public places would be a lot cleaner as nobody would be dropping their used cigarettes and there would therefore be less litter.

Susan Bradley
Glasgow

SUBMISSION FROM TOM BRADLEY

Smoking disgusts me and I do not like the smell of it therefore I think it should be prohibited in all public places. More importantly, passive smoking can cause cancer and I do not want to suffer from this due to someone else's habit.

Tom Bradley
Glasgow
SUBMISSION FROM MRS PAULINE BROWN

Ban of Smoking in Places Where Food is Served

I am writing to express my views related to smoking in public places and would like you to please consider these in support of your bill.

I am very much against smoking in public places and indeed am quite passionate about a ban being imposed. I am forty-two years old and have over the years moved from being quite concerned about breathing in other people's smoke but 'understanding' that they have an addiction and 'tolerating' smoke when I went out for a meal, sat in a pub with fellow students when I was younger to feeling as I do today.

Over the years I have tolerated, listened to smokers saying that it is their right to choose whether or not to smoke and indeed it is but so too is it mine and other non-smokers like me. I choose NOT to smoke and yet I have to if I choose to go out and enjoy an evening with my husband, family or friends - I am forced to breath in smoke.

My husband, family and my friends are non-smokers and I am disappointed to say that we have stopped going out to avoid sitting in smoke, breathing in smoke and at the end of the night smelling of smoke. We do attend the cinema where it is a smoke-free zone. We are also delighted that Brambles in Broughty Ferry, Dundee is now a smoke-free zone and we can go there for lunch and tea and not feel 'clogged up' when we come out! Many places have smoking and non-smoking areas however the smoke just does not know where one area begins and one ends thus making a nonsense of this attempt at making my chosen area, the non-smoking one, exist!!

My husband, eight year old son and I recently went to the Carnoustie Hotel to celebrate my husband's birthday and we reserved a table in the 'non-smoking area' which was right next to double-doors which led into the smoking area and bar area. These doors were opened in order for the staff to serve the meals in both areas. We enjoyed a lovely meal and wonderful service, polite and friendly, however our evening was completely marred by the smoke which affected our sinuses, left us smelling of smoky and caused me stress. Stress in terms of my frustration at stating a choice of seating and then being forced to breath in smoke in a supposedly 'smoke-free area', anger at my eight year old having to breath in chemicals which are released in the air every time a cigarette is lit and my frustration at the level of apathy which still exists. This scenario is not restricted to the Carnoustie Hotel it exists in the majority of places - I have mentioned this particular evening since it is a recent experience.

The majority of people are non-smokers and I think that the excuse that a ban of smoking in public places will cause people to loose jobs is a nonsense. I know that I speak for a number of my friends and acquaintances who would go out more and be very happy to go out more if we were to sit in a smoke-free environment.

People who work also deserve not to breath in smoke. I noticed, again in the Carnoustie hotel, many young people serving the food and wondered if they were silently putting up with breathing in their customers' smoke. I would not be happy if my son were working there or anywhere else for that matter - having no choice. He does not smoke at home, at friends' homes or in places which we select to go to and we have to select these.

We, family and friends, often discuss the attitude of smokers and can sympathise with their addiction and acknowledge that support and help is needed for them but some smokers see a ban as an 'infringement of their human rights' can they not see that in reverse? Don't non-smokers have rights? The majority of people are non-smokers and they deserve some consideration.

Another occasion of a night out spoiled by smoke I would like to relay. Whilst in England we chose to have a bar meal in "The Hungry Horse" hotel and after checking that they had a 'non-smoking area' we were served our food. It was a very hot evening and the fire door, a table down from us, was open. A customer at the next table to us, beside the fire door, lit up her cigarette and held it by the door. The smoke of course blew in and towards us. I started to talk to my husband about this but we were
cowards and did not want to create a fuss. The issue I suppose was with the Manager of "The Hungry Horse" - a chain of pubs in England, but we opted out. They were very busy and we did not want a fuss. I feel that we would have been "the rotters".

Why do non-smokers feel like this??

We have to change the mind-set and would like this to be done through our Laws.

I think that you can tell by my letter that I would support very much a ban on smoking in public places and think that the 'scare stories' related to loss of jobs etc. is unfounded. I would certainly feel that I could go out more and not feel like a weekend prisoner - our choice of venue, as I am sure you will appreciate, is very limited.

When I spoke to the staff in the aforementioned' Brambles' some mentioned the fact that they felt quite ill in the initial stages of the ban, they thought due to "withdrawal symptoms" even though they were non-smokers themselves. I found this frightening.

They also explained that after quite a few abusive comments from smokers in the initial stages of the ban they are busier than ever with non-smokers who have congratulated them, and they are delighted to work in a 'free from poisonous-fumes atmosphere'!

I am sure also that it goes without saying that the health of children is extremely important too as well as the health of their parents, families and carers.

Thank you very much for taking the time to read this and I hope that you can represent my views and the views of other non-smokers. It has taken many years of having a shower when I come home from an evening out, coughing over the toilet next morning because of the smoke from the previous night and of feeling disgruntled up to the present day when we have just stopped going out. Please try to do something about this.

I would like very much to support your bill and if there is anything else that I can do I would welcome your advice.

SUBMISSION FROM SAM BUTLER

With reference to the above subject and the recent article in the West Lothian Courier, my wife and myself are in full support of a total ban in smoking in public places.

A large number of work places already have such a ban in place and the main problem in public is smoking in licensed premises.

There is nothing worse than going out to a social event and having to put up with the noxious smell of cigarette smoke throughout the evening and then to take the smell home with you on your clothing and body.

I noticed that Mr McConnell seemed to be favouring a partial ban which would not include licensed premises. No doubt they would have to have no smoking areas. We all know, however that these tend to be small areas, usually adjacent to smoking areas, which offer little are no protection from second hand smoke.

I wonder what the civil position is with regards to licensees, if I was injured or had my clothing damaged due to negligence on their premises then I could take out a claim for damages. If then my clothing requires cleaning due to being impregnated with smoke on their premises would they be liable to the costs. They would have been aware of the hazard on their premises and chose to subject their customers to it! I also feel that it is grossly unfair that staff in these premises are constantly subjected to smoke whether they want it or not.
It is about time the views of the silent majority are listened to. and not just those who shout the most!

Yours sincerely

Sam Butler

SUBMISSION FROM C CAMPBELL

I wish to support the Bill for Prohibition of Smoking in Regulated area (Scotland) submitted by Mr Stewart Maxwell MSP

C Campbell

SUBMISSION FROM MARTHA CAMPBELL

I think that smoking should be prohibited in all public places as I think it is a danger to my health and other non-smokers. I also feel that my choice to not smoke should be respected. Smoking causes my clothes and hair to smell and I think this is disgusting and I should not have to put up with this as I have chosen not to smoke but this is not the case as others around me who smoke cause this to happen.

Martha Campbell

SUBMISSION FROM W A CARMICHAEL

As an asthma sufferer I would urge the committee to pass Mr Maxwell’s bill The Prohibition of Smoking in Regulated Area’s.

I also think it would be beneficial to those people that work in these areas, it would also benefit non-smoking members of the public that frequent these places and lets not forget the children who are also unwitting smokers in restaurants etc.

I also think the Bill will help to educate and discourage the general public from smoking which is recognised as a health hazard and a drain on our National Health resources.

W A Carmichael

SUBMISSION FROM MARTIN CARR

Member’s Bill to prohibit smoking in enclosed places

My views on the Bill are as follows:

Yes I do support the general principles of the Bill

I would like the committee to extend the ban to all shared rooms, space, offices etc within the workplace.

I am satisfied with the quality of consultation and implementation of key concerns.

I have no comment on the practical implications of putting these provisions in place.

Martin Carr
SUBMISSION FROM DUNCAN CHILD

I would like to state a case against the proposed abolition of smoking in public places. I fully agree with the fact that all constrictions on smoking will lead to a reduction in the number of smokers and therefore better the health of our nation. However, in this day and age those whom do continue to smoke know the damage that they are causing themselves by continuing to do so, and whether through addiction or personal choice continue to do so. I do through personal choice, and I raise the issue that smokers contribute more to the NHS than they generally receive in return for treatment of the associated health problems. Ruling this out as an excuse for the public ban, is there any evidence of market forces pushing venues, particularly the on-trade, towards a ban on smoking. I do not know of a single establishment that has opened as or changed to a completely non-smoking environment within the on-trade due to public demand. There may be examples that I have not encountered and if this is so I would appreciate being made aware of these before the proposed ban comes into effect.

I do fully agree with providing effective no-smoking areas for those whom would appreciate a smoke free environment. However, if we were to impose a ban on smoking in such establishments against market forces, would this not lead us towards a ‘Big Brother’-esque leadership? To what extent can we legislate against individuals who do not conform with the party line? Is there a similar ban being considered against alcohol due to the anti-social behaviour it causes?

In conclusion, I fully agree that non-smokers should not have to suffer the passive effects of those of us that choose to smoke. However, the ostracism of a group of adult, free-thinkers is unacceptable. Therefore a ban on smoking in areas where it is impossible to segregate (ie the Underground, art galleries etc.) should continue to impose a ban. Then again smokers should be allowed to congregate with fellow smokers if they choose to do so.

I would appreciate any comment you have to my argument.

Kindest regards

Duncan Child

SUBMISSION FROM GRAHAM CLARK

I wish to add my support to the resolution banning smoking in all areas in Scotland where establishments are serving food.

SUBMISSION FROM GAVIN CLELAND

The Prohibition of smoking Bill introduced by Mr. Stewart Maxwell MSP, must not, under any circumstances be allowed to fail or the new parliament will have betrayed the Scottish people. This is a groundbreaking opportunity for the new Scottish Parliament to show not only a moral lead to the Scottish people, but also to the rest of the world. The Westminster government should have introduced this law years ago, but due to its darker, sinister and immoral side, decided it preferred to let people die in agony rather than lose money in tax revenues from the tobacco companies; what a truly repugnant way to run a country.

Banning smoking in public places is absolutely necessary if we as a nation are intent on looking after the health and well being of our people so that they can live to enjoy life free of disease and chronic illness which will dog them for the rest of their life and place a huge burden on the health service which we all have to pay for.

Petty arguments on costs by the monstrously evil tobacco industry must be put aside for the greater good of the people of this country. It must be a step in the right direction to eventually ridding mankind of one of the most evil and useless inventions he has ever come up with which kills people by the millions.
SUBMISSION FROM JOANNE COATES

I would like to see smoking prohibited in all public places including restaurants and bars.

I used to work in bars part-time to help fund my studies, and being a non-smoker, didn't find it fair that I had to inhale the smoke from people’s cigarettes. It also left a disgusting smell in my hair and on my clothes.

Now, I like to socialise in restaurants and pubs, and although it is my choice to enter them, it is not my choice to have to inhale the smoke of others. I think it is very unpleasant for non-smokers to be in a smoky atmosphere.

Thanks

Joanne Coates

SUBMISSION FROM CRAIG COCKBURN

Please find below my submission to the committee in respect of the above bill. This submission is from a member of the general public and is not on behalf of any organisation.

1. Do you support the general principles of the Bill and the key provisions it sets out?

Yes

2. Are there any omissions from the Bill that you would like to see added?

Yes, the bill should be extended to all public places, as has been implemented in many other countries already.

With regard to the specific areas of the bill, namely where food is supplied and consumed, this will clearly include all pubs and bars. My background is that I have been campaigning at a UK level for more smoke free areas in pubs since 1990. I have spent 3 years working in pubs and have many years experience of promoting Scotland to tourists. I have sat on the ASH Scotland expert panel on smoking in public places.

Even as long ago as 1990 it was clear this was a long overdue change with the polling organisation NOP finding in July 1987 that non-smokers would visit pubs more often if pubs provided smoke free areas. The Consumer's Association reported in Jan 1988 that smoke free areas were the most wanted change in Scottish pubs. A separate survey also indicated it was the top desired change for pubs in England and Wales.

Having campaigned for the introduction in 1992 of a "smoke free" symbol in the Good Beer Guide for pubs with a smoke free area, I have seen the numbers of such pubs grow, yet they remain a disappointingly small proportion of the total.

16 years have now elapsed since the Consumers Association survey, yet little has changed as regards pubs and smoking. The only notable exception is the highly successful Wetherspoon chain which has a smoke free area in every pub, if only other chains had been similarly enlightened.

I was originally of the view that separate smoking and non smoking areas were the way forward, however 14 years of campaigning have taught me otherwise and now I favour a ban in all public places, the reasons are as follows.

1. The creation of "no smoking" areas is not enough. It is not smoking that is the problem, it is smoke. It is not a no smoking area that I seek when I am out, but a no smoke area. Many is the time I have been out with my wife and children (current ages 3 months; 2 years and 4 years) and found a non
smoking seat only to find smoke drifting over. This hasn't been limited to pubs either but has included
the cafes in shopping centres in Livingston, Stirling and Dunfermline and the restaurant of Sainsbury's
Blackhall in Edinburgh. I do not consider it acceptable to expose very young children a few months
old to unfiltered second hand smoke when doing essential shopping. I also do not consider it
acceptable that they should see people smoking or become acclimatised to the smell in any way as
this could make the habit more appealing as they grow older. I am very much of the view that
anywhere that children are permitted, smoking must be completely banned. This certainly covers
cafes, restaurants and pubs with children's certificates.

2. The Health and Safety Act and the Common Law Duty of Care both require that workplaces be
safe. Clearly this covers employees who work in pubs and other places where food is served. As
former bar staff myself, I do not accept that I should not need to accept a workplace where there is in
an increased risk of contracting lung cancer through secondary smoking. The majority of us now
enjoy smoke free workplaces and employees where food is served deserve no less. The Froggatt
Report, Mar 1988 (Independent Scientific Committee on Smoking and Health) concluded that there is
a 10-30% increased risk of developing lung cancer if you are a non-smoker exposed to other people's
smoke. It is unacceptable, especially given Scotland's poor record on health, that there are still
substantial numbers of employees spending many hours per week in places where cancer inducing
chemicals in the air are considered by their employers to be normal and acceptable. If this was any
other toxic substance we would not be having this debate, a ban would have been put into place long
ago already.

3. Having the current voluntary approach is no longer working nor making significant headway. It has
simply created a small minority of pubs with no smoking (rather than no smoke) areas. This allows
other pubs to just continue as before.

4. There are significant economic benefits as well as health benefits to having a ban where food is
served, as ASH reports here:http://www.ash.org.uk/html/factsheets/pubplacechron.htm "A Shropshire
publican reports that turnover has increased by a third since a ban on smoking was introduced 18
months ago." By catering for the non smoking majority rather than the smoking minority, pubs and
restaurants can widen their customer base and appeal to more customers. This not only means that if
we want to eat as a family we will have more choice besides McDonald's, Burger King, Tesco and
Pizza Hut. Instead, we will be able to choose from small independent cafes, from bars catering for
children and from more local owner managed businesses rather than large chains. There is also a
benefit for tourism, especially from North American tourists, who in 2002 spent 294 million pounds in
the Scottish economy, reference: http://www.scotexchange.net/know_your_market/tis5.htm These
visitors, used to smoking bans in their own countries, expect no less when they come here and with
other countries (especially Ireland) introducing bans, Scottish Tourism will lose out if visitors consider
Scotland to be dirty and smelly in comparison to alternative destinations.

I close with the following recent quotes from the BBC website which hopefully emphasis the argument
from an independent point of view:

"The scientific evidence is now clear. We need clear legislation which prevents smoking in the
workplace and in enclosed public places. The time for excuses and half measures is gone."

"In the UK, passive smoking is estimated to be responsible for 1,000 deaths each year."

"More than three-quarters of people questioned for a BBC poll want a ban on smoking in public places
in Scotland."

I trust this information has been of use to you in considering the Bill before parliament.

Craig Cockburn
SUBMISSION FROM FRANK COLDWELL

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am an interested individual and would like to comment on the bill.

Do you support the general principles of the Bill and the key provisions it sets out?

Yes.

Are there any omissions from the Bill that you would like to see added?

I would like to see prohibition of smoking in all public spaces, but accept that this bill could provide a stepping stone toward that ultimate goal.

What are your views on the quality of consultation, and the implementation of key concerns?

No views.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

As mentioned, I would favour a complete ban.

I think the area of most concern to me is bars and restaurants/ cafés, since most other places are relatively smoke free. Obviously restaurants and café must continue to serve food, but a bar might stop doing so. I wonder about the definition of food - this is obviously to preserve the ability of, for example, bar owners to serve such food, but on one view that is not really a logical distinction. It might well be the case that there could be some debate about the breadth of the exclusion from food. In fact, I am not sure why consuming drink is an activity that requires less protection from smoke than consuming food. I would favour the protection of areas for the consumption of drink too - particularly non-alcoholic drinks.

However, my concerns are minor compared with my overall support of the bill.

SUBMISSION FROM AINE COLLINS

I support anything that will reduce smoking in public places. The majority of people don't smoke and shouldn't have to be exposed to the dangers and the smell of smoke. Amongst the smokers, many are trying to give it up and the most difficult place to give it up is at the pub or café, a ban would help these people and I'm sure have their support. The hardened smokers will have become ill and died in the next 20 years anyhow, so why not make the leap and ban it. I used to smoke at home and at work. The first step for me was when it was banned at work and my housemates banned it from the house, my smoking friend moved away and all I had to deal with was the withdrawal. Ireland has banned it and it seems to have gone quite well. I look forward to going out for the evening and not having to wash my hair before I go to bed because of the smell!
SUBMISSION FROM KEITH COLVER

I wish to add my support for a total ban on smoking in public places.

We need to act now to protect the innocent majority of people living, visiting and working in Scotland who are exposed to the proven dangers of other peoples tobacco smoke.

Regards
Keith Colver

SUBMISSION FROM FRANK COPPINS

We fully support any proposed smoking ban, similar to the one in Eire

Frank Coppins

SUBMISSION FROM LINDA CORMACK

I wish to register my support to Stewart Maxwell MP's Bill to prohibit smoking where food is consumed. It is absolutely disgusting that people have to suffer from other peoples smoke when dining out. I feel all smoking should be banned in public places and fully support this well overdue bill.

Mrs Linda Cormack

SUBMISSION FROM JAMES CORMACK

I am writing to support the Member's Bill to prohibit smoking in enclosed places where food is served ie and consumed.

There is overwhelming evidence from the World Health Organisation the passive smoking kills and maims people. There is conclusive evidence that passive smoking increases the risk of an acute coronary event by 30%, it increases the risk of lung cancer by 25%, and there is substantial evidence that it can cause a stroke.

My wife is allergic to cigarette smoke so this limits drastically our choice when eating out. We travel widely and this measure has been introduced in many cities worldwide. From New York to Dublin there has been no noticeable drop in tourist numbers or in trade in general because of the introduction of this measure.

I, therefore, would like to register my support for the general principles of this bill.

James Cormack

SUBMISSION FROM CHARLIE CROFT

I fully support Mr. Stewart Maxwell's anti-smoking Bill.

I make a good earner out of cleaning off nicotined stained surfaces in pubs, houses etc. Try to clean a pub ceiling prior to painting and the filthy tarry muck that coats the surface (and your lungs) would make only the most suicidal want to smoke.

Charlie Croft
SUBMISSION FROM ROSS CROOKS

I wish to support a ban on smoking in public places including restaurants and pubs. Having a social life should not mean also having to subject yourself to other people's smoke - it is extremely unpleasant, unhealthy and makes yourself stink also.

Regards

Ross Crooks

SUBMISSION FROM CHRISTINE CUMMING

I wish to register my support of a workplace smoking ban/public places smoking ban.

SUBMISSION FROM JACQUELINE DALRYMPLE

I would like to take this opportunity to express my support for the above bill as I believe it is a very important piece of legislation. In view of Scotland's appalling health record and the links that can be made between this and the high prevalence of smoking within our society, I believe it is imperative that the Scottish Parliament takes a leading role in discouraging smoking, particularly in public places. We can no longer plead ignorance of the effects and the harm caused by passive smoking and we must therefore take steps to protect the public from such harm, if we are to have any hope of improving the health of our society. For those who work in bars, pubs and restaurants, they must be protected in the workplace from the harms of passive smoking. No one's health should be put at risk in the workplace, regardless of the sector in which they work.

With my first child soon to be born I am keen to see the curtailing of smoking in public places so that my children will not be subjected to the harms of passive smoking. Future generations should be able to consider that their right rather than a mere luxury.

Regarding the quality of consultation on this matter; the consultation only came to my attention as a result of being informed by one of my regional MSPs. I think that more publicity should have been given to the consultation process as I feel that it is an issue on which many people will have strong views and one which would have received widespread support across Scottish society.

I trust that my views will be taken into consideration.

Yours faithfully

Jacqueline F Dalrymple

SUBMISSION FROM DR ALISTAIR DORWARD

I write to support the above Bill to prohibit smoking in regulated areas. I write because as a respiratory physician of 25 years I see on a daily basis the terrible suffering of patients who have smoked - we see 180 patients with lung cancer here in Paisley; 95% and more were or are smokers. The majority are dead within the year and the outlook for these patients has not really improved in my time - more get treatment which has improved and become targeted, but the outlook is really no different.

Even worse than this is COPD (chronic bronchitis) with 600 to 800 admissions a year to this hospital alone. The public does not really realize that this is the 4th commonest cause of death in the western world and solely due to smoking. This disease brings huge suffering on patients who can have extreme breathlessness on any exertion or even at rest.

Of great concern to me is the rise in women with smoking related disease. When I started in the late 70s it was much rarer to see smoking related respiratory disease now my ward is mainly filled with
woman with lung cancer, COPD and other smoking related diseases many of whom are still unable to give up the habit. Yet again this week from the BMJ of 24.4.04 there has been another publication from New Zealand proving that non-smokers die from passive smoking.

We hand out nicotine substitutes and have smoking cessation classes but these are trifling measures to deal with smoking and have barely any effect on the population at large. All great public health measure are carried out by political action. Banning smoking in certain public places will have a significant effect on the health of Scotland - much more than I can in my professional lifetime.

I urge you to support this Bill.

Consultant respiratory Physician
Royal Alexandra Hospital
Paisley

SUBMISSION FROM IAN DUFF

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am in favour of this bill as a first step towards the greater protection of non smokers from the health affects of other people's smoke.

Given the existing medical evidence I feel that a shift is needed to change people's attitudes towards passive smoking. At present most smokers feel they have the right to impose their smoke upon anyone who happens to be in their vicinity. This is not only highly unpleasant for the passive smokers but is also harmful for their health. It is impractical to expect people to regulate their own surroundings and this is where the legislation comes in. Smokers are effectively using offensive weapons against innocent bystanders. Many will also take offence if asked to refrain from smoking. People who simply wish to breathe relatively polluted air need some form of protection.

Having lived in Spain and the US I have seen both extremes in terms of public acceptance of smoking. I now find that in Spain my enjoyment of the country is often ruined by the presence of other people's smoke. I certainly believe that Scotland would benefit from moving closer to the US model whereby smoking is increasingly viewed as a dangerous and antisocial activity.

To reiterate; I support the bill as a first step towards the greater protection of non-smoking citizens. Encouraging people to live a healthy lifestyle, but failing to protect them from people who contaminate the very air they breathe, just makes no sense.

Ian Duff

SUBMISSION FROM J B ELLIOT

I fully support the Bill. My wife was a smoker but since separating I have really enjoyed not being subjected to tobacco smoke and would not now knowingly eat where smoking is permitted. However smoke can drift from other areas and some people ignore polite notices so regulation is necessary.

Regards

Councillor J B Elliot
SUBMISSION FROM ATHOLL FALCONER

I would like to record my support for the general principles of the bill.

Mr A G Falconer

SUBMISSION FROM LYNN FARDELL

In response to the above, as a taxpayer and smoker I am concerned with the proposed Members Bill and the overall cost of trying to administer such a Bill. The somewhat depleted and over-worked police force is fighting a losing battle with crime in Scotland. The police are at present stretched to the limits trying to keep speeding motorists off the road, resulting in more serious crimes remaining unsolved.

This Bill would cause unnecessary irritation in the public sector and problems for businesses. As a smoker I enjoy a cigarette when on licensed premises, but of course, I respect non-smokers, as they respect my right to enjoy a cigarette.

Please lodge my objection to this Bill

Lynn Fardell
Silver Sands Leisure Park
Lossiemouth

SUBMISSION FROM BETTY AND STUART FARQUHARSON

Having had a family member who was a heavy smoker and who died at an early age from smoking related cancer, we are delighted that Stewart Maxwell has put forward this bill and give it our wholehearted support.

All too often eating out is spoiled by people adjacent smoking and clothes are left reeking from stale smoke, goodness knows what it is doing inwardly.

We do hope that this bill will be carried and that our country will become a healthier place to live in.

SUBMISSION FROM NORMA M FEE

I would like to support the above Bill put forward by Mr Stewart Maxwell to prohibit smoking in enclosed places, especially where food is supplied and consumed.

My husband died five and a half years ago with cancer of the bladder and lungs - all due to smoking. (Unfortunately of his own choice). I have an asthmatic grandson and I know smoke aggravates his condition whilst in enclosed spaces.

I have never smoked and I detest having a meal with other peoples smoke wafting over my food. I know we cannot choose what others do with their lives, however it may help them to stop if more establishments were smoke free.

SUBMISSION FROM IAIN M FORBES

I write to advise that I am very much in favour of the aims of the above Bill. In particular I favour the ban on smoking in areas where food is consumed as the latest medical evidence appears to confirm, without doubt, that passive smoking is harmful to people of all ages. The particular risks to asthma sufferers have been highlighted and the Bill would reduce the danger of attacks to this group of people.
The long term benefits to the health of the population at large are undoubted and the eventual financial savings to the N.H. S. would be significant, allowing the money allocated to it to be spent on any number of conditions which may currently be deprived of funds to cater for smoking related illnesses.

I sincerely hope that the Health Committee will give its full backing and support to this Bill.

Iain M Forbes

SUBMISSION FROM GORDON C FORD

Dear Sir

I hope that this bill succeeds . My son worked as a barman (don’t they all) when he was a student. About 8 years later and only a year after he was married he had throat cancer. He does not smoke. And the Beatson think he got it thru his student job working in a pub.

Thankfully it has cleared up (fingers crossed) but he still goes to the Beatson every six months.

The cancer rate in Scotland is totally appalling and the medical pro need all the help they can get.

Surely it is the duty of the Scottish Govt to aid them in their task.

Lets pray that this bill is successful.

Gordon C Ford

SUBMISSION FROM VICTOR FORRESTER

I would very much like to see Stewart Maxwell's Bill to stop smoking in public places become law in Scotland.

SUBMISSION FROM MR & MRS D FORSYTH

To whom it may concern:

I write to voice my support for this proposal currently being introduced as a member's bill by Stewart Maxwell MSP.

SUBMISSION FROM SHARON FRANCE

The Prohibition of Smoking In Regulated Areas (Scotland) Bill

In response to the above request, below is my feedback on the requested points.

Firstly, having read both the Policy Memorandum and the Bill, I can confirm that it gets my total backing and feel assured that it covers all the necessary points to bring this law into practice.

Do you support the general principles of the Bill and the key provisions it sets out?

Wholeheartedly yes! Since coming back from Australia in January 2003, where smoking is banned in all public places, I am much less tolerant of people lighting up in restaurants. Certainly if the Regulated areas were law, it would make eating out a much more pleasurable experience. I also
agree that there should be a severe penalty otherwise it will not be taken seriously. Aside from where food is consumed an example of the law being flouted is in Lothian buses where smokers continue to defy this and smoke on the top deck.

Are there any omissions from the Bill that you would like to see added?

Not at this stage.

What are your views on the quality of consultation, and the implementation of key concerns?

The consultation appears to have included all the relevant parties however, I would like to see clear public information displayed in a variety of media in order that people understand and support the proposed regulation (refers to Q.8 no.68 Policy Memorandum).

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

I would propose that by penalising the proprietors as well as the smokers this should reduce the anticipated non-compliance. (Refers to Policy Memorandum, pg.8, point 48).

I would not accept that Air treatment systems would be a suitable alternative as this would not help to bring about a change in attitude e.g. people still seen to light up whilst non-smokers next to them are consuming food. (Refers to Policy Memorandum, pg.12, point 83).

I would accept a ban in all public places as being more considerate of non-smokers who work in bars and clubs, a lot of whom are students trying to make extra money whilst at university and who do not have a great deal of choice where they can earn this extra money. (Refers to Policy Memorandum, pg.13, point 89).

I do not agree in maintaining the status quo as this clearly shows a `dithering government' and one, which clearly does not fully accept the issues at hand. Clearly, the voluntary charter does not work and unless it is law totally and unequivocally, proprietors will continue to flout the laws in order to gain financial reward. (Refers to Policy Memorandum, pg.13, point 91).

Sharon France

SUBMISSION FROM CRAIG FRANCE

I am writing to support Stewart Maxwell's `Prohibition of Smoking in Regulated Areas Bill'. This is based on my own experience of the negative impact of passive smoking on me both in the present as a restaurant diner, and in the past as an employee in a Pub.

1. Experience as an Employee exposed to smoke

In my early 20s I worked for a couple of years as both a part- and full-time Bartender in a number of Pubs in Melbourne, Australia. While that is now over 20 years ago, the memory is still vivid of coming home after an evening shift at the Pub with my clothes and hair reeking of cigarette smoke. I would often experience a hacking cough for an hour or so after I'd left the Pub but I kept myself very fit through running and swimming so figured I was counteracting the adverse effects of the amount of passive smoking I was doing on the job. Such side-effects were just accepted as part of the job.

However, I now experience a mild form of asthma which results in a dry persistent cough whenever I encounter any sort of irritant, be it dust or cigarette smoke and although no causal link can be proven between my exposure to smoke in the work-place on an almost daily basis over a 2-3 year period, I think it's fair to suggest that a possibility exists of such a link, the long-term effects of which could be even worse.
For much of the time I was working in this environment, it was out of necessity in order to support myself while undertaking tertiary studies during the day. In retrospect, I resent the fact that in order to obtain part-time work to make ends meet as a student, the only option open to me at that time was to work in an environment that was damaging to my health. My experience has left me with a deep empathy for those young people I see having to work in this same unhealthy environment in Scotland today.

2. Experience as a restaurant diner

I believe there is supposed to be some sort of voluntary code in place regarding the allocation of non-smoking areas in restaurants. My experience is that this amounts to little more than tokenism. As air, and therefore smoke, does not respect arbitrary lines of demarcation on the floor, the concept of non-smoking areas side-by-side with smoking areas is ludicrous. Any High School biology student knows that the sense of `smell' is actually a key constituent of what we experience as `taste'. As a non-smoker, it takes only a small amount of smoke in the air to noticeably taint the `taste' of a meal. So aside from the well-documented negative health impact of passive smoking, the actual enjoyment of the meal is significantly reduced by even a relatively low level of cigarette smoke.

My wife and I always make a point of requesting a non-smoking area but there is often no such thing. This is not acceptable.

3. Experience of success of Australian smoking ban

My wife and I have made a couple of visits to Australia in recent years and have been hugely impressed by the absence of cigarette smoke in restaurants and indoor areas in general. Proprietors of restaurants, coffee shops and pubs with whom we spoke were universal in their declaration of the success of a legislation-driven approach. They believed that it created a `level playing field' and reported that even smokers were largely in favour of it as it provided them with an incentive to cut back.

The result is that my wife and I found that the pub or dining experience in Australia is way ahead of that in Scotland.

4. Final Statement

It's obvious that we're not going to be able to protect people from every known carcinogen but there are certain steps we can take to at least incrementally roll back our exposure to them. Given the acknowledged death-toll and health impacts caused by smoking, I couldn't help but be cynical of a Government's motives for not taking such a simple public health measure as that proposed in Mr Maxwell's Bill. After all, Governments make big money from tobacco tax revenues so they're hardly going to want to dramatically ruffle the feathers of this goose that lays the golden eggs.

Why does the Government ban hard drugs? Presumably because they're addictive and harmful to the health of the user. With smoking we've got an addictive drug which is not only harmful to the user but to everyone else around them, with an annual global death toll of Holocaust proportions. It would seem to be a little inconsistent to then take no action to protect the public from smoking, particularly when it effects more than the immediate user.

The `democratic rights' and `freedom of choice' of smokers are expressions which seem to get a lot of airplay in this sort of debate. But I'd like to be able to eat in a restaurant without having my meal spoiled by some other diner exercising their "freedom of choice" to smoke and damage their health, thereby negating my "freedom of choice" not to.

As far as the hospitality industry's fears over loss of trade from a smoking ban are concerned, a simple example can perhaps illustrate how this is a two-edged sword. Last Sunday my wife and I went for a walk from our flat in Newington to Klondike Garden Centre at Mortonhall. We returned past the Stables Bar, a nice cosy pub with an open fire, which serves good food. We would have liked to have stayed for a meal and a pint of Guinness but the strong smell of cigarette smoke put us off and we
decided to go home instead. When we got home, we phoned four Italian restaurants but none offered a non-smoking section so we decided to stay in and cook instead! So that was five potential eateries who missed out on our business that evening because they placed the rights of smokers ahead of those of non-smokers. We're not particularly 'bolshie' people but Mr Maxwell's Bill has helped raise our awareness of the negative health effects of smoking sufficiently that we're no longer prepared to compromise our health for the sake of a night out. We're not unusual either and have friends and family who will definitely avoid eateries that allow smoking.

Non-smoking areas in restaurants are something of a joke as well, given that airborne smoke fails to recognise any arbitrary line on the floor demarcating smoking from non-smoking areas. Air filtration units seem to be of little benefit in my experience. In fact one particular pub/restaurant in Edinburgh (Montpeliers) seems to have one of these but never bothers to turn it on! I know a number of people who no longer frequent this place because of its excessively high smoke levels!

I endorse this Bill wholeheartedly and look forward to its becoming law. I'm certain that we'll look back in 5 years time, much as the Australians do, with a sense of disbelief that there was a time when staff were expected to work in smoke-filled environments and diners were expected to simply put up with people lighting-up at a neighbouring table.

Craig France

SUBMISSION FROM ALAN FRASER

To whom it may concern

I absolutely support the general principle. Scotland is often deemed the ‘sick man of Europe’ and it is about time that rather than complain that we take action for ourselves. We expect the NHS to solve the diseases caused by smoking to not only smokers but also to passive smokers but at what cost? The amount of money and resource spent on simply solving the current problem is simply draining the country of valuable resources not only money but quite simply its people. Currently 30% of the population smoke and nearly 40% of people aged between 20-34 smoke so the issue is not going to go away.

By banning smoking in certain public area’s will hopefully raise awareness throughout the population and people will finally stand up against the dangers of passive smoking. Most people I know have no problem with people smoking but are against smokers who light up when it suits them with no consideration for others, whether it is in the street, whilst eating or next to children. If they want to do in private then fine but why should the majority of the population be forced to accept something we don’t want by the minority. Smoking and Non-smoking area’s simply don’t work the air conditioning systems cost too much money and are inefficient - you still smell the smoke and you can still see the smoke ‘invade’ the non smoking area’s.

The majority of smokers that I know have no problem with not smoking where food is served and in fact suggest that it is a good idea, in some cases they suggested that by having to think where they can / cannot smoke would help them to try and finally stop smoking… If it can encourage people to stop smoking and potentially save lives then it can only be a good thing.

I don’t know anyone who enjoys someone smoking over their food whilst eating. I don’t know anyone who would want someone smoking into their children’s faces and I certainly don’t know anyone who wants to die from someone-else’s smoke.

If it can help save lives…then surely this should be supported.
We live in a democratic society, 30% of the population smoke, 70% therefore do not, why not put it to the vote and see how many would prefer a non smoking environment for themselves and their children!!

Thank You

Alan Fraser

SUBMISSION FROM P GIBSON

Re Member’s Bill to prohibit smoking in enclosed places where food is served.

I am writing in support of the above Bill.

I am age 75 and have never smoked. I was afflicted by a lung disorder two years ago which I attribute to the affect of passive smoking.

P Gibson

SUBMISSION FROM MR R GIBSON

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

General Principles of the Bill

I would like to indicate my very strong support for the principles and key provisions outlined in this bill. It is time that the Scottish Parliament took a proactive approach to dealing with the number one health issue in Scotland.

As the Chief Medical Officer, Dr Mac Armstrong, notes in the "Health in Scotland 2003" report, chapter 2 (http://www.scotland.gov.uk/library5/health/his03-03.asp), the majority of people in Scotland no longer smoke and should be protected from the harmful effects of exposure to tobacco smoke. The evidence for the harmful effects of passive smoking is well established. The International Agency for Research on Cancer notes that "Even the typical levels of passive exposure have been shown to cause lung cancer among never smokers." (http://www.iarc.fr/pageroot/preleases/pr141a.html). Again in the Scotsman newspaper earlier this month a summary of various pieces of international research have shown that even just 30 minutes of exposure to second-hand smoke can damage the lining of the blood vessels supplying the heart (http://news.scotsman.com/features.cfm?id=415112004).

Given the seriousness of this issue and the devastating effect it is having on both smokers and non-smokers, I believe that strong, decisive action has to be taken. While the Voluntary Charter introduced by the Executive was well intentioned, it is clear that is not being effective (http://news.bbc.co.uk/1/hi/scotland/3130652.stm). If Scotland is to shake off the ‘sick man of Europe’ label the Scottish Executive must be willing to show the strong, proactive leadership that Ireland have recently shown in banning smoking in all places of work.

Omissions from the Bill

While I feel that the bill being passed in its current form would be a great step forward for our country, there are a few areas that I believe could be improved.

Firstly, it would be beneficial to extend the regulated areas to include all places of work (as they have done in Ireland) as opposed to just public places. Related to this, I see no reason for an exemption to exist for public transport vehicles. On the contrary, it is even more important for smoking on public transport to be banned as, for many people, there is often no choice at all in the means of public transport they can take to commute to their workplace (or for other purposes). With other public
places there is generally a choice (e.g. in which restaurant to go to) and smoky venues can be avoided. With public transport this is not usually the case. If the Scottish Executive is serious about encouraging increased use of public transport then this is one case where ‘joined up thinking’ is required. The very first priority must be in making public transport safe and that includes providing a smoke free environment (especially considering the research mentioned earlier which found that even 30 minutes of passive smoking causes damage). I am aware that smoking is generally not permitted on public transport at the moment but, as a frequent bus user, I am very aware that it happens constantly.

The last omission that I would like to mention is the issue of smoking in the entranceways to public places. I’m concerned that, should this bill be passed, there may be a significant rise in the number of people smoking in the entranceways of public places. I believe the majority of people find it very irritating to have to ‘run the gauntlet’ of smokers in order to enter a building and would suggest that some inclusion be made in the bill to deal with this.

Consultation

The main comment I would like to make about the consultation process is more of a request that the voice of the Scottish people should be heard above the voice of the tobacco industry because the Scottish Executive and Parliament exist to serve the people. In line with that I would urge that the position of both the British Medical Association and Scotland's Chief Health Officer be given appropriate weight as representatives who have the interest of the public at heart rather than their own profits.

I would expect that a reasonably high proportion of the public is not aware of the consultation process for this bill. I believe it would be appropriate therefore, to give consideration to independent surveys and polls that show the general will of the public. In a recent survey for the BBC it was found that 77% of people in Scotland supported a smoking ban as opposed to a UK average of 73% - this despite the fact that more people in Scotland smoke than in the rest of the UK (http://news.bbc.co.uk/1/hi/scotland/3562701.stm). There is a determination among the Scottish people to deal with this issue that I hope will be reflected in the Scottish Parliament.

Other objective statistics are also relevant to this consultation. Currently in Scotland approximately 31% of the population smoke. As Dr Mac Armstrong, notes in the "Health in Scotland 2003" report, about 70% of those smokers want to quit. That means that 91% of Scots either do not smoke or would like to not smoke.

Practical Implications

I do not believe that there is anything in this bill that cannot be successfully implemented. The tobacco industry and some parts of the hospitality industry often cite objections that a ban of this sort is impractical and that it will have a detrimental affect on pubs and restaurants. Neither objection is based on fact.

With regards to the practical implementation of this bill, the precedent has already been set with smoking bans in place in many areas of the USA, Canada, the whole of Ireland and very shortly, Norway. It's difficult to argue that the regulation of smoking proposed is impractical when it is already being done in other places.

Norway:http://news.bbc.co.uk/1/hi/health/3210185.stm)

The second common objection is that of negative economic impact on the hospitality industry. Unfortunately (for the smoking lobby), this too is not borne out by the facts. The most current, relevant study is perhaps that commissioned by the Office of Tobacco Control in Ireland that concludes that “the weight of evidence is that smoking bans have little or no effect, in aggregate, on sales in the hospitality sector” (http://www.otc.ie/article.asp?article=192). This report also quotes the work of Joe
Durkan and Moore McDowell who analysed approximately 100 research papers and concluded that ‘policy makers could proceed with smoke-free regulations secure in the knowledge that there would be no adverse business impact’.

Other studies in the USA and Canada further confirm these conclusions and point to either no impact from smoking bans or an improvement in business. (http://www.breath-ala.org/html/work_anr.htm)

I think it is clear that a smoking ban is both very practical and very necessary. I am further convinced that any attempt to dilute the strength of this bill will ultimately cost more lives of the people of Scotland, both smokers and non-smokers.

SUBMISSION FROM DAVID GILLHAM

As a non smoker I am opposed to such a ban for the following reasons:

1. Prohibition simply does not work

2. It is hard to see what benefits can really be gained from such prohibition. Smoking does not directly cause cancer but is, rather, a "helper" (i.e. a carcinogen). If ALL carcinogens were to be banned then I could see the point but they are not (specifically diesel fumes). Even then, finding the real cause of cancer would, in my opinion, be something we could better direct our energies towards

3. "Nanny State" and "dictatorship" will be the reaction of many. People who are determined to smoke will continue to do so and tempers will flare on both sides, especially where those who feel aggrieved that their right not to breathe other peoples smoke is being undermined when the inevitable refusal to obey the new law happens (look at smoking in buses right now -that still continues despite the law). Yet theirs would only be a false sense of security in any case (i.e. they would not necessarily be better protected from catching cancer simply because there was a public smoking ban if other atmospheric pollutants are not also banned at the same time)

4. Such a ban could not possibly be intended to actually stop people smoking. That could be achieved far more effectively simply by banning the manufacture and sale of tobacco products. However, a true reduction in smoking would cause a dramatic drop in government revenues with resultant rises in general taxation to compensate

Hope this point of view is useful to you

David Gillham

SUBMISSION FROM MYRA GRAHAM

I have looked forward to a ban on smoking in public places for many years and am excited about the prospect becoming reality. Here are the reasons I am in such favour:

Only 30% of adult population are smokers

- So why should the rest of the 70% be subject to passive or second hand smoke? Not only is it a health hazard but it makes your hair and clothes smell bad too! I have been forced to end good nights out early due to excessive smoke inhalation.
- Ventilation systems specifically designed to reduce smoke levels are expensive and put pressure on the environment when a simple ban would eliminate the need for a high tech solution.
- Of those 30% - at least 50% are trying to quit. By removing the temptation to light up in restaurants, it is easier to quit than if other smokers surround you.
- The government is spending money on campaigns to encourage smokers to quit - this step would be in line with this message
There is overwhelming evidence that second hand smoke is just as dangerous to your health, perhaps more so, than directly inhaled smoke. By banning smoking, you are protecting the general public from this danger.

- A ban would also protect the staff and would give greater choice of work places for everyone.
- With a catering background, I refused to work in smoke filled areas; therefore I was restricted to which places I could work in.
- In Canada, there are the first law suits against employers where staff are able to prove they never smoked, yet have developed lung cancer from passive smoke. I hope we never have situations like that here. I don't agree with lawsuits being the driving force behind laws - common sense and government caring for the well being of its citizens should be the driving force.

Voluntary bans are nice in theory but they have no muscle when it comes to enforcement. This legislature would enable the public to stand up for the right to clean air (especially in confrontational situations).

There is evidence that business actually increases in non-smoking establishments (see attached article).

- Although I do not have hard statistics, I have noticed in the restaurants I frequent, those that have banned smoking have become busier. Some owners are reluctant to enforce such a ban for fear of losing custom, however, a legal ban would take away this fear.
- It would also make a level playing field so that everyone had access to places, not just those that offer non-smoking.

As it is now, it could be argued that it is discriminatory NOT to ban smoking in public places, especially where food is served. Smoke filled premises are propitiatory for people with asthma and other breathing related disorders. It is also medical fact that children are far more likely to develop asthma when exposed to passive smoke and since they usually don't have a choice, it is even more vital that the law protects their interests. Since the government sees fit to require suitable access to public places for the disabled such as ramp, parking spaces and toilets as a right, surely it can be argued that the public have an equal right to clean air in public places.

I trust that you will consider my views on the ban of smoking in public places, especially where food is served and look forward to one day enjoying days out without the stench or hazard of other people's smoke.

Thank you

Myra Graham

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SUBMISSION FROM MEAGAN GRAHAM

The topic of banning smoking in public places is one of the most controversial issues at present. Some people refuse to confirm their favour or otherwise of a ban on smoking in public places, as they are not sure what this ban would entail. To clarify, a public place is an area or building open to the people as a whole (including restaurants, bars and pubs and so on).

Many smokers feel that it is their right to smoke, where ever they choose. They say they can not fully relax without their cigarette and they know of all the risks to their health, but decide to pay them no attention and are entitled to do so. Numerous people however, dislike smoking and many feel it should not be allowed in their presence, due to both the obvious and less obvious health risks, violation of their rights to clean air and so on. Nonetheless, the question still remains; should smoking in public places be banned in Britain?
The main risk associated with smoking is health. It is a fact that if you smoke, the chances of contracting heart disease, cancer and other respiratory problems significantly increases. This should be enough grounds to introduce a ban, as anything this hazardous to health should not be allowed to continue, where more health-conscious others congregate.

Most smokers admit that there are serious health risks, but some state that they wish to continue to smoke, even though they know of all these dangers. They argue that there are numerous dangers in other recreational activities - such as extreme sports - and they take these into account, but these dangers do not deter them.

This is a fair argument; however they are not taking into consideration the risks to other people, due to second-hand smoke. Statistics regarding the effects of second-hand smoke have been emerging more and more rapidly over the last few years. In a study published by the U.S. Environmental Protection Agency (EPA) it is reported that second-hand smoke is responsible for approximately 3,000 lung cancer deaths each year in non-smoking adults and impairs the respiratory health of hundreds of thousands of children. It is estimated that 200,000 to 1,000,000 asthmatic children have their condition worsened by exposure to environmental tobacco smoke and new cases of asthma have presented in children, who have not previously displayed symptoms.

A ban on smoking in public places would greatly reduce these numbers, as many people would no longer be subjected to tobacco smoke, while they are out to dinner, socialising in pubs and so on. In my opinion, if smokers wish to continue to smoke and ignore the health warnings, they should be allowed to do so, but not where it endangers others, who do not.

Another issue brought up with the proposal of a ban on smoking in public places is infringement of rights.

Many smokers argue that they have the right to smoke and if they desire to smoke in a public place, for example in a restaurant, then they have the right to do so. They feel that if someone wishes to be in a smoke free environment then they should look for a place which is either non-smoking or has a non-smoking section.

Non-smokers maintain that they have the right to clean air and should not have to be subjected to serious health risks. They feel they should not have to search for the few non-smoking places in their area, simply because the minority of people choose to disregard the health warnings they try to pay attention to. Only 30% of the population smoke; why therefore, should the majority have to accommodate their harmful habit? And what about the people who work in these smoke-filled pubs, restaurants and so on? They also have the right to work in a safe environment; free from health risks, such as smoking. Not all of the people working in these atmospheres have the option of working else where, as there is a limited number of smoke-free restaurants and fewer bars.

A ban on smoking would support the majority's decision not to smoke and would also protect those who have no choice but to work in a smoke-free environment.

In my opinion a ban on smoking public places would improve the atmosphere for everyone, smokers included, as not only is smoke harmful to health, but destructive to surroundings.

Finally, many disagree about the extent to which they can relax, with or without smoking.

Those who smoke, feel they cannot fully relax in social situations and so on, if they are not allowed to smoke. They feel, therefore that a ban on smoking in public places would upset their means of unwinding.

On the other hand, the reason they feel such a noticeable relief when they smoke is because they are in fact relieving their nicotine withdrawal symptoms. This purely highlights the addictiveness of cigarettes and cigars. The fact of the matter is that 70% of smokers are trying to quit. A ban on smoking in public places would remove the habit of lighting up when socialising. This would consequently help smokers quit, as part of giving up smoking is breaking the patterns the smokers get
into when they light up. Non-smokers also argue that they cannot fully relax when someone else is smoking, as they do not like it and would rather not be subjected to it, while they are trying to chill out. I think a ban on smoking in public places would not only help many smokers kick the habit, but also ensure that non-smokers can feel at ease in their surroundings.

As a confirmed non-smoker, from a mostly non-smoker background, I find smoking a truly unpleasant habit and would feel much happier and healthier if I encountered the same smoke-free air when out as I do at home. Smokers cannot dismiss the obvious health hazards posed to both themselves and the surrounding public. It is true they have the right to smoke in most public places; however, they take no responsibility for the other people they endanger. They are the minority, yet the majority have to put up with their unhealthy decision. Over half of those who smoke want to give up and a ban on smoking would help many to break the habit of lighting up on a night out, for example. I conclude, therefore, that a ban on smoking in public places would benefit more or less everyone.

**SUBMISSION FROM DAVIE GRAHAM**

I would like to see smoking banned in pubs and restaurants.

Many thanks

Davie Graham

**SUBMISSION FROM EVAN GREGG**

The Scottish Parliament's Health Committee has invited comment on a number of aspects of the above Bill, falling into the following general areas: general principles, omissions, quality of consultation, the implementation of key concerns, the practical implications of putting the proposals in place, and consideration of alternative approaches. I welcome the opportunity to contribute to this process. This response will address only the last two of the areas outlined.

The provisions in the Bill, Section 1 (Regulated Areas) subsections (1) and (4), will compel owners and managers of any commercial property (restaurants, public bars, clubs etc) or community facilities (such as parish halls) at which food is served to impose a complete ban on smoking at those locations. A local smoking ban would be required because of the "prescribed period" of five-days before food supply and consumption, during which smoking is not permitted.

This is contrary to the accompanying "Policy Memorandum" paragraph 39, which claims that the "prescribed period" should allow flexibility to vary the use of premises. However, in practical management terms, the only way to ensure that even a single patron would not have smoked a single cigarette for five days prior to an event would be prohibit smoking at any time at that location. This can be demonstrated by considering the likely use of a hall or function room: would any owner or manager allow a mid-week event at which smoking was permitted or even permit a cleaner who smoked to enter the premises, if it meant that a subsequent week-end event booking could not be accepted? A simple answer based on economic prudence would be, "no". Therefore, the five-day "prescribed period" is effectively a complete smoking ban at any location at which food is supplied or consumed.

What is the rationale for a five-day "prescribed period"? Is this more sensible than a five-minute "prescribed period" or even the absence of such a period altogether? The answers to such questions are best addressed by consideration of scientific data relating to the persistence and the kinetics of decay to background concentrations of specific chemicals or particulate matter after smoking has been permitted in enclosed spaces. This is a topic that has been discussed at great length in scientific meetings and in numerous conferences on indoor air quality and a detailed discussion would certainly require a much longer response than that requested by the Scottish Health Council. However, the scientific literature is easily accessible and a several studies that were obtained by simple literature searching on this topic are included as a list at the end. I am unaware of any studies that show the
persistence of chemicals or particulates for five-days in a ventilated space that has been subjected to normal cleaning procedures.

A further set of questions relate to why does the Bill single out only public spaces where food is prepared or consumed? Two answers to this question are possible: first, that there is a real problem with indoor air quality at locations where food is prepared and consumed; and, second, that these areas are seen as a "soft" target for the initial introduction of indoor smoking restrictions. If the Bill seeks to address the first potential problem, then why should the focus be solely on smoking? An air quality standard for such locations would be a more practical and non-socially divisive approach. I will not comment further on the second possible reason.

Considerable background information is presented in the accompanying "Policy Memorandum" paragraphs 4 - 10 (Health issues). One of the sources cited was the California EPA, an agency that has looked at the potential health implications of numerous environmental substances. The California EPA website links to their Office of Environmental Health Hazard Assessment's website that has a "fact sheet" on Diesel exhaust (see http://www.oehha.org/air/diesel_exhaust/index.html), which is described as "one of the most widespread and toxic substances in California's air". Despite many similarities in their health claims regarding environmental tobacco smoke and Diesel exhaust, the California Office of Environmental Health Hazard Assessment propose a managed approach to Diesel exhaust, suggesting "a 75 percent reduction in particle emissions from diesel equipment by 2010 (compared to 2000 levels), and an 85 percent reduction by 2020". A similar, managed reduction approach to the question of environmental tobacco smoke could be achieved by simply focusing on existing targets to reduce the prevalence of smoking in Scotland, without the need to introduce additional measures restricting smoking in public spaces.

In summary, the Prohibition of Smoking in Regulated Areas (Scotland) Bill is both arbitrary and capricious and it does not command support. It is arbitrary because it addresses, without justification, only indoor locations where food is supplied and consumed and it is capricious because no evidence is presented to support a five-day "prescribed period" prior to food supply or consumption. The Bill appears to be an attempt to introduce a smoking ban in public areas by social engineering. If a managed approach were to be taken to a reduction in smoking prevalence in Scotland, then exposure to environmental tobacco smoke would also decline at all locations, without the need for the measures proposed by the Bill.

Scientific literature on indoor air quality in relation to smoking
(Not an exhaustive list)


SUBMISSION FROM MIKE HARPER

As a reformed smoker I would support the ban on smoking in public places. I thought it would be difficult to give up but now I don't know why I smoked in the first place. Smokers may find it hard now but they will thank you in the long run if they give up.

Mike Harper

SUBMISSION FROM MAIRE HARPER

Come on Scotland, lead the way in Britain and ban smoking in public places including pubs, restaurants, bus/train stations etc.

Màire Harper

SUBMISSION FROM DON HARWOOD

I would be pleased to see a ban on smoking. Public places would be a start. Perhaps it would remove the peer pressure on youngsters, if their pals can't smoke they wouldn't feel the need to "try it". It may also give those trying to quit smoking enough of a push to succeed. Non smokers could then enjoy a "smoke free" eating and drinking environment; as would the people employed to serve in these establishments.

Not only would there be considerable benefits with regard to the N.H.S. but maybe we would encourage more tourism from countries already implementing this healthy policy.

I quit smoking 11 years ago and my only regret was starting to smoke 30 years earlier.

Don Harwood

SUBMISSION FROM STEVE HAY

Dear Parliament,

The above proposals have received strong support from the medical and cancer support groups. This surely suggests the correctness of this Bill being passed. The dangers of passive smoking are
becoming more documented and this would constitute a valuable measure to aid the fight against it. Only last Friday I'd a coffee break with an elderly relative ruined by tobacco smoke from a nearby table!

Thank you for your consideration of this matter.

Steve Hay

**SUBMISSION FROM DAVID HAY**

I write to support the bill to ban smoking in enclosed places, proposed by Stewart Maxwell MSP.

I stopped smoking many years ago and subsequently found that each time I visited a smoky pub or club, that I developed a cough and/or produced sputum for several days thereafter. In addition, the smell of stale tobacco smoke clinging to my clothes, hair and skin was very obvious to myself and my family (these signs symptoms were previously masked by my own smoking habit).

The solution for myself was of course relatively simple, as I avoided these smoky places. Which is unfortunately an option not available to employees and may well be a compounding factor, for the reasons stated above, for current smokers or those who have recently stopped smoking.

Whilst the experience of one person may not be conclusive evidence, it does highlight two points:

Firstly, Smoking does affect others health and secondly, the claims of publicans and others that their business would be adversely affected by this Bill may be exactly the opposite as both my wife and myself will be far more likely to visit smoke free pubs and clubs in the future.

**SUBMISSION FROM JOHN HEATHERILL**

I would like to comment on Stewart Maxwell's prohibition of smoking in regulated areas bill as invited/notified in the Press & Journal Feb 14th 2004.

I fully support the bill and would like to see this in place as soon as possible. I think it will receive a mixed bag of response but I am absolutely sick of people lighting up when they have finished their meal in relatively fresh atmosphere, polluting the area for others - i.e. depriving them of their rite to clean air. The first thing myself and my wife do when we return home from an outing is to change our clothing as they are smelling of stale cigarette smoke - my wife actually washes her hair as she finds that she is annoyed with the smell of smoke when lying on her pillow.

We do not allow anyone to smoke in our house and a few of our friends have adopted the same stance now whereas previously they would never have said a word, just suffer in case that offended anyone by asking them to step outside if the wanted to smoke.

I think that the bill is a good starting point and that once it is in place then it could be developed to cover places that don't serve food. Perhaps it could be related to floor area e.g any room open to the public of a floor area greater than 2500 square metres should prohibit smoking within that area - a separate area of less than 2500 square metres may be (but not necessarily) provided for those who wish to smoke.

I am delighted to be given the chance to put my views forward.

Regards

John Heatherill
SUBMISSION FROM T HONEYMAN

Hi

Why not stick to laws you might be able to enforce e.g. motoring/speed limits although mobile phones are still widely in use. If you ban smoking in public places you are going to be ignored why not ban drinking in public places or the use of Hydrogenated fats. Stop trying to be important, you are the Silly Parliament after all. You don’t actually think anyone is going to take notice of anything you say.

Although an ex-smoker I would be happy to come along and light up just to preserve freedom. Stick to laws you can enforce although I cannot really think of anything that would apply.

T Honeyman - Ordinary Citizen

SUBMISSION FROM REVEREND PETER M HOUSTON

Very many thanks for yours in connection with the Bill introduced at the Scottish Parliament in connection with the prohibition of smoking in enclosed places where food is supplied and consumed.

The Bill has my unqualified support. I do believe that many of us, too many of us, have spent our home-lives and our working-lives in environments (in this country) where toxic pollutions and non-toxic pollutions (like artificial light) have been tolerated for too long.

Currently I'm in locum charge of the parish of Kilmaronock Gartocharn: I have already identified a strong support for the prohibition of smoking in public places - food or no food. If evidence gathers quickly, I will get it to your Paisley office by the 23rd.

SUBMISSION FROM GAVIN A HOWAT, B.SC., M.I.BIOL., C.BIOL, DIP.H.S., M.I.O.S.H

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I would like to make the following submission on the above Bill:

I welcome the intent of the Bill and fully support its aims and would wish to see it become law. However I do not believe that it goes far enough.

The Bill should be redrafted to prohibit smoking in all enclosed workplaces, except those subject to a specific exemption - the exemptions in Schedule 1 paragraph 2 are reasonable but paragraph 1 should be deleted as enclosed spaces in vehicles should be smoke free on both health grounds and for the purposes of safety. Private cars should be exempted.

Food should be defined as including drink and those items specified in section 10 under food - any place where any form of food or drink is served, supplied or consumed should be smoke free.

A clause should be introduced to prohibit smoking in the immediate vicinity of any entry or opening to a public space at any time - it is not acceptable for people who do not smoke and do not wish to be exposed to the waste smoke of those who do whilst entering or exiting a building. We all so often see a congregation of smokers around the doors of buildings.

I have personal experience of the ill health effects of smoking in my family and would wish to see all measures possible taken to reduce the toll of disease and death caused by smoking reduced. This Bill would be at least a small step in the right direction and I urge all members of the Health Committee and of the Scottish Parliament to give it their full support.
SUBMISSION FROM I IRVINE

I am writing in reply to your letter there should be no smoking in premises where food is being cooked and served. I am not a smoker bit it is not nice going for a meal and some people just light up there should be a smokers room out of the way so I am all for no smoking

I Irvine

SUBMISSION FROM PATRICK JONES

Do you support the general principles of the Bill and the key provisions it sets out?

Yes

Are there any omissions from the Bill that you would like to see added?

Not that I can think of.

What are your views on the quality of consultation, and the implementation of key concerns?

I only heard about today being the last chance to submit feedback on the radio this morning!

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

No. Smokers can smoke outside. The vast majority will appreciate the clean air and the help in stopping.

SUBMISSION FROM DR PETER D KEIGHTLEY

Dear Health Committee

I am writing to support the introduction of the Prohibition of Smoking in Regulated Areas (Scotland) Bill, introduced by Mr Stewart Maxwell.

I would like to highlight an important reason for implementing a ban on smoking in public places.

With 70% of smokers wishing to give up, non-smokers like myself often wonder why more do not succeed in doing so. A principal reason is that they are continually exposed to tobacco smoke plus the visual stimulus of others smoking in social environments such as restaurants and pubs. For example, a close friend who has not smoked for 10 years tells me that she still experiences powerful urges to have a cigarette in such circumstances. In her case, she has the will power to resist, but the addictiveness of nicotine causes many people to relapse, especially in social settings with alcohol. An important effect on a ban on smoking in public places would therefore be an increase in the rate of smokers successfully giving up and a decrease in the rate of young people becoming entrapped. The long term health benefits are potentially large.

As a first step, there is no doubt that a ban on smoking in places where food is served would be a popular measure, as evidenced by the successful introduction of measures in 9 US States, many individual US cities, and Australia. I very much hope that the Scottish Parliament can have the
courage to implement a ban. Leadership is called for because we are dealing with one of the most addictive substances known, and an industry that continues to promote it. We would be proud of the impact such a move would have on the Nation's health.

Yours sincerely

Dr Peter D Keightley

SUBMISSION FROM MR MICHAEL KEIGHTLEY

I am writing in support of the Prohibition of Smoking in Regulated Areas (Scotland ) Bill, sponsored by Mr Stewart Maxwell MSP.

The health risks of passive smoking are now well documented. Of particular concern is the risk to children, and medical opinion now strongly recommends that children should not be exposed to environmental tobacco smoke (ETS). Apart from the home, pubs and restaurants are places in which Scottish children are most at risk from exposure to ETS.

Many pubs now serve food, and welcome children when accompanied by adults, and most restaurants in Scotland also welcome children. However, the committee will be aware that there is only one completely non-smoking pub in Scotland, and completely non-smoking restaurants are still a small minority. Under the present regime in Scotland, it is therefore impossible for children who visit the majority of pubs and restaurants not to be exposed to ETS. Although some pubs and restaurants offer segregated areas, these are virtually always joined to or in the same room as smoking areas, and concentrations of ETS are little different from the smoking areas themselves.

Furthermore these areas are usually in unattractive parts of the establishment, which deter people with families from going there.

It is therefore clear that the only way that we can achieve the aim of preventing children becoming exposed to ETS is to ban smoking in all public places.

Michael Keightley

SUBMISSION FROM WILMA KELLOE

As an individual, I have followed with great interest the progress of the Members Bill introduced by Stewart Maxwell MSP. Raised awareness of the dangers of passive smoking and the reality of being in such an offensive environment has made me more inclined to shun many premises. The voluntary measures currently in place are not adequate to ensure complete protection from passive smoking. I feel concern that the long term effects of those employed in smoke filled premises must have a financial implication on the NHS. Therefore I welcome a Bill, which prevents people from being exposed to the effects of passive smoking in all public places where food is supplied and consumed. I fully support the general principles of the Bill and its key provisions.

However, I feel that the Bill should be extended to include public places, where food is not supplied and consumed. If the danger of passive smoking exists in public places, where food is supplied and consumed, then it also exists in public places, where food is not supplied and consumed. Passive smoke does not make the distinction between food being served and consumed or not. Members of the public visiting and employees working are entitled to the protection of the Bill to maintain a clean and safe environment regardless of which public place they have entered.

The interested bodies, which are to be consulted, have a wide-ranging remit as far as hospitality and tourism are concerned and therefore it is fair that the Committee should consult with them on the contents and implications of the Bill.
I am concerned about how the practical implications of putting the provisions in place. The layout of many premises may be inadequate to allow a corridor between the restricted and non-restricted area especially if premises have food being served and consumed in one part of the building and no food supplied and consumed in a nearby but not connected area. Already, many premises have inadequate ventilation, which does not prevent the spread of smoke to other parts of the premises. Equally, having to walk through smoke filled rooms to reach the only toilet facilities on the premises.

Although I fully support and welcome a Bill, which will deal with the dangers of passive smoking in certain public places, I feel that it has not gone far enough in dealing with an important health issue. I would like to see the Bill extended to all public places regardless of whether they serve food or not.

I would therefore urge the Health Committee not only to consider this Bill but also give consideration to the addition of premises, where no food is served or consumed. Although nearly two thirds of Scotland's population does not smoke, smoking related disease still continues to be a major health problem. It is, therefore, essential that every possible measure should be taken to tackle the problem. Eire has just introduced a similar measure and Norway is expected to follow in June. The overwhelming evidence against the dangers of passive smoking makes it essential that Scotland should be amongst those leading the way in Europe.

SUBMISSION FROM JENNY KEMP

I am writing in an individual capacity and am happy for this submission to be treated as a public document.

My comments on the Bill are as follows:

I strongly support the general principles of the Bill and the key provisions it sets out. I would prefer to see smoking prohibited in all public places, but while the Scottish Executive remains resistant to this, I would support any measures which will limit smoking in certain public places, and raise awareness of the dangers of both passive smoking and smoking.

I believe that smoking should be prohibited in the regulated areas specified in the Bill (and hopefully, eventually, in all public places) for a range of reasons.

1. To protect the health of staff who work in the places where smoking is still allowed. It seems anomalous that people's rights to a healthy and safe working environment do not currently extend to the right to work in a smoke-free environment, given how dangerous second-hand smoke is. This is detrimental to individual staff, and also to the hospitality industry, as establishments are currently able to recruit from only a limited pool of people (many potential job applicants, including women of child-bearing age and people with respiratory complaints, will be put-off by the prospect of working in a dangerous smoky atmosphere). The industry is also exposed to the risk of legal action from employees whose health has suffered due to the smoke in their working environment, a risk which could be lessened by the passing of this Bill.

2. To protect the health of customers of restaurants etc. The health risks of passive smoking are significant and well documented and yet it is still commonplace to have to tolerate smoke if you wish to patronise certain restaurants or other such establishments.

3. To reduce the risk of sex discrimination. At present there are many more women in service industry jobs such as waitressing and bar work than men so allowing smoking in e.g. restaurants when it is commonly prohibited in offices and more male-dominated workplaces is indirectly discriminatory. Pregnancy issues also have to be considered: women are likely to feel forced to resign from service industry jobs if they become pregnant and wish to avoid exposing their unborn children to tobacco smoke. Men do not face this dilemma. This differential impact also applies to women as customers. Any practice which has a more detrimental impact on one sex has to be justified or it should cease - and smoking in public places where food is consumed should cease.
4. To reduce the risk of disability discrimination. The arguments above apply equally in terms of customers and staff/prospective staff who have certain disabilities which could be exacerbated by smoke inhalation, e.g. asthma. Allowing smoking in public places effectively indirectly discriminates against people with these disabilities, as it limits their ability to work or enjoy leisure time in these environments.

5. For reasons of comfort. Tobacco smoke has a strong and unpleasant smell and taste as well as damaging health effects, and non-smoking patrons of restaurants and other such establishments often have to suffer these even in 'no-smoking' areas, because smoke drifts and cannot by its very nature be confined to one area of a room. In my experience, ventilation and the use of separate areas do not work.

6. To take account of the balance of smokers versus non-smokers in the population. A minority of people smoke and yet this minority is given the right to pursue an anti-social and unhealthy habit which dictates the attractiveness of supposedly public places for the majority.

7. To send out a message about the acceptability of smoking. Scotland's health record is one of the worst in the developed world but we could begin to change that by making smoking a minority, marginalised activity which is not widely tolerated. Prohibiting smoking in environments where food is prepared and consumed would be a good start.

I urge the Health Committee to support this Bill.

SUBMISSION FROM JEANANNE AND WILLIAM KIDD

We fully support the Prohibition of Smoking in Public Places (Scotland) Bill as we do not enjoy being surrounded by smokers in restaurants, etc.

Jeananne and William Kidd

SUBMISSION FROM BILL KIRKTON

I and all my friends support the general principles of the proposed legislation outlawing smoking in public places. It should, however, go beyond 'regulated areas' and be extended to ALL public spaces. I rather feel that this tiny little contribution of mine will have little effect (even though I'm sure there'll be many others) but I hope we're not going to have to wait until the numbers of deaths caused by passive smoking are so great that even the smoking lobby will have to acknowledge them.

Smoking affects the quality (and duration) of life for everyone. My friends and I are constantly noting how, in relatively crowded restaurants, just one or two smokers contaminate the air. I can't believe that anti-smoking legislation is anything other than a vote winner.

Please pursue it vigorously.

Good luck

Bill Kirkton

SUBMISSION FROM WM LAWRIE

Although is not clear to me what exactly is meant by "evidence" regarding submissions to the Health Committee I do wish to let you know that I earnestly hope that your bill to prohibit smoking in public places is fully accepted by Parliament and passed into legislation.
My mother, one of two uncles & both my younger sisters all died of lung cancer due to the effects of smoking. That left me with no surviving maternal side to my family. Whilst that is a very personal reason for my outlook on this, it all happened some time ago and no doubt many other families have had similar experiences.

However there are many other considerations at the present time which also think support your effort to change the social climate on smoking.

1. In the USA there have been successful civil class actions brought against Tobacco Companies in connection with smoking related illnesses and death. These have resulted in huge sums being paid in compensation to the plaintiffs. Perhaps our MSPs should avoid such a possibility in their timidity!

2. It is now fully accepted that smoking is not allowed on planes, buses, trains, and taxis. Today for example it is reported that Ryan Air have banned for life, several travellers who were caught smoking on their aircraft.

3. Many businesses no longer permit smoking in their workplaces. They will save on cleaning and insurance, apart from possible claims for compensation from workers who might otherwise have suffered ill health from smokers in their workplace. Good examples are the GP doctor's Surgery, Hospitals, Supermarkets and food shops, Department Stores and in their restaurants, even also in my local shopping Mall in Stirling. Moreover in workplaces where smoking clearly would present an imminent danger of explosion it has been prohibited for a very long time by the Factory Acts and other related legislation. Further sensible inhibitions in the public interest must be reinforced by similar unambiguous legislation.

4. Thus there is an overwhelming case for extending this to all restaurants (including `Takeaways'!) and in Public Houses. It is quite inexcusable when eating to find that people arriving at a nearby table begin to smoke whilst they study the menu or when later their coffee arrives! - often taking great care to hold their cigarette clear of their own friends thus ensuring that other diners have to put up with it !

In the past when I have raised this with restaurant owners many have simply said that -if it was made unlawful then they would have no difficulty in enforcing it in their premises and without upsetting their normal wide range of customers. Whilst many Restaurateurs do ban it anyway, they need support.

5. There is I believe a very large proportion of the public who no longer smoke, and a great many others who would very much like to give it up. Legislation would, by altering the social climate, make it much easier for people to give up smoking in much the same way as the wearing of seatbelts did for safety.

6. Recent legislation has banned the use of mobile phones whilst driving. Smoking whilst driving does seem to carry similar risks to one's proper control of a vehicle!!

7. One frequently hears now about the rights of smokers. Sure they have rights, but I am quite sure that those do not include an opportunity to damage other peoples' health. I believe that the dangers of 'passive smoking' have now been established quite clearly.

8. Our National Health Service who have to treat the dreadful effects of smoking related illnesses would be helped in time, particularly so if young people can be persuaded by legislation to avoid smoking. I feel that your proposed legislation would go a long long way towards this and I shall be watching to see who among your colleagues in all parties, has the simple courage to support you. I am not a member of (nor a supporter of) any pressure group associated with this question. Neither do I belong to (nor subscribe to) any political party. The views which I have expressed here are based on my past experience, and observation of the present scene surrounding this matter.

10. Today, Wednesday March 10th 2004 is, I believe, designated as `No Smoking Day'
I trust that the arguments which I have expressed will be of some use to you in your endeavours.

Yours sincerely

Wm S Lawrie

SUBMISSION FROM GORDON LAWRIE, MORAG LAWRIE AND GRAEME LAWRIE

There exists sufficient evidence to support the prohibition of smoking in public places and this Bill is an important first step in improving the health of our Nation.

Smoking in public places has already been banned in several areas of several countries and Scotland should be in the vanguard of this action. The Bill has the support of myself and my household.

SUBMISSION FROM STEVEN LAWRIE

I would like to support Mr Maxwell's Bill prohibiting smoking in restaurants etc. for the following reasons:

1. Public Health: There is a clear need to reduce smoking for reasons of public health. The statistics on Scottish health and life expectancy will no doubt be familiar to you. For whatever reason Scottish people seem more susceptible to the risks of smoking than people of other nations. I don't think that a helpless shrug is an adequate response to this. Instead we should help people to look after themselves better. The health costs to the economy are one benefit, fewer family tragedies in the form of early death and crippling illness another. Is this the "Nanny State"? Yes, it is, but there are precedents e.g. the seat belt legislation, which dramatically reduced serious head injury and deaths from road accidents. Who now would argue for its repeal?

The proposed legislation does not prevent people from smoking but it will help to change the social climate to make not smoking the norm and will help smoking to be seen as odd, and as the antisocially unpleasant habit that it is. This downward pressure is likely to reduce the number of cigarettes consumed, which will, in turn, lead to improved health.

Some legislative action is needed as voluntary advertising restrictions are easily got around by product placement etc. in popular entertainment. "Non-smoking areas" are just a joke. Air moves around and the smoke goes with it.

2. Health of staff: You will doubtless receive information on this. It should not be ignored. Nor overplayed. The level of pollution will determine the level of risk and this is variable. The problem is much greater in pubs than in restaurants, however if Mr. Maxwell's Bill has a flaw, it is that it does not protect pub workers (and their non-smoking customers).

3. Health of non-smokers. Here I would like to advance an argument regarding the group and its dynamics. "I'm not going into the smoking section" or "suit yourself then we are...". Clear choices for the non-smoker - lose your friends or put up with passive smoking. Coming back to the seat-belt laws, at the time many people did not use belts for fear of offending the driver or seeming somehow un-macho. Overnight when the law came in these people buckled up. All they needed was a face saving excuse to do what they had always wanted to. I believe that there are many who say when faced with the choice of "Smoking or non-smoking section?" say, "Oh I don't mind..." to be polite and avoid tension in the group. Banning smoking in restaurants will send the message that it is the smoker who is out of step and they who should forego their right to smoke as opposed to the non-smokers' right to breathe smoke-free air. Like it or not social life revolves around pubs, clubs and restaurants for most people, particularly young people. I have children who will soon be "out there". To accept that they mix with others their age is to accept that they smoke. Passively or actively - to "fit in", look cool and be victims of advertising manipulation. No parent could tell whether their child was smoking actively or passively, the smell on clothes would be the same either way. Children have the right to be protected...
from this insidious peer group pressure to take up smoking. Again, the Bill will help but does not go far enough in this respect.

4. Not just unhealthy, also unpleasant. Time spent in a smoky environment means a smelly person. Clothes that need washed, even dry-cleaned. All so that a minority of the population can express their right to smoke? What about my right not to. There are other laws regarding public nuisance, - drink by all means but not drunk and disorderly, noise abatement laws, light pollution and rubbish control are all restricted by law. Why should smokers be allowed to foul my air? By what right?

There is an enormous quantity of research on this issue. A quick search of the "Medline" medical research database produced 68 000 articles on smoking, 5000 on passive smoking and 188 review articles, in English, on the effects on Humans of passive smoking.

BMJ 2002;325:174-175 ( 27 July ) is an editorial in the British Medical Journal accompanying an original research article. An extract reads,

"The figures from the review1 are startling and would make workplace smoking bans by far the most effective short term smoking cessation strategy, barring outright prohibition, available to any government. In the United Kingdom, smoking prevalence is stuck at around 27% of the adult population.2 Comprehensive workplace bans could reduce it to 23%. Achieving this effect with tax rises would require a doubling of the price of cigarettes.3 The English national smoking cessation guidelines estimated that comprehensive general practitioner advice to stop, coupled with referral to smokers clinics and widespread use of medications such as nicotine replacement therapies, could reduce prevalence by perhaps 1% in a given year."

The original article by Fichtenberg CM and Glantz SA. In: BMJ. 325(7357):188, 2002 Jul 27.

Title: Effect of smoke-free workplaces on smoking behaviour: systematic review.[see comment]. [Review] [52 refs]

Abstract

OBJECTIVE: To quantify the effects of smoke-free workplaces on smoking in employees and compare these effects to those achieved through tax increases. DESIGN: Systematic review with a random effects meta-analysis. STUDY SELECTION: 26 studies on the effects of smoke-free workplaces. SETTING: Workplaces in the United States, Australia, Canada, and Germany. PARTICIPANTS: Employees in unrestricted and totally smoke-free workplaces. MAIN OUTCOME MEASURES: Daily cigarette consumption (per smoker and per employee) and smoking prevalence. RESULTS: Totally smoke-free workplaces are associated with reductions in prevalence of smoking of 3.8% (95% confidence interval 2.8% to 4.7%) and 3.1 (2.4 to 3.8) fewer cigarettes smoked per day per continuing smoker. Combination of the effects of reduced prevalence and lower consumption per continuing smoker yields a mean reduction of 1.3 cigarettes per day per employee, which corresponds to a relative reduction of 29%. To achieve similar reductions the tax on a pack of cigarettes would have to increase from $0.76 to $3.05 (0.78 euro to 3.14 euro) in the United States and from 3.44 pounds sterling to 6.59 pounds sterling (5.32 euro to 10.20 euro) in the United Kingdom. If all workplaces became smoke-free, consumption per capita in the entire population would drop by 4.5% in the United States and 7.6% in the United Kingdom, costing the tobacco industry $1.7 billion and 310 million pounds sterling annually in lost sales. To achieve similar reductions tax per pack would have to increase to $1.11 and 4.26 pounds sterling. CONCLUSIONS: Smoke-free workplaces not only protect non-smokers from the dangers of passive smoking, they also encourage smokers to quit or to reduce consumption. [References: 52]

Now Mr Maxwell's bill as good as specifically excludes pubs form the ban. He would no doubt take the view that it is better to take one step forward, which can be taken, will be accepted and will lead in the future to further steps. He may be right. I note that this week the Irish have been somewhat bolder. Other places have or are planning to introduce similar more extensive smoking bans soon. Why can't we be so bold? Mr. Maxwell's bill is really a very small step. If we want to reduce the pressure to smoke (and therefore the number of young people taking it up), reduce the opportunity to smoke (and
therefore the absolute number of cigarettes smoked) and reduce the health damage caused to workers in pubs and restaurants, this Bill must be enacted as soon as possible. Preparation for its extension in the near future to all public places should begin straight away.

Yours sincerely

Steven Lawrie

**SUBMISSION FROM JIM LEACH**

I support the general principles of the bill.

I would like to see provision for a ban on smoking in pubs as well as restaurants.

The consultation was not publicised very well, very few people knew about it.

Regards

Jim Leach

**SUBMISSION FROM P M LEE**

I am concerned that the bill depends on a policy memorandum that includes a totally one-sided view of the evidence relating to possible health effects of ETS exposure. I also feel it is misleading to cite conclusions from IARC Monograph 83 "Tobacco Smoke and Involuntary Smoking" when this monograph has not yet been published or subjected to outside review. A publication date of June 2002 is given, but that is when an unreferenced and unsupported summary of conclusions appeared.

I have been carrying out research on smoking and health for 40 years and have published widely on ETS for over 20 years, and disagree strongly with the expressed view by the BMA that there is conclusive proof that passive smoking can be the cause of a wide variety of health effects. Below I comment on some of the claimed health effects which I have analysed in detail.

**Lung cancer** - The argument that ETS causes lung cancer is based mainly on the combined evidence from over 60 epidemiological studies of lifelong non-smokers which suggests that the risk is some 20% higher for those who are married to (or living with) a smoker than for those who are not. The evidence also shows a dose-response relationship between lung cancer risk and the number of cigarettes smoked by the spouse and the duration of exposure. A 1997 paper in the British Medical Journal\(^1\) is one of a number of papers summarizing such evidence.

In fact detailed examination of the evidence, as presented in a series of five papers by myself and my colleagues\(^2\) shows clearly that an inference of causation cannot be made from this evidence. We show that the claimed association and dose-response relationship essentially disappears if (i) bias due to the tendency of some smokers to deny smoking is removed, (ii) proper adjustment is made for confounding by fruit, vegetable and dietary fat consumption and by education, (iii) attention is restricted to studies that adjusted for age, and (iv) correction of evident errors in one study is made.

There is also some indication from the overall evidence that lung cancer risk among non-smokers might be weakly associated with workplace ETS exposure. However, only three of 31 relative risk estimates are statistically significant, and biases that apply to the spousal data are also likely to apply to the workplace data. Thus, the "16-19%" increased risk cited in section 10 of the policy memorandum for "non-smokers exposed to ETS in the workplace" cannot be considered to be proven to be a causal effect of ETS exposure.

A recent detailed summary of the latest evidence on ETS and lung cancer is available elsewhere\(^7\).
Coronary heart disease - The argument that ETS causes coronary heart disease is based on very weak evidence indeed. While some small studies have reported a moderate increase in risk in lifelong non-smokers associated with spousal smoking, the reported increase in studies of over 1000 heart disease cases is quite small, less than 10%, and two of the very largest studies have found no association whatsoever. A false impression is given by some reviewers, who omit some of the relevant evidence for reasons which seem more politically than scientifically based, pay little attention to the fact that many of the studies fail to consider the possibility of confounding by the numerous lifestyle factors associated both with smoking and heart disease, and ignore bias arising due to misclassification of some current or former smokers as non-smokers. Elsewhere I give the relevant data in full, enlarge on the arguments summarized above and present the appropriate references.

Cot death - Cot death, or SIDS (sudden infant death syndrome), has been shown to be associated quite strongly with parental smoking in a number of epidemiological studies. However, a very large number of other factors, many associated with parental smoking, have also been found to be associated with SIDS. The extent to which the association of SIDS with parental smoking represents an artefact due to confounding by other factors or is a true causal effect of ETS exposure (or perhaps maternal smoking in pregnancy) is far from clear. Some of the studies reporting an association between SIDS and ETS exposure have not adjusted for any other risk factors at all, while many others have only taken a few into account. Four studies have taken into account quite an extensive list of potential confounding variables in analysis. In three studies, such adjustment explained about 80% of the excess risk of SIDS associated with maternal smoking and in a third study it explained about 50%. Since such adjustments will inevitably be incomplete - partly because not all such factors will have been considered, and partly because data errors or use of surrogate variables limit the ability to control for confounding - it is not implausible that all of the association between ETS and SIDS could in fact be explained by confounding. Again, fuller documentation of the data, arguments and references is presented elsewhere.

Low birthweight - While meta-analyses have estimated that ETS exposure is, on average, associated with a decrease in birthweight of about 25 to 40 g, this difference does not necessarily imply harm to the infant and can be compared with an estimate of 102 g for the reduction in birthweight relating to birth at an elevation of 1000 m. There are considerable difficulties in interpreting the weak association between ETS and reduced birthweight. Many of the 60 or so studies that have investigated the possible relationship of birthweight to ETS have accounted for no or very few potential confounding variables, and of the 13 that have adjusted for eight or more such variables, one found a significantly higher birthweight associated with ETS exposure, and eight found no significant association at all. Although a significantly lower birthweight was reported in the other four studies, these were only in isolated analyses for specific endpoints and exposure indices, and no clear pattern was evident. A fuller discussion of the evidence is available elsewhere.

I would also like to comment on the most dubious claim in section 9 that as many as 17,000 hospital admissions in a single year of children under the age of five are due to parental smoking. This is based on data from the 1970 British birth cohort study reporting that the risk of admission is increased by 10%, 20% or 30% depending on whether the mother smokes 1-9, 10-19 or 20+ cigarettes a day. Not only is this data wildly out-of-date, but the estimates were not adjusted for many of the relevant factors associated with parental smoking such as education, degree of affluence and age of the mother. I note that one of the other references cited in the policy memorandum, the 2002 Annual Report of the Chief Medical Officer for England and Wales, presents an estimate of hospital admissions in the United States due to ETS that is an order of magnitude lower, emphasizing the considerable uncertainty here.

I have no particular personal interest in whether or not smoking is permitted in certain public areas. However, I do have a considerable objection to basing a bill on health evidence that is so weak. I should make it clear that I have worked for many years as a consultant to various tobacco organizations and companies, but that all my views derive from my own personal assessment of the evidence as an experienced medical statistician and epidemiologist. The tobacco industry make no attempt whatsoever to affect my views. I would be willing to present further oral or written evidence as required.
References:

7. Lee PN. Epidemiological evidence on environmental tobacco smoke and lung cancer. 2004. [www.pnlee.co.uk](http://www.pnlee.co.uk)
8. Lee PN. Epidemiological evidence on environmental tobacco smoke and heart disease. 2004. [www.pnlee.co.uk](http://www.pnlee.co.uk)
10. Lee PN. ETS and sudden infant death syndrome. 2002. [www.pnlee.co.uk](http://www.pnlee.co.uk)
12. Lee PN. ETS and birthweight. 2003. [www.pnlee.co.uk](http://www.pnlee.co.uk)

SUBMISSION FROM A JAMES LEGGE

Dear Sir/Madam,

Following the article in the Press & Journal I wish to register the support of my wife (Julia Helen Legge [nee Hogg]) & myself for this campaign.

We support the general principles in the Bill.

We believe that all smoking should be banned from any Public Place, including Public Transport.

The quality of consultation could have been better, as not everyone purchases a daily newspaper and perhaps TV & Radio could have assisted to give a broader coverage.

Yours faithfully

A James Legge A.A.M.S.

SUBMISSION FROM MATTHEW LEGGE

I write to make you aware of my support for the "Prohibition of Smoking in Regulated Areas (Scotland) Bill", and to, hopefully, give the lie to Jack McConnell's assertion that: "there is not widespread support for a complete ban" (on smoking in public places).
This matter is a frequent subject of debate in my workplace, amongst my friends and in pubs and clubs. I know not everyone shares my views, but many, I believe the majority, do, and I hope you will bear that in mind as you consider Stewart Maxwell's Bill.

**SUBMISSION FROM LINDA LEVY**

I understand that the above Bill is looking at bringing a ban on smoking in public places. As a smoker and regular visitor to Scotland this alarms me considerably. Surely it is taking away the rights of every individual smoker or not. I am acutely aware of the position it places many small business who face losing their livelihood.

I understood that the First Minister Jack McConnell said 'a full smoking ban was not in the pipeline,' but it would now appear that this decision has been rescinded.

Please lodge my objection.

Linda Levy

**SUBMISSION FROM KATE LOTHIAN**

I very much support your idea. Although my husband is a "considerate" smoker, who does not wish to give up, I still feel a ban would at least reduce the risk to non smokers. Smokers may have the right to smoke but non smokers also should have rights.

Good luck with your Bill.

Kate Lothian

**SUBMISSION FROM JOHN LOVE**

I would initially make it clear that I am a non-smoker and I strongly welcome the proposed legislation.

Whilst nobody would now argue with the published dangers of smoking (either active or passive), Scotland continues to suffer very high rates of smoking-related illnesses, with the consequent knock-on affect on Scottish health and the economy. Why some parts of our population continue to harm themselves and others in this way is unclear but unfortunately what is clear is that the message of the dangers of smoking are not getting through to younger people and, within that group, particularly females.

Consequently I believe that this Bill would be a first step in the right direction to turning Scotland into a smoke-free zone and I believe that legislation is necessary as there is absolutely no chance of any meaningful change coming about by voluntary measures or codes of practice.

There is already an acceptance that a growing list of public areas should be smoke-free zones (cinemas, shopping malls, shops etc..) and the concepts of segregation and choice are slowly extending to some eating places. However, it is often the case that the barrier between the smoking and non-smoking zones is not physical and in such cases the benefit of a smoke-free area is diminished or nullified completely. Some eating establishments have gone completely non-smoking - however, this is more often found in hotels (although I understand that the Pizza Hut chain took this pioneering step some time ago) and this has to be extended for it to be meaningful. So far as the vast majority of food-serving pubs and restaurants are concerned it is still a case of either having two areas (with smoke drifting from one area to the other) or one general area with no segregation whatsoever.
I also believe that there are a vast number of smokers who would wish to give up the habit and that this legislation would make the task just a little bit easier for them, as they would not have to make the decision to smoke or not smoke when they were eating out.

My work sometimes takes me to the Republic of Ireland - they have recently introduced legislation which goes much further than that currently proposed for Scotland but they also have (in my opinion) a smoking culture which is at least as problematic as that which exists in Scotland, particularly amongst the younger population. Scotland should press ahead with the proposed legislation and then learn from the Irish experience going forward.

I know that it is often repeated but it is no less true for that - smoking is the only known activity which is conducted legally and which, if you follow the manufacturer's instructions, will either kill you or have a severe detrimental effect on your health. What has been given much less consideration through the years is the detrimental effect on those of us who have to suffer from passive smoking and this Bill goes some way to addressing that problem.

SUBMISSION FROM DR SUSAN P LUMLEY

Please find attached (in word format as requested) information from the BMA web site of relevance to the above.

As a medic, I despair when I see smokers inflicting their unwanted and potentially very damaging exhaust fumes on anyone unfortunate enough to be seated near them, or worse - providing a service to them - in an enclosed space (such as a restaurant).

I fail to understand why a smoker's "right" to do want they want (i.e. to smoke) overrules the "rights" of the many people around them (to breathe smoke-free air, to avoid future cardio-respiratory illness, or avoid aggravation of current health problems such as asthma, or to avoid their hair and clothes picking up the disgusting smell of cigarette smoke).

I can think of few other comparable situations in which one person can inflict so much unpleasantness on a significant number of other people without a public outcry being made.

If someone was to walk into a restaurant, and start spraying noxious fumes into the atmosphere I have little doubt that they would be speedily ejected, and charges might well be brought against them. Unfortunately, the success of the Tobacco Industry in making smoking socially acceptable / fashionable in previous decades (all in the name of boosting profits) has blinded people to how socially unacceptable smoking really is.

I have no doubt that there will be significant financial input from the Tobacco companies in order to fight the introduction of this Bill, and am concerned that there has not been sufficient advertisement of how the man / woman "in the street" (or restaurant !) can contribute their opinions.

People should be allowed to smoke if they wish to, but not to the detriment of those around them who do not wish to smoke.

Many smokers are socially minded, and remove themselves from a group in order to smoke. Unfortunately, not all are so considerate for the rights / health of others, and only the introduction of legislation will be sufficient for them to "see the light".

Yours sincerely

Dr Susan P Lumley
Inverness
SUBMISSION FROM CHRIS LYNDEN

Dear Sirs & Madams

I whole-heartedly support Mr Maxwell's bill. Let us hope that it will be enacted...on behalf of those that work and visit these smokey areas on grounds of health and general unpleasantness.

Yours faithfully

Chris Lynden

SUBMISSION FROM CAMERON MACANDREW

I have been passed on your details by a friend, who indicated that you were keen to receive views of people in West Lothian regarding banning smoking in public places.

( I am a resident (born and bred) of West Lothian, living in Whitburn, and I would very much support a ban on smoking in public places. I find cigarette smoke irritating at best, and I resent carrying the smell of smokers habits on my clothes for a considerable time after being in their presence; and at worst, I find the attitude of smokers offensive in that they are knowingly putting the health of others at risk through passive smoking.

I applaud the people of Ireland by banning smoking, and if there are any consequences of the ban, then surely these are far outweighed by positive health benefits to the community at large. I hope the politicians of our country are brave enough to follow the lead of our celtic neighbours.

I hope you will find my views of interest, and hopefully representative of the majority of people in West Lothian, and in Scotland generally. We owe it to ourselves and to our children to clean up the air that we breathe.

Whilst writing, can you give assurances that the sulphur smelling fumes emitted by the coal tip from the former Polkemmet Colliery in Whitburn is not detrimental to the people in the locality?

Best regards

Cameron N Macandrew

SUBMISSION FROM MRS MACAUSLAN

I hope I am now too late to offer my support on your introduction of a Member's Bill to prohibit smoking in enclosed places. Smoking is a nauseating habit and totally spoils the atmosphere and enjoyment of any meal or function.

You have my 100% support in your efforts to put through this Bill.

With best wishes for your success.

Mrs Macauslan

SUBMISSION FROM HELEN AND GORDON MACIVER

On behalf of my husband and myself I would like to send you our views on smoking.
For many years we both smoked, but were always considerate to others and only smoked in the privacy of our own home.

Having stopped smoking some years ago we find it very offensive to have to endure other peoples smoking habits.

Visiting the Almondvale or McArthur Glen centres in Livingston you are greeted at every doorway by a group of smokers.

This only serves to turn us away from the centres as we do not wish to run the gauntlet of smoke alley.

Within the Almondvale centre smoking is still permitted within the eating establishments, these are all at the doorways and the smoke soon spreads around the centre.

We have three grandchildren that we would like to be able to take shopping but feel we cannot inflict smoke into their young bodies.

We feel if people insist on smoking then they should do so in their own home only and leave others to enjoy being able to breath as fresh air as possible.

Helen & Gordon MacIver

SUBMISSION FROM JOHN MACLEAN

Consultation on Smoking in Public Places

I wish to express my opinion that smoking in public places ought to be banned, certainly in restaurants and bars. The health reasons for this are well understood and I don't think I need to list them here. If I spend any time in a space where even one cigarette is smoked I notice it and I can assure you that I suffer rather unpleasant consequences several hours later.

I also think it is time that bus companies made some effort to enforce their often ignored 'no smoking' signs. This so-called ban is ignored in some areas of Glasgow and it is a brave or foolish traveller who will protest to the smoker.

I know all the arguments that are used by the 'smoking lobby' and no doubt they will be presented to you. I know that smoking is the cause of a great deal of illness and distress to victims and families. It is time that the Scottish Executive had the courage to implement a smoking ban. I urge you to add my opinion to this point of view.

Mr John Maclean

SUBMISSION FROM JEAN MACLEAN

I should like to record my support for a ban on smoking in public places ie particularly restaurants and bars, not least for the health of the workers in these establishments but also the health and enjoyment of customers. In this day and age when we are so much concerned with preventative medicine, health awareness I think it is time the Executive grasped the nettle and supported a ban. I refuse to believe that smokers would stop patronising bars etc. if this were the case. The money saved by the Health Service if smoking related diseases fell would be astronomical. I look forward with interest to the result of the consultation. I live in hope.

Jean Maclean
SUBMISSION FROM ALISTAIR MARQUIS

I am responding to the request in this week’s edition of the West Lothian Herald & Post for comments about the Member's Bill to ban smoking in public places.

The health and well-being of the nation this step is long overdue. The costs to the public purse in terms of health care needs arising from people smoking is appalling and everything that can be done to encourage young people and others to stop smoking or deter them from starting in the first place must be put in place. Those who view stopping individuals smoking where they wish have lost sight of the rights of everyone else to a safe and healthy environment. I would be absolutely delighted if Scotland can take the bold step to eradicate smoking in all public places. At the outset there will be many who will be unhappy with such a move. However, that short-term moan will become a longer-term realisation that this is the only wise step which can be taken in a modern Scotland. If MSPs try to sit on the fence or fudge the issue with voluntary codes etc then they will be culpable in the on-going damage done to the nation's health.

On a personal note, I detest coming home from a smoke-ridden atmosphere in a restaurant or public house, absolutely reeking of smoke. After such an event I find the smell of smoke on my clothes and in my hair - goodness knows what it is doing to my lungs. Many is the time I have sat with my family in a restaurant at a table free from smoke and just started my meal when ill-considered patrons arrive, sit at a nearby table and light up cigarettes, totally oblivious to the personal space of others around them. Fine for them - they are not eating, but we are and our meal is virtually ruined. They then sit in a smoke free atmosphere when their meal arrives - lucky they! Let's have fairness and equality of provision which means we all look out for each other and that starts by banning smoking completely in all public places. Too often the present small allocation of space to non-smoking areas in public places does not meet needs, particularly those with children and teenagers. Anyway, most extraction systems fail to remove the smoke entirely from an establishment's atmosphere and the damage is done to one and all strength to the proposal. Its acceptance and implementation simply cannot come fast enough! The nation expects, needs and demands that Parliament delivers on this as soon as possible.

Alistair F Marquis

SUBMISSION FROM STEPHEN MATHISON

I would welcome a law to prevent smoking in regulated areas. A complete ban in public areas would be the best. We should be introducing the same law as Eire has.

SUBMISSION FROM MARGARET MAXWELL

I write to support the general principles of the Prohibition of Smoking in Regulated Areas (Scotland) Bill

As the law stands my right to enjoy a meal free from the effects of inhalation of cigarette/cigar/pipe smoke is being breached.

I accept that people have the right to choose to smoke but they do not have the right to impose the effects of this on others.

This Bill would be a step towards rectifying the current situation of the effects of passive smoking being imposed on people and in particular, children.

Mrs Margaret Maxwell
SUBMISSION FROM B D MAYCOCK

Proposed Smoking Ban

I write to endorse your proposal and I ask that this letter be treated as a representation that should be passed to any parliamentary officer should be appropriate.

I am aged 72, I smoked for about 36 years giving up in my fifties. I am seriously inconvenienced rather than crippled by having been a smoker, that said I seek to avoid contact with smokers and tobacco as far as I can. My house is a no smoking location and requests to smoke in it are always refused. At meeting as a matter of routine I ask that there be no smoking if the majority so wish. Usually the majority so wish.

Any moves that reduce smoking in public places must be good and I say this as a member of the majority that does not smoke.

Any steps that even incidentally reduce the exposure of children to tobacco smoke is worthy of support.

I have copied this letter to Mike Rumbles my M.S.P and by doing so I have asked for his support for your proposal.

B D Maycock

SUBMISSION FROM KEVIN AND ZOE McCARTHY

We wish to add our views that we are in favour of complete smoking ban in all public places especially pubs. We find having to breathe and sit in other peoples smoke when out for a drink to be very unpleasant and a risk to our health. More often than not we chose not to go to pubs due to the certainty that our clothes and persons would stink like a stale ashtray after a couple of hours in a pub. If smoking were banned in pubs we would be more inclined to go to a pub for a drink. I believe there are many others like us which would lead to an increase in business.

A complete ban would have overwhelming public support. Over 70% of people do not smoke. Why should this huge majority have to suffer due to the addictions of the minority. Additionally a majority of smokers wish they had never started to smoke and would use a ban to give up as well. Friends of mine in Ireland who were smokers have been delighted with the ban and have chosen to try to quit as a result.

Go on be courageous. Take a lead within the UK. Make Scotland noticed for something other than the parliament fiasco. Ban Smoking in public places Totally Now!!!

SUBMISSION FROM BILL MCCONNACHIE

I would like to confirm my support for the above Bill being introduced by Stewart Maxwell MSP.

I am now retired and spend some time at meetings in public places and in cafe /bars where the owners have made the effort to provide non-smoking areas.

However this in my opinion just does not work as smoke does recognise smoking and non-smoking areas. I am particularly concerned for the staff who have to work in a smoke filled environment throughout the day whereas customers can leave at wi".

I look forward to the implementation of this measure as quickly as possible

Bill McConnachie
SUBMISSION FROM IAN MCCULLOCH

As a smoker I have absolutely no problem with smoking being banned in public areas.

I understand however that in the Irish Republic owners or managers of premises are not allowed to provide completely segregated areas for smokers where there is no danger of contaminating the fragile health of non smokers. This seems to me to be a complete denial of the rights of smokers who, through their own choice participate in a completely legal habit, however misguided that choice may be.

Ian McCulloch

SUBMISSION FROM JOHN MCDONALD

I am responding to your invitation to share views about smoking in public places.

I have visited places where a ban on smoking in all eating places, pubs and public places has been in force for a number of years such as Los Angeles and parts of Ontario.

It appears that businesses are on a win win situation with a total ban. Pubs for example don't lose their drinkers and benefit by attracting new customers. In the Kitchener/Waterloo area of Ontario new business were opening up and thriving. I would look forward to be able to visit pubs here without having to come out smelling like an ashtray.

It is also important that the message gets through to youngsters that smoking is not an acceptable, adult habit. It seems extraordinary that cigarettes can be legally sold to sixteen year old children some of whom are below the statutory school leaving age.

Thanks for inviting our views.

John McDonald

SUBMISSION FROM ROBERT MCGILL

Dear Sir or Madam:

I am writing to add my voice to the people who would like to see a smoking free environment in all public areas. Indeed I would like to see Scotland follow the example of New York City that has made it illegal to smoke in all buildings. I find it unbelievable that my right to health is being undermined by people who choose to smoke and believe the Parliament has an obligation to ensure that everyone, customers and workers in all buildings should be enable to enact their right to a healthy environment.

Thank you for listening,

Yours faithfully

Robert McGill

SUBMISSION FROM MR A MCGINNIGLE

I would like to express my whole hearted support for the new Members Bill proposing smoke free areas in designated places.

I think smokers now realise that they have responsibilities as well as rights and that this Bill would be a sensible step forward in the public health sector.
My own home was strictly non-smoking as my mother was asthmatic, if anyone smoked a cigarette near her, it would bring on an immediate attack of asthma.

As you know the quality of fresh air is of the utmost importance to the unfortunate people who are afflicted with the various diseases of the respiratory system.

Hopefully, if the Bill is passed, I'm sure businesses and public will comply with it willingly given time to get used to it.

Perhaps businesses may suffer temporarily financially and the smokers not too pleased to say the least, but I can see an upsurge in business happening when the Bill has cleared the air for all of us.

Thank you for your invitation to write.

Mr A McGinnigle

SUBMISSION FROM HELEN MCGLONE

Please count my vote as I oppose the smoking ban.

Helen McGlone

SUBMISSION FROM KERRY MACKENZIE

Prohibition of Smoking in Regulated Areas (Scotland) Bill introduced in the Scottish Parliament on 3 February 2004.

Call for Written Evidence

Do you support the general principles of the Bill and the key provisions it sets out?

The Bill is the first step of a process that aims to protect people from the harmful effects of environmental tobacco smoke and to support a step change in attitudes and behaviour in Scotland in relation to smoking. The evidence of harm to babies, children and adults as a result of passive smoking is overwhelming in terms of asthma, childhood infections, heart disease and lung cancer. A legislative approach to increase smoke-free provision is now required to protect Scotland’s children, young people and communities from passive smoking.

Are there any omissions from the Bill that you would like to see added?

The Bill addresses its stated objective of "preventing people, including children, from being exposed to the effects of passive smoking in public areas where food is being supplied and consumed." The Scottish Executive should be banning smoking in all public places and workplaces, not just where food is supplied and consumed. Scotland is ready to adopt the approach taken by countries like Ireland.

What are your views on the quality of consultation, and the implementation of key concerns?

Passive smoking is a key public health issue and as such the twin objectives of health protection and health improvement must take precedence over moral or economic views.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

The voluntary approach to smoking restrictions has not been effective in terms of protecting people from the harmful effects of ETS and a legislative approach is necessary. The Bill will make a
significant contribution to getting the message across that smoking is unacceptable and anti-social and also to influencing smoking behaviour. Implementation must be accompanied by an appropriate health promotion campaign highlighting the risk of ETS. Recent surveys in Scotland found that the public's understanding of the true risk of ETS is poor, particularly among smokers. This highlights the need to further inform and educate people about the effects of passive smoking on everyone, especially children.

Kerry McKenzie


SUBMISSION FROM MRS MAUREEN MCKERROW

Prohibition of Smoking in Regulated Areas Bill

Thank you for this opportunity to respond to your proposed bill. As a past President of the Scottish Licensed Trade Association and a current licensee I am aware that the smoking issue is an important one but believe that your bill, as it stands, is ill thought out and damaging to small business.

Pubs and bars in my area are already struggling - business simply isn't what it was. We must also comply with other current regulation, such as the disability act, which requires significant financial investment. To provide a totally enclosed room, as you suggest, would require further building works which I can ill afford and as mine is a listed building I would require special permission which I would probably not be granted.

A large proportion of my trade comes from food, but I still need to provide somewhere for my customers to smoke. It would be impossible therefore for me to comply with your regulations without losing trade as I would be forced to choose between allowing smoking or serving food.

For small businesses like mine, and the other licensees in my area, we need every customer to maintain a viable business, so your regulation could be disastrous for us.

I am currently working with Environmental Health, the local licensing board and Health Board on a tobacco strategy document to help local businesses improve their air quality. This includes complying with the Voluntary Charter on smoking and helping them to use non-smoking zones wherever or whenever they can. This is a practical and effective way of improving air quality, which concentrates on achieving the possible in all venues immediately, and then encouraging future improvement and investment.

I believe that working in partnership like this is the key to providing choice and increasing better practice in this important area. By providing non smoking zones and displaying Charter smoking policy signs, venues can attract customers in who will then drive the business by choosing venues that provide what they want. Businesses will always reflect what their customers want and in this way everyone wins - customers, staff and operators.

I would like to request that you consider the possible difficulties that your Bill will cause and hope that you will choose to work with the industry, instead of against it, so we can achieve your aims of providing better quality air without damaging our business.

Sincerely

Mrs Maureen McKerrow
SUBMISSION FROM ROBERT McLEAN

I am a pensioner living in Sheltered accommodation with a communal lounge. Some years ago I appealed to the East Renfrewshire council to have the lounge designated a No Smoking Zone, for, as very few of the residents smoked, it was mainly care staff and visitors who polluted the atmosphere.

This request was refused on the grounds that it would have to be applied to all Sheltered housing in the district.

If this Bill was enacted it would help to enable people like myself to use the common rooms in their homes without the discomfort and danger of exposure to passive smoking.

SUBMISSION FROM ISABELLA McLEAN

I am a retired civil servant who was employed by the D.H.S.S. and spent many years working at a large communal desk in a smoke filled atmosphere. Any protests about those conditions were brushed aside even though at times it made me physically sick I had to struggle on, or leave the job.

I am delighted to know that at long last something is being done to bring an end to enforced passive smoking and wish to record my support for the adoption of this much needed bill.

SUBMISSION FROM J McMEMEY

I write to you to support the health service reform bill. Especially the ban on smoking in places where food is being served. The scientific evidence on passive smoking is overwhelming and I don't see why any individual's right to a safe environment anywhere should be compromised. It is my personal experience that one person's selfishness in this case, smokers, endanger other citizens health and personal enjoyment of life. Smokers are a blight on the health of our nation.

The Scottish Parliament has an obligation to protect its people, especially children who often have no say as to the type of environment they eat in.

This law should have been passed years ago and should extend to all public places.

SUBMISSION FROM EVELYN MACMILLAN

I am writing in support of the proposed bill "The Prohibition of smoking in Regulated areas (Scotland)"

In restaurants the smoking area is often situated close to the entrance, forcing non-smokers to walk through this area. Even if this not the case, smoke can still be a problem for the seated at the edge of the non-smoking area, as smoke drifts over to them.

I should have liked the bill to go further, and ban smoking entirely in all public areas, but welcome this as a first step.

Mrs Evelyn MacMillan

SUBMISSION FROM MR CAMPBELL MCNEILL (BSC HONS)

I wholly support the bill you propose.

I regularly visit public places, and find the smoke present both uncomfortable, and unpleasant. I would like to see this bill put through for 3 reasons.
1. To protect the staff that work in these locations
2. To protect the non smoking majority
3. To promote general cleanliness and well being

I feel that many staff are given little choice but to accept work in bars and restaurants, and by this are forced to inhale a large amount of smoke. This not only leads to the health problems associated with passive smoking, but also, makes them much more likely to take up the habit themselves.

In my group of friends, of the 10 or so of us who regularly go out to socialize in Edinburgh, not one of us smoke. We actively invite friends who do some to do it somewhere else when in our presence. I believe, that groups like are own are now in the majority. I feel that the hardcore few who still feel the needs to smoke in public cause a disproportionate amount of discomfort to those who choose not to engage in smoking.

Public places exposed to a large amount of smoke smell. After going into a place where smoking is permitted, my clothes smell. You can smell smoke in my flat the day after going out simply because my clothes smell that bad from the smoke particles they have picked up. Why should I have to put up with this unpleasantness because of someone else's disgusting habit. If smoking were less accessible, it would lead to fewer absences from work, and more efficient use of employees' time. It would be better for the wellbeing of Scotland as a whole. I fully support Scotland, but I do feel our citizenship needs to take more pride in themselves and Scotland as a whole, and stop settling for anything less than the best.

I feel any trade lost by restaurateur and publicans would be offset by new business of customers who chose not to use these facilities due to their issues with a smokey environment.

This move may also help Scotland's asthma issues.

I offer my full support.

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SUBMISSION FROM CRAIG MCNICOL

I am writing to express my views on the proposed Prohibition of Smoking in Regulated Areas (Scotland) Bill.

1. I agree with the general principles of the Bill, which is long overdue. Having visited Boston, USA within the last month (where smoking has been banned in all pubs and restaurants), it was a pleasure to visit those bars where it was previously too smoky to enter for any period of time. On returning to Scotland, it only took 5 minutes of being in a pub for smoke to start affecting me. I know many Americans and Canadians who will not actually go into pubs here because the smoke is so bad.

2. The major omission that I see is that it is limited to premises serving food and the definition of food is not as all encompassing as that in the Food Safety Act. Why should those employees in pubs serving only snacks not receive the protection from smoke that those in restaurants will? In addition I feel that many pubs currently serving food will drop food provision so that they will not have to comply with the legislation. If this Bill is aimed at protecting those who have no choice but to breathe in other people's smoke then I think that smoking should be banned in all cafes, pubs and restaurants and it should be the first step in banning smoking from all public places.

3. I feel that it will be too complicated to enforce the 5 day rule and that it will just be simpler to ban smoking in all public places.

Yours sincerely

Craig McNicol
SUBMISSION FROM MARY MEICHAN

I believe that the ban would be a great idea and I support it 100%. Most people dislike smoking because of the smell or health risks, but they never look at the bigger picture. My son is four and a half year old. He uses oxygen at times if his breathing becomes ‘erratic. One of the main things which causes breathing problems is other peoples' smoke. For me, it would be a luxury if I could go shopping with Christopher without being forced to carry an oxygen cylinder. However, I am forced to because of the tolerance of smokers in restricted areas. For example, the McArthur Glen is Livingston has a large food court which I can easily manoeuvre the wheelchair in. On a down side, is that the smokers are seated right beside the lift so when the doors open I have to put Christopher on oxygen. Segregating the smokers does not help as the smoke is carried all over the food court. The same thing happens in the Howgate in Falkirk. Sealing off a little area for smokers in ridiculous and a waste of time. The smoke still carries over into the rest of the mall.

One area in particular which I am both disgusted and shocked about is St John's Hospital in Livingston. Out of the two entrances I use, both cause problems. Clearly there is no smoking inside the building. So, the smokers congregate outside the main doors, blocking the whole area. Again. I have to put my son on oxygen to enter the building. On rainy days, they smoke inside the building at the foyer between the two sets of doors. This happens in the maternity unit, of all places. They don’t care that new born babies are being moved past them constantly. I have complained about this on several occasions, and the hospital do all they can to stop it, but it’s simply not enough. Bigger, nation-wide steps have to be taken. For me, a ban on smoking in public places will help considerably. I could go shopping without having to worry that Christopher might be in the hospital that night with breathing problems. Non-smokers have had to put up with other people’s smoke for far too long. I firmly believe it’s time that action was taken to stop those who chose to smoke polluting the air of others.

Mary Meichan

SUBMISSION FROM JOHN MELLISH

I wish to support the Bill, on the prohibition of smoking in regulated areas, (Scotlan), introduced by Mr Stewart Maxwell (MSP) on the 3rd February 2004.

I would hope that the Bill would be amended in time to cover all Public places.

John Mellish

SUBMISSION FROM J C MELLISH

I wish to support the general principles of the bill introduced by Mr Stewart Maxwell MSP on 3rd Feb 2004.

I have personal reasons for supporting this bill having lost 2 very great friends through passive smoking and find it totally offensive to dine out where smoking is allowed.

The health of the nation is at stake.

J C Mellish
SUBMISSION FROM ROBERT MITCHELL

Ban of Smoking in Places Where Food is Served

I know that the closing date for submissions related to your backbench bill to ban smoking in places where food is served is Friday 23rd April and I would wish to support this ban. Not only in public places where food is served but in public places.

I really avoid going out because I cannot bear to breathe in other people's smoke. If I go out for a meal in the evening I feel that even in a non-smoking area I still return home smelling of smoke, feel my sinuses clogged up and feel quite stressed and frustrated knowing that the smoke won't have done my health much good either!

The long and short of it is that I just don't go out any more and feel that this is unfair.

There must be many people who feel as I do and it is about time that we stopped apologising for 'daring to speak out about smoking'. I would be delighted if something was done to ban smoking in places where people eat and beyond. Ireland have implemented this and I think that this is wonderful. We have plenty of evidence from health experts to state the devastating effects of passive smoking and it time to act on this for future generations in order that the non-smokers really do have a choice in the matter of choosing not to smoke!

Good luck and if there is anything else I can do to support your bill please do not hesitate to contact me. Many thanks for the effort you have put into this to date.

SUBMISSION FROM MRS HELEN MITCHELL

I know that the closing date for submissions related to Stewart Maxwell's backbench bill to ban smoking in places where food is served is Friday 23rd April and I would wish to support this ban. Not only in public places where food is served but in public places.

I often go to Wellgate-Centre in Dundee and if I sit down, pass the open-air cafes I am very aware of the smoky atmosphere. I have suffered a heart-attack in the past, am a non-smoker yet find that if I stop to have a seat, which I do frequently, people sit beside me to "have a cigarette' and I have to move. I can't bear to breathe in the smoke and wonder what it is doing to my health. I worry about the effects of smoking on smokers but more am very concerned about passive smoking.

My grandson was recently invited to a party in-a hall and although he loved every minute of it when he came out he was coughing, sneezing and his clothes were smoky. Were the people at the party smoking? No they were not. It was smoke 'left over' from a celebration the night before. The mother of the child holding the party was concerned when she went into the hall to set the party-up but what could she do? Cancel the party??

I would like to add my support to banning smoking in public places just as Ireland have done. America done it very successfully and we are always years and miles behind America - let's get on with it Independent Research from abroad has shown that a ban is very good for business, Latest innovation from New York which introduced a ban a year ago shows that tax revenues and employment have risen in the Hospitality Industry so the fears that a ban would harm business is unfounded. Are smokers or the tobacco industry feeding US these unfounded fears and scare stories??

I would welcome your comments.
SUBMISSION FROM ELIZABETH MOLES

Dear Sir

I support strongly the principles behind this bill.

Indeed noting that the south of Ireland is moving towards a ban, that the EU is considering using its powers to enforce legislation and that California and many states in the US enforce one I would see a case for even firmer legislation.

I do write as a lifelong sufferer from sinusitis - with asthmatic friends - which means that I actively suffer from the effects of smoke when I enter smoke filled bars/restaurants: the effect is unpleasant and immediate. I have no objection to people wishing to smoke but; my not smoking impinges on nobody's health. Their smoking impinges on mine.

Smoking by now is generally accepted as being actively and passively deleterious to our health- ranging from babies of smoking mothers, employees in workplaces, notably bars, pubs and restaurants-whose insurance has I gather to be higher to cover against claims for ill health resulting from exposure to passive smoking-to the smokers themselves and their families.

It markedly annoys American visitors and tourists here to whom I have spoken.

My last visits to Amaryllis-now closed-and to Le Chardon here were marred by smoke: the packed Le Chardon had a laughably tiny non smoking g area and the smoke from the larger area just filled it. This is the case in the too few places with non smoking provision all too often Closer to home in Bc 55 Drymen Rd I went in with a friend recently to find smokers occupying the non smoking area: the person in charge said: 'Sorry - didn't notice..' but did nothing. WE left: the smokers were not asked to move.

The feeble talk of voluntarism simply does not work- any more than it seems to have worked with the placing of sweets and crisps in supermarkets in the fight against obesity. The nanny state in practice is a toothless and spineless spectre of impotence in the face of rising proof that smoking damages all our lives. It blights our environment. In France - where they are going to try to enforce their non smoking regulations more strongly I saw that at Val Thorens where they pick up 30000 butts beneath one chair lift they know that this is enough to pollute the equivalent of 500 swimming pools. They are selling portable ash trays. We are not doing the same with all the butts outside working buildings where smokers congregate here. Can Scotland not set a firm lead here-worthy of its proud traditions??

I stress that a least non smokers should have equal rights- as opposed to no rights-and that they should not be made standard objects of derision- as they are all too frequently in our press, cartoons etc.

Please let this bill be passed-every cancer/heart specialist will thank you- let alone all those of us suffering from chronic respiratory disorders. I speak as one brought up with passive smoking- who has never smoked.

Initially people might stay away a bit - then they would come back. I am not against provision for smokers but I want proper provision for my kind as well.

Elizabeth Moles

I write to ask the committee to take into account evidence from abroad in favour of a ban on smoking. Today's Times reports that the ban on smoking in public places in Helena, Montana has cut hospital admissions for heart attacks by 40 %.
Furthermore, census records collected at the Wellington school of medicine in New Zealand and at its Harvard school of public health showed that non-smokers who had lived with smokers were 15% more likely to die of cancer etc than those who lived in non-smoking households.

I am about to peruse reports of our own report here on how much we would save by banning smoking in the workplace and in places like pubs and restaurants. I was recently asphyxiated in the allegedly non-smoking area of the restaurant at Le Chardon d’or-Maule’s place.

We should also consider that the EU is considering a ban in general and we should not be too far behind.

I would also point out that the use of ventilators—much as I would welcome them as an improvement on the current situation—does nothing to alleviate the evil effects of the chemicals produced by smoking.

I cannot say how strongly I favour this bill—apathy and accusations of authoritarianism have bedevilled progress towards a healthier and wealthier Scotland long enough.

**SUBMISSION FROM R F MORRISON, N J MORRISON, S R MORRISON AND ERICA MORRISON—SMITH**

My wife and family would like to record our unqualified support for this bill as drafted.

Thank you for proposing some really worthwhile legislation.

**SUBMISSION FROM JAMES MORRISON**

Smoking in public places should be banned. I support the bill.

**SUBMISSION FROM CHARLES NICOL**

I would like to register my support for a ban on smoking in restaurants, bars and all other public places.

Why should I put up with passive smoking, paying out prescription charges etc, after contracting conditions related to it, when I have not chosen to involve myself in this disgusting habit? People with breathing conditions have a terrible time, when they go out for a meal and find that their air is polluted and their meal ruined, even when they are seated in so-called non-smoking areas. Indeed, some people with asthmatic conditions cannot get out and about as a result of this.

I would support an outright ban on smoking in all public areas—restaurants, bars, all shops, bus/train stations and on all public transport. It is noticeable that, even when bus companies have a no-smoking policy, we often find drivers puffing away.

My question about all of this is, how will a ban be implemented? Often, we find that smokers are very ignorant and few will try to intervene and ask them to put out their cigarettes/cigars/pipes.

Kind Regards

Mr Charles Nicol
SUBMISSION FROM M NICHOL

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Why should I put up with passive smoking, paying out prescription charges etc, after contracting conditions related to it, when I have not chosen to involve myself in this disgusting habit? People with breathing conditions have a terrible time, when they go out for a meal and find that their air is polluted and their meal ruined, even when they are seated in so-called non-smoking areas. Indeed, some people with asthmatic conditions cannot get out and about as a result of this.

I would support an outright ban on smoking in all public areas - restaurants, bars, all shops, bus/train stations and on all public transport. It is noticeable that, even when bus companies have a no-smoking policy, I often find drivers blowing smoke in our faces.

My question about all of this is, how will a ban be implemented? Often, I find that smokers are very ignorant and few will try to intervene and ask them to put out their cigarettes/cigars/pipes. I once pointed out a non-smoking sign on a train to a smoker and I was answered with a barrage of abuse.

Kind Regards

Mrs M Nicol
Swinton, Glasgow

SUBMISSION FROM W NIMMO, M NIMMO AND A NIMMO

We write in support of a member's bill to prohibit smoking in enclosed places where food is supplied and consumed.

We welcome this member's bill, because we believe that smoking and passive smoking kills people. We have seen this happen recently to friends. One partner smoked, the other did not. The non-smoking partner died of lung cancer and the smoking partner died of the same disease quite soon afterwards. The Roy Castle Charity was set up in memory of Roy a non-smoker, who died of lung cancer. He had worked in smoky areas for years.

We would fervently hope that the health committee will recommend to parliament to legislate in accordance with Mr Maxwell's member's bill.

W Nimmo

SUBMISSION FROM ADAM PALMER

The reasons for my support of the proposed ban are:

- self-regulation not working - very few public places have proper facilities for non-smokers eg adequate ventilation etc, and many "non-smoking" areas are adjacent to smoking areas, and are also often in less pleasant parts of an establishment. No smoking areas are often full, with no option but to sit in a smoking area, or go elsewhere - often encountering the same problem
- I have no wish to expose myself and family to other people's smoke, with the relevant health risks, and also sheer unpleasantness, particularly when eating
- health & safety of staff - again, people should not be exposed to these risks at work

With thanks

Adam Palmer
SUBMISSION FROM HEIDI PARK

Sir/Madam,

This has got to be one of the best ideas since sliced bread! There's nothing worse when you're out for a meal and you happen to be next to a group of smokers, I don't understand why they can't wait for a couple of hours when they're outside or back in their own home to have a cigarette. As an asthma sufferer and a mother of a 2 year old who might be prone to get asthma I fully support the idea of having a breath easy life!!

Good luck with the Bill Stewart I really hope for everyone's health it will go through.

Heidi Park

SUBMISSION FROM ALF PETRIE

Dear Sir or Madam,

I am writing to say I hope you will be supporting Stewart Maxwell's Bill regarding "Prohibition of Smoking in Regulated Areas"

Passive smoking is a personal nightmare for me and find very few places in which to socialise.

I find it very sad in this day and age that children and non smokers have to breathe in carcinogens from other people's smoking.

Yours faithfully

Alf Petrie

SUBMISSION FROM DENNIS PRICE

Thank you for asking me to pass on my submissions of support to the Health Committee, it was written rather hastily and I am concerned that it is not formal enough. Certainly the often overlooked issue of passive smoking in the newborn and the premature newborn is overlooked in the wider media. I would be happy to give my support in any way I can, you may pass on my submission to the Health Committee.

Regards

Dennis Price

SUBMISSION FROM ELEANOR QUIGLEY

Written evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill

Do you support the general principles of the Bill and the key provisions it sets out?

I wholeheartedly support the general principle of safeguarding the health of people in Scotland by preventing them from being exposed to passive smoking in public areas.

Are there any omissions from the Bill that you would like to see added?

I would prefer if the Bill was extended to include all public areas but feel that the implementation of this Bill is a good start in improving the health of people in Scotland and also in encouraging people to
What are your views on the quality of consultation, and the implementation of key concerns?

My view is that the consultation has been wide-ranging and comprehensive. The research that has been carried out into the effects of passive smoking and also into the effects of a restriction on smoking in public places has also been extensive.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

I consider that any practical difficulties in implementing the provisions of the bill would be minor and would only affect businesses in the very short term. It has been shown that alternative approaches, such as voluntary charters, have not worked in Scotland to reduce smoking in public places. I feel that legislation to protect people's health is the only alternative that is likely to work.

SUBMISSION FROM BARBARA RAST

Dear Health Committee

I am writing to support the "Prohibition of Smoking in Regulated Areas (Scotland)" bill, sponsored by Mr. Stewart Maxwell MSP. I wish to draw the committee's attention to the social alienation engendered by environmental tobacco smoke.

The health risks of passive smoking are now well publicised. In view of these risks, I no longer wish to expose myself to environmental tobacco smoke. However, this desire is incompatible with leading a normal social life in Scotland because there are no non-smoking public houses and only a minority of restaurants offer non-smoking areas. Furthermore, where non-smoking areas are offered, they are usually not separated from smoking areas or are in an inferior part of the establishment (e.g., next to the toilets or in a poky separate room). Many colleagues and friends have the same feeling of social alienation due to the prevalence of tobacco smoke in public places.

On health and social grounds, I therefore very much hope that the Bill is passed.

Yours sincerely

Barbara Rast

SUBMISSION FROM COLIN REEKIE

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I support the general principles of the above Bill - that of banning smoking in public spaces where food is supplied and consumed (including pubs/bars) - but would like to think this could be extended in the future to include all public spaces as has been successfully implemented in other countries.

Colin Reekie

SUBMISSION FROM GERARD REILLY

I agree with the general principles of the bill
SUBMISSION FROM EILEEN RENFREW

I am writing in support of Stewart Maxwell's Members Bill to prohibit smoking in enclosed places where food is supplied and consumed.

As an ordinary member of the public who enjoys eating out it is unpleasant to have smoke drift across from smoking areas of restaurants so I think a complete ban is the answer.

I do not think that I am being a killjoy in this opinion as most surveys say that the majority of smokers would like to give up smoking if they could.

I think that the Scottish Parliament should take a lead in passing this bill to show the rest of the United Kingdom we are serious about the health risks of smoking.

Eileen Renfrew

SUBMISSION FROM A M RODGER

I herewith submit my reasons for supporting the ban on smoking in certain public areas.

I suffer from Asthma and my social life is limited in that I can no longer go to a large number of restaurants, cafes and public events in Town Halls, Burgh Halls and Village Halls. Where some establishments have separate areas for smoking, the stench still permeates the non-smoking areas and the reaction I get from the merest whiff of nicotine is horrendous to my respiration.

I wish to record my support for the Members Bill referred to above.

Yours truly

Mrs A M Rodger

SUBMISSION FROM ARCHIE ROSE

I believe that the proposed bill does not go far enough in accepting the health risks of passive smoking or the effects of this on people in public places.

For too long the vast majority of members of the public have had their health compromised by the actions of a sizeable minority. Smokers argue for their right to smoke and I do not dispute that it is their right but what about the rights of others e.g. other people who cannot get the choice if sat near or in the same small room as a smoker, or for workers who have no choice whatsoever when in an area where smokers are. The usual argument put up is that I can choose not to go there but why is it me who has to choose when none of my actions are putting anyone else at risk in any way.

Public places should be clean, safe and healthy and, therefore, the only fair conclusion is to ban smoking in all public places. At the same time there should be a large campaign to assist smokers to give up or to realise the consequences of their action on others.

The argument about pubs and clubs being exempt does not carry weight are we seriously saying that it is OK for a worker in these places to be put at risk? where in other places they may be protected. e.g only those places where food is served this is potentially discriminatory and could be open to legal challenge.

There has been a voluntary code in place for some time but the licenced trade have mainly ignored this altogether. The owner in my local pub would like to ban but would get too much hassstle from smokers while it is discretionary.
I look forward to the day when I can come home from a night out and don't have to put every stitch of clothing into the washing due to the smoke attached to me - what is it doing to my insides and what about those who have to do this every night because of their work?

I hope that these comments are taken seriously

Archie Rose

SUBMISSION FROM RONALD G ROSS, HEATHER ROSS AND RUAIRIDH G S ROSS

To whom it may concern, the three people at this household support the bill to stop smoking in enclosed and public places.

SUBMISSION FROM BILL ROSS

Smoke-free Guinness. in the Republic. But what about Scotland?

Congratulations and jolly well done the Irish!

The similarity Interestingly, Scotland has a very similar population and culture to that of the Republic. We, like the Irish, have for too long accepted the right of the few to smoke cigarettes (polluting the airspace), to the detriment and annoyance of the many.

Scotland suffers from the same smoking-related diseases and premature deaths that also afflict the Emerald Isle. In addition, around 30% of the population smoke in both countries.

The Irish Commitment However from 29 March 2004, the Irish Republic acted decisively, by introducing new smoking regulations, including widespread smoking bans.

The Result:-

1) Employees are protected from passive smoke in the workplace
2) Customers and staff are protected from passive smoke in pubs, clubs and - - restaurants
3) The culture of combined "smoking and drinking" in licensed premises will forever be broken. This will result in fewer people smoking and more importantly, fewer young people "taking up a lifetime addiction to nicotine".
4) The health of the nation will soon start to improve!
5) Breathing smoke-free air in public places has been enshrined in Irish law, as an individual's right. (And by default, the law of the land now protects the majority of its non-smoking citizens viz 70%)

In my opinion, the Scottish Executive has now been shown an exemplary example by the Irish Republic.

The Executive must now show the same commitment to Scotland's health needs.

Firstly It is time that Tom McCabe stopped "talking about the problem (It's a waste of time, we've heard it all before).

Secondly You should be taking effective action - we all know the problem, we need a solution!

Thirdly You could save the nation £7m plus, on proposed anti-smoking advertising funding.

Fourthly You must now start acting responsibly, and let's have a complete ban on smoking in an public places, with new legislation as soon as practicality possible.
And finally a recent report in the media suggested that 1000 deaths/annum in Glasgow alone, were caused by passive smoking. Just how many more medical opinions and reports do you need before you get round to doing something?

Yours sincerely

Bill Ross

SUBMISSION FROM ELSPETH ROSS AND KEN DAROCH

We wish to support the above bill.

We feel it will be beneficial to general health of the nation, also as we feel as individuals we welcome the idea of going into a restaurant without cigarette smoke.

Elspeth Ross
Ken Daroch

SUBMISSION FROM DAVID J ROY

I support the principle of prohibition of smoking in certain public places.

These should include restaurants.

A knock-on effect that needs to be considered is smoking by persons immediately outside the entrances to no-smoking buildings.

A specific example is my local hospital, St John's at Howden, Livingston, West Lothian.

Any visitors or patients entering the hospital by the main entrance currently have to run the gauntlet of a mass of smokers just outside the main entrance. I understand hospital employees have dedicated smoking facilities. However there is no provision for patients and / or visitors. Consequently they congregate immediately outside the main entrance, causing mess and distress to the non smoking public.

I have raised the issue in writing with the hospital management and have received written reply that they plan to take no specific action.

They state that provision of a facility would cost money that they cannot justify diverting from other budgets. Also they say they cannot ban smoking in the grounds outside the buildings (even thought they are in the hospital campus) or afford the effort to police a no smoking policy at the main entrance.

SUBMISSION FROM CHRIS SAGAN

My family and I fully support the general principles of the above Bill and the key provisions it sets out.

As a family living in the West End of Glasgow we like to enjoy going to the restaurants and cafes in the area and consider it an important part of our lifestyle and we would greatly appreciate being able to enjoy eating out without the occasion being ruined by a nearby smoker. As non smokers we resent having our meal ruined and the health of our children affected by cigarette smoke.

Neither my wife and I are shy about commenting to a restaurateur about our feelings however we find that the response often makes an unpleasant situation worse.
We believe it is right and proper for the Scottish Parliament to use its powers to impose the above prohibition which will benefit the community at large. It does seem that the population in general supports this Bill and would celebrate its introduction.

We look forward to a future of smoke free eating out.

Chris Sagan

SUBMISSION FROM CLAIRE SAVAGE

Hi

I fully support the bill to ban smoking in restaurants and place where food is supplied. I would also support a bill to ban smoking in all public places, i.e. pubs and bars. If this is not possible, at the very least smoking should not be allowed whilst standing/sitting at the bar and pubs and bars should be obliged to provide no smoking areas.

Regards

Claire Savage

SUBMISSION FROM COUNCILLOR ANDREW SCOBBIE

I feel that as much smoking in public places as possible should be banned. Smoking is the single most damaging legal thing that we do and I feel that it is very much incumbent on all of us to restrict it as much as possible especially keeping it away from all who don't smoke.

Councillor Andrew Scobbie, City of Edinburgh Council.

SUBMISSION FROM DR ROBERT SCOTT MBChB MRCGP FRCP

Dear Committee Members

The harmful effects of passive smoking are no longer in question. It is now only a matter of estimating more accurately the full extent of the risks.

To help preserve the health of the present generation and safeguard the health of future Scots, seize the opportunity to limit the damage that tobacco smoke will cause and put this bill into Law.

SUBMISSION FROM ANDREW SEVERN

I am writing to you to offer my views on the current debate surrounding the proposal to ban smoking in public places in Scotland.

I wholeheartedly endorse the campaign to ban smoking in public spaces on the grounds that smoking not only has a desperate impact on the nation’s health - a topic that should be close to your hearts - but that it should be demonstrated to a new generation of potential smokers that this disgusting habit is not socially acceptable.

It can only be political cowardice that prevents a ban not already being in place - you have the chance to put Scotland at the forefront of a UK health drive for once - seize this opportunity, as you have, from those many people that I have spoken to, got the vast majority supporting a ban.
I have just been visited here in Edinburgh by friends from New York. They commented on how better New York is for enforcing a smoking ban and how Edinburgh would benefit enormously too.

Please show some strength of character and endorse a ban on smoking - for all our sakes.

SUBMISSION FROM ANNETTE SHAW

I would like to make the following points regarding smoking in food outlets.

As far as I am concerned smokers’ rights do not entail others having to suffer the health hazards of passive smoking and the horrible stench of the stinking foul weed.

Staff have to work in a smoke filled atmosphere which is also detrimental to their health.

I am allergic to cigarette smoke and it is often difficult to find somewhere in places like Glasgow where there is a no smoking policy. We are very fortunate in Hamilton that we have quite a few coffee shops etc. which are no smoking and they are kept very busy, so the excuse that they would not be popular is rubbish. There is nothing worse than other people’s smoke getting up your nose or in your mouth when eating. I therefore find it very strange that shopping malls have banned smoking except in designated areas which are always - food outlets!

Another annoying thing is even where there is no smoking areas the horrible stinking weed drifts into that area helped by smokers who hold their cigarettes above shoulder level so that everyone but themselves get the dubious ‘benefit’ of the foul weed. Very few places have fans and those who do often don’t use them. That should have been made compulsory! I also find that toilets are often in the smoking area and that if you have to go to the counter to order food it is also in the smoking area.

Smokers sometimes ignore no smoking signs and are annoyed if they are told this is a no smoking area. Staff should be told by management to enforce the rules in the no smoking areas. After all, at the moment they can move to an area in the food outlet where they are allowed to smoke. This enforces the argument that smokers don't care about other people's rights, so smoking should be banned altogether and enforced if they ignore the rules.

Many food outlets have two separate areas for eating food but no attempt is made to make one of them non smoking BBs at The Forge is one example. The Parade off Alexandra Parade is another.

It is unhealthy and impossible for some people with asthma, bronchitis etc. to sit in restaurants etc. where is not even a no smoking area and miss out on nights out etc. It is certainly not good for children and pregnant women either.

I am sick of hearing about the rights of smokers. I have the right to clean air and not to have to inhale their ghastly smoke.

I visited Canada recently and all the restaurants and other food outlets were non smoking and it worked very well. The USA and Ireland are other examples of this policy working. People complained about wearing seat belts when it was being introduced but it has been very successful.

Many smokers want to give up their disgusting habit and not being able to smoke in food outlets will also help them to help themselves.

Please do not be wimps and have the courage to support Stewart Maxwell's Bill.

Annette Shaw
SUBMISSION FROM GRANT SISMAN

I welcome the Scottish Executive's initiative on the problems caused by smoking and their intention to ban smoking in public spaces.

However I am disappointed to hear the ban may not apply to bars; this would create a loophole in the legislation because venue operators who want to allow smoking would merely have to install a 'token bar'. There are already many entertainment venues with an integral bar that are no-go places for non-smokers. I have also noticed that other venues with bars and no smoking are well attended by smokers and non-smokers e.g. The Hub, the Queens Hall, The Usher Hall, Linlithgow Jazz Club etc.

At one time there was a misconception that smokers had to be accommodated, but smokers are now reconciled to not smoking in planes, trains, buses, cinemas, concert halls, theatres, offices, banks, hospitals and shops: Surely they have no greater need to smoke in bars than in these places! And surely there is a duty to protect all employees everywhere from the effects of passive smoking.

The quality of life and choice for a vast number of people including sufferers from asthma, allergies and other respiratory ailments has improved greatly but will continue to be less than satisfactory unless they have smoke-free access everywhere.

We should achieve a universal acceptance that it is socially unacceptable for anyone to inflict smoke on others anywhere.

Yours sincerely
Grant Sisman

SUBMISSION FROM M M SMART

Sirs

I fully support the bill proposed by Stewart Maxwell.

I am a retired chef and a non smoker, I have never smoked but all my working life I was surrounded by smokers, both my parents smoked and died of related symptoms to smoking.

Smoking should not be allowed where food is prepared, served or eaten, my wife and I do not go out to eat or drink as everywhere we go there is a blue haze and on return home our clothes smell of smoke.

We have a new pub restaurant opened in Wick, (Wetherspoons), they made a big thing of a no-smoking area, but to reach this area, you have to walk the length of the pub which is a smoking area, what is the point?

I support the bill

Regards

M M Smart

SUBMISSION FROM CHRISTINE SMITH

While I am delighted there is one MP that has the courage to take the smoking issue forward, I would like to see the Bill go further and ban smoking in all public places.
I am a union steward and while in my private life I manage, more or less, to avoid smoke stacked environments, there are some instances which are beyond my control. I find that my union colleagues have taken to smoking with a passion and I suffer severely from the effects of smoke, this takes the form of immediate sinus and throat problems which continues for the next day or so. My options are to persevere with the effects or give up representing my workplace members even though I am a dedicated steward. To date I have chosen to put my members before my health.

While I appreciate the right of people to choose whether they smoke, I also believe as a non smoker I have the right not to inhale other people's cigarette smoke. Why do smokers have more rights than non smokers? I am not saying they cannot smoke, I appreciate everyone is different and there are many people who participate in things I would not wish to be involved in, I accept their right to choose and know they would not force their lifestyle/pleasures on me. There are some pursuits that are better undertaken in privacy/personal social environment and smoking is one. In society our behaviour has to conform for the sake of order and respect for others wishes and to make life tolerable, smoking falls into this category of acceptable behaviour.

I have been in California and British Columbia since they have banned smoking in public places and I did not find any problems, their restaurants/bars were extremely busy and nobody appeared to be having problems with the ban. There was no evidence of people standing outside smoking, maybe they have all given up on the weed!!!! It certainly was a pleasant place to be.

One further comment, the lack of action by the executive and the fact they have backed away from this issue last year makes me wonder whether there are a substantial number of smokers in the Parliament protecting their own bad habits!!!!!!! Remember the Parliament is there to represent the people not members of the executive.

SUBMISSION FROM DR ROBIN SMITH

Prohibition of Smoking in Regulated Areas (Scotland) Bill - Call for evidence by Health Committee

As a health professional who spends much time dealing with the consequences of smoking I am writing to offer my support for the above bill.

Smoking is clearly very harmful to those who partake in the habit and there is some evidence that passive smoking in individuals in the vicinity of smokers produces harmful effects. Although I believe the effects of passive smoking are important, a far more powerful argument for restricting smoking in public places is, I believe, the effect it will have on the image of smoking and thus the effects on young people taking up smoking anew.

Although the overall number of people smoking is slowly declining there remains an alarmingly high prevalence of smoking amongst young people, particularly young women. I believe that this bill would help in giving cigarettes a more unsociable image and thus discourage young people from starting smoking.

Similar legislation which has been introduced in New York, California and Dublin have generally been perceived as being a success and initial concerns that bars and restaurants might suffer financially as a consequence have not been realised. Paradoxically trade in non-smoking bars and restaurants have in fact increased in these areas, the argument that human rights are being infringed by barring smoking is not valid in my opinion and are outweighed by infringements to non-smokers human rights by individuals smoking in their vicinity. Furthermore, other laws such as enforcement of wearing seatbelts have been found to be socially acceptable and have had dramatic health benefits.

I would therefore strongly support Mr Maxwell's bill and I hope that it will contribute positively to the change in cultural attitude that needs to happen in this country towards smoking.

Dr Robin Smith
SUBMISSION FROM LESLIE SMITH

I, Leslie Smith OBE, wish to object to the Prohibition of Smoking Bill (SP20) promoted by Stewart Maxwell MSP.

Leslie Smith OBE

1. Declaration of Interest

I am making this submission as an individual who smokes.

I have no connection with the tobacco industry. For a period of about three years I subscribed to 'Forest' but some time ago withdrew, mainly because I found that they did not have the resources to be effective in campaigning for 'smokers' rights'.

2. Personal Details

I am 67 years old. I worked for the railways for 42 years, retiring in 1994 as Managing Director Freight.

I was brought up in a family, and a society, when smoking was at least as dominant as abstention is now. I have smoked 60 cigarettes a day (or for a period, their equivalent in cigars and pipe tobacco) for 50 years. I regularly have comprehensive health checks. So far there are no symptoms stemming from my habit. I mention this without pride or, equally, apology, but it may be a pointer, from my forebears' lifespan as well, that genetics has a heavy bearing on longevity besides lifestyle and environmental factors.

I am strongly supportive of measures to control and dissuade smoking especially amongst the young. I endorse better provision for non-smokers but, in balance, a reasoned tolerance for smokers. I write on the presumption that Parliament would want to continue to dissuade, rather than repress smoking by making it a criminal act in the remaining public, social, spaces.

3. The Control and Regulation of Smoking

It should hardly need rehearsal but, given the scope of the Bill, it is salutary to outline the measures already taken.

Overwhelmingly, smoking is proscribed in offices, shops, public transport and entertainment venues. There is no advertising of the product but concerted contra-advertising. (The bold messages on cigarette packets are a very public rebuke to smokers).

4. The Bill

The proposals seek to extend proscription through a linkage to the places where food is served. The definition of 'space' at section 1.5 would make the catchment of premises very wide and this is reinforced by the provision at 1.4 that a cordon sanitaire of 5 days either side the provision of food would obtain. Since nearly all pubs now serve even rudimentary fare (say the traditional Scotch Pie) few establishments would be exempt apart from 'boozers'.

Roughly one third of the population would find themselves in forced abstention if using restaurants, cafes, nearly all pubs and even private clubs and social centres.

Or stay away, which amounts to a serious measure of social exclusion. This applies, particularly, to pubs which have always been a place for people to socialise - like blether - whereas other leisure venues are basically for watching and listening rather than participating. Casual observation would show that, in pubs, the proportion of people smoking is broadly the reverse of the general incidence.
The Bill, in its objectives, does not say if its measures are assessed to reduce the absolute incidence of smoking. While very casual smokers may be deterred, those who want to smoke will continue to do so (though providing a sorry spectacle on the streets outside pubs and restaurants...)

5. Objections

Given my profile it will be readily inferred that I view the prospect of enactment with, literally, depression. As a divorced, single individual my social life is mainly dependent on eating out and, particularly, drinking in pubs with friends. Incidentally, none of them who are non-smokers has any objection to the pub 'atmosphere' though they would if I smoked at their home - which I wholly understand and accept.

My stance, as a mere individual, is that of a lifetime consumer of a product, still legal, which long had social acceptability, then tolerance, until comparatively recently. I have not forgotten my roots, however, and have wider concerns, which I will set out in the next section.

6. Quality of Consultation

I perceive that there is a hazard of democratic (and especially demographic) deficit in this process for these reasons:

a) The Bill only specifically requires that consultation be pro-actively carried out with certain bodies representing the food, drink and tourist industries. (The Scottish Licensed Trade Association's circular letter seeking the opinions of publicans and their customers has been issued so belatedly and is so poorly framed that, as a plebiscite, I doubt its results will be representative.)

b) While a third 'only' of the population smokes, this proportion would not usually be termed a 'minority' in social or political considerations, but

c) Smokers in recent years have been so relentlessly stigmatised that most are psychologically cowed, and therefore probably less than ready to make a case for themselves.

d) They do not have any effective body in Scotland to represent them. For example 'Forest' has no specific presence whereas 'Ash' (Scotland) has a substantial establishment, is well funded, and prosecutes its case with consistent vigour.

e) Most potentially telling is the demographic pattern of smoking. The percentage of users is heavily skewed across the socio-economic classification (see 'Smoking Statistics' British Heart Foundation, 2004, Table 2.7 and section 2.2 of 'Reducing Smoking and Tobacco Related Harm' NHS Scotland 2003). It is a matter of record that protest groups are mainly most effective where middle or upper class issues are at stake because of the articulate-ness of the objectors and their social and political networking. The less advantaged are much less likely to be aware of impending legislation, its implications for them and how to make representations.

f) Given that in socio-economic classes IIIm, IV, and V, 61% of adults smoke (only 19% in categories I and II) any prohibitive legislation would bear on them very disproportionately. These are the same people, in general, who live in the most deprived localities where the use of both prescribed anti-depressant and illegal drugs is most rife. It is there that stress, and the lack of capacity to abstain, is most marked (see para 6.1of 'Smoking, Low Income and Health Inequalities' ASH and Health Development Agency, May 2001). To deprive them, under eventual guillotine, the occasional outlet of a meal and drink in social surroundings (no fag even in a 'greasy spoon') would, it is posited, only exacerbate their feelings of isolation and at worst despair. In these circumstances tobacco could be considered the least tendentious of several dependencies or addictions.

g) Another example of the demographic variation in smoking rates is a range of 15% to 71% amongst postcode sectors (ibid para 2.3).
h) A key issue should therefore be: will the consultation process reach, and so reflect, this majority of dependent or even addicted smokers?

7. Alternative Approaches

a) Following the (then) UK Department of Health's White Paper `Smoking Kills' 1998, the trade bodies promoted their 'Public Places Charter on Smoking'. While so far its targets have been met they were not that exacting. In the main restaurants have been more proactive than pubs. The guidelines are of course, at this stage, voluntary. On the other hand it is to be noted that only a minority of restaurants and virtually no pubs have set themselves up as totally non-smoking.

b) There are two key ingredients in the measures: segregation and ventilation. Apart from one-roomed establishments, there should be little difficulty in demarcating separate zones with a presumption, depending on customer demographics, of more space for non-smokers.

This will only work satisfactorily however if state of the art ventilation is both installed and deployed. It is irritating, even to a smoker, to see that ventilation is available but not regularly used, presumably to save electricity.

c) Which brings in, as always in the end, money. Really effective ventilation would be quite expensive to install and proprietors will be loth to invest if they believe that a total ban is likely to be enacted relatively soon.

d) In this context, it needs to be noted that `proprietors' range from individuals to substantial chains. About three-quarters of bars are now owned by 'Pubcos'. The latter will be quite self-interested and therefore uncaring of either set of customers in a trade off between cost and potential loss of income.

e) Given the number of people who express a strong preference for smoke free establishments, one would have expected market forces to meet their demands. But not enough have, since they are reluctant to face the likely loss of some custom.

g) To motivate those owners who would prefer to go no smoking, but are reluctant to face the likely loss of custom, some financial incentive could be offered. A suggested mechanism would be a carefully calibrated premium to be exacted through the licensing system, or council tax, to apply to proprietors wishing to continue smoking provision - which ought to incentivise those with an inclination to convert to smoke-free.

h) For those premises who wish to continue, it is suggested that Parliament should agree more rigorous specifications with the industry which become effectively mandatory if an establishment still wants to cater for smokers as well as non-smokers. A period of up to, say, 3 years should be allowed for strict adherence.

i) Such is the diversity of the layouts of the range of restaurants and bars that detailed prescriptions would fairly have to be set down for each establishment. While painstaking initially these terms could then be a codicil to their licence with periodic, checks made to ensure compliance by Health and Safety or other appropriate officials. This would be little more taxing than policing the proposed total ban. Exacting conditions would be required where owners want to retain children's certificates.

j) The outcome of such an approach should be a wider choice for those who want absolutely smoke free facilities and a much better environment where smoking is permitted. Smokers would welcome such developments.
8. Political Implications

a) The impetus for the prohibitory route originated in California. Adopting a similar `scorched earth' programme would represent yet another yield to the Americanisation of our culture.

b) The absolutists may have been emboldened by the apparent lack of mass protest in the Republic of Ireland. I would suggest however that there will be a well of simmering resentment about such a repressive imposition which may well manifest itself in unforeseen ways. Historically, prohibition and 'temperance' have often had quite unintended consequences.

c) There could be a temptation for Scotland to follow this lead and make a mark for the new parliament within the UK and further afield. That would not, in my view, reflect Scotland's tradition of tolerance and in particular, as I have emphasised, its distinctive care for the underprivileged. That, I would venture to suggest, is where Parliament's overall health improvements should be focussed.

d) In essence my case is that, in a democracy, reasoned regulation is always to be preferred to prohibition even though that is, seductively, administratively simpler. Legislation leading to a significant degree of social ostracisation, with the threat of criminalisation, would hardly be progressive or enlightened.

SUBMISSION FROM HAROLD B SMITH

I write in support of the above bill being proposed by Mr Stewart Maxwell MSP. Smoking in confined areas such as food establishments etc is, apart from being unhealthy, most unpleasant to non-smokers and particularly to the health and wellbeing of our children.

Harold B Smith

SUBMISSION FROM MARY SMITH

I write in support of the above bill being proposed by Mr Stewart Maxwell MSP. Smoking in confined areas such as food establishments etc is, apart from being unhealthy, most unpleasant to non-smokers and particularly to the health and wellbeing of our children.

Mary Smith

SUBMISSION FROM ALASDAIR SMITH

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I would like to express my support for the implementation of this bill for the following reasons:

1 promoting good health

Studies of the effects of passive smoking have proved that being in an environment where there are people smoking is dangerous to your health even if you are a non-smoker. The implementation of this bill would reduce the number of smoke filled environments and therefore reduce the health risk to smokers and non-smokers alike.

I would favour the introduction of a smoking ban as I value my health and the health of my children.
2 Economy

The implementation of the Bill would reduce the number of people smoking and would therefore improve the health of the nation and reduce the financial burden on the health service dealing with patients with smoking related diseases.

Businesses such as restaurants, pubs, clubs etc. would benefit by encouraging a smoke free environment as the number of smokers is generally falling and non smokers would favour a smoke free restaurant, pub over a smoke filled establishment. Personally I would always prefer to eat or drink in a smoke free environment as would most non smokers especially those with children and families. The economy would benefit as profits from these establishments would increase. Establishments that have banned smoking in other areas have increased their profits. The main industry in Scotland is tourism and visitors to Scotland would favour a healthy environment while staying at hotels and eating in restaurants/ pubs.

3 Creating a smoke free Scotland

I feel that this bill would be the first step towards a smoke free Scotland. Scotland historically has a reputation for the worst health record in Europe and this trend needs to be reversed if Scotland is to prosper both in terms of the health of its people and in terms of economy. The only way to improve the health record is to enforce no smoking in public places and make smoking socially unacceptable. It has worked in other places e.g. California, and recently in Ireland.

Regards

Alasdair Smith

SUBMISSION FROM MARY STEVENSON

I wish to state that I fully support Mr Maxwell's Bill to prohibit smoking in regulated areas. Having read the BMA publication, "Towards Smoke Free Public Places", I am aware that there is overwhelming evidence that passive smoking greatly increases the risk of strokes, lung cancer, acute coronary events and asthma attacks in adults. In children it increases the risk of ear infections, asthma attacks, and, terrifyingly, cot death. No one should be involuntarily exposed to these risks. People are dying, every year, in Scotland due to the effects of passive smoke. We all have a right to be protected from the appalling health effects of environmental tobacco smoke, and I believe that the state has a duty to protect us.

Scotland has a woeful health record, and our position in EU league tables on health has been worsening for years and years. The rest of the world is legislating against the effects of passive smoking; if we do not do so then we can expect to see Scotland’s health ranking fall even further. I do not think the Bill as it stands goes far enough. I believe there should be a full public places ban on smoking.

The only alternatives to legislation that I can think of are the use of ventilation and non-smoking areas. Ventilation does not work. The Scottish Executive position on ventilation is that it does not protect people against the hazards of smoke. Non-smoking areas do not work. Smoke travels freely in an enclosed space.

If smoking is banned in all restaurants then there is no economic disadvantage for any one restaurant. I believe that Scotland will find, like California and New York, that restaurant business increases after a ban on smoking.

I have no comment on the practicalities of enforcement except to state that all sorts of measures, such as drink-driving laws, seat belt laws, etc are enforced with no difficulties at the moment. It does not seem to me that the enforcement of non-smoking areas will be uniquely difficult: In fact the evidence from bans on smoking in cinemas is that the public complies without much fuss.
This is an excellent opportunity for the Scottish Parliament to improve the health of people in Scotland. I believe that this Bill should become law.

Yours faithfully

Mary Stevenson

SUBMISSION FROM LORD STODDART OF SWINDON

Prohibition of Smoking in Regulated Areas (Scotland) Bill

As you may know, two private Members’ bills have recently been introduced in the House of Lords. The bill introduced by Lord Faulkner of Worcester proposes to make it an offence to smoke in an enclosed public place or workplace, except in defined exempt places or part of the place which is designated a smoking area (to be determined by regulations). The bill extends to England and Wales only. The bill introduced by Baroness Finlay of Llandaff proposes to enable the National Assembly of Wales to prohibit, by regulations, smoking by any person in a public place in Wales. Both these bills claim as their object the protection of the public health. Likewise does the above bill of Mr Stewart Maxwell MSP. Given my particular interest in the bills in the House of Lords, I have a natural interest also in Mr Maxwell's bill.

I was a pipe smoker until 1987. However, unlike many ex-smokers, I have not become paranoid about those who wish to smoke tobacco and I believe it to be entirely wrong that smoking should be prohibited by law in any public place or work place. Tobacco products are not illegal and they provide very substantial tax revenue which the state is perfectly willing to levy and use. I firmly believe that smoking policies applying to public places should be driven by the preferences of customers and owner/operator's responding in their own commercial best interests; in the work place, smoking policies should be determined after full consultation between employer and employees. Such policies are generally working well.

The most recent available data for the UK shows that 50% of people work in places where smoking is prohibited and 36% in places where it is permitted only in designated areas. After allowing for the 5% who work on their own, it leaves only 9% of the working population not subject to formal restrictions on smoking. That represents a substantial reduction over the last seven years - down from 13%.

Many public places are already smoke-free and an increasing number of businesses in the hospitality sector are providing smoking and non-smoking facilities that reflect the choices of their customers. Market mechanisms are working.

However, strong as is my support for individual freedoms and the current successful voluntary approach, my principal objection to Mr Maxwell's bill concerns the justification which it claims in the pronouncements of the authorities on environmental tobacco smoke. This is laid out principally at paragraphs 5 to 10 of the Policy Memorandum on the bill. There, the authorities quoted - the USEPA, IARC(WHO), the CMO for England & Wales, the BMA and RCP - are impressive, but that does not mean that they are right in their claims as to the health risks to non-smokers of passive smoking.

I believe that the public has been misled by the way in which scientific and statistical investigations have been constructed and their findings interpreted, and particularly by the way in which results have been translated into headlines to influence the public. All too often, the media, in particular the television media, have been unwilling to give both sides of the argument relating to claims about the damage from environmental tobacco smoke. As a consequence, the general public is provided with a distorted picture.

All the pronouncements on environmental tobacco smoke cited in Mr Maxwell's policy memorandum rely predominantly on investigations into population groups in countries other than the UK. They are concerned with diseases that can have many causes, but most of the studies fail to investigate the relation of those other possible causes with disease. The so-called 'smoking-related diseases' are not
confined to smokers; nor are they confined to non-smokers exposed to tobacco smoke. There are significant differences in the construction and quality of the studies and their findings, which are also not consistent. They are also studies largely investigating the health of non-smokers living, perhaps for a lifetime, with a smoker. They are not about non-smokers being exposed to tobacco smoke in restaurants.

Significant also is the fact that the UK calculation of the estimated annual numbers and rates of death and ill-health amongst non-smokers in the UK resulting from exposure to environmental tobacco smoke, uses rates calculated for the USA by the California Environmental Protection Agency, whose calculations are in turn based on the assessments made by the US EPA. Although the review of the EPA published in 1992 has come to be treated as the 'gold standard', it seems to have escaped the notice of UK authorities, or perhaps they wish to ignore it, that in 1998 a US District Court determined that in producing its report the EPA had knowingly, wilfully and aggressively disseminated false and misleading information with the purpose of influencing public opinion and with far reaching regulatory implications. The Court subjected the EPA’s report and the manner in which it reached its conclusions to a thorough and detailed, forensic examination. The UK authorities have not done the same.

The largest case-control study undertaken in Europe of the effects of environmental tobacco smoke (WHO/IARC:Boffetta et al 1998) had the aim of establishing, as unequivocally as possible, the extra risk of lung cancer faced by non-smokers living with smokers. It found only a small and non-significant odds ratio for spouses exposed to smoking of 1.16. That lay within the region at which the IARC itself conceded that unequivocal results might never be achievable. Yet following a negative interpretation of their results in the media, the WHO/IARC team publicly insisted that their findings 'added substantially' to previous evidence of the link between environmental tobacco smoke and lung cancer. Their press release implied that the results proved a link, which on IARC’s own previous admission it did not.

Much more recently, ASH and others hailed a New Zealand study (Hill et al) as conclusively showing the risks of passive smoking to non-smokers. That study found an odds ratio of 1.15 as the association between passive smoking and all cause mortality - "Adults who had never smoked and who lived with smokers had about 15% higher mortality than never smokers living in a smoke-free household." It was not mentioned that 1.15 was a very low order of relative risk and lower, I believe, than in any previous study. Given the well-known shortcomings of epidemiologic studies, it can hardly be considered as even proving a certain link with smoking, let alone one of cause. Indeed, as the researchers reported they simply found a "modest association" amongst non-smokers living with smokers.

Nonetheless, as on previous occasions, reporters swallowed the misleading bait of popularising the results by quoting percentages. TV viewers and readers of numerous newspapers were given the impression that the increased relative risk was high. It was not. An odds ratio of 1.15 for all causes of death was extremely low.

The relative risk estimates relied upon by the BMA, SCOTH and others in this country for such diseases as lung cancer and heart disease in non-smokers living with smokers are similarly not reliable and are of a low order. I believe that for each disease they are in the region of 1.25 or lower. Taking lung cancer as an example, that means that the increase in risk is of the order of 2.5 lives in every 100,000, that being the excess over the estimated rate in non-smokers not exposed to passive smoking of 10 per 100,000. That is of an order that can just as well be explained by the designs of the studies, misclassification of data, bias, confounding, chance, all of which are factors for which complicated statistical corrections, often based on questionable assumptions, are made.

I therefore find myself also at odds with the Chief Medical Officer for Scotland, Dr Mac Armstrong, and the claims he makes in his recently published annual report. The figures he quotes for Scotland as regards the health risks to the smoker of smoking, and the risks to the health of non-smokers from passive smoking, are no more than simplified, subjective and contentious judgements of statistical studies that are fraught with uncertainties, assumptions, qualifications and probable flaws for which corrections have not been made.
The misinterpretation of statistical studies and data is, I fear, a common and too regular failing. It is most noticeable with regard to smoking issues, but is no less the case with regard to other topical issues of the day, such as diet and obesity.

I do not believe that there is any evidence whatsoever to justify the provisions of Mr Maxwell’s bill. That which he claims in science is on findings of very low order of risk. What is more, those findings are not even related to non-smokers exposed to smoking in places where food is served and consumed; it is related to non-smokers living for long periods, perhaps for a lifetime, with smokers. The excess risk relevant to his bill - if it exists at all, which I do not believe - would be so minute as to be not capable of being measured.

So far as concerns the interpretation of passive smoking relative risk estimates and the data on deaths of smokers claimed to have been caused by their smoking, I believe that two parliamentary Written Answers given by Baroness Jay, then a Health Minister, in 1998 and 1997 respectively, are illuminating:

Baroness Jay of Paddington (Minister of State, Department of Health): Relative risk provides a measure of the strength of association between a factor and an illness. It is an important way of measuring increases or decreases of risk over time or between different groups by comparing the incidence of an illness or hazard within a population to some baseline (for example, if drinkers are twice as likely to suffer from a particular disease as compared with the general population, a factor of 2 may be cited). A stronger association of greater than 2 is more likely to reflect causation than is a weaker association of less than 2 as this is more likely to result from methodological biases or to reflect indirect associations which are not causal. The significance of any such number does though need to be considered in context and from a number of viewpoints.

First, there is a statistical significance: in other words, what confidence is there in the number itself. This will depend on the quality and extent of the available data. Scientists usually express these by giving a confidence interval: rather than by saying that the relative risk factor is 2, they will say that (for example) one can be 95 per cent certain that it lies between 1.6 and 2.4.

Even when the strength of an association is precisely determined, it is insufficient in itself to confirm a direct causal link between possible cause and illness. The strength of an association is only one of several criteria which must be considered in the assessment of causation.

Other criteria include:

- the cause must precede the effect;
- the biological plausibility of the association - is the association consistent with other knowledge e.g. experimental evidence?;
- the consistency of the finding - is the same result obtained from different studies using different methodologies elsewhere?;
- the presence of a “dose-response” relationship - an increased response to the possible cause being associated with an increased risk of developing the illness.

All these factors would be taken into account in trying to pinpoint cause.

The practical significance of risk factors, also needs to be considered and depends on how great is the underlying risk. Doubling a very small probability (risk), say 1 in 100,000, still results in only a very small risk of illness. Doubling a risk of, say, 1 in 100 could, depending on its nature, be more serious.

In practice, scientific judgments will be made and debated on a case-by-case basis. The Government can draw on the expertise of independent scientific advisory committees which are constituted to provide balanced judgment on the questions covered above.

House of Lords, Written Answer, 31 March 1998, Official Report Cols. 31-32
Lord Stoddart of Swindon: What are the so-called smoking related diseases from which they (the Government) estimate 120,000 die each year and at what age in each case death occurred and what percentage were smokers at the time of death? How many men and how many women who died of so-called smoking-related disease were above the average age of life expectation when they died, and how many were smokers at the time of death? What percentage of total annual deaths is represented by the number of deaths from so-called smoking-related diseases?

Baroness Jay of Paddington (Minister of State, Department of Health: It is estimated that 120,000 people died as a result of smoking in the United Kingdom in 1995. The diseases attributed to smoking and used to estimate the total number of deaths are cancers of the lung, upper respiratory, oesophagus, bladder, kidney, stomach, pancreas and myeloid leukaemia; ischaemic heart disease; cerebrovascular disease; aortic aneurysm; atherosclerosis; myocardial degeneration; chronic obstructive pulmonary disease; pneumonia; ulcer of stomach and duodenum.

The following table shows the estimated age at death:

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-45</td>
<td>6,000</td>
<td>2,000</td>
<td>8,000</td>
</tr>
<tr>
<td>55-64</td>
<td>12,000</td>
<td>5,000</td>
<td>17,000</td>
</tr>
<tr>
<td>65-74</td>
<td>27,000</td>
<td>15,000</td>
<td>42,000</td>
</tr>
<tr>
<td>75+</td>
<td>32,000</td>
<td>21,000</td>
<td>53,000</td>
</tr>
<tr>
<td>Total</td>
<td>78,000</td>
<td>43,000</td>
<td>121,000</td>
</tr>
</tbody>
</table>

The proportion of the 120,000 people who died who were smokers at the time of death is not known; such information is not recorded on the death certificate and analysis is not available at individual death level.

The table shows that about 32,000 of the male deaths were at an age above the average life expectancy for men of 74 years and an estimated 15,000 of the female deaths were at an age above the average life expectancy for women of 79.

It is estimated that 19% of the total number of deaths in the UK in 1995 were caused by smoking (120,000 deaths in the UK in 1995 were due to smoking compared with a total number of deaths of 642,000).

House of Lords, Written Answer 24 July 1997, Col WA171/2

In 1995, the total number of deaths in the UK was 644,000 of which around 2/3rds were by a 'smoking-related disease'. Half of all deaths of non-smokers were from 'smoking related diseases'.

44% of those who were claimed to have died as a result of smoking died at an age in excess of the average life expectancy.

Nonetheless, the estimate of the number of deaths caused by smoking remained highly questionable. Deaths from smoking could not and cannot be estimated directly. Individuals claimed to have died from smoking cannot be identified.

Even were smoking status included on the death certificate, it would not be possible to identify which deaths were actually caused by smoking, since a proportion of smokers die from a disease that smoking can cause, not on account of their smoking but due to other causes of the disease.

In calculating the estimates of deaths caused by smoking, the proportion of deaths from each disease due to smoking is derived from the proportion who are smokers and ex-smokers, and an estimate of their excess mortality risk - their risk of dying from the disease relative to that of people who have never been smokers. The UK authorities use the US calculations of excess risk mortality.
I trust that I have given convincing reasons why smoking and mortality data, and estimates of the risks to non-smokers of exposure to tobacco smoke, should be treated with great suspicion, curiosity and caution.

**SUBMISSION FROM KEN STORRIER**

The open air is a public place, yet nothing is being done re the damage caused to health by exhaust fumes. Something that no one can escape. There has been an incalculable rise in motor transport in the last 50 years, yet nothing said about the damage caused by this. Danger from passive smoking is insignificant compared to this, get the plot right EH!

Regards

Ken Storrier

**SUBMISSION FROM ALASTAIR STRACHAN**

In light of Ireland now banning smoking in bars, food establishments it is now time for Scotland to follow suit.

The risk of smoking passively should not be imposed on non smokers.

Especially where food is served.

A total ban should be implemented.

Regards

Alastair Strachan

**SUBMISSION FROM JOEY STRICKLAND**

My wife and I support a ban on smoking in all public places in Scotland.

**SUBMISSION FROM MARILYN STUART-CHIVERS**

Prohibition of Smoking in Regulated Areas (Scotland) Bill


I feel that this Bill is long overdue, as the problem of smoking causing health problems has been known for decades. From a common sense point of view it is obvious that smoke inhalation, however small, is at the best unpleasant and at the worst totally alien to the well-being of the human body. For many years I have avoided all smokers as I find it abhorrent and have refused to work in a smoky atmosphere. Unfortunately, smokers generally tend to think that if they exhale the smoke "in the air" it has no harmful effect, or alternatively if they hold the cigarette away from their body this they think reduces harm or annoyance to other individuals. Nothing could be further from the truth.

I remember about 50 years ago when very young refusing to go upstairs in the bus because of the thick cloud of smoke permeating through the upper deck. Thankfully, we have moved on from there, but we must not be complacent. I therefore see this Bill as a step towards protecting non-smokers and also smokers from themselves. Any savings which can be made to the National Health Service as a result of improved lung and heart function and decrease in asthma and bronchitis in the population is to be applauded.
Having mentioned my own aversion to smoking, I have to mention that my sister (a non-smoker) who worked in smoke filled offices for a number of years, developed asthma in later years and was told by her G.P. that it was caused by passive smoking. To inflict this type of illness on anyone in the 21st century is unacceptable. We must make the world a cleaner and safer place to live in. It is important that we lead by example.

2. Omissions from the Bill

I note that adjoining spaces, i.e. buffer areas, are also proposed to be included within the legislation. It is true to say that it is pointless having any no-smoking area if consumers are then subjected to smoke from other non-restricted sections of the premises wafting towards them or that they are subjected to passing through a cloud of smoke as they leave the premises. However, this also applies to the fact that smokers tend to congregate around entrances/exits to buildings. I would suggest that this area should also be regulated.

3. Consultation

It appears that comments have been gleaned from a variety of sources all of which appear to promote the anti-smoking campaign.

4. Practical Implications/Alternative Approaches

Section 7 of the Policy Memorandum - Chief Medical Officer for England and Wales - advocates that "very serious consideration should be given to introducing a ban on smoking in public places soon".

I consider that the Bill does not go far enough and I think that smoking should be banned in all enclosed public places. This surely would be easier to implement as there would be no misunderstanding about zoned areas. I think that legislation should be clear and concise with no grey areas that can be misconstrued.

Policy Memorandum 25 - I wholly support the Republic of Ireland in their progressive approach to anti-smoking. Can we not follow their example and ensure that all public places should be smoke-free? We owe it to our children to provide a healthier environment for them in the future.

Policy Memorandum 41 gives power to Scottish Ministers to extend the restrictions of the Bill to any other places in the future. I reiterate my last point - why not now?

Thank you for giving me the opportunity to comment on the proposals.

Marilyn Stuart-Chivers

SUBMISSION FROM CHARLES TANNOCK MEP

As an elected representative it will be obvious why I take a keen interest in tobacco and health policy at a Community level, in Member States and, in particular, in the United Kingdom. I am therefore fully aware of the legislative proposals before the Westminster and Scottish Parliaments that variously seek to prohibit or regulate smoking. For the record I wish to state that I have never smoked personally and fully support the principle of health warnings on cigarette packets to the smoking population.

I have great concern about the principal assertion that is pivotal to the argument of those who wish bans to be imposed, namely the claim that passive smoking has been reliably established to be the cause of serious diseases amongst non-smokers. This appears to be Mr Stewart Maxwell's principal justification for his bill, on which the Committee is to report to the Scottish Parliament.

I believe that the assertion based on current evidence as I understand it lacks any certain or reliable scientific base. Rather, I agree with Professor George Davey Smith's editorial review in the British
Medical Journal which stated that "the impact of environmental tobacco smoke on health remains under dispute". That issue of 17 May 2003 carried a front cover headline "Passive smoking may not kill", referring to the results of the new large-scale study which did not support a causal relationship between environmental tobacco smoke and tobacco related mortality, although they did not rule out a small effect.

When replying to the ensuing protests from the medical community about the publication of the study and the editorial comment, the BMJ editor replied: "Of course the study we published had flaws - all papers do - but it also has considerable strengths: long follow-up, large sample size, and more complete follow-up than many such studies. It's too easy to dismiss studies like this as fatally flawed with the implication that the study means nothing." He continued: "I found it disturbing that so many people and organisations referred to the flaws in the study without specifying what they were. Indeed, this debate was much more remarkable for its passion than its precision."

The classic definition of science is that it uses observations and experiments to make logical inferences, formulate and test hypotheses, arriving at conclusions that can be generalised and expressed as testable laws and principles. The ultimate scientific test is experiment, but this is not ethically acceptable when it would involve exposing people to potentially harmful substances or agents. However, in the case of passive smoking, even without the prospect of experimental proof, the process by which it acquired its causal tag was not the conventional scientific route. The scientific investigation did not proceed by asking whether or not tobacco smoke in the air might qualify as a cause of certain diseases ("rejecting the null hypothesis"), but with the a priori affirmation that it did cause disease in non-smokers. Thus, the epidemiologic studies that have been undertaken into passive smoking have tended strongly to seek confirmation of that claim, rather than to investigate all the risk factors that might be relevant.

The epidemiologic studies have, for the most part, been based on case control studies of non-smokers living with smokers compared to non-smoking couples. Such studies rely upon personal recollections of the frequency and intensity of exposure to tobacco smoke by non-smoking spouses of smokers, generally over a period of many years.

Indeed, the findings of passive smoking epidemiology are susceptible to forms of bias that can arise as a result of misclassification and other flaws in data collection; study design or analysis inherent to case control as opposed to cohort studies; prejudice or one-sidedness in the interpretation of results; or publication bias, resulting from the fact that not all available information is published - generally studies showing a statistical significant relationship are more likely to be published than those that do not, and it must be remembered that even when there is no actual real difference by definition 1 in 20 studies will show conventional statistical significant difference by chance alone.

The findings are also particularly vulnerable to confounding, meaning the distortion of the apparent effect of exposure brought about by an association with other factors which can influence the outcome. This is a very important consideration when observed risks are only modest and also when the diseases concerned are well recognised to be multi-factorial, as is the case with the so-called tobacco related diseases which are not by any means confined to smokers. For instance it might also be the case that heavy smokers drink more coffee, alcohol or eat less healthy diets (some studies have associated such behavioural patterns as associated with cardiovascular disease or cancer risk) than the general population and therefore their spouses are also more likely to be associated with such risk exposure by sharing a common lifestyle even if non-smokers.

The results of individual passive smoking epidemiologic studies have not demonstrated consistency in their findings. Taken individually, they are generally inconclusive, tending to show a positive, but not statistically significant relation between passive smoking and lung cancer/coronary heart disease. This has led to the adoption of a 'weight of evidence’ approach as by increasing sample size and the power of the study it is easier to show significance with a weaker effect. This is achieved through meta-analysis - a statistical synthesis and re-analysis of the data from separate studies to provide a quantitative summary of the pooled results. Meta-analysis is most properly applied to groups of highly homogenous studies, which is not the case in this instance. Therefore, further significant
methodological and statistical adjustments are generally made to achieve corrections that are considered to be appropriate.

The application of meta-analysis to selected individual passive smoking studies has suggested that the relative risk - which provides a measure of the strength of association between a factor and an illness - is in the region of 1.25 in respect of lung cancer and coronary heart disease. For lung cancer, this represents an increase in cases from a typical 10 per 100,000 non-smokers to 12.5 per 100,000.

Given the inherent shortcomings of epidemiologic studies into passive smoking, the methodological and statistical adjustments to which data is subjected, the inconsistency in findings of individual studies, the appropriateness or otherwise of meta-analysis, and the low order of relative risk found when it is applied, it is difficult to draw an objective conclusion that passive smoking is definitely the cause of serious diseases. That is why biological plausibility has been recruited in support of causality.

It is known that tobacco smoke definitely causes disease in smokers; it would therefore seem plausible that it might have the same effect in the case of non-smokers. There are, however, significant physico-chemical differences between the smoke inhaled by the smoker, the smoke exhaled by the smoker, sidestream smoke from a burning cigarette and aged tobacco smoke in the air. In attempts to make a plausibility assessment of epidemiological findings, the likely intake of tobacco smoke by non-smokers has to be estimated. In one study by Hackshaw et al it was assumed that smokers typically consumed 25 cigarettes a day, faced a relative risk of 20 and that there was a linear dose risk. It found a relative risk for non-smokers living with smoking partners in the region of 1.19. However, that study relied on biological markers of exposure to passive smoking not linked to carcinogenic potential and ignored the evidence from other direct studies of exposure to passive smoking that consistently point to much lower levels of exposure. In a series of studies in European cities by Phillips et al, a much lower median exposure of around 0.02 cigarettes a day for the most exposed passive smokers was found. This suggests a plausible relative risk for passive smoking of around 1.02, an excess risk 10 times lower than that estimated in the Hackshaw study and very close to a finding of a nil effect.

I have only briefly stated my reservations about the reliability of the currently available scientific evidence on passive smoking. By voicing those reservations, I do not wish to convey anything more than that I believe the evidence to be weak and inconclusive. The risk, if any, to the non-smoker of tobacco smoke is of a low order of magnitude. It is not of an order that in my opinion would justify on public health grounds the blanket prohibition which Mr Maxwell's bill proposes. Additionally it must be noted that the available scientific data on passive smoking relates for the most part to non-smokers living with smokers, often over many years. Those findings cannot then be applied by extrapolation to situations where non-smokers, occasionally and for short periods, spend time in a place such as a pub, club or restaurant where there are smokers. There is even an old school of scientific thought that very low level exposure to environmental toxins may actually stimulate body immune systems and DNA repair mechanisms to combat diseases like cancer.

Dr Charles Tannock MEP
(Conservative-London Region)

SUBMISSION FROM BEN TAYLOR

I am writing to voice my support for this member's bill tabled by Mr Stewart Maxwell MSP on 3 February 2004. Smoking in public areas is already banned in the Republic of Ireland, as well as several states in the USA, and has been welcomed by the medical profession as a great leap forward in public health. Where similar legislation has been introduced, it already significantly reduced the prevalence of tobacco smoking and increased tourism and business for bars and restaurants.

The health risks of tobacco smoking are irrefutable. However, in recent years there have been several studies that have showed that 'passive inhalation of second-hand tobacco smoke also has significant public health risks. I The one study that did not show a link was heavily funded by the tobacco
I believe that people who understand the risks of smoking have the right as grown adults to continue to take the health risks associated with smoking tobacco. However, I choose not to take these risks and do not smoke. My informed choice and my right to abstain from cigarette smoking are infringed by people smoking around me, and forcing me to inhale their second hand fumes. Aside from the strong risks to my health, it is also extremely unpleasant.

People who work in smoke filled regulated areas, such as restaurants and public houses are exposed to a massive amount of cigarette smoke. Although I do not regard anecdotes as evidence, one only has to look at the case of Roy Castle, a lifelong non-smoker who died from lung cancer, believed to have been caused by occupational exposure to passive smoking. Occupational health risks cannot be ignored. Those exposed to asbestos and coal dust in the past are now able to launch legal action against their former employers because the businesses and the government failed to take measures to protect their health, despite knowing the risks.

The question now stands, what is the best possible way that we can protect those who currently have an occupational exposure to second hand tobacco fumes? The tobacco industry, and smokers’ interest groups such as FOREST have proposed ventilation to protect non-smokers from passive smoking. However, a MEDLINE search did not show any credible evidence that this offers adequate protection, and the World Health Organisation does not support their use, stating that “Since there is no evidence for a safe exposure level [to second hand smoke], legislation limited to ventilation design and standards cannot achieve smoke-free workplaces and public places”. Banning smoking in certain areas of an establishment, such as by the bar, although initially attractive, is not very effective. Employees who go around collecting glasses or serving tables in smoking areas are still exposed.

This now leaves two options- you can either require employers to issue all Staff gas-masks, or legislate to stop people from smoking in public places. Ignoring the issue is not an option, and gas-masks are frankly impractical! A ban on smoking in public places will protect bar staff entirely from occupational exposure to passive smoke. It can be enforced as it is in other parts of the world. Police and private door Staff are already able to enforce other laws in bars and restaurants (for example, people fighting in a bar will be prosecuted and usually banned from the establishment).

If we were to ban smoking in public places, it would go much further than protecting the health of employees in public places, children, asthmatics etc. In California, it appears that the prevalence of cigarette smoking has declined since the introduction of a similar bill. Smoking causes a host of disabling diseases, and is responsible for a tremendous amount of morbidity, and mortality worldwide. The public health of Scots is particularly poor, and we have a shockingly high incidence and prevalence of cerebrovascular disease, acute coronary events/ coronal heart disease, bronchial carcinoma and chronic obstructive airways disease. It is perhaps no accident that these are all diseases that are caused and exacerbated by cigarette smoking. Therefore a ban on smoking in public places would benefit us all, and make Scotland a far healthier place to live.

Ben Taylor

SUBMISSION FROM DAVID THOMPSON

I am writing in favour of the Prohibition of Smoking in Regulated Areas (Scotland) Bill, launched on 4th February 2004 by Mr Stewart Maxwell MSP. I fully support this Bill, and in fact would go much further in saying that smoking should be banned in all buildings to which the public have access, and that includes Pubs, which ,after all ,were initially set up for the consumption of alcohol only. In those times, smoking of course, was never ever thought to be a danger to health in any way ,and people smoked just about anywhere including Pubs and Cinemas, thankfully, now there is a no smoking policy regarding the latter, but nothing whatsoever has been done about smoking in Pubs and other buildings to which the Public have access. For instance, my wife went into a Baker’s shop the other day and smelt cigarette smoke right away.

SUBMISSION FROM DAVID THOMPSON
Now whether it was the staff or customers responsible does not really matter. The fact is that nobody should be smoking in these premises at any time. I am only one of the great majority of people in this country who are sick of smoke filled atmospheres in places as mentioned above. After an evening in a smoke filled Pub, the clothes you were wearing at the time, smell of cigarette smoke sometimes for days afterwards. One can only imagine what effect the same smoke has on your lungs. This situation is totally unacceptable. Nowadays, we are left in no doubt as to the dangers of smoking, with expert medical opinions regarding same, coupled with health warnings on cigarette packets etc. etc., yet still, in spite of numerous warnings, people will carry on smoking, regardless of the feelings of anyone around them.

I realise that this Bill only concerns eating places, and so I will concentrate on this at the moment. The present set up of smoking and none smoking areas in these premises is nothing short of farcical, and is obviously in place to please smokers. I can think of no other reason for this situation, than Governments past or present, do not wish to lose votes from smokers at election time, and, or, are concerned at losing revenue from cigarettes in one way or another. This way of thinking is beyond me, as stopping people from smoking in Eating places or Pubs, will unfortunately not affect the sale of cigarettes in any way. Would it not be grand if the present government would have the courage to come off the fence in favour of the none smokers. One thing for sure is that it is going to happen sooner, rather than later, as the vast majority of the population who are none smokers, are fed up with the situation. Now, down to basics. I have a grandchild who is asthmatic. My son will not take her into any eating premises where smoking is permitted as she has been affected by passive smoke in similar places in the past. Imagine drawing a line and sitting someone who smokes on one side, and someone on the other who does not. In other words, every area has boundaries, and whether you are twenty feet or one foot away from someone smoking, (which is the present set up ) then you are still affected by smoke in one way or another and if the premises are busy, then you would be as well sitting in the smoking area. I would like to know who thought this one out. A smoker without doubt. As far as eating places are concerned, you only need to ask yourself this question, If smokers can sit for HOURS on an aircraft without being allowed to smoke ( Airlines have for some time now had a no smoking policy on aircraft as you know), then surely the same people can sit in say a restaurant for one hour without a cigarette. Smokers will object at first of course, but they will just have to accept the situation and if desperate, go outside for a smoke. (Can't do that in an aircraft, can you?)

Much is made of Human Rights these days. In that case, it is everyone's right to breathe clean air at all times, especially so when eating, or for that matter, while drinking in Pubs or other places.

As cigarettes are now, without doubt, known to cause Cancer and other illnesses often resulting in death, then doing nothing about the situation is not an option.

Other countries have already introduced No Smoking policies in all buildings to which they have access.

Why are we taking so long?

David Thompson

**SUBMISSION FROM NATHANAEL TINGLE**

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

My name is Nathanael Tingle and I am a recently graduated Civil Engineer in Aberdeen. I am 23 and am looking forward to a long and healthy life in which I can enjoy myself and raise a healthy family. I have a 21-year-old wife and a 6-week-old son.

I have worked for 5 years both part and full time as a waiter in a restaurant during my student life and am intimately acquainted with the areas which will be prescribed as regulated areas in this bill.
I have been required to serve smoking customers in confined areas despite rigorous objections on my part. I have been serving food and having to be polite to customers while standing within 5 metres of sometimes a dozen lit cigarettes (within a confined area indoors). This was very difficult and I found that I often coughed and had trouble breathing during this. I found this to be very unfair on me and felt that I had no option open but to put up with this or quit my job. Although my boss was understanding and tried to give me a ‘non-smoking section’ of the restaurant, I was also required to serve in a ‘smoking section’ quite often.

I personally support this bill and am very keen for this to be passed so that we can all have healthy and comfortable surroundings in which to enjoy food and leisure activities. I applaud countries like Ireland for their stance on smoking and look forward to Scotland taking an equally bold and progressive stance towards improving our national health and quality of life.

I will describe my support for this bill from several angles to explain why I strongly believe that there is an urgent need to do something about smoke filled eating establishments.

Professional working practices

I am sure that most people will be aware that companies are required by the HSE and health and safety legislation to provide personal protection equipment (PPE) for their staff in all environments in which they may be at risk.

If someone worked in a noisy environment, earplugs would be provided to avoid hearing damage. If someone worked in a construction environment, steel capped boots and a hardhat would be provided to avoid physical injuries. If someone worked around water, a life jacket would be provided in order to avoid drowning. If someone worked around hazardous fumes and chemicals, breathing apparatus or a facemask would be provided to avoid lung damage.

With all of this care and attention to staff welfare, the restaurant industry along with others ignores the danger that passive smoking can cause. I was never offered the choice whether or not I wanted to wear any kind of PPE while serving smoking customers. As described earlier, I had some breathing difficulty and was offered no assistance despite raising the issue with my duty manager at the time.

This is unacceptable and although a staff member could choose to take up a different job, I don’t see why catering staff should all be forced to passively smoke.

I applaud Pizza Hut for their blanket no smoking policy and I hope this bill will cause the whole of Scotland to follow suit.

So-called ‘non-smoking areas’

My wife and I went into a restaurant while she was pregnant with our son and had to walk through a visible cloud of cigarette smoke in order to approach the welcoming staff member and get a seat. Undeterred, we asked to sit in a non-smoking table in the hope that this would ensure us a pleasant meal together. As we were seated, I commented on the thick cloud of cigarette smoke hanging above the table and asked if we could sit further from the smoking area as I was already having to hold my breath slightly to avoid coughing. Despite this being a well-respected restaurant, the best they could offer us was a dingy corner (which was still fairly smoky). We thanked them and made our exit before having dinner at home instead. We had only been in the place for less than 5 minutes, but already my jacket and hair was rank with the smell of somebody else’s cigarette smoke. I was disgusted and will not be eating there again unless they become fully non-smoking.
This is not an isolated incident and I have eaten many a time in places where people were smoking on tables directly adjacent to mine. I have also had to leave many restaurants that I would have loved to have eaten in, for this same reason.

I am not a health freak and I don't have any breathing difficulties, but I have rarely been into a restaurant where the non-smoking section is truly smoke free. The presence of a smoking section in any restaurant is enough to taint the whole place with smoke fumes. Theoretically, ventilation should take smoke out of the building and away from non-smokers. I am sure that some places have adequate ventilation and extraction facilities, but this is rare.

I feel that non-smokers currently do not have the right to eat in a smoke free environment and as such are highly restricted in their choice of eating establishment. Restaurants having 'smoking' and 'non-smoking' sections is laughable and is not a strong enough policy to protect public health and provide a safe and clean environment for eating.

Intrusion into my life

I feel very violated when I go somewhere to have a good time and can't because I'm choking on someone's smoke. The places here in Aberdeen where I feel uncomfortable are many (and most serve food too). Bowling, playing pool (anywhere), playing arcade games, shopping (in some shopping malls), visiting any pub, eating out in a restaurant and sometimes just walking down the street are places where inconsiderate people breathe their smoke into my face and lungs and intrude on my life.

This is an unacceptable intrusion. I have a choice to both damage my body and put myself through discomfort (in order to socialise and enjoy some leisure activities) or to limit myself immensely as to where I go and what I do.

I can understand that smokers would like the right to be free to smoke where they like, but I would like the right to be able to be free to not smoke when and where I like. At the moment, this balance is swung heavily in favour of the smoker and the non-smoker has no rights.

Children and the nation's future health

This is maybe a point for debate, but I strongly believe that children pick up on the example of their parents and of other adults. This means that if we smoke and allow smoking in all places, children will grow up with not only damaged lungs through passive smoking, but also an image that to smoke is a socially acceptable practice. I do not mean to demean anyone who smokes, but I think that it is clear that smoking damages health and that none of us dream that one day our kids will smoke 40 a day and die young.

We need to make a stand to show that smoking is a damaging pastime and that the long term future of Scotland is a healthier one. This should not be an issue of smokers vs. non-smokers, but it should be an issue of health and creating a comfortable and safe environment for all. I would like to be able to take my son’s delicate and newly formed lungs with me when I go out for some food or social activities without being concerned for his health.

I hope that in the future this will be the case.

Conclusions

In my opinion, it is not unreasonable to ask people who choose to smoke (and take up the health risks associated) to wait until they leave a restaurant before they light up. They should be able to wait for an hour to have a cigarette or they need professional help!! Nobody can claim that smoking is not a problem when they cannot wait through a meal before smoking. They do it at work for five days of the week.
Smokers should not feel marginalised, but they should respect the fact that others have made a healthier choice. Smokers should not impose their unhealthy lifestyle onto those who wish to live longer and avoid that particular risk.

I have been on both sides of the table in restaurants and I have experienced a great deal of discomfort in both roles. I am an Australian born British citizen but have lived in Scotland for 5 years and am proud to be here. I hope that we have a future here and that we can do away with smoking from regulated areas. I also hope that this will be a vital step in the long process to ensure that we smoke less in the future and have a healthier lifestyle.

Thank you for your attention to this and I anticipate success for this bill.

SUBMISSION FROM RICHARD TRAIL

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I write in support of the general principles of the above Bill. As a non-smoker myself I will appreciate the absence of smoke in restaurants. The elimination of smoking from trains, and planes has been most welcome and it is astonishing that we put up with it for so long. Smoke-free restaurants seems like the next logical step.

The health of the Scottish people should be one of the priorities of the government of Scotland. The continuing pressure to reduce the number of people smoking is one of the cheapest and easiest ways of improving the general health of the population. And it brings an improvement in the quality of life for those of us not addicted to the weed.

SUBMISSION FROM NIALL URQUHART

Evidence on Stewart Maxwell's Bill on Prohibition of Smoking in Regulated Areas

Do you support the general principles of the Bill and the key provisions it sets out?

I strongly support the principles of the Bill and its key provisions. Scotland has a high rate of smoking (34% of adults smoke), and 1 in 5 people die as a result of smoking in the UK (114,000 people annually in the UK, 13,000 in Scotland). 1 in 3 cancers are caused by smoking. Scottish men have the second highest rate of lung cancer in Western Europe (after Belgium).

Excess deaths due to smoking are not limited to those who smoke. There is clear and increasing evidence that passive smoking is a serious health risk and contributes to these figures. In the United States, the Environmental Protection Agency has classed environmental tobacco smoke as a Class A (known human) carcinogen along with asbestos, arsenic, benzene and radon gas. Action on Smoking and Health (ASH) estimate that, each year in the UK, about 600 lung cancer deaths and up to 12,000 deaths from heart disease in non-smokers may be attributed to passive smoking. In recognition of the risks and discomfort associated with passive smoking, most employers, public organisations and public transport operators have introduced voluntary bans or restrictions to ensure that workers and customers are not exposed to tobacco smoke. The Health and Safety Commission's Approved Code of Practice on Passive Smoking will, when implemented, effectively ban smoking in most workplaces. However, the Code will not be legislation and is unlikely to result in a ban on smoking in places of entertainment, including public houses and restaurants.

In pubs and restaurants in Scotland, very little progress has been made to address the issue of passive smoking. Although a Government charter has been introduced to encourage the provision of smoke-free areas and to protect bar staff from passive smoking, progress in implementing its terms has been disappointing and it does not go far enough. Therefore, it is particularly important that steps are now taken to introduce legislation to restrict smoking in restaurants and public houses. Such an initiative would assist in reducing the number of excess deaths from passive smoking, protect both...
customers and staff from the damaging and unpleasant effects of inhaling tobacco smoke and protect the rights of those with conditions exacerbated by tobacco smoke, such as asthma. Given the success of voluntary arrangements for controlling smoking in most public places and workplaces and the likely introduction of the Code of Practice to help strengthen this control, I do not consider that a blanket legislative ban on smoking in public places is necessary. However, action should be taken to control smoking in public houses and restaurants where inadequate voluntary action has been taken to restrict smoking and where exposure levels continue to be very high.

In seeking to tackle smoking in places where food is served, the Bill would take an important first step towards improving the air quality and comfort of customers visiting public houses and restaurants. While it is likely to be desirable to extend restrictions to all public houses regardless of the serving of food in time, I do not believe that there is general support for this at present. Continued efforts to raise awareness of the dangers of smoking and to effect cultural change as regards smoking will be required before smoking could be entirely banned in pubs in Scotland. Introducing legislation for a total ban would be likely to prove extremely difficult to enforce and would place an Unacceptable burden on the police and EHOs. I do, however, feel that the proposed Bill is a very good first step to raising awareness and finding a workable compromise at this stage.

1 Statistics from Action on Smoking and Health (ASH) Scotland and the British Heart Foundation
2 Respiratory health effects of passive smoking. EPA/600/6-90/006F United States Environmental Protection Agency, 1992
3 Involuntary smoking. Summary of Data reported and evaluation. IARC, 2002.

Are there any omissions from the Bill that you would like to see added?

I believe that the Bill is satisfactory as it stands with few exceptions. Further consideration does however require to be given to the need to protect all staff in the hospitality industry from the adverse effects of passive smoking. Employees are often not in a position to choose whether or not to work in a smoky atmosphere and therefore require legislative protection from threats to their health. Consideration should be given 0 steps such as requiring mandatory ventilation and air filtering standards in all public louses and further protection for staff where appropriate.

A further link should be made in the Bill between those public houses and restaurants where children are permitted under licensing legislation and areas restricted areas where smoking is not permitted. Environmental tobacco smoke exposure doubles the risk of asthma, lung infections and middle ear disease in young children. Lung growth and development is also affected, possibly leading to a higher risk of lung disease in later life.5 There should be a clear statement in the legislation that all areas in which children are permitted should be "restricted areas" in terms of the proposed legislation.

What are your views on the quality of consultation and implementation of key concerns?

The quality of the consultation has been more than adequate, particularly given that an earlier similar consultation had already been carried out.

Practical implications of putting these provisions in place and consideration of alternative approaches

Given the restriction of the provisions to those places where food is served, the legislation should be possible to implement and enforce without excessive cost and difficulty. The legislation would have the advantage of generally raising awareness of the issue of passive smoking in pubs and restaurants while also being more likely to be seen as "fair" by the public than legislation which imposes an outright ban. The clause requiring the display of signs is essential to ensure that it is clear that a no-smoking rule is in place and must be adhered to, as is the offence of allowing smoking in a restricted area. The responsibility for implementation should fall primarily on the licensee or an appointed person where the premises are not licensed.

The issue of alternative approaches is dealt with in the answer to question 1 above.
SUBMISSION FROM DR DAVID VERNON

I write as a Consultant Chest Physician in SE Glasgow. I am very strongly in support of Stewart Maxwell's proposed Bill. The health burden due to smoking related diseases is well recognised, though sadly often played down or ignored. Here (SE Glasgow) we see about 200 new cases of Lung Cancer each year. 80% of these people will be dead within one year of the diagnosis; a reflection of the nature of this disease and not of our incompetence. Most patients are inoperable at presentation, because of disease site or extent or because of associated adverse health factors which may themselves be smoking related e.g. chronic bronchitis, emphysema, ischaemic heart disease, peripheral vascular disease, etc. Our other treatments are very largely palliative in intent; surgery offers the best hope of cure. Probably 90% of Lung Cancer is smoking related. The UK death rate from this disease alone is approx. 100 people daily. A similar number are dying from Chronic Obstructive Pulmonary Disease (bronchitis and emphysema). This latter group are of course chronically ill for a much longer period and make quite a substantial health and financial burden. Often too such people are from the social classes who will find it harder to cope with handicapped health.

Therefore anything that can be done to reduce the opportunity to smoke in public places should be done. I think that the proposed Bill has a sensible balance in stipulating Regulated areas where the prohibition will be enforced, chiefly where food is prepared and consumed. I appreciate that there will be an outcry from Publicans and Breweries. All I can say is that I would only go for a Pub Meal in a non-smoking environment, and I am sure I am not alone.

I hope that this Bill might have an additional beneficial effect in reducing the exposure of children to the risks and temptations of smoking. Anything further that can be done to prevent tobacco sales to under-age clients should also be done. The smoking rate in young girls in particular is possibly now rising. (Perhaps boys are interested in sport and fitness where girls wish to be slim and beautiful - tobacco is a powerful appetite suppressant).

David Vernon

SUBMISSION FROM PHILIP WADLER

Scotland should follow Ireland in banning smoking in restaurants (and pubs).

* Workers are entitled to a smoke-free environment, and is only right that this should apply to service staff as well.

* It will encourage Scots to quit smoking.

* It will reduce the burden on the NHS in future years.

Philip Wadler

SUBMISSION FROM NANCY WALKER

I wish to express support for the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

The vast amount of credible documentary evidence which highlights the damage caused by passive smoking is a grave cause for concern to the well-being of the public in general.

I understand that the Scottish nation has the highest instance of asthma in the world - this can only be exacerbated by such widespread enforced passive smoking. A close relative of mine (who worked as a cook) had serious asthmatic health problems due to living and working in an environment where it was considered acceptable by others to carry on smoking in areas where many non-smokers were working and eating.
Passive smoking directly increases the risk of different types of cancer, it also increases the risk of heart disease. Again, Scotland has a very high incidence of both these diseases. Instead of talking about statistics, is it not time for action by taking some positive measures to protect the general public?

In many cases people who smoke are totally irresponsible in insisting on smoking despite the rights of the general public to eat, relax or work in a clean air environment. A voluntary ban on smoking will not work.

Ventilation is not the answer either - the World Health Organisation states that "Since there is no evidence for a safe exposure level (to second hand smoke), legislation limited to ventilation design and standards cannot achieve smoke free workplaces and public places".

Smoking should be banned from all public places, as well as all places of work. In an office environment with 1 smoker and 9 non smokers, the majority's health is indisputably put to serious health risk by the 1 smoker. Quite clearly, this is an unacceptable situation.

I believe that the Scottish Parliament has a duty of care to the nation, and must ensure, by bringing in whatever Bills are necessary, that the public’s health is not further endangered by being forced to inhale the thousands of chemicals in each and every cigarette (or cigar/pipe smoke).

I wholeheartedly support Stewart Maxwell's Bill to prohibit smoking in enclosed places where food is supplied and consumed.

Nancy Walker

SUBMISSION FROM BRYAN WARREN

Reference to your letter requesting personal views on the smoking in public places.

For the past ten years I have given up most weekends throughout the summer to raise money for the Roy Castle Lung Cancer Foundation. This charity came into being precisely for the same reason that you are presenting in the bill. Roy Castle as you will know was a non smoker, who inhaled other peoples discarded cigarette smoke. Which in the end was the cause of his death.

I became involved because of my mother’s death, believed to be caused by passive smoke. It is not natural for the body to accept and I do believe that non smokers, and children, should forced though no fault of their own to this very unpleasant and dangerous pastime of others.

My family and I fully support your bill and wish you every success.

Bryan Warren

SUBMISSION FROM W HUNTER WATSON

Dear Sir or Madam,

Smoking in Regulated Areas Bill

I hope that the Health Committee is able to give this Bill its support. On several occasions I have entered premises where food is served hoping to eat and felt obliged to leave before ordering because of the smoky atmosphere. Occasionally, when meeting up with former colleagues who, like
me, I have eaten in a hotel dining room where there has been smoking. When I returned home my wife found the smell of smoke on my clothes offensive, a smell that lingered for more than 24 hours.

Yours sincerely

W Hunter Watson
Aberdeen

SUBMISSION FROM CHARLES M WEBSTER

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I have read the above Bill. I understand that few problems have been experienced in the implementation of prohibition in the Republic of Ireland, which has gone much further than the provisions in this Bill. I have, therefore, no hesitation in giving my full support to the Bill as published.

Charles M Webster

SUBMISSION FROM MARGARET WEIR

I wish to express my support for Mr. Maxwell's Bill as described on your website.

Margaret Weir

SUBMISSION FROM RALPH WEIR

I wish to express my support for Mr. Maxwell's Bill as described on your website. As a non smoker, I find it difficult to find a variety of restaurants which have non-smoking areas. I do not believe non-smokers are adequately catered for.

Ralph A. Weir

SUBMISSION FROM ALAN WESTWOOD

I have just seen the call for written evidence on this bill. I can see no reason for delay in its implementation in full. The consistently poor record for the health of Scots when compared with other countries speaks for itself, and the bill has my full support.

Alan Westwood

SUBMISSION FROM CLIFF WHITE

I've read that the Scottish Executive plans to ban smoking in restaurants and public spaces in the near future. I applaud this decision and hope they can also add Public houses to the list.

Regards

Cliff White
SUBMISSION FROM GEORGE WHITELOCK

Re: Prohibition of Smoking in Regulated Areas (Scotland) Bill - Call for evidence by Health Committee

As a health professional who spends much time dealing with the consequences of smoking I am writing to offer my support for the above bill.

Smoking is clearly very harmful to those who partake in the habit and there is some evidence that passive smoking in individuals in the vicinity of smokers produces harmful effects. Although I believe the effects of passive smoking are important, a far more powerful argument for restricting smoking in public places is, I believe, the effect it will have on the image of smoking and thus the effects on young people taking up smoking anew.

Although the overall number of people smoking is slowly declining there remains an alarmingly high prevalence of smoking amongst young people, particularly young women. I believe that this bill would help in giving cigarettes a more unsociable image and thus discourage young people from starting smoking.

Similar legislation which has been introduced in New York, California and Dublin have generally been perceived as being a success and initial concerns that bars and restaurants might suffer financially as a consequence have not been realised. Paradoxically trade in non-smoking bars and restaurants have in fact increased in these areas, the argument that human rights are being infringed by barring smoking is not valid in my opinion and are outweighed by infringements to non-smokers human rights by individuals smoking in their vicinity. Furthermore, other laws such as enforcement of wearing seatbelts have been found to be socially acceptable and have had dramatic health benefits.

I would therefore strongly support Mr Maxwell's bill and I hope that it will contribute positively to the change in cultural attitude that needs to happen in this country towards smoking.

Yours faithfully

George Whitelock

SUBMISSION FROM STEPHEN WILLIAMS

I completely support the Prohibition of Smoking in Regulated Areas (Scotland) Bill, and furthermore, would like to see the ban extended to more public areas, including such places as public houses.

Additionally, I think areas where large groups of people gather in confined spaces, where enclosed or otherwise, such as train stations, should also be covered by the ban. This obviously ties in with wish of the Scottish Executive to improve usage of public transport -I for one am strongly opposed to subjecting my two year old boy to the smoke-filled atmosphere experienced at Waverley Station in Edinburgh, but in particular on the platforms at Haymarket Station in Edinburgh.

People should not have to be subjected to passive smoking in such circumstances.

Kind regards,

Stephen Williams

SUBMISSION FROM MARTIN WILLIAMSON

I would like to add my support to the motion that smoking is banned in public places in Scotland.

Martin Williamson
SUBMISSION FROM BRUCE WILSON

I was appalled to hear on BBC Scotland this morning that the Surgeon General is apparently of the opinion that Scotland is not ready for any form of anti-smoking legislation to prohibit smoking in public places.

On the same program I also heard that Eire is doing exactly that later this month!

The inference I draw from this is that the Surgeon General’s view is that the Scots are not adult enough to decide this issue.

I am not aware of the actual statistics but carry in my head that approximately 25% of the population smoke. Why is it that that minority is allowed to hold sway over the habits of the majority?

The BBC program interviewed smokers in Los Angeles who, after the implementation of legislation to ban smoking in public, actually feel it is correct, despite having vigorously opposed its implementation at the outset.

Much is also made in this silent debate about the economic arguments. These seem to centre around the fact that publicans and restaurateurs will lose money hand over fist. Personally as an adult asthmatic my ability to go into public houses and even restaurants is hugely curtailed. I suspect that I am not alone in avoiding ‘public places’ because I have no desire to pollute my lungs, clothes etc. In addition I run to keep fit (I am almost 50) and cannot abide choking on every breath I take when I am trying to drink a coffee or eat some food.

If there was a smoking ban, I suspect that smokers will still frequent public houses and restaurants as before. After all if they want a night out, a pleasure I have to abstain from because of smokers, everywhere will be the same. The publican in Edinburgh ploughing a lone furrow on his own does indeed face an economic chance, however, if I lived in Edinburgh there would at least be a choice for me as a non-smoker.

I cannot see any dis-benefit to publicans etc. Indeed, they have a duty of care as employers to their employees to protect their health whilst on the employer’s premises, and must face at some time in the not too distant future the prospect of legal action. I mentioned I am an asthmatic, a disease that is almost becoming rampant in Scotland. Smoking must play a part in that. Both of my parents smoked and I cannot help but form the opinion that that figures large in my having the condition.

I have always played sports, from rugby as a seven year old until the game got too dangerous for me in my mid twenties, to cycling, swimming and running, the latter which of course I still do with the most frequency.

The cost to the Health Service of dealing with smoking related illnesses must far outweigh the cash inflow to the Treasury of tax on tobacco. How do you measure the premature death at age 63 of anyone anyway? I know that the pension industry is in a tailspin (generated largely in my humble opinion by Gordon Brown tinkering with the tax credit system on company dividends) just now, but it seems to me that allowing people to die before they can draw their pension is a radical way to sort the problem!

The BBC program mentioned that the life expectancy of an adult male in Shettleston is the same as that of an adult male Iraqi. That expectancy is 63 years of age. Diet and smoking are the main culprits. It is unforgivable in my view that the Executive will simply sit on its hands in this issue, it has a responsibility to the people of this nation which it purports to represent.

Can you let me know where you stand on this issue and ask that you actively campaign to achieve a ban on smoking in public places in Scotland so that we can all enjoy living in this country which will be seen as forward thinking, dynamic and progressive in thought and deed.
Failing to grasp this nettle will give us the appearance to the world at large of being Luddites unable to move forwards, still stuck firmly in the past and displaying the characteristic of being assailed by self doubt. Let there be no doubt, ban smoking in public places for the health and comfort of the nation.

SUBMISSION FROM WILLIAM A A WITHAM

My wife and I fully support the above Bill introduced by Stewart Maxwell, MSP.

We both feel it is vitally important that staff who have to work in such establishments must be protected from the effects of passive smoking.

It is equally important that staff who work in open offices (such as Drawing Offices, Banks etc) are also protected from passive smoking.

SUBMISSION FROM DAVID F WRIGHT

Dear Health Committee

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

I wish to submit evidence in support of this Bill from the vantage point of someone suffering from chronic and periodically life threatening asthma and bronchiectasis (my wife). It is imperative that my wife avoid all exposure to the smoke of cigarettes, pipes and cigars. While she has enjoyed considerable freedom in recent years in respect of transport (planes, trains and buses - although bus queues and shelters are still a problem with the last, and smoke sometimes penetrates non smoking train carriages) and cinemas and theatres, eating places remain remarkably resistant to change.

There are still surprisingly few non-smoking restaurants in Edinburgh and surprisingly many which have no non smoking provision. Worst of all, paradoxically, are those establishments which claim to have non smoking areas which are inadequately insulated from smoking areas. These are worst because they seem to promise well but result in greater embarrassment and inconvenience than straightforwardly no go places. We have before now had to leave in the middle of a meal when someone has lit up nearby and smoke has wafted across.

I do not think it is necessary, or appropriate for me, to argue for the damage to health from passive smoking. I wish to highlight the social disadvantage suffered by those seriously allergic to other people's smoking. We would not tolerate as a common fact of life in the case of individuals with physical or other disability.

Since the restaurant and café management seem too reluctant to put their own house in order, voluntarily, it seems to be time for the Scottish Parliament to prohibit smoking where food is served and consumed. Of course there will be protest, but action in pursuit of better health and social equality must be prepared to ride out short term unpopularity. I urge support of this bill.

David F Wright

SUBMISSION FROM DOUGLAS A YATES

I am writing in support of the Member's Bill introduced by Stewart Maxwell MSP. With more and more people suffering health problems due to the effects of passive smoking, I feel it is entirely sensible to enforce smoke-free public places. Those who resist the perceived need of non-smokers to be in a smoke-free environment, especially when consuming food, are, in my opinion very selfish. Those wishing to smoke may do so in the privacy of their own homes or in other places which is non-injurious to others.
I, therefore, support the general principles of the proposed Bill and the key provisions it sets out wholeheartedly. I am pleased that there has been a wide level of consultation on this Bill and hope that there is a strong weight of public opinion in its favour.

Douglas A Yates

SUBMISSION FROM VICTORIA YOUNG

I refer to the article in the current edition of 'The Ayrshire Post' dated June 18th, regarding the ongoing debate concerning smoking in public places, & in which you requested the opinions of the general public.

I smoke. I do not drink. That is my choice. I have no problem with people who choose to drink. That is their choice. I would not even dream of suggesting to drinkers to move away from me in a restaurant or any other establishment because 'the smell of their alcohol makes me feel sick'. If I inadvertently walk into an establishment which smells strongly of alcohol, I leave & go elsewhere. I ensure that the places that I go to are not the ones which smell like breweries, but where fresh air circulates freely (or, as in today's climate, the areas are sectioned) & customers who choose to drink during or after their meal can do so & considerate smokers who choose to enjoy a cigarette after their meal can do likewise & not be made to feel like a social outcast.

I feel strongly that this whole issue has now become ridiculous, with the anti-smoking lobby becoming more & more malicious in their attack on smoking. I would agree that it most probably is not 'good for you' but neither is exhaust fume, so can we expect a ban on cars in public places soon.....? Or is that being just too ridiculous.......?

I would like to register my opinion with you that smoking in public places should not be banned. Common sense has to prevail in this argument - publicans & restaurants owners, if need be (& they know their customers better than anyone) can segregate smoking & non-smoking areas. It is happening now & it is working. I would therefore appeal to your sense of reason not to enforce an all out ban.

Mrs Victoria Young

SUBMISSION FROM ANGUS COUNCIL

Prohibition of Smoking in Regulated Areas Bill

Thank you for your letter of 18 March 2004 giving an opportunity to submit views on the above Bill. Since the well publicised smoking bans in New York and Eire, the momentum for change in Scotland is gathering pace.

This is a health issue and the rationale for the New York and Eire bans has been to protect workers at their place of work. This, in effect, also means that in many places the public cannot smoke leading to protection from secondary tobacco smoke for non-smokers, including children. There seems to be an acceptance in both those instances that the ban is inevitable and irreversible.

The Stewart Maxwell Bill is seen by many as a first step, protecting people where they go to enjoy a meal. This would be especially so where families decide to enjoy a meal together, including children, and they can do so in a pleasant atmosphere protected from tobacco smoke. However, this restriction does not extend protection to people at work many of whom will be non-smokers not happy at working in smoky atmospheres.

Consequently, there is a very strong argument that the Maxwell Bill does not go far enough, by not replicating the bans in New York and Eire.
In many parts of Canada, including Toronto, smoking bans have been introduced mainly again aimed at protecting people at work. Scotland needs to heed what others are doing in health promotion and protect workers from secondary tobacco smoke.

The health argument is extremely strong, and the only reasons for not introducing smoking bans are economical and political. Businesses in New York and Dublin have found and are finding ways to allow die-hard smokers to smoke (smoking buses outside the premises) and there is no reason why we cannot adapt in a similar way to allow those who insist on smoking to do so without them harming the non-smokers.

It is also being accepted that mechanical ventilation of premises is not the answer. Such filtration systems only improve the atmosphere and do not extract harmful particles from the air in the premises.

We believe it is only a matter of time before a worker is successful in an action against an employer for damage to their health caused by secondary tobacco smoke and the result could be punitive. Whilst Environmental Health Officers presently carry out routine inspections of premises in the service sector under Health & Safety legislation, there are no express powers to deal with the smoking issue. Secondary tobacco smoke is probably one of the major hazards to employees in the sector and if legislation allowed, risk assessments could be more rigorously supported as a means of controlling this health hazard.

Better we bite the bullet now and make health the priority. Non-smokers deserve to be treated better and if it encourages some smokers to give up as a result that is even better news for the health of our nation.

In respect of the Bill as it stands at present, the only reservation we have is in regard to enforcement. We do not concur with Stewart Maxwell that it will police itself (i.e. that law-abiding Scots will comply). In our view, in the initial stages, much persuasion and arm-twisting will be necessary to make it work. Some form of back-up enforcement regime will need to be in place to ensure the ban becomes workable and respected.

**SUBMISSION FROM ARGYLL AND BUTE COUNCIL**

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

This Bill is designed to prevent people from being exposed to the effects of passive smoking in certain public spaces, and focuses on areas where food is supplied and consumed. It is anticipated that the Bill will raise awareness of the dangers of passive smoking and smoking, and will assist in changing the attitudes of the public towards smoking in general.

The general principles of the Bill in terms of recognising the need to address public health issues in relation to smoking are welcomed. It is undoubtedly the case that Scotland needs to adequately address levels of smoking within the population in order to improve our statistical profile regarding preventable illnesses and premature deaths caused by smoking related diseases such as coronary heart disease, stroke and respiratory disease. These matters must be addressed by way of targeting smokers themselves, and by making provision for non-smokers to avoid passive smoking wherever possible. To this end, the Bill is to be welcomed.

The key provisions which the Bill sets out are clear and concise, and incorporate provisions regarding the offences of smoking in a regulated area, permitting smoking in regulated areas and failing to display signs in relation to regulated areas. There is concise provision in relation to responsibilities within organisations including bodies corporate.

The Bill is well constructed, and a good first legislative move in relation to the issue of smoking in public places. From a public health perspective however, the Bill does not go far enough regarding
the wider issue of smoking in public in general, as opposed to only in places where food is being consumed. The need for this legislative position to be considered cannot be overstated.

In consideration of the Explanatory Notes regarding the Bill in relation to estimated numbers and costs etc of likely prosecutions resulting, the practical implications of the Bill appear to be well thought out and reasonable, with most enforcement action capable of being undertaken within existing resources of appropriate bodies, and the likelihood of high levels of compliance in regulated areas. This will require ongoing assessment and evaluation to ensure that the projected enforcement outcomes remain relevant, and to ensure that where necessary extra resources can be diverted to those agencies who may in fact pick up an enforcement burden as a result of the Bill.

To summarise, the Bill is an effective first step in addressing the issues of smoking and passive smoking within the Scottish population. The effects of it's enactment should be closely monitored to assess outcomes, and should then be used as a basis for future legislation in relation to more widespread control of smoking in public places as one means of addressing Scotland's public health profile.

SUBMISSION FROM THE ASSOCIATION FOR NONSMOKERS' RIGHTS (ANSR)

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

ANSR is delighted to support the general principles of the Bill and its key provisions, insofar as if it becomes law, this measure will take Scotland a considerable way forward on the road to achieving a fairer, healthier atmosphere.

We recognise that limitations have been placed on the scope of the proposed legislation, concentrating on eating places - and congratulate Mr Maxwell and his colleagues on the production of very clearly stated documents - especially the main text of the Bill itself and the Policy Memorandum.

In particular, we are pleased to see well-documented acknowledgement of the dangers of relying on ventilation systems to do the work of cleaning smoky air. ANSR has been campaigning for a number of years on this issue, having been fully persuaded, in the 1980s, of the unreliability of claims made by companies which sell air-cleaning and ventilation systems and of the eagerness of the tobacco industry to form dangerous liaisons with air-cleaning manufacturers and, in turn, with the various branches of the hospitality industry. In effect, the hospitality sector has become a tool of the tobacco industry, whereas there is no natural connection between eating and drinking and the fouling of the air by puffing smoke into it.

ANSR is also pleased to note, from item 41 of the Policy Memorandum, that `the Bill gives power to Scottish Ministers to extend the restrictions of the Bill to any other places in the future'. We are particularly happy to see this provision since the proposed exemption of some spaces (in the Bill, as it now stands) alarms us. Our comments on the proposed exemptions are as follows:

Health Service premises are workplaces where people do lengthy shifts. Patients may also have to spend considerable periods of time there. Therefore provision should be made for a healthy atmosphere, not for resistance to clean air.

Long-stay residential care premises are homes for non-smokers, just as much as for smokers; no one there should have to be subjected to tobacco smoke. If smoking is allowed in such buildings, it should be confined to patients' separately-ventilated rooms. Even this provision would leave nursing staff and cleaners, as well as visitors, open to the unwanted effects of tobacco-smoke and its residues.

Many people (usually women) care for the sick and elderly as `home helps', employed by local authorities. ANSR believes it is unfair to allow these workers to be subjected to tobacco pollution (breathing in smoke, cleaning ash) in private homes, which are, in effect, also workplaces. At the very least, patients should be asked to refrain from smoking during the hours the home help is with them. Thought should be given about how to protect workers from contamination by air-borne and `settled' residues of tobacco smoke in clients' homes.
Prisons and remand centres and especially young offenders’ institutions, should surely be places where smoking is restricted, to protect non-smokers - prisoners, as well as members of staff. Tobacco is just as much a drug as heroin or cocaine and the smoking culture should not be allowed to remain ‘normal’ in such places, especially in eating areas.

Smoking materials are fire hazards and are usually found to be the cause of the highest number of deaths in residential fires. A strong case therefore exists, on these additional grounds, for banning smoking in hospitals and care homes and also in prisons.

We are of the view that, if the Republic of Ireland can agree on a fairly comprehensive Act to restrict smoking in public places, including bars, it ought to be possible for Scotland to be just as single-minded.

We therefore strongly recommend that the Bill should include second-stage proposals, for implementation once the first stage has been given six months or a year to run. Specific dates should be proposed, as we understand to have been in case in the preparation of other clean-air laws, notably in Sweden.

We suggest that nicotine replacement patches and chewing gum may provide solutions to the special difficulties associated with restricting smoking among hospital patients and prisoners.

We agree with the proposed implementation policy and think that high-quality, high-profile television spots will greatly assist the progress of legislation in this area, by giving the public a very positive ‘take’ on regulations that should really be seen as ‘provision of clean air’, rather than ‘prohibition of smoking’.

It may be relevant to point out that I am a Scot and that ANSR is a UK organization which began in Edinburgh in 1981, pioneering clean-air campaigning in Scotland with an early Good Air Guide (to restaurants and other eating places). Our primary focus has always been on the right to breathe air that is free from tobacco-smoke pollutants.

SUBMISSION FROM AUTOMAT DISTRIBUTORS

I wish register my support for my customers in Scotland who run cigarette vending businesses in Public Houses, Hotels, Bars & Clubs throughout Scotland against the proposed legislation.

This proposed Bill will have major impact on their trade (the cigarette vending trade & my customers) in the ability to sell a legal product in the public domain.

The result of this Bill being passed will make a large number of machines redundant, which in turn will have a knock on effect to my own business in supplying the services and new machines to them.

Charles Fletcher
Managing Director, Automat Distributors Ltd, UK

SUBMISSION FROM THE BELHAVEN BREWERY

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am writing to give you Belhaven’s views both on the above Bill and on the smoking issue generally.

Belhaven is Scotland’s leading regional brewer with integrated brewing, distribution, pub retailing and leased estate activities. We own 230 public houses in Scotland and we supply beer to a further 2,000 licensed units in Scotland (pubs, hotels, sports clubs, restaurants, etc). We employ over 1,400 people. Our annual turnover is circa £100m and our profit for the year to March 2004 will be circa £14m (if you
believe our house broker's forecast). Belhaven is a public company, listed on the London Stock Exchange.

Belhaven's contribution to the civic purse this year will be in excess of £20m (PAYE, NI, VAT, Excise Duty, Corporation Tax, Rates and Water Rates).

Belhaven is an excellent case study for politicians who wish to assess the impact on Scottish commerce of a total or partial ban on smoking in public places. So I hope our views will be of interest.

The Stewart Maxwell Bill

Tom McCabe, Deputy Minister for Health and Community Care recently issued "A Breath of Fresh Air for Scotland" which laid out in detail the Scottish Executive's Tobacco Control Action Plan. Belhaven finds this to be a very well thought out and well balanced document. We support its objectives and I was very pleased to be given the opportunity (in my capacity as an office bearer of Scottish Beer and Pub Association) to sit on the Advisory Group which the Minister has set up to oversee the delivery of the action points outlined in the Plan.

These action points include an intensive consultation process over the summer months on the impact of passive smoking in public places. The timing of Mr Maxwell's Bill is therefore extremely unfortunate. There is no point in this Bill going through its process stages when, simultaneously, a major consultation exercise is being undertaken. It is logical for politicians to await the outcome of the consultation rather than "jump the gun". For that reason, Mr Maxwell should be asked to withdraw the Bill. At the present moment in time it is an unwelcome irrelevance and it will only serve to confuse the public who cannot be expected to be conversant with the nuances of the legislative process within Holyrood.

Insofar as the content of the Bill is concerned, Belhaven would not support it. Frankly, it is over-prescriptive. What evidence does Mr Maxwell have to justify a five day time gap to allow for the impact of passive smoke to be neutralised? Even the anti tobacco lobby groups such as ASH have said that the effect of smoke can be cleared from a room with good ventilation within a few hours if not minutes. The Bill is also hugely naive in terms of costs; the expense of creating rooms which are separated by two sets of doors would be hugely significant in most pubs and totally impractical in many. Planning, building control and environmental health permission/approvals would be required for such changes and thought would have to be given as to whether or not local authorities have the resources to cope with the deluge of work which this Bill would trigger.

If Mr Maxwell had proposed a Bill banning smoking in public places where and when food is served, Belhaven would have been able to support it, in broad principle.

The Smoking Issue Generally

Belhaven fully supports the objectives of the Scottish Executive to make Scotland as smoke free a country as possible. The evidence of the impact of tobacco on the health of smokers seems irrefutable although the evidence of the impact of tobacco smoke on third parties is sketchy and anecdotal at best. It is a very difficult area in which to prove causal link.

Banning smoking in public places would undoubtedly help make Scotland more smoke free but how do we achieve that without decimating the leisure industry in the process?

We have to declare self interest here. Many of our pubs (both in our own estate and the licensed premises which we supply) are located in the more deprived areas of our country which would be hardest hit by a total ban as smoking is much more prevalent in these sectors. We were interested to read in the press of comments attributed to Jack McConnell concerning Ireland where a total ban was introduced on 29 March. It is of course a very sensible move for the Scottish Executive to track progress in Ireland to see if the ban works there and to see if it has significant impact on commercial business and the contribution to the civic purse, etc. However, we would suggest to Mr McConnell and the Scottish Executive that Scotland and Ireland have quite disparate drinking cultures. In
Scotland more than 40% of all beer sold is consumed off premise. In Ireland the figure is less than 10%. The Irish have a culture of sociability which is much stronger than in Scotland where, regrettably, we are becoming a nation of couch potatoes. In our country a ban on smoking would greatly exacerbate the couch potato syndrome and would put many businesses at risk, especially those which are highly borrowed and would have difficulty servicing existing loans (because of a drop in turnover). The impact of a smoking ban on small businesses, jobs and the civic purse could be enormous and to impose a ban could be a big mistake.

No matter which side of the fence you sit on vis-a-vis this issue, it cannot be disputed that, at best, a smoking ban is a huge risk to Scottish commerce. We will need to carefully compile a plan as to how the impact on Irish businesses is going to be (a) measured and (b) assessed.

But we realise we cannot bury our head in the sand and hope the problem will go away. It won't. We are aware of the mounting pressure on politicians to improve the comfort/health of non-smokers who visit public places and Belhaven wants to help the Scottish Executive find a solution which will satisfy all stakeholders, including existing pub-goers.

We believe the Voluntary Charter should be given further time to deliver meaningful results and we think that the Scottish Executive should play a leading role in setting the objectives for the Voluntary Charter. If the VC fails to meet the targets we would agree that legislation is required. There are approximately 11,500 on licensed premises in Scotland (about 5,500 pubs with the balance being restaurants, hotels, sports clubs, night clubs, etc) and a matrix

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<td>Ban on Smoking</td>
<td>x+200%</td>
<td>x+400%</td>
<td>x+800%</td>
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<tr>
<td>Ban on Smoking at bar counter</td>
<td>x+50%</td>
<td>x+75%</td>
<td>x+100%</td>
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<tr>
<td>Segregated Area for Smokers</td>
<td>x+25%</td>
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<td>Designated Area for Smokers</td>
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Note: x = the starting position at the commencement of the three year period

We would stress that these figures are submitted by way of example and we would obviously have to consult with different factions of the licensed trade to agree what the VC could deliver. However, we know from our own connections with the Scottish Licensed Trade Association and the Scottish Beer and Pub Association (of which Belhaven is a member) that the trade takes the issue very seriously and is determined to achieve positive results.

Belhaven's position and vision is that, after the three year period, we should have moved to a position where all licensees will readily accept a complete ban on smoking where and when food is served and a complete ban on smoking at the bar counter. The next three year period would then set even tougher targets for segregated areas and all public places would have to have clearly designated smoking areas as a very minimum.

After the first three year period smokers would get the message loud and clear that their habit is anti-social and the Scottish smoking culture would be on the wane. The public's acceptance of the undesirability of allowing smokers to do so in public places will make it so much easier for the owners of public places to "rule the roost" on the issue.

The dissenters will ask the question - what about staff? The ban on smoking at the bar counter will be hugely helpful and, as smoking in the workplace is a reserved matter, Scotland should fall into line with Westminster policy on the subject. It does not make sense for Scotland to "go it alone" on such a crucial issue which is not within the authority of Holyrood. Indeed, on the wider issue, it is Belhaven's view that it is folly for Scotland and England not to act in unison on such an important issue as this regardless of whether political control is devolved or reserved. The fact of the matter is that there is no passport controlled border between Scotland and England and tourists to the UK will become hugely confused if there are separate regulations north and south of the border.
I hope this letter is of assistance and, for information purposes, I have sent a copy to each Scottish MSP. Scottish politicians are probably being bombarded by different pressure groups who have vested interests in achieving a solution which is either white or black. But J

There are many shades of grey and tobacco is not a banned substance. There are many people who feel they have the right to smoke where and when they want to and it is up to the Scottish Executive, working with the licensed trade, to educate them on the rights of non-smokers to enjoy their leisure without the discomfort of passive smoke.

Scotland can greatly reduce the number of smokers in our country and the Belhaven solution will work, especially if it is supported by a comprehensive "damage to health" marketing campaign and a material rise in excise duty on tobacco as a further deterrent (obviously this needs the support of Westminster).

Thank you for considering our observations

Stuart Ross

SUBMISSION FROM BRITISH AMERICAN TOBACCO

Introduction

British American Tobacco supports the development and implementation of sensible public and workplace smoking policies and is pleased to provide this submission. British American Tobacco is located in London and has affiliated operating tobacco companies located throughout the world.

There are many serious issues surrounding the use of tobacco. We believe that Government, public health groups, tobacco companies and other interested parties should work together to reduce the health impact of tobacco use. This includes efforts to prevent under-age smoking, ensure strong public health education of the real risks of tobacco use, provide smokers with practical advice on how to reduce risks, including quitting, and seek consensus on ways forward with respect to tobacco products that might reduce the risk of smoking. For example, we have advocated to the English Department of Health that the legal age for the sale of tobacco should be raised from 16 to 18 years, in line with the age restrictions on alcohol, and we are strong supporters of the CitizenCard initiative that assists retailers to identify the age of those seeking to purchase tobacco products. In addition to these matters, we agree that environmental tobacco smoke is an issue of public importance, that it should be the subject of public educational efforts, and believe that smokers should be mindful of others' comfort and should not smoke around young children.

On all these issues, we consider that all regulatory proposals should be based on sound, evidence-based regulatory approaches, and support the UK Government's intentions to improve evidence-based decision-making. As the Government has noted, this should include consultation with all interested parties and consideration of non-regulatory approaches. Where regulation is considered the best approach, it should include a rigorous and transparent regulatory impact assessment.

1. The science of Environmental Tobacco Smoke

Many contend today that, in addition to being a cause of disease in smokers, tobacco smoke can be a cause of disease in non-smokers exposed to other people's smoking. Environmental tobacco smoke (ETS) has been claimed to be a human carcinogen, a cause of non-malignant respiratory disease, a cause of heart disease, and a contributing factor in the incidence of many other conditions in non-smokers. So it is understandable that people might be concerned if they or their children cannot avoid situations where tobacco smoke is accumulating in the air.

British American Tobacco believes smoking to present real risks of serious diseases in smokers. Put simply, smoking is a cause of certain diseases in smokers. The epidemiological studies that underpin
the view that smoking is a cause of various diseases typically report that risks increase with the number of years that people smoke and the number of cigarettes smoked each day.

We believe, however, that the claim that ETS exposure (or "passive smoking") has been shown to be a cause of chronic disease is not supported by the science that has developed over the past twenty or so years. In our view, it has not been established that ETS exposure genuinely increases the risk of non-smokers developing lung cancer or heart disease.

1.1 ETS is not the same as "mainstream" smoke

Given that, primarily on the basis of many years of epidemiological findings, smoking is a cause of various diseases, including lung cancer, chronic bronchitis and emphysema, and various heart diseases, it is superficially plausible to speculate that exposure to ETS might also cause disease in non-smokers. Hence it is important to consider whether the potential effects on the non-smoker could simply be extrapolated from data on the effects of smoking on the smoker.

ETS is a mixture of the smoke released from the burning end of a cigarette (termed "sidestream" smoke) and the smoke exhaled by a smoker between puffs. This smoke quickly mixes with the ambient air and becomes highly diluted, and the process produces important differences between the chemical and physical composition of "mainstream" (inhaled) smoke and that of ETS. In all normal circumstances, ambient air contains a large number of substances, whether or not smoking has taken place. Such substances can include dust, pollen, bacteria, fungi, trace chemicals from vehicle emissions and other sources of "pollutants", as well as, in certain circumstances, emissions from cooking and heaters. Research suggests that the types of substances found in indoor air are generally similar, with or without the presence of ETS.

1.2 Non-smokers' exposure to the components of ETS is very low

It is difficult to measure real-life ETS exposure. The concentrations of the various substances that make up ETS are generally very low and many of the chemicals in ETS are likely to be present in the air anyway, as a result of other sources. Moreover, ETS is a complex and constantly changing mixture, making it difficult to extrapolate from the measurement of an individual chemical marker to total ETS exposure.

However, the results of studies seeking to quantify exposure suggest that concentrations of chemicals in ETS are typically much lower than permissible exposure limits to these chemicals approved by regulators. Studies have, not surprisingly, also reported that non-smoker exposure to ETS is much lower than smoker exposure to mainstream smoke. Generally such studies have looked at exposure to nicotine, not because airborne nicotine is widely thought to cause lung cancer, heart disease or respiratory disease, but because it is almost unique to tobacco smoke and can be measured even at low concentrations. For example, one study reported that, on average, in the course of a year, non-smokers had an exposure to airborne nicotine which was less than the amount delivered to a smoker from just five cigarettes (at 12mg tar: 1mg nicotine per cigarette). Another study of British women exposed to ETS in various settings reported that on average a non-smoker would only be exposed to the equivalent nicotine of smoking a single cigarette after a period in excess of two years.

A variety of studies which have measured the biological metabolites of nicotine have suggested ETS exposures of the average of 0.2% to 0.4% of active smoking, while estimates of particulate exposure suggest a factor of around 0.05% to 0.1%. Measuring uptake, as compared with exposure, of ETS by non-smokers presents its own problems. The most commonly used markers are nicotine and its metabolite cotinine, which can be analysed in subjects' body fluids. Subjects do vary, however, in the rate at which they metabolise the nicotine, and nicotine and cotinine are not quantitative markers for exposure to other components of ETS.

It is also important to note that most scientists accept that there is a threshold for carcinogenesis and other disease processes. That is, while a substance taken at high concentrations may cause disease, there may be no detectable health risk to exposure to the same substance at lower concentrations.
The findings on the nature of ETS suggest that no firm conclusions can be drawn on the possible health effects of ETS without adequate supporting evidence from clinical, experimental and epidemiological studies.

1.3 Studies on ETS and chronic health effects in non-smokers are weak and unconvincing against normal standards

Virtually all of the epidemiological evidence on ETS involved exposed subjects who are reported to be life-long non-smokers. This is mainly because it is likely to be extremely difficult to detect reliably any effect of ETS exposure on disease in the presence of a history of smoking.

Few of the epidemiological studies on which claims about ETS and chronic disease are usually based have attempted to measure ETS exposure or uptake in the study populations. Exposure was usually estimated by administering questionnaires. Aside from the comparative unreliability of individuals' memories, known by epidemiologists as "recall bias", the questionnaires were often administered not to actual members of the populations being studied, but to surviving family members, thus increasing recall unreliability and introducing possible sources of bias.

Of these statistical studies, around fifty have examined the incidence of lung cancer in women who say they have never smoked, but who are married to smokers ("spousal" studies) or the nearest equivalent index such as co-habiting with a smoker. Many have reported a small increase in risk, though a significant majority of these studies have not reported overall statistically significant increases. Where a statistically significant association was reported, the magnitude of relative risk reported was so small (i.e., typically below 2.0), that it would be generally regarded as too weak, by normally accepted epidemiological standards, to form a basis for public health policy. For example, Baroness Jay of Paddington, providing Her Majesty's Government's view on relative risk factors, stated "A stronger association - of greater than 2 - is more likely to reflect causation than is a weaker association - of less than 2 - as this is more likely to result from methodological biases or to reflect indirect associations which are not causal."

The positive trend in such studies, although it generally falls short of statistical significance, might be explained by a combination of factors. For example, non-smokers living with smokers tend to have different lifestyles and diets than those living in wholly non-smoking households. It is also unclear that all studies have adjusted at the appropriate rate for the likelihood that some self-reporting never-smokers are in fact former or current smokers. This is especially problematic because former and current smokers not only have an increased risk of lung cancer, they are also more likely to have married smokers and thus be included among those exposed to ETS in these studies.

Some attempts have been made to combine the results of the individual studies, using a method known as meta-analysis. The results from such meta-analyses have been unpersuasive. In 1993 the United States Environmental Protection Agency (EPA) released a report that claimed that ETS was a known human carcinogen. However, the Agency was accused of altering "confidence levels" in the original published papers, and of bias in its study selection, in order to generate a statistically significant result in their meta-analysis. Such criticisms were upheld by a US Federal Court in North Carolina which vacated the EPA's conclusions on ETS and lung cancer, the judge commenting that the EPA had "changed its methodology to find a statistically significant association". The Judge listed a variety of faults in the scientific approach taken by EPA, including "EPA disregarded information and made findings on selective information; did not disseminate significant epidemiologic information; devoted from its Risk Assessment Guidelines; failed to disclose important findings and reasoning; and left significant questions without answers. EPA's conduct left substantial holes in the administrative record. ...EPA produced limited evidence, then claimed the weight of the Agency's research evidence demonstrated ETS causes cancer.".

One of the largest and most recent studies, undertaken by the International Agency for Research on Cancer ("IARC"), a body funded by the World Health Organisation, combined results from several European countries including the United Kingdom. This study reported no overall statistically significant increase in risk of lung cancer from ETS in any of the situations where people were exposed to ETS. These included exposure at home, at work, at home and at work combined, during
childhood, in public settings and through exposure in vehicles. Despite these research findings, IARC concluded that ETS was associated with lung cancer, though it is difficult to see how they reached these conclusions given their own guidelines of epidemiological best practice. Small increases in relative risk are sometimes reported in percentage terms. A relative risk of 1.2, for example, is often popularised as 20% increase in risk, giving an impression that if 100 people were exposed to the risk, 20 of them would contract the disease. This is highly misleading. A 20% increase in a number which is small produces a number which is still small. Again as Baroness Jay of Paddington noted "The practical significance of risk factors, also needs to be considered and depends on how great is the underlying risk. Doubling a very small probability (risk) - say one in 10,000,000 - still results in only a very small risk of illness." A relative risk of 1.2 for a disease with a non-exposed population incidence of 10 per 100,000 person-years would mean that the incidence in the exposed population would be 12 in 100,000 person-years. If the relative risk is not statistically significant, as was the case with the IARC study (which reported a non-statistically significant overall relative risk for living with a smoker of 1.16) then it cannot be ruled out with the scientifically accepted level of certainty that there was no increased incidence of the disease.

The data generally on ETS exposure at work is even less conclusive than the spousal data. Only a very small minority of the studies on ETS and lung cancer have reported an overall statistically significant increase in risk. Similarly, most studies which have looked at ETS exposure in social settings and during childhood do not report an overall statistically significant increase in risk of lung cancer.

The epidemiological data on ETS and heart disease is similar in nature. Most studies do not report statistically significant increases in risk. Two of the most substantial pools of data on this subject are the databases of the American Cancer Society's Cancer Prevention Study, and the database of the US National Mortality Followback Survey. Analyses of these datasets have reported no overall association between ETS and heart disease. Not one of the studies considering ETS exposure at work and heart disease has reported an overall statistically significant increase in risk. A further large study of ETS and heart disease was published last year in the British Medical Journal and also reported no increase in risk. Given that the coronary heart disease relative risks for active smoking are substantially lower than the risks for lung cancer, it seems implausible that an effect in non-smokers could be detected. A report of the United States Surgeon General in 2000 noted "because smoking is but one of the many risk factors in the etiology of heart disease, quantifying the precise relationship between ETS and this disease is difficult." Writing an Editorial in the New England Journal of Medicine, Professor John Bailar stated "I regretfully conclude that we still do not know, with accuracy, how much or even whether exposure to environmental tobacco smoke increases the risk of coronary heart disease."

Epidemiological studies of the relationship between ETS exposure and respiratory disease in non-smoking adults, taken overall, do not demonstrate an increase in risk. Clinical studies of the reaction of adults highly sensitive to ETS (e.g. asthmatics) have had difficulty in prompting a measurable response, though clearly some asthmatics will experience a non-specific exacerbation of symptoms in smoky environments.

1.4 ETS and children

There is a large body of research on ETS exposure and respiratory disorders in children. These are hard to analyse overall, as there is great disparity in study design, age ranges of subjects, the symptoms measured and methods of diagnosis. There are quite a number of reports of statistically significantly increased risk of respiratory disorders in pre-school age children exposed to ETS. It is unclear to what extent this increase is influenced by other factors more statistically common in smoking households, such as poor diet, housing conditions and quality of pre-natal care. The pattern of increased risk is not consistently replicated for children of school age, suggesting that a real effect, if one exists, is short-term.

Although smoking by parents has been associated in some studies with an increased risk of "cot death" (sudden infant death syndrome), a long list of other risk factors has also been reported.
Some recent studies have reported that incidence of "cot death" has been reduced by up to 50% where parents have followed government advice not to put their child to sleep in the "prone" position. However, no one yet fully understands the reasons or mechanism behind this syndrome. Some have suggested that there may be some residual effects of mother's smoking during pregnancy. In our view there should be strong public health advice to women not to smoke during pregnancy.

It is also British American Tobacco's view that it is right that parents and other adults be particularly sensitive to the needs of young children, especially infants, for a clean, comfortable environment. It makes sense not to smoke around infants, especially in poorly ventilated environments and not to smoke around children for long periods.

2. ETS in public places

In the context of the Maxwell bill we believe that there are preferable ways to reduce ETS exposure in non-smokers. We wish to work with elected officials and other interested parties to find practical ways to reduce exposure to environmental tobacco smoke while at the same time providing reasonable accommodation for smokers. This includes efforts to ensure that parents receive advice that they should not smoke around young children, especially infants, encouraging further research into cost effective devices for reducing ETS and providing support for practical solutions in the hospitality industry.

We do not suggest that people should be free to smoke wherever they like. A reasonable policy will take into account the preferences of both non-smokers and smokers - and clearly there are more non-smokers in society than smokers. We support initiatives that aim to reduce exposure to ETS while at the same time reasonably accommodate smokers. We believe that voluntary approaches that encourage the provision within public venues of non-smoking areas, supported by good ventilation, are the sensible and practical way forward.

To give practical backing to this position, British American Tobacco supports the worldwide Courtesy of Choice campaign run by the International Hotel and Restaurant Association. This aims to help the hospitality industry accommodate all its customers across a variety of venue types and involves technical analysis of ventilation and venue owners allocating flexible smoking and non-smoking areas. In the UK, British American Tobacco supports, through the Tobacco Manufacturers’ Association, the "AIR" campaign, which works with the pub and club industries to encourage the provision of cleaner air and accommodation of smokers and non-smokers. Under the voluntary Charter agreed with Government, the hospitality industry appears to be making significant progress.

Policies on public and workplace smoking that are too liberal can lead to friction and stress for non-smokers and smokers. The same is true for policies that are too restrictive. Employers and managers should be permitted to select the most appropriate smoking policy for their particular workplace or venue, in consultation with their employees or consumers where that is practical. We do not think, particularly given the presence of a voluntary mechanism to improve the situation regarding ETS, that legislation is a sensible regulatory approach. Legislative provisions restricting smoking in public places would need to be enforced, resulting in the diversion of police or other enforcement agency's resources. We also suggest that regulatory proposals should have the benefit of a proper detailed risk and regulatory impact assessment, in line with general Government commitments to produce better regulations.

1 For more on British American Tobacco’s views, see www.bat.com
3 C. Proctor, The analysis of the contribution of ETS to indoor air, Environmental Technology Letters, 9, 553-562, 1988
5 G.B. Gori and N. Mantel, Mainstream and environmental tobacco smoke, Regulatory Pharmacology and Toxicology, 14, 88-105, 1991
The Prohibition of Smoking in Regulated Areas (Scotland) Bill

The following evidence is submitted to the Health Committee from the British Lung Foundation as part of its consideration of the Prohibition of Smoking in Regulated Areas (Scotland) Bill. Please do not hesitate to contact us for further information or clarification on any of the points raised.

1. Do you support the general principles of the Bill and the key provisions it sets out?

The British Lung Foundation welcomes the overall aim of the Bill in reducing the number of smokers and the negative effects of secondhand smoke on non-smokers.

The damage to lungs from secondhand smoke has long been acknowledged and we believe it is vital that people protect themselves from these dangers.

Cigarette smoke contains a large number of different substances which can damage the lungs. The smoke has two parts: the particulate phase, tiny portions of solid matter which contain the tar, and the gas phase which contains carbon monoxide and nitrogen oxides. These toxic substances are drawn directly into smokers' lungs in mainstream smoke. The filters in most cigarettes reduce the amount of large particles and allow some dilution with air, but let most of the harmful chemicals into the lungs.

The tar content of cigarette smoke damages the cells in the airways of the lung. Eventually this damage can produce cells that grow uncontrollably leading to cancer of the lung or voice box (larynx). The body's protective cells detect other harmful substances from the smoke. These cells move to the lung and try to defend it but are destroyed by the cigarette smoke. The dead cells release substances that damage the structure of the lung, leading to chronic bronchitis and emphysema or COPD (Chronic Obstructive Pulmonary Disease).
Cigarette smoke often troubles non-smokers, especially if they have asthma or other lung problems.

A significant proportion of the UK population are exposed regularly to secondhand smoke - around 7.3 million adults and 5 million children.\(^1\)

Passive smokers not only inhale smoke which has been breathed in and out by smokers but also the sidestream smoke from the burning tip of the cigarette, which contains more of the harmful chemicals than the smoke which has been filtered by being drawn against the cigarette.

It is estimated that secondhand smoking accounts for around 1000 deaths per year in Scotland.\(^2\)

Scotland has fewer smoke-free workplaces than the rest of the UK.\(^3\) 31% of working men and 21% of working women had been exposed to other people’s smoke at work in the week preceding the most recent Scottish Health Survey.\(^4\)

International Agency for Research on Cancer (IARC) found that non-smokers living with a smoker have a 20-30% increased risk of lung cancer compared to those who live in non-smoking households. For non-smokers exposed in the workplace the risk of lung cancer is increased by 16-19%.\(^5\)

The Californian Environmental Protection Agency found conclusive evidence that passive smoking causes lung cancer in adults.\(^6\)

In people with asthma, exposure to secondhand smoke is associated not only with more severe symptoms but also with lower quality of life, reduced lung function and increased use of health services for asthma, including hospital admissions.\(^7\)

Regular exposure to secondhand smoke also increases the risk of coronary heart disease by around 25%.\(^8\)

Children growing up with parents who smoke are more likely to develop lung problems. The risk of sudden death in young children is also increased when parents smoke.

In the UK, 42% of children live in a house where at least one person smokes.\(^9\)

In the UK, it is estimated that 17,000 under five-year-olds are hospitalised each year as a result of passive smoking.\(^10\)

Passive smoking increases the risk of lower respiratory tract infections in children.\(^11\)

Children whose parents smoke are 1.5 times more likely to develop asthma. Approximately 10-15% of childhood asthma may be attributable to parental smoking.\(^12\)

There is conclusive evidence that passive smoking causes asthma, bronchitis and pneumonia in children.\(^13\)

More than 800,000 people have a lung condition in Scotland and all of them are severely aggravated by exposure to secondhand smoke. The British Lung Foundation believes that people should have the right to socialise and work in smoke-free environments without damaging their health.

2. Are there any omissions from the Bill that you would like to see added?

The British Lung Foundation would prefer to see a Bill which covers all enclosed public places, not just those where food is served.

People who work in public houses and nightclubs where food is not served will still be forced to work in smoky atmospheres and suffer the unpleasantness of second-hand smoke in addition to the negative health effects.
People with existing lung conditions will still be discriminated against by being unable to visit those places where smoking is permitted for fear of a lung attack or a worsening of their symptoms.

A recent survey from the British Lung Foundation found that 43% of people with chronic obstructive pulmonary disease (COPD) avoided going to the pub for fear of a worsening in their condition - that equates to 3.45 million trips to the pub that otherwise would have been made.

3. What are your views on the quality of consultation, and the implementation of key concerns?

The consultation to consider the Bill should be far reaching and inclusive of as many different sectors of society and viewpoints to ensure a balanced consideration of the issues raised.

The British Lung Foundation is delighted to have been invited to contribute to the consultation and is happy to provide additional information at a later date to assist the committee in their consideration of the Bill.

It is vital that the Bill is sufficiently detailed in its implementation to avoid any loopholes which could be exploited to allow smoking to continue in restricted areas without penalty.

4. Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Evidence has shown that air conditioning and filtering does not provide the complete protection needed.

Using current indoor air quality standards, ventilation rates would have to be increased more than a thousand-fold to reduce cancer risk associated with environmental tobacco smoke to a level considered acceptable to federal regulatory agencies. Such a ventilation rate is impractical since it would result in a virtual windstorm indoors.\textsuperscript{14}

To be at all effective in reducing the concentration of smoke in a space, any air cleaner must process many room air volumes per hour.\textsuperscript{14} Even large, expensive air cleaners with efficiencies for captured particles are capable of reducing, but not eliminating the environmental tobacco smoke tar particles in room air, and are not at all effective for gases, which contain most of the irritants.\textsuperscript{14} Even expensive particulate air cleaners cannot remove enough tar particles in room air to eliminate the cancer risk from environmental tobacco smoke.\textsuperscript{15} In general, filtration of indoor air to remove environmental tobacco smoke tar particles is futile - like trying to filter a lake to control water pollution.\textsuperscript{15}

Ventilated smoking rooms leak smoke into the rest of the building, harming everyone in the building. A recent research study conducted by and published for the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE)\textsuperscript{16} showed that up to 10 percent of smoking room air enters non-smoking areas just by opening and closing of a swing type entry door,\textsuperscript{16} with supply and exhaust air flow that are practical for small smoking rooms, leaving the smoking room door open results in a large flow of air to adjoining non-smoking areas.\textsuperscript{16}

Separating smoking and non-smoking areas does not work as smoke disperses throughout the room, affecting everyone.

Separation of smoking areas does not protect the workers and occupants within the smoking area. When separation is properly done (and this is not common), it can reduce the exposure of occupants in the non-smoking areas, but there is no quantitative assurance that the remaining exposure meets any current health standard or goal.\textsuperscript{17}

In managing workplace environmental tobacco smoke risks, smoking policies such as separating smokers from non-smokers in the same space or on the same ventilation system expose non-smokers to unacceptable risk.\textsuperscript{18}
Implementing a Voluntary Code of Conduct does not work.

The Voluntary Charter on Smoking in Public Places do not protect health, either for staff in the leisure industry, or for the public who use these facilities. It is possible to put up a sign and comply, without doing anything to provide smoke-free areas. Voluntary agreements have proved ineffective in other areas of tobacco control policy, such as advertising.

A recent audit\(^1\) of the Voluntary Charter's impact showed that after nearly three years:

- More than 7 in 10 Scottish pubs and bars permit smoking throughout
- Nearly 4 in 10 of all Scottish leisure industry sites - including superstores, sports grounds, sports centres, as well as pubs and restaurants - permit smoking throughout
- Only 1 in 7 of all leisure industry sites complies with all key aspects of the Charter.

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\(^{1}\) Smoking Statistics (2004) British Heart Foundation - figures estimated from the General Household Survey

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SUBMISSION FROM RONALD BISSELL (THE CASK)

I am most concerned about Mr Maxwell's proposed Bill regarding smoking.

I have run my own public house in Dundee for some 13 years and am a non smoker myself.
Whilst I only sell snacks, I feel that it is the choice of the "man on the street" whether he or she enters my bar and accepts that smoking goes on throughout.

I have no space whatsoever to accommodate a non-smoking area but I do the utmost to ensure the pub is well ventilated and smoke pollution is minimal.

Several years ago I purchased from John A Buchan (Perth) Ltd, two F90A air purifier machines costing in excess of £1000.

These machines are serviced fortnightly also at a considerable cost and I feel that this is the way forward, instead of the complete ban.

People have the right in our country to go where they want and this right should remain.

Whilst I do agree that many outlets could be doing more, I think the complete ban would be "over the top." Perhaps the setting-up of a "body" which would go round and advise Publicans/restaurateurs alike on what ventilation is required and then give them a set amount of time to do the work, would be the way forward.

I urge you to look very closely at Mr Maxwell's proposals and take into account the amount of people employed in the leisure industry and how it would be affected by these changes.

Ronald Bissell

SUBMISSION FROM BILLY MALCOLM (THE CLACHAN BAR)

I have carried out the survey as I was asked, both my staff and customers filled in the questionnaire.

The outcome was they wish to smoke when and where they want with no restrictions at all.

I do not serve food at my pub so I don't have no smoking restrictions anywhere.

The Clachan Bar is a fairly small pub we do not do much passing trade it is all regular customers, whom have drunk here for years, my staff also have worked here for years.

I would definitely lose customers then I would have to pay off staff which I wouldn't like to do.

I think the proposed fines are terrible, what about everyone's choice surely everyone should have a choice so I am asking you on behalf of my customers and staff please do not ban smoking.

Billy Malcolm

SUBMISSION FROM COSLA

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I refer to the Health Committee's call for written evidence on the above-mentioned Bill.

COSLA, as the umbrella organisation representing 31 of Scotland's local councils is concerned about the implications of tobacco smoking and how the issue is addressed.

In March, as part of a Joint Future Summit with the Scottish Executive, we published jointly with ASH Scotland and NHS Health Scotland 'Tobacco at Work - Guidelines for Local Authorities' to assist councils with the development and implementation of tobacco policies. The document, prepared following an earlier audit of councils' smoking policies, is available at [www.cosla.gov.uk/attachments/execgroups/sh/6904health1.pdf](http://www.cosla.gov.uk/attachments/execgroups/sh/6904health1.pdf) and represents tangible evidence of
COSLA’s and its member councils’ commitment to addressing the problems caused by tobacco smoking.

We have had sight of a number of our individual council submissions on the Bill to the Committee and clearly there is strong support for its general principles. The concerns expressed are generally repeated in most submissions - the difficulty of protecting staff from passive smoking; the limited scope of the Bill and inconsistency in excluding areas such as beer gardens; enforcement issues; potential economic problems; and possible financial implications for authorities. Equally there is general consensus about the positive outcomes of the legislation and the advantages to be derived from a more widespread approach.

COSLA is represented on the Scottish Ministerial Advisory Group on Tobacco Control and as such is aware of the forthcoming Scottish Executive consultation on smoking with which we will be involved and which will generate detailed debate. By the end of that consultation period councils will also have had the opportunity to consider the ‘Tobacco at Work’ Guidelines in relation to their current policy. We therefore feel it would be sensible to wait until September before attempting to come to a single local government position on tobacco smoking by which time we will be better informed and better able to reflect in our views the outcome of the debate over the summer months.

I hope that these comments are helpful.

Yours sincerely

Sylvia Murray
Policy Manager

SUBMISSION FROM ROSS MCKAY (THE CROFT INN)

Having conducted the SLTA ballot on smoking in public houses, and considered the implications, might I impress upon you the following comments which I hope you will give due regard to.

My wife and I took on this business about 18 months ago and knew that to keep a rural pub going as a viable business we would have to cater for the needs of all sections of the ‘trade’, especially the ‘locals’ who form the backbone of our business. The tourist trade is very unpredictable in terms of numbers and frequency.

The majority of our local trade is very hard working young farmers who use the premises as a social gathering place and most of them ‘smoke’. Along with this we have a significant number of ‘professional’ people, many of whom do not smoke. As this is one of a very few pubs within a 10 mile radius we offer them a service which they appreciate; including the right to smoke. We do serve meals and we do have a separate ‘non-smoking’ room to satisfy the needs of the diners, and non-smokers. We also have two ventilating fans in the bar and an open fire that draws away the excess ‘smoke’. The ballot has clearly shown that nearly all of our customers are aware of the fact that what you are proposing could cause the end of this rural facility. The cost to implement the proposals would be too heavy for the business to bear, or institute. This is a very ‘old’ building that cannot be easily modified, at a sensible cost, and consequently the non-smokers are prepared to accept that it is better to accept that smoking is permitted than lose the pub. In general terms they feel that we have addressed their needs as best we can. This ‘trade’ is struggling to survive due to the availability of cheap supermarket prices on alcohol and what you are proposing will, I feel, drive more people to drink at home if we are forced to follow your proposals.

We are, also, one of the few places where the many people who stay in B&B’s and ‘Self catering’ holiday establishments can ‘dine out’ and, they too, have indicated that an overall ban would have serious implications for those businesses as we all feed off the same customer base. Therefore, you could cause harm to the ‘Rural tourist trade’ by forcing our hand. I feel that what you want is feasible in the cities and towns where people have the choice of many premises, but ‘out in the sticks’ that choice does not, often, present itself. Surely if a place is known to allow smoking it is the right of the
individual to choose whether, or not, to enter that place by their own judgement rather than by a
government edict, no matter how well intended.

By your suggestions you have stimulated serious discussions that have caused both sides of the
smoking divide to evaluate their own thoughts on the matter. We have embraced the "voluntary
charter" and already provide a ventilated smoking bar and separate dining room. The one thing that is
apparent is that all are prepared to accept the 'voluntary charter' as being adequate for their needs
and that no further legislation is required. The split of the vote came out as 65% asking for 'No
restrictions' need be added, and 35% for a 'total ban'. If we were to proceed 'democratically' I would
urge you to consider all the ramifications of your proposals and allow some 'common sense' to
prevail. Therefore might it be suggested that it is the 'voluntary charter' that should become
'compulsory' so that those of us who have tried our best to cater for the needs of all sectors of the
'trade' are not punished. We both left a long career in teaching because of the increase in
'bureaucracy'- is this to happen to us again?

Yours sincerely

Mr. Ross McKay (Proprietor of `The Croft Inn', Glenlivet)

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SUBMISSIONS FROM ROD BULLOUGH (CUMBRIA VENDING SERVICES)

There is already legislation, which has been approved and is being monitored by, Central
Government.

This is the Air Smoking Charter. Everyone has heard of this and evidence can been seen in pubs and
clubs and other outlets allowing smoking across the land - not just Scotland - how many people in
Scotland now about the Maxwell Prohibition of Smoking in Regulated Areas (Scotland) Bill? How
much publicity has this had? How many opinions has the research obtained from their general
public? The Smoking Charter has been researched and agreed by all parties and as it improves air
quality for smokers and non smokers in these areas must be a good thing. The area of providing
better ventilation within premises allowing smoking is the way to approach this situation not an
outright ban with more than non smokers being affected. Colleagues in Cumbria will be affected by
this Bill as their jobs are now on line - so may mine be and I am in Essex. Everyone has a right to
choose and smokers are having that right taken from them. As a smoker I agree there are areas-
hospitals, libraries, swimming pools where smoking is not appropriate but I and my non smoking
friends, family and colleagues agree that smoking should be allowed to continue in pubs and clubs
etc. where adequate ventilation and air cleaning systems are in place.

I strongly object to the proposed ban on smoking in Scotland.

Joseph Wood
Duckworths
Blackpool

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A Wilkinson
Duckworth Cellar Services
Blackpool

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I strongly object to the proposed ban on smoking in Scotland.

Colin Wood
Duckworths
Blackpool

Too many people will lose their jobs and too much money from taxes etc will be lost should this ban go ahead.

Why not allow the current Smoking Charter to continue - this is a much better idea and more than enough legislation.

Too many choices are being taken away from the individual today, better air quality by the installation of Air Cleaning Systems is the mature and forward thinking answer.

Jason Scott
DCS
Blackpool

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Stuart Reid
DCS
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of Air Cleaning Systems is the mature and forward thinking answer.

Keiran Jones
DCS
Blackpool

The licenced trade and others have agreed a Smoking Charter with the British Government, targets
have been met and everyone is happy - why isn't this good enough for Scotland?

How many jobs will have to go and businesses lost? The bill for benefits etc will be picked up by the
whole British public not just Scotland's.

Air Smoking Charter is the way forward - better air quality for everyone not just non smokers.

Please register my objection to the proposal

Liam Kirkham
DCS
Blackpool

I work for Cumbria Vending Services and my job is now at risk because of this bill. I have seen the
Air Smoking Charter prove to be a success and it has been agreed by the Government.

There is no need for legislation to ban smoking - improve air quality with cleaning systems that is the
answer. As a non smoker I cannot see the need for a ban and potential loss of my employment, I
work with cigarette and I see the right to smoke as an individuals choice take that away and I see it as
an infringement on their rights - today smoking - what tomorrow?

Let the people of Scotland continue to have their freedom of choice and address the matter of air
cleaning systems - this will get rid of the need for a ban.

Donald Brown
Cumbria Vending Services

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Ian Blake
DCS
Blackpool

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Wayne Astin
DCS
Blackpool

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How many jobs will have to go and businesses lost? The bill for benefits etc will be picked up by the whole British public not just Scotland's.

Air Smoking Charter is the way forward - better air quality for everyone not just non smokers.

Please register my objection to the proposal

Paul Reader
DCS
Blackpool

I am a smoker and even I find smoky, cloudy pubs too much to bear. However since installing air cleaning systems the air quality in my local has improved enormously, there is no need for separate smoking and non smoking areas as even non smokers agree the air quality is such that we can all sit together.

This legislation that improves air for everyone is surly better than a total ban which would undoubtedly loose people jobs and the public revenue?

This ban is yet another infringement on people's rights, how many of the Scottish Public would vote for this ban if they were given a chance to air their opinions?
I object to the proposal.

Paul Harman  
South Shore  
Blackpool

I work for Cumbria Vending Services and my job is now at risk because of this bill. I have seen the Air Smoking Charter prove to be a success and it has been agreed by the Government.

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Let the people of Scotland continue to have their freedom of choice and address the matter of air cleaning systems - this will get rid of the need for a ban.

Mike Bell  
Cumbria Vending Services

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Let the people of Scotland continue to have their freedom of choice and address the matter of air cleaning systems - this will get rid of the need for a ban.

Marion Pringle  
Cumbria Vending Services

I work for a successful cigarette vending business in Carlisle that operates in the Scotland. I have eight colleagues, many of whom, like me have worked for the company for years.

Our livelihoods are now under threat because of the proposed smoking ban in Scotland. The company I work for and my colleagues all pay taxes and contribute to our communities. We want to work and continue to take pride in our achievements for our employer not be put out on the street and out of work. Families are under threat.

We have distributed all the Air Charter information to all our outlets and have had an enormous success rate with its implementation. If this voluntary legislation is being so successful and exceeding Government targets why change it?

People have the right to choose - we choose to work. The legislation has made a huge impact within places I visit and I am and always have been a non-smoker.

I totally object to the proposed ban and wish my objections to be registered and noted.

Mike Simpson  
Cumbria Vending Service

I register my objection to the proposed ban on smoking in Scotland. Colleagues of mine will lose their jobs as will many other people should this ban go ahead. At present there is the Air Charter Smoking Act in place which is working and there is no need for anything else.
People have a right to choose - let smokers and the people of Scotland have this right.

Trevor Bines
Rochford
Essex

Today Scotland tomorrow the Nation? Is the Scottish Parliament trying to show itself as concerned for the people who voted for it and concerned for the image it portrays to the world and as pioneering with this bill? If it is it is not doing a very good job! The Licensed Trade and Tobacco industry as a whole have approached the matter in a far more logical and forward thinking way with the Air Smoking Charter AND what's more the British Government think so too.

Banning smoking in public places won't make it go away, but providing better ventilation and air cleaning systems and better air quality for the whole of the public will make a difference. This is a far reaching and practical way forward not a closed narrow minded ban.

The consequences for Scotland are enormous - job losses and loss of public revenue are just two, does Scotland want to be known as a dictatorship by taking away a persons right to enjoy a cigarette? Personal space is one thing but public areas are another when steps can be taken to improve things for everyone.

Please register my vote against the proposed bill.

David Wilkinson
Wells Vending Services
Essex

Even as a non smoker I must object to this proposed bill and I wonder, if given the chance, how many people in Scotland would too. Freedom of choice is at stake not to mention thousands of jobs and hundreds of businesses. At the moment smoking is contained inside this will spill to outside meaning there will be smoking and drinking on the streets - is this the image Scotland wants to give its thousands of tourists?

The current Air Smoking Charter is enough legislation - if it wasn't working then there would be cause for concern however it is and Central Government agree it is. By providing better air quality and improving the environment for everyone to socialise together prevents a divided community and helps maintain thriving communities by preventing job losses and the subsequent decline that it brings with it.

Please register my objection.

David Anderson
Wells Vending
Essex

There is already legislation, which has been approved and is being monitored by, Central Government.

This is the Air Smoking Charter. Everyone has heard of this and evidence can been seen in pubs and clubs and other outlets allowing smoking across the land - not just Scotland - how many people in Scotland now about the Maxwell Prohibition of Smoking in Regulated Areas (Scotland) Bill? How much publicity has this had? How many opinions has the research obtained from their general public? The Smoking Charter has been researched and agreed by all parties and as it improves air quality for smokers and non smokers in these areas must be a good thing. The area of providing better ventilation within premises allowing smoking is the way to approach this situation not an outright ban with more than non smokers being affected. Colleagues in Cumbria will be affected by this Bill as their jobs are now on line - so may mine be and I am in Essex. Everyone has a right to choose and smokers are having that right taken from them. As a smoker I agree there are areas -
hospitals, libraries, swimming pools where smoking is not appropriate but I and my non smoking friends, family and colleagues agree that smoking should be allowed to continue in pubs and clubs etc. where adequate ventilation and air cleaning systems are in place.

I strongly object to the proposed ban on smoking in Scotland.

Jeff Bines
Wells Vending Services
Rochford

Why ban Smoking in Scotland where there is already legislation in place by voluntary agreement with the Licenced Trade, Tobacco companies and associated companys and the Government?

This voluntary legislation is being carefully watched by Government and is surpassing the targets that it has set. Clean air in smoking places is a better solution than a ban it will help everybody not just non smokers.

We have a right to choose - and I choose to object to this Bill and to smoke.

Ian Harrison
Rochford

I register my objection to the proposed ban on smoking in Scotland. Colleagues of mine will lose their jobs as will many other people should this ban go ahead. At present there is the Air Charter Smoking Act in place which is working and there is no need for anything else.

People have a right to choose - let smokers and the people of Scotland have this right.

Bob Blowes
Rochford
Essex

I am a smoker and even I find smoky, cloudy pubs too much to bear. However since installing air cleaning systems the air quality in my local has improved enormously, there is no need for separate smoking and non smoking areas as even non smokers agree the air quality is such that we can all sit together.

This legislation that improves air for everyone is surly better than a total ban which would undoubtedly loose people jobs and the public revenue?

This ban is yet another infringement on people’s rights, how many of the Scottish Public would vote for this ban if they were given a chance to air their opinions?

I object to the proposal.

Rob Williams
Rochford
Essex

I register my strong objection to the proposed ban in Scotland for smoking. As a non smoker myself I see no reason for this far reaching proposed legislation. I am based in Essex but I am sure that should this bill go ahead it will affect us even down here from up in Scotland.

Measures such as the bill are not needed, there is already sufficient voluntary legislation in place by the Licensed trade and tobacco companies, that are working.
Don't fix what is not broken and allow people to choose - as is their right.

Colin Darby
Rochford
Essex

I am a manager for a cigarette vending company and have helped to build the company over the last 10 years to the success it is today. The proposed Maxwell Prohibition on Smoking in Regulated Areas (Scotland) Bill will have serious far reaching consequences for all businesses such as cigarette vending across our Nation.

Many jobs will be lost, including some of my colleagues up in Carlisle. The financial consequences of this as enormous.

At present the whole tobacco industry and licensed trade are cleaning up their act with the Air Smoking Charter which requires the installation of air cleaning systems in any outlet where smoking is currently allowed. This allows both smokers and non smokers to enjoy a social life together. OK where children are concerned these areas should have separate areas for smoking as should restaurants but as a non smoker myself I see no reason to punish those who do and to take away that right from them.

Better, regulated air quality is the way for governments to tackle this problem. Other forms of pollution are monitored so why not this one?

Have the Scottish people been asked for their opinions on this proposal? Have the Scottish Parliament taken in to account the whole society’s views? Probably not.

For the above reasons I object to the proposed Maxwell Bill

Mrs J Sorrell
General Manager
Wells Vending Services

I am a director and an employer of a cigarette vending company that operates in the Scottish Borders.

Some of my employees may now have to be made redundant, a task I am not looking forward to. With my husband we have built our company over 25 years of hard work and sacrifice and we feel that we are not being treated fairly.

Legislation would penalise not only smokers in Scotland but many others whose livelihood depends on the tobacco trade. It is unjust and unfair especially when the Air Smoking Charter under voluntary legislation and monitored by Central British Government is working and exceeding Government targets.

This Charter is the way forward to solve a problem for both smokers and non smokers - clean air provided by better air cleaning/ventilation systems in public places where smoking is currently allowed. My company sells these systems and encourages their installation every time we site a cigarette vending machine. We are very successful. The licensed trade recognises the need to clean up its act for all concerned and is working hard, in alliance with NACMO, ACM and the major tobacco manufacturers.

Taking away peoples freedom of choice is not the answer - the answer is to solve the problem for everyone’s benefit.

I am a non smoker and having seen better air quality in pubs and clubs that I visit am quite happy to allow the Charter to continue as it can be seen to be working. Shortly it will be moved on to a second, more detailed stage.
This is the way forward - please note my comments and register my strong objection to the proposed Maxwell Prohibition of Smoking in Regulated Areas (Scotland) Bill.

Mrs A L Bullough
Director
R Duckworth (Blackpool)

I work for a cigarette vending company, who like the rest of the Leisure Industry recognise a need to cater for both smokers and non smokers. To this end we have started to sell air cleaning systems.

When we install a cigarette vending machine we strongly advise the premises, if they haven't already, to install an air cleaning system. The Air Smoking Charter is introduced to them again and updated as necessary. We sell and install many of these cheap, easy maintained and effective little wall units. They do make a difference.

This works hand in hand alongside an industry under threat of legislation. We recognise the need for better air quality despite selling one the very items accused of polluting it!

Allowing freedom of choice for individuals with better air, as well as maintaining employment, revenue and government votes seems to be the only way forward.

Please note my comments and register my objection to the proposed ban on smoking in Scotland

James Bullough
c/o R Duckworth (Blackpool) Limited

The Leisure Industry are currently cleaning up their act by installing air cleaning systems as they recognise the right for an individual’s freedom of choice - in this instance the right to enjoy a cigarette whilst socialising.

This is the only way to go without losing jobs and revenue. Why can't Scotland see this?

Have the Scottish people even been asked their opinions?

Most strongly do I register my objection to this proposed ban

David Chapman
Necton
Norfolk

The licenced trade and others have agreed a Smoking Charter with the British Government, targets have been met and everyone is happy - why isn't this good enough for Scotland?

How many jobs will have to go and businesses lost? The bill for benefits etc will be picked up by the whole British public not just Scotland's.

Air Smoking Charter is the way forward - better air quality for everyone not just non smokers.

Please register my objection to the proposal

Steven Edwards
Beccles Suffolk

Voluntary legislation sufficiently covers the problem with the Air Smoking Charter. This has been embraced by the licensed trade and is the best solution for everyone.

Employees keep their jobs, the government keeps its revenue, pubs keep their trade and the individual keeps its right to choose.
I register my objection herewith.

Nicola Maguire
Halesworth

As a non smoker I do not feel that banning smoking is the correct thing to do. Many of my friends and family smoke and I see this as their personal right to choose. I would not be happy for them to have to stand outside just to have a cigarette - think of the mess the butts would make! I am happy and choose to visit a well ventilated pub and socialise with my smoking friends. My local has installed ventilation and the difference is tremendous - as a non smoker I feel this benefits everyone. My local displays the Smoking Charter ventilated premises sign as required and the decision was made under voluntary legislation.

Surely this is preferable to unemployment, lost taxes, benefit payments?

Please register my disgust and objection to such an absurd proposal.

Scott Neve
Great Yarmouth
Suffolk

I wish to register my objection to the proposed ban on smoking in Scotland. Has this been thoroughly researched? The Smoking Charter has - and this in my opinion is the answer for every one - smokers, non smokers, the people who would lose their jobs, the people who would lose their businesses, the tax payers who would foot the bill for lost former tax payers revenue and the newly unemployed benefits and the government who has a healthier but still happy public who will no doubt vote for them again.

Another point is who actually knows and who has been consulted on this proposal? Wake up Scotland your individual right to smoke is being taken away!

Charles Fletcher
Nantwich

Why ban smoking and cost money in lost revenue and people losing their jobs? This is not the answer. Cleaning air systems are the correct way to deal with this situation - keeping smokers and non smokers alike happy together. Everything else is legislated - spirits, beer and noise - why not air where applicable?

Strong objections to this proposal from Lynne Simons in Lowestoft, Suffolk

My colleagues in Carlisle face unemployment due to this ridiculous proposed ban. A better solution is to adopt a policy along the Air Smoking Charter lines. This voluntary legislation which is beating government targets, has been thoroughly researched and investigated and is working. Why the need for more?

Everyone has a choice – let’s keep it that way with better air quality not an unnecessary ban I object to this proposal.

Michael Palmer
Halesworth

Voluntary legislation sufficiently covers the problem with the Air Smoking Charter. This has been embraced by the licensed trade and is the best solution for everyone.

Employees keep their jobs, the government keeps its revenue, pubs keep their trade and the individual keeps its right to choose.
I register my objection herewith.

Michael Way
Manningtree
Suffolk

I object to the smoking ban in Scotland even though I live at the other end of our country. I know about the ban through working in the trade but how many of the Scottish people do? Will this be another Ireland?

No consultation, too many jobs lost and numerous financial implications. More cost effective idea would be to regulate the air quality in the places where smoking is allowed, mainly adult leisure places - pubs etc.

Noise pollution is monitored and beer, wines and spirits are regulated so why not air? This would allow everyone to have a choice and relax knowing they are being looked after. Much simpler, much cheaper and infringing nobody’s individual right to choose.

Please register my objection for the above reasons against the proposed ban.

Bernie Wilkinson
Stevenage
Herts.

Too many people will lose their jobs and too much money from taxes etc will be lost should this ban go ahead.

Why not allow the current Smoking Charter to continue - this is a much better idea and more than enough legislation.

Too many choices are being taken away from the individual today, this is just another example of a Nanny State.

Nicholas Todd
Chesgrave

Better air quality in agreed areas where smoking is allowed is the answer not new legislation.

People have a right to choose this includes smokers. Better air quality is beneficial to everyone not a ban.

Michael Allen
Bradwell
Norfolk

More legislation? It is not the answer! Take some pointers from the licensed trade who are currently and voluntarily adhering to the Smoking Charter. Installing better cleaning systems for better air quality is in everyone’s interest from every point of view surly?

How much revenue would be lost and how many jobs will people loose should this absurd ban go ahead?

Patricia Willia
Wissett, Suffolk

More legislation? It is not the answer! Take some pointers from the licensed trade who are currently and voluntarily adhering to the Smoking Charter. Installing better cleaning systems for better air quality is in everyone’s interest from every point of view surly?
How much revenue would be lost and how many jobs will people lose should this absurd ban go ahead?

Tony Willis  
Wissett, Suffolk

There is no need to ban smoking in public places - smokers and non-smokers could all get along fine together if sufficient breathable air was supplied in the main culprits pubs and clubs. We have separate areas in many places but this alienates people and won't work... better air cleaning systems are the way forward, allowing everyone a choice to smoke or not to smoke. I am a smoker and I agree there are some places smoking should not be allowed and is not allowed already - flights, swimming pools, hospitals, libraries and any where there is children. I even agree that smoking in restaurants is not a good idea. But why take away all the smokers' rights when there is no need?

The Air Smoking Charter - currently beating its agreed targets - is campaigning for better air quality and this is the way forward.

Adrian Palmer  
Lowestoft  
Suffolk

Dear sir

I strongly object to the Smoking Ban in Public Places.

I believe the current Smoking Charter is sufficient to deal with the issues concerned.

If a Ban should be imposed it should be on eating areas and restaurants only. Being a smoker myself, even I do not like people smoking whilst I am eating.

The country is full of do gooders who always seem to get their way because Parliament is to frightened of losing votes to oppose them.

Phil Clarkson  
Company Accountant

No! Smoking should not be banned. Too many people will lose their jobs and too much money will be lost from the revenue gained from the cigarette vending industry alone as an example.

Friends of mine in Carlisle will may lose their jobs as they have cigarette vending machines in Scotland.

In Scotland have people even been asked about the legislation? Have other views and opinions been asked for? The ventilation in places where smoking is allowed needs to be improved to let smokers and non-smokers enjoy a pint together. Where this has happened locally there has been a big difference in the air quality both for smokers and non-smokers - then the issue is freedom of choice for the individual - who pay tax on fags - as to whether they smoke or not. This freedom of choice should not be taken away.

I object to the non smoking ban

Jim Thompson  
Duckworths

I am seventeen years old and I have just started my first full time job with a cigarette vending company.
I am a smoker and I object to the proposed ban on smoking in Scotland. My new colleagues are now under the threat of losing their jobs and if this proposal goes ahead I too may face losing my job too in England. I have just started paying my taxes I don't want to get them back in benefits I would rather contribute to society as would the Cumbria Vending Staff. Why not get better air cleaning systems in place in pubs and other places like them to make sure that everyone can socialise together? Why always pick on smokers - we have a choice. I've been asked to put my opinion to you but have the Scottish been asked what they think? Governments today - voted for by the public (not me yet) make decisions that affect so many people and the people never seem to get a choice!

I object to the smoking ban.

Kelly Paterson
New Employee
R Duckworth (Blackpool) Ltd

Please register my formal complaint and objection to the proposed ban on smoking in Scotland.

I have friends and colleagues who may end up unemployed because of this unnecessary proposal. They work for Cumbria vending service who operate cigarette vending machines in Scotland. Why should these people be facing this horrendous event when there is already adequate industry imposed legislation in force that the British Government is happy is working. This Smoking Charter allows everyone to a basic entitlement under British constitution that of CHOICE. By providing better air quality everyone has the same choice - lobby for ventilation to be fitted in all pubs and clubs. Never mind separate areas improve everyone's quality of life.

Mrs L Slaney
c/o R Duckworth (Blackpool) Limited

Freedom of choice means no legislation. I agree we should not impose smoking on those who object but why can't we continue with separate smoking areas with decent ventilation. People will be put out of employment unnecessarily because voluntary legislation is working, colleagues of mine in particular who operate in the Scottish area. I frequent a public house which has a separate non-smoking area, a completely separate room, it has speakers in for quiz nights etc so it is not deliberately isolated. Everytime I go to the pub it is empty – smokers and non smokers alike are all sitting in the same room socialising together and they all agree because the ventilation system in the main part of the pub maintains good air quality there is no problem. Surly this indicates public opinion?

I strongly object to this proposed ban.

Mr Keith Kimberly
453 Waterloo Road
Bpool

Banning smoking will lead to unemployment and further infringements on an individual's right to choose.

Has any one asked the people of Scotland if they want this bill? Has anyone considered that the voluntary Air Smoking Charter is enough legislation seeing as though it is actually working and allowing people a choice at the same time. Air quality - better ventilation is what is required not a ban. If a ban goes ahead the financial repercussions would be enormous. As a non smoker I am quite happy to sit with a smoker where there is adequate ventilation, but I am capable, as are the Scottish Public, of making my own mind up. I do not want my friends and colleagues to be treated unfairly - goodness knows they pay enough taxes!
Please note the points above and my objection to any proposal banning smoking in Scotland or anywhere else.

Ms C Murray
Blackpool

Smoking Ban - what smoking ban? Only through involvement in the tobacco industry do I know anything about this.

Do the people in Scotland know - do they get a choice? Smokers and non smokers have a choice, but yet again smokers are victimised. That's how it feels - like a victim. We pay taxes on our cigarettes and as an employee of a cigarette vending company I pay taxes on my wages - as do my smoking colleagues in Carlisle who now have an uncertain employment future as they operate machines in Scotland.

How many other jobs will be lost should this proposal go ahead and how many other choices will be taken away from individuals?

The Air Smoking Charter more than covers the requirements for air quality which allows both smokers and non smokers to live together. This charter is also being upgraded shortly too. Better ventilation allowing everyone the individual right to freedom of choice and not inflicted legislation.

Objection in every possible way to this proposal.

Sue Thompson (Ms)
Chelsea Court

Please register my objection to the proposed ban on smoking in Scotland. I have colleagues who now face unemployment as the company operates cigarette vending machines in the Scottish area. The Air Smoking Charter is working so why change things? I am a non smoker and I am happy to be able to make an informed choice and I have seen improvements first hand under current voluntary legislation. Freedom of choice should not be taken away from the people.

I register my objection to the proposed ban.

Mark Dunnett

I object, in the strongest possible manor, to the threat my colleagues now face due to the Maxwell Prohibition of Smoking in Regulated Areas (Scotland) Bill.

My employers operate a cigarette vending company that operates in the Scottish area. Now the people working, and paying taxes, in the Carlisle branch, are looking forward to potential unemployment.

Everyone in the cigarette vending business has made a successful effort to see that the current voluntary Air Smoking Charter legislation is enforced and so have the pub/club trade. The targets set by the government have been met. Why do my colleagues face unemployment and why have people had their right to freedom of choice taken away?

There is no need for this proposed ban. I wish for my strongest objection to be noted.

Wayne Jones

Voluntary legislation, the Air Charter, is exceeding government targets to regulate the industry with regard to smoking in public places. Things have certainly improved and everyone connected to the industry has made a huge effort to get outlets to comply. Now these people face an uncertain future due to the outrageous proposed ban on smoking in Scotland. Some of these people are colleagues.
They pay taxes and are a part of their communities and they and others like them will suffer. Whatever happened to freedom of choice?

Kevan Luckett

Why legislate to ban smoking when the industry and those connected to it e.g pubs, clubs etc. are already under voluntary regulation with the Air Charter? This self imposed legislation is monitored by central Government and it has reached all desired targets - and surpassed them to boot!

Colleagues face unemployment due to this unnecessary proposed ban on smoking and it is unfair to take away their livelihoods and people's freedom of choice.

I register my objection most strongly.

Mike Hill

There is no need for a smoking ban in Scotland by legislation by the Scottish Parliament because current voluntary legislation - The Air Charter - is exceeding Central Government's targets already. People will be put out of work and reveue to public finances will be lost as a result.

Please register my objection to this proposal.

Peter Bell

Give people a choice! Keep people in work! Two reasons why a ban on smoking should not go ahead in Scotland - or anywhere.

Colleagues work in the Scottish area now face unemployment due to the proposed ban. Government benefits loom for them after years of contributing to their community and country with their hard earned taxes. What sort of reward for them is that after the effort they have put in distributing and helping to implement the Air Charter voluntary legislation. This has worked better than everyone thought it would - including the government.

Why do we need legislation when there is a voluntary system in place that is working? Why do we need to put people on the dole when people have freedom of choice?

Please register my strong objection to this proposed ban.

Trevor Ticehurst

I wish to register my total objection to a smoking ban in Scotland. People I know work for a cigarette vending company that operates in Scotland and I have no desire to see them out of work. As an employee in another vending company I have seen the current Air Charter voluntary legislation being implemented in many outlets I visit as part of my daily employment. If this is working why do we need Government legislation and the unemployment this will bring with it?

Paul Emmess
South Shore
Blackpool

I have spent 20 years managing and helping to build a thriving cigarette vending business in Carlisle that operates in the Scotland. We employ eight people many of whom have worked for the company for years.

Our livelihoods are now under threat because of the proposed smoking ban in Scotland. The company I work for and my colleagues all pay taxes and contribute to our communities. We want to work and continue to take pride in our achievements for our employer not be put out on the street and out of work. Families are under threat.
We have distributed all the Air Charter information to all our outlets and have had an enormous success rate with its implementation. If this voluntary legislation is being so successful and exceeding Government targets why change it?

People have the right to choose - we choose to work. The legislation has made a huge impact within places I visit and I am and always have been a non-smoker.

I totally object to the proposed ban and wish my objections to be registered and noted.

Mr George Pape  
General Manager  
Cumbria Vending Service

A smoking ban in Scotland will make thousands of people out of work - some of them are my colleagues.

Benefits instead of wages is not an option for them. At present the Smoking Charter is working and is all the legislation that is needed.

Freedom of choice should be left to the people not taken away by Government!

John Lord

Have you gone mad? Ban smoking! Why? People have a right to choose and that should not be taken away from them. I have friends who work in Scotland in the tobacco industry – cigarette vending. What's going to happen to them when they lose their employment? Who is going to pay benefits to them? Where is the money from their taxes and their employers company taxes going to come from?

Current Air Charter legislation is working - let it carry on - don't fix what's not broken.

Allow the Air Charter to continue  
Allow people to work  
Allow freedom of choice

Nick Stansfield  
Blackpool

I am a non smoker but see no reason for a ban on smoking in Scotland or anywhere else! At the moment the trade seem to be doing a good enough job with their own voluntary legislation which has made a big difference in the places I frequent.

People have the right to work and there will be thousands of jobs lost should this proposed ban go ahead. What about the implications for that. Colleagues will be out of work and on the dole - more drain on public finances. Not to mention the lost revenue from the companies who employed these people. Add the revenue gained from each packet of cigarettes sold as well - who will generate that income for public finances? Everyone - smokers and non smokers with their PAYE that's who! IS that fair?

Don't ban smoking - give people their right to choose and allow voluntary legislation to continue - it has proven itself so far.

John Hackman  
Penrose Avenue  
Blackpool
Why does government have to interfere with something that is working? Namely the Air Charter which is being implemented by the trade without legislation. Can't we have freedom of choice anymore?

People I know and work with have their jobs in jeopardy now as they work in the tobacco trade. What will happen to them - made redundant through no fault of their own. Claiming benefits instead of paying taxes! Who foots that bill - non smokers too! Their families will suffer, their communities will suffer just because we have no freedom of choice.

Voluntary legislation is working - leave it alone!

Mrs J Ashworth
Blackpool

I believe in freedom of choice and see no reason why smoking should be banned in public places. As a non smoker I am more than happy with the new arrangements put into place by the trade voluntary Air Charter which allows me to make an informed decision.

To ban smoking in Scotland would be an infringement on people's rights.

Mrs Barbara Bullough
Lytham St Annes

I strongly object to the proposed ban on smoking in Scotland. I have colleagues who work in the cigarette vending business in Scotland and I fear for their jobs and for those of many others in the cigarette vending industry.

The Air Charter voluntary legislation is more than adequate to ensure that people can make an informed choice - this is exceeding central government targets at present and is being stepped up a gear shortly.

A ban on smoking will mean a loss of thousands of jobs - who will pay the price then? This is a legitimate business paying taxes like every other just like their employees. Working and not claiming benefits!

Has this really been thought through?

Karen Ticehurst

I work for Cumbria Vending Services and my job is now at risk because of this bill. I have seen the Air Smoking Charter prove to be a success and it has been agreed by the Government. There is no need for legislation to ban smoking - improve air quality with cleaning systems that is the answer. As a non smoker I cannot see the need for a ban and potential loss of my employment, I work with cigarette and I see the right to smoke as an individuals choice take that away and I see it as an infringement on their rights - today smoking - what tomorrow?

Let the people of Scotland continue to have their freedom of choice and address the matter of air cleaning systems - this will get rid of the need for a ban.

G Proctor
Cumbria Vending Services
SUBMISSION FROM DR PAUL RAFFERTY

Prohibition of Smoking in Regulated Areas (Scotland) Bill
Stewart Maxwell MSP

As a respiratory physician I deal on a daily basis with the hazardous effects of smoking. Most people are now well aware of the dangers of smoking, including heart disease, strokes, lung cancer etc., and for smokers -if they choose to continue smoking -then that is a matter of free choice if they wish to submit their own bodies to the toxic effects I feel no compulsion to stop them. However, there is considerable evidence that inhalation of other people's smoke (passive smoking) also has deleterious effects, including an increased incidence of bronchitis, respiratory tract infections and even a small increase in lung cancer.

I would strongly support the Bill proposed by Stewart Maxwell that smoking should be banned in indoor areas where people are employed or areas regularly used by children as it seems unjust to inflict passive smoking upon non-smoking employees and children. Similar Bills have been successfully introduced in several states in North America, particularly with regard to restaurants and licensed premises -where these regulations have been well accepted.

I would strongly urge the Scottish Parliament to support this Bill.

Dr Paul Rafferty

SUBMISSION FROM EAST AYRSHIRE COUNCIL

Since it's inception in 1996, East Ayrshire Council has recognised the dangers of the effects of passive smoking and has implemented a policy on smoking designed to ensure that all Council employees are not subjected to passive smoking while at work.

In general terms, East Ayrshire Council supports the concept of a Bill which would prevent people, including children, from being exposed to the effects of passive smoking in certain public places. In formulating its policy on smoking, the Council took account of the fact that there are certain areas to which the public have access where smoking is not permitted (e.g. houses of worship, cinemas, theatres etc) and the public appear to have accepted that they will not be allowed to smoke in such places.

The Council would support the concept that there should be no smoking on public transport and in areas where food is supplied and consumed.

As far as the question of food is concerned, the Council would prefer to see some definition of "food" as many of the premises where smoking has played an integral part of the patrons social activities (e.g. public houses) have in recent years been encouraged to provide food in the form of wrapped savouries and chocolates.

The Council is aware of a section of the community which promotes the concept of adequate ventilation being provided as an alternative to a ban of smoking in certain areas. While in theory it is possible that a controlled environment could be achieved in some premises to ensure that passive smoke was retained within a refined area, such an arrangement would not protect the health of those employed in the premises who would obviously have to enter such area for the purpose of serving patrons.

On the information available, there is no indication as to where responsibility for enforcement would be placed. If such responsibility were to be given to local authorities, significant additional resources would require to be provided as it is anticipated that the bulk of enforcement visits would be carried out during evenings and weekends.

In conclusion, the Council recognises the right of individual members of the public to enjoy smoking tobacco and tobacco products. However the Council recognises that passive smoking (as a by-
product of the practice) poses a significant threat to the health of others, including children and in such circumstances then the rights on non-smokers must take priority.

William Stafford
Executive Director of Neighbourhood Services

SUBMISSION FROM EAST RENFREWSHIRE COUNCIL

In response to the above Bill and after discussion at Cabinet on the 22nd April 2004, East Renfrewshire Council fully supports the bill and the proposal contained within it.

If you require any further information please get in touch.

Regards
Frances Bain

SUBMISSION FROM FALKIRK COUNCIL

I have been invited to comment on the consultation on behalf of Falkirk Council. The deadline for consultation responses, however, has precluded any opportunity to have the subject discussed at Committee level. Consequently, the response essentially reflects the views of officers.

Do you support the general principles of the Bill and the key provisions it sets out?

The general principles of the Bill are fully supported. The key provisions are also supported, subject to the additions noted under the following point.

Are there any omissions from the Bill that you would like to see added?

The omission of public houses from "Public Places" listed in Schedule 2 is considered inappropriate, particularly given the inclusion of "Clubs" at Schedule 2 (1) and "Hotels" at Schedule 2 (4).

It is considered appropriate, if the initiative is to be fully taken in applying what is a significant public health protection and improvement measure, that controls should apply across all licensed premises selling "food" as defined in the Food Safety Act 1990. To this end, the exclusion of drink, or biscuits, nuts, potato crisps, chewing gum, confectionery and other similar products from the definition of "food" at Section 10 is also seen as an omission.

I have no additional comments to make on implementation or application of provisions at this time.

SUBMISSION FROM THE FEDERATION OF ENVIRONMENTAL TRADE ASSOCIATIONS

The Air Cleaner Manufacturers' Association (ACMA) is the representative body for air cleaning equipment manufacturers in UK. Our members' equipment is used in approximately 45% of pubs, according to the Publican Market Report, where it provides a vital function in reducing the amount of environmental tobacco smoke in the air.

Whilst we recognise that air cleaners on their own cannot remove all of the contaminants in a room where smoking is taking place, they can greatly reduce the amount of contamination in the air. In recent tests on actual installations in operational pubs on busy nights we have identified that this equipment can reduce exposure to tobacco particles by over 90%, this can be reduced further by the addition of fresh air ventilation. We have also carried out extensive test work with the Building Services Research and Information Association (BSRIA) to establish the effectiveness of individual models and to model the behaviour of tobacco smoke.
The Bill proposes that rooms in which smoking has taken place at any level should remain smoke-free for five days before food can be served in them. This period would undoubtedly pose considerable difficulties for licensees and restaurateurs, greatly reducing their flexibility in utilising their premises as cost-effectively as possible. In our test work we modelled the ‘decay rate’ of tobacco smoke and established that its half-life (the time that it takes to reduce by 50%) in a sealed, unventilated chamber with a high level of cigarette smoke was 172 minutes. Thus if smoking stopped at midnight the level of smoke would be half the original level at 0252, a quarter at 0544, an eighth at 0836 and so on. In 20 hours the smoke would be reduced by over 99%. In the ‘real world’, natural or mechanical ventilation would greatly accelerate this decline. It therefore seems totally unreasonable to require a five-day smoke-free period before a change of use to food services.

If an air cleaner were used in this space the rate of decline would be very much accelerated. The level of particulate contamination within the space in which the smoking had occurred would be reduced to the background level of the contamination outside (for example from car exhausts) and depending on the circumstances, often well below this level. We would therefore propose that your Bill be redrafted to allow for the use of air quality equipment and especially air cleaners to clean the room of contaminants before a change of use. The period, in practical terms, would only need to be a couple of hours depending on the circumstances. We would be very happy to model and demonstrate this effect for you. This would make the change of use far simpler and - with the wide availability of the equipment - greatly facilitate change of use without the risk of contamination from any residual particles.

The other area in which our technology could greatly assist your Bill is in removing the requirement for adjoining areas to be non-smoking, which would clearly be impractical for almost all premises that chose to serve smokers and food - even in separate rooms. By using appropriate air cleaners (the standards and testing methodology can be found at www.air-cleaners.org.uk) the level of particulate in any adjoining space can be substantially reduced. The exact amount of this reduction would of course vary according to individual circumstances - although we would propose a minimum air exchange rate of 10 times an hour. With the addition of low level fresh air extract ventilation this would prevent, through air pressure, any ingress of smoke into the non-smoking restaurant room or area.

The relatively high penetration of our products in this market would make these options practical and cost-effective for operators to achieve and would remove the unfortunate side-effect of the proposed measures of licensees being forced to decide between serving smokers and serving food. This practical approach would go far to reduce the concerns of the licensed trade about the feasibility of the Bill and the damage that it might cause them.

**SUBMISSION FROM FIFE COUNCIL**

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

Comments

Name: Vivienne Brown  
Designation: Health Improvement Adviser  
Service: Policy and Organisational Development, Fife Council

Do you support the general principles of the Bill and the key provisions it sets out?

We would support the general principles of the Bill. It supports the work of Fife Health and Wellbeing Alliance to "promote the development of smoke free shopping centres and other public places in Fife" as outlined in A Healthier Future for Fife, our Joint Health Improvement Plan. Fife Tobacco Issues Group proposes to consult on its framework for action around reducing the impact of smoking in Fife and the Bill will strengthen this work around smoking in public places.

Are there any omissions from the Bill that you would like to see added?
What are your views on the quality of consultation, and the implementation of key concerns?

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Fife has taken very positive action around Scotland's Healthy Choices Award over the past few years. There are already smoking criteria within the award, which are currently under review, and it would be useful to tie in the key provisions of the Bill to these new criteria and use the Scottish Healthy Choices Award Scheme to promote the principles of the Bill.

SUBMISSION FROM ALAN MCDEVITT (GLASGOW GPS COMMITTEE)

At a full meeting of our GP Subcommittee in Glasgow, we discussed your member's bill to prohibit smoking in enclosed places where food is supplied and consumed. The Committee, which consists of ordinary working GPs, was unanimous in its support of your bill.

As we are the representative body for Glasgow GPs, we wish to offer our full support on behalf of our colleagues. As working general medical practitioners, we see the terrible effects of smoking on an individuals' health on an everyday basis. Your member's bill would offer some protection from passive smoking in a wide variety of public places, would go a long way to protecting the seventy percent of the adult population who are non smokers in Scotland. It may also benefit smokers by reducing the amount of tobacco they consume.

We hope that your member's bill will receive cross party support to enable it to protect and improve the health of the people of Scotland.

Yours sincerely

Alan McDevitt
Assistant Medical Secretary

SUBMISSION FROM MR WILLIAM GOLD (THE HIELAN JESSIE)

I am writing with regard to your Bill "Prohibition of Smoking in Regulated Areas".

As a non smoker myself I am all in favour of no smoking areas, especially in food serving outlets, surely adequate ventilation and filtration will allow non smokers to enjoy their meal in the "Non smoking" area of food premises.

I have invested is upgraded ventilation and have leased filtration equipment which helps greatly in keeping air quality good in my bar.

I feel that my business would be badly affected by a smoking ban, there good ventilation no smoking areas and the appropriate signage is surely the way forward.

I fully support any initiative aimed at helping smoker give up and would hope that the executive would pursue this route to cutting down on the numbers continuing (and starting) to smoke.

William Gold

SUBMISSION FROM HONEYWELL CONTROL SYSTEM

I believe that absolute ban on smoking in public places in Scotland is unnecessary because there are means available to remove tobacco smoke, without banishing smokers. There are several means of removing the discomfort of tobacco smoke and harmful particles which are widely available to
employers, including ventilation and air cleaning systems. Combinations of these technologies can be shown to reduce the effects of airborne pollutants, such as environmental tobacco smoke, to levels that are acceptable to employers, employees and patrons alike.

Whilst Honeywell does not condone smoking, our opinion is that non-smokers and smokers alike should be given the choice as to where they spend their leisure time. The particular method that we promote to enable this choice is to have a published smoking policy within premises, and signage on external entrances to indicate whether smoking is allowed, and if so, what standard of ventilation is installed, and are there any non-smoking areas within the premises? This allows the potential patron to decide before entry whether the indoor air quality is likely to be acceptable. The choice is then simple. To enter or not? Importantly, this choice is then a matter for the individual patron. More information on this method can be found on the Atmosphere Improves Results web site (http://www.airinitiative.com/), or alternatively the Air Cleaner Manufacturers Association web site (http://www.air-cleaner.org.uk/).

The proposal within the bill to limit smoking to more than five days prior to serving food appears to be based on personal opinions, with no basis of fact. Where is the supporting case for the need for this time period? The Building Services Research Information Association in Bracknell has done a lot of research into tobacco smoke removal. Their information indicates that the natural decay rate for tobacco smoke in a sealed room is a half-life of 172 minutes. This means that 99% of all smoke particles would have disappeared in less than one day. If you add adequate ventilation or air cleaning to this, the figure becomes much lower.

Market forces will determine whether public premises eventually become non-smoking throughout, and the voting public should be allowed the freedom to choose where and how to spend their money. I hope that the above meet with you approval. Should you wish to see demonstrations of the technologies that are available to remove tobacco smoke, then please do not hesitate to contact myself at the address above.

Yours sincerely

Martyn Stanton
Product Manager, IAQ Division

SUBMISSION FROM HUNTERS & FRANKAU LTD

Hunters & Frankau is the main importer to the UK of hand-made cigars from Cuba and other Caribbean and Central American countries. We are a small company based in South West London employing just under 60 people including one full-time member of staff who is resident in Scotland. We do not distribute any tobacco products other than cigars.

We are members of the Imported Tobacco Products Advisory Council (ITPAC).

We supply cigars to a wide range of licensed businesses in Scotland including restaurants, hotels, pubs, wine bars, casinos and golf clubs. In 2003 the value of our cigars sold in Scotland at retail price including VAT amounted to just over £400,000 adding a comparatively small but valuable turnover to the Scottish hospitality industry.

The General Principles of the Bill

Hunters & Frankau opposes the general principles of the Bill because we consider them to be unsound and unnecessary.

Much of the justification for its introduction is based on the supposed danger to health caused by 'passive smoking' or Environmental Tobacco Smoke (ETS). The Policy Memorandum accompanying the Bill claims that there is conclusive proof that ETS causes serious illnesses and deaths. However we do not believe that this is supported by objective analysis of the available evidence. In this context
we would refer the Committee to a paper entitled `Environmental Tobacco Smoke - Fact and Opinions' published by the Tobacco Manufacturers' Association, which is not given a mention in the documentation. This paper recognises that the annoyance caused by tobacco smoke, particularly to non-smokers, is an issue that must be addressed but refutes in detail the claim that there is a causal link between ETS and disease. Whilst it may be easy for Committee to dismiss the paper as representing the vested interest of the tobacco industry, we would urge members as responsible holders of public office to give due consideration to all sides of the scientific debate before embarking upon legislation, which should be the last resort to the implementation of any policy.

We therefore believe that it is unsound to embark upon the legislative road in the absence of clear evidence that ETS represents a serious risk.

Instead we believe that adequate, effective measures can be taken to address the issue by voluntary means supported by market forces. The indisputable progress that has been made by the Scottish Voluntary Charter on Smoking in Public Places demonstrates what can be achieved and we would welcome and support any measures to speed up its development.

We would dispute the assumption that restaurants and other places where food is served are correctly defined as `public places'. Members of the public are at liberty to make their own decisions as to whether they wish to patronise a particular restaurant on many grounds, one of which is the policy it follows on smoking. The owners of such premises should remain at liberty to respond to the demands of their customers just as much on the issue of smoking as on the many other issues that face anyone, who seeks to run a successful restaurant business.

We conclude therefore that legislation is unnecessary to achieve a goal proportionate to the nature of the problem.

Practical Implications

We are concerned that whilst the Bill creates three new criminal offences, it does not provide clear provisions for their enforcement. In the accompanying documentation the view is expressed that a low level of prosecutions will result similar to those experienced with seat belt legislation. Given that in this Bill there will always be two potential offenders, the smoker and the proprietor or manager of the establishment, we foresee ample opportunity for argument and dispute which mat well demand prosecution to resolve. This will be costly and arguably put an unnecessary burden on a legal system, which is already stretched.

Of particular concern is the 5 smoke-free days rule in rooms where food is to be served. We note that there is no scientific or medical justification for this period of time offered in the Bill nor its accompanying documents and we consider that it is likely to give rise to many practical and probably unforeseen problems. For example it would mean that the law would require a restaurant to be closed for five days if there was an accidental or malicious use of a tobacco product on the premises leading to a substantial loss of income to the proprietor. It would be particularly difficult to control such activity in a room that was rented for a private function such as a conference in a hotel or even in a venue such as a village or church hall. Strict compliance could in these circumstances put the commercial viability of such establishments at risk.

The Bill, if enacted, would bring unprecedented change to long established customs and practices associated with the sale and consumption of tobacco products and, as a result, is likely to have many unforeseen side effects. One such side effect that we consider to be quite likely is that certain elements of the hospitality industry will take the opportunity to create specialised, compliant smoking venues. In such places it will be permissible to serve alcohol but not to offer substantial food. This will only serve to encourage one of the worst forms of alcohol consumption, that is to say, on an empty stomach. In view of the level of public and political concern about `binge' drinking, particularly amongst the young, it seems illogical to consider the introduction of a measure that would, if anything, seek not to discourage this practice.
We would also like to take issue with two particular points concerning the likely economic impact of the Bill that are mentioned in the accompanying documentation.

The first is the example of the effects of the smoking ban in bars and restaurants in New York, which was introduced just over a year ago. Particular mention is made of the study by the city's Department of Health and Mental Hygiene, which claimed that that restaurant and bar business had increased since the ban was introduced. In the same vein as the interpretation of research on ETS, we strongly recommend the Committee to consider all sources of information on this issue and not to depend on those where vested interests may lie.

We would draw members' attention to a letter that appeared in April in the London Evening Standard from Brian Nolan, Executive Director of the United Restaurant & Tavern Owners of New York, which read as follows:

"The United Restaurant & Tavern Owners represents some 500 bars in New York City. Since the smoking ban last year, New York bar business is not up by 8.7% as Mayor Bloomberg announced recently. Most bars that we represent have lost between 15% and 25% of their custom.

Tourist-dependent Maryland and business-savvy Connecticut have enacted laws that allow smoking in bars and designated restaurants where modern air-purifiers are used.

Other states are voluntarily adopting stringent air-filtration standards in bars.

The UK may follow New York's and Ireland's lead, but you should be aware of the dire consequences."

This organisation has no vested interest beyond the well-being of its members and, in our opinion, its views should be considered seriously in country where tourism is a £4 billion industry employing some 200,000 people. We would add that our products, notably our Cuban cigars, have a particular appeal to visitors to the UK from the United States as is borne out by the level of our sales to golf clubs in Scotland at the time of major international events.

A second point arises from the statement in the Explanatory Notes that some of the costs of compliance can be offset against savings made by not having to install air cleaning and ventilation equipment. This pre-supposes that the only source of air pollution in a bar or restaurant emanates from tobacco smoke. In the modern world where pollution levels for a wide variety of different sources are increasing alarmingly, this is clearly not the case and any restaurateur or bar owner is well-advised to install such equipment regardless of tobacco smoke if he has the comfort of his customers at heart.

Consultation

From the researches we have conducted through our Scottish representative, we are concerned that the level of consultation with individual hospitality businesses has been low. Whilst the publicity that the Bill has received has made most people aware of its existence, very few have been contacted directly to establish their views.

Nowhere was this more evident than in Edinburgh, where at the end of March, we contacted the General Manager one of the city's leading hotels to find out his views. Although he was aware of the Bill, he was unaware of the call for evidence and the deadline by which comments were required. By coincidence our inquiry took place on the day before a major meeting of the General Managers of all the leading Edinburgh hotels. As a result of our action the Bill was discussed at this meeting. We understand that none of those present had been aware of the consultation exercise but we believe that they have subsequently considered its implications and made their submissions.

As a general comment we would have expected that the Scottish Parliament should have ensured that there was widespread knowledge of their consultation process amongst those in the Scottish
hospitality industry. In this context we would ask that this company should be kept informed of developments on the Bill and any other tobacco related issues.

We hope that you will give due consideration to all our comments.

Yours faithfully

Simon Chase
Hunters & Frankau Ltd

SUBMISSION FROM IMPERIAL TOBACCO LIMITED

General comments

Imperial Tobacco Limited welcomes this first opportunity to submit evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill provided by the Health Committee.

Whether or not to ban or severely restrict smoking in public places is an issue for debate. We recognise that other people's tobacco smoke can be unpleasant or annoying, and raises health concerns for many. We also accept that some non-smokers would prefer not to be exposed to other people's smoke, and that therefore some sensible accommodation is required.

Whilst it may be sensible to place some restrictions on where and when people can smoke, we do not believe that unjustifiable restrictions or wholesale bans are necessary. We believe that an accommodation to satisfy both smokers and non-smokers can be found through sensible arrangements, defined by local needs and circumstances.

The Prohibition of Smoking in Regulated Areas (Scotland) Bill is an example of unjustifiable and excessive regulation. The Bill seeks to ban smoking in any enclosed public space where food is supplied or consumed. In practical terms, it will impose a ban on smoking in a wide variety of establishments, including restaurants, pubs and bars. It will also impose potentially unworkable restrictions upon some clubs, hotels, village and community halls or centres and other similar facilities.

This Bill sets out a 'reasonable' and balanced approach to the issue of public smoking, but in effect will impose a ban on public smoking across a wide range of establishments. Whilst the preparation and consumption of food is used as the basis for the proposed restrictions, the Policy Memorandum fails to put forward a single argument linking the issue of food and smoking.

General principles behind the Bill

The debate about the regulation of smoking in public places, including the workplace, has intensified in recent months with a number of national and local organisations publicly stating their support for further regulation. Imperial Tobacco believes that such calls are misplaced and unfounded for a number of reasons:

The science

The scientific evidence, based upon around sixty studies, does not demonstrate that Environmental Tobacco Smoke (ETS) causes lung cancer, heart disease or other diseases in non-smokers when considered as a whole. The five largest studies produced inconsistent findings with one reporting a small increase in risk, three reporting no statistically significant increase in risk, and one reporting a statistically significant decrease in risk.

Where a statistically significant association was reported, the magnitude of relative risk reported was so small (typically below 2.0) that it would generally be regarded as too weak by conventionally accepted epidemiological standards to form the basis for public health policy. The UK Government
has provided its own view on relative risk factors: “A stronger association - of greater than 2 - is more likely to reflect causation than is a weaker association - of less than 2 - as this is more likely to result from methodological biases or to reflect indirect associations which are not causal”.

Small increases in relative risk are sometimes reported in percentage terms. A relative risk of 1.2, for example, is often popularised as a 20% increase in risk, giving an impression that if 100 people were exposed to the risk, 20 of them would contract the disease. This is highly misleading. A 20% increase in a number that is small produces a number that is still small. To put it simply, a relative risk of 1.2 for a disease for which the incidence is 10 per 100,000 per year in a non-exposed population implies that the incidence is 12 per 100,000 per year in an exposed population.

Consequently the studies that have been conducted, when combined, show a relative risk to lung cancer of about 1.2 for spouses of smokers and of 1.1 for colleagues of smokers at work. This compares with diesel exhaust fumes (2.6) and electromagnetic fields (3.2), which in line with normal statistical practice on such studies are treated as not significant and within experimental error. Similar numbers are produced for population studies on ETS and heart disease.

Although the views of many in the medical and regulatory communities are unequivocal, there are notable exceptions. The editor of the British Medical Journal, which is strongly anti-tobacco, recently stated: "We are certainly interested in whether passive smoking kills, and it’s clear to us that the question has not been definitively answered. Indeed it may never be answered definitively. It’s a hard question, and our methods are inadequate".

In general, however, it is extremely difficult to achieve any rationale dialogue on the science, as regulators have adopted the position they wish to for political purposes from the highly inconclusive data and do not engage on the statistical and rather esoteric scientific issues.

To summarise, we do not believe that the scientific evidence, taken as a whole, is sufficient to establish that other people's tobacco smoke is a cause of any disease. The population studies which have led to claims of any health risk are subject to methodological flaws, but at most indicate a very small risk. As a result we do not believe that prohibitions on smoking in an "enclosed public space" where food is supplied and consumed are justified by the scientific/health arguments.

Choice and fairness

Central to this debate are the concepts of choice and fairness. Smokers and non-smokers are reasonable people who are looking for fairness and balance. This issue can be resolved through common sense and courtesy, and by introducing practical solutions such as well-ventilated smoking and no-smoking areas. The bottom line is about giving people choice and information, and letting them decide.

It is clear that ventilation and air filtration can provide substantial improvements in air quality, and do so in many situations including operating theatres, electronic manufacturing sites, and elsewhere. Thus even the annoyance of other people's smoke can be eliminated or reduced to a minimum.

It is often portrayed that a majority are in favour of bans - this is not the case. Recent evidence from the largest surveys presently conducted suggest that a large majority - somewhere between 57 and 76% of people are against a ban on smoking in bars and pubs. These are not figures produced by the tobacco industry, but rather the London Health Commission's 'Big Smoke Debate', MORI/the Greater London Authority poll and MORI/SmokeFree London UK poll.

Whilst an undisputed majority of people wish to see the provision of non-smoking areas increased, it has not expressed a view that this should be achieved by prohibiting smoking when voluntary, self-regulation is proving to be increasingly effective.

Significant progress has been made by the Scottish Voluntary Charter on Smoking in Public Places, which mirrors the agreement with the hospitality industry operating in England and Wales. Whilst further and more rapid progress is always desirable, it would be nonsense to reject the Scottish
Voluntary Charter outright at a time when the UK Government is negotiating with the hospitality industry in England and Wales for higher compliance levels within an accelerated timeframe.

The Bill defines restaurants and other places were food is served and consumed and ‘communicating spaces’ as being ‘public places’. However, these are not generally public places or spaces. They are privately owned premises. Authorities should not have a natural right to control how they are operated. Whether an establishment permits, prohibits or otherwise regulates smoking is rightly a matter for the owner/operator to determine. They know what makes good business sense to provide what their customers want. Where there is a demand for a smoking ban, or for separate areas for smokers and non-smokers, commercial operators will and do respond with appropriate local initiatives. If they do not respond to local concerns, then their trade will suffer.

The Bill assumes that consumers or customers are somehow compelled to eat food in areas that may also permit smoking. This is clearly not the case. Consumers are in no way compelled to give their custom to an establishment if they do not care for some aspect of the place. Smoking may only be one out of many and varied reasons for customers to choose not to patronise a particular establishment.

The Bill supposedly only prohibits smoking in certain enclosed public spaces. However the definition of a regulated area is written in such terms as is likely to lead to much dispute and argument and in many instances would effectively ban smoking throughout in certain establishments. The definitions of ‘regulated area’ and the inclusion of ‘connecting spaces’ including stairways and passageways as a public space will force very many establishments, particularly the smaller ones, to choose between the serving of food or allowing smoking. This is not a reasonable measure but rather the introduction of a part smoking ban under the guise of considered regulation.

One of the suggested principles behind the Bill is that food must not be served or consumed in the same area as smoking. Whilst some customers may not find this desirable, no evidence or argument is put forward making any link between the consuming of food and smoking.

Practical implications

The Bill will impose potentially unworkable restrictions upon some clubs, hotels, village and community halls or centres and other similar facilities. The requirement that an enclosed space must be smoke free for five days before food is provided should be of particular concern to hotels where the use of conference and private rooms may need to be varied from day to day. The rule itself is wholly unwarranted and not justifiable on any sensible grounds.

The Bill legislates for all premises where food is supplied and consumed, taking no account of the vast variety in premises. This single regime for such regulated areas will have significant cost implications for proprietors. The costs of compliance for any person providing food and wishing to provide facilities for smokers outside the area where the food is provided would, in many instances, be high and for a great many would be prohibitive, potentially involving design, layout and structural changes to the premises that in cost would far exceed any possible savings.

There have been high-profile public smoking bans in New York and Ireland in recent months. It will be some time before the true economic cost of these bans is known. Surveys do show mixed results - with those claiming no or a positive impact receiving more publicity. Others do show a negative impact. For instance, the Vinters’ Federation of Ireland commissioned ICR (International Communications Research) to conduct a study exploring the effects of the smoking ban in New York City on 300 businesses in September and October 2003.

Two-thirds of responding establishments said they were seeing fewer customers now than when the ban went into effect.
Consultation

Imperial Tobacco did not make a submission to the Member's consultation in 2001 on the proposal of Ken Gibson. Consequently we were not invited to submit evidence in the 2003 consultation undertaken by Stewart Maxwell. As a result, this is the first time that Imperial Tobacco has submitted evidence to the Scottish Parliament's consideration of this issue.

Imperial Tobacco does not make any excuses for opposing a ban or unreasonable restrictions on public smoking. As a company producing a controversial product, we are willing to accept sensible and practical regulation and will participate in dialogue with governments and regulators to achieve this. However, we do not regard this measure as reasonable.

We do have a commercial interest in this issue - the fact is that millions of people like to smoke with a meal or when they are having a drink. But we also believe we have a legitimate right to defend the rights of these customers - over one million of whom live in Scotland. We do not believe that it is fair or just to make potential criminals out of these one million smokers.

Concluding remarks

The key issue on public smoking is how large (if any) is the risk, and what should be done to protect non-smokers from the small risk (if any) or at least the very real annoyance which is caused to non-smokers. Outright bans are disproportionate, but what is reasonable to protect non-smokers? Can local solutions, agreed locally, be sufficient to suit local needs?

The objective of the Bill, as set out in the Policy Memorandum, is to prevent people, including children, from being exposed to the effects of passing smoking in certain public places. This is based on perceptions of health risks that are themselves based on flawed interpretations of epidemiological studies. Imperial Tobacco does not believe that the Bill is justified on public health grounds.

We believe that local and sensible arrangements can and should be made to allow smokers and non-smokers to coexist. Segregation is often possible, and ventilation and air filtration can also provide the improvement required. Studies have shown that significant improvements can usually be achieved, which should be perfectly adequate to deal with the annoyance, once a sense of perspective is achieved. We suggest that Scotland should wait for the outcome of the negotiations with the hospitality industry on the new Charter before proceeding with bans.

The decision about whether to ban smoking should be up to the owner or proprietor of an establishment. Consumers should then be forewarned of the policy (as per the signage used in the Charter agreement) and allowed to make their own choice.

1 US National Cancer Institute, `Dirty Water', Reason, 28, 1, p.52, 1996
2 House of Lords Hansard Written Answer, columns 31-32, 31 March 1998
3 British Medical Journal, 18 May 2003 [an almost identical letter by the same author was published in BMJ Volume 327, 30 August 2003]
4 London Health Commission's `Big Smoke Debate', December 2003, London, 34,446 self-selecting sample, 43% of respondents were in favour of pubs and bars being "completely smokefree"
5 MORI/Greater London Authority poll, November 2003, London, 1,002 sample, 36% of respondents were in favour of pubs and bars being "completely smokefree"
6 MORI/SmokeFree London, September 2003, Great Britain, 2,046 sample, 24% of respondents were in favour of pubs and bars being "completely smokefree"
SUBMISSION FROM THE IMPORTED TOBACCO PRODUCTS ADVISORY COUNCIL

Introduction

ITPAC represents the interests of 12 importers of tobacco products, the majority of which are small private companies, engaged in the distribution of tobacco products on a national scale within the UK. A number of ITPAC's Members are principally engaged in the distribution of specialist tobacco products including cigars, and they will be particularly affected by measures which curtail the responsible usage of their products in the hospitality sector.

ITPAC welcomes the opportunity afforded by the Health Committee's invitation for consultation on the above-mentioned Bill and would make the following comments:

Key Points

1. The Public Health Justification for the Bill

There have been many studies into the effects of environmental tobacco smoke (ETS), and it is widely recognised that these studies are inconclusive. The findings have been inconsistent and, even where a positive association has been indicated, it has been of a very low order of relative risk and well below that normally regarded as being significant and indicating a causal link. It is not considered appropriate to pursue the path of legislation when there is no firm evidence to prove that ETS represents a serious risk.

2. Government Position

Government at Westminster continues to favour the voluntary approach to restrictions on smoking in public places.

The Scottish Executive is following a similar path with its Scottish Voluntary Charter on Smoking in Public Places, and we understand that the Department of Health and Community Care are loath to introduce legislation unless it has the clear support of the public.

Should such support become evident the question of the possible consequences of the regulation of smoking in Scotland becoming different from that in England and Wales is not addressed in the Bill, its Explanatory Notes or the other accompanying documents.

3. Legalistic Approach

There is no need to add to the law. The legalistic approach to regulating smoking is inappropriate and unnecessary; market mechanisms and voluntary responses driven by consumer demand are the appropriate and proper route.

The public wishes to see the provision of more non-smoking areas; it has not expressed a view that this should be achieved by prohibiting smoking when voluntary self-regulation is proving to be increasingly effective. In this context much progress is being made by the Scottish Voluntary Charter.

4. Rights of Owners/Operators

The Bill is not proportionate and doesn't strike a fair balance between the rights of individual proprietors and the general interest in protecting public health.

Whether an establishment permits, prohibits or otherwise regulates smoking should rightly be a matter for the owner/operator to decide. These people are driven by customer demand and commercial expediency; where there is a requirement for a smoking ban, or for separate smoking areas, they will and do respond.
5. Freedom of Choice

Consumers are not compelled to give their custom to an establishment if they do not care for some aspect of that particular place. If they have concerns about the establishment's cleanliness, service, smoking policy or any other issue they will express their freedom of choice with their feet and their wallet.

6. Definition of a Regulated Area

Whilst the Bill only prohibits smoking in certain enclosed public spaces, the definition of a regulated area is written in such terms as is likely to lead to much dispute and argument; the terms are such that they would effectively prohibit smoking throughout in certain establishments.

7. Clarity of Enforcement

It is wholly unsatisfactory that the Bill, which creates 3 new criminal offences, does not contain explicit provisions for enforcement; given the absence of such provisions it is possible to foresee a high degree of non-compliance and disrespect for the law.

There could be much dispute about the application of the Bill's provisions to individual premises and also dispute about the separate offences of permitting smoking, and smoking in a regulated area.

8. 5 Day Rule

The requirement that an enclosed space must be smoke free for a minimum of five days before food is provided should be of particular concern to hotels where the use of conference and private rooms may need to be varied from day to day. It will also have a particular impact on the use of village and community halls, centres and other similar facilities. The rule itself is wholly unwarranted, not justifiable on any sensible grounds, and will indeed seriously undermine the actual ability of significant numbers of premises to survive.

9. Cost

The Bill legislates for all premises where food is supplied and consumed; its provisions take no account of the vast variety of such premises and the implications of the application of a single regime for such regulated areas. The costs of compliance (involving design, layout and structural changes to the premises) for any outlet providing food and wishing to provide facilities for smokers outside the area where the food is provided would, in many instances, be high and for a great many would be prohibitive leading to the closure of those premises.

10. Tourism

Tourism in Scotland is a £4 billion industry which employs 200,000 people and which plays a significant part in supporting the social fabric of fragile and remote areas; an important part of this is high value added tourism (particularly from the USA and key European countries) involving such activities as Scotch Whisky industry hospitality trips, golfing, fishing, stalking and shooting. The imposition of draconian regulations on the hospitality infrastructure could well be expected to have an adverse influence on the decision by certain customers to visit Scotland.

11. Estimates of Compliance

The estimates of compliance and prosecutions provided in the Financial Memorandum are fanciful and unrealistic and have no relevant sound basis.

Conclusion

This Association considers that such a prohibition imposed by way of legislation is not the regulatory route preferred by the wider public. Market forces and the voluntary adoption of self-regulatory
measures are achieving rapid progress in the adoption of smoking policies that meet the preferences of customers and reduce the exposure of non-smokers to the smoke of others. We therefore do not believe that this Bill is justified.

We feel that the issues we have raised above are important and we trust you will give them due consideration.

Should the Committee wish for further elaboration of this evidence, or any other additional information, ITPAC will be pleased to respond.

Wyndham Carver
Secretary-General

SUBMISSION FROM JACKO’S BAR

Subject: Mr Stewart Maxwell's ‘Prohibition of Smoking in Regulated Areas’ Bill

As proprietors of the above named establishment and non smokers ourselves we feel compelled to contact you with regards to the above subject bill as proposed by Mr. Stewart Maxwell MSP.

Scotland's first minister recently publicly announced his commitment to supporting tourism within the country, as you are no doubt aware Scotland, and in particular the North of the country relies heavily on the tourism industry. The backbone of said industry in the North is the eating and drinking establishments which are visited by numerous tourists from all over. Mr. Maxwell's proposed bill is therefore, surely not in line with the first ministers as it endangers the very existence of these businesses.

Our establishment is a single roomed bar housing a small non-smoking section within; we provide food to the general public. We cannot accommodate a completely separate smoking room which would be separated from the dining area by two doors. In the event that the proposed bill is passed then it would have the following effects on our small family business:-

Based on the contents of the proposed bill we would have to cease with the supply of food to the public which would have an estimated negative effect on the turnover of our business of approximately 25 to 30%. Further, it would lead to the termination of approximately 50% of our staff and, as Nairn is a small community with high unemployment this would have a detrimental knock-on effect for the area.

As for the minister’s proposal to fine both customer and person in charge up to £1,000 per offence, this would appear to be unreasonable towards both. The person in charge of the establishment has no power to stop a member of the public from smoking; as long as any government supplied signage is displayed then the business should be considered compliant with law. The customer should have the right to choose whether they wish to smoke or not. The proposed level of fine could easily be mistaken as yet another form of 'stealth' tax!

We all appreciate that smoking is not beneficial to health, but neither is alcohol and you are not proposing a ban on that! Smokers have the right to smoke as do non-smokers have the right to sit at the opposite side of the bar from the smoker. Perhaps a solution would be to investigate the vast range of effective air purification systems which are available on the market and set an air quality standard which premises must comply with, or the bar should display signage out front identifying whether the premises permit smoking or not, thereafter the public can decide whether to enter or not; after all we should all have the freedom to decide by ourselves (the latter is part of the outcome of a recently performed survey on the premises)!!!!

Finally, the Scottish Parliament was voted in with the good of our country in mind, this does not appear to be reflected in this proposed bill which could potentially put numerous establishments out of business, as is already proving to be the case in Ireland after the recent no smoking bill was enforced.
Perhaps the government's thoughts should be more akin with the majority of Europe whose good health we are constantly preached about, yet a large number of them smoke and we will almost definitely be part of in the future, instead of the United States who have serious obesity concerns about the population and which we shall never be part of!

We do not expect a reply to this letter but if the minister feels compelled to do so then please do not hesitate to contact us as indicated above.

Yours sincerely
Sharon & James Magee
Partners

SUBMISSION FROM TRICIA, MIKE AND JAMIE CRESDEE (KILFINAN HOTEL)

We own a hotel in Argyll and obviously am interested in your new proposals re smoking.

We are fortunate in that there are sufficient areas in the hotel to accommodate the regulations if they come into force. Incidentally the Restaurant in the hotel is already non-smoking. However, it concerns us that many in the trade are not so fortunate and livelihoods could be affected in what already can be a precarious business.

There is concern that surveys which have been carried out (i.e. the man in the street approach) do not fully represent the people who frequent public houses on a regular basis. Legislation which affects peoples' lives should be concentrated on those who use and benefit from a facility, not based on a blanket ban where people who do not avail themselves (or rarely) have their opinions counted.

The 'Nanny State' in which we now live seems to have taken over the individual's right to decide on how they live their lives.

On a related matter, that of the 'children's' licence', I think the decision of whether or not to enter a licenced premises should fall on the parents/guardians of the children. If the parents consume alcohol, then I think it fair to say that they also consume alcohol in their homes, where the children can see them pour drinks. If they do not wish their children to be affected by drinkers then there are many alternative premises they can visit. Shopping malls are full of them, with a distinct absence of any licenced places where adults can go in peace!

Give people the right to choose - places where they can go to drink and smoke, places where the licencee decides (again using his own right to do so) that there will be no smoking. No-one is forced to go where they don't want to go and that should always be the criteria. Give us back the right to have our rights!

SUBMISSION FROM NHS LANARKSHIRE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

We are delighted by the Scottish Executive's proposal to ban tobacco smoking in almost all public places as we consider that its implementation would significantly reduce the health, personal, NHS and societal burdens of smoking.

We anticipate that this normalization of non smoking would have three important benefits:

i) the majority of the adult population (approximately two-thirds), who are non smokers, would no longer have to tolerate the unpleasantness of stale tobacco and environmental tobacco smoke (ETS), particularly those working in the hospitality industry;
ii) a reduction in the number of smokers or the amount they smoke, and thus a reduction in the personal, NHS and economic consequences of smoking related diseases;

iii) a reduction in the health effects of passive smoking, in particular for children.

In Lanarkshire the prevalence of smoking in people aged 16+ years is over 30%, the figure being slightly higher in men; in 2002 27% of pregnant women were smoking at the time of their booking visit; and 8% of 13 year olds and 21% of 15 year olds smoked were regular smokers (at least one cigarette each week).

Smoking-related diseases are our commonest causes of death, and of these more than 800 deaths are estimated to have been attributable to smoking in 2002 (Table 1).

<table>
<thead>
<tr>
<th>Disease No. of deaths, 2002 Estimate of deaths attributed to smoking(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischaemic heart disease 1266 228</td>
</tr>
<tr>
<td>Cerebrovascular disease 422 51</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease 285 217</td>
</tr>
<tr>
<td>Cancer of bronchus and lung 423 343</td>
</tr>
<tr>
<td>Total 2396 829</td>
</tr>
</tbody>
</table>

Table 1 Deaths attributed to smoking in 2002 among Lanarkshire Health Board residents
1 Attributable risk based on data for UK in 1988, and is therefore only a guide to numbers.

In 2002 deaths more than 1 in 7 of all deaths were therefore estimated to have been caused by smoking.

The effects of passive smoking are best documented for children. Smoking during pregnancy accounts for a third of perinatal deaths; it contributes to low birth weight; it is now thought to be associated with behavioural disorders and increases the risk of diabetes in later life. Children whose parent smoke have an increased chance of developing a range of diseases including asthma, middle ear disease, and sudden infant death syndrome.

Smoking related disease are chronic, and incur primary and acute care resources as well as considerable human suffering. Although we do not have access to disease specific costs, the average costs for acute care in Lanarkshire are shown in Table 2.

<table>
<thead>
<tr>
<th>Acute care in Lanarkshire Average cost per case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient £1561</td>
</tr>
<tr>
<td>Day case £389</td>
</tr>
<tr>
<td>Outpatient £44</td>
</tr>
</tbody>
</table>

Table 2 Costs of providing acute health care in Lanarkshire in 2002

Many of the recent arguments have focussed on employees being able to work in an environment free from ETS. Smokers' counter argument has been that if they do not like tobacco smoke employees should choose to work elsewhere. The hospitality industry (e.g. public houses, restaurants) are often staffed by some of the lowest paid employees who are prepared to work the unsocial hours this can require in order to ensure an income. Their employment choices may be limited by their skills, and their social and financial situations.

In Lanarkshire, as elsewhere, there have been various campaigns and efforts over many years to reduce both the incidence and prevalence of tobacco smoking, but with limited effect. Most of it, however, has focussed only on smokers, and not on the wider population.

The key question is whether a ban on smoking in public places will reduce smoking prevalence. Its introduction will not only affect smokers, but will also benefit non smokers, who themselves will help to police it by their reactions if someone should start to smoke in a banned location. Also, as smokers are banned from smoking in increasingly more locations, the amount of time available to them to smoke will reduce. This suggests that at population level the health burden of smoking should gradually reduce.
Health promotion theory argues that an environment which supports desired behaviour, or is obstructive to undesired behaviour, will help to increase or reduce it respectively. Studies have shown that when the initiative is applied to a whole or 'closed' population situation such as this, it has been effective.

California and the Republic of Ireland have already shown that the introduction of such an initiative is feasible in Western democratic cultures. In the case of California the normalization of non smoking using a wide ranging approach to reduce tobacco consumption, in ten years has resulted in:

- a 57% reduction in cigarette consumption;
- a decrease in the number of heavy smokers;
- a significant decrease in the prevalence of adolescent smoking to 7.7%; and
- an increase in the 12-13 year olds who have never smoked.

In the UK fiscal policy has kept the cost of tobacco high, the smoking advertising ban is in place (although not quite universal); and a smoking ban would be a significant extra factor in normalizing non smoking. We therefore believe that the evidence supports this additional and major initiative, urge that it should be adopted, and strongly recommend that the Executive should either implement it in all public places, or should state that it will extend the ban to all public places within a further three years.

Bibliography


Mr David Pigott Dr Dorothy Moir
Chief Executive Director of Public Health

SUBMISSION FROM LLOYDSPHARMACY

In response to the Scottish Parliament Health Committee's call for Written Evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, Lloydspharmacy would like to take this opportunity to set out our position with regard to the detrimental effects of smoking.

Over 1.2 million people in Scotland currently smoke on a regular basis (30% of the Scottish population). Diseases caused by smoking cost NHSScotland over £184 million in 2001 and 13,000 Scots die each year from these diseases. This equates to between 20-25% of all deaths in Scotland and is one of the main reasons why disadvantaged people are more likely to have poorer health and
die younger. However, it is clear that deaths and hospitalisations are not just confined to those who choose to smoke themselves. Passive smoking is also a significant threat to Scotland's health. It has been estimated that 17,000 children are admitted to hospital every year as a result of parents' smoking. The British Medical Association has conservatively estimated that over 1000 deaths a year in the UK can be attributed to passive smoking. Action on Smoking and Health (ASH) believes this figure could be as high as 12,600. Fundamentally, deaths and diseases from passive smoking are preventable and there are many options, including the prohibition of smoking in regulated areas, which should be considered.

Lloydspharmacy, community pharmacists, provide a wide range of health care services through over 150 branches across Scotland. Lloydspharmacy is strongly committed to the concept of 'social pharmacy'. This entails a strong emphasis on helping people to maintain their own health and well-being, not just dispensing drugs to them. Consequently, we appreciate the reasons behind the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

We provide help in the cessation of smoking and the benefits of living a healthier lifestyle as part of our commitment to this concept of social pharmacy. A comprehensive information leaflet entitled "Ready to quit smoking" is available in all our branches, our pharmacists are fully trained to offer a personal quit programme and we can offer essential contacts such as advice services and help-lines for those wanting to give up. As an all round approach to health care, smokers trying to quit are also encouraged to adopt a healthier lifestyle.

Lloydspharmacy feels that the Prohibition of Smoking in Regulated Areas Bill (Scotland) omits any mention of the roles that Community Health Partnerships (including community pharmacy) and Primary Health Care Trusts can play in reducing the number of people who smoke in Scotland. As described above, smoking is fundamentally a health concern and all attempts to limit detrimental effects (to smokers and non-smokers alike) should we feel, be made in tandem with the appropriate health authorities.

However we do not feel that Lloydspharmacy is in a position to submit support or opposition to the legislative provisions of the Prohibition of Smoking in Regulated Areas Bill (Scotland) and as such, have not attempted to address the invitation's 3 other key areas of focus.

SUBMISSION FROM KAREEN GILLESPIE (LOCHSIDE TAVERN)

I have written this letter to highlight a few points I have regarding the Bill against smoking in public houses, hotels etc.

Firstly, we do not serve food in our establishment.

Second, if this Bill was passed we would not consider serving food.

Third, we would lose a staggering amount of customers and trade if this Bill is passed.

Fourth, we do not have a room separated by two doors and we could not accommodate this with the layout of our establishment.

Fifth, the proposed fines of £1000 per offence are very unfair. In an establishment which has an open bar and lounge area, with one person working on their shift it would be very difficult to keep vigilant when busy to ensure that any person did not light up a cigarette, especially in the toilet areas. We have had discussions with customers regarding this Bill, the customers who smoke have said that if smoking was banned in our establishment, ‘their local pub’, they would not return. They feel their ‘Freedom of choice’ would have been taken out of their hands.

We have non-smokers who have also discussed this issue with us. Their views are that they have a ‘good local pub’ with a lot of friends (many of them smokers) and that smoking has never stopped them returning.
We have two smoke filter machines installed which help greatly with the extraction of smoke, and are cleaned on a regular basis.

We strongly disagree with this Bill, we feel our customers' trade will be greatly affected, which will result in loss of earnings, loss of staff, and potential loss of a great local public house.

SUBMISSION FROM MR WILLIAM GOLD (THE LOG CABIN)

I am writing with regard to your Bill "Prohibition of Smoking in Regulated Areas".

As a non smoker myself I am all in favour of no smoking areas, especially in food serving outlets, surely adequate ventilation and filtration will allow non smokers to enjoy their meal in the "Non smoking" area of food premises.

I have invested in upgraded ventilation and have leased filtration equipment which helps greatly in keeping air quality good in my bar.

I feel that my business would be badly affected by a smoking ban, there good ventilation no smoking areas and the appropriate signage is surely the way forward.

I fully support any initiative aimed at helping smoker give up and would hope that the executive would pursue this route to cutting down on the numbers continuing (and starting) to smoke.

William Gold

SUBMISSION FROM DR DEREK BELL

I would strongly support this action.

It is clear that other countries, in particular North America, are moving in this direction. This is based on a ground- swell of public feeling and recognition that passive smoking in itself can contribute to ill health. It is also worth noting that we now do not allow smoking in aircraft or indeed in the London Underground because of the risk of fire and the potential loss of life associated with this.

This Bill would send a clear message from the Scottish Parliament that it is interested in health and in particular tin health promotion and healthy living. As such, I would strongly support this bill.

Your sincerely
Dr Derek Bell
NHS Lothian

SUBMISSION FROM TRACEY MOONEY (MACAULAYS)

I run a successful and growing Pub business and the introduction of a non smoking Policy to regulate smoking within a food area would have a serious effect upon my business. I surveyed over 100 customers and 95% indicated that they prefer no restrictions on smoking. You should be aware of the serious consequences to my business and the people I employ by introducing a non smoking policy coupled to the customer service of food provision. Within my establishment I have introduced a food menu which I would have to cease. This would be a reduction in service to my customers as they would be restricted to only alcohol and soft drinks. This is obviously not good as I try to promote a balanced service and sensible attitude to alcohol consumption.
If your proposed bill was introduced I would have to cease a food service and subsequently would not require serving staff.

Tracey Mooney
Macaulays

SUBMISSION FROM MACMILLAN CANCER RELIEF

General principle of Bill and key provisions

Macmillan Cancer Relief is fully supportive of the general principles of this Bill and its key provisions. With 90% of lung cancers and 30% of all cancers caused directly by smoking, Macmillan as an organisation and through Macmillan postholders, sees at first hand the impact of tobacco smoke on people in Scotland. We are fully aware of the impact of smoking on coronary heart disease, stroke, pregnancy, cot death, asthma, ear infection etc, but will leave it to others to comment on these. There is conclusive evidence that second-hand smoke contributes to these problems.

The principle of legislation is sound, as the voluntary charter has not worked (and indeed has not worked in any country in the world). The voluntary charter is also founded on false principles as (a) ventilation systems do not adequately remove cancer-causing chemicals, and (b) separation of a space for smokers is shown to be ineffective in protecting people from the effects of second-hand smoke (unless they are physically isolated from smoking areas).

With 7 in 10 Scottish pubs and bars permitting smoking throughout, the time has come for action through legislation and political leadership.

The general context is that Scotland has amongst the highest rates of lung cancer in the world and the lowest survival rates. The cultural change implicit in the Bill means that this will have a direct impact on quantity of cigarette consumption by smokers and on smoking cessation rates as it will assist smokers to give up, if the experience in other countries is replicated in Scotland. This will directly impact by reducing deaths from lung cancer and other diseases.

We see this Bill as one step in a number of measures addressing the prevalence of smoking and, in particular, ensuring that for the first time this gives precedence to the views of those who wish to breathe air free from tobacco smoke. Consequently, this should be a major step in changing the culture of Scotland to one where smoking is not a social norm. With 70% of people being non-smokers, this seems entirely reasonable.

We accept that passive smoking in other workplaces will not be affected by this legislation. However, studies have shown that hospitality workers have a 50% higher risk of lung cancer than the general population, and therefore this is the highest priority group of workers to be protected.

Omissions

Macmillan would prefer to see a ban on smoking in all enclosed public places and workplaces, but accepts this Bill as an important first step.

Quality of consultation and implementation of key concerns

Is ventilation a useful tool in combating ETS and therefore an alternative? It has been conclusively shown and accepted by the Executive that ventilation does not remove the risk from passive smoking.

Impact of voluntary charter With only 11% of premises complying with the voluntary charter, this has been shown to be a failure. Given that some of the measures in the voluntary charter do not protect people from the adverse effects of passive smoking, continuation of this voluntary approach is illogical.
Smoking restrictions in restaurants and / or pubs There is no defence against continuing to expose workers in the hospitality industry to the high level of risk to which they have conclusively been shown to be exposed.

Financial impact on trade, tourism and health There is no evidence from similar legislation round the world of any adverse impact on trade from independently funded studies. The most recent evidence from New York is showing an increase in employment and tax revenue.

Implementation of the legislation The timescale is a matter for political judgement, but the 'Big Bang' approach, as in the Republic of Ireland, certainly produces an impact, but being clear about the date on which any measure comes into force in various settings must be well publicised. This assumes that it will be preceded by a public education campaign.

Breaches of the legislation This is quite clearly articulated in the explanatory notes. Compliance has not been found to be a major issue in other countries. The previous experience in, say, London Underground or London Transport does demonstrate isolated pockets, but enforcement is easier in static premises, as experience in New York and in the Republic of Ireland has recently demonstrated.

Support for legislation The issue about a public information campaign is fundamental, as we are talking about cultural change.

Overall view on the quality of consultation and the implementation of key concerns

In Macmillan's view the quality of the consultation was excellent. As an organisation that is fully supportive of this approach, we are aware that key concerns on business impact raised by the Licensed Trade Association could not be conclusively allayed. The key issue for Macmillan is what the Executive decides is the priority. We maintain it has to be to protect workers in the hospitality industry and non-smokers' rights in support of health policy, as opposed to a hypothetical impact on business which would be the first such time that legislation would have produced a negative effect.

Comments on the practical implications of putting provisions in place, and the consideration of alternative approaches

Air treatment systems These do not work, and this is accepted by the UK Government and the Scottish Executive.

Prohibit smoking in all public places This would be our preferred solution, but we accept that this is a stage on the way.

Maintain status quo Given that 100 people are dying from the effects of other people's smoke every year in Scotland, this is not acceptable. Public attitudes to smoking continue to demonstrate that there is a growing acceptance of this amongst the public, with independent polls showing more than 70% in favour of action.

SUBMISSION FROM MORAY HEALTH IMPROVEMENT STRATEGY GROUP

Prohibition of Smoking in Regulated Areas (Scotland) Bill

In response to the questions set by the Health Committee:

1. Do you support the general principles of the Bill and the key provisions it sets out?

The Moray Health Improvement Strategy Group supports the general principles of the Bill to prevent people, including children from being exposed to the effects of passive smoking in certain public areas, particularly where food is supplied and consumed.
The Moray Health Improvement Strategy Group would be in favour of taking a stronger stance than the proposed bill and would approve of a smoking ban in all public places.

Evidence clearly shows the voluntary code has not had the effect it was hoped for. It may have worked in large populated areas where a food business could cater for a specific part of the population but in less densely populated areas to have a viable business they have to be seen to cater to all parts of society. To make the ban statutory gives those businesses who would like to become non smoking a level playing field.

The Health Improvement Strategy Group supports the view that the Bill is only part of the process of safeguarding peoples' health from the effects of tobacco smoke, and that there needs to be ongoing:

- awareness raising of the dangers of both passive smoking and smoking
- support systems to change the attitudes of the public towards smoking in general
- encouragement and support for people who want to stop smoking and to ex smokers to prevent them from relapsing, by providing a smoke-free environment

There are current initiatives in Moray that support smoking cessation and awareness raising:

A Smoking Advice Service is available to adults who want support to stop smoking. A Smoking Advisor provides ongoing support and appropriate medication to small groups and individual in local areas according to demand.

There is also a Young People's (15-25 year olds) Tobacco Project (Fag Break): One of 8 national youth smoking cessation pilot projects, the Moray project is funded by Ash Scotland and NHS Health Scotland for a 3 year period (April 2002-March 2005). The young peoples' advisor provides ongoing promotion and support in community locations and registration of young people to the service. External evaluation is ongoing.

Awareness-raising in schools, community groups and workplace are ongoing locally and supported by regional and national policy and campaigns: Grampian Tobacco Action Plan and National No Smoking Day.

2. Are there any omissions from the Bill that you would like to see added?

Moray Health Improvement Strategy Group is of the view that this is just the beginning, once implemented and shown to be successful, the regulated areas could be expanded. The group would like to query that there is sufficient clarity regarding premises where food is supplied ie. food within a pub/hotel where food is designated for part of the area and not other parts. (Do they need to be separated by fixed walls? - or could there be spaces within an "open plan" environment with different designations?)

3. What are your views on the quality of consultation, and the implementation of key concerns?

The Moray Health Improvement Strategy Group approves of the opportunity to comment on the Bill, as well as on the initial consultation "Regulation of Smoking Bill: a Consultation issued in November 2001. The consultation process appears to have covered all interested parties. The group supports the principle of being able to influence national policy and local implementation through consultation.

Implementation of the key principles of the Bill would require commitment through the development of policies at a local level from all organisations and support as a statutory requirement, from the Scottish Parliament.

4. Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

The implementation of the above Bill and policing is the most important part. It is not realistic to expect premises to be inspected for compliance and another approach is needed. It is acknowledged
that not all premises will be licensed but the vast majority, who have not complied with the voluntary
code, will be. It will be imperative to get the licensing board to accept their responsibility towards
public health. The licensing board must make it plain to the licensees that any adverse report of
breaching this legislation WILL affect the licence for the premises. The licensing board will have to
acknowledge the medical evidence rather than their own prejudice and/or ignorance. The public will
have to be involved in the policing as well, indirectly by boycotting premises that allow smoking and
directly by reporting breaches to the relevant authorities. It is interesting to note the surveys
conducted in other countries who have had the audacity to stand up to the tobacco giants and there is
no reason why Scotland will not follow these excellent examples.

SUBMISSION FROM THE NATIONAL ASSOCIATION OF CIGARETTE MACHINE OPERATORS
(NACMO)

On behalf of The National Association of Cigarette Machine Operators (NACMO) I as Chairman of
this Association am writing in response to the above Bill.

We do not support the general principles of the Bill or its key provisions.

We have worked very hard over the last 8 years to re-site cigarette vending machines in public outlets
to ensure their control by on site staff and in conjunction with the Westminster Department of Health,
we agreed a Code of Practice and a Code of Machine Siting and Display Guidelines which we believe
to be working effectively thus helping to prevent purchases by under 16’s from these machines.

On the subject of Environmental Tobacco Smoke, we have fully supported the Atmosphere Improves
Results Campaign (AIR) and have persuaded our customers in the licensed trade to implement the
signage required for their particular outlet and continue to believe a voluntary agreement is the way
forward. Whatever future policy is agreed in Charter 2 on May 5th 2004 we will continue to support
and help licensed trade customers to implement that policy.

A ban on smoking in regulated areas as proposed in the Scotland Bill my Scottish NACMO Members
believe will not only seriously damage their businesses, the licensed trade and the tourist economy
but will also result in unemployment within the leisure industry.

It is the view of the Scottish NACMO Members and indeed all Members of our Association throughout
the UK that to implement this proposed Bill does not make sense when so much has already been
achieved by voluntary agreement and which can continue after 5th May.

We would be pleased to provide any further oral or written evidence to the Bill at Stage 1 in June
2004.

Should your require any further information from me or our Scottish Members, you can contact me -
Ken Simcox, NACMO Chairman

SUBMISSION FROM NATIONAL ASTHMA CAMPAIGN SCOTLAND

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

Q. Do you support the general principles of the Bill and the key provisions it sets out?

National Asthma Campaign Scotland welcomes this Bill as a positive step towards smoke free public
places. We support the general principles of the Bill and the key provisions that it sets out.

Secondhand smoke has a massive impact on people with asthma. Not only can it make asthma
worse, but research has found it can actually cause asthma.

Even at low levels of exposure, secondhand smoke is associated with asthma symptoms.
Secondhand smoke is a major asthma trigger, reduces lung function and causes more frequent attacks.

Research published at the end of 2003 concluded that secondhand smoke also causes asthma in adults. For people exposed to asthma at work the risk of developing adult onset asthma is doubled, for people exposed to asthma in the home the risk is increased fivefold.

A Personal Perspective

Elaine has asthma and explains how smoking in pubs and restaurants affects her life:

"About 14 years ago and after a very healthy and busy social life where I played squash for my university and ran up the hills of Snowdonia I developed late onset asthma. How life changed! The most vicious trigger was cigarette smoke and so overnight I became a prisoner in my own home. I could not go with my friends and family to pubs, parties or restaurants. They all found this hard but not half as hard as I did. Imagine declining all meals out, going to pubs with friends, school/parent socials and parties. Sometimes I would sit at home alone and send my husband out to enjoy himself because I didn't see why he should be a victim too. I pathetically looked forward to the annual Christian Aid Ceilidh in the local Church hall because smoking was not allowed. I sometimes became very angry at the ignorant rhetoric in the papers about the rights of smokers. They have no right whatsoever to pollute the air I or any other person breathes. Restricted areas are not effective as the smoke is still hanging in the air, evidenced by how people smell when they come out! Eventually I found a non-smoking restaurant in Edinburgh called Parrots and took all my friends and family there. More recently others have sprung up, probably about three and of course Starbucks are all non smoking so at least we can go for a coffee now. The first non smoking pub/restaurant in Edinburgh has emerged and this is great news."

Elaine goes on and asks the committee:

"Please can we have a ban on smoking in public places? At the moment many people with asthma have had their choice and freedom of movement removed. With a ban, people who smoke can still choose where to go however their choice to pollute the air we breathe will be removed. That is justice."

Research from National Asthma Campaign has found that:

- 82% of people with asthma say that other people's smoke makes their asthma worse
- 55% of parents of children with asthma avoided restaurants and places with smoky atmospheres
- 40% of adults with asthma avoid smoky pubs and restaurants
- Secondhand smoke is the second most common asthma trigger in the workplace
- 1 in 5 people with asthma feel excluded from parts of their workplace where people smoke

Q. Are there any omissions from the Bill that you would like to see added?

This Bill is limited in its scope in terms of the fact that it only applies to places where food is served. National Asthma Campaign Scotland would like to see this extended to all public places, but we realise that public opinion may not yet be at this stage. Therefore we welcome this Bill as enabling people with asthma and other respiratory conditions to go out and enjoy a meal without the fear of having an asthma attack.

Q. Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

National Asthma Campaign Scotland understands that prohibiting smoking in areas where food is served will cause concern for smokers and restaurant owners. However, we believe that the overwhelming health arguments outweigh these personal liberty arguments put forward by smokers,
particularly when compared with the personal liberty of people with asthma, who have a right to go to a restaurant without fear of having an asthma attack.

This may lead some to consider alternative approaches such as smoke free areas or ventilation systems. However, scientific research has shown that neither of these measures is effective.

Smoke free areas have been compared to swimming in the chlorine free half of a swimming pool. It simply does not exist. Smoke free areas are still contaminated by cigarette smoke and the carcinogens and toxins that it contains.

Ventilation systems have also been suggested as a possible way forward. Again, scientific research has shown that ventilation systems are simply not effective in removing toxins and carcinogens from the air.

Conclusion

Preventing smoking in public places is the only way that we can protect people from the adverse effects of secondhand smoke. Other measures that try to find common ground between interest groups, such as ventilation or smoke free areas are a compromise, and a compromise that is dangerous to health. While in politics we often try to find a common path, or a compromise that brings different groups together, on this issue such a policy could lead to solutions that are detrimental to health and therefore cannot be pursued.

National Asthma Campaign Scotland supported the voluntary code on tobacco control as a stage in the progression towards smoke free public places. The voluntary code has been shown to be ineffectual, therefore, in order to protect the health of the population of Scotland, we must now go further.

Concerns have also been raised that prohibition of smoking in areas where food is served will result in a loss of business for owners. However, evidence from around the world proves the opposite. A year after New York’s smoke free legislation, trade was up 12% and 1,500 new jobs had been created.

National Asthma Campaign Scotland supports this Bill as a positive step forward in improving the health of our nation and are happy to provide the Committee with oral evidence if requested.

SUBMISSION FROM DR PETER SEMPLE

Dear Sir,

Prohibition of Smoking in Regulated Areas (Scotland) Bill - Call For Evidence By Health Committee

As the only Consultant Respiratory Physician in Inverclyde, covering a population of 135,000 in the West of Scotland, I have a major interest in the impact that smoking has on the population which I serve.

The above Bill, if implemented, would prohibit smoking in enclosed areas open to the public, where food is supplied and consumed. There will be many arguments in support of such a measure and I would highlight three below.

(1) If smoking is accepted as the norm., for instance sanctioned in such places as restaurants, young people will assume that cigarette is indeed "normal behaviour", which it clearly is not. Preventing smoking in such areas will go some way to reduce the number of young people adopting the smoking habit thus helping to reduce the current high level of morbidity or mortality caused by cigarette smoking.

(2) Increasingly people, including young families, "eat out". The restaurant business is expanding rapidly and is an important industry in Scotland. For non smokers, if they are in the company of active cigarette smokers while eating, this very significantly reduces the pleasure of eating out and indeed
can spoil the event completely. Whereas it might be argued that prohibiting smoking would dissuade active smokers from visiting restaurants, I believe that there would be a net gain in that more non-smokers would visit restaurants and other establishments.

(3) The impact of passive smoking is very small compared with active smoking, but none the less it is responsible for a number of cancer deaths every year. However large numbers of people with asthma or allergies are particularly susceptible to cigarette smoke and these pre-disposed individuals may have their restaurant outing completely spoiled if they are exposed to cigarette smoke. Those employed in the catering industry, in kitchens etc., would be at particular risk of passive smoking if smoking was sanctioned in kitchens etc and it is extremely important that smoking be prohibited there also. In addition to that there are issues of hygiene relating to cigarette ends, ash etc.

I believe that there would be a strong majority consensus within Scotland to support the above Bill which, I believe, would send out all the right messages and would reflect similar moves in other European countries.

Yours sincerely

Dr Peter Semple

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**SUBMISSION FROM NHS DUMFRIES & GALLOWAY & DUMFRIES & GALLOWAY COUNCIL**

Prohibition of Smoking in Regulated Areas (Scotland) Bill 2004

Do you support the general principles of the Bill and the key provisions it sets out?

Agree with:

a) Prevent people including children from exposure to ETS in certain public places
b) Focus on where food is supplied and consumed
c) Raise awareness and safeguard health of Scotland
d) Encourages cessation, but some expansion is required on what follow up support is provided.
e) Would hope that an additional principle of this Bill would be that it is the first steps for Tobacco Control in public places and will set the scene for future action in Scotland. However the 5 day rule for premises where smoking is allowed, seems reasonable until you work through the practicalities of enforcement and also what evidence is there that the harmful chemicals have actually dispersed and are no longer viable after 5 days.?

Are there any omissions from the Bill that you would like to see added?

1. There is a question over the enforcement of the 5-day rule and how this will work in practice.

2. Only the eating areas appear to be covered in school/educational establishments, however as we are seeking to reduce the rate of children smoking would it not be prudent to include the whole of these types of enclosed establishments within this section.

3. It appears that the emphasis has been directed towards the larger buildings/places, is this because it will be easier to achieve, dilution of the air is greater etc. As per the recommendation in Reducing Tobacco Related Harm that there should be focus on small businesses - 5.52(in relation to the adoption of the Voluntary Charter) what help/encouragement would therefore be given to the smaller premises to support this recommendation?

4. There needs to be some more thought given to hospitals, nursing/residential homes, we know these are always sensitive premises to dwell upon, but there is the occupational exposure and in certain areas such as maternity etc should we not be encouraging cessation and stating this within the Bill that particularly vulnerable groups of society are considered to be a priority in smoking cessation.
5. There needs to be more mention of the protection required for employees from the occupational exposure to Environmental Tobacco Smoke.

6. Ventilation/Filtration - with the varying interpretations of the effectiveness or not of mechanical ventilation/filtration, there needs to be some guidance of what is acceptable etc in this area. I feel that the Bill is looking towards smoke free areas without the assistance of mechanical ventilation, but this is just not clear.

7 Can we submit that the omission of health premises that do not form the long-term residence of patients should be included in the audit of the Bill? If the Parliament wishes to send a strong message this may help.

8 We feel that given the investment from The Scottish Executive in smoking cessation services that the Bill should be explicit in directing organisations and individuals to seeking support from these services.

9 We feel that this Bill should state as an objective that this is a first step for regulating smoking in Public Places and should not be seen in isolation or detriment to current and future work of Tobacco Control in Scotland.

What are your views on the quality of consultation and the implementation of key concerns?

1. What are the costs of implementation and how is this to be carried out and by whom?

2. Will the police have the resources to respond to complaints etc, and how high will it be listed on their priorities? would it therefore be prudent to also have the back up of another enforcement agency, but not as an absolute alternative.

3. Agree with the fixed penalty fine in principle, but could be issues with those who are under the influences of alcohol etc.

4. What are the transitional arrangements, if any?

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

1. What training if any will be available to enforcement staff, businesses and who will be giving this advice?

2. What information and resources regarding this Bill will be provided to Licensees

3. How quickly will this be rolled out? Will there be a lead in for businesses?

4. Guidance for Licensing Boards: re: consideration of applications with regards to complaints or prosecutions against the premises, on renewal etc of their licenses. Could smoking issues be considered as competent objections?

5 How will the success of the Bill be assessed, will there be any follow up with Licensees (for example a sample survey)

SUBMISSION FROM NHS LANARKSHIRE

To date, the Government has only focused on voluntary measures to prevent smoking in public places. As someone with the responsibility of promoting 'not smoking as a positive choice' to children and young people, I think it's encouraging that this proposed legislation is to be considered by Parliament and I support the general principles of the Bill. However, I see it only as a first step towards all public places becoming smoke free.
Tobacco smoke is a cocktail of over 4,000 chemicals, more than 50 of these are cancer causing. The British Medical Association have reported that there are approximately 1,000 preventable deaths every year as a result of passive smoking and that there is no safe level of exposure to tobacco smoke, and adverse effects can be seen at low levels of exposure.

Children are one of the population groups who are considered to be particularly vulnerable. Exposure to second-hand smoke increases the risk of middle-ear infections, lower respiratory tract illnesses and asthma amongst others. A report by the Royal College of Physicians estimated that as many as 17,000 hospital admissions in a single year of children under the age of five were due to parental smoking.

There is evidence from countries with legislation in place that it does not have a negative impact on business and that there has been a drop in smoking rates and consumption.

In conclusion, this proposed Bill is very much welcome in terms of a first step towards all public places becoming smoke free which would hopefully send a strong message to young people that smoking is not normal.

N Kane

SUBMISSION FROM NHS LOTHIAN

I am writing on behalf of Lothian NHS Board in response to your consultation on the proposals for the prohibition of smoking in regulated areas (Scotland) Bill. We see this legislation as a welcome step and supporting positive public health policy. I would like to take this opportunity to comment on some specific aspects of the proposed Bill. We have outlined our views, relative to the four areas you have suggested, below.

This response incorporated comments from managers and professional interests involved in smoking related work taken by NHS Lothian

Support for general principles of the Bill

We unequivocally support the general principles of the Bill. The legislation will serve the specified main purpose of protecting people, including children, from exposure to the effects of second-hand smoke. It is well known that smoking is the largest single cause of preventable serious ill-health and premature death, and that exposure to tobacco smoke pollution is not only discomforting but also dangerous to health for both adults and children, increasing coronary heart disease, cancers and respiratory illnesses and deaths.

Evidence, epidemiological trends and experience all suggest that efforts to reduce smoking to date need fortification. Smoking rates are not decreasing as rapidly as was hoped. This legislation plays a crucial role within the multiplicity of strategies required to tackle smoking whilst simultaneously lending credence to them. Experience in other countries suggests that such legislation would contribute significantly to the reduction in smoking prevalence and the evidence would suggest that ultimately tobacco-related disease and death among both smokers and non-smokers would be affected.

Omissions from the Bill

Our principal concern is the limited breadth of public and enclosed spaces the Bill covers, for example premises serving food. The UK has recently signed up to the World Health Organisation (WHO) Framework Convention on Tobacco Control. This includes the need to 'take measures to protect all persons from exposure to tobacco smoke'. Further to this, the recent Wanless report (2004) supports a smoke-free policy for all workplaces and recognises this as the simplest, cheapest and most effective measure for reducing smoking prevalence (and thereby benefiting smokers) and (in reducing health risk to non-smokers. The initiative taken by Ireland and other countries, where such a policy
has been undertaken and found to be supported by the majority of the public, should be seen as a positive example.

Expanding legislation to cover all workplaces and public places would further decrease exposure to second-hand smoke. It may also contribute to increased rates of smoking cessation and reduce tobacco-related sickness, absenteeism and death and their associated economic implications. Those in all public places have the right to the same level of public health protection. A stronger message regarding social acceptability would also be inherent in legislation with a broader reach.

More detail on the enforcement issue, and whose responsibility this is, would be helpful. Additionally, more details on the timescales would also be welcome.

Quality and implementation of consultation

Support is lent to this Bill by health professionals, evidence, the public (non-smokers, V ex-smokers and smokers), tourists, and most recently, businesses. Such legislation implemented elsewhere has proved to have a neutral or even beneficial impact economically. Economic arguments claiming likely business hardship if the Bill is implemented have been disproved by experience elsewhere. In places where a smoking ban has taken place already (for example Australia, California), it has been found that a strategic and incremental approach is best.

Current public information campaigns highlighting the risks of passive smoking such as those presented by NHS Health Scotland and current smoking, cessation services go hand-in-hand with the implementation of such legislation.

Practical implications and alternative approaches

We have already stated that legislation on prohibiting smoking is of greater benefit to health than, for example, ventilation systems, separation policies and voluntary codes which are known to be less effective.

Lessons on implementation, monitoring and enforcement of the legislation can be drawn from Ireland, Norway, New York City and other areas taking similar action. Naturally, potential difficulties may be raised, and real difficulties will be encountered. However, experience elsewhere shows. these will not prove insurmountable and, lessons can be adopted from such countries.

This Bill can be seen as a helpful part of addressing the effects of smoking on the health of our population. It should be supported by effective smoking cessation programmes, mass media campaigns, education programmes advertising restrictions and action on counterfeiting and smuggling. From a wider perspective, it is also important to address the issue of EU tobacco subsidies. In these terms we presently find ourselves in the position of spending vastly more on tobacco subsidies and on treating tobacco-related ill-health than on smoking prevention programmes. Positive action on all fronts will make significant impact on smoking related ill-health.

A final point to consider is that of health inequalities. A strong socio-economic gradient is evident in smokers, with the most disadvantaged being the most likely to smoke. This legislation is likely to have a positive effect on this group due to aiding reduction in tobacco consumption and thereby easing smoking cessation attempts. However, the Bill should be seen as addressing 'tobacco' and not the 'smoker'. This approach will help to reduce potential 'alienation' of the individual. Once again, this demonstrates the need for multiple activities, in this case the continuance of provision of smoking cessation services targeting those experiencing deprivation.

In summary, we welcome the proposed Bill and believe that there is a moral responsibility to protect the nation’s health from this environmental health hazard. This would be in line with other consumer protection standards and public health measures which are tightly controlled for less lethal hazards.
We also believe that such legislation, in conjunction with the continuance of existing tobacco control initiatives in place, would contribute significantly to the reduction in smoking prevalence and ultimately tobacco-related disease and death among both smokers and non-smokers.

Yours sincerely

Dr Dermot Gorman
Acting Deputy Director of Public Health

SUBMISSION FROM ORKNEY DRUG, ALCOHOL AND SMOKING ACTION TEAM (DASAT)

Response to consultation

Prohibition of Smoking in Regulated Areas (Scotland) Bill

DASAT is a multi-agency group involved in the planning, and monitoring of activity to prevent the harmful use of drugs, alcohol and tobacco in Orkney.

DASAT broadly welcomes this bill and supports its intention to prevent exposure to passive smoking.

DASAT recognises that the narrow and specific emphasis on enclosed premises where food is served is a logical first step towards reducing passive smoking in a wider range of enclosed public spaces. However, it will be important to raise awareness about the exact purpose of the bill with the public, as there is a risk of losing the passive smoking message in a perceived link with food hygiene.

DASAT would like clarity over how the bill will be enforced and how situations where the law is disregarded will be dealt with, and by whom. It is important to be clear about the situation of community halls, church halls etc which are used for many purposes, with not all of these involving the serving of food.

It would be useful to back up the introduction of the bill with an information campaign linked into local sources of advice and support such as Health Promotion Departments or Environmental Health Services.

For premises like public houses, it might be useful to provide suggestions about creating separate areas for smoking in order to promote choice and allay fears about loss of business.

Mr Harry Garland
DASAT Chair/ Director of Community Social Services
Orkney Islands Council
School Place
Kirkwall
Orkney

SUBMISSION FROM NHS (QIS) QUALITY IMPROVEMENT SCOTLAND

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Thank you for this opportunity to comment on the Bill and this constitutes the response from NHS Quality Improvement Scotland (NHS QIS).

NHS QIS welcomes this Bill as it will improve the health of people in Scotland. It is well known and accepted that smoking of tobacco, and other substances mixed with tobacco, causes harm to the smokers themselves, to their unborn children and to others who inhale that smoke passively. This harm may be the development of disease directly attributable to smoking and /or exacerbation of pre-existing diseases / conditions such as asthma.
Although a large number of people in Scotland do smoke, more than fifty per cent do not. People should be protected from the harmful effects of passive smoke wherever and whenever possible. Prohibiting smoking in enclosed public places where food is being supplied and consumed will offer some degree of protection.

The costs to the NHS and to society in general related to smoking are immense. Reducing the risks to the population will help prevent further disease and disability associated with smoking.

It is the duty of care of each employee of the NHS to promote health, not just the detection and treatment of disease. The passing of this Bill will go some way to reduce this burden on NHSScotland and as such is wholeheartedly supported by NHS QIS.

SUBMISSION FROM TONY FRANCE

I am a hospital consultant physician with a special interest in chest diseases. On a daily basis I see the ill health and premature death of Scottish smokers due to the effects of tobacco smoke. Scotland's record on smoking related disease is a national disgrace. I will support any measure to discourage people from smoking.

I hope the Scottish Parliament will not be deceived by pressure groups claiming that the pub and restaurant trades will suffer. Firstly, Non-smokers will return to the pubs and restaurants they deserted years ago when the smoke became insufferable. Secondly, these trades will also benefit from having customers who live longer and therefore continue to visit pubs etc long after the smokers have died off or become too breathless to get to the pub. In short, a long lived healthy customer is a better business proposition for these trades.

Yours sincerely

Tony France

SUBMISSION FROM NORTH AYRSHIRE COUNCIL

Having considered the terms of the draft Bill, North Ayrshire Council would offer the following comments:-

General Principle

The Council supports the principle of prohibiting smoking in regulated places as it links with the vision statement in the Council's Community Plan - “A Caring and Healthy Community", as well as with the strategic aim - “To Promote Positive Health and Well Being”.

Equally, the terms of the proposed legislation do not extend to all public places and are primarily linked to the supply and consumption of food. Accordingly the legislation does not prohibit the act of smoking in many places of entertainment including, by exception, pubs.

Comment on the Draft Bill

The Bill seeks to make it an offence to smoke or to permit someone to smoke in designated areas where food is consumed (or to be consumed). The important parts of the Bill are the definition clauses, sections 1 & 10 and schedules 1 & 2. There is a wide definition of public place within a variety of public places (section 1(5) and schedule 2) and it would appear to cover most examples of public places with one major exception. Under schedule 1 paragraph 1, vehicles for carriage of fare paying public would appear to be exempt from the prohibition. It would seem to be inconsistent to ban smoking from places where food is consumed yet exclude dining areas in trains, boats or hovercraft. On this basis, it is suggested that the provisions of paragraph 1 schedule 1 should be deleted.
As for the provisions exempt from the prohibition, places where the food supplied and consumed is only crisps, nuts, biscuits or confectionery, there is a possible conflict in, for example, public houses where bar food covered by the definition in section (10) could be served alongside crisps, nuts etc. It would make it virtually impossible to regulate whether the ban on smoking covers this type of establishment. If it is intended that there should not be a ban on smoking in all licensed establishments, then it would be better not to distinguish the types of food, including the reference to “drink”, and simply to make all public houses exempt from the provisions of this legislation.

The defence set out in section 2 (3) is very wide and will present difficulties to the courts if left in this form. Clearly if the owner or responsible person fails to display a notice under section 5 then in that event, there would be a successful defence, otherwise there is no need for a specific reference to “not knowing” as in section 3 (2).

As far as enforcement of the provisions are concerned, the Bill leaves open the opportunity for a defence of “all reasonable steps” (section 4 (4)) to be offered up. Equally, the onus of proof is based on the fact that the accused knows or reasonably could have known (section 4 (3)). As for prosecutions under section 3, the options offered are too wide and would present prosecution defence and judges alike with great difficulty in proving anything.

Finally, under section 5 (5) (Regulations to vary provisions re. Display of signs) an additional sub paragraph (f) should be inserted to require consultation with Local Authorities and the provider of leisure services.

**SUBMISSION FROM ORKNEY ISLANDS COUNCIL**

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Do you support the general principles of the Bill and the key provisions it sets out?

The introduction of a prohibition on smoking in regulated areas is welcomed as part of the Health Improvement agenda. Orkney Islands Council introduced a non-smoking policy some years ago for its public buildings, as have other public agencies. By extending such policies to privately owned/managed establishments, the proposed legislation will extend the Health Improvement agenda. Concern has been expressed, however, about potential difficulties in monitoring and enforcing the “five day” rule.

Are there any omissions from the Bill that you would like to see added?

It is noted that public transport is excluded from the provisions of the Bill. This omission may detract from the food safety message, in that passengers using restaurant facilities on such transport could continue to be exposed to the effects of passive smoking.

What are your views on the quality of consultation, and the implementation of key concerns?

The consultation appears to have been widespread amongst the statutory agencies and those who may play a part in enforcement. It is less certain that the consultation has reached the general public as widely as it might.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

It is considered that the environmental health officers employed by local authorities are the most appropriate persons to enforce the legislation, because they are already engaged in promoting and protecting public health and have powers (under various food safety/health and safety/public health enactments) to regulate the types of premises included in the proposals. While paragraph 61 of the Financial Memorandum suggests that enforcement will be carried out by the police, it is believed that this issue will of necessity have a very low priority for the police compared with other criminal activity.
Other questions raised by officers were:

Will there be a phased introduction?

Will guidance be available to advise premises on implementation? Which agency or agencies will provide advice? Will local authorities be supported in local implementation of the provisions i.e. awareness raising and training amongst local businesses and the general public?

Will there be any financial support for owners to alter/modify premises to comply with the regulations? Some premises have a central bar/serving area shared between several public seated areas.

Monitoring and enforcement of the "five day" rule would have to be carefully and objectively applied. How is this envisaged? What evidence may be presented to identify whether or not smoking took place in an area within the previous five days? If the intention is to have a total ban on smoking in any area where food is likely to be served, misunderstanding or potential misinterpretation may be prevented by omitting the "five day" rule completely.

Many community halls and other premises are let for private functions which include serving food. If the organisers of such functions gain access to the premises only on the day of the event or the previous day, smoking in the building in the period leading up to their function is out with their control. Clear rules/guidelines must be in place for all users, and it may be that a complete ban on smoking in these multiple-use areas would be easier to enforce.

SUBMISSION FROM DR DAVID STONE

Further to the call for the submission of evidence, I wish to draw the attention of the Committee to an editorial on the subject of smoking in restaurants I published some years ago.

The reference is Stone DH, Carr SV. Smoking in restaurants. Journal of the Royal Society of Medicine 1995;88:545-6. Although this was published in 1995, the salient facts are still valid - notably the risk posed to public health by passive smoking and the failure of both the voluntary code and the EC directive.

I would be pleased to send you a hard copy of the paper if requested.

David Stone

SUBMISSION FROM DR ELIZABETH HAY

I write in support of Mr Maxwell's proposed Bill to legislate against smoking in places where food may be served. This must be the most important piece of legislation you are considering, with respect to the health of every man, woman and child in Scotland, unless by some outside chance, you believe you can outlaw the family car.

Dr Elizabeth Hay

SUBMISSION FROM PHILIP MORRIS INTERNATIONAL

Philip Morris International welcomes this opportunity to provide comments to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

Public health authorities have concluded that secondhand smoke causes diseases, including lung cancer and heart disease, in non-smokers. In addition, public health authorities have concluded that environmental tobacco smoke can exacerbate adult asthma and cause eye, throat and nasal irritation.
We believe the public should be guided by the conclusions of public health officials regarding the effects of secondhand smoke in deciding whether to be in places where secondhand smoke is present; or if they are smokers, when and where to smoke around others.

Philip Morris International believes that the conclusions of public health authorities are sufficient to warrant measures that regulate smoking in public places. We believe smoking bans are appropriate in many places including educational establishments, health care facilities, and places providing services to children. In general, people should be able to avoid being around secondhand smoke in places where they must go, such as public buildings, many areas in the workplace and public transportation.

At the same time, government regulations should recognise that some business owners and their patrons wish to permit smoking in certain locations. Regulation should provide business owners with the choice to permit or prohibit smoking, and to decide how best to address the preferences of non-smokers and smokers, such as through separation, separate rooms and/or high quality ventilation.

We do not believe that a total prohibition on all smoking in all premises serving food is either necessary or justified. We believe the issue can be addressed more pragmatically by requiring a combination of separation between smoking and non-smoking areas coupled with ventilation and warning signs which state the public health community's conclusion that secondhand smoke causes diseases in non-smokers.

Addressing the issue in a more flexible way would allow people to choose whether they want to patronize a restaurant which permits smoking or whether they would opt for a restaurant which does not allow any smoking at all. We also believe, for example, that approaches such as the Voluntary Charter on Smoking in Public Places by the Scottish Licensed Trade Association and the Scottish Tourism Forum can serve as a platform for effective and pragmatic solutions.

As regards the requirement that no food may be served in a room where smoking has taken place within five days prior to the serving of the food, we see no reason for such a restriction. While secondhand smoke can linger in unventilated areas, it seems more sensible to require that any areas where smoking has taken place be well-ventilated before they are used for serving food.

Philip Morris International's intention is to work cooperatively and constructively with the Scottish Parliament and other governments throughout the world to achieve effective tobacco regulation and to address issues that are of legitimate concern to both governments and consumers. We look forward to additional opportunities to discuss tobacco related issues with the Committee.

SUBMISSION FROM PUNCH PUB COMPANY

I am writing on behalf of the Punch Pub Company in response to the above bill.

Punch own 430 pubs in Scotland and 4,700 across the whole of the UK. Individual retailers run Punch pubs as their own businesses, renting premises from us on flexible agreements. The Punch estate is highly diverse in Scotland, including community local pubs, rural pubs and city centre bars. We are proud to have been named Pub Company of the Year for the leased and tenanted sector at this year's Publican Awards in London.

As signatories to the Scottish Executive's Voluntary Charter on Smoking in Public Places via the Scottish Beer and Pubs Association, we are pleased with the progress achieved to date. Within Punch, our area managers are ensuring every one of our 430 pubs has a policy in place and that our retailers take the charter seriously. We hope to achieve 100% compliance with this by August of this year.

We support the objective of a smoke-free Scotland but are aware that this is unlikely to happen overnight. Nonetheless, we are very much in the business of helping to find solutions, and working to
address Scotland's smoking problems. We would like to participate fully in the Scottish Executive consultation on passive smoking when it is launched this summer.

Given our support of the Voluntary Charter to date, we do not support the legislative approach of the draft Bill. We would strongly urge that the voluntary approach be continued and we are confident that it can deliver a well-balanced and effective route to firstly reduce and ultimately eliminate the practice of smoking in public places.

The Punch Pub Company does not, therefore, support the general principles of the Bill and the key provisions it sets out. It seems illogical and unnecessary for a draft Bill to be introduced prior to the commencement of the Scottish Executive's period of consultation on the Tobacco Action Plan and we are strongly of the opinion that Mr Maxwell be asked to withdraw the Bill as it will only serve to confuse the public and all relevant stakeholders.

S. P. Allen
Regional Operations Director

SUBMISSION FROM NHS FIFE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I write in support of the above Bill.

Tobacco smoking is the greatest preventable cause of ill health and death, especially in the Western World. Scotland currently has an unenviable position in any league table of tobacco-related ill health. This Bill if enacted would be a significant step in protecting a workforce and non-smoking members of the public from the effects of bystander cigarette smoke. It will also support individuals considering, or in the process of, quitting tobacco. If it can be achieved in New York and in Eire, it should be so in Scotland.

In general it sends and supports an important public health message.

Yours faithfully

Colin Selby
Consultant in Respiratory & Intensive Care Medicine

SUBMISSION FROM QUEEN'S NURSING INSTITUTE SCOTLAND

Statement in support of Stewart Maxwell MSP's Prohibition of Smoking in Regulated Areas (Scotland) Bill

The Queen's Nursing Institute Scotland (QNIS), as an independent voluntary organisation which promotes and supports the professional development of community and primary care nurses in Scotland, is keen to support the Prohibition of Smoking in Regulated Areas (Scotland) Bill, proposed by Stewart Maxwell MSP. The QNIS strongly supports this initiative to legislate for smoke-free air in areas where food and drink are consumed.

The dangers of smoking are well documented through scientific research, and highlight a link with increased rates of coronary heart disease, cancer and pulmonary disease. In striving to improve the health of Scotland, there is a need to reduce the nation's smoking habits and also to change the culture of acceptance of eating and drinking in a cigarette smoke impregnated atmosphere.

The banning of smoking in regulated areas would provide an opportunity to not only raise awareness of the damage to health caused by smoking, but also alert people to the dangers of passive smoking. This first step towards a ban on smoking in public places would be highly beneficial to staff who
currently are exposed to a severe occupational health hazard through breathing contaminated air in their workplace.

Smoking has such a detrimental effect on health that, as a nation, Scotland needs to push forward strategies to reduce tobacco usage. The prohibition of smoking in public places would provide a clear signal that the Scottish Executive clearly supports a radical change in smoking habits to enable the whole population to remain healthy and to protect vulnerable people from the dangers of inhaled smoke.

We wish you success in the passage of this Bill.

Julia Quickfall
Nurse Director March 2004

SUBMISSION FROM RENFREWSHIRE COUNCIL

Consultation on Prohibition of Smoking in Regulated Areas (Scotland) Bill

Consultation Comments From Council Departments

1. Do you support the general principles of the Bill and the key provisions it sets out?

We support the main purpose of the Bill which is to prevent people from being exposed to the effects of passive smoking in certain public areas where food is supplied and consumed.

The negative health effects of passive smoking have been increasingly highlighted and public concerns about these effects have consequently been growing. The Bill goes some way to addressing these concerns and to meeting the significant challenges of changing behaviour to protect the public from these effects. However it does not go as far as the steps taken in other countries where smoking has been banned in all public places and workplaces.

This Bill will protect the health, safety and welfare of employers, employees and members of the public. A similar rationale is underpinning the review of Tobacco policy currently being undertaken within Renfrewshire Council in relation to smoking within a range of Council premises, including those where food is supplied and consumed.

We also welcome the wider intention of the Bill to raise awareness of the dangers of passive smoking and to change the attitudes of the public towards smoking in general. This will help to contribute to the wider aims of 'Fresh Air for Scotland: A Tobacco Control Action Plan'.

2. Are there any omissions from the Bill that you would like to see?

The Bill is to protect people from the effects of Environmental Tobacco Smoke (ETS) in areas where food is supplied and consumed. We would suggest however that there are a number of omissions:

1. The definition of regulated areas should be extended to include places where food is brought in to the premises by staff themselves and consumed therein, e.g. staff rest rooms, workers bothy's etc.

2. Those areas identified in schedule 1 as exempt from the Bill should be included. Given the permanent or temporary resident status of people within these areas, it could be argued that it is important to have designated smoking zones. However it would seem reasonable that smoking is not permitted where food is being supplied and consumed.

3. Section 5.5 should also refer specifically to the need to consult with organisations who may be involved in the monitoring the implementation of the Bill who may have specific knowledge and expertise in this area.
As indicated above in relation to question 1, the Bill goes some way to addressing the concerns about the negative effects of passive smoking upon employees and members of the public. However it does not go as far as the steps taken in other countries where smoking has been banned in all public places and workplaces. This would require amongst other things, the existing definition of food under Section 1 of the Food Safety Act 1990 to be retained.

3. What are your views on the quality of consultation, and the implementation of key concerns?

The issuing of the consultation document by the Health Committee provides key stakeholders with clarity upon the details of the proposed Bill. It also usefully provides them with the opportunity to comment upon the proposals contained within the Bill.

4. Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

It would be helpful to have greater clarity in relation to how the Bill should be enforced and what types of reporting and monitoring systems should be in place in respect to signage and smoking activity. In respect to these arrangements, greater guidance upon the respective roles and responsibilities of Local Authority Environmental Services and Legal Departments, as well as of the Police would be helpful.

Consideration should be given to the resource implications arising for organisations who may be involved in the implementation of the Bill and to the possibility of offering appropriate levels of funding to support this process. These may include Local Authorities, the Police and local retailers.

It would be advisable if a major media campaign was supported before the implementation of the Bill. This should be designed to inform both public and proprietors of the types of premises affected by the Bill and how its implementation will be monitored. It would be helpful if such a campaign also identified resources to support local initiatives to reinforce the message being conveyed nationally. For example, campaigns could be undertaken in conjunction with the advertising of local smoking cessation.

SUBMISSION FROM J H GRAVIL

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am a chest physician working in the Royal Alexandra Hospital in Paisley. I write imploring you to support the Member's Bill being lodged in Parliament to prohibit smoking in certain regulated areas. As a chest physician I see many, many people with severe disabling breathlessness from COPD secondary to cigarette smoking and many cases of fatal lung cancer. The best way to prevent these diseases is to stop smoking and by prohibiting smoking in public places it will hopefully discourage youngsters from starting smoking and reduce passive smoking.

On a personal note, I currently actively avoid any restaurant and bars where cigarette smoke is present because it is most anti social. It would be nice to be able to eat and drink wherever I would like in the knowledge I will not be exposed to cigarette smoke.

I therefore hope that you will support this Bill.

J H Gravil
Consultant in General and Respiratory Medicine
SUBMISSION FROM THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

The College supports the general provisions. The College recognises that within the Bill there is provision for Scottish Ministers to change the definition of a "regulated area" but is disappointed that initially the restrictions will apply to areas serving food only.

Omissions from the Bill

Attempts to seek reductions of smoke exposure in public places by voluntary action have proved ineffective. Evidence suggests that improved ventilation, extractor fans, etc., are not an effective means of protecting non-smokers from second-hand smoke in public places. This is particularly true for those who work in smoky environments. The College believes all places of work must be identified as "regulated areas". The current proposals allow pubs and clubs (which are so attractive to young people) to avoid the restriction by not serving food in some areas.

Evidence Base for action on Second-hand smoke

The College strongly believes that Scotland must act to reduce the death and misery caused by tobacco.

In Scotland smoking causes 13,000 deaths annually, a high proportion in those of working age. Coping with smoking-related illnesses costs the NHS in Scotland £140m a year (Buck D. Cost effectiveness of smoking cessation: What do we know? Internat J Health Education 1997; 35: 44-52).

Public health initiatives should aim to reach smokers early, and to create a culture where smoking is unacceptable to the majority. Creating restrictions in terms of social activity will encourage smokers to stop and discourage teenagers from starting.

A recent Public health survey indicated that approximately 70% of smokers indicated a wish to quit. International evidence indicates that a ban on smoking in public places reduces smoking rates by 4%, as well as reducing the risks associated with second hand smoke (Fichtenberg, British Medical Journal 2002; 325:188-91).

The International Agency for Research on Cancer (IARC), an organisation formed under the aegis of WHO, have just published the full version of their monograph no 83 (2004) on tobacco smoke and involuntary smoking, which confirms the very considerable health risks of passive smoking in the development of various cancers.

The Scientific Committee on Tobacco and Health plans are to publish an updated SCOTH Report, probably in May 2004, which details the health risks of second-hand smoke not only from the point of view of cancer, but also a range of other conditions including coronary artery and other vascular diseases, and non-malignant respiratory disease. There is no doubt that second-hand smoke poses a significant risk to health.

SUBMISSION FROM ROYAL ENVIRONMENTAL HEALTH INSTITUTE OF SCOTLAND

Prohibition of Smoking in Regulated Areas (Scotland) Bill

On behalf of the Royal Environmental Health Institute of Scotland (REHIS)*, I should like to respond to the call for written evidence in respect of this Bill.

1. General Principles

REHIS welcomes the Prohibition of Smoking in Regulated Areas (Scotland) Bill as an important first stage in the control of smoking in public places. REHIS recognises that smoking can have a serious
effect on the health of smokers and of those who passively smoke. It is also a basic tenet of occupational health and safety law that workers should be protected from substances which might affect their health. It is the Institute’s view, therefore, that smoking should be controlled in public areas to allow non-smokers protection from passive smoking. In addition REHIS supports the right of all workers to work, safely, in a smoke-free environment.

2. Omissions

The Institute is of the view that an improvement could be made to the Bill by using the definition of ‘food’ given in the Food Safety Act 1990, which would extend the proposed prohibition to all premises where food or drink is sold.

3. Quality of Consultation

The consultation was of a very high quality indeed and all concerned are to be congratulated. The Institute is consulted by many Departments and these consultations range greatly in quality. This one cannot be faulted.

4. Practical Implications

The Institute suggests that the proposed Section 3(2) defence when ‘No Smoking’ signs are erected should be deleted.

John Frater
Chief Executive

* The Royal Environmental Health Institute of Scotland (REHIS) has more than 1,000 members and can trace its origins to 1975. The Institute is Incorporated by Royal Charter and has the following objects:

The objects for which the Institute is established are for the benefit of the community to promote the advancement of Environmental Health by:

(a) stimulating general interest in and disseminating knowledge concerning Environmental Health;
(b) promoting education and training in matters relating to Environmental Health; and
(c) maintaining, by examination or otherwise, high standards of professional practice and conduct on the part of Environmental Health Officers in Scotland.

SUBMISSION FROM ROYAL HOTEL, CROMARTY

Prohibition of Smoking in Regulated Areas Bill

I refer to the above which you are currently attempting to have passed.

I understand that the Bill is specifically aimed at banning smoking in rooms where food is served.

We are a hotel with a restaurant and bars - the serving of food is a large proportion of our business. We currently serve food in a number of areas:

Dining Room – no smoking policy
Lounge Bar – designated smoking and non smoking areas
Conservatory – designated smoking and non smoking areas
Public Bar – smoking area
Outside tables – n/a

If introduced, the above Bill will have a seriously negative impact on my business for the following reasons:
It would be well nigh impossible for us to have a completely separate smoking room separated by two
doors for the dining area. This would involve significant alterations to the building which would not be
financially viable.

You might suggest from the above serving areas that say the lounge bar could be a smoking area and
the dining room a non-smoking area. This would not be acceptable for a number of reasons:

a) We only operate our dining room in the summer months. To operate throughout the year would not
be financially viable.
b) Some customers only wish to eat in the lounge bar as this is less formal than the dining room.
c) Climatic conditions mean that the conservatory is only really used in the summer months
d) Smokers who wish to eat could not be restricted to the public bar due to our differing clientele in the
bars.

When we took over the hotel coming up for 2 years ago, there was no smoking policy with smoking
permitted throughout with no designated areas. Following customer research/feedback, we introduced
the policy detailed above. This has proven perfectly acceptable to all our customers and we have had
nil complaints regarding our smoking policy.

I am certain that the introduction of your Bill would lead to a loss of custom for the hotel. This would
undoubtedly have a knock on effect on the number of staff we employ leading to job reductions.

As you will no doubt be aware, the majority of the tourism industry in Scotland operates in an
extremely fragile environment – global issues, VAT leads us to be less competitive than our overseas
friends, huge increases in water rates and insurance premiums etc etc. I am not ‘whinging’, I chose to
come in to this industry and knew when I came in where the goal posts were. These goal posts are
continually changing and becoming closer and closer together. Introduction of your Bill will only make
my situation (and many like me) much more difficult.

Since taking over this business, we have made significant investment from retained profit in upgrading
the business and the subsequent quality / customer experience. Introduction of the Bill will lead to
less investment, less jobs, less visitors to Scotland and more people from the UK choosing to go
abroad rather than to holiday in Scotland.

Finally, the proposed fines are ludicrous and well out of line with the ‘crime’. It seems to me that as an
example, someone driving dangerously under the influence of alcohol could well receive a lesser fine!

A sensible solution would be what we have already introduced. A clear policy which meets the
majority of people’s needs.

I do hope you will take my points into consideration when considering the introduction of the Bill – and
think again!

Yours sincerely

Neil Q Campbell
Partner, Royal Hotel, Cromarty

SUBMISSION FROM THE SCOTTISH BEER AND PUB ASSOCIATION

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am writing on behalf of the Scottish Beer and Pub Association (SBP A) in relation to the above.

SBPA membership is made up of both major brewers and multiple retailers who operate their
businesses in Scotland. We are a major component part of the wider Drinks and Hospitality industry,
which as a sector are Scotland's largest employers with some 200,000 people employed.
Our response in this instance is particularly relevant to our retail membership involving over 1,200 pubs, which by definition are all small and medium enterprises.

As signatories to the Scottish Executive’s Voluntary Charter on Smoking in Public Places along with the Scottish Licensed Trade Association, the Scottish branch of the British Hospitality Association and the Scottish Tourism Forum (who all support us in this response), we are heartened by the progress achieved by the voluntary approach to date. As quoted in the document “A Breath of Fresh Air for Scotland” reference P24 Point 5.6:

"An independent evaluation, published on 23 September 2003 of smoking policies in the Leisure Industry would suggest the industry had met three out of the four targets set under the Charter, including the key target of availability of smoke-free provisions. We welcome progress made under the Charter and believe that it demonstrates the progress that can be made through partnership with the business community in this most challenging of sectors. We now intend to work with partners to step up these effects in order to accelerate progress in smoke-free provision across all sectors of business in Scotland”.

We support the objective of a smoke-free Scotland but are aware that this is unlikely to happen overnight. Nonetheless, we are very much in the business of helping to find solutions, and working with politicians to address Scotland’s smoking problems. We are pleased to have been asked to join the recently formed Ministerial Advisory Group on Tobacco Control chaired by Tom McCabe (and our representation of the Charter Group) through one of our members, Stuart Ross, who is Chief Executive of The Belhaven Group plc. We plan to participate fully in the Scottish Executive consultation on passive smoking when it is launched this summer.

Given our support of the Voluntary Charter to date and our forthcoming role in the Scottish Executive consultation, we do not support the legislative approach of the draft Bill. We would strongly urge that the voluntary approach be continued and we are confident that it can deliver a well-balanced and effective route to firstly reduce and ultimately eliminate the practice of smoking in public places.

The SBPA does not, therefore, support the general principles of the Bill and the key provisions it sets out. It seems illogical and unnecessary for a draft Bill to be introduced prior to the commencement of the Scottish Executive’s period of consultation on the Tobacco Action Plan and we are strongly of the opinion that Mr Maxwell be asked to withdraw the Bill as it will only serve to confuse the public and all relevant stakeholders.

However, we attach a few observations on the practical aspects of the Bill and we will be happy to provide oral evidence to the Committee, if called upon to do so.

Gordon Millar
Chief Executive

Appendix 1 -Practical Implications of the Prohibition of Smoking in Regulated Areas (Scotland) Bill
Note: paragraph numbering mirrors that of draft Bill

1. Regulated Areas.

The definitions contained in this paragraph carry major implications for our members. Much structural work will need to be carried out to take account of the definitions of "enclosed public space" and "connecting space" to allow proper division of properties into smoking and non-smoking areas, which would be necessary for pubs to continue to serve existing clientele. This has major financial and resource implications and cannot happen overnight. Should this legislation be enacted, then an appropriate period of time would be required to allow owners and operators to adapt to the new regulations.

The definition of "prescribed period" before food is supplied and consumed is excessive, and will mean that many pubs will cease serving food altogether, with resultant loss of revenue to the licensee and less choice for the consumer.
3. Offence to smoke in regulated areas

The effect of this paragraph means that pub users would be criminalised for using a product which is firstly legal and secondly in worldwide distribution. Should this be enacted it would without doubt encourage pub users to simply stay at home to avoid breaking the law. The consequences on the financial viability of our members’ business would be devastating, in our opinion.

4. Offence to permit smoking in regulated areas.

The effect of this paragraph is to make multiple individuals responsible for breach of the legislation. In particular, making employees liable for prosecution and fines will be a major deterrent to undertake work in pubs. In addition, given the part time or job share nature of much pub employment, policing smoking in regulated areas would be at best disjointed and at worst impossible in many cases. The enforcement of these offences would of course carry a man power requirement the cost of which has to be absorbed in any new system. Should that cost be passed on to pub owners that inevitably would drive up prices of products to consumers. As in the points above, yet another reason for pub users to stay at home.

5. Offence to fail to display signs

Please note that the Brewers’ and Licensed Retailers’ Association of Scotland is now known as the Scottish Beer and Pub Association.

7. Bodies corporate etc

Since our retail membership is made up of multiple owners whose businesses will either be managed on their behalf or leased out this section suggests they will also be proceeded against and punished accordingly. This is impracticable particularly in leased premises where the lessee will effectively be in control of the business on a day to day basis.

10. Interpretation.

The list of foods exempted from the draft Bill is excessively narrow. At a time when the industry is being encouraged to widen its appeal to all sectors of society by, amongst other things, offering a more consumer-friendly service which inevitably involves the service of food or snacks, the restriction to the items listed is counter-productive. The end result will be many pubs ceasing to serve food altogether. In addition because of the food element this would automatically exclude many late night venues which do not provide a food offer. These venues can accommodate in many cases over 1,000 customers. The risk to pubs is that customers particularly in the younger age brackets will take their business to these venues where they will be allowed to smoke.

Schedule 1 (Exempt spaces) 2 a,b &c

Since the purpose of the bill is to improve health we find it bizarre that health service hospitals, independent health care units and state hospitals are exempt from the proposed legislation. Why?

Financial Memorandum (in Explanatory Notes)
(Note: paragraph numbers mirror those in Financial Memorandum)

48. Introduction.

Q The statement that costs for businesses are more than likely to be offset by savings in other areas is both naive and disingenuous. Complying with this legislation would involve major financial outlay by most proprietors and operators.
63. Costs on owners/proprietors.

See comment above. Large outlays will be required for structural alterations to comply with this legislation. Signage, which the drafters seem to think will be the main cost on proprietors, will in reality be a small part of total compliance costs. The savings suggested - in reduced cleaning, no further need to supply ashtrays, hypothetical reduction in insurance premiums - are either negligible or without evidence.

66. Loss of Business.

This statement relies on incomplete and anecdotal evidence, much of it unsupported by credible research. The closest comparator for Scotland is Ireland, and until such time as statistically significant samples are available from the Irish ban and elsewhere then the effect on business must remain pure conjecture. It is our contention that the introduction of a smoking ban will result in significant loss of business for our members’ pubs with consequent impact on jobs, tax (PAYE, NI, Schedule D, Corporation Tax, VAT and Excise Duty) and the tourist trade (in its wider sense).

SUBMISSION FROM THE SCOTTISH BREAST CANCER CAMPAIGN

The Prohibition of Smoking In Regulated Areas (Scotland) Bill

The Scottish Breast Cancer Campaign supports the above Bill in regulating smoking in places which are open to the public and where food is supplied and served.

The evidence on the dangers of smoking and inhaling other people's tobacco smoke is extremely concerning. Tobacco smoke contains 4,000 chemicals, over 50 of which are known or are suspected of causing cancer. It is estimated that approximately 1000 people a year die within the United Kingdom, as a result of being exposed to environmental tobacco smoke, and that, within Scotland 100 people will die every year from being exposed to second - hand smoke. Evidence also states that passive smoking increases the risk of lung cancer and coronary heart disease. Other vulnerable groups at risk from passive smoking include children, pregnant women, and people who have asthma or respiratory disorders.

In Scotland, it is estimated that 30% of the population smokes. The protection of the health and the rights of the 70% of the population, who do not smoke, must be safeguarded.

We therefore support the general principles of the Bill as a step in improving the health of the people of Scotland. Any provision to reduce the high rates of a devastating diagnosis of cancer on the lives of so many people in Scotland must be supported. Limiting exposure to passive smoking will reduce the effects of other people's smoke on 70% of the public, and will protect the health and rights of non-smokers including employees in restaurants and eating places. In addition, the regulation of smoking in public places will give support and encouragement to smokers who do want to give up.

In Scotland we are constantly being reminded that we are an unhealthy nation and we are encouraged to take responsibility and adopt changes to improve our health by having a healthy diet with plenty of fruit and vegetables, increasing physical activity and having a moderate consumption of alcohol.

Cancer in Scotland - Action for Change Annual Report 2003 states that,

'Smoking is the single greatest cause of ill health and accounts for 13,000 deaths per year. Each year more than 35,000 people are admitted to hospital with smoking related diseases at an estimated cost of £200 million.'

These figures are shocking. Non-smokers are being exposed to the dangers of passive smoking. The Scottish Executive has a duty to take responsibility to protect the health of the majority of people in
Scotland who do not smoke by ensuring that they are not exposed to environmental smoke in public places.

The above Bill will raise awareness not only of the dangers of smoking but the dangers of being exposed to environmental smoke. It will help to change the attitude of the public to smoking and help to improve the health of people in Scotland by reducing the risk of cancer, heart disease and other illnesses.

In general, the public has complied with legislation which has been introduced for their own safety and the safety of others, e.g. speed restrictions, the wearing of seatbelts, the restrictions on drink/driving, the ban on the use of mobile phones when driving, the ban on drinking alcohol in public places. Given the evidence regarding the harmful effects of passive smoking, there is no reason to assume that the public will not comply if smoking was prohibited in regulated places.

Other countries such as the Republic of Ireland, Sweden, Norway, Australia and Canada as well as the City of New York have introduced legislation to regulate smoking in certain public places and the public have complied with these restrictions.

In conclusion, we therefore support The Prohibition of Smoking in Regulated Areas (Scotland) Bill as we believe that it would contribute significantly to reducing the greatest cause of ill-health affecting the lives of the people of Scotland today.

SUBMISSION FROM THE SCOTTISH CANCER COALITION

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

Introductory information:

The Scottish Cancer Coalition comprises 15 major charities that are active in the field of cancer in Scotland (see Annex A). This membership demonstrates the strength and diversity of the voluntary sector.

General Principles of the Bill:

The members of the Coalition wholeheartedly welcome and support this Bill, which has major public health protection and improvement potential. We also see it as an important first step towards a more comprehensive smoking control policy in Scotland.

In developing our first Calls for Action, launched in 2003, the Scottish Cancer Coalition members were very conscious of the burden of cancer and other significant causes of avoidable morbidity and mortality in Scotland that is attributable to the effects of inhalation of tobacco smoke. We were also aware of the convincing evidence of the role that passive smoking plays in this scenario. We urged the Scottish Parliament to take priority action to prohibit smoking in all workplaces and public places and therefore commend this Bill as an initial step towards the attainment of our goal.

Others will no doubt rehearse the statistics and other evidence to support the risks associated with smoking and passive smoking of tobacco. We will therefore not repeat them in detail in this submission, except to highlight the relevant content of the most recent report of the Chief Medical Officer for Scotland and the alarming estimate that smoking is implicated in the causation 90% of lung cancers and 30% of all cancers.

Omissions:

We are concerned that the definition of 'food' means that most pubs and bars that serve only snack foods will be excluded from the regulated areas covered by the Bill. This is most regrettable as this is one set of premises where employees are subjected to very heavy levels of smoke inhalation, with obvious resultant occupational health risks. We understand that effectiveness of ventilation systems in alleviating this risk is limited. As the majority of adults in Scotland are non-smokers they are also
subjected to unpleasant exposure to tobacco smoke with its attendant health risks when patronising pubs and bars.

We also regard the exclusion of other workplaces and enclosed public spaces as significant omissions that will detract from the full public health protection and improvement potential. We would urge that these more radical but entirely justifiable measures be borne in mind for future legislation.

Practical implications and alternative approaches:

The limitations of ventilation systems as an alternative to prohibition have already been noted and this should not be considered as a safe and effective alternative to prohibition.

Some submissions from other sources will no doubt challenge the feasibility of implementing the proposed legislation. We would cite the experience in parts of America, Australia and, most recently, Ireland as convincing evidence that such measures are attainable if there is commitment at government and local level. In the context of Scotland it is highly significant that a substantial majority (circa 70%) of the population do not smoke tobacco and that the recent surveys of public opinion have confirmed that a majority of respondents would support the measures in the Bill and even more radical prohibition of smoking in all enclosed public places.

Fears that prohibition will impact adversely on the commercial viability of sections of the leisure industry have also not been substantiated by experience in other countries. Indeed we note that in some localities the profitability of such operations has increased. This is hardly surprising as the majority of non-smokers in the population are more likely to patronise establishments in which they can enjoy their leisure time without the being exposed to the unpleasantness and health risks of tobacco smoke generated by a minority.

In summary, the 15 member organisations that comprise the Scottish Cancer Coalition (see annex) support this Bill, regret its limitations, but would urge the Scottish Parliament to enact and implement the relevant legislation as soon as possible.

Annex A: Members of the Scottish Cancer Coalition

Association for International Cancer Research
Breast Cancer Campaign
Breast Cancer Care
CancerBACUP
Cancer Black Care
Cancer Research UK
Colon Cancer Concern
Macmillan Cancer Relief
Maggie's Centre
Marie Curie Cancer Care
Roy Castle Lung Cancer Foundation
Sargent Cancer Care for Children
Scottish Association of Prostate Cancer Support Groups
Taktent Cancer Support
The Scottish Breast Cancer Campaign
Prohibition of Smoking In Regulated Areas (Scotland) Bill

Written evidence

The Bill aims to prevent people from smoking in public places where food is supplied and consumed, by making it a criminal offence to smoke or to permit smoking in these areas. These are described as “regulated areas”. The purposes of the Bill are:

- to prevent people, including children, from being exposed to the effects of passive smoking in regulated areas;
- to raise awareness of the dangers of smoking and passive smoking; and
- to change the attitudes of the public towards smoking in general.

It would have the additional benefits of encouraging people who want to stop smoking, and helping ex-smokers from relapsing.

1 Do you support the general principles of the Bill and the key provisions it sets out?

The SCC considers that the Bill is based on the following principles and assumptions:

- Smoking, and the effect of passive smoking, are significant contributors to poor health in Scotland.
- Businesses and other enterprises providing food and drink to consumers in Scotland have not voluntarily moved towards providing smoke-free environments for consumers.
- There is no alternative to introducing regulation, in this case criminal sanctions, to promote this aspect of public health in Scotland.

The Scottish Consumer Council would like to contribute a consumer perspective on these issues, and will address each of these in turn.

1.1 Smoking, passive smoking and public health in Scotland

In its tobacco action plan “A Breath of Fresh Air”, the Scottish Executive states:

Smoking has long been recognised as the most important preventable cause of ill-health and premature death in Scotland, accounting for more than 13,000 smoking-related deaths every year. We know that it is linked to diseases of the heart and blood vessels, the lungs, stomach, kidneys and other organs and that as a result, it has been estimated the NHS in Scotland spends up to £140 million every year on treating smoking-related disease - at current prices this would amount to over £200 million.

The SCC recognises the serious impact which tobacco use has in Scotland.

Substantial research programmes in the USA, Australia and the UK have shown that passive smoking is a risk factor for a wide range of medical conditions including asthma, bronchitis, pneumonia, coronary heart disease, stroke, lung cancer, low birthweight and cot death, amongst others. Studies of lung cancer and passive smoking have shown that non-smokers living with smokers increase their risk of lung cancer by 20-30%. Similar research has been carried out in relation to heart disease. The World Health Organisation has estimated that almost half the world’s children are exposed to tobacco smoke. The Royal College of Physicians estimated in 1992 that 17,000 children in the UK under the age of five are admitted to hospital as a result of illnesses resulting from passive smoking. Action on Smoking and Health (ASH) has estimated that there are at least 2 million incidences of illnesses caused by passive smoking in the UK, including 12,000 deaths from heart attacks and more than 30,000 cases of respiratory disease in infants.
The tobacco lobby denies the validity of this evidence, criticising the research (for example the designation of someone as a never-smoker), countering it with research showing that passive smoking is not harmful, or comparing the harmfulness of passive smoking with other activities such as eating a high fat diet or drinking alcohol, neither of which is illegal. Some of this research, including a recent article in the BMJ has been criticised or discredited by the fact that it has been funded by the tobacco industry.

The SCC believes that the balance of evidence does show that passive smoking contributes to poor health in Scotland.

1.2 Is this a case of market failure?

An unresponsive market

The increasing concern about the effects of passive smoking, and the recognition that many people prefer a smoke-free environment, has led to changes in policy and practice by many service providers to limit the amount of exposure which consumers or employees have to environmental tobacco smoke (ETS). Almost all public transport, cinemas, and other public entertainment venues now ban smoking, as do most workplaces.

However, the provision of smoke-free areas in the hospitality industry has not increased significantly, and there are almost no smoke-free pubs in Scotland. The Scottish Voluntary Charter on Smoking in Public Places introduced in May 2000 has had very limited impact. In 2003, three years after the introduction of the voluntary charter, 21% of restaurants had banned smoking, but no public houses had done this.

The proportion of people smoking in Scotland has fallen considerably, and is now around 30%. Almost three-quarters of people (73%) who responded to a BBC survey wanted a ban on smoking in all public places as a way to cut tobacco-related illness. However, the market has not responded to this consumer demand.

The market in this sector is characterised by some differences from the classic market situation in which individuals make choices based on their own needs and situation. People going out to a pub or restaurant are often in the company of others, and as long as one of the party smokes, they may be more likely to opt for a pub or restaurant which allows smoking. Since restaurants will normally cater for smaller groups and couples, and since more people will want to eat in a smoke-free environment, it is understandable that the number of non-smoking seats and environments has increased more in this sector. Pizza Hut has recently introduced a no smoking policy in all its restaurants.

It is also natural for a market to want to retain the largest possible number of consumers. To create non-smoking premises means reducing the size of the potential market, even if it may at the same time increase its appeal to one sector of the market. This may explain why the Wetherspoon chain has called for a ban on smoking in public places: they recognise that to introduce non-smoking pubs on a unilateral basis is likely to be bad for business if the choice remains for people to smoke in other licensed premises.

The SCC considers that the pub and restaurant business has failed to respond to the majority of the Scottish population who do not smoke and who would prefer to eat in a smoke free environment.

Externalities

A market can also be described as failing if it has an impact on an economic activity outside its own market, for example if a factory creating pollution imposes costs on other enterprises: this is known as externalities. It is possible to see the food and drink sector in Scotland as imposing costs on people and organisations not directly involved in the particular market transaction. For example, the NHS bears considerable costs resulting from smoking and passive smoking, while employees in pubs are at risk from their exposure to environmental tobacco smoke.
1.3 Response to market failure: is there an alternative to regulation?

There are various factors in the present situation which might mean that the market will respond without it becoming necessary to impose a ban.

Threat of a ban on smoking

There is some evidence that if there appears to be a real prospect of legislation akin to that introduced in Ireland, the market might respond to this threat in order to avoid the compulsion of legislation.

Such a threat does exist, as the Chief Medical Officer has argued that a smoking ban in workplaces in Glasgow would mean that up to 1,000 fewer people a year would die of heart disease, respiratory diseases and cancer. He said it was his duty to speak in favour of a complete ban on smoking in public places and he urged the executive to take the lead and introduce legislation which would result in such a move.

However, the problem here, as described above, would probably be that many businesses would be unwilling to be the first to make a move because it restricts the size of the market.

Threat of compensation claims

There is potential for employees to take legal action against employers who expose them to ETS. ASH in association with a trade union law firm is trying to encourage employers to respond to this threat. While employees may initiate such claims, this is not a realistic option for consumers, as they would find it even harder than employees to prove causation, and there are aspects of the legal process which act as a deterrent to using the law in this way, for example the length of time and cost of legal action, and the lack of class actions in Scotland.

Effect on profits

There is contradictory evidence about the impact of smoking bans on business profits. While businesses fear that a ban will mean people stay at home to smoke, or spend less time in a pub, there is evidence from New York that businesses have not been adversely affected, with some businesses experiencing increased profits following the ban on smoking.

However, the real fear for pubs and, to a lesser extent, restaurants is of the effects on profits of voluntarily introducing smoking bans. This appears to be a real obstacle to progress being made without regulation and the introduction of criminal sanctions.

Regulation

Some businesses are in favour of a ban, as evidenced by the chair of the Wetherspoon pub chain who called on the government to follow the example of Ireland, which recently outlawed smoking in public places. The Chairman of Wetherspoon has argued that self-regulation is not the answer.

"I think it would just be commercially very difficult if it's not done through a government ban. It requires a cultural adaptation by people and I think they wouldn't be prepared to do it if it wasn't the government cracking the whip."

However other publicans have come out strongly against a ban, arguing that it cannot be justified to ban something which is not illegal. They argue that cultural change will lead to many more non-smoking premises in time, but that in the short term a ban would force many independent pubs out of business.

On balance the SCC believes that the difficulty of influencing the market through the individual choice of consumers, combined with externalities in the market, means that a significant shift to smoke-free eating environments will only be achieved by regulation in the food sector. On this basis the SCC supports the principles and assumptions underlying the Bill.
2 Are there any omissions from the Bill that you would like to see added?

The Bill is limited to premises and areas of premises where food is served. It does not go as far as banning smoking in all workplaces, which would have the effect of banning smoking in pubs. It should be seen as a first step in creating the clean environments preferred by most consumers.

3 What are your views on the quality of consultation, and the implementation of key concerns?

No comment

4 Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

The Bill takes the approach of introducing criminal sanctions. There can be problems with using criminal sanctions, in particular the willingness of the police and procurator fiscal office to undertake prosecutions. It is important that any law can be enforced and that resources are available to do so.

While it can be effective to introduce criminal sanctions, there are also examples where such legislation has not been so effective – in relation to criminal sanctions for dropping litter, for example. It is difficult to judge what would be effective in advance of implementation.

The reluctance of service providers to leave themselves open to criminal prosecution could lead to unintended consequences. For example, some pubs might stop serving food, leading to a reduction in consumer choice, and a move away from the trend in Scotland, which has been towards a wider range of services and a more open style.

Conclusion

In conclusion, the SCC seeks a balanced approach to this problem. We are not in favour of making smoking illegal, and our response is informed primarily by our wish to see the market respond more effectively to the wishes and needs of the majority of consumers in Scotland in this area. We believe that the failure of the market to respond to the preferences of consumers requires regulation, to ensure a shift to smoke-free eating environments.

SUBMISSION FROM SCOTTISH LICENSED TRADE ASSOCIATION

The Scottish Licensed Trade Association was established in 1880 and counts within its membership Public Houses, Hotels, Restaurants, Entertainment and Off-Sale Licence Holders. The Association is the only body representing all sectors of the industry in Scotland and its three key roles are Trade Development, Trade Liaison and Trade Protection. The Association currently represents nearly 2000 independent Licensed Trade Premises and, as the largest body of its type in the country, is seen by many as the "Voice" of the trade in Scotland.

The Scottish Licensed Trade Association firmly supports the efforts of our members and the trade in general, to reduce the amount of environmental tobacco smoke in their premises, by the implementation of smoking restrictions, as and when appropriate, and improvements in ventilation systems. The Association has worked consistently to achieve these improvements in agreement with the Scottish Executive and with the Voluntary Charter on Smoking in Public Places Group. The Group, consisting of the Scottish Beer and Pub Association, the Scottish Tourism Forum, the British Hospitality Association and The SLTA, was established following extensive consultation with the Scottish Executive, the Action on Smoking and Health group and the Health Education Board of Scotland. With little resources and considerable problems with the supply of materials to enable our members to voluntarily implement the Charter principles, the industry in general, still managed to achieve the following results:-
<table>
<thead>
<tr>
<th>Description</th>
<th>2000 status</th>
<th>2003 target</th>
<th>2003 Result</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking policy in operation</td>
<td>46%</td>
<td>56%</td>
<td>68%</td>
<td>+12%</td>
</tr>
<tr>
<td>Written smoking policy</td>
<td>25%</td>
<td>35%</td>
<td>34%</td>
<td>(1% below target)</td>
</tr>
<tr>
<td>External policy signage</td>
<td>16%</td>
<td>26%</td>
<td>28%</td>
<td>+2%</td>
</tr>
<tr>
<td>Non-smoking provision</td>
<td>39%</td>
<td>49%</td>
<td>58%</td>
<td>+9%</td>
</tr>
</tbody>
</table>

These results demonstrated that the industry could be relied upon to deliver against the targets agreed between all interested parties, including the Scottish Executive. The Scottish Licensed Trade Association also has the substantial backing of our members to further support the Voluntary Charter on Smoking in Public Places. In a consultation exercise conducted earlier this year, 89% of Association members agreed, or agreed strongly, that, "If the Scottish Executive was to set further targets for compliance with signage and the provision of non-smoking areas and/or high quality ventilation, we would actively work to achieve these". At The Scottish Licensed Trade Association's Annual Conference held recently, Association Members voted unanimously that compliance with the Voluntary Charter should become compulsory for all Licensed Premises. With the degree of achievement for the Voluntary Charter in the past, particularly with the increase in the provision of non-smoking areas, the willingness to work to new targets in the future and the commitment of members of this Association to adopt the Charter, this Association can see no reason for the introduction of legislation.

In response to the measures proposed in the Bill, The SLTA would make the following comments:-

The Bill proposes that smoking should not be allowed in an enclosed space where food is served, nor in a "connecting space" if there is any opening "which is capable of being closed" between the two spaces. This in effect, means that a bar separated by a wall from a restaurant, but with an interconnecting door, would be forced to ban smoking. The only other option for a licensee would be to install a second wall and door between the two spaces, basically an "airlock" system, in order to continue to allow smoking in the bar area. It is almost inconceivable that a licensee would be in a position to do this, for a number of reasons, and so this Bill, if introduced, would effectively ban smoking throughout premises serving food. The suggestion that the cost implications would be offset by increased business are naïve in the extreme and purport that all licensees will increase their turnover by banning smoking in their premises. The hype of increased business in New York and other cities/countries, which have introduced a ban, are, according to our information, simply not the case when other factors are taken into consideration and when you speak directly to licensees in these areas.

Should this Bill succeed, it will only force the licensee into a choice between whether to allow smoking, or eating in any part of his premises. The vast majority of our members and the trade in general now provide food and this has been one of the great successes of recent years in helping to "civilise" the local pub, and the standards continue to increase. Completely banning smoking where food is sold or served, will only result in this trend reversing as licensees are forced to choose between serving the 65% of their regulars who are smokers, and serving food.

A considerable proportion will choose to stop serving food, leading to a reduction in amenities for local workers and communities and employment for chefs and other foodservice personnel. This would only be a backward step for this industry and would be of no benefit to anyone. We are extremely concerned that this negative implication has not been considered in drafting this Bill or in the promotion of its aims.

The proposed Bill implies that Environmental Tobacco Smoke can only effectively be stopped from drifting into a non-smoking area by this form of double barrier. We believe that there is no justification for this. We have evidence which demonstrates that ETS can be prevented from drifting into a non-smoking area through the proper use of ventilation alone - even when the areas are only partially partitioned. Common sense and experience show that separating smoking and non-smoking areas by
a substantial space, or a wall, would have a similar effect. The SLTA believes that the clause referring to physical limitations is unworkable and unduly onerous.

The insertion of a `prescribed period' into the Bill as with the `connecting space' clause above seems aimed at greatly extending the remit of the Bill. This clause would effectively mean that any space that had been used for smoking, at whatever level, would have to be non-smoking for the next five days before it could be used for food service. We assume the "prescribed period" has been included in the Bill due to pressure from anti-smoking groups who suggest that the fabric and material within premises is contaminated and takes five days to clear. Slightly digressing, if this is the case then how do we deal with the material and fabric of the customers who frequent the premises, (Cloths, personal effects, etc). In our view, once Environmental Tobacco Smoke is no longer being generated by smoking, the level of contamination drops off very rapidly as the particles settle and the gases disperse. Even in unventilated premises the amount of particulate in the air will drop rapidly. The Building Services Research and Information Association (BSRIA) has tested this in a small, smoky unventilated chamber and established that over 99.5% of particulate matter is dispelled within a twenty-four hour period. This Association is constantly bombarded with the view that ventilation makes no difference and contaminants are not dispersed. In our opinion this is a subject that requires proper analysis before conclusions can be drawn. We have strong evidence that relatively simple ventilation can cut out ETS gases and particles, including by extension any carcinogens, by between 85% and 95%, thus greatly reducing exposure of staff and customers. To support this we have commissioned the University of Glamorgan to carry out research in a typical Scottish "Pub" and we currently await their findings. Once completed, we will be releasing the data and will forward a copy to the Health Department. We believe that this clause is totally unnecessary and has no basis.

The Association notes that Ministers can "add such places as they think fit" to the "regulated areas" under the Bill without recourse to Parliament or any consultation with the industries most affected by the Bill. It is perhaps instructive that this Bill proposes that the industry should be consulted on the "number, size, style and content of signs to be displayed", although there is no suggestion that the industry's advice would be taken, and would not even be consulted if the Minister decided that the Bill should be extended into a total smoking ban.

We anticipate that pressure for the provisions of this Bill to be extended into a full smoking ban would be intense as soon as it was passed, not least by some of those who support it currently.

This process could be regarded as an attempt to circumvent the normal process of democratic accountability and so we believe is totally unacceptable. The SLTA is extremely concerned that this Bill aims to use public support for smoking restrictions in restaurants, whether voluntary or compulsory, as a means to effectively ban smoking throughout any premises that serve food, in any part of the premises.

The Campaign for Real Ale carried out an Omnibus survey in December 2003, which showed that 30% of the public favours a total ban in pubs (18% of pub users). The considerable majority of those that visit pubs and even those that do not visit them, oppose a ban. When offered an option, 83% of adults supported the view that pubs, where possible, should make provision to meet the needs of both smokers and non-smokers. Only 6% disagreed with this position.

As an Association we support and promote the implementation of non-smoking areas and rooms, and where there is sufficient customer demand, non-smoking pubs. Market forces are strong in our industry with its very high proportion of entrepreneurs seeking new market niches. In Scotland for the first time, we are seeing the establishment of seemingly sustainable, non-smoking pubs. These innovations have attracted considerable media attention and are being keenly watched by competitors. If there is considerable demand for non-smoking pubs it will be reflected in the success of these venues and copied elsewhere. Evidence to date, suggests that these are niche operators and that the customer demand is not yet in place that will make a wide-scale rollout of non-smoking pubs viable.

The Bill, as drafted, would force many of our members to choose between ceasing to serve food or ceasing to serve smokers. Neither of these options is attractive. Approximately 96% of our members
provide some form of food service. Virtually 99% serve smokers, who account for, on average, 65% of their regular customers, (visiting 3 or more times a week), and well over half of their business. A similar choice was forced upon the trade in the Dundee Licensing Board Area, where, without prior consultation, the renewal of Children's Certificates were refused by the Licensing Board, unless smoking was banned in premises catering for Children. The effect of this was quite simply, Public Houses stopped catering for children - it did not stop smoking in Licensed Premises.

We believe that this Bill, if passed, would have a similar effect with the great majority of premises ceasing to serve food and fear for the following consequences:-

- A Reduction in the employment of chefs and food service staff in pubs and bars
- A Reduction in the variety and accessibility of inexpensive food available to customers
- Putting the viability of some premises into doubt - especially country pubs and bars that have diversified into food to compensate for losses in their core drink business.
- The attraction of foreign visitors to Licensed Premises.

In summarising, this Bill proposes a full smoking ban in all premises that serve food, even in separate rooms, and we believe this would quickly be translated into a full smoking ban in all premises without any further scrutiny or discussion.

We are absolutely opposed to this measure on the following grounds:-

- Self-regulation is working under the Voluntary Charter; we have met the targets set and have the strong support of our members to work to achieve further targets that are agreed
- The inclusion of 'connecting spaces' and a five day prescribed period in the Bill have no basis in ETS science and make the measure unworkable for the large number of premises that allow smoking and eating on the premises, even in separate rooms
- Only a minority of the public supports the total ban on smoking that would logically ensue from this measure; most favour separation of smokers and non-smokers according to circumstances
- Market forces are already driving change and the evidence 'on the ground' is that there is no huge desire for non-smoking pubs at the moment - although this of course may change in the future

The measures, if implemented, would reduce consumer choice in our members' outlets rather than promote it and would cause job losses and business failures.

The Scottish Licensed Trade Association does not support the general principles of this Bill and is of the view that this Bill is totally unnecessary, considering the Scottish Executive Consultation exercise, "A Breath of Fresh Air for Scotland".

Yours sincerely

Colin A.Wilkinson
Secretary.

SUBMISSION FROM THE SCOTTISH NHS CONFEDERATION

The Prohibition of Smoking in Regulated Areas (Scotland) Bill: submission to the Health & Community Care Committee

Introduction

1. The Scottish NHS Confederation represents NHS boards and special health boards in Scotland. We are very pleased to be able to comment on this important Bill. Direct and indirect tobacco use is perhaps the most immediately pressing public health concern in Scotland, as confirmed by the Chief
Medical Officer in his recent report on Scotland’s health, and we congratulate Stewart Maxwell MSP for bringing this Bill before the Scottish Parliament. It is particularly timely that we are able to discuss this Bill against a background of recent international action to curb smoking in public places - such as in the Republic of Ireland and the city of New York - as well as the Scottish Executive’s own proposed consultation on the issue.

2. The Confederation consulted its members widely on their views of the Bill. We circulated a briefing which described the Bill's proposals and the background to it, and posed a number of questions:

- Do you agree with the aims of the Bill? Will its proposals contribute to smoking cessation and the improvement of health in Scotland?
- Does the Bill on its own go far enough? Should there be a wider smoking ban in public places?
- Should there be national legislation to restrict smoking or should it be left up to local discretion?

This submission summarises the responses to these questions and presents a sample of comments made by respondents.

3. The Scottish NHS Confederation received the largest number of responses that we have had to any consultation with our members so far. Views came from a large and diverse number of individual healthcare professionals and organisations. They showed near-unanimous support for the Bill as a vital contribution to supporting smoking cessation, protecting non-smokers from the effects of second-hand smoke, and improving Scotland’s health overall. Only one respondent expressed the personal view that legislation was undesirable as it overruled personal choice. The majority of respondents made strong expressions of support for the Bill, with many citing evidence both of the dangers of second-hand smoke to non-smokers and the efficacy of smoking restrictions in contributing to cessation by smokers:

"For more than a decade, convincing scientific evidence has been available to demonstrate that exposure to second-hand smoke both harms health and worsens existing health problems. It is estimated that at least 1,000 people die each year in the UK as the result of exposure to other people’s tobacco smoke and some studies put this figure much higher."

*NHS Highland*

"The evidence that passive smoking kills is now incontrovertible, as confirmed by the English Chief Medical Officer in July 2003...people who live with smokers have a 20-30% higher risk of lung cancer ands heart disease, and passive smoking is associated with cot death, asthma, respiratory illness and middle ear disease"

*Consultant in Dental Public Health*

"It will hopefully create a surrounding which is conducive to the prevention of relapse. As Marlatt and Gordon (1985) illustrate, premises where alcohol is served are high risk situations for pre lapse stage, leading to relapse...Therefore a ban fits into the equation of any smoking cessation strategy by assisting in preventing situations that may lead to relapse."

*NHS Ayrshire & Arran*

"As a direct result of banning smoking in Forth Valley Acute Hospitals last year, I attended a smoking cessation clinic and have not smoked in the last year. I doubt that if this initiative had not been enforced I would have even attempted to stop."

*Clinical Effectiveness Co-ordinator*

4. Another common theme from respondents, was the view that the cultural message sent by prohibition was just as important as the likely immediate health benefits:
"Banning smoking in public places sends a clear message that smoking is unacceptable and anti-social."

_Tobacco Co-ordinator_

"We need to recognise that the right to breathe smoke-free air should have priority over the right to smoke."

_Head of Administration_

"What we are looking at here is a chance to bring about cultural change, the seat belt law being an example."

_NHS Ayrshire & Arran_

"One of the most important aspects of a ban on smoking in public places is the message it gives to young people that non-smoking is the norm is society"

_NHS Highland_

5. Some respondents also pointed out that Scotland lags behind the rest of the UK in providing protection from second-hand smoke, both for workers and consumers:

"Currently Scotland has fewer smoke-free workplaces than the rest of the UK and only half of all UK workplaces are smoke-free. Those working on low-incomes, in small businesses or in the hospitality industry are at greatest risk"

_NHS Highland_

"It is my observation since moving up here 18 months ago that there are far fewer smoke-free or non-smoking partitioned restaurants in Scotland than I have experienced south of the border. It does concern me that taking children out to eat is restricted so much north of the border if you want to try and find a smoke-free environment."

In this context, a number of respondents pointed out that the exemption of NHS hospitals from the definition of 'regulated areas' - in a Bill that aims to promote health - could be seen as sending mixed messages:

"We are puzzled as to why the Bill exempts health service hospitals - surely their catering areas would be automatic candidates for a smoking ban?"

_Consultant in public health promotion_

6. Although support for the Bill was all but unanimous, all of those respondents who expressed a view were of the opinion that it should be regarded as only a 'first step' in tackling exposure to tobacco smoke and that a far more wide-ranging ban on smoking in public places should be the ultimate aim. Although there were mixed views on how quickly this could or should be implemented, a clear majority supported strong action against smoking in public places, taken on a Scotland-wide basis.

"Transparent legislation that applies to everyone is easier to enforce than legislation that applies only to some types of buildings or applies differently at different times. A comprehensive ban on smoking in public places could be framed to cover the majority of Scottish workers, as well as the public...we would strongly recommend national legislation to restrict smoking."

_NHS Highland_
"We now take it for granted that we cannot smoke in cinemas, on planes etc and should pursue as wide a ban as possible"

Director of Strategic Planning

"I would support a full national ban. The piecemeal application of local policies throughout the country is inappropriate when we are talking about something that impacts so heavily on the health budget."

Clinical Pharmacist

A considerable number of respondents cited the recently implemented Irish ban as a model for Scotland to follow:

"Follow the Irish example. Would be the biggest public health gain possible."

"...we should look to what is happening in the Republic of Ireland where strong leadership (based on evidence) is helping to pave the way to improved public health both now and for the generations to come"

Head of Organisational Change and Development

7. Finally in this section, we were struck by the large number of respondents who expressed strong views about the role of the Parliament and Executive in reducing direct and indirect exposure to tobacco smoke through legislation. There are very clear messages for all MSPs from the health professionals who responded to our consultation, that they expect national politicians to demonstrate clear leadership in taking action to improve Scotland's health:

"The politicians should be brave enough to do something which is for the public good, even if it may lose some votes!"

GP

"If the Parliament is serious about improving the health of the population, it should take very opportunity to tackle one of the biggest causes of premature death in Scotland."

General Manager

"National implementation [of legislation] also sends out the message that Parliament means business and conveys to the public the seriousness with which government takes this matter"

NHS Ayrshire & Arran

The Confederation's view

8. The Scottish NHS Confederation believes that the Prohibition of Smoking in Regulated Areas Bill is one of the most important that has come before the Scottish Parliament so far and that it provides MSPs with an unrivalled opportunity to improve the health of the population. The Bill makes a long overdue attempt to address Scotland's smoking culture directly and at a national level. We believe that, if it is enacted, it will act as a powerful public health measure, making a significant contribution both to smoking cessation and to reducing the exposure of non-smokers to second-hand smoke. Furthermore, it will help, over time, to contribute to the formation of a culture in Scotland in which public smoking - much like drink-driving in recent decades - is no longer viewed either as normal or as merely a matter of choice for individuals, but as an anti-social act that has a direct, adverse effect on the health and environment of people other than the smoker. The health professionals and organisations who responded to our member consultation deal in and out with the ill-health, disease and premature death that are the consequence of smoking in Scotland: their overwhelming support for the Bill indicates that this is a piece of legislation that will make a real, practical and measurable difference to Scotland's woeful public health record. Bold action by national politicians is
required to improve the health of our population: this Bill provides that action, and we urge members of the Health & Community Care Committee to give it their full support.

9. However, the Confederation also fully supports the view expressed the majority of our respondents that, crucial thought this Bill is, it should be looked upon as just the first step in a campaign to achieve a smoke-free Scotland. We acknowledge that this is a goal that cannot be achieved in one swoop, and we recognise that further discussion and consultation has to take place before action beyond the scope of this Bill is implemented. Nonetheless, we would ask members of the committee to maintain a focus on this issue, to closely monitor the progress of developments in the Republic of Ireland and elsewhere, and to urge the Scottish Executive to include wider restrictions on public smoking within the scope of its own proposed consultation on the subject later this year. As the comments from our respondents indicate, this is an issue on which health professionals in Scotland want and expect their national politicians to provide strong leadership. There has never been a more favourable time than now for them to do so.

The Scottish NHS Confederation

SUBMISSION FROM SINCLAIR COLLIS

Introduction

Sinclair Collis Limited is a Cigarette Vending Machine Operator whose business is centred solely on supplying and operating cigarette vending machines, cigarettes and tobacco products (cigars and some tobaccos) to the leisure sector (Public Houses, Hotels, Restaurants, and Clubs).

This proposed legislation would directly affect all areas of our trade.

We have approximately 350 employees in the UK, 36 of which are directly working in Scotland and as such will be directly affected.

Whilst it is too early to judge the results of similar legislation in Ireland, if the decline in cigarette vending sales in our specific market place were of the magnitude referred to in recent press reports (50% - 60% decline) then our whole business profitability would be undermined, resulting in major redundancies or closure of our business.

Consultation

Sinclair Collis welcomes the opportunity to comment on the general principles and practical implications of the Prohibition of Smoking in Regulated Areas (Scotland) Bill ("the Bill"). The comments set out in this document are a summary of the key concerns of Sinclair Collis and as such we would welcome to opportunity to expand upon the issues raised.

Sinclair Collis did not make a submission to the Member's consultation in 2001 on the proposal of the Member of Scottish Parliament ("MSP"), Ken Gibson. Consequently Sinclair Collis was not invited to submit evidence in the 2003 consultation undertaken by the MSP Stewart Maxwell. Sinclair Collis understands that the Bill is drafted on the basis of the submissions received during the 2003 consultation. Consequently, this is the first time that Sinclair Collis has submitted evidence to the Scottish Parliament's consideration of this issue.

Objectives of the Bill

The Bill is stated to have a number of objectives: to prevent people, including children from being exposed to the effects of passive smoking in certain public areas; raise awareness of the dangers of passive smoking and smoking; assist in changing the attitude of the public towards smoking, and encourage smokers who want to quit smoking and help ex-smokers from relapsing.
The objectives regarding the effects of passive smoking or environmental tobacco smoke ("ETS") are on perceptions of health risks which based on flawed interpretations of epidemiological studies.

Sinclair Collis does not believe that the Bill is justified on public health grounds and that any measures taken in this regard should as a matter of law be proportionate. The wider and practical impact of the Bill would be disproportionate to the stated objectives.

Many scientific studies have investigated possible associations between ETS and lung cancer, heart disease or other diseases. Such studies and research does not demonstrate that ETS causes lung cancer, heart disease or other diseases in non-smokers when considered as a whole. The five largest studies produced inconsistent findings with one reporting a small increase in risk, three reporting no statistically significant increase in risk, and one reporting a statistically significant decrease in risk.

In summary, the evidence and studies, when considered as a whole, do not justify prohibitions on smoking in an "enclosed public space" where food is supplied and consumed.

Freedom of Choice

The Bill does not recognise the concepts of choice and fairness. Smokers and non-smokers are reasonable people who are looking for fairness and balance. This issue can be resolved through introducing practical solutions such as well-ventilated smoking and no-smoking areas. The Bill fails to afford the opportunity for choice and information.

It is clear that ventilation and air filtration can provide substantial improvements in air quality. Other people's smoke can be eliminated or reduced to a minimum by implementing practical solutions.

Whilst an undisputed majority of people wish to see the provision of non-smoking areas increased, it has not expressed a view that this should be achieved by prohibiting smoking when voluntary, self-regulation is proving to be increasingly effective.

Significant progress has been made by the Scottish Voluntary Charter on Smoking in Public Places, it is unreasonable to reject the Scottish Voluntary Charter outright at a time when the UK Government is negotiating with the hospitality industry in England and Wales for higher compliance through its Charter programme.

The Bill defines restaurants and other places where food is served and consumed and ‘communicating spaces’ as being "public places". However, these tend to be privately owned premises. The owner/operator should have the right to determine if their establishment permits, prohibits or otherwise regulates smoking. They know what is good for their business and what their customers want. Pizza Hut for instance introduced its own ban without the need of legislation. Where there is a demand for a smoking ban, or for separate areas for smokers and non-smokers, commercial operators will and do respond with appropriate local initiatives. If they do not respond to local concerns, then their trade will suffer.

Consumers are in no way forced to give their custom to an establishment that permits smoking if they do not care for some aspect of the place. Smoking may only be one out of many and varied reasons for customers to choose not to patronise a particular establishment.

The Bill supposedly only prohibits smoking in certain enclosed public spaces. The definition of a regulated area is written in such terms as is likely to lead to much uncertainty and in many instances could effectively ban smoking throughout certain establishments. This is not a reasonable measure but rather the introduction of a part smoking ban under the guise of considered regulation.

One of the suggested principles behind the Bill is that food must not be served or consumed in the same area as smoking. Whilst some customers may not find this desirable, no evidence or argument is put forward making any link between the consuming of food and smoking.
Practical Implications

The requirement that an enclosed space must be smoke free for five days before food is wholly unwarranted and not justifiable.

The Bill legislates for all premises where food is supplied and consumed, taking no account of the vast variety in premises. This 'one size fits all' approach for such regulated areas will have significant cost implications for proprietors. The costs of compliance for any person providing food and wishing to provide facilities for smokers outside the area where the food is provided would, in many instances, be high and for a great many would be prohibitive, potentially involving design, layout and structural changes to the premises that in cost would far exceed any possible savings.

There have been high-profile public smoking bans in New York and Ireland in recent months. It will be some time before the true economic cost of these bans is known. Surveys do show mixed results - with those claiming no or a positive impact receiving more publicity. Others do show a negative impact. For instance, the Vinters’ Federation of Ireland commissioned ICR (International Communications Research) to conduct a study exploring the effects of the smoking ban in New York City on 300 businesses in September and October 2003. Two-thirds of responding establishments said they were seeing fewer customers now than when the ban went into effect.

Conclusion

Sinclair Collis considers that the Bill is not justified on its public health ground objectives and is disproportionate in its effect.

The imposition of legislation which has the practical implications outlined above is not the regulatory route preferred by the general public. Voluntary self-regulation, which has been shown to deliver workable and practical solutions is the preferred to regulation and prohibition.

SUBMISSION FROM DR ROBERT MONIE

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I think there are three main areas that I would like to highlight:

1. I think anything that reduces the acceptability of cigarettes is likely to reduce the numbers of people starting to smoke. I think one thing that both smokers and non-smokers can agree upon is the desire that young people should not start smoking. Nicotine is the most addictive substance known to man and is more addictive than either heroin or cocaine. Plus I think we would see a reduction in youngsters starting to smoke and would also help those individuals who are trying to stop from relapsing. It is obviously much more difficult not to have a cigarette if you are in an atmosphere where cigarettes are being consumed.

2. There is also the risk of passive smoking. Respiratory Physicians see every year increasing numbers of young women with lung cancer. Some of these people have never smoked. Whilst, clearly some of them clearly have had exposure within their households, it may well be that smoking friends have helped to induce the cancer. It is not just the development of lung cancer. We know that children are particularly susceptible to inhalation of cigarette smoke and children in a smoking atmosphere, in a public place are more likely to have respiratory tract infections, glue ear, asthma etc. Finally, there are adverse effects on a foetus when a Mother inhales nicotine passively. I once undertook a survey for Scottish Television a number of years ago and we showed that by about 10.00pm, those people in a Pub, who had never smoked, had inhaled about a third of the carbon monoxide in the atmosphere compared to smokers. These very gross figures show that passive smokers can inhale up to a third of the nicotine that smokers do whilst in a smoky atmosphere.

3. I think everybody would enjoy an environment of clean air and at the end of the day, the majority of people in Scotland are non-smokers and have the right not to inhale other people's smoke.
I would wish to add my full support to this proposal and I hope the Health Committee will agree.

Robert Monie
Consultant Respiratory Physician
Southern General Hospital
Glasgow

SUBMISSION FROM THE STAR INN

Presently I have a public house with a non-smoking area, though there is no provision for food and not for the immediate future. My customers and my staff are of the understanding that a separate non-smoking area is sufficient and fair to the minority of non-smokers that I have in my pub. Personally if I thought it would generate custom then I would have made my pub non-smoking a long time ago!

A smoke free pub would have a detrimental effect on my business and profits. This would result in less staff employed and a dramatic loss of earnings I would not see a long-term future for myself trading in a pub that offers only wet sales to customers.

My customers leave their houses where, probably, they do not smoke or drink and visit their local pub to have a drink and smoke in a relaxed social atmosphere. To take this luxury away will just fuel resentment towards my staff and I, and a growing disappointment in the system as a whole.

Additionally, I think the proposed fines are excessive and a huge step in the wrong direction. Such a move is just another way for our Scottish Parliament to generate income through indirect taxes. The practical alternative solution is self-regulation. As a Licensee I deal and confront a number of overwhelming situations i.e. intoxicated persons, drug possession and offensive weapon possession to name but a few. I work closely with my local constabulary. My staff and I would not like to find ourselves in pointless confrontations with customers. An approach towards a customer who I may refuse to extinguish a cigarette, could result in a scenario of ejecting that customer from the premises even though no-one was offended by their actions! Through self-regulation I have implemented measures to conform to a well ventilated pub with a non-smoking area. I have installed air-purifiers also. I don't believe that customers leave my pub because of excessive smoke.

I listen and cater to my customers needs and that has proved essential in the smooth running of my business. The customers' voice must be heard. The majority do not want a smoking ban!

I thank you for taking the time to read my letter and hope a decent and acceptable policy is decided.

Scott Padden

SUBMISSION FROM SHARON AND BRIAN PERRY (STONE INN)

Re: Smoking Ban in Pubs

I would like to bring to your notice my husbands and customers objections to the proposed banning of smoking in public houses in Scotland. I have today been observing the debate as the law comes into force in Dublin, and note that many publicans like I myself are concerned about the affect this will have on their business.

My business is a small rural public house in Argyll & Bute. I gave up my home in Renfrew and put all my life savings into buying and maintaining this pub and it has been in the village for 170 years. This pub has been more like a community centre and meeting place for the villagers where all the problems of the world are discussed, debated and solved. The majority of my regular customers smoke, and I have already researched their views and the results of this show I will lose their custom if the total ban comes in to place. I would not then be able to sustain the business, therefore, this
would result in the closure of my premises, the loss of my life savings and last but not least, the loss of my home. At present I already operate a no smoking policy in the lounge when meals are being served, and this is acceptable to my customers. It would be a great loss to the community, as many of my customers would confirm. At the moment the profits of the pub are not enough to sustain the business and I have to work in Glasgow to pay the bills. I do not have passing trade, I know who my customers and potential customers are.

Research has already shown in New York profits in some pubs have dropped by 30% after banning smoking. Large town/ city pubs can sustain this by cutting staff and increasing prices etc. but in a small pub like my own, which my husband and myself both work in, plus help from two part timers would result in 5 people being unemployed.

The license trade has implemented a voluntary action plan to create non-smoking areas with ventilation and a choice of smoking or non-smoking pubs. I feel this is the way forward as people then can choose whether they go into a pub that allows smoking or "not. After all we are adults, we can make a choice, we do not require nannies.

There are other problems that a total ban could raise i.e. who will police it. In a rural community there is very little police presence, and asking an irate person who lights up a cigarette to put it out could be confrontational and would certainly cause problems. Also females having to leave their drinks and going outside to smoke could also be in danger of their drink being spiked. Even people taking others seats when they're gone I for a smoke could cause problems. The non-smoking lobby will make no compromise, but we are willing to, by making it a voluntary ban, and asking all pubs to make their smoking policy aware to customers. The customer can then make the choice of whether to frequent a smoking or non-smoking pub.

The smokers' voice must be heard, as well as the welfare and safety problems I have highlighted. It is not only about physical health of people but also about their social and mental welfare. I would like you to make our voice heard and lobby to stop this law being passed.

Sharon & Brian Perry

SUBMISSION FROM TABAC WORLD LTD

The Prohibition of Smoking in Regulated Areas (Scotland) Bill

We are TABAC WORLD LTD a small national distributor of specialist tobacconist products, including Pipe Tobaccos and Cigars. As such, we declare an interest in the Private Members Bill introduced to the Scottish Parliament by Mr Stewart Maxwell MSP recently. This Bill seeks to overly restrict the perfectly legitimate activity of tobacco smoking.

There are a number of points we wish to bring to the attention of your Government officials which we believe are valid in any debate on this subject. Briefly they are as follows.

To enact a new restrictive law relating to the general public's way of life that will place Scotland at variance with the majority of the UK population, we believe, may create difficulties in general acceptance by the public.

If it is a health concern relating to 'second-hand' tobacco smoke, the proposed Bill is overly onerous and totally unnecessary. The vast majority of smokers do not and would not have the discourtesy to smoke in small enclosed areas (lifts, buses, etc) but they do expect to enjoy their activity in areas dedicated to relaxation if permitted by pub landlord or restaurant manager. Currently, pubs & restaurant are able to determine whether they operate a non-smoking policy, dedicated non-smoking areas or smoking throughout policy. Such decision being made on a personal view basis, level of ventilation available or dictated by market forces. A well run business, as most are, will be swayed by the latter and no new legislation is required, the public have already voluntarily made the decision.
One suggested requirement in the Bill is for premises to be smoke free for five days prior to food being made available. Would this not create an impossible situation for operators of rooms that are continually used for a variety of purposes? For instance convention centres, hotel and service station meeting rooms, Masonic and church halls, etc.

If this law was passed, how would it be effectively policed without additional funding from the taxpayer? The present cost estimates do not appear to have been well thought out and a serious review should be undertaken and made available for discussion prior to any enactment taking place.

Finally, we all must accept that any perceivable danger from passive smoking is unproven and that being the case, does the distaste for smoking have more to do with smell than anything else? To pass a law on such perception could lead us down a very dangerous path.

SUBMISSION FROM TAYBANK MANAGEMENT SERVICES

I write this letter in response to your bill to ban smoking in pubs that sell food with the threat of a fine of £1000 for non compliance.

This is a disgraceful and ill thought through bill especially in Scotland with its many rural communities and I would on behalf of my customers urge you to think long and hard about its content, please consider a country or village Inn some miles from its neighbour and on a Friday! Saturday evening the local farm workers and others gather for an evening of community get together, half of these people are smokers and half are not, we have a good filtration system installed at considerable cost (which will under your bill become redundant, compensation ???? ) take away the rights of the smokers to have their much loved and needed ciggie in this local and the non smokers will still come but my survey shows that of the smokers only 25% would bother to still come down to the pub, preferring instead to sit at home with their cheap carry out as they would feel like pariahs having to nip outside regularly to have a puff while in company, think also of the mess that would be made outside each pub with cigarette litter by the 25% who still decided it would be worth the effort to support their local, Nay Mr Maxwell there are many more pressing issues to be dealt with before a total ban on smoking is enforced and have you asked yourself about the cost of policing it, imagine the scenario, the local police get a call that a customer refuses to put his cigarette out in a rural pub, they have to attend, meanwhile some old lady is being mugged or someone is being assaulted and there is nobody available to attend as they have responded to the earlier call and are busy filling out the necessary reams of paperwork, please get your priorities right.

If we are to have a totally healthy society with everyone living to 100 imagine the knock on effect, catastrophe! Pollution from vehicles is way, way, way above that from cigarettes and no doubt you jump in your car regularly and pollute the air that I want to breathe while out for a walk in the country, but nobody is trying to ban you from driving on the roads that I use. Let’s get real and have our politicians lead the way in .more important .issues and when they are resolved q then we can consider Issues like banning cigarettes In public houses, after all most of us have got prominently displayed signage stating our policy on smoking and if a non smoker chooses not to enter the premises that is their right and should suffice.

We are getting too wrapped up in political correctness and what all the minorities want.

Yours sincerely

W G Keenan
SUBMISSION FROM TAYLOR VENDING AND WHOLESALE

Prohibition of Smoking in Regulated Places (Scotland) Bill

Dear Sirs

We refer to the above proposed bill and wish to make the following comments.

1. We feel that the individual Publicans and Restaurateurs should have the right to decide whether their establishments / Businesses allow smoking to be permitted. In our opinion the current procedure of non-smoking and smoking areas seems to work perfectly. Perhaps improved ventilation could be an alternative to the above Bill.

2. The above-proposed Bill would have a devastating effect on our cigarette vending business. The Bill would result in a vast loss in turnover and in return we would be forced to reduce our staffing levels.

3. Tobacco products are a legitimate product sold in every high street in the country.

4. To isolate Scotland with this particular Bill could have a jeopardising effect on our Scottish Leisure and Tourism Industry. This could also have an adverse effect on "local socialising" i.e. people deciding to stay at home.

5. Who will be responsible for Policing of the Bill? We believe that the smoking regulations will be impossible to enforce and enforcement will not work if significant numbers of the population decide to ignore the law.

6. This company has invested substantially in machinery over the last 20 years! Who will compensate for the machinery that will no longer be required by the businesses who decide to remove a purchase opportunity of a "banned" product.

7. The Scottish Voluntary Charter in Public Places was introduced in 2000 and we feel improvements have been made and will continue in the future.

8. The effect to the licensed trade could be devastating, further depressing our wholesale turnover also.

9. If the Bill is successful in its present form could it be changed in the future without consultation?

We hope you find this letter constructive and if you require any further information, please do not hesitate to contact us.

Martyn Simpson
Cigarette Vending Specialists & Wholesale Confectioners & Tobacconists

SUBMISSION FROM TENNENT CALEDONIAN BREWERIES

Prohibition of Smoking in Regulated Areas (Scotland) Bill

I am writing on behalf of TCB as President of the Scottish Beer and Pub Association (SBPA) regarding the above.

TCB is a member of the SBPA and we are a major component part of the wider Drinks and Hospitality industry in Scotland with over 5,500 customers stocking our brands.
We have actively supported the Scottish Executive’s Voluntary Charter on Smoking in Public Places along with the Scottish Licensed Trade Association, the Scottish branch of the British Hospitality Association and the Scottish Tourism Forum (who all support us in this response), we are heartened by the progress achieved by the voluntary approach to date. As quoted in the document “A Breath of Fresh Air for Scotland” reference P24 Point 5.6:

"An independent evaluation, published on 23 September 2003 of smoking policies in the Leisure 8 Industry would suggest the industry had met three out of the four targets set under the Charter, including the key target of availability of smoke-free provisions. We welcome progress made under the Charter and believe that it demonstrates the progress that can be made through partnership with the business community in this most challenging of sectors. We now intend to work with partners to step up these effects in order to accelerate progress in smoke-free provision across all sectors of business in Scotland”,

We support the objective of a smoke-free Scotland but are aware that this is unlikely to happen overnight. I believe that all industry participants must work together to address Scotland’s smoking problems.

Given our support of the Voluntary Charter to date and our forthcoming role in the Scottish Executive consultation, we do not support the legislative approach of the draft Bill. We would strongly urge that the voluntary approach be continued and we are confident that it can deliver a well-balanced and effective route to firstly reduce and ultimately eliminate the practice of smoking in public places.

TCB and the SBP A do not, therefore, support the general principles of the Bill and the key provisions it sets out. It seems illogical and unnecessary for a draft Bill to be introduced prior to the commencement of the Scottish Executive’s period of consultation on the Tobacco Action Plan and we are strongly of the opinion that Mr Maxwell be asked to withdraw the Bill as it will only serve to confuse the public and all relevant stakeholders.

Mike Lees
Managing Director

SUBMISSION FROM TOBACCO WORKERS’ ALLIANCE

Do you support the general principles of the Bill?

The Tobacco Workers’ Alliance is concerned that the Bill is the thin end of a wedge that ends in a Draconian smoking ban.

The TWA recognises that the Bill is focusing on a health-oriented agenda in regard to smoking and agrees with this approach. However, tobacco products are legally manufactured, sold and consumed in the UK and while this remains the position adults should not be marginalised or vilified because they smoke. The Bill bans smokers rather than cutting smoke.

Are there any omissions from the Bill that you would like to see added?

1. A mechanism to review the effects of the Bill’s implementation on employment in both the hospitality and leisure industries concerned and on a wider scale.

For example, the TWA has colleagues working in Scotland as part of the tobacco company sales forces, who are reliant on the trade provided selling to venues with vending machines. A lot of these establishments will inevitably remove the vending machine, should there be a smoking ban imposed on their premises. This would put the sales jobs under threat.
2. Recommendations for how smokers should be accommodated.

The Bill merely pushes what it perceives to be the problem (the smoke and the smoker) outside or off the premises. It does not provide for the consequences of such measures - litter from cigarette butts, noise from smokers stood outside establishments in residential areas, fire hazards from smoking in less well-defined areas. If a smoker is inside an establishment ashtrays are on the tables, noise is inside the building and smokers know exactly where they can and cannot smoke.

What are your views on the quality of consultation, and the implementation of key concerns?

The two previous consultations appeared extensive in terms of those who responded. However, the policy memorandum behind the Bill is highly selective and does not represent the key concerns of a number of parties involved in the consultation. This may be demonstrated by the paragraphs on ventilation, which misquote the Government paper (para. 87). This misleadingly aids the argument against ventilation. As far as the TWA is aware, the statement that "no system of ventilation provides adequate protection against ETS" comes from an ASH document (http://www.ashscotland.org.uk/issues/pass_smok_pub02.html) and not from the Smoking Kills 1998 paper. The Government's paper acknowledged that it could not actually endorse ventilation. However, it also stated that it was involved in "the development of agreed standards for [ventilation] equipment which we can endorse".

The University of Glamorgan is carrying out studies of ventilation in public places, similar to those places that will be affected by the Bill. These case studies are based on actual measurements of ventilation efficiency as opposed to estimates. The Committee may be interested in seeking out the results of those studies.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

In terms of the practical implications, the TWA is concerned about the way in which the Bill will be enforced. Will employees come under undue pressure from their managers and employers to enforce the Bill? Despite the fact that employees will not be liable, those who could be fined may expect their employees to be the enforcers of the Bill. This could open up workers to abuse from, for example, pub customers who may have had a few drinks and might not be as amenable to being asked to stub out their cigarettes.

Regarding alternative approaches, the TWA believes that the Public Places Charter can be improved by encouraging signatories to install effective ventilation, ban smoking at bars and increasing smoke-free areas. The Charter uptake may benefit from increased support and endorsement from the Scottish Executive.

By prohibition of smoking the ability to effectively manage where smoking takes place is lost.

SUBMISSION FROM UNISON SCOTLAND

Introduction

UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Scottish Parliament's Health Committee regarding the above Bill. While welcoming the general principles and aims of the Bill, UNISON Scotland would like to comment on some of the issues highlighted in the call for evidence.

General Principles

UNISON Scotland supports the general principles of this Bill, namely to prohibit smoking in regulated areas, these being enclosed public spaces where food is supplied and consumed and which also includes a prescribed period before food is supplied and consumed. Essentially this will apply to
restaurants, pubs and clubs but will also include higher and further education facilities as well as local authority premises such as community centres and any other venues which may be let out for events in which food may be supplied or consumed.

The detrimental effects of smoking are well known with it being the single greatest preventable cause of ill-health and premature death in Scotland, accounting for more than 13,000 deaths and 33,500 hospital admissions - at an estimated cost of £200 million each year.

The British Medical Association (BMA) estimates that 1,000 people a year die in the UK as a result of being exposed to Environmental Tobacco Smoke (ETS). Also the Government White Paper on Tobacco (1988) highlighted that non-smokers who are exposed to ETS in the workplace have their risk of lung cancer increased by 16-19%. Passive smoking also increases the possibility of an acute coronary event by 25-35%.

UNISON Scotland therefore believes that under health and safety legislation employers must protect the health of employees and provide a healthy and safe working environment. With today's level of awareness on passive smoking it would be difficult for any employer to argue that they are not in breach of these duties by not prohibiting smoking at work in all areas except for specifically designated places where non-smokers have no reason to enter.

This Bill will impact on a range of UNISON Scotland members, both in regard to providing them with a healthier workplace but may also place some in danger of committing a breach of two of the offences described in the Bill. These are permitting smoking in a regulated area or a failure to display signs indicating that smoking is not permitted. These offences are aimed at the owner, occupier, manager or any other person for the time being in charge of the regulated area as well as the owner, manager or any other person for the time being in charge of the food operation in the regulated area.

UNISON Scotland would like further clarification on the definition of a person 'for the time being in charge' of either the regulated area and/or food preparation in the regulated area, in order to ensure that all staff are aware of their duties and responsibilities under this proposed legislation.

UNISON Scotland also has concerns in the case of venues let out to the public. In this case we believe that the person hiring the premises (community halls etc) should be regarded as the person 'for the time being in charge' rather than local authority staff (i.e. hall keeper/ caretaker etc.). This could be achieved by having clear lettings policies that make this responsibility clear to anyone wishing to hire such premises.

We would also welcome some clarification on the role of employers, especially in regard to having some obligation to provide training to employees to ensure that they are aware of their responsibilities under this proposed legislation. We also believe that employers should be made fully aware of their responsibilities and the proposed penalties that they may be liable for under the proposed legislation in order that any corporate responsibility is not wholly thrust on individual employees.

Omissions

As mentioned earlier UNISON Scotland believes that all employees should enjoy a healthy and safe working environment. As such we would prefer sensible no smoking policies, drafted in consultation with safety representatives and branches, for all workplaces.

However in the context of regulated areas UNISON Scotland welcomes the general principles and aims of this Bill.

Consultation/ key concerns

UNISON Scotland believes that there has been adequate consultation on this Bill and that the call for evidence provides organisations and individuals with the opportunity to raise their concerns.
Practical Implications

As mentioned above, UNISON Scotland would like some clarification on who would be regarded under this Bill as the ‘person for the time being in charge’ of the regulated area and/or the food preparation in the regulated area. There may also be some concern for staff safety when requesting people to not smoke in regulated areas.

SUBMISSION FROM DR NEIL THOMSON

Dear Sir or Madam

Prohibition Of Smoking In Regulated Areas (Scotland) Bill - Call for Evidence By Health Committee

The WHO has estimated that there are approximately 1.25 billion smokers in the world with around one third of them living in developed countries. In many western countries around 1 in 4 adults smoke cigarettes. In Scotland 28% of the population smoke and smoking rates are slightly higher particularly among those with low incomes and in young adults.

Cigarette smoking not only causes great harm to the health of smokers in Scotland, but also through the effects of passive or secondhand smoking adversely affects the health of non-smokers. Some of the important harmful effects of passive smoking on non-smokers are:

- Increase the risk of chest and ear infections in children
- Makes it harder for asthmatics to breath
- Increases the risk of lung cancer and heart disease
- Acute irritation of the eyes and coughs

I would urge you to lend support to this Bill, which I believe is an important step to improving the health of the people of Scotland

With best wishes

Yours sincerely

Neil C Thomson
Professor of Respiratory Medicine
University of Glasgow

SUBMISSION FROM DR M R AL-SHAMMA

I am writing in support of Mr Stewart Maxwell, MSP for West of Scotland Bill regarding the prohibition of smoking in regulated areas in Scotland.

I am a hospital Consultant with an interest in respiratory medicine, and I see a lot of patients who have suffered from the consequences of active and passive smoking.

I am strongly in favour of the above bill.

M R Al-Shamma
Consultant Physician
SUBMISSION FROM WATER COOLERS

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Do you support the general principles of the Bill and the key provisions it sets out?
Are there any omissions from the Bill that you would like to see added?
What are your views on the quality of consultation, and the implementation of key concerns?
Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Dear Sir/Madam,

I am a director of a small business with bases of operation in Kelty and Inverness. We are principally concerned with the supply of Water Coolers and with Air Cleaning and Ventilation Systems.

The arm of the company concerned with Air Cleaning & Extraction is known as John A Buchans and we have been suppliers to the licensed trade in one form or another for approximately 15 years. This arm of the company provides turnover of approximately £300k and forms a quarter of the total company turnover. Currently this arm of the business employs six full time staff and two part time staff in installation, service, sales and administration roles. Implementation of this bill would result in the redundancy of all eight staff and impact severely on the viability of our company as a whole.

Obviously my professional interest would be best served by a recommendation for the installation of Air Cleaning and Extraction equipment to improve the air quality in public places. I feel list MSPs Mr. Maxwell and Mr. Gibson before him, have neglected to fully understand the impact on air quality that effective Electrostatic Air Cleaning and associated intake and extraction fans can provide. The AIR initiative (www.airinitiative.com) shows the possibilities for improvement without imposing draconian restrictions on our civil liberties or the unsustainable related costs to the licensed trade. I would urge you to contact me for a customer list, which you may use to survey those premises which have adequate air cleaning and ventilation as specified by the CIBSE (Chartered Institute of Building Surveyors and Engineers).

I feel the bill is skewed by research from pressure groups such as the often hysterical ASH, and while it accepts readily the findings of such organisations it dismisses outright research from commercial bodies which contradict these findings. As a soon to be new parent and proud Scot I am only too aware of the impact that smoking has on our collective health, but I am equally concerned about unwarranted government interference and the freedom to make our own choices as adults, I find it more than a little ironic that while every adult in Scotland has choice to enter a bar where smoking is allowed or not, we do not have the luxury of choosing List MSPs such as Mr. Maxwell and Mr. Gibson.

Without being flippant I cannot stress seriously enough, the impact this bill will have on the lively hood of my staff and myself and on the freedoms of Scotland's population. As a resident of the Highlands I have been witness to the gradual improvement in quality of hospitality service we provide to our tourists. To try to explain to a group of free spending Italian or Spanish Tourists that they are no longer welcome to enjoy the same freedoms they have at home when socialising is preposterous. Is this seriously the type of message we want to give to our visitors?

Mr Maxwell has provided examples of Companies such as Pizza Hut which have noticed no impact on their trade since implementation of a smoking ban but is this seriously an example which he hopes will apply to the average bar/restaurant. Establishments such as Pizza Hut are by their very nature fast food purveyors, most customers are in and out within an hour, and this is a time frame which would not trouble all but the heaviest smokers. Is Mr. Maxwell aware that the hospitality trade in Scotland aims to hold onto their customers for slightly longer than that? In providing a relaxed atmosphere where adults are able to enjoy adult pursuits, the licensee hopes his customers stay longer and spend more.

Air Cleaning and Extraction systems provide a realistic alternative to a ban where premises are not large enough to provide smoking and non smoking areas. A blanket ban will be catastrophic for
companies like ourselves and for the Licensed Trade. The Licensed Trade is one of Scotland's largest employers and raises considerable revenue for our National and Devolved Governments, why have their views been so readily dismissed by Mr. Maxwell. The Licensed Trade is not the enemy and deserves greater respect.

I would urge you to accept that responsibility for our own health and well being belongs to the individual. The proposed measures of this bill will not stop people smoking but they will empty our bars of paying customers.

David Traill

SUBMISSION FROM WEST DUNBARTONSHIRE COUNCIL

Do you support the general principles of the Bill and the key provisions it sets out?

All respondents answered: - yes

Are there any omissions from the Bill that you would like to see added?

Not supportive of exemption for beer gardens etc. Also for same reasons re sports stadiums, when food is being consumed for example on viewing terraces "we don't want someone's smoke contaminating our food". Sports stadiums should be entirely smoke-free, not just the food servery/sitting areas.

Would also like to see it extended to all areas of public buildings.

What are your views on the quality of consultation, and the implementation of key concerns?

Would be worthwhile for those who feed back on consultation questions to see the outcomes of their contributions. A 'post' consultation summary stating what may be considered for change, or future action, in reflection of the consultation.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Would like to see provision for enforcing authority to take action based on corroborated report from public as per e.g. Civic Govt (Scot) Act.

SUBMISSION FROM THE WINDSOR TAVERN

Presently I have a public house with a non-smoking area, though there is no provision for food and not for the immediate future. My customers and my staff are of the understanding that a separate non-smoking area is sufficient and fair to the minority of non-smokers that I have in my pub. Personally if I thought it would generate custom then I would have made my pub non-smoking a long time ago!

A smoke free pub would have a detrimental effect on my business and profits. This would result in less staff employed and a dramatic loss of earnings I would not see a long-term future for myself trading in a pub that offers only wet sales to customers.

My customers leave their houses where, probably, they do not smoke or drink and visit their local pub to have a drink and smoke in a relaxed social atmosphere. To take this luxury away will just fuel resentment towards my staff and I, and a growing disappointment in the system as a whole.

Additionally, I think the proposed fines are excessive and a huge step in the wrong direction. Such a move is just another way for our Scottish Parliament to generate income through indirect taxes.
The practical alternative solution is self-regulation. As a Licensee I deal and confront a number of overwhelming situations i.e. intoxicated persons, drug possession and offensive weapon possession to name but a few. I work closely with my local constabulary. My staff and I would not like to find ourselves in pointless confrontations with customers. An approach towards a customer who I may refuse to extinguish a cigarette, could result in a scenario of ejecting that customer from the premises even though no-one was offended by their actions! Through self-regulation I have implemented measures to conform to a well ventilated pub with a non-smoking area. I have installed air-purifiers also. I don’t believe that customers leave my pub because of excessive smoke.

I listen and cater to my customers needs and that has proved essential in the smooth running of my business. The customers voice must be heard. The majority do not want a smoking ban!

I thank you for taking the time to read my letter and hope a decent and acceptable policy is decided.

Scott Padden

SUBMISSION FROM DR KIA SOONG TAN, CONSULTANT CHEST PHYSICIAN, WISHAW GENERAL HOSPITAL

Do you support the general principles of the Bill and the key provisions it sets out?

I think it is vitally important that we reduce smoking in Scotland. I see many patients whose health has been blighted by smoking. Although it has taken a long time to recognise the ill-effects of smoking on health, the side-effects of second-hand smoking are only just realised. It is estimated that secondhand smoke accounts for about 1000 deaths per year in Scotland. In addition, secondhand smoke can exacerbate those with asthma or other chronic respiratory condition. Importantly, secondhand smoke adversely affects the health of children. For example, secondhand smoke causes asthma, bronchitis and pneumonia in children.

Are there any omissions from the Bill that you would like to see added?

I would prefer to see a Bill which covers all enclosed public spaces, not just those where food is served. People who work in public houses and nightclubs where food is not served will still be forced to work in smoky atmospheres and suffer the consequences.

What are your views on the quality of consultation, and the implementation of key concerns?

It is important that the consultation should be as far-reaching and inclusive as possible. It is vital that the Bill should be sufficiently detailed to avoid potential loop-holes.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Unfortunately, air-conditioning and air filtration systems are insufficient to deal with secondhand smoke. Segregation of smoking and non-smoking areas has to be properly done so as not to allow for contamination of non-smoking areas.
Delegated powers scrutiny: The Committee considered the delegated powers provisions in the following Bill—

the Prohibition of Smoking in Regulated Areas (Scotland) Bill at Stage 1

took evidence from Stewart Maxwell, the member in charge of the Bill,

and agreed to consider the Bill further.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

The Convener: For item 2, delegated powers scrutiny of the Prohibition of Smoking in Regulated Areas (Scotland) Bill at stage 1, we have with us Stewart Maxwell, the member in charge of the bill—he is a member of the committee, of course. He is happy to answer questions on the bill.

There are three powers in the bill with which we are concerned. The bill aims to prevent people, including children, from being exposed to the effects of passive smoking in certain public areas, and specifically in areas where food is supplied and consumed.

The first power is mentioned in section 1(4), and allows the extension of the prescribed period—the period during which smoking is prohibited in a regulated area prior to food being consumed there—from five days. The order-making power is subject to the affirmative procedure; the question is whether that is adequate.

Christine May (Central Fife) (Lab): Although I am content for there to be a power to extend the prescribed period, I wonder if legislative good practice should also allow for the ability to restrict the period, subject to changing scientific evidence, for example. I am aware that this might be straying into the policy elements of the bill. Would it not be better practice to allow for the prescribed period to be changed and to leave it at that, rather than specifying either extension or restriction of the period?

The Convener: We will take on board members’ points and then ask Stewart Maxwell for his comments.

Gordon Jackson: It is up to Stewart to tell us what he thinks, but I think that we are straying into policy matters. That is an easy thing to do with this bill, as we all have quite strong views about its policy—some are for and some are against. It does not seem particularly unusual to fix the prescribed period at a minimum by statute, but for the power to change the period to come under subordinate legislation. There might be a policy decision to be made about whether five days is the right period with respect to the scientific evidence but, subject to what Stewart Maxwell has to say, I cannot see much wrong with the provision being subject to the affirmative procedure. We will come to other regulations in the bill where I do have objections, but it seems normal to use the affirmative procedure for the provisions under section 1(4).

Alasdair Morgan (South of Scotland) (SNP): I agree with Gordon Jackson. It is not a totally analogous situation but, in cases where there is a power to vary fines, for example, the powers are always to increase them; we do not usually have powers to decrease fines. The starting point is set according to the policy decision; subsequently, such things tend to get varied upwards.

Mike Pringle (Edinburgh South) (LD): I would not have put five days for the prescribed period; I would have put a longer period. I would not want it to be reduced. If we are going to extend the period from five to 10 or 15 days, I would be all in favour of that. I would certainly not be in favour of reducing the period to less than five days. Having the power to extend the period is the right way forward.
Murray Tosh (West of Scotland) (Con): The point about the five days is a policy point. I do not think that Christine May was arguing that the time should be reduced; she was arguing that there should be the facility to reduce it, in the light of changed scientific analysis. It might also be that better ventilation would allow the period to be safely reduced. It is not so much a question of whether the period will actually be reduced; it is a question of whether the facility to do that should be in the bill, and of whether there should rather be almost a presumption that the time can be lengthened, but not changed the other way; that seems a bit unusual.

The Convener: Being a former science teacher, I can see the point that members are making. The scientific evidence might change. I invite Stewart Maxwell to respond to those comments.

Mr Stewart Maxwell (West of Scotland) (SNP): This is effectively a policy matter for the most part. We have chosen a five-day period; we could have chosen a shorter or longer period but, based on the scientific evidence and the average room size, average furnishings and so on, that judgment seems to be legitimate. As I said, that is all about policy.

On the question whether an allowance should be made to shorten the prescribed period, I take Alasdair Morgan’s point about it not being unusual to have provisions in primary legislation that start from a base point, which may be moved onwards, upwards or higher, rather than moved back the way. I can say with a fair degree of certainty that if there is evidence in future to say that smoking, passive smoking or the inhalation of any of the substances involved will become less dangerous. We know that smoke lingers in the atmosphere and is absorbed by materials in a room and can subsequently reappear in the atmosphere. We also know that ventilation does not deal with that problem. Therefore, it seems entirely appropriate to draw a baseline of five days. As we have agreed, that is a policy matter, but a baseline of some sort should be established.

If there is evidence in future to say that that five-day period is inadequate, and that smoke in fact lingers for longer, then the regulatory power is there to extend that prescribed period to ensure that people are protected from the dangers of passive smoking. It is entirely appropriate to draw a line in the sand and say that that is the minimum period.

The Convener: The committee feels that section 1(4), which provides for secondary legislation to be made under the affirmative procedure, is the normal way in which to proceed in such situations. However, the measure is also a policy matter and is dependent on scientific evidence. There is concern that the period of five days has been chosen and that that might not be the required number of days in future, perhaps because of better ventilation. The period could be shortened rather than stretched out—we do not know. I suggest that the lead committee on the bill should discuss the matter. Are members content with that suggestion?

Members indicated agreement.

The Convener: I am looking at Alasdair Morgan because he argued for the measure.

Alasdair Morgan: I am sure that the lead committee will discuss the matter anyway.

The Convener: We move to the more controversial order-making power in section 2(1), which allows the definition of the term “regulated area” to be altered. At the moment, the term relates solely to enclosed public spaces where food is supplied and consumed, but section 2 gives the Scottish ministers the power to amend the definition so that the term applies to other areas. However, the power cannot be used to remove any of the areas that the bill covers. Any order would be subject to the affirmative procedure. The legal adviser has pointed out that the power would extend to amending the definition of the term “public space” and removing the exemptions in schedule 1. We must take on board those points.

Do members think that the power and the use of the affirmative procedure are appropriate or do changes need to be made to the bill?

Christine May: The first line of the bill refers to “smoking in regulated areas”, but at that point it does not refer to public areas. Therefore, it is at least in theory possible for ministers to make an amendment under which any area could be regulated, including my house or other private or public areas. That is far too broad a provision. If the first line mentioned “regulated public areas”, the issue would not arise.

The Convener: The legal advice is that the power is very wide.

Alasdair Morgan: I tend to agree. No matter how one looks at the issue, the power is broad and it goes beyond what one might expect on a first reading of the bill. The fact that the area that the bill covers can be extended simply by order to include other areas that might not even be premises, but might be outdoors, raises serious questions, albeit that that would have to be done under the affirmative procedure.

Murray Tosh: I agree with those points. This may be more of a policy issue, but it seems that the enthusiasm on the part of the bill’s promoters is impelling them faster and with more momentum than we would have expected if no-one had any
emotional or intellectual capital invested in the issue.

Mike Pringle: I am interested to hear what Stewart Maxwell says.

10:45

Mr Maxwell: The power in section 2 is the crux of the bill. I accept that the situation is unusual in that we are in danger of straying into the policy or principle of the bill, which is to create a power to allow further regulated areas to be created. The bill will create one regulated area, but the main purpose is to establish the principle that the Parliament accepts that smoking can be regulated or prohibited in certain enclosed public areas.

The policy memorandum makes it clear that it is not the intention that outside areas such as beer gardens be included—they are certainly not included in the bill as it stands. It is unlikely that the exemptions in schedule 1 would be removed because that would raise issues under the European convention on human rights. In several of the exempt areas, particularly state hospitals and prisons, people do not have the liberty to choose to go to another place. Given that people have that liberty elsewhere—they can choose to smoke outside or in their home or car—there may be an ECHR issue in removing the right to smoke of people who are locked in one area and are unable to move. It is unlikely that those exemptions would be removed.

The Henry VIII power is wide in the sense that other regulated areas can be created. As I said, that is a policy matter and if the Parliament agreed in principle that smoking should be regulated in public places, it would be entirely appropriate to use that power. However, the power is narrow in the sense that it does not apply to other legislation, but purely to the bill. Many Henry VIII powers that the committee has seen allow ministers to change measures in a range of different legislation, whereas the present power relates only to this one bill. Any order would have to be considered under the affirmative procedure. The bill also constrains ministers in that they must—not may—consult with appropriate bodies. There are safeguards—people will be consulted and any order must go through Parliament under the affirmative procedure.

Given that in anti-smoking legislation round the world, and in other legislation here, an incremental approach is taken, the bill is entirely appropriate and fits into that overall approach. We will start with the principle and lay down the first regulated area, which in future can be extended to new regulated areas. It is entirely appropriate to use subordinate legislation to do that because if the original principle or policy is accepted by the Parliament, the regulated areas can be changed as and when that is deemed appropriate, with the safeguards of the affirmative procedure and the consultation that must take place.

I do not accept that there is a problem with the power, which is appropriate and is in line with the bill’s policy intention. I reject the wilder suggestions that the bill could be used to create a non-smoking area throughout the whole of Scotland. That is clearly not the intention—that would fall outwith the scope of the bill and it would not be done.

Alasdair Morgan: I accept the argument that the bill aims to regulate smoking and that once that power has been created, it is perfectly logical that ministers should be able to vary the regulated area. However, I am concerned about Stewart Maxwell’s argument that it is not the intention that the bill be used to extend the regulated area to open spaces or whatever. My response is that if that is not the intention, why do we not simply alter the wording so that not only is that not the intention, but it cannot actually be done. That would be a much happier position at which to arrive.

Christine May: Whatever the intention is, we must be careful that the bill does not give such a wide opportunity to somebody who is less well intentioned than the current ministers are.

Section 5(5) lists those who must be consulted, which is an issue we may discuss further later. If none of the prescribed bodies were to exist any longer, we would be left with “such other bodies as the Scottish Ministers consider appropriate” and it might be deemed appropriate to consult with no more than a couple of chosen bodies, so the consultation provision would become almost null and void, almost irrelevant. The power is too wide, and Alasdair Morgan’s suggestion that there should be a slight amendment to the bill to prevent such circumstances makes legislative sense.

We should forget about whether the policy is right or wrong and whether we support it or not—as a reformed smoker, I do—because we are about making good laws and eliminating the potential for malign beings to do things that were never the intention of the bill’s promoter or of those currently in office.

Mike Pringle: If we ignore the ministers’ role, although they would have a vote if an order were to come before the Parliament, we are saying that we might end up with 129 malign people. I have no problem with the power; it has to come before the Parliament through the affirmative procedure and, if it has to be changed, it must go before the Parliament again. If a majority in the Parliament at
some point in future wishes to extend the regulated areas, that is democracy, and I suggest that the affirmative procedure is the right way forward. I am more than happy with that aspect of the bill and am very much in favour of the bill—I hope that it will become law. If we wanted to change it in any way in future, the affirmative procedure would mean that the proposed change would have to go before the 129 members of the Scottish Parliament, who would decide whether it was right or wrong.

Murray Tosh: That is a romantic view of how secondary legislation works.

The Convener: There speaks the Deputy Presiding Officer.

Murray Tosh: Secondary legislation is take it or leave it. There has been debate about whether to pass some secondary legislation, which has been passed because members liked 80 per cent of what was in it and were prepared to swallow the other 20 per cent. That is always the risk with secondary legislation.

I do not know enough about the sweep of secondary legislation to question the analogies, but the power is not like the National Parks (Scotland) Act 2000, which wills a national park and under which we bring in a series of variations on a central model. The power has more of a ratchet effect—I realise that that is a policy objection—because, if it were used, the provisions would advance further and include more categories. If that is the intention, it should be clear in the bill.

I am a non-smoker and I signed Kenny Gibson’s proposal for a bill to regulate smoking in the first session of the Parliament, but I will vote against Stewart Maxwell’s bill in this session. I am grateful to Stewart Maxwell, the quality of whose argument I appreciate, because he has clarified for me why I will do that: the power goes too far. The intention should be spelled out more clearly, and there is an intention to introduce measures beyond those that public opinion supports.

The legal briefing makes the point that extending the regulated areas will be controversial, which is right. Debate is likely to be squeezed out if the power is used—as other legislation has been—to convey unacceptable or contentious issues through behind something that will, on balance, be supported. The point is not whether malign people will do that, but whether we want to subscribe to the use of delegated powers to allow a policy objective to ratchet up the measures that are proposed in the bill.

Mr Maxwell: Some things must be put straight. Murray Tosh is surprisingly incorrect in his comments, and I thought that he would know better. Mike Pringle is right that, when an affirmative instrument comes before the Parliament, it is for the Parliament to decide whether to accept or reject it; that is democracy.

Murray Tosh: But the Parliament cannot amend such an instrument.

Mr Maxwell: You were here through the first session, Murray, and if you have a problem with that, perhaps you should have introduced proposals to amend the procedure.

On a number of occasions, committees of the Parliament have rejected affirmative instruments—the Justice 1 Committee has rejected the same one twice. Given that the affirmative procedure has that level of protection and that we have experience of affirmative instruments being passed and rejected, it seems to me that, once we accept the principle of creating non-smoking areas—or regulated areas, as they are called in the bill—that is an entirely appropriate level of scrutiny.

To talk about going beyond what is publicly acceptable or supported is also incorrect: because it has taken us a year to reach this point, the bill is now way behind public opinion on the matter. The bill would ban smoking in places in which food is consumed, which is supported by just short of 90 per cent of people according to all the surveys and opinion polls that I have seen. Opinion on banning smoking in public and other areas more widely is in the region of 77 per cent to 90 per cent. There is no problem with the level of support, so Murray Tosh is incorrect to say that we are going beyond what is publicly acceptable.

I return to the use of the affirmative procedure for the power to extend the regulated areas. Christine May talked about ministers who are less benevolent than the current Executive using the power, but the power will not be exercised by ministerial diktat. Ministers will be able to introduce measures, but the Parliament can reject them, and, as I have said, that has happened in the first five years of the Parliament’s existence. The suggestion that ministers could force a majority of the Parliament to pass legislation that is against the public interest, that the public do not support and that is against normal human rights does not hold up. The power will not be exercised by ministerial diktat, but by an order being laid before the Parliament, discussed in the committees and voted on in the Parliament. That is what the affirmative procedure means, and, if we accept the principle of introducing new regulated areas—we are straying into policy—the affirmative procedure is entirely appropriate.

The Convener: I will make a suggestion again. As most of us, apart from Mike Pringle, feel that the powers are too wide, we have two alternatives: we can wait for Stewart Maxwell to
mull over what we have said and come back to say more about it; or we can write our report to the lead committee fairly rapidly and pass on our concerns. I gather that there is no hurry for us to report to the lead committee, so if committee members wanted to, we could leave the matter for a while, see how the debate about the bill develops, come back to it when we know a little more of Stewart Maxwell’s ideas and make our final report.

Murray Tosh: Is there any point in that, convener? What we have heard from Stewart Maxwell shows a level of commitment that makes me think that he is unlikely to wish to reflect on what we have said this morning. It is an object lesson in how absolutist approaches slough off support at the margins.

Mr Maxwell: I will not comment on that. It is entirely appropriate for me to come back to the committee in a week or two, because there is time.

I did not cover Alasdair Morgan’s and Christine May’s comments about the intention versus the actuality, although I should have done. It is not the intention to invade private space or regulate open spaces. Even though Murray Tosh thinks that I am absolutist, I would be more than happy to consider the comments on such spaces. The arguments have merit, and I would certainly consider supporting any amendments that were lodged to deal with that issue and restrict potential extension to enclosed public spaces of the kind about which I have been talking. I do not support restrictions in, for example, the open air, private homes or private vehicles, and that is not the policy intention, so if the bill requires amendment on that, I am open to considering it.

Alasdair Morgan: Those comments are helpful—in their light, we should leave the matter for a couple of weeks.

The Convener: We are agreed that we will leave the matter until a little further down the road. Thank you, Stewart.

Murray Tosh: He just needed a nudge.

11:00

The Convener: The third issue is the signage requirements in section 5(4). The legal advice is that that section is perfectly adequate; our only concern is that if the definition of the term “regulated area” were to be extended, some of the bodies in the list in section 5(5), which Christine May mentioned earlier, might not be appropriate and others might go out of existence. Alasdair Morgan had another point.

Alasdair Morgan: It was about the potential ephemerality—if that is the right word—of some of the bodies on the list, given that they are not statutory bodies. However, in the great scheme of things, that is not a major problem.

Mike Pringle: I have a question on a completely different point. In section 6, which deals with penalties, Stewart Maxwell has chosen a level 3 fine on the standard scale. My understanding is that that means a fine of up to £1,000. I would like to know why he chose level 3 and not a higher level.

The Convener: We can ask Stewart Maxwell about that, but that really is a policy matter.

Mike Pringle: Okay. I will speak to him after the meeting.

Christine May: The points that the convener made about the list in section 5(5) are relevant. However, the matter is one of policy and is for the lead committee. I am not sure whether it is appropriate for our report to raise such matters with the lead committee, but, if not, I am sure that Stewart Maxwell will take our comments on board.
Present:

Dr Sylvia Jackson (Convener)               Stewart Maxwell
Christine May                             Alasdair Morgan
Mike Pringle                              Murray Tosh

Delegated powers scrutiny: The Committee considered the delegated powers in the following Bill—

the Prohibition of Smoking in Regulated Areas (Scotland) Bill at Stage 1

took evidence from Stewart Maxwell, the member in charge of the Bill, and agreed the terms of its report.
Scottish Parliament

Subordinate Legislation Committee

Tuesday 25 May 2004

(Morning)

[THE CONVENER opened the meeting at 10:30]

Delegated Powers Scrutiny

Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

10:32

The Convener: We return to the Prohibition of Smoking in Regulated Areas (Scotland) Bill at stage 1. Stewart Maxwell is with us as both a member of the committee and the member in charge of the bill. Members will recall that the committee questioned whether the bill potentially made it possible for a ban on smoking to be imposed in almost all public areas. Stewart Maxwell was to take the matter away for consideration and return to us with his response, so I hand over to him.

Mr Stewart Maxwell (West of Scotland) (SNP):

It is my intention to lodge an appropriate amendment effectively to debar private places from the scope of the bill, so that a private space could not be created as a regulated area. Any private space would be protected and further primary legislation—a separate bill—would be needed to change that. Following amendment, the power under section 2(1) could not be used to regulate somebody’s home, car or other private space.

The main concern on the part of the committee—and rightly so—was that the power under section 2(1) as drafted could effectively allow private places to be regulated. For instance, somebody’s car, home or other private space could potentially be regulated. Obviously, that is not the policy intention. I am happy to accept the comments that the committee made on 11 May.

The Convener: Could you elaborate on the example of a hotel bedroom, which we considered the last time we discussed the matter? Secondly, could you clarify your stance with regard to more open public spaces, rather than enclosed public spaces?

Mr Maxwell: I checked the position on the example of hotel rooms, about which there was some dubiety. I have received clarification on the matter from lawyers, and I understand that hotel rooms would be considered as private spaces. Once they are hired out, and guests have a key to their lock, they become a private space, so they would not be caught under the bill.

Murray Tosh (West of Scotland) (Con): Would a hotel’s function suite or meeting room also be considered to be a private space, or would it constitute a public space?
Mr Maxwell: I think that such rooms would constitute public spaces, but I reiterate that a hotel bedroom would be exempt. It could not be included as a public space under the bill.

On open spaces, there is a clear distinction between an “enclosed public space” that is completely enclosed, such as this room, and places that are wide open. There is no policy intention to create restrictions or regulated areas in wide open spaces. There are places that fall between the two, which the bill does not cover. At the moment, a regulated area could not be created for somewhere that is partially enclosed. As is mentioned in the policy memorandum, a beer garden that was attached to a premises, or that was located outdoors and next to regulated premises, would not be included. Whether or not such places would be included at some point in future would be a matter for the Parliament to take up.

Christine May (Central Fife) (Lab): As one of the members who was concerned, I welcome what Stewart Maxwell has told the committee this morning. Obviously, we will want to see the precise terms of the amendment but, if it lives up to the spirit of what has been said this morning, I imagine that the committee will welcome it and—without wishing to pre-empt a decision—would recommend that it be agreed to.

Alasdair Morgan (South of Scotland) (SNP): We must report on the bill as it is, having heard what Stewart Maxwell has said. We will not see his amendment before we make our report, but we welcome the clarification that it is intended to make at stage 2.

The Convener: Is it agreed that we will report to the lead committee on that basis?

Members indicated agreement.
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

17th Meeting, 2004 (Session 2)

Tuesday 1 June, 2004

Present:

Ms Wendy Alexander          Mr Ted Brocklebank
Fergus Ewing (Deputy Convener)    Kate Maclean
Des McNulty (Convener)        Jim Mather
Dr Elaine Murray            Jeremy Purvis
John Swinburne

Also present: Mr Stewart Maxwell MSP

Prohibition of Smoking in Regulated Areas (Scotland) Bill: The Committee took evidence on the Bill’s Financial Memorandum from—

Stuart Ross, Chairman of the Year, and Colin Wilkinson, Secretary, Scottish Licensed Trade Association; then

Colin Cook, Head, Substance Misuse Division; Mary Cuthbert, Alcohol and Smoking Team Leader, and Calum Scott, Economic Adviser, Analytical Services Division, Health Department, Scottish Executive; then

Mr Stewart Maxwell, MSP, Member in Charge; and David Cullum, Clerk, Non-Executive Bills Unit.

The Committee agreed to seek written evidence from the Scottish Beer and Pub Association in advance of its consideration of its draft report.
The Convener (Des McNulty): I welcome members of the press and public to the 17th meeting this year of the Finance Committee. As usual, I remind people to switch off all pagers and mobile phones. I think that Wendy Alexander and Jeremy Purvis will be joining us a bit late.

I welcome our first set of witnesses, who are from the Scottish Licensed Trade Association: Stuart Ross is the chairman of the year and Colin Wilkinson is the secretary. I will give Stuart Ross the opportunity to make a short statement, if he wishes to do so. We will then move to questions, if that is okay.

Stuart Ross (Scottish Licensed Trade Association): Thank you for giving us the chance to be here to give evidence. I apologise to the committee for the fact that we were unable to provide a written submission in advance. We have prepared some material that we would like to present to you now and perhaps read through with you. Would that be okay?

The Convener: I would prefer it if you did not read out the whole submission; it would be helpful if you could summarise it. Our general practice is that we do not take read-out versions of submissions on the day.

Stuart Ross: I will do that. We are here to represent the Scottish Licensed Trade Association, which has a membership of 2,200 licensees. Most of our members are self-employed business people who are engaged in trading in pubs and hotels, but we also represent restaurateurs, club owners and take-home operators.

As you said in your introduction, convener, I am the chairman of the year, which is akin to a non-executive role on the board of directors of a company. I am also chief executive of the Belhaven Group plc—Scotland’s largest regional brewery—the turnover of which is in excess of £100 million per annum and which has an estate of 240 pubs and more than 1,400 members of staff. I have been able to use my Belhaven experience to help the SLTA to prepare its submission. We are endeavouring to address the bill’s financial implications, not just for the SLTA’s membership, but for the wider field of the entire Scottish licensed trade, which includes sports and social clubs. I am joined by Colin Wilkinson, who is the association’s secretary and the pivot of member services and administration, which are based in the west end of Edinburgh.

Our approach to the bill has been driven by three key questions. How would the trade react to the bill? What would be the capital cost of providing non-regulated areas? What would be the on-going annual revenue cost to the trade of compliance with the bill? The four options that we identified are listed in our submission. From our experience and from discussions with our members, we have concluded that, in licensed outlets that already have segregated areas, food would be served in one area, which would become regulated, and the other area would become a non-regulated area in which smoking was permitted. However, most premises do not have the segregated areas that the bill demands. We believe that, where practical, licensees would want to create such areas, to enable them to have a regulated area and a non-regulated area.

In the submission, we have tried to do the arithmetic on the capital cost of providing segregated areas and the on-going cost of running two bars instead of one—which, in effect, is what would be necessary. We calculate that, for the 5,000 of the 11,500 on-premises licensed outlets that would be affected, the capital cost would be £85 million. We used many guesstimates and estimates to determine that figure. We in Belhaven conducted research in 38 of our outlets and found
that, in seven of them, it would be impossible to comply with the terms of the Maxwell bill.

The creation of a segregated area and a separate bar brings into play many issues, one of which is whether the licensee could supervise the business effectively, in compliance with the Licensing (Scotland) Act 1976. We estimate that, in half the cases, a bar would have to be provided in the segregated area to enable supervision. That puts up the capital cost by quite a bit.

All the figures that we have prepared are clearly laid out in table 1 in our submission. Members might well question some of our assumptions—everyone has their views on these things—but, based on our review of our businesses, those are the sort of percentages that we think would apply.

As for the on-going running costs, by far the biggest cost in the provision of segregated areas is that of additional labour. The capital cost works out at a one-off figure of £85 million. Our calculation of the recurring costs is about £110 million, which, as I said, is mainly in additional labour costs.

We do not agree with the assumption that is made in paragraph 63 in the financial memorandum to the bill. The member in charge of the bill is clearly of the view that no adjustment in the manner that we have suggested would need to be made to licensed premises and we think that that is an unrealistic line to take. Because licensees would not want to lose trade, they would simply create segregated areas. If the licensees did not respond in that way, in effect all that the bill would do would be to create a divide in Scottish licensed trade premises between wet-driven smoking pubs and food-driven non-smoking pubs.

I am not sure whether that is the objective of the member in charge of the bill, but the reaction of the trade would not be as he suggests.

We have not had time to challenge the important assertion that is made in paragraph 66 in the financial memorandum, which states:

“There is also clear evidence from other jurisdictions that there will be no loss of trade costs to businesses.”

We would like to ask the committee through the convener whether we could be allowed further time to study paragraphs 29 to 37 of the policy memorandum, in which details supporting that assertion are given, and to respond with our views at a later date. Perhaps the convener could tell us how to get hold of those paragraphs, as they are fundamental to an assessment of the financial implications of the bill to businesses. Perhaps that evidence could be made available to us.

Although there is a lot of anecdotal talk about what has happened in places such as New York, Australia and Ireland, I have not seen much factual evidence. If there is any, the Scottish licensed trade would welcome the opportunity to study it. That sums up our preliminary statement.

The Convener: I do not understand why you have not seen the policy memorandum, as it is relatively freely available. On your comments about having further opportunities to submit evidence, the committee has to finalise its report at our meeting of 22 June. Any witnesses who wish to make further submissions can do so. That said, we would need to receive the evidence a good week before our meeting of 22 June so that it can be processed.

There is a huge gulf between what you and Stewart Maxwell are saying in respect of the financial memorandum. Can I just be clear about your view? One way of interpreting the information that is provided in your submission is that, at £85 million, the proposals under the bill represent a prohibitive cost for businesses. Another way of viewing it is to say that it represents an argument for going further than Stewart Maxwell’s bill by going down the route, which I understand has been taken by both Ireland and Norway, of a complete ban on smoking in licensed premises. What is your view of going further than the bill and having a complete ban? Obviously, the bill has been introduced, but it can be amended.

10:15

Stuart Ross: Yes. We thought that the committee might ask us that question. The financial repercussions of a total ban would depend on whether businesses held on to their custom. The exercise in that respect is quite different from the approach that we took in the preparation of our submission. Everyone has their own views on what the impact of a total ban on smoking in public places would be on trade. The SLTA has made a submission on the Maxwell bill and there are various other submissions, but we have serious concerns about the damage that would be done to the licensed trade if there were a total ban.

There is already a couch-potato syndrome in Scotland: 40 per cent of beer sales are through the take-home trade in Scotland, compared with 8 per cent in Ireland, so there is a much stronger pub-going culture in Ireland than there is in Scotland. What concerns our members is whether a total smoking ban would further exacerbate the trend towards take-home drinking. That is a massive issue, which we would have to address.

We must consider how such a ban would impact on individual members of the SLTA. In the wider trade, how would a ban impact on companies such as Belhaven, which are totally reliant on the on-trade for their profitability? Such an assessment is
a huge exercise and it is all driven by fundamental assumptions about what the impact would be on the top line and how that would fall through to the bottom line. That is why I am saying that it is important to get fact-based evidence from countries where smoking bans have been implemented. There is far too much anecdotal talk in the press and in various papers; it is vital that fact-based evidence is studied before submissions are formally made.

Dr Elaine Murray (Dumfries) (Lab): My first question relates to table 1 in your submission. It states that there are approximately 11,500 on-premise licensed outlets in Scotland. How many of those premises serve food?

Stuart Ross: It is estimated that 65 to 70 per cent of those currently serve food. Obviously 100 per cent of hotels and restaurants serve food, but on the pub side about 65 per cent serve food.

Dr Murray: I am slightly surprised that you suggest that people would opt to have very expensive adaptations done to their premises. I would have thought that the easiest thing would be either to decide not to serve food because people want to continue to have smokers on the premises or to ban smoking. Some preliminary results from Ireland were mentioned on the radio this morning. Those suggest that the trade in Ireland has increased, as more people are going out to eat because they know that they will not be annoyed by smoking.

Stuart Ross: As I say, I am not prepared to respond to anecdotal evidence. In relation to someone deciding to stop serving food in a pub, it is important to note that food represents about 20 per cent of turnover in public houses and that it drives quite a bit of the wet sales. If someone was to stop serving food, that would have a big impact on the bottom line. If such premises were to become regulated areas, pubs that serve food would lose their drink trade, which generally kicks in from about 8 o’clock in the evening. If they lost a lot of their drink trade to pubs that were non-regulated areas, they would lose commercial advantage. Those are the two reasons why we make the assumption that we would favour segregated areas. I cannot speak for 2,200 members of the SLTA, although Colin Wilkinson can perhaps touch on research that the association has done, but I can talk for Belhaven and say that that is definitely the way that we would go.

Dr Murray: People do not tend to stay in the same licensed premises all night. Is it not possible that people would go to the place that served food in order to eat food and if they wanted to smoke they would go on to somewhere else that allowed smoking?

Stuart Ross: You do not understand the time point, which I have just made.

Dr Murray: They would possibly move later on.

Stuart Ross: A lot of trading in pubs is done between 8 pm and closing time. If pubs that serve food did not have segregated areas, they would not be allowed to have smokers in their bars at night. People generally go out in crowds and about 60 per cent of pub-goers smoke, so the chances are that, in any crowd, those people will be looking for a pub where smoking is permitted. Therefore, the pubs that are not regulated would have great commercial advantage over pubs that are regulated. That is the simple answer to your question.

The Convener: You said that 60 per cent of pub-goers smoke. Where does that statistic come from?

Stuart Ross: From research that has been done.

Colin Wilkinson (Scottish Licensed Trade Association): We surveyed our membership of 2,200 on the specific question of the number of customers who smoke on their premises. The answer was that roughly 62 per cent of customers smoke.

The Convener: How did you conduct that research?

Colin Wilkinson: We asked each of our licensed trade members to provide a specific questionnaire to their customers.

The Convener: How did they make a judgment? Did your members poll the people in their bars?

Colin Wilkinson: It was a ballot of pubs. The results will be announced officially next week.

Kate Maclean (Dundee West) (Lab): Stuart Ross asked about the policy memorandum and when he would get a copy. The memorandum is not based on anecdotal evidence; it is based on studies that have been done, some of which are listed in the memorandum, so he will be able to get hold of them. The conclusion of the independent surveys was that the bill would not have a negative effect on trade.

Colin Wilkinson said that 62 per cent of people who go to pubs smoke, but that does not reflect the population as a whole. I imagine that the reason why fewer non-smokers go to pubs is that the atmosphere is smoky. Those people who could not have a drink without a cigarette might drink at home, but other customers who would not normally go to a pub or a restaurant where smoking is permitted because they find it impossible or obnoxious to sit in such places might go to pubs with non-smoking areas. The evidence is that there is no negative financial impact on
businesses in places such as New York, where there has been a ban on smoking in public places for some time.

It could be argued that, if pubs were to become non-smoking establishments or have non-smoking areas, there would be far fewer costs for maintenance, redecoration and damage to furniture and fittings from cigarettes and that that would balance up some of the additional costs of capital works that would have to be done. In that respect, there would be an on-going saving rather than a one-off cost. What are your comments on that?

Colin Wilkinson: You mentioned the situation in New York. We have heard about that survey umpteen times in relation to the hospitality sector, but there was no focus on the pubs that were affected by the ban. We have had discussions with the equivalent licensed trade association in New York and it reports that its customer numbers are down by 20 per cent to 30 per cent. However, we are focusing on the pubs that the Maxwell bill would affect. That is a different story from what one hears in the press about the survey that was done in New York.

Kate Maclean: In a country that wants to attract tourism, many people would think that pubs should also be part of the hospitality sector, albeit that they offer a different type of service from the service that restaurants offer. Non-smoking pubs might attract people who would not normally go into pubs because they do not like smoking.

Colin Wilkinson: In New York, licensed traders report that customer numbers are down by 20 per cent or 30 per cent. The individuals whom you mention have not been replacing the smokers.

Kate Maclean: Which survey do you refer to? I would like to look at it.

Colin Wilkinson: It was by the United Restaurant and Tavern Owners of New York. I have the details here.

Stuart Ross: Kate Maclean makes a couple of decent points. If we were talking about having a total smoking ban, there would be a clear divide. There is no doubt that pubs would not be as badly hit in the more enlightened parts of society and there is merit in the argument that there are potential consumers who do not currently go to pubs but would go to them if the atmosphere in them was less smoky. However, members probably know that smoking is more predominant in the deprived areas of the community.

I am a member of Tom McCabe’s working party on the tobacco action plan. At the previous meeting, Tom McCabe provided statistics that showed that around 43 per cent of people in the more deprived areas smoke, whereas, on average, the figure is 30 per cent. There is no doubt that the businesses that would be worst hit would be community bars in deprived areas, most of which would suffer huge losses. There are always net gainers and net losers with any piece of legislation, but the key questions are where they would be and how much they would gain or lose. Those questions are difficult to answer, which is why it is important for Scotland’s licensed trade fully to understand what the financial impact has been in countries in which total bans have been imposed and how that impact has been split between restaurant-type businesses for which there should be a net gain and bar businesses in community areas for which there will definitely be financial losses. Answering those questions is difficult—we are talking about crystal-ball stuff—but any fact-based evidence from other countries is welcome. I take the point that has been made.

I am not sure what is meant by cost savings in regulated areas. There would be a less smoky atmosphere and perhaps people would not have to paint places as often, but other than that I cannot see where any economic benefits would come from. Certainly, there would be atmospheric benefits, but the economic benefits are doubtful.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): The committee’s job is to consider the bill’s financial implications and not its rights and wrongs. As you know, that matter is for another committee.

Stuart Ross: That is what we have done.

Fergus Ewing: I appreciate that; indeed, the information that you have provided is extremely helpful. However, I am struck by the massive gulf between your evidence and Mr Maxwell’s evidence. Mr Maxwell says that there would be virtually no costs, but you have identified capital costs of £85 million and additional costs of £110 million for labour, energy and cleaning. I presume that those costs are per annum.

Stuart Ross: Yes.

Fergus Ewing: That is before any allowance for loss of trade is considered, the implications of which you have begun to consider. By contrast, Mr Maxwell rather optimistically states that there would really be no impact. There is a huge gulf in the evidence. I noticed that the capital figure of £85 million in table 1 does not include provision for additional fire escapes, which might be necessary.

Stuart Ross: That is right—that is mentioned in a note on the table.

Fergus Ewing: In addition, the figure does not include the cost of providing access or egress for disabled customers. If a new space must be created, it is likely that building regulations would require additional costs in such areas that would
fall to be considered on top of the other figures that you have provided. You seem to contend that the worst-hit premises would be working men’s pubs in small towns and villages in Scotland. If the capital costs per unit of £8,000—

**Stuart Ross:** May I intervene before you continue? Small community pubs would be worst hit only with a total smoking ban. Under the bill, the impact would be fairly neutral for them, as such pubs probably do not serve food anyway.

**Fergus Ewing:** I am grateful for that clarification. Let us consider premises that would require to decide what they should do and whether they should have only wet sales and should stop serving food, or whether they would want to continue with both in order to maintain the turnover if they have at least a substantial component from food sales. I want to consider the matter from the point of view of a small pub that wants to continue to serve food. You have set out capital costs of around £8,000 per unit for creating a non-regulated area and ventilation costs of £4,000 per unit, before extra labour costs are considered. Am I right in saying that many small pubs are, frankly, finding it difficult enough to survive and operate profitably and that, if they face those extra costs, they may well be forced to close their doors? If so, can you give us any quantitative evidence of how the members of the SLTA might be affected?

10:30

**Stuart Ross:** Those are good questions. In table 1 of our submission, we have listed the number of licensed outlets in Scotland by type. We have made the assumption that most leased tenanted pubs and managed pubs, which are generally owned by multiple plc-type companies, will try to adapt and will have the financial resources to do so. We have made a much more modest assumption about the number of independent pubs that would provide segregated areas for the reasons that you have stated: because they cannot afford it or because they are too small to justify it. It is difficult for us to say that the figures in our submission are accurate. We state that we can use only our best estimates—indeed, guesses—and you will appreciate the fact that we had only a short time between our being asked to study the matter and our reporting on it today.

**Fergus Ewing:** You have provided detailed figures in a short space of time. We appreciate that. You should also have had a chance to look at paragraphs 29 to 37 of the policy memo, which cover the comparative evidence from other countries.

I would like to pursue the effect of the bill on small, independent pubs. Since the bill’s publication, have you conducted a survey of your members to find out how the bill will impact on them? If not, might you want to do that to assist the committee in determining as best we can—bearing in mind the fact that it will be a forecast—how your independent members with smaller licensed premises who wish to continue to provide food as well as wet sales will be affected by the bill?

I agree that the committee should not pay heed to anecdotal evidence when we are trying to assess the impact of the bill on businesses, which is the main aspect of the bill. I do not think that we should be listening to anecdotal evidence from the radio, who we spoke to last or what some newspaper says about what might be happening in Ireland. It would be very helpful to us if you could, perhaps through a survey, elicit what the specific impact of the bill will be on your members. I am sure that, at some point in the debate, that information would be of immense value to the Parliament in its consideration of the bill.

**Colin Wilkinson:** We would be happy to survey our members on that. From speaking to them, we know that if they cannot afford to change their premises to suit the conditions that are proposed in the bill, they are faced with the choice of losing the 20 to 25 per cent of their turnover that is based on food, or losing the 65 per cent of their customers who are smokers. Any business that faces a loss of 20 per cent of its turnover becomes unviable in today’s climate.

**Fergus Ewing:** There seem to be quite a lot of pubs in Scotland that have a lounge bar and a public bar, with the bar serving area common to both. As I understand it, such an arrangement would not comply with the bill’s requirements and there would need to be segregation. However, if an amendment to the bill provided that premises with separate public and lounge bars, but a common serving area, would not fall foul of the bill, that would, at a stroke, lessen the impact of the bill while allowing one of those areas to be non-smoking. Do you agree that common sense would dictate that we should at least explore that option? If so, could the proposal be put to your members to see whether, if an amendment to that effect were introduced, that would satisfy a reasonable proportion of them?

**Stuart Ross:** Yes. Such an amendment would be welcomed. Everybody has their view on what should be done to improve the health of Scotland—especially regarding the comfort of non-smokers in public places. Everyone in the Scottish licensed trade agrees that we want to move towards a healthier, smoke-free Scotland; however, the question is how we can ratchet in
that direction without impacting hugely on commerce. Obviously, we have a vested interest in that because, after all, we do not want our businesses to be knocked for six. Who would?

As I have said, we support the idea of a smoke-free Scotland and Stewart Maxwell’s bill is a good piece of legislation that I think would find broad support in the trade. I should point out that, when I say that, I am not really speaking for the SLTA but for Stuart Ross of Belhaven. I do not know whether that is the case in the SLTA, because I have not really researched the matter. However, if the bill prohibited smoking when and where food was served, that would be a good step towards a smoke-free Scotland and would send smokers the message that they have to cut back on their habit.

That said, although the bill is not a bad idea, it is overly prescriptive. The problem for the Scottish licensed trade is that any sudden ban or action would have a financial impact. Although we must find ways of improving Scottish people’s health, we must do so in a sensible and orderly way. In that respect, I would use the word “ratchet” to describe the kind of approach that we should take. One of the ways in which we could do that would be to amend the bill to ensure that smoking is prohibited where and when food is served and to forget the five-day prescribed period set out in section 1(4).

The Convener: Expanding on Fergus Ewing’s point, I think that it would be useful to get financial projections that were as well founded as possible on the parameters within which legislation might be made. After all, members must take into account financial issues and issues of principle in considering how the bill might proceed.

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): I think that we all understand the cost implications that Stuart Ross has outlined. Indeed, the difference between his figures and the figures that Stewart Maxwell provided is staggering.

As Mr Ross has mentioned, however, we must take into account other costs, such as those to the nation’s health. I am talking not only about customers in pubs being affected by passive smoking; bar staff and the people who work in those establishments also face health problems. For example, according to the Royal College of Physicians, passive smoking raises the likelihood of someone contracting lung cancer by up to 20 per cent and of someone having acute coronary events by up to 35 per cent. That evidence is not anecdotal. We need to address those problems in some shape or form.

Should legislation not emphasise creating segregated areas for smokers instead of creating such areas for eaters? In other words, the norm should be that people can enjoy a meal and have a glass of wine in a smoke-free environment instead of trying to find an air-conditioned corner in a place full of smoke. Is the emphasis wrong? Should you not take that approach into account when you assess cost implications?

Stuart Ross: I agree. Indeed, we have done precisely what you have suggested and have said that there should be segregated smoking areas. However, I can speak about only Belhaven pubs. If you are asking me about my vision in that respect, I think that any segregated area would be a smaller area where smokers can go. We have to ensure that we do not alienate those people, but also that we improve the comfort and lot of the principal bar staff and the main body of customers.

Mr Brocklebank: Again, you mentioned anecdotal evidence. It is still early days to talk about New York and Ireland, because the ban on smoking was introduced there only relatively recently. However, it is in your interests to examine the activities of chains such as Pizza Hut, which decided a year or 18 months ago to have a total no smoking policy. The evidence should be starting to come through about how well Pizza Hut is doing compared with competitors such as Pizza Express. Clearly, you are interested in getting that from your members’ point of view.

Stuart Ross: Indeed. I do not mean to be negative, but Pizza Hut is an out-and-out restaurant. In our businesses, 70 or 80 per cent of turnover is wet. We are not quite comparing apples with apples. The comparison is interesting, but it is not wholly pertinent.

Mr Brocklebank: However, it would be worth knowing about.

Stuart Ross: Absolutely.

John Swinburne (Central Scotland) (SSCUP): Presumably, you are here this morning on behalf of the Scottish Licensed Trade Association because you are worried about the profit margin that you will lose if the bill is enacted. Is that correct?

Stuart Ross: We are here because we were asked to appear before the committee. We are responding to an offer to give evidence. Obviously, we are concerned about any bill that impacts on our trade.

John Swinburne: You suggest that the amount of alcohol consumed could drop if the bill is enacted. That leads me to think that the bill is better than I originally thought. There are 300,000 people in Scotland who are alcohol dependent, which costs the national health service a fortune. Consumption of drink has doubled in the past 30 or 40 years. If we can reduce the amount of alcohol that is consumed as an offshoot of Stewart Maxwell’s excellent bill on smoking, that is a
double whammy and would save the health service resources in the areas of both drinking and smoking. Do you agree?

Stuart Ross: Not at all. The trends in alcohol consumption very much favour the take-home trade, to which I have already referred. On-premises alcohol consumption is declining. The member is seeking to address alcoholism. That is not limited to the question of whether pubs allow smoking—it has many other facets.

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): I apologise to the committee and to the witnesses for arriving late. I hope that my question has not already been covered.

You said that the trend is towards an increase in the take-home trade. Do you have evidence of whether more people would be attracted to licensed premises if in future there were smoke-free food areas? That would be a way of reversing the trend to which I have referred and accessing the market of those who are turned off by pubs, perhaps because of smoking—although that may be the case for other reasons. Have you surveyed customers or staff on that issue?

Stuart Ross: At the moment most Scottish licensees are making greater provision for non-smokers, because we understand that there is demand for eating and drinking in smoke-free areas. If I may wear my Belhaven hat, most of our bars have an area that is set aside for non-smoking tables, although in many cases it is not practical to segregate or to have separate rooms for smokers and non-smokers, as the bill suggests. In almost all of our 90 managed houses, we have banned smoking at the bar counter. We are trying to move towards a situation in which smokers are made to feel that they should keep their habit to themselves and not interfere with non-smokers. There is definitely commercial advantage in that.

Colin Wilkinson: The independent trade is also going down the road of banning smoking at the bar and increasing the size of non-smoking areas.

Jeremy Purvis: Your decision is based purely on the business case that by providing a different environment you will attract more people from the take-home market.

The figures that you have provided are extremely helpful and we will question Stewart Maxwell on the basis of them. From your perspective, might a phased approach in legislation—which would be an extension or acceleration of what you are doing at the moment—assist on their way licensed members who are not moving down that road fast enough? That would achieve a balance for public health and licensed businesses, especially as all of us are attuned to the needs of the smaller operators whom we have talked about. Would a phased approach be practical under the bill?

10:45

Stuart Ross: As I have said, Stewart Maxwell’s bill would be a sound proposition were it not for the five-day rule. If smoking were banned where and when food was served, that would be a good step forward for the public’s perception of the smoking habit in public places and would not have a heavy impact on commercial interests. In essence, we would support a ratcheted approach.

Jeremy Purvis: I was struck by what you said about the percentage of smokers in areas that are termed deprived. The phrase “deprived areas” is used quite a lot and it is hard to find out its meaning, but if we take that situation as read and if we say that smoking is one of the biggest causes of premature death in Scotland—I assume that you accept that—would it not be in your commercial interests that people should live longer so that they can go to the pub more? For argument’s sake, if smoking causes death five years prematurely, I presume that you can work out how much your typical customer aged 65 in such an area spends on average in the licensed trade and add on another five year’s-worth.

Stuart Ross: I read in a paper the other day that the life expectancy of the average male in a deprived area is 63 years, whereas the average throughout Scotland is 75. Your argument certainly has merit.

Jeremy Purvis: Would the industry research that?

Stuart Ross: It must be remembered that we have day jobs, too.

Jeremy Purvis: Absolutely.

Stuart Ross: The Scottish Licensed Trade Association is a relatively small organisation with five full-time employees. The resources that are available to us are not great. I was interested to note that the committee asked the Scottish Licensed Trade Association but not the Scottish Beer & Pub Association to give evidence, although it is mentioned in the bill. Greater resources are available to that association through the British Beer & Pub Association, so perhaps it could afford to undertake the research that the member looks for.

Such research is time consuming—that is a serious point. We work in a demanding and highly competitive industry. What the cost of Stewart Maxwell’s bill would be seems a simple question, but it could be answered in 10 or 20 ways, all of which could be substantiated by decent assumptions and guesstimates. Answering such questions is not easy. That is not easy for
politicians either, and I sympathise with members, because assessing many of the issues that you deal with is a tough task. Research is time consuming and costly. I do not know who will bear the cost.

The Convener: It is normally Jim Mather who goes on about demographics, but Jeremy Purvis has pre-empted him a bit.

Jim Mather (Highlands and Islands) (SNP): I will endeavour not to disappoint the convener on that front. I am interested in Mr Ross’s comments about the commercial implications for licensees. My two favoured howfs in the Highlands—the Lochailort Inn and the Glenuig Inn—are not smoky pubs, but I imagine that segregation in them would damage the ambience and have an impact on turnover. However, public opinion on the matter is shifting. I am interested in how you might expand on your ratchet idea and in how that might have a positive impact to put both sides in a win-win situation.

Colin Wilkinson: The trade has discussed more licensees banning smoking at the bar, after which a standard 20 or 30 per cent of licensed premises should be non-smoking areas. That percentage would be increased over one, two or three years to educate people that the trade wants to go in that direction. Those are the basics of what we would like to agree with the necessary bodies.

Stuart Ross: As you probably know, there will be a consultation period, during which the organisations that are involved in the voluntary charter will make a detailed submission on how we expect ratcheting to work, but I do not know whether the consultation paper from the Minister for Health and Community Care is out yet.

Jim Mather: I will build on that and on the point that Jeremy Purvis made earlier. At a recent lecture in the Allander series of lectures that Wendy Alexander initiated, Nicholas Crafts from the London School of Economics talked about Scotland’s life expectancy having been the eighth highest in Europe in the 1950s, the 14th highest in 1975 and the lowest in Europe from the 1990s to the present. He said that, if we could bring our life expectancy up to the English level—which is marginally below the level in Ireland, which has a higher preponderance of people who go to the pub—we would have an uplift in our economy that would be equivalent to 21.3 per cent of gross domestic product. With that in mind, does the SLTA have any other positive thoughts about how we might evolve the pub of the 21st century, emulate the Irish and help to create a healthy customer base that keeps coming back and using your premises?

Stuart Ross: I will make a few observations on that. If the Irish life expectancy is higher, perhaps Guinness is good for you, but if everybody is going to live to 85, the Chancellor might have a few problems with his pension provisions and I do not know how much tax we will all end up paying. I am glad that I just run Belhaven and that I am not a politician.

We have made our statement on how we can achieve what you suggest. The organisations that are involved in the voluntary charter will produce quite a detailed submission for regional seminars and a national seminar, which will be held on 9 September. We are positive about the subject; you may think that we come with a negative stance, but we do not. We support a smoke-free Scotland and we want to get there, because it will benefit everyone, but we want to ensure that our businesses do not get torpedoed in the process because we have a clear vested interest in that not happening.

Jim Mather: You are all careful, cautious, experienced and successful business people, but are you worried that, in the current climate—with the publicity and media attention that the bill has had—there might be a rash of legal action from staff and former staff that might create a problem for you?

Stuart Ross: Belhaven employs 1,400 people, 1,200 of whom are employed in retail, but I have not had a single complaint about the issue and it has never been raised with me at any of our internal meetings. I do not think that pub staff perceive the issue in the same way as the press do at the moment.

Fergus Ewing: I will ask about one specific provision of the bill, namely the five-day rule, which seems to me to be a rather odd rule. As I understand it, the bill’s main aim is to ban smoking in places where food is supplied, but it also states that the period of the ban begins not when the food is being prepared or even when it is served, but five days before. I hope to ask Mr Maxwell about his rationale for that in a moment.
you welcome the removal of the five-day period so that, as well as designated areas, you could have the flexibility to have smoking bans for specific durations in the periods when your customers would be expected to want meals? Thereafter, once the period had come to an end, smoking would be permitted. There would be no emission of smoke, which I understand is the main concern of Mr Maxwell, and rightly so. What is your view of the five-day period? Would you like it to be removed from the bill?

**Stuart Ross:** Yes. It is over-prescriptive. I understand the rationale behind it, because there is lingering smoke. I am sure that Mr Maxwell will be perfectly able to answer on that for himself. However, as I said earlier, in terms of achieving the aim, we can do it all in one stage or we can move towards it. I have made clear my view that we should move towards it; therefore, the removal of the five-day rule would be of great help.

**Mr Brocklebank:** You say that designating certain tables as smoke free would be progress, but the smoke does not know which of the tables are smoke free. People might not be smoking at the bar, but they will be smoking elsewhere, and the smoke goes wherever it wishes to go. Personally, I get round that by using a little gadget that I saw Larry Hagman using, which is a little personal windmill. It blows the smoke back at the person who is blowing it at you. However, more of those would be needed to make a place smoke free. Smoke does not go where you decide it will go.

**Colin Wilkinson:** I hear that point. We have said that smoke-free areas should be coupled with good ventilation. We carried out research, because people say that ventilation does not work. In one of the premises that we looked at, fresh air was brought in where the staff were working at the bar and was extracted on the other side of the bar, which was where the smoking tables were. If the area is well planned with good ventilation, we are of the opinion that smoke can be controlled.

**The Convener:** If everybody had the windmills, there would be a local wind farm. I thank our witnesses for coming along today. I repeat the point that I made before—

**Mr Stewart Maxwell (West of Scotland) (SNP):** May I question the witnesses?

**The Convener:** We are taking you after them. I do not think that officially—

**Mr Maxwell:** It is unusual, but it is allowed.

**The Convener:** Go on.

**Mr Maxwell:** I will try not to detain the witnesses or the committee, but a number of points have been raised in the evidence that I want to cover.

Will the witnesses tell me where the bill forces premises to invest in separate areas?

**Stuart Ross:** It does not, but we were asked for a submission on the financial implications of the bill. You have assumed that the status quo would prevail, but we have made a totally different assumption. It is clear from our paper that there are four ways to respond to your bill. We think that the paper describes the way in which the licensed trade will respond.

**Mr Maxwell:** But you agree that the bill does not force licensed premises to spend a single penny.

**Stuart Ross:** It does not force any capital spend on anyone, but there would be serious revenue ramifications for premises if there was no capital spend.

**Mr Maxwell:** We will move on to the assumptions. The last statement was obviously an assumption about the loss of revenue. Can you tell us about any independent scientific and objective research that proves the assumption of the loss of turnover that you have talked about?

**Stuart Ross:** I am not sure to which loss of turnover you refer.

**Mr Maxwell:** You said at some point that between 20 and 30 per cent of your trade would go if a ban was introduced.

**Stuart Ross:** That is from research that we have—

**Colin Wilkinson:** It is from our equivalent in New York, from the pub owners themselves.

**Mr Maxwell:** But what independent scientific and objective research has been done to prove that there is a loss of trade from a smoking ban?

**Stuart Ross:** We just answered that. The research is independent of us.

**Mr Maxwell:** Sorry. It is not from you; it is from other licensed trade people.

**Stuart Ross:** It is from a licensed trade association, the members of which trade and have business revenues. It totals the revenues and tells one how they compare with last year. You can decide whether that is independent or not.

**Mr Maxwell:** Do you refute the New York figures that show that, after a year, business tax receipts from pubs and restaurants rose by 8.7 per cent?

**Stuart Ross:** That is a very good point, about which Deborah Arnott of Action on Smoking and Health wrote to me. I wrote back asking about the time lag between the trading and the collection of the tax receipts, but I still do not have an answer. Given the time lag in collecting taxes, we must ensure that, in comparing the periods pre and post
the change in legislation, we are not comparing apples and pears.

Mr Maxwell: We are comparing apples with apples. Do you refute the fact that an additional 10,600 jobs were created in New York and that there was an absolute gain of 2,500 in the restaurant and bar industry once figures were seasonally adjusted?

Colin Wilkinson: Those figures refer to the hospitality industry; we are talking about how the bill would affect public houses. We refute evidence of increasing staff levels and business in public houses.

11:00

Mr Maxwell: I want to focus on liquor licences in New York. At the end of 2003, there were 9,747 active liquor licences, compared with 9,513 at the end of 2002, which shows an absolute net gain of 234 during the period of the ban. Do you not accept those figures either?

Colin Wilkinson: We are talking about public houses, rather than the hospitality industry. You made a point about the increase in tax revenue. If I remember correctly, the increase was measured against the increase just after 9/11, after which there would not have been any increase in tax revenue in New York.

Stuart Ross: Given that Mr Maxwell is trying to use the situation in New York as a foundation for his arguments, it is important for the committee to realise that, as I understand it, within the New York legislation there is protection for smaller businesses that employ two or fewer staff at any given time, as the smoking ban is not implemented. Therefore, the impact on smaller businesses is not felt in New York in the way that it would be felt in Ireland. We are being asked questions as though we are experts. We are just guys who do daytime jobs who have come along here. We cannot be expected to know the ins and outs of New York legislation and I do not think that the questions are particularly fair.

The Convener: Stewart Maxwell will have the opportunity to make his points.

Stuart Ross: How would we know how many jobs have been created in New York or the reasons for that? I run Belhaven Brewery; I do not know anything about that.

Mr Maxwell: The witnesses have said that the bill is all about assumptions. I am giving research figures. It seems entirely reasonable to point out that there is a great deal of information and research on the issue. None of the figures that I quoted is based on assumptions. The latest research from Ireland, which was published yesterday, shows that trade has increased in Ireland; more non-smokers have gone out and there has been no drop in the number of smokers attending pubs.

Stuart Ross: If that is the case, that is fine, but could you give us a chance to consider the evidence that has been gathered? We are not being negative; we are more than happy to consider all the research, as long as it is fact based and compares like with like. If what Stewart Maxwell presented is the news from Ireland, that is great. I have been to Galway since the ban came in to see what was happening there. It is certainly true that people there are obeying the smoking ban. Let us see the impact on commerce over 12 months, after the winter. The ban was introduced in April and what happens in Ireland is that everybody goes outside the pub to smoke. According to friends of mine there, marriages are being made outside the pub. We are talking about adapting practices. Let us see the statistics once the pubs have traded through a winter. We are not saying, "We're right and you're wrong." We have done research among our members and I can speak for Belhaven and tell you that 60 per cent of our customers smoke, so we are obviously concerned that if there was a smoking ban, 60 per cent of our customers would move elsewhere. Is that not a natural and reasonable assumption or fear to have?

The Convener: From the Finance Committee's point of view—it is our evidence-taking session after all—the issue is getting the best possible information to inform our report, which will be crucial in the bill's progress.

Mr Maxwell: The witnesses say that they have not had time to consider the evidence. I presume that they are aware of the Scottish Licensed Trade News—their trade newspaper—which has carried out a survey and states clearly that the Irish example has been a huge success. What do they think of that?

The Convener: To be fair, that is not a question for the Finance Committee.

Mr Maxwell: With all due respect, convener, my question was about the assumption that there would be a loss of trade, which I contest.

The Convener: Mr Maxwell asked whether the scheme in Ireland was a success, but the precise issue is about the loss of trade.

Stuart Ross: I have already answered the question. We must consider the matter over a 12-month period, which would include a winter. People do not fancy going outside in the winter as much as they do in the summer. I do not have a crystal ball. Who knows what would happen in Scotland? In making estimates, we must take a balanced view about the total number of smokers in Scotland and the drinking trends and culture.
The honest truth is that I know no better than the committee does what would happen.

**The Convener:** I thank Stuart Ross and Colin Wilkinson for their evidence. I reiterate that the more information that we are provided with, the better a job we and, ultimately, the Parliament can do. I accept that resources are limited, but organisations in the licensing trade should ensure that their views and projections are as well set out as possible. We are grateful for the written information that the witnesses have provided and for their oral responses. If they can provide us with any further information in the next couple of weeks, we would be pleased to receive it and to incorporate it into our report.

**Stuart Ross:** Point taken.

**The Convener:** We overran a little on our evidence taking from those witnesses. I ask members to be a little more restrained in questioning our next witnesses, who are from the Executive. I am particularly pleased that we have Executive officials before us today because, in dealing with members' bills in the past, there have been concerns that we have not received information from the Executive. I welcome Colin Cook, head of the substance misuse division; Mary Cuthbert, alcohol and smoking team leader; and Calum Scott, economic adviser from the analytical services division of the Health Department.

Colin, do you want to make a brief opening statement?

**Colin Cook (Scottish Executive Health Department):** If I may. I want to give some context to the basis on which we are here today. References have already been made to what the Executive is doing and I will try to clarify that.

The Executive launched a tobacco action plan in January, chapter 5 of which dealt with the approach that we are taking to minimise the impact of passive smoking in Scotland. That includes a programme of advertising and communication to raise awareness of the risks of passive smoking, followed by what the plan describes as an open public debate on the issue. As the plan states, we must be prepared to hear all shades of opinion in the argument. As part of the process, legislation along the lines that are outlined in the bill—and different approaches—will be considered, but we will also consider a renewed and strengthened approach to the voluntary measures that were mentioned earlier.

The public debate will include a conference with international speakers, who will share their experiences of the results of actions that have been taken to limit the impact of passive smoking. The process will also include regional debates, organised by the Scottish Civic Forum, and a programme of research, which will involve reviews of international experience to get behind what has happened elsewhere. Detailed research will be carried out into current Scottish business practice and, given that the impact of action could go well beyond the licensed trade, into attitudes in a range of Scottish businesses. The research will also include an analysis of public opinion and an assessment of the likely health and economic impact on Scotland based on the evidence.

We believe that taking the time to examine those issues will give us the strongest basis on which to proceed. Therefore, we have adopted a neutral view on Stewart Maxwell’s bill. Final decisions should be taken when we have considered all the opinions and evidence that we have gathered during the consultation process. In those circumstances, I hope that the committee understands that we cannot comment on the bill’s policy intentions. However, we are more than happy to take questions on the likely financial implications from our perspective.

**The Convener:** That is welcome. Can I just ask about timescales for the consultation processes and for the various bits of work that you described. When would you expect them to be completed?

**Colin Cook:** The formal announcement of the open public debate phase will be made shortly; we will announce the date on which that consultation period will begin. At the beginning of the year, we began the process of advertising and communication of the issues around passive smoking.

**The Convener:** That was not an answer about the timescales, was it?

**Colin Cook:** As I said, the announcement of the date on which the debate is to start will be made to the Parliament in the near future.

**The Convener:** How long would a reasonable consultation period be likely to last?

**Colin Cook:** I think that the consultation period will last for about four months.

**The Convener:** Okay. That is helpful.

**Dr Murray:** We have heard claims from the Scottish Licensed Trade Association that the cost of adaptations could be as high as £85 million. Indeed, the Scottish Executive submission indicates that the financial memorandum does not take account of the cost of such structural alterations. I am not sure whether the Executive would have this information, but would you be able to provide us with an estimate of the cost to the trade if the bill was to be passed? Do you agree with the figures that the association has provided?

**Calum Scott (Scottish Executive Health Department):** We have not made a calculation of...
the aggregate conversion costs because of the lack of evidence. Until Stuart Ross tabled the association’s submission this morning, we were not aware of any estimate of the aggregate cost. If the convener was to push me for an opinion on the two different assumptions, I would have to say that it is likely that the figure would fall between the two. It is difficult to estimate the proportion of businesses that would have to convert. I have not seen the Scottish Licensed Trade Association’s submission yet, but based on a quick calculation, it would appear that its assumption is that 65 per cent of the licensed premises that serve food would undergo conversion. I think that the figure might be high. We have not tried to replicate the association’s calculation because of the lack of independent evidence on what businesses would do.

Dr Murray: We have been advised that 60 per cent of customers who go to public houses are smokers. That is twice the percentage of smokers in the Scottish population at large. Do you agree with those percentages? Do you have figures to substantiate that evidence?

Mary Cuthbert (Scottish Executive Health Department): No, we do not have any firm figures; we have only those that the licensed trade has produced. However, as we gather evidence over the next few months, we might do so. One of the pieces of consultation that we will do is a specific consultation with pub customers. That might reveal whether the association’s estimate is a true estimate.

Colin Cook: Certainly, we will be able to cross-reference studies of public opinion and analyse in some detail the data on the number of people who hold different views—whether or not they are pub customers.

The Convener: One of the pieces of available evidence, which results from the Irish experiment, is the additional resources that the Irish Government has put into the process of inspection, regulation and enforcement. Will you say something about your estimate of £1.1 million costs for local authorities? Is the figure adequate? How does it relate to the provisions of the bill or to other options that might arise during the Parliament’s consideration of the bill?

Calum Scott: I should perhaps start with a clarification or a correction of the figure, which should read £1.027 million instead of £1.156 million—although it is in the same ball park. We based that estimate on the assumption that one extra environmental health officer per local authority would be required to police the bill, at a cost of £32,100 per EHO, based on the current costs.

The Convener: Did you make the same assumptions for Clackmannanshire Council as you did for Glasgow City Council?

Calum Scott: Yes. We do not have hard evidence about the additional costs, but we provided that figure to illustrate the possible costs for local authorities of using additional EHOs to police the bill.

11:15

John Swinburne: What is your broad assessment of the cost implications for the health service? Would the implementation of the bill lead to savings for the health service, because fewer people would become ill with lung cancer and associated cancers?

Mary Cuthbert: That is always a difficult question to answer. There would not necessarily be immediate savings, but there might be long-term savings. We know that the cost of smoking-related diseases to the health service is an estimated £200 million, but there can be no hard and fast figure, given the types of diseases that are caused by smoking, such as heart disease and lung cancer. In the long term, if the ban were to lead to a reduction in smoking rates—there is clear evidence from elsewhere that that happens—savings on that figure of £200 million might well accrue.

Mr Brocklebank: I want to ask about the publicity campaigns about smoking. The financial memorandum says:

“NHS Health Scotland is allocated £1.5 million a year in order to target smoking prevention activity”.

The memorandum also says that about £200,000 per year is spent to increase public awareness of issues around passive smoking. Are you surprised that only 39 organisations replied to your consultation document, although you sent out 145 copies? Are we getting value for money from all that publicity?

Colin Cook: I clarify that you are referring to the consultation on the bill that Mr Maxwell organised, not to the general consultation on passive smoking that the Executive is planning, which we hope will generate considerably more than 39 responses.

Mr Brocklebank: Will the current allocation of £1.5 million be increased in a much more targeted campaign? Evidence from the Scottish Licensed Trade Association suggests that there needs to be much more education to ensure that the public goes along with a ban, as they have done in Ireland. Are we getting value for money?

Mary Cuthbert: The figure of £1.5 million is the total cost of the tobacco-related activity that NHS Health Scotland undertakes. Since we launched the tobacco control action plan at the start of the
year, there has been more activity to raise awareness around passive smoking as part of the lead-in to that work. We said that there would be a two-phase consultation process and that the first phase would concentrate on raising awareness. I am not sure about the timing of the consultation on the bill, but I suspect that, when it was launched, many of the new activities, such as the new television adverts, had not had a chance to impact on people's awareness. However, the volume of correspondence that the Executive receives from members of the public has increased dramatically as a result of the publicity around the bill, the television adverts and other work.

Jeremy Purvis: You mention that an estimated £200 million per year is spent on treating smoking-related diseases and you have gone into the evidence on compliance rates in some detail. Do you have evidence from elsewhere of the impact of a ban on smoking levels? Have any studies been carried out on smoking levels? Is it still too early for indications from the areas where bans have been introduced?

Colin Cook: It is too early for us to make what might be described as a scientific judgment, but some anecdotal evidence and the research that Mr Maxwell has quoted suggest that part of the health impact from action in this area is a fall in overall smoking rates. We are in the middle of carrying out a comprehensive analysis of international evidence on the topic and we hope to draw that work together in the next couple of months as part of the consultation process.

Jeremy Purvis: Does the same hold true for compliance rates? Although the financial assumptions in the financial memorandum are based on evidence from New York, you say in your submission that the compliance rate in New York might be slightly less than the figure on which those assumptions were made. Would that have an impact? After all, the proposals in the bill might not be identical to the action that was introduced in New York. If the proposals in the bill that we are considering turn out to be more complicated, should you indicate that the compliance rate might be less than 98 per cent, but no less than the 90 per cent on which you have founded your parameters?

Calum Scott: It is fair to say that we expect the bill's complexity to impact on the compliance rate, which is why we have provided figures based on rates ranging from 90 to 100 per cent. However, those figures are included only for the purposes of illustration; we are not necessarily saying that the compliance rate could not be even less than 90 per cent. They are meant to give members an idea of the range of cost figures that we are talking about.

Jeremy Purvis: Other than being part of the group that was invited by the committee to give evidence this morning, have you been involved with Mr Maxwell in the process up to now?

Mary Cuthbert: No. We were aware of the bill, because a similar proposal had been made before. However, the bill's team has worked independently of the Executive, although I cannot say that we have not had discussions with officials on drafting matters.

Jeremy Purvis: Do you mean discussion on drafting the financial aspects?

Mary Cuthbert: Yes.

Jim Mather: I want to follow up an earlier comment about the input of Nicholas Crafts, who said recently that, if life expectancy in Scotland reached English levels, we would have a 21.3 per cent uplift in GDP. By my calculations, that comes to the very considerable sum of £16 billion. Have you carried out any actuarial work on the direct or subliminal effect of the bill's message about smoking?

Colin Cook: The modelling that we carry out as part of the research programme allows us to try to make some assumptions about the health and economic impact of the bill in Scotland. In the modelling, we will also try to examine the difficult issue of the dual impact of increasing overall life expectancy and closing the gap between the least and most deprived areas that we need to strive for with any health improvement measure. Although we will still make some assumptions, they will be founded on a review of the international evidence that we have been able to acquire.

Fergus Ewing: In two fairly brief paragraphs in its submission, the Executive comments on the costs on individuals, companies and other bodies. In its evidence, the SLTA has identified certain capital and revenue costs and made its views known on the possible adverse impact on trade for premises that wish to continue with food and wet sales. What information will be gathered in the consultation exercise about the impact on businesses?

Colin Cook: Our review of international research examines economic impact, which includes costs on businesses. It will consider both published peer review journal-type research and some of what might be described as the grey literature around the matter. Moreover, the conference that we are hoping to hold in September as part of the consultation process will include at least one Irish business representative who will talk to the audience about the impact of the ban on their industry and trade.

Fergus Ewing: I read a newspaper report recently that suggested that the Labour Party in
the UK is planning to include a commitment regarding this general topic in its manifesto for the next election. I presume that the consultation that you propose is to be carried out by the Scottish Executive. If so, how will that link in with any work that is to be carried out at Westminster?

Colin Cook: I am sorry, but I am unable to speak for the Westminster Government. In January, we set out for the first time our proposals for a Scottish action plan on tobacco, which includes the consultation period. I am sure that the Westminster Government and various people will look at the experience and the views that are expressed in Scotland, but there is no formal link in that sense.

Fergus Ewing: As has been pointed out, it is difficult to make international comparisons because different laws apply in different places—for example, the bill is perhaps more complicated than a bill in Ireland would be—and it seems that we are automatically comparing apples with pears. Further, the argument was made earlier that for a comparison to be of any use, it must be carried out over a fairly long period if the data are to be of value. The ban has only just been introduced in Ireland; therefore, it is difficult to see how any data—even from the next couple of years—on the impact and financial consequences of the legislation will be particularly informative or reliable.

In his detailed papers, Mr Maxwell has pointed out that, in several countries, bans have been in place for a long time. In paragraph 26 of the policy memorandum, we are told that a ban has been in place in Norway since 1995 and in Sweden for a longer period. Will the research that you are planning to undertake look closely at the experience in those countries, where a ban has been in place for a much longer period? Will it consider the effects of the ban on health and on mortality rates as well as the impact that there appears to have been on businesses? Will it consider the impact specifically on licensed premises rather than premises that are, problematically, lumped together as hospitality premises? The SLTA is talking primarily about pubs, not Pizza Hut and other restaurants. Compiling that research will be a difficult task, but I am concerned that there is a dearth of reliable data on which we can judge the bill.

Colin Cook: Yes, the research will draw on the experiences of Norway and other Scandinavian countries as well as the experiences of Australia, New Zealand and Canada, where different approaches have been operating for some time. Whether we will be able to break the industry figures down as you describe will be a question of how evidence has been gathered in those countries. I do not know how that has been done in those areas.

The Convener: That is the end of the committee’s questioning. It would be helpful if you could give us an indication of what research you expect to undertake. I know that it may be difficult for you to do that in advance of an announcement; however, given the fact that the bill is under way, it would be useful for us to get as much relevant information as we can as quickly as possible. That may not be in time for our consideration of the financial aspects, but I am sure that Stewart Maxwell and others would welcome any information that would inform the process in which we are engaged.

Stewart, do you have any questions that you want to ask the Executive?

Mr Maxwell: Perhaps unsurprisingly, I have some questions. However, I would like to clarify one point before I begin. The Executive’s submission suggests that the prosecution rate would be 1.52 per cent. Where did you get that figure? We propose that the figure would be 7.6 per cent.

Calum Scott: The figure of 1.52 per cent is an annual figure based on the information in the bill. The figure of 7.6 per cent is the prosecution rate over a five-year period. For any one year, I assume that the prosecution rate is a fifth of that—1.52 per cent.

Mr Maxwell: Thank you for that clarification.

On costs in regard to prosecutions, you say in paragraph 6 of your written submission that the “range of costs is comparatively small and could reasonably be absorbed within existing budgets.” Do you accept that, no matter whose figures we use—mine, yours or anybody else’s—there will be no real cost implication for the Scottish courts or the prosecution service?

Mary Cuthbert: Yes—on the basis of the assumptions that we are working on. We are assuming that the costs would be low, but until the bill was implemented in practice we would not know that for certain.

11:30

Mr Maxwell: You would agree that so far, on the basis of the evidence from other parts of the world—including New York and Ireland—compliance rates run at significantly higher levels. Compliance rates of 98 per cent and 97 per cent are not uncommon.

Mary Cuthbert: The difficulty with your measures compared with the measure in Ireland, for example, is that there is a blanket ban in Ireland, which means that it is relatively easy to
know whether or not there is compliance. Some aspects of your bill are slightly more complicated. For example, with the five-day rule, how would one know that there had been no smoking for five days? That sort of thing makes matters slightly more difficult.

Mr Maxwell: Will you clarify what enforcement regime you believe that the bill proposes?

Mary Cuthbert: Perhaps I have read the bill wrongly, but it seems to propose a self-enforcing regime—in other words, the owner of the premises would be responsible for enforcement.

Mr Maxwell: I just wanted to clarify that there was a clear understanding of the enforcement regime.

Let us go on to consider your assumptions on the cost to local authorities. In effect, the bill's regime would be self-policing. The reporting of any complaints or any breaking of the law would be done through the normal procedure—offenders would be caught by individuals or reported by members of the public, or the police might go into premises for other reasons and see the law being broken. Given that that is the case, why did you decide to use the idea that we would have a raft of additional environmental health officers to enforce a measure that is self-enforcing, at a cost of in excess of £1 million?

Calum Scott: If there were no requirement for additional environmental health officers, we would not have estimated that additional cost. The evidence from Ireland suggests that it would not be unreasonable to assume that some extra environmental health officer resources would be needed. The figure that we have given, which I have since corrected slightly, is based on the assumption that one extra environmental health officer would be needed per local authority. That is the basis on which the figure has been included.

Mr Maxwell: That is not part of the enforcement regime that the bill proposes. It is based on an assumption on your part.

Colin Cook: We specify quite clearly that the financial memorandum assumes that no additional enforcement officers would be required.

Mr Maxwell: In paragraph 8, you mention that the provision of a helpline that people can use to report breaches is another potential cost and that such a helpline could cost between £50,000 and £100,000 in the first year. Why do you assume that is something that we would have in Scotland?

Colin Cook: Again, we made that assumption on the basis of the Irish experience. I know that there is also a similar facility in New York, although I do not know how it is funded. It is a reasonable possibility for us to raise.

Mr Maxwell: Can you tell me which other laws we have a special phone line for? For example, is there a phone line for breaches of the law on the wearing of seat belts? Can you name one such law?

Colin Cook: I am not aware of any phone lines for specific laws, although that area is not within my expertise. However, I am aware that phone lines of that nature exist in other countries in which smoking bans operate.

Mr Maxwell: So you agree that the normal procedure is not to have phone lines but for people to phone the local police station.

Colin Cook: Yes—or, indeed, Crimestoppers or a similar organisation.

Mr Maxwell: You mention a figure of £50,000 to £100,000 a year. Are you aware of the figures from Ireland, which show that complaints represent about 44 per cent of the total number of calls that the phone line has received so far, that more than half of them were received in the first week alone and that only six per cent of them were received in week 5? Given that the Irish have already decided to scale down their phone line, because it is clear that it is not needed, do you think that £100,000 represents a reasonable assumption for the cost of a phone line in its first year?

Colin Cook: I think that it is reasonable to assume that we should consider the Irish experience and learn from it. If that is the experience in Ireland and other countries, we will make judgments on the basis of that experience. That is all that we have been saying.

Mr Maxwell: The policy memorandum and the explanatory notes mention studies from the around the world. Paragraph 10 of the Executive’s submission mentions “other relevant factors” that might account for an increase in business for bars and restaurants in New York. Do you accept that all independent scientific research that is not funded by the tobacco industry has found that there has been no loss in trade? Such studies have been made not only in New York, but in virtually every part of the world. I am not using New York as the only example.

Colin Cook: I agree that a significant evidence base is emerging that suggests that there has been little or no significant impact on trade, but we want to look into the matter. There are specific issues with the New York research relating to the 9/11 factor, which Stuart Ross mentioned, and it is only right and proper that we have the most in-depth look at all the international research that we possibly can.
Mr Maxwell: Part of paragraph 1 of the Executive’s submission is in bold, which I assume was intentional. That part states:

“A full Regulatory Impact Assessment has not been prepared on the Bill but this paper outlines officials’ preliminary views on the assumptions made within the Financial Memorandum.”

You are right to say that no RIA has been carried out on the bill, but I have figures from two RIAs that were carried out in Canada and the USA. Would you comment on the figures and say whether it would be reasonable to assume that there would be the same impact here?

Canada’s regulatory impact analysis statement, which was prepared for the federal Non-smokers Health Act 1988, estimated that $32.2 million could be saved from reduced smoke and related property damage, depreciation, maintenance, cleaning costs and savings to the health care system through reduced ill-health effects of environmental tobacco smoke exposure. Given that that was in 1989, the figure would be much higher now. In the US, a similar impact assessment said that the benefits would be between $39 billion and $72 billion as a result of reduced absenteeism and boosted productivity. Neither cost-benefit analysis assessed the enhanced quality of life accruing from reduced smoking or the reduced exposure of non-smokers to environmental tobacco smoke.

Two large RIAs have therefore been carried out in Canada and the United States. Do you accept that it would be reasonable to assume that there would be similar effects here?

Colin Cook: I cannot comment on a regulatory impact assessment that was done in another country and which I have not seen. A specific approach was taken largely on a state-by-state or city-by-city basis to deal with the issue. I would be happy to consider the findings and I am sure that there are things that will be picked up in the research. We are interested in such findings, but I cannot comment specifically on them.

The Convener: I thank the Executive witnesses for coming to the meeting. It would be helpful for the committee to receive further information about the research that they intend to do as soon as they have that information.

Our final evidence is from Stewart Maxwell—once he moves round the table—and from David Cullum, who is a clerk for the non-Executive bills unit. As with the previous witnesses, Stewart Maxwell has a brief opportunity to make an opening statement on the financial issues relating to the bill.

Mr Maxwell: I agree with previous witnesses that predicting what will happen in the future is difficult. We all accept that, to a lesser or greater extent, we are dealing with assumptions, but I have certainly attempted to use all the available comparative evidence from around the world. Some of that evidence has already been discussed this morning and much of it is contained in the policy memorandum, the explanatory notes and the financial memorandum.

We have used results not only from Ireland, New York and throughout the world, including countries such as New Zealand and Australia, but from comparators from within the United Kingdom in respect of likely effects, impacts and prosecution rates. It is reasonable to use other laws in the UK and Scotland as comparators in that regard.

When the bill was drafted some months ago, the Irish ban was not yet in force and only the figures for the first six months of the New York ban were available. We made an assumption that, as the rate of compliance in New York was 98 per cent, it would be the same here. A year later, as the Executive pointed out, the figure has fallen by less than 1 per cent to around 97 per cent. I think that the figures coming out of New York, Ireland and elsewhere can be taken to show that compliance is high and the loss of trade is non-existent.

I know that the Finance Committee is primarily concerned with the costs of the bill, but the savings that the bill will bring about far outweigh the costs. Pubs will make massive savings as they will need to redecorate less often, have lower insurance costs, be less at risk from fires and not have to install extremely expensive ventilation systems, which is especially problematic for small pubs. Similarly, there will be great savings for the health service.

It is pertinent to point out that, in every independent survey that has been carried out, public opinion has supported the introduction of legislation to ban smoking in various public places. The responses that have been received by the Health Committee have supported the view that more business will be created by the introduction of such legislation. The first study of the situation in Ireland, which was published yesterday, showed that the number of smokers who went into pubs remained the same but that the number of non-smokers who went into pubs increased by 3 per cent. Those figures show us that the assumptions that we made based on the available evidence have been borne out by the evidence that has come out subsequently.

John Swinburne: Eliminating passive smoking and the dangers thereof is a laudable thing to try to do but would you agree that you are only tinkering at the edges of the problem? If smoking were not such a phenomenal source of wealth for the Exchequer, it would be banned completely.
How much do you envisage someone would be fined if they did not comply with the legislation? What would it cost them if they were found guilty in court?

**Mr Maxwell:** The bill makes it clear that the fine would be—at the absolute maximum—level 3 on the standard scale, which is currently £1,000. I suspect that the procurator fiscal's normal response would be to impose a fairly low-level fine. I do not expect that the first person to breach the law will be fined £1,000.

On your point about tinkering, there is a difference between the right to smoke and the right to damage other people’s health. I have no issue with people having the right to smoke. Tobacco is a legal substance and if people want to smoke, that is up to them. However, they do not have the right to damage other people’s health. The bill is not tinkering at the edges of an issue; it is attempting to protect people’s health. That is the right thing to do with this Parliament that we now have.

**John Swinburne:** What would be the legal costs of imposing a fine of up to £1,000? How much would we have to pay the legal profession to prosecute the case? Is that another hidden cost that you have not yet revealed?

**Mr Maxwell:** The costs of prosecution are contained in the notes that I have provided. They are estimates, obviously, but, as the Executive witnesses accepted, even the highest cost would still be a small cost that could easily be borne by the Procurator Fiscal Service and the Scottish Courts Service.

**John Swinburne:** Do you envisage any Orwellian smoke-detecting police going about the place, at quite a cost to the council tax payer, as they help Ted Brocklebank to avoid the need to waft his windmill?

**11:45**

**Mr Maxwell:** The answer is no, I do not envisage smoke police. We do not have specific police for any other laws; we have the police who enforce the law. Given the compliance rates around the world, it would be a waste of money to have smoke police. The Irish Government assumed that it would be difficult to introduce a ban and put in place a lot of measures that have already been scaled back because they were not needed, such as the helpline that I mentioned. We do not need smoke police; the suggestion is nonsense.

We consulted environmental health officers on the issue. They go into premises where there is food as a routine part of their job, so they could look for evidence of smoking as a routine part of their job. However, they did not want to be regarded as smoke police and we do not envisage them having such a role.

**The Convener:** As you rightly point out, the role of environmental health officers is to check compliance with environmental health regulations. In connection with licensed premises, that relates specifically to regulations on hygiene and the preparation of food. The assumption is that it might be part of environmental health officers’ normal duties to check compliance with smoking-related regulations, but most of the issues that relate to the administration of the licensing of premises are normally dealt with by licensing boards in Scotland. Is the matter one for licensing boards or for environmental health officers?

**Mr Maxwell:** It is an issue for both, in a sense. The point is that, if environmental health officers were to check compliance, they would not be smoke police, and I do not envisage any additional environmental health officers being recruited specifically to enforce the measures in the bill. Part of an environmental health officer’s duties is to go into premises and ensure that all the regulations, byelaws and laws are being enforced, so the ban would be another one of the laws that they would have to check.

Licensing boards certainly have a role to play. They take into account all sorts of reports that come before them when they decide whether a licence should be renewed, replaced, extended or removed. I expect that they will have that role, rather than a role that is part of the daily policing of the ban.

**The Convener:** I suppose that it is not our concern to consider policy issues, however the bill identifies three offences: an offence of smoking in a regulated area; an offence of permitting smoking in a regulated area; and an offence of failing to display signs. Two of those offences would fit relatively neatly within the functions of licensing boards—the failure to display signs and permitting smoking in regulated areas—but I am interested in how you envisage the enforcement of the offence of smoking in a regulated area. Would that be a matter for the licensed trade—the pub owner or the bar manager—to deal with? What legal powers could they draw on? Would enforcement issues and financial enforcement issues be associated with that?

**Mr Maxwell:** I do think that any financial issues would be associated with that but, on the policy matter, it would be the bar owner’s or bar manager’s responsibility to ensure that people did not smoke in regulated areas. That is clearly the case. Licensing boards would take into account any reports of breaches of the regulations, and it would be up to them to decide what to do about such breaches. Beyond that, I am not sure what
you are getting at. If somebody who is or appears to be under age goes into a bar, it is the bar owner’s or bar manager’s responsibility not to serve them alcohol and to deal with the consequences of not serving them. It is also the owner’s or manager’s responsibility to deal with somebody who has drunk too much, is singing offensive songs or is otherwise behaving unacceptably. Bar owners and managers enforce rules and regulations on their premises every day, and the bill will be the same in that respect.

The Convener: That deals with sections 4 and 5, but it does not really deal with section 3, in which the offence is the individual’s. You create two offences for the bar manager or the pub owner, but the first offence that you create is for the individual.

Mr Maxwell: It is illegal for people to do a number of things on licensed premises, and the managers and owners are responsible for enforcing those laws. If the bill became law and somebody started to smoke in a pub, I would expect the manager or owner to enforce the law in the same way as they do in other cases: they would tell the person to put the cigarette out and if the person refused to do so, they would ask them to leave. If the person refused to leave, the manager would not serve the person any more and would call the police to deal with the problem. The situation would be the same as with any other regulation that must be enforced in public bars or licensed premises.

Dr Murray: You have referred to the consultation that Kenny Gibson carried out and the one that you carried out. Did you specifically consult the Scottish Licensed Trade Association?

Mr Maxwell: Yes. Both Kenny Gibson and I consulted the Scottish Licensed Trade Association and the British Beer & Pub Association. The associations responded to Mr Gibson’s consultation exercise with various estimates of the terrible impact of the measures on trade, which earlier witnesses repeated this morning. In response to my consultation, the associations said that they had nothing to add but would like to reserve the right to comment at any future date. No additional material was sent to me.

Dr Murray: Was the estimate that such measures could cost the industry around £85 million raised in Kenny Gibson’s consultation?

Mr Maxwell: No. I have the Scottish Licensed Trade Association response to Kenny Gibson’s consultation before me—it states that the expected loss of trade is between £129 million and £200 million.

Dr Murray: Is that just the revenue cost, not the capital cost?

Mr Maxwell: Yes.

Dr Murray: I do not know whether the SLTA said this to Kenny Gibson, but in evidence to us, its representatives said that around 60 per cent of the pub-going population smokes, which is about twice the average for Scotland. The association feels that the bill might result in a loss of trade if establishments have to opt either to be smoke-free and serve food or to be food-free and allow people to smoke. Do you feel that the figure indicates that a significant proportion of the population is actually put off going to pubs or going somewhere to eat because they know that smoke will be in the environment?

Mr Maxwell: Yes. A significant proportion of the population are put off going to pubs as a result of smoking, particularly those who suffer from certain ailments. A recent survey by the British Lung Foundation found that 43 per cent of people with lung problems deliberately did not go to places where smoking is allowed because of their illness—that equates to about 3.5 million pub visits a year. An Asthma UK survey of asthma sufferers found that about 100,000 people in Scotland who have asthma do not go into pubs because of the smoke. There is a huge untapped resource of people who could go into pubs for a drink or something to eat, which would boost trade. That has been found elsewhere in the world, such as New York, and, given the figures that were published yesterday, Ireland in the past two months.

Dr Murray: It has been suggested that if you dropped the five-day requirement and the need for there to be a physical partition between segregated areas, that would make it much easier for publicans and others to comply with the bill. What would be the effect of those suggestions on what you are trying to achieve?

Mr Maxwell: I disagree with both those suggestions. The five-day barrier is included in the bill because, as the licensed trade people themselves said, a residue of smoke is left in the atmosphere after people have smoked. However, the situation is worse than that. Research in Sweden has found not only that smoke remains in the atmosphere for a considerable period after people have smoked—even with ventilation—but that the particles and gases in smoke are absorbed by furnishings such as carpets, chairs and tables. The material then leaches back into the atmosphere over a period of time.

It is difficult to estimate for a small or large pub, a small or large restaurant or a multiroomed restaurant how long it would take to eliminate the material from the room and the atmosphere. However, it is clear that it would not be a case of allowing smoking up to 12 o’clock, enforcing a smoking ban at 12.01 and lifting it again at 2
o'clock. That would be virtually pointless, because the smoke would still be there and people would still be absorbing and breathing in the materials that were in the atmosphere or which had been left in the furnishings and were leaching back into the room. There has to be a buffer-zone period to allow for getting rid of that material. It has been suggested that we could get rid of the five-day allowance for getting rid of that material. It has been proposed that we could have a smoke-free atmosphere during mealtimes is scientifically incorrect.

On the suggestion of allowing there to be two separate rooms with a communal bar, it is clear that smoke drift would be a problem in such a situation. If I were in a non-smoking seat and Mr Cullum, who is sitting next to me, were in a smoking seat, what would be my protection? There would be no protection. Dozens of pieces of research show that the difference between the absorption of smoking materials—the toxins, gases and carcinogenic materials from tobacco smoke—in smoking areas and non-smoking areas is virtually nil; people absorb almost the same amount in both areas. Even if we put a door between a smoking area and a non-smoking area, there would still be a problem, which is why we have included in the bill the connected spaces rule. I refer to the conclusions of a report on that, which states:

“Nicotine vapour air monitoring in a non-smoking area of the airport, adjacent to a smoking room … reveals elevated levels of ambient nicotine vapour in excess of what would be expected in a completely non-smoking environment. This study shows that airport smoking rooms expose non-smokers in adjacent non-smoking areas to a significant concentration of nicotine vapour from SHS”,

or second-hand smoke. That refers to areas where a door was in place.

Fergus Ewing: It seems to me that the questions that Mr Maxwell put to the Scottish Executive exposed the shackles of the foundations of the argument that there will need to be an extra environmental officer in each local authority. Goodness knows how the officer in the Highlands would cope with policing Glenuig in the morning and the Old Ship Inn in Aviemore in the afternoon before nipping up to Nairn in the evening. The helpline idea seems to be totally spurious; nothing in the bill requires a helpline.

The two main issues are the impact on health and the savings, both in terms of money and human life, and the impact on businesses. On the impact on businesses, I want to raise issues that arise from the evidence from the SLTA. It is difficult to compare like with like. Paragraph 30 of the policy memorandum, which is on economic issues, refers to the 97 studies that have been done, in countries in which there has been some kind of legislation, on the impact on the hospitality industry. It seems to me that a possible criticism of Mr Maxwell's methodology is that that category is too broad. The SLTA is talking about pubs, but the hospitality industry is much broader, because it includes all sorts of restaurants and hotels. Does Mr Maxwell accept that his methodology could perhaps be criticised on that valid ground? If so, can he provide information specifically on the impact on pubs in countries where some sort of ban is in place?

Mr Maxwell: I do not accept that the methodology is flawed. The paragraph of the policy memorandum to which Fergus Ewing refers is a collation of 97 studies from around the world, some of which considered the broad spectrum of the hospitality industry, including parts of the leisure industry such as clubs, and some of which looked at restaurants or bars. A range of different studies was included. Given that the paragraph covers all the studies that were available at the time, I suggest that the methodology is sound. Twenty-one studies met the three independent criteria and were not funded by the tobacco industry; they all found that there was no impact on trade, so in that sense the methodology is sound.

12:00

Fergus Ewing: Under “Economic issues”, paragraph 33 of the policy memorandum states that 21 studies met the criteria of which you approve and that all 21 studies found that smoke-free restaurant and bar laws had no negative impact on revenue or jobs. However, that is only 21 studies out of a total of 97. The policy memorandum also states that 35 studies, whose methodology you dispute, concluded that such laws had a negative impact. However, it does not tell us the conclusions of the remaining 41 studies—a figure that, if I am not mistaken, is greater than the two figures that are mentioned.

Be that as it may, another point that emerged in evidence this morning is that small pubs in New York are exempt from the ban if they have only one or two employees. I do not know whether that is factually correct, but I am sure that you will know, given all the work that you have done on the subject. If small pubs in New York are exempt, what allowance has been made for that factor in your analysis of the research emanating from the New York ban?

Mr Maxwell: The three criteria to which the policy memorandum refers were selected not by me, but by the authors of the study to ensure that their study was objective, scientific and statistically relevant. That is a reasonable point to make.

On whether some bars in New York have an exemption, let me point out that my bill would allow all bars that so wished to be exempted from
the ban. The bill will not enforce the prohibition of smoking on any licensed premises; it will give people the choice. It will be up to the licensee, so there will be no forcing of anybody to do anything. The licensee will be able to decide whether to ban smoking—which is what I hope would happen—or to carry out renovations or to stop serving food. It will be entirely up to the licensee; the bill will not force people to do anything.

Whether a small number of bars in New York are exempt from the ban does not change anything. The study that is mentioned in the policy memorandum is not about New York, which is only one of many places around the world from which data were gathered. Moreover, the information on the ban in Ireland, which has been in force for two months, is 100 per cent in agreement with the information on the experience of other places such as New York, Norway, Australia, Canada, New Zealand, Hong Kong and South Africa. I do not accept that one small variation in New York changes anything.

Fergus Ewing: However, the growth in licensed premises in New York may well arise from other factors, such as economic growth since 9/11. Indeed, the growth in licensed premises might be due to small bars opening to cater for the smoking market, but we do not know that because we do not have the data before us. I am not being critical, but we need to compare like with like. That is a difficult if not impossible task, which makes our task of scrutinising the likely financial impact of the bill much more difficult. However, I suspect that we might just agree to disagree about that.

The third line of criticism that arose, which I think seems valid, is that it is far too early to draw any conclusions from the ban that was introduced in Ireland on 1 April. As we heard from the SLTA, we would be rash to assume anything from the Irish ban until the first winter has been experienced. Just after the ban was introduced, I had the pleasure of visiting Cork, where many people seemed to be sitting outside to enjoy a pint and a fag, but I doubt that they will do that in October, November, December, January, February or March.

In Ireland, all sorts of ingenious devices are being planned such as the boogie bus, which will allow people to go from one pub to another and take their pints with them. People are also talking about drilling holes into pub walls so that they can smoke through an aperture with the cigarette outside. However, my serious point is that I do not see how we can conclude anything from the Irish experience—I am slightly surprised that you have tried to do so—until there has been a long period in which research can be conducted. Perhaps you have overstated your case by arguing that the Irish experience can be used as evidence, despite the fact that the Irish ban has been in force for just two months.

Mr Maxwell: We can put the Irish experience aside for a moment, although the Office of Tobacco Control has issued its first study on the ban’s impact, and it is reasonable to use that study as part of the discussion. From my knowledge, New York winters are pretty harsh. New York has had its first winter since the ban, yet the figures that are coming out of there are very encouraging indeed. I agree that California is generally a warm place and a temperate part of the world. It has had a ban in place for many years. However, Norway is pretty cold and, too, has had a ban in place for many years. Following the Irish example, Norway has introduced a complete ban today, but for more than a decade it had smoking regulations and smoking bans; there seems to have been no effect on trade over a decade of Norwegian winters.

The Convener: The big impact on the trade might be the price of the beer.

Mr Brocklebank: As Stewart Maxwell knows, Norway is not typical. In Norway, people drink in hotels; there is not the pub culture that there is in the United Kingdom. As was mentioned earlier, booze is supplied by licensed premises for people to take home. There is nothing like the equivalent of our pub on the corner. There are beer gardens in summer and there are hotels, but the impact in Norway is not the impact that there would be here, so Norway is not an example that should be quoted when it comes to pubs in Scotland.

Mr Maxwell: Norway is not Scotland, but neither are New York, Ireland, Australia, California, New Zealand, Hong Kong, South Africa, parts of India and so on. None of those are Scotland, but surely there comes a point at which we have to say that if a ban works in all those places, we cannot continually say, “But that’s not Scotland.” Surely there comes a point at which the evidence is overwhelming that a ban does not have a negative impact on trade, that it is successful, and that compliance rates are exceptionally high—higher than for virtually any other comparable law. I bet you anything you like that the compliance rate for the recent law on mobile phone use in cars is nothing like 97 or 98 per cent.

Mr Brocklebank: You are not driving in the same places that I am.

I think that policing the bill would involve greater expense than you think. I have a feeling that if the bill had advocated a total ban, as there is in Ireland and elsewhere, it would have been relatively simple to police. However, you are talking about licensed premises in which people are allowed to smoke in one part but not in another. The room for error will be vast. If pub staff are to control what is happening in different areas
and in the passageways that go from one area to the other, that will put an incredible burden on them. You say that the trade should self-police, but the trade has a difficult enough job to do in policing what goes on in pubs. That is your one problem: unless you talk about entirely separate units, you will have massive policing problems.

The Convener: We may be straying into policy areas and moving away from finance.

Mr Brocklebank: It is about the cost of policing.

Mr Maxwell: If your argument—and that of others—is that we should have a total ban in public places, I am open to that argument. Many people in the licensed trade have said that they would prefer a total ban. That is up to them. Most of that argument is about whether the scope of the bill should be wider or narrower and that can be dealt with by amendments at stage 2. However, I do not accept the argument that Scotland is unique, in the sense that we could not police a ban within the existing situation. It is rather strange to suggest that people here would break the law more than would people in Ireland or anywhere else, and that it would be impossible to police a smoking ban in a room in a licensed premises, when it is perfectly possible to police a ban on under-age drinking—which seems to me to be more difficult to enforce—in those premises.

Ireland has banned smoking everywhere, including in company cars. How difficult must it be to enforce a ban in company cars or in trucks that are workplaces? I think that that would be incredibly complex and difficult, so if people are suggesting that my bill is more complex, I do not think that I can agree.

Jeremy Purvis: I presume that you expect there to be a reduction in levels of smoking, but by what percentage?

Mr Maxwell: It is difficult to say. Everywhere that a ban has been introduced, there has been a reduction in smoking by smokers. A couple of things should be pointed out for clarity. There is a group of smokers who are usually referred to as social smokers. They smoke on Friday nights, when they go out and borrow a cigarette from a friend, or they smoke a few cigarettes at the weekend. I suspect that, as has happened elsewhere, that type of smoking would disappear almost immediately. In New York, in the past year, there has been a massive drop in the number of people smoking, so I expect that there would be a similar impact here.

In Norway, it was announced last June that a ban would be coming into effect this June. In the year before the introduction of the ban, the smoking rate fell by 3 per cent, from 29 per cent last year to 26 per cent this year, which demonstrates the impact of legislation. Surveys in Norway showed that between 25 and 30 per cent of smokers intended to use the introduction of the ban as a reason to give up. I suspect that we will begin to see a much steeper reduction in the smoking rate in Scotland, which has unfortunately reached a plateau in recent years. The legislation would help to enforce a reduction.

Jeremy Purvis: You do not know the percentage.

Mr Maxwell: Sorry?

Jeremy Purvis: There is not an anticipated percentage reduction as a result of your bill.

Mr Maxwell: There are surveys and figures, but I do not have them to hand. I can certainly write to you with them, if that would be helpful.

Jeremy Purvis: If you do not know, you do not know; that is fine. I am just interested in knowing whether you have gone down your chosen route for the bill without knowing its anticipated impact on smoking rates. When we determine the cost with regard to the bill’s impact on business—

Mr Maxwell: No; I know the impact that the bill will have. I gave you a couple of examples from New York and Norway, where the introduction of legislation led to an immediate and sudden drop in smoking rates. I fully expect the same thing to happen here. I can write to you with the figures from the survey evidence, although unfortunately I do not have those figures to hand and I cannot remember them. Everywhere that a smoking ban has been introduced, there has been a sudden and sharp decline in smoking; I do not expect it to be any different here.

Jeremy Purvis: Ted Brocklebank asked about policing, and you mentioned a couple of examples of practices that require policing, one of which was selling to under-age drinkers. The selling of cigarettes to under-age smokers in newsagents must also be policed, and a lot of money is spent on the detecting and policing of that practice, particularly by local authority trading standards departments. Why would you expect your bill to be any different if you want it to be just as effective? You do not know what percentage reduction in smoking there will be, but presumably you want the bill to be enforced as rigorously as possible to ensure that that percentage is as high as possible. Why do you say that your bill will not require the kind of policing that exists for newsagents who sell cigarettes to under-age smokers?

Mr Maxwell: I believe that to be the case because I look at the evidence from elsewhere and draw assumptions based on the fact that compliance rates are exceptionally high—higher than they are for most other comparable legislation that affects what people do. Given the fact that such legislation has compliance rates in
the region of 97 or 98 per cent in a variety of places all round the world, it seems entirely reasonable that we should not waste enormous sums of money on bringing into force smoking police, for want of a better term, when they will not be required.

People say that we cannot use examples from Ireland, but there are already examples of non-smokers assisting in the policing of the ban. They have not contacted the smoking police or phoned the helpline, but if somebody goes to light up a cigarette they have said, “You’re not allowed to do that. There’s a ban in force. You cannot smoke near me.” People use the legislation as back-up for their own protection, and it is clear that that is working very well.

We already have bans in the UK. We have bans in planes, in theatres and on the underground, as well as in various workplaces. Lots of bans are in place—

The Convener: We are beginning to drift away from the financial aspects of the bill.

Mr Maxwell: The point that I am trying to make is about enforcement. The bans that are in place in theatres, cinemas and museums or on the underground work perfectly well. I go to all those places and I do not see people smoking all over the place—

Mr Maxwell: In much of the public transport that I use, phone numbers are advertised that people can phone to report smoking incidents.

On the five-day barrier, if there are going to be offences and evidence has to be corroborated for the fiscal to pursue a case, how would the five days be determined?

Mr Maxwell: The five days will be dated from the last incidence of smoking.

Mr Maxwell: In the case of an event in a village hall—if there had been a wedding or something like that—at which food was served, people would be allowed smoke after the food had been dispensed with: there could be a meal and smoking would be allowed afterwards, if there was a dance or whatever. For five days following the end of that event, a smoking ban would be in place to allow the smoke to dissipate. If somebody smoked in the premises during that five-day period, that could be reported to the police. The offence would not be particularly difficult to prove—signs would be in place during the five days, which the managers and owners of the premises would have to put in place.

Jeremy Purvis: You do not expect that any equipment will be needed to determine whether smoking had taken place during the five days.

Mr Maxwell: No. The people who used the premises would report it.

Jeremy Purvis: In section 2, we are told that Scottish ministers can amend the definition of “regulated area”, possibly quite dramatically. Do you not anticipate that, if the definition of “regulated area” was determined by ministers without the committee having an opportunity to scrutinise such an amendment, there might be an impact on costs?

Mr Maxwell: I cannot cost what is not in the bill. If, at some future point, the Executive or Parliament decided to introduce a statutory instrument to create another definition of “regulated area”, Parliament would scrutinise that statutory instrument at that time. I cannot anticipate what the Executive or Parliament will do.

Jeremy Purvis: Why was no regulatory impact assessment carried out?

Mr Maxwell: Such an assessment was not required. The number of regulatory impact assessments that have been carried out for Parliament over the past five years is minuscule. Given the fact that the impact assessments that have been carried out elsewhere have showed massive savings for business, we deemed it to be unnecessary.

Jim Mather: I have a question that might give the SLTA and the Scottish branch of the British Beer & Pub Association some comfort. Given the proximity of Ireland and the likelihood that there must be some restaurant, hotel or pub group that operates in that jurisdiction and here, are you doing anything to try to persuade it to come forward and say, “This is the impact that legislation in Ireland has had on us in terms of turnover, sales mix and bottom line”?

Mr Maxwell: Organisations and companies in Ireland have already done so. There is evidence to which I alluded earlier, which Scottish Licensed Trade News has reported widely. That publication spent the past six months running a campaign against the bill but, having surveyed pubs in urban and rural Ireland, it has found that there are extremely high compliance rates—100 per cent in many places—and that there has been no impact on trade in restaurants or bars. It has decided that the impact on businesses here will be either neutral or positive in terms of attracting tourists or locals. That publication has concluded that the bill should, because there is no need to oppose it, be embraced as being inevitable and that licensees should move forward with it, as the Licensed Vintners Association in Ireland has.
Fergus Ewing: I wish to raise a point that occurred to me following your response to Jeremy Purvis. Perhaps I have misunderstood the provisions of the bill with regard to the five-day rule. You said that if a special function took place at which smoking was permitted, there would need to be five days after that function during which there would be a smoking ban.

Section 1 of your bill refers to the “prescribed period” when the public space will be regulated—that is, the period when the bill will apply. Section 1(1)(b) says that the space will be regulated “during the prescribed period before food is supplied and consumed”.

However, you said that the prescribed period of five days would start after the smoking had taken place, to allow the smoke to disperse. Is there something wrong with the definition of the prescribed period?

Mr Maxwell: No—perhaps I did not make myself clear. Mr Cullum will explain.

David Cullum (Scottish Parliament Non-Executive Bills Unit): The prescribed period is the five-day period. The bill will require that there be five smoke-free days before food can be served. For example, if there is a function on a Saturday, at which no food is served and smoking is permitted, five clear days—Sunday, Monday, Tuesday, Wednesday and Thursday—would have to elapse before there could be a function at which food was served. It would be Friday before food could again be served in those premises. That is the purpose of the prescribed period in section 1.

The Convener: Again, I think that we are beginning to move away from pure and simple financial issues.

I thank the witnesses for coming along today. As I indicated to other witnesses earlier, we will consider the issues that we have discussed on 22 June, so if the witnesses could let us have any further information within the next fortnight, that information could be used in our considerations.

Mr Maxwell: I have already agreed that we will write to the committee with the figures that Jeremy Purvis asked about. I may even include a copy of Scottish Licensed Trade News, which will tell you clearly what is happening in Ireland.

The Convener: I thank Stewart Maxwell and David Cullum.

Fergus Ewing: I wonder whether we could take some evidence from the Scottish branch of the British Beer & Pub Association. Mr Stuart Ross said that he was of the understanding that we had not sought advice from that association. Its members would probably feel that they should be consulted, as they will be directly affected. To inform our deliberations, would it be possible to ask the association to provide us with a written submission?

The Convener: I do not think that there would be a problem with our asking for a written submission.

Mr Maxwell: Obviously, the decision is entirely up to the committee, but the submission by the Scottish branch of the British Beer & Pub Association to the original consultation was on behalf of the association’s Scottish branch and the Scottish Licensed Trade Association. They have been working together.

The Convener: Yes, but there is no problem with our writing to the branch to ask for a written submission.

Mr Maxwell: I assume that, if the association is invited to the committee, I would have the right of reply.

The Convener: The proposal was not to invite the branch but simply to ask for a written submission.
Smoke-free Environments

The Deputy Presiding Officer (Murray Tosh): The next item of business is a debate on promoting choice and good citizenship: towards more smoke-free environments. The debate will be concluded without any question being put.

14:46

The Deputy Minister for Health and Community Care (Mr Tom McCabe): I am pleased indeed to have the opportunity to open this important debate, which, while focusing on increasing the number of smoke-free environments, actually centres on issues close to the heart of this Parliament: personal choice, good citizenship and a desire to improve Scotland’s poor health record. I want to set out more fully our approach to the consultation on smoking in public places, which we launched on Monday and which will run until the end of September this year. I also want to reflect on some of the key facts and figures around smoking and passive smoking, and I want to try to dispel some of the myths that have been perpetrated.

Let us look at some of the facts. Though it is improving, Scotland’s health is poor by United Kingdom and European standards. That is a fact. Smoking kills and debilitates, and that is a fact. Smoking is a major factor in health inequalities, with smoking rates in our poorer communities being twice as high as those in our better-off communities. On average, smokers can expect to live 16 years less than a non-smoker, and that is a fact. Exposure to second-hand smoke increases a non-smoker’s risk of heart disease and cancer, and that is a fact. Exposure to second-hand smoke is also a cause of respiratory illness and asthma in children.

I could go on and on. The health impact of smoking and passive smoking is now a given. Even the tobacco industry is beginning to acknowledge that fact.

Mr Stewart Maxwell (West of Scotland) (SNP): Given that even the tobacco industry now accepts that its own product kills people, does the minister wish to comment on John Reid’s comments about smoking actually being a pleasure for those in our poorer communities, when smoking is, in fact, not a pleasure but a killer?

Mr McCabe: It may well be a pleasure, but it is a misguided pleasure. There are many misguided pleasures and it is the purpose of Government to try to ensure that citizens do not engage in habits that will restrict their life journey and life expectancy.

I remind members that we are holding this debate about the effects of passive smoking because we have a devolved Parliament. We are here today to find Scottish solutions to Scottish problems. It is our health outcomes and our lifestyle choices for a healthier Scotland that we debate today. Ministers south of the border are held accountable for their comments by the Westminster Parliament, not by this Parliament.

I would like to share a few quotes with members. One states:

“Smoking is dangerous and addictive.”

Another states:

“There is no such thing as a ‘safe’ cigarette.”

A third states that

“the conclusions of ... health officials concerning environmental tobacco ... are sufficient to warrant measures that regulate smoking in public places.”

Members could be forgiven for thinking that those are the words of the chief medical officer or of a surgeon who has to deal day in, day out with the consequences of smoking, but they are not. They are the words of a major tobacco manufacturer, Philip Morris, and they can be viewed on the company’s official website. If they do nothing else, they demonstrate that that company is facing up to the truth about its products and their consequences.

When each and every one of us in the chamber takes a moment to ponder the indisputable evidence on the dangers attached to smoking; when we ponder the friends and loved ones who have suffered the ill health that can go with smoking; and when we remember lives cut short and the indignity of a lingering death from cancer, we should ask this question: is there a greater service that we as an Executive—and we in this Parliament—can do for our people than to take clear and firm action to reduce the toll that smoking and passive smoking take on our society?

Dr Sylvia Jackson (Stirling) (Lab): Will the minister join me in congratulating Stirling Council, which at a meeting last night decided to ban smoking in all the public places that it owns?

Mr McCabe: I am more than happy to join in the member’s congratulation of that council. Its decision will lead to better outcomes and to the citizens of that area thinking longer and harder about their lifestyle choices that they make. That can only be good—not only for those individuals but for the community in general.

The debate that will rage over the next four months will force all of us—parliamentarians as well as every woman and man in Scotland—to face up to the challenge of revolutionising lifestyle choices in Scotland. The first ever tobacco control action plan designed
specifically for Scotland—"A Breath of Fresh Air for Scotland", which we published in January—is aimed at doing just that. The comprehensive programme of action under the plan ranges from a major rethink of the current approach to prevention and education, through to support for those wishing to quit—with an injection of an additional £4 million from 2005-06 for smoking cessation services—through to protection and control measures to reduce the availability of cigarettes, especially to children and young people. The plan also addresses the issue of second-hand smoke and confirms our intention to sponsor a major public debate on measures to increase the number of smoke-free environments in Scotland. The health impact of second-hand smoke is clear and irrefutable.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In May 2003, the British Medical Journal published the results of a study that said that the link between environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed. What is the minister's comment on that?

Mr McCabe: The use of the word "may" is very interesting. I point out to the member that the British Medical Journal is a vehicle for the expression of various strands of opinion within the medical community. Some people have said that there is no link and eminent people in the medical community have said emphatically that there is a link. I am happy to debate that here or at any other time.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): I totally agree with what the minister says about the link. My father died of lung cancer, but I am a smoker, as is John Farquhar Munro. When the minister talks about things that might be rolled out, does he include doctors and nurses targeting people like me who need to kick the weed? They might lean on us rather more strongly than they do at the moment.

Mr McCabe: That is a very important point. The evidence tells us that 70 per cent of people who smoke want to give up, but only 2 per cent manage to do so without specific help. That is why we have allocated considerable additional finance to enhance smoking-cessation services, to help as many people as possible to kick the habit and improve their life expectancy and their life journey.

Tobacco smoke contains about 4,000 different chemicals, including more than 50 that can cause cancer. Long-term exposure to second-hand smoke increases the risk of lung cancer and heart disease by between 20 and 30 per cent. Babies and children who are exposed to second-hand smoke are at particular risk, because of links to asthma and other respiratory disorders. Thus, the case for protecting employees and members of the public from breathing tobacco smoke in enclosed public places is strong. Smoke-free workplaces and public places are therefore clearly the ideal. Make no mistake; this is the direction of travel. The question to be resolved is how and when we get there.

In spite of the speculation, let me make it clear that, in the consultation, nothing is ruled out and nothing is ruled in. This will be a genuine debate. We enter it with an open mind. We promised the people of Scotland an opportunity to contribute to the debate and that is what we are doing. Of course an extension of the current voluntary charter, which involves partnership with business interests, remains an option. We will welcome constructive ideas on how that can be made to work. However, progress so far has been disappointing.

Christine Grahame (South of Scotland) (SNP): I seek the minister’s guidance. I am trying to find out what has happened to a document called “Smoking Epidemic” by Laurence Gruer, who gave evidence to the Health Committee yesterday. The Executive was doing a survey with the Public Health Institute for Scotland. It commissioned research, which it was said would result in the production of an atlas showing the estimated prevalence of smoking and smoking-related mortality rates by postcode sector and at local authority, parliamentary constituency and NHS board levels. That work was due for completion in the autumn of last year. I have been unable to trace what happened to that. I wonder whether the minister can assist.

Mr McCabe: I can certainly write to the member with the exact details. I know that more work had to be done on the data to ensure that they were properly focused on those areas. As the member can imagine, that is a very precise piece of work. It is still the intention to produce the smoking atlas of Scotland.

Statutory controls are also an option and, if the overwhelming strength of evidence and public opinion point to such a move, the Executive will not shrink from its responsibility to legislate.

There is everything to play for in the consultation; it is designed to ensure the widest possible public response and to complement wider evidence gathering. People will be able to pick up copies of the consultation, which will take only a few minutes to complete, from doctors’ surgeries, pharmacists, a variety of health board and local government outlets, including libraries, and as many other public outlets as we can reach. They will also be able to make known their views through the internet.

In addition to the public consultation, we are undertaking a number of pieces of research to
help us form a view on the best way forward. That work will include examining the international experience, evidence about health, and the economic impact of action to reduce exposure to second-hand smoke. The experience in Ireland and New York, where high-profile statutory bans in public places have recently been imposed, will of course be considered.

During the consultation period, in conjunction with the Scottish Civic Forum, we will hold a series of public forums to allow local communities to have their say. There will be events targeted specifically at children and young people, the first of which I will attend next week. I will also attend a number of the public forums. In September, we are hosting a major conference with international speakers to enable us to hear about the experiences of other countries at first hand.

Today’s debate is a good opportunity to provide some context for our considerations. I have mentioned the stark facts and I will now deal with some of the myths.

I am conscious that, during the debate, we will hear much about the right to choose and civil liberties. Those values are close to the heart of the Parliament and the Executive. Nothing that we do will run counter to personal choice or civil liberty. However, the debate needs to be balanced; we need to recognise that we all have rights and freedoms. We are not talking about banning smoking but, just as smokers have the right to smoke, non-smokers have the right not to be exposed to someone else’s smoke. More than anything, the debate is about good citizenship and respect for others.

We will hear scare stories about businesses—pubs in particular—being under threat from smoking bans and economic disaster. Research into the international experience will help us to assess the potential impact.

Margaret Smith (Edinburgh West) (LD): Some members of the Equal Opportunities Committee were lucky enough to spend yesterday and the day before in Dublin on parliamentary business. Purely in the interest of research, I went into a couple of pubs, which was a very pleasant experience all round. We have been hearing that banning smoking in public places would cost a lot of money, but the anecdotal evidence in Dublin suggested that the pubs were booming because of greater food sales and so on. A ban on smoking in public places is not all bad news.

Mr McCabe: That was a timely intervention.

There is no doubt that evidence is beginning to emerge about the economic benefits to business. Our research will ensure that balance is injected into the debate when necessary. Seventy per cent of the population does not smoke. As awareness grows, we are seeing a mood swing towards smoke-free environments. We should not automatically assume that all is gloom and doom. The restriction or banning of smoking in a public place can and should be viewed as a positive business opportunity.

In direct response to Margaret Smith’s comment, on Monday of this week we launched our consultation in the Phoenix pub in the centre of Glasgow, which started its smoke-free life three months ago. Since that time, the pub has seen a 6 per cent increase in drinks sales, a 30 per cent increase in food sales, and an overall increase in trade of 12 per cent.

Murdo Fraser (Mid Scotland and Fife) (Con): Will the member give way?

The Deputy Presiding Officer: No. The minister is over his time.

Mr McCabe: In conclusion, I am confident that the comprehensive approach to the consultation will allow all the relevant issues and shades of opinion to surface and to be debated. Despite the SNP’s claims to the contrary, the consultation, which is wide-ranging and fully inclusive, is the first that the Executive has undertaken on smoking in public places.

I want to be clear that the Executive is determined to improve the health of the people of Scotland. For too long Scotland has featured near the top of the tables for the incidence of major health conditions such as heart disease and cancer. Smoking, actual or passive, is the main cause of premature death and ill-health in Scotland. We are committed to taking action to reverse this and we want to take the people of Scotland with us when we do so.

The consultation can be a catalyst for change and for lifestyle choices. The prize for success is enormous, but the cost of failure would be poorer life journeys, lower life expectancy and a nation that had become expert in managing serious preventable disease while it ignored what could be done to prevent it.

I hope that everyone in Scotland takes the opportunity to participate in the consultation. I urge all MSPs to do so and to encourage their constituents to do so too.

I apologise for running over time, Presiding Officer.

15:01

Mr Stewart Maxwell (West of Scotland) (SNP): I was disappointed that the minister did not take the opportunity to distance himself from the reprehensible remarks of John Reid, the so-called Secretary of State for Health. It is totally abhorrent
that a Secretary of State for Health should try to discuss a ban on smoking in terms of class warfare.

Kate Maclean (Dundee West) (Lab) rose—

Mr McCabe: Will the member give way?

The Deputy Presiding Officer: Minister.

Mr McCabe: I repeat the point that I made earlier. The debate is taking place in a devolved Scottish Parliament. Members should concern themselves with the actions of the two ministers who have responsibility for health in Scotland. We are the people who can make the decisions about health for the people of Scotland.

Mr Maxwell: It is obvious that the minister is embarrassed by John Reid's remarks and that he does not want to comment on them. I appreciate that.

I thank the Executive for at least bringing to the chamber a debate on an issue that I believe to be the single biggest public health issue that faces Scotland today. However, the issue is not new. This year marks the 400th anniversary of the first anti-smoking publication, “A Counter-blaste to Tobacco”, which was written in 1604 by James VI. Contrary to what members might think, smoking bans in public places are also not new. In 1641, the country of Bhutan banned smoking in government buildings. The argument and debate on the subject and the knowledge about what smoking can do have been around since smoking first appeared in Europe and elsewhere.

Although most other parts of the world have only recently started to catch up, the movement for change is gathering pace, with bans being introduced in Australia, New Zealand, Canada, all over the United States of America—including California and New York—and, most recently, in Ireland and Norway. The idea is one whose time has come and Scotland should join the growing ranks of places around the world in which the protection of public health is the top priority.

At the moment, Scotland has a voluntary charter, but it has failed. After four years, seven out of 10 pubs allow smoking throughout and a mere one in 10 premises meets all four of the targets in the charter. The voluntary charter was never going to reduce exposure to second-hand smoke. That is because it is possible to comply with the charter without doing a single thing to protect people from environmental tobacco smoke. In fact, all that those who are responsible for a premises need to do is to put up a very small sticker that says “Smoking Allowed Throughout”, which protects nobody.

I welcome the fact that something is finally being done, but it is almost unbelievable that it has taken the Executive and its army of civil servants six months to draw up what can only be called a flimsy survey document; it is a document that a secondary school pupil could have knocked out in an afternoon. The consultation document has a total of six questions on smoking. The fact that it took the Executive six months to think up six questions does not seem like a high work rate to me.

At a time when we need action, all that we are getting from the Executive is delay and prevarication. Scotland needs a smoking ban in public places. Every year, there are somewhere in the region of 13,000 smoking-related deaths in Scotland. More premature deaths result from smoking than are caused on the roads or by alcohol or by any other avoidable cause.

Of course, what is at issue is not only the number of people in Scotland who are dying, but the number who are being made ill. In Scotland, 35,000 hospital admissions every year are as a result of smoking-related diseases, of which the annual cost to the health service is approximately £200 million. Executive members are fond of continually asking, “If you want to spend money on something else, tell us which schools and hospitals you are going to cut to fund it.” I ask the Executive, if it does not take the necessary steps to tackle the problem by banning smoking in public places, whose children will not get the education they deserve and which patients will not be treated because £200 million a year is being wasted by having to be used to deal with smoking-related ill health?

Maybe—just maybe—an argument could be made for people’s right to self-harm, were it not for the fact that smoking does not just harm those who smoke. Many non-smokers are made ill and killed by other people’s smoke, as the minister acknowledged. They are the victims of passive smoking, but they are also the victims of inaction by this Parliament when it comes to protecting their right not to have their health damaged by others. Make no mistake about it: passive smoking damages people’s health and kills them.

This is not the first consultation on the topic that we have had in this Parliament; it is the fourth. Kenny Gibson had a consultation, I had a consultation, the Health Committee had a consultation and the Executive is carrying out the fourth consultation.

It is no surprise that passive smoking damages people’s health. Tobacco smoke contains 4,000 chemicals, including 47 regulated hazardous wastes, 5 regulated hazardous air pollutants, more than 50 known cancer-causing agents, and chemicals that increase blood pressure, damage the lungs and cause abnormal kidney function. The World Health Organisation has classified environmental tobacco smoke as a human
particularly lung cancer, as well as heart disease, smoking is involved in a range of cancers, birth weight and premature birth. In adults, passive smoking is involved in a range of cancers, particularly lung cancer, as well as heart disease, bronchitis, asthma and stroke.

**Mr McNeil:** That is all very interesting and is all clearly disputed by other evidence. We have had two or three minutes of Stewart Maxwell’s speech. Is he seriously suggesting that we will have no diseases, no asthma and no children with ear ache when we ban smoking?

**Mr Maxwell:** Duncan McNeil should listen, because I said no such thing. I said that smoking is linked to all those diseases. That is all I said. If we take away smoking in public places, we will reduce the effect of those diseases. Most lung cancer cases are linked directly to smoking.

**Mr McNeil:** To passive smoking?

**Mr Maxwell:** I did not say that either. I said that they are linked directly to smoking. Duncan McNeil should open his ears and listen to the scientific evidence of Asthma UK, the British Lung Foundation and all the other groups that work in the field, which shows the damage done by smoking and passive smoking.

Numerous scientific studies from around the world show the damage to health that is caused by passive smoking, but I will outline just one that starkly illustrates what passive smoking does and the effect that a ban can have on public health. In a place called Helena, in Montana, a public places smoking ban was in place for just six months. Heart attack rates in Helena in the months and years before the ban ran at a constant rate but, during the period of the ban, heart attack admissions to hospital fell by 40 per cent. When the ban was lifted, the heart attack rate returned to the pre-ban level. The evidence of research such as that is clear: passive smoking kills and maims, while smoking bans save lives and protect health.

Part of the debate rightly centres around promoting choice, but it is not the deceitful concept of choice for the few that the tobacco companies push that is important; it is choice for all. As things stand, smokers have a choice, but non-smokers have no choice. What choice is there for a family with children or for those who suffer from asthma, a heart condition or a chest or lung illness? The reality is that there is no choice for the 70 per cent of the adult population in Scotland that does not smoke. If they wish to go out for a drink or a meal, they must decide whether to go out and breathe in second-hand smoke, with all that that entails, or to not go out at all. If Scotland followed the example of other places around the world and banned smoking in public places, there would be genuine choice for all, because smokers and non-smokers could enjoy a night out and staff would not be faced with the stark choice between risking their health on the one hand and facing unemployment on the other.

**Murdo Fraser:** Does Stewart Maxwell accept that there are already restaurant chains, such as Pizza Hut and others, that have introduced a voluntary ban on smoking? Is not that the way to go? Why do we not let the market decide whether we should have smoking and non-smoking places, so that people have a real choice?

**Mr Maxwell:** Is Murdo Fraser really saying that, if a family wants to go out, their only choice should be to go and get a pizza? I do not think that it should be the only choice; people should have a genuine choice to go where they wish.

Of course, the tobacco industry and its supporters claim that choice can be provided for everybody by using ventilation in enclosed premises and bars. I will tackle that claim head on, because it is, to be frank, nonsense. The Scottish and United Kingdom Governments do not endorse ventilation as the answer, and the European Commission’s view is clear from its September 2003 statement, in which it said:

“Changes in ventilation rates during smoking do not have a significant influence on the air concentrations of tobacco components. This means, in effect, that efforts to reduce indoor air pollution through higher ventilation rates in buildings and homes would hardly lead to a measurable improvement of indoor air quality.”

Ventilation manufacturers themselves put disclaimers on all their products saying that they do not protect from the effects of passive smoking.

All great leaps forwards in public health have come about through enlightened legislation. In the 19th century, it was legislation on clean water; in the 20th century, it was the clean air acts; and in the 21st century, it should and must be a ban on smoking in public places. We can make a real difference. If members came into politics to try to make things better, this issue gives them a chance to do just that. We must all show that we put the protection of public health at the top of our agenda, and by voting in favour of banning smoking in public places when we get the chance later this year, we will strike the biggest single blow against ill health that we possibly could.
Together, we can make a difference, so let us get on and do it.

The Deputy Presiding Officer: Before I call the next speaker, I advise members that we lost 12 minutes in the exchanges that took place before the debate and, to ration the time equitably, I propose to reduce the speaking times in the open debate to five minutes in the hope that I will be able to call everyone.

Mr David Davidson (North East Scotland) (Con): I congratulate the Executive on initiating the debate, even though no vote will be taken, because it is important that we welcome the consultation. Some people are concerned about the quality of the consultation, but the most important thing is that we all go through and encourage the consultation process, and I am happy to do that in the north-east of Scotland.

I am a passionate non-smoker—I have never smoked—and I am also a health professional, so I recognise some of the points that the minister and Stewart Maxwell made about the damage that can be caused by smoking directly or passively. Many illnesses, such as asthma, which Duncan McNeil mentioned, are triggered but not necessarily caused by smoking. We cannot run around saying that smoking causes all the problems, but it certainly exacerbates them.

It is not illegal to smoke. The minister started off talking about personal choice and defending civil liberty, and although we accept that smoking can cause damage to health and is an irritant to many people, we still have to balance those facts with the ideas of civil liberty and personal choice. What should government do? We must change the culture about smoking. People jump up and down and say that the Irish have done it overnight, but the Irish have spent 14 years developing legislation, and it was through the surprise action of the Irish Minister for Health and Children that the ban came into pubs. At the moment, it seems to be working, although there are disputed figures from different organisations about what the effect on trade is and how long it will last.

There is a risk in the idea of a ban instead of control. There is a world of difference between having control and having a ban, because control can allow people to have choice within premises. I agree with Stewart Maxwell, as I have done in the past, that if we are to have separate places in which to smoke, they must be physically distinct—there is no point in having an open door or a wide open space, because that is not the same thing. I find that smokers are usually happy not to smoke when they go into a restaurant, so that is not a major issue.

Scotland would be a better place if we had proper education and gave decent cessation support to those who give up what is a physical and psychic addiction. One of the first talks that I gave after I qualified was to 250 ladies in a women’s union in London who wanted to know how they would recognise whether their children were on drugs. I asked, “Does anybody know what a drug addict looks like?” Everyone replied no. I asked those who smoked to put their hands up and then asked those who did not smoke to look at the people with their hands up. I then explained what addiction was about. We must grasp the facts.

Addiction services are poor in Scotland, regardless of whether the problem is the use of alcohol, tobacco or illegal drugs. We need to provide rehabilitation services. Ultimately, we must accept the fact that people make lifestyle choices, and we should try to ensure that people make educated and informed lifestyle choices. Government has a role in that and I do not believe that enough effort is being made. I hope that that comes out in the consultation process.

Brian Adam (Aberdeen North) (SNP): The member argues that we should leave it to choice, that we should have designated smoking places and so on. He suggests that, somehow or other, smokers’ rights might be infringed by a ban. We already have publicly accepted bans on smoking in aeroplanes, in cinemas and on buses and, although that last ban might not always be completely honoured in some parts of the country, they are honoured by and large, and people know that they cannot smoke for a limited time. Why should there be a distinction between those examples and visiting pubs and restaurants?

Mr Davidson: Because they are private properties that are owned, managed and run by people who make a choice about what product they wish to offer in the marketplace.

Mr Maxwell: What about aeroplanes?

Mr Davidson: The airlines happily got involved. However, we are not arguing over that point—although I do not like being on an aeroplane on which smoking is still allowed, which is the case in some parts of the world.

We come from a voluntary perspective. There is undoubtedly a niche market for non-smoking establishments. There are not too many of them around, but their number is growing day by day. Industry representatives have said that they would rather have a total ban on smoking than a set of partial bans, as there would then be a level playing field.

At the moment, an opportunity exists in the marketplace for non-smoking establishments to be developed or for clear areas to be set up within
establishments, which people may choose to go to. I accept the fact that those who run a one-room pub in a village, where there would be no opportunity to have anything other than a total ban, might find it difficult, but I know that some publicans have contacted their customers about the issue, have carried out polls and so on. That shows active management. I gather that the Federation of Small Businesses has indicated that its members are actively seeking to improve choice and facilities and that some of them will make a total change in what they do, although that is a slightly different argument.

I ask ministers to recognise the success of the Scottish voluntary charter on smoking in public places. The figures are not perfect on all fronts, but why can we not move to a second stage, at which bigger targets are set? People are becoming involved, and I think that the minister himself admitted that to an extent. It is an awfully sad day when we are deciding by law what people will or will not do when their actions are not necessarily an offence against society. Rather, passive smoking might be viewed as an offence against an individual. It is sad that we are not approaching the issue by going down that route.

I worry a wee bit about the fact that the consultation clashes with the passage of Stewart Maxwell's Prohibition of Smoking in Regulated Areas (Scotland) Bill. There seems to be an element of pre-emption there. There could be some good debate on the subject—I do not know—but the Government should be very careful before it comes out with blanket bans on anything without good evidence and public acceptance.

15:18

Nora Radcliffe (Gordon) (LD): I apologise to the Parliament for the fact that I will have to leave for part of the debate, because I have a previous commitment that I made before realising that I would be speaking this afternoon.

The consultation that the Executive has launched this week says that about 19,000 premature deaths are caused by smoking each year in Scotland. Successive Governments have been far too slow and far too timid in tackling the huge amount of ill health, misery and death that are caused by smoking. Why is it that, as a society, we have so far failed in our efforts to make a real difference on smoking? Is it because too many of our citizens are hooked on the drug nicotine? Is it because big business has too much invested in it? Is it because we do not want to interfere in people's rights to do what they want to do with their own lives?

I want to be clear that no one is talking about banning smoking. The Executive's consultation is about smoking in public places. No one is considering stopping people who choose to smoke doing so; we are considering only whether to take legislative action to tackle passive smoking.

Passive smoking means breathing in other people's tobacco smoke. Surely people have the right to breathe clean air. As a Liberal Democrat, I am a strong defender of individual rights, as long as they are not exercised at someone else's expense. Do not non-smokers—the majority of the population—have the right to breathe clean air that is unadulterated by tobacco smoke? I believe that they do. Evidence of the harm that passive smoking does is clear. The Scientific Committee on Tobacco and Health concludes that exposure to second-hand smoke is a cause of lung cancer and heart disease and represents a substantial public health hazard.

Helen Eadie (Dunfermline East) (Lab): One of the issues around Stewart Maxwell's Prohibition of Smoking in Regulated Areas (Scotland) Bill is that it proposes to prohibit smoking in public places where people eat and undertake other activities voluntarily. However, it does not address the fact that people who have to go to work to earn a living could be subjected to passive smoking there in the same way as they could be in public places. Does the member agree that perhaps that is an area of controversy, as people might say, "I can choose whether to go to a restaurant—I can use market forces for that—but I cannot choose where I go to work"?

Nora Radcliffe: Helen Eadie makes a good point, which I was about to cover.

The chief medical officer has made it clear that smoking is the single biggest cause of preventable and premature death and ill health in Scotland. Employers have a duty of care to their employees and, under section 2(1) of the Health and Safety at Work Act 1974, they have the duty to ensure, as far as is reasonably practicable, the health, safety and welfare at work of all their employees. I suggest that that could be interpreted to mean that employers already have a legal duty to act to prevent their employees from suffering the effects of passive smoking, but it seems that the courts do not believe that that is the case; otherwise we would already have a workplace smoking ban.

It is for Westminster to legislate to clarify that duty of care. Although we in the Scottish Parliament do not have the authority to legislate on employment law, we have the authority to take action on smoking in public places outwith the workplace. When my colleague Mike Rumbles welcomed on behalf of the Liberal Democrats the Executive's tobacco control action plan back in January, he said that banning smoking in public places can become a realistic option only if there is widespread support for it. I welcome today's debate and the Executive's consultation.
Since January, we have had the opportunity to study the many responses that the Health Committee has received to Stewart Maxwell's bill. Fears about a lack of support from the public for enforcing a ban on smoking in public places where food is served have proved to be groundless. I believe that there is widespread support for moves on this issue and that, for once, we politicians are lagging far behind the Scottish public.

Christine Grahame: Do I take it that Nora Radcliffe, like her colleague Mike Rumbles, supports Stewart Maxwell’s bill?

Nora Radcliffe: I support the fact that Stewart Maxwell has introduced it and I would like to see the results of the consultation. We will proceed in the way that the Parliament does so well by taking all the input into account and acting accordingly. If the public response to the Executive’s consultation is anything remotely like the response to Stewart Maxwell’s bill, I am sure that the time for action will not be far off.

For Liberal Democrats, three key issues need to be taken into account. First, it is undoubtedly the role of government to promote good health, to which the coalition Executive is committed. Secondly, there needs to be public support for action taken. Thirdly, we must acknowledge that people have the right to smoke as long as they do not harm others. Perhaps we should add a fourth: that we must acknowledge that smoking is an addiction that needs to be treated. As far as I am concerned, those three tests—the promotion of good health, public support for a ban on smoking in public places and recognition of the rights of the individual—have to be met. Once it is clear that they have been met—and the Executive’s consultation should provide us with the answer that we are seeking—swift action will be required, for all our sakes.

15:25

Johann Lamont (Glasgow Pollok) (Lab): First, I confess that I come to this issue as a sceptic, and a recently converted one. That is a dangerous mixture and I will explain my position. Originally, I resisted the idea of banning smoking in public places because I thought of some of the people in local communities that I represent who smoke and the reasons why they do so. However, in my conversion, I have had to accept the need for political consistency. It is true that there is a need to educate people and to support and work with people in difficult circumstances who smoke, but there is also a need for enforcement measures to encourage a drive in the right direction. The balance between the rights of smokers and the rights of communities and individuals to live and work in smoke-free environments is important.

To those who feel able to support that balance of rights and enforcement measures in relation to smoking, I say gently that they should do so in relation to other aspects of antisocial behaviour that impact directly on people’s lives. In discussions that we have had about measures to combat that sort of antisocial behaviour, many people say, “We have to understand more,” “We don’t want to criminalise people” and “We don’t want to make it difficult for them.” There is a balance to be struck in relation to all of the issues that we are discussing.

I support measures to ban smoking in public places, not least because of having seen the ban in action in the north of Donegal in Ireland. I know that we cannot legislate by anecdote and, as an illustration of my suggestibility, I point out that, the last time I was in Ireland, I came back in favour of the euro. However, it struck me that the smoking ban seemed to be accepted without difficulty and with a sort of joking manner in even the most remote local pubs. Only when I saw the ban in action did I realise what is possible and what it is like to be in a completely smoke-free hotel, public house or other public place. Speaking to people who work in those places, I realised what a difference it makes to their lives.

The banning of smoking in public places is sometimes characterised as being a hugely radical step, but we must recognise that there has been a huge culture shift over time from the days when I was a smoker. I used to see nothing wrong in not smoking at the table but smoking between courses. We have to accept that smoking is pleasurable for some people. I stopped smoking not because I did not like it but because it became socially unacceptable. Again, that is why I am in favour of moves towards a ban on smoking in public places.

The debate highlights huge differences in some of our communities and raises difficulties of which the whole of Scotland must take ownership. We have to recognise that anyone who smokes has an individual problem and that our health strategy must support them in their efforts to stop. However, in some of our communities, smoking is
accompanied by a clear public information campaign”.

“Sixteen (40%) of the respondents wanted legislation to be accompanied by a clear public information campaign”.

There also needs to be an understanding of why some of the statistics in constituencies such as mine have come about. With that understanding, there must be a commitment to drive money into those communities and to address health issues in their broadest sense and the broader issues that make some people reckless with their health.

We need the broadest definition of public health. We need our rhetoric to be accompanied by hard resources. A commitment has to be made to those communities. The Arbuthnott formula needs to be applied more rigorously in health, local government and across the Executive’s spending in order to prioritise those communities and people who smoke due to conditions and experiences that do not enable them to prioritise stopping smoking.

By using that approach, in parallel with a general approach that makes it difficult for all of us, including our children, to smoke and which makes smoke-free places a pleasure to be in, we will make a real change. That would be the really radical step that the Scottish Parliament could take as a result of the consultation. As well as a general approach to smoking, there should be a specific approach to the communities that suffer most from it.

Nicola Sturgeon (Glasgow) (SNP): Politicians should be prepared to take the lead on this issue. They should be prepared to take a principled stand and then to try to win people over instead of consulting continually in the hope that some sort of public consensus will emerge behind which we can safely shelter. The big irony about the timidity that sometimes exists around the issue is that many surveys show that majority support already exists for a ban on smoking in public places.

Nicola Sturgeon: The member is misquoting the survey’s findings. I can quote the member a BBC survey that shows that 77 per cent of people in Scotland want a ban, and an Office of National Statistics survey that shows a figure of 88 per cent. The point is that politicians should sometimes lead from the front and not simply follow timidly behind.

Mr McCabe: Will the member take an intervention?

Nicola Sturgeon: Not now—I want to make some progress. I will take an intervention from Tom McCabe later.

Tom McCabe rightly said that smoking kills—it kills 13,000 people in this country every year. I heard and understood Johann Lamont’s comments about what John Reid said, but when John Reid says that smoking is the only pleasure that working-class people have, he should be thoroughly ashamed that that is still the case for so many people in this country after seven years of Labour government. He should also reflect on the fact that, every year, people who live in our most deprived communities, more than any other group in our society, have their lives cut tragically short by smoking-related illnesses.

Irene Oldfather (Cunninghame South) (Lab): Will the member take an intervention?

Nicola Sturgeon: Not now.

The tobacco industry ruthlessly and cynically targets those people to boost its sales, as its internal marketing strategies will show. That is not an argument for leaving things well alone—it is an argument for shaking ourselves out of our complacency and for doing something about the problem. I agree with Johann Lamont that strategies must deal with complexities and that they must be about health improvement and closing the health gap. To do nothing is simply not an option.

The chief medical officer’s 2003 report stated:

“Smoking is the single biggest cause of preventable premature death and ill-health in Scotland.”

My view is simple: we should do anything we can to cut smoking rates in Scotland. That is why three years ago I introduced a bill to force action to ban tobacco advertising and why I support Stewart Maxwell’s bill. I congratulate him on taking the initiative, although he knows that I think that his bill does not go far enough. I think that the case for completely banning smoking in public places is overwhelming. International evidence suggests that that would cut smoking rates by up to 4 per cent. Many other countries throughout Europe, as
well as parts of the States and Canada, have already gone down that road and the sky has not fallen in on any of them. Compliance rates in respect of bans are exceptionally high.

Those who disagree with that argument will cite the rights of smokers. I have no problem with smokers’ rights, but what about the rights of non-smokers? One fact that is sometimes overlooked in the debate is that non-smokers form the majority in this country. We are not a minority—we are the majority, so what about our rights? Every time somebody lights up a cigarette in a pub, in a restaurant or in any other public place, the rights of non-smokers are infringed. We have heard about the horrific effects of passive smoking. The chances of a non-smoker getting lung cancer are increased by 30 per cent by passive smoking.

There is another important point to make. Many people who smoke support a ban on smoking in public places. Surveys show that a majority of people who smoke—the minister told us that it was 70 per cent—want to give up. I know many smokers who say that they would find it easier to give up smoking if they were not surrounded by people smoking every time they walk into a pub or restaurant. Many people say that pubs and restaurants will face economic ruin if we go down the road of a ban. That is absolute nonsense—there is no evidence to suggest that that will be the case. I make the point again that non-smokers are the majority. I presume that people will not give up smoking if they were not surrounded by smokers who say that they would find it easier to give up their local pub just because it no longer allows smoking. Trade might be increased rather than decreased.

I finish on the point with which I started. Some people say that we should not proceed to a ban until there is public consensus. As I have said, there are already signs that that public consensus exists. This last point is fundamental. Politicians sometimes—even if only occasionally—have a duty to lead public opinion, not just follow it. A change in legislation can change attitudes, and it is time to take action.

15:36

Irene Oldfather (Cunninghame South) (Lab): Normally, I do not agree with anything that Nicola Sturgeon says because we usually meet in European debates; however, I agree with a great deal of what she said today. I agree that politicians have a duty to take the lead, although that does not necessarily preclude our taking the opportunity to consult and debate to allow people to discuss the serious issues.

Nicola Sturgeon: Does the member accept that there has already been extensive consultation in the context of Stewart Maxwell’s bill, Kenny Gibson’s draft bill in the previous session and in other forms, and that there is already a wealth of evidence about public opinion? There comes a point at which we have to stop talking and get on with it.

Irene Oldfather: The minister stated clearly today when that point will be: it will be in September. We are in a fluid and changing situation. I will speak about that a bit later.

The facts about smoking and ill health are now irrefutable. I doubt that if previous generations—our parents, grandparents and great-grandparents—had known about the dangers, tobacco would be as widely available as it is today. Tobacco is a drug; it is addictive and it kills. People of previous generations smoked at a time when it was cool, suave, grown up and—I suppose for women—sophisticated. To be frank, they did not know the facts. Smoking accounts for 13,000 deaths and 33,500 hospital admissions a year and costs the NHS £200 million a year. Between 20 per cent and 23 per cent of all deaths are the result of direct or indirect smoking. During this debate, several people in Scotland will die because of smoking. Such deaths are preventable, so we need to take action.

I agree with Stewart Maxwell that the voluntary charter is not enough. We must make progress on that, although some has been made. The culture that surrounds smoking is changing. People are—rightly—less tolerant of smoking in restaurants and, in my experience, non-smoking areas in restaurants that operate the voluntary code are far more popular.

We talked earlier about airlines. I recall the debate about smoking on airlines that took place some time ago. People said that if a smoking ban was introduced on long-haul flights, people would not travel by air, but that has not happened. Most people nowadays would be astonished if they were exposed to cigarette smoke on an aeroplane. The culture is changing and that is a good thing.

I respect the right of individuals to smoke if they wish to do so. However, seven in 10 of us do not smoke, and I believe that those who do not—in particular, our children—should not have to put up with something that unarguably affects their health and may even kill them. I recognise the difficulty that many people face in trying either to quit or to stop smoking for long periods—it is not easy to do. An 84-year-old constituent of mine gave up smoking at the age of 79, having smoked for 60 years. That was my mum, and I am proud of the fact that she found the willpower to do that. The message is that it is never too late to give up smoking.

I am sympathetic to points that were raised by my colleague, Nora Radcliffe. I noted similar points in relation to employers and their legal
duties. It is only a matter of time before litigation forces action in relation to employment law. It would be so much better if the Governments in Scotland and at Westminster acted instead of reacting. That is something that we should bear in mind. We will have to give careful consideration to enforcement and the messages that will be sent out during the first weeks of a ban will set the tone for the future.

I am running out of time, so I urge people the length and breadth of the country to respond to the consultation. I have no doubt at all that the overwhelming weight of opinion will be in favour of a ban; the only question will be about how far it should go. I will be interested to read and hear the views of others but, at the moment, I am persuaded that the road that has been taken by Ireland and Norway is a sensible way forward.

In putting a ban in place, we would have the opportunity to change for the better the lives of future generations, to increase average life expectancy and to use the money that would be saved by the NHS for research, new technology and new drugs so that we can treat illnesses for which there is no help available such as Huntington’s chorea, multiple sclerosis and motor neurone disease. There are lists of such diseases that that money could be put into.

I look forward to welcoming the minister to my constituency on Tuesday, when he will meet young people from Kilwinning Academy. I am confident that the message that he will receive on Tuesday will be reflected throughout Scotland.

15:41

Mark Ballard (Lothians) (Green): I welcome this debate on an important matter that affects smokers and non-smokers. I will put my contribution in the wider contexts of polluted air, health and safety at work and environmental justice. For those whose health is affected by their unwitting and often unavoidable exposure to polluted air—whatever its cause—it is a simple matter of environmental justice.

The health of many people in Scotland is being harmed by air pollution, including by smog that is caused by traffic fumes, toxic emissions from power stations and incinerators and inhaling of pesticides among farm workers. There is a long list. In a member’s business debate last week, we heard and spoke about the serious problems that have been caused by working with asbestos, and we heard about the legacy of ill health and painful death that many workers have faced, and continue to face, as a result. In my speech in that debate, I mentioned how workers on Clydeside were showered with killer asbestos as they worked. The wives of shipyard workers also died because of exposure to the dust on their husbands’ clothes. When asbestos was first used, no one seriously considered the future health of those who were working with it. Now that its devastating effects on health are understood, it is universally accepted that no one should work or live in such an environment, and rightly so.

We should learn the lessons from asbestos. There are strong parallels between passive smoking and working with asbestos. The health of many non-smoking members of the public and the work force is threatened by being around people who smoke. As we have heard today, that is especially true for people who work in the hospitality industry, so we should not allow that to continue.

It took many years to establish that asbestos is the killer that we now know it is. The real scandal lies in the 30 or so years that we took before we started to protect the people who worked with it. In the case of cigarette smoke, no such uncertainty exists. We know—we have heard today—that it causes serious illness and premature death, so we must act to protect people. That is why Green party policy is to impose a ban on smoking in all enclosed premises that are used by the public and why we support Stewart Maxwell’s bill.

In a way, I hope that that ban will have a major economic effect on one industry. I hope that it will seriously damage the profits of tobacco producers and multinationals, who I believe have been responsible for selling ill health and misery here in Scotland and around the world. I hope that banning smoking in public places will in part help to reduce the profits of that industry, but I also believe that it will help the hospitality industry and contribute to improved health and safety at work, which is why we should welcome such a ban.

Today we have heard many statistics about the impact of smoking on Scotland’s health. We have heard many ideas about how to spend the money that we currently spend on treating tobacco-related diseases. We know that smoking is the biggest single cause of preventable death in Scotland, which is why I believe that it is vital that the Scottish Parliament fulfil its duty by ensuring environmental justice for those who are exposed to the cigarette smoke of others in enclosed public spaces.

I hope that the public will respond to the Executive’s consultation and I hope that they will state that public spaces should be free of smoke. Workplaces and pubs should be enjoyable environments where nobody faces the risks that are caused by passive smoking. I feel confident that public opinion will mirror that of the experts. Smoke-free public places are vital and must be legislated for.
Murdo Fraser (Mid Scotland and Fife) (Con): I declare an interest in that, despite my racking cough today, I am not a smoker and I do not like being in smoky environments. When I go into a restaurant or pub, I go to the no-smoking section. If no such facility is available in the establishment and if I am bothered by the smoke, I simply go elsewhere.

I am perfectly happy with that situation. It is called having a choice. Unlike some members in the chamber—for whom the word “choice” is an expletive—I think that choice is a wonderful thing.

Stewart Stevenson (Banff and Buchan) (SNP): Will the member give way?

Murdo Fraser: I will in a moment, but let me develop this point.

Choice is a wonderful thing and it must be protected. That is why I oppose utterly a ban on smoking in public places.

What constitutes a public place is another important issue that I must address. Contrary to what many members believe, pubs and restaurants are not public places but private places. They are owned by people who, at their discretion, allow customers entry to their premises. A restaurant or a bar is no more public than somebody’s house, so let us put that myth to bed right away.

Kate Maclean: Will the member give way?

Stewart Stevenson: Will the member give way?

Murdo Fraser: I will give way in a second.

The owner of a pub or restaurant should have the right to choose their own smoking policy without interference from the state—many do so already. Figures related to the 2003 Scottish voluntary charter on smoking in public places show that three in five businesses already make provision for non-smokers. Indeed, many businesses have banned smoking altogether. As has been mentioned, the Pizza Hut chain has banned smoking and the Federation of Small Businesses in Scotland, representatives of which I met this morning, says that many of its members are considering extending provision for non-smokers and no-smoking areas.

McKirdy’s Steak House in Edinburgh is experimenting with a smoking ban. I am very happy with that situation, but others who like to have a cigarette with their fillet steak will be unhappy. McKirdy’s might lose a few customers, but it will probably pick up some new ones. That is called having a market. That nice concept, which was developed by Adam Smith many years ago, has provided untold benefits throughout the centuries and around the world and I am happy to champion it.

Stewart Stevenson: I am sure that John Reid, who said this morning that he is not in favour of instructing adults on how to make choices, will be extremely grateful for Murdo Fraser’s support.

As an arch-privatiser, Murdo Fraser will no doubt have welcomed the opening of a private motorway in the vicinity of Birmingham. No doubt he wishes that all motorways in the UK were like that. Does he accept that there would be an increase of some 500 road deaths per annum if we then removed speed limits from private motorways? Would that be an acceptable thing in a private place of that kind?

Murdo Fraser: Mr Stevenson wants to start a very interesting intellectual debate, but I would need to get my head round the idea that he has mentioned. I would rather deal with why he wants to remove people’s choice whether to smoke.

I have never had problems finding a pub or restaurant that meets my needs as a non-smoker. If I had a problem, there would doubtless be others like me who would create a demand that would be met in due course. That is how the market operates. In his opening remarks, the minister highlighted how the Phoenix bar had been a great success because it had banned smoking. We do not need a law banning smoking in order to make a success of pubs that have non-smoking areas. I hope that we will see many more non-smoking pubs throughout the country as a result of the success to which the minister referred. We do not need legislation.

The reality is that the proposed ban on smoking is just another excuse for the politically correct people in Parliament to boss around ordinary people and tell them how they must live their lives.

Mr McCabe: Will the member give way?

Murdo Fraser: I will give way in a second.

I have some sympathy for one thing that John Reid said. We are not natural bedfellows, but I agree that there are too many people in this country who seek to tell others how to live their lives. He is right: those who disapprove of fox hunting want to ban it for everyone; those who disapprove of parents smacking their children want to make criminals out of those parents who do so; and those who are concerned with obesity want to ban or tax fatty foods. The nanny state is alive and well.

I am sure that it is only a matter of time before the Executive appoints a smoking tsar to go with the tsars that we already have for children, transport, discipline, culture, racism in football, equality, food and even berries.

Mr McCabe: The member mentioned the nanny state. On the first day of the consultation, we received 950 responses—950 people in Scotland...
enjoyed the opportunity to engage in the process of making public policy. That is not the nanny state; that is modern politics.

Murdo Fraser: I have no problem with the minister consulting people; I am more interested in what he will do with the consultation. We cannot legislate by referendum because we would then have capital punishment and birching for antisocial hooligans. I suggest that that is not something that the minister is about to propose.

We in Parliament should speak up for individual responsibility. I do not smoke and I do not like sitting next to smokers, but that should not give me any more right to ban smoking than I have to ban “Big Brother” from our television screens because I regard it as puerile and morally degrading entertainment.

If ever there were a time that we should remember what it took and what it means to be free, it is now. In the week in which we have been celebrating the 60th anniversary of D-day, what would Winston Churchill, that great champion of freedom, have made of a ban on smoking? I do not think that he would have had much time for it. In a week in which we have seen the death of that other great champion of freedom, former President Ronald Reagan, let us remember that freedom is hard fought for, hard earned and hard kept. I value the freedom that the people of this country enjoy, but I wonder why so many other people in the chamber are so desperate to give it up.

15:51

Kate Maclean (Dundee West) (Lab): As a bit of a “Big Brother” fan, I do not feel morally degraded—Murdo Fraser makes a trivial point when we are discussing a subject as serious as whether we should allow people to be exposed to second-hand smoke in public places.

Unlike Nicola Sturgeon and Stewart Maxwell, I welcome the consultation. As the minister said, there have already been a great number of responses. I sit on the Health Committee and I have seen some of the information that is already available. I hope that more members of the public will respond to the consultation so that we get a good idea of what they think about their right to be able to go into smoke-free places. I am fortunate to have seen much of the evidence on Stewart Maxwell’s bill that has come before the Health Committee.

Predictably, there are entrenched opinions on both sides of the argument, some of which we have heard today. Somewhere in the middle of that argument, the majority of people are confused because there are lots of conflicting advice, information and scientific reports. However, the one thing that everybody—including the tobacco industry—accepts is that direct smoking is dangerous to health. Even the tobacco industry accepts that second-hand smoke causes some health problems. The real argument is about whether the risk is significant enough to merit a complete or even a partial ban on smoking in public places.

In the evidence from the tobacco industry, it is stated that the relative risk of smoking-related disease in non-smokers is so low that it does not merit the imposition of a ban. The industry bases its evidence on studies that it likes to quote, but there are probably more studies that come to the opposite conclusion. At the Health Committee yesterday, it was interesting that although the representative from the Tobacco Manufacturers Association said that he did not think that there were risks of smoking-related illness from second-hand smoke, he did say that it would be unwise to take babies or children into smoky areas. He admitted that the two points of view were inconsistent and that he could not explain them. That shows that, although the tobacco industry has a pecuniary interest that it wants to protect, most people in the industry have enough common sense to see that the scientific evidence supports their being dangers in second-hand smoke.

Murdo Fraser spoke about choice. What choice do employees who work in the places that he mentioned have? In Glasgow or Edinburgh, for example, the hospitality industry offers great choice of places to work, so someone could choose to work in a bar that permits smoking or in a non-smoking bar. However, if one goes to rural or remote areas, there might be only one establishment. People who need to work there do not have a choice and are forced to breathe in other people’s smoke.

Many comments have been made about the economic impact that a ban would have on the hospitality industry. However, although we can measure the effects of the smoking ban in New York only over a short timescale, evidence is piling up that it has had a positive impact on the economy.

I know that Stewart Maxwell and Nicola Sturgeon are impatient about how long the consultation will take, but things have changed tremendously over the years. For example, I can remember being able to smoke in cinemas and theatres and on aeroplanes. In fact, when my daughter was born 24 and a half years ago, the babies were taken away from the ward at seven o’clock at night and ashrays were handed out so that people could smoke. The babies had to come back into that ward the next day. As I have said, things have really moved on.

Although I do not necessarily agree with the way in which John Reid articulated his comments, I
absolutely agree with the sentiment behind them—he was simply stating a fact. Some people who live in deprived communities probably see smoking as their only pleasure, so if we make it impossible for them to buy packets of 10 cigarettes, they will simply buy packets of 20 cigarettes. I believe that if we seek to impose a ban—even a partial ban—on smoking in order to protect people from second-hand smoke, we should also seek to protect people from first-hand smoke. As a result, we must ensure that any policy is fully funded so that people in the most deprived communities are helped to stop smoking. After all, we do not want to make people’s lives more difficult. The tobacco industry in Scotland and around the world receives far more income from deprived communities than it does from other communities. We should do what we can to stop that.

As for the question whether I support Stewart Maxwell’s bill, I am beginning to lean towards a full smoking ban in public places. However, as I said, there must be fully funded policies in place to ensure that we do not make people’s lives worse instead of better.

15:57

Brian Adam (Aberdeen North) (SNP): Smoking is entirely a matter of personal preference; I respect that principle. However, the purpose of any smoking ban in public places is to protect the health of people who choose not to smoke. Just as surely as the 30 per cent of Scots who smoke cannot be forced to quit, the 70 per cent of Scots who do not smoke cannot be forced—as they are at the moment—to inhale second-hand smoke. Far too often, active smoking in public places forces second-hand smoke on others.

We must remember that smoking is the most preventable cause of death. I am glad that the tobacco industry now recognises that that is the case. Indeed, on its website, the major American cigarette manufacturer Philip Morris states that it “agrees with the overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases in smokers. ... There is no safe cigarette.”

Although the company might be some way from agreeing with the overwhelming scientific evidence that passive smoking also causes the major health problems that it lists, it has condemned itself out of its own mouth.

It is clear that there is no safe cigarette in public places because substantial evidence shows that exposure to other people’s smoke is dangerous to health. A study by Professor Konrad Jamrozik of Imperial College London estimates that domestic exposure to second-hand smoke in the UK leads to 3,600 deaths a year from a variety of causes.

We should not forget that other people find smoking unpleasant and we should not minimise the unpleasant aspects of the habit. Although much is made of the fact that those who smoke get pleasure from it, we should bear it in mind that they also cause a lot of discomfort and make things unpleasant for other people when they smoke in public places. Many people object to others’ smoking nearby because of the unpleasant smell. The smoke makes clothes smell, it affects people’s breathing, it makes them cough, it gets in their eyes and it creates an uncomfortable atmosphere. It might be just a question of comfort, but many people find that it is a real problem. We should not minimise that.

Second-hand smoke harms not only patrons, but is dangerous to employees. Restaurant and pub employees work in smoke-filled atmospheres. Professor Jamrozik estimates that 49 deaths a year occur from exposure to smoke at work in restaurants and pubs. Non-smokers who are exposed to smoke in their workplaces have an increased risk of between 16 and 19 per cent of contracting lung cancer. In 1994, which is some time ago, the state of California banned smoking in all public places. Since then, the respiratory health and lung capacity of its bar employees have improved significantly.

Apologists for the tobacco industry suggest that we should have designated places for smoking that have ventilation. However, the fact is that ventilators only disperse and dilute the smoke. To get rid of the smoke would require an airflow equivalent to a hurricane. The smoke is only 15 per cent particulate; it is 85 per cent gas. Filters may well remove a substantial part of the particulate matter, but they do not remove the gas. The only way the gas—the bulk of the smoke—is dealt with is by dispersal. Voluntary bans and ventilators in designated areas do not help.

Johann Lamont: I understand the argument about passive smoking and how important it is to make the case against it. However, does Mr Adam agree that there is a strong case for a smoking ban in public places in that it would make smoking unattractive for people who smoke or who might smoke because they might not want to stand outside to smoke? A ban would make smoking a less normal habit that would not be a part of everybody’s normal discourse. We can sell a ban better not just by recognising the rights of those who do not smoke but by recognising that bans actively discourage smokers from smoking and young people from being impressed by those who smoke.

Brian Adam: Absolutely. I also agree with Johann Lamont’s earlier point that deprived communities have a greater prevalence of smoking and that health inequalities come as part
of that. We need an education process that makes smoking even more socially unacceptable. However, I believe that legislation can help in that process; it would not prevent smokers from smoking, but would merely restrict the opportunities for people to smoke where they can harm others. Other arguments relate to economic activity and the current evidence is that, when smoking bans are introduced, economic activity rises.

16:02

Donald Gorrie (Central Scotland) (LD): As other members have said, ideas are changing and the flood of world public opinion is moving towards having more regulation on smoking. During my national service, when we were stood at ease for a bit, that was officially described as a smoke break. When we went to the cinema, we could hardly see the screen because of all the smoke; moreover, the people on the screen were incessantly smoking. Things have changed a lot, but it is important that we consult people properly. I do not adhere to the position of those who criticise the minister. On a major social issue such as smoking, it is important that we carry public opinion with us.

In my view, we made a mistake in the way in which we started handling the section 28 debate a few years ago by not preparing public opinion and sounding people out properly; instead, the debate was bounced on to them. Consulting people is the right thing to do. The criticism that there are few questions in the Executive’s document is misplaced. A similar Government document that is going around on another subject has 60 or 70 questions. I have put the document aside because I am not going to answer 60 or 70 questions. It is better to have a few well-targeted questions.

Stewart Stevenson: Would Donald Gorrie have supported the introduction of the breathalyser for drink-driving, which was opposed at the time of its introduction by the great majority of people in our society?

Donald Gorrie: I do not know; I might have done. We do not live by plebiscite, but it is important to be guided by public opinion. It is difficult to foist something like a smoking ban on people if public opinion is hostile to it. I do not think that public opinion is hostile to such a ban, but we should find that out.

Johann Lamont and other members have raised the important question of class and the despondency and unhappiness of lots of people. The experience in the former Russian empire was that everyone smoked, because life was so hellish that that was about the only entertainment that people had. Figures show that people in poorer social groups smoke much more than those in better-off, professional or middle-class social groups. It is important that any progress on a ban is linked to strong educational and support systems to help people to give up smoking. A specific target group is girls. Mostly, boys cause more mayhem than girls, but girls smoke far more than boys do and they are a target group that needs to be addressed.

I now understand the media a bit better than I did before. I never quite understood why the media are totally depressed and take a negative view of everything, but I see that a report has shown that smokers are more likely to be pessimistic than other people are—as most people in the media smoke, I have cracked that mystery.

I went on a visit to New York with three colleagues, including Michael McMahon, who is in the chamber today, to promote Scotland. We took the opportunity to have several sessions with New York city officials and police officers. The officials were enthusiastic about the success of their smoking ban in pubs, restaurants and places of work. They had been considerably concerned about putting the ban into effect, but the success of the ban and its acceptance by the public had exceeded their expectations.

One question is whether we should ban smoking only in restaurants and where people are eating or whether we should go for pubs as well. I am sorry that Murdo Fraser has left the chamber, because I wanted his advice. When socialising with people who have respiratory problems, I have yet to find a smoke-free pub in Edinburgh. I have obviously been looking in the wrong place, so if anyone can advise me, their recommendations would be most welcome. There are partially smoke-free restaurants, but not pubs, in my experience.

I think that we have to go for protecting people. People have the right to kill themselves through smoking, but they do not have the right to kill other people through smoking. I support a ban. The issue is exactly how the ban is put into effect, how far it goes and to what extent we can educate people to give up smoking.

16:07

John Swinburne (Central Scotland) (SSCUP): I support 100 per cent what Tom McCabe is trying to do in the consultation that he has launched. We have been bombarded with statistics today, but one fact that I found interesting is that only 2 per cent of people give up smoking without help. I smoked my first cigarette at the age of 13, about 60 years ago, and I stopped at the age of 27. If someone is smoking 20, 40 or 60 cigarettes a day, giving up is not easy, but I was one of the 2 per cent who succeed.
Since then, I have taken a more relaxed attitude towards tobacco and I enjoy the occasional pipe or cigar. I am what I would term a civilised smoker; I do not smoke in any area where my smoking will offend anyone. I smoke outside. I do not smoke in my car or at home and I do not smoke in public places, but I enjoy the occasional cigar or pipe. I see nothing at all wrong with that and I would consider it an infringement of my civil liberties—and I am not a politically correct person—if someone were to ban tobacco from sale. By the way, tobacco is a lucrative source of income for any Government. If that were not so, tobacco would have been banned years ago, but it is an extremely lucrative source of income and we should never forget that.

A few years after stopping smoking, my brother-in-law contracted lung cancer and died at the age of 40. That was many years ago, before a genuine link was established between tobacco smoking and cancer. I said to the surgeon who operated on him, "What was the cause of this?" He said, "Well, put it this way. I've been cutting out 10 lungs a week for the past 20 years but I have yet to operate on a non-smoker." I do not know what that says about the argument about passive smoking, but that surgeon had cut out thousands of lungs and had not operated on a single non-smoker. That makes me a trifle sceptical towards those who get uptight about passive smoking in its various forms.

As a legislating body, we would be better to consider alcohol, which is a tremendous killer and a tremendous strain on the national health service. I have yet to hear of anyone being beaten to death with a wet Woodbine, but anyone who goes into a pub in Glasgow and gets smashed over the head with a pint measure will be in a bit of a mess, I imagine. One cannot kill someone by smoking, but one can kill someone if one is a drunk driver. Therefore, when we consider all the issues, we should take a more balanced view.

Irene Oldfather's old mother gave up smoking at 80—probably because her pension was not keeping pace with the price of cigarettes as the chancellor put it up. Very many eminent people have been smokers and no doubt there will be eminent people who are smokers in future, so the argument that the only people who smoke are poor or of inferior intelligence is a lot of rubbish. Nothing could be further from the truth and that argument is not a good way of persuading people that smoking is wrong.

16:11

Christine Grahame (South of Scotland) (SNP): I want to talk about delay and then about freedom of choice. A calculation of the possible impact of a ban on smoking in workplaces in Glasgow suggests that up to 1,000 fewer people would die each year of heart disease, respiratory diseases and cancers. The source of that figure is the chief medical officer's annual report of 2003. Therefore, if on the inception of this Parliament in 1999 legislation had been introduced, 5,000 more people might still be alive in Glasgow alone. Delay is an issue. I look forward to being informed of the progress of the smoking atlas that the minister referred to. Many members would find that very useful.

When we consider freedom of choice, we have to place the arguments on health against the arguments on personal liberty. Individuals' freedoms function within the context of the greater public good—unless one lives on a desert island and can do what one likes. I wish to drive my Mazda at 128mph. That would be my choice. However, evidence revealed that speed kills and maims on our roads, so we made prohibitive laws, redesigned our roads and made regulations to deter speeding. I concur with those laws and regulations, partly because of the deterrent effect of penalty points or, indeed, a criminal conviction, partly because of consideration of the greater public good and partly because I know the facts.

The situation is similar with drink-driving. I remember when society was opposed to any interference with the individual's right to drink socially and then to drive. Over time, statistics exposed the reduced competence to drive of anyone who was under the influence of drink or drugs. Not only is legislation now firmly in place as a regulatory and a preventive measure, but there has been a culture change. Those who drink or take drugs and then drive—whether or not they cause an accident to themselves or others—face the opprobrium of society. If caught, they face an immediate one-year ban, at least, for being over the limit.

Against the background of those two issues, I will move on to discuss smoking. Like John Swinburne, I am an ex-smoker. I was a heavy-duty smoker. I am also a libertarian who is pretty tolerant about the choices and pleasures of others as long as they do not inflict harm on society. I am therefore sympathetic to the addictions of smokers. I have trudged through a Fife blizzard for a packet of 10. When I found that there was one packet left in the ciggie machine, I was thrilled—it was the highlight of my year. I have since stopped smoking but I am still an addict. Even now, after 30 years, I have to resist the urge to "borrow" a cigarette from a friend.

I support a ban—at least in public places where people eat. Stewart Maxwell knows that I did not always hold that view. However, recent statistics have revealed the impact of passive smoking. On heart disease, passive smoking has led to an
increase in acute coronary event by 25 to 35 per cent. I will give just one more statistic; I do not want to provide too many. It is estimated that, each year in the United Kingdom, more than 17,000 children who are under the age of five are hospitalised because of the effects of passive smoking. That is a disgraceful figure, given that the children concerned have no choice. That said, I acknowledge that such situations are not necessarily the parents’ fault—I accept what other members have said about the social reasons for smoking in certain areas. The evidence and the facts are there, as my examples have shown.

Asthma UK Scotland made an interesting comment on the balance between the freedom of the individual and health. It said that it believes “that the overwhelming health arguments outweigh these personal liberty arguments put forward by smokers”—or, indeed, by people in the commercial sector. I agree with that.

I welcome Stewart Maxwell’s bill, which I foresee producing a culture change of the kind that happened with drink-driving. Although smokers might continue to contaminate their own lungs, they will not contaminate the lungs of others. The time for change is short. That is why I urge the minister to support Mr Maxwell’s bill as a first step. If he cannot do that but, instead, intends to introduce an Executive bill, I ask him to advise the Parliament when that legislation will be in place.

16:16

John Farquhar Munro (Ross, Skye and Inverness West) (LD): I am pleased to represent the other side of the argument in what has been an interesting debate.

Although I first started smoking at a very young age, it does not seem to have done me any harm. My family all smoked: my dad smoked a pipe and, remarkably, my mother smoked Capstan Full Strength all her life. She lived to the ripe old age of 90 and was not taken away by one of the ills that we are hearing about today. When I went to school, my teacher smoked and I had the great pleasure of going to get her cigarettes every day—she smoked Kensitas cigarettes. Members who are old enough will remember that “Four for your friends” was written on the side of Kensitas packets; I used to get them when I delivered the 20 back to the school. I have had a long apprenticeship.

The medics now seem to promote ideas about the damage that tobacco does to people’s health, although some are more enlightened. Some 15 years ago, I decided that I was going to stop smoking. I do not know why; it seemed to be the fashionable thing to do at the time. I stopped for six months until one night, at about 2 o’clock in the morning, I started gasping for breath in bed. My wife asked whether I was going to take a heart attack. When I said that I did not know, she said that she was phoning the doctor. The doctor came along, examined me and could not find anything wrong. He asked me whether I smoked—a standard question for the medics these days. I said, “No.” He said, “Did you ever smoke?” I said, “Yes.” He said, “What did you smoke?” I said, “A pipe.” He said, “Where is it?” I said, “Through in the house.” He told me to go and get it. I lit it up and here I am—I smoke the pipe on doctor’s advice.

I do not support the view that we are hearing today, which is that there should be more restrictions on smoking. Extending the current restrictions on smoking would be a severe imposition on the civil liberties of smokers such as me, to say nothing of our freedom of choice, which several speakers have mentioned. It would also call into question the laudable principle of social inclusion. Nowadays, smokers seem to be pushed to the fringes and regarded as a major health hazard to the general public. Well, I ask you! People say that smoking is a plague on society.

I suggest that, given all the traffic congestion and bus and diesel fumes, we inhale far more pollution in the 10 minutes that it takes to walk up the bridges or the Royal Mile than we would do—

Mr Maxwell: Is the member aware of the evidence from New York, where the department of health measured the amount of smoke in the atmosphere in pubs and compared it with the concentration of fumes in the atmosphere at the entrance to one of the busiest tunnels in the city at the height of the rush hour? It found that the fumes were 50 times worse in the pub than they were at the entrance to the tunnel in rush hour.

John Farquhar Munro: I wonder what they were using to monitor the pollution. Coming up the Mound in the morning or walking back down it in the evening, I would say that there is far more pollution from the traffic than there is from smoking.

As we heard today, the Treasury needs the revenue that it draws in from taxes. Unless we have a tax on tobacco, how will the chancellor raise his revenue? He might put further tax on fuel or—worse still—put tax on alcohol, which would be dreadful. I am sure that that would not be welcomed by my parliamentary colleagues—smokers and non-smokers—who I see are getting scarcer in the chamber by the minute.

Mark Ballard: Will the member give way?

John Farquhar Munro: Sorry, but I cannot.

I have no wish to inflict my simple pleasure of smoking on any individual. I respect the no-
smoking zones that have been established. However, let us draw a line in the sand—we have gone far enough. As we have heard, the public have to be with us. Unless that happens, no one will win. If we change someone’s mind against their will, they are of the same opinion still.

I want to say something to all the people who have spoken about the terrible problems that smoking causes and have said how proud they are to be non-smokers. In my book, it is no honour to be a non-smoker. In my book, it is no honour to the debate neither as a zealot for a smoking ban—nor, under the guise of freedom of choice, as an apologist for the tobacco industry. I come to the debate as someone who wants to hear what the Scottish people wish to say in the consultation that was launched last week. I welcome the consultation and the opportunity for parliamentarians to contribute to the debate today.

The debate about smoking is not new. In the late 16th century, Sir Walter Raleigh brought back tobacco from Virginia and proclaimed it to be a pleasant, sweet-tasting weed. As Stewart Maxwell said, that event was followed a few years later by the publication in 1641 of James VI’s pamphlet “A Counter-blaste to Tobacco”, in which he lambasted those who smoked and even the taste of tobacco. The sort of debate in which we are indulging this afternoon has been going on for the past 400 years.

If we were to take a snapshot of what members have said in the debate, we would think that the situation is very bad indeed and that we are still living in a society in which the vast majority of people are smokers. That is not the case, however, as the vast majority of people no longer smoke. Over the past few decades, our smoking record has improved. I agree that the number of young people and, in particular, the number of young women who take up smoking is an issue. If we look at the figures in a historical context, however, we see that far fewer people smoke nowadays than in the past.

I am perhaps not as discriminating in my drinking habits, or my viewing habits, as Murdo Fraser is. My choice of pub is determined not by whether it has an extensive no-smoking area, but by the quality of the beer—I am opposed to that ghastly chemical lager. Over the past few years, I have noticed the complete absence of smoke in a number of pubs that allow smoking. Pubs are not like they used to be when I first started drinking 20 or so years ago. I find that I do not come home from the pub absolutely stinking of smoke as I used to do. In fact, I find that it is possible to sit in a pub nowadays in which few—if any—people are smoking. The issue is not quite as extreme as some members have suggested.

That said, we should not underestimate the effects of passive smoking. I remember when my former employer, Fife Regional Council, banned smoking in its workplaces in the mid-1990s. The ban caused a huge problem for a lot of staff who were addicted to tobacco. It was also a bit discriminatory: it would have been okay for me—if I had still been smoking—to continue to smoke, because I was in a room on my own, as supposedly befitted my status at the time. People who shared rooms, however, were not allowed to smoke in that room. The council’s two-tiered approach created a lot of resentment at a time when it was trying to improve workers’ health.

We need to consider where we are going on the issue of workers’ rights. As Murdo Fraser and other members said, it is all very well to talk about choice—about people being allowed to smoke if they so choose—and even about the market deciding, but some employees have no choice about the environment in which they have to work. We must recognise that. It is too easy for people to say that the issue is just about avoiding going into an establishment where smoking is allowed to eat or drink, because people still have to work in such environments. We have to take their rights on board as well.

Johann Lamont: Does Scott Barrie agree that there is an issue about the protection that we give to certain kinds of workers? As a schoolteacher, I was protected by the decision that people were not allowed to smoke in public places. Local authority workers often had such protection, too. However, people in low-paid jobs in public places may not have that protection. It can be argued that those of us who are in professional jobs are protected, but people in low-paid jobs are more vulnerable, which is a further argument for extending a ban.

Scott Barrie: I concur with Johann Lamont. However, the point that she makes applies not only to low-paid jobs. In my former occupation in social work, staff were required to visit the homes of people who smoked, which exposed the staff to a risk.

If we are serious about curtailing people’s habits and encouraging them to live healthier lifestyles, we must talk seriously about smoking cessation services. We need to ensure that they are available when people need them. I do not know what the situation is like in other parts of Scotland, but in my part of Fife the demand for such services far outstrips the local health service’s ability to deliver them. A member of staff in my office was
looking to stop smoking earlier this year, but when
she contacted the local health service to find out
about a smoking cessation class she was told that
she would have to wait 15 weeks. Anyone who
has successfully given up smoking knows that it
cannot be planned in that way. People want to
stop when they want to stop. We cannot have a
situation in which people want to stop and want to
receive assistance but cannot do so.

A number of members referred to the comments
made yesterday by the UK Secretary of State for
Health. A number of things that John Reid said
were perhaps taken out of context. I will finish by
echoing what Johann Lamont said in her speech
and put some of what John Reid said into context.
He said:

“We want everyone to live a healthy lifestyle but not
everyone lives in the same circumstances ... If we wish to
change people’s habits we will ... have to help change the
circumstances in which they live.”

We have to take that on board if we are to be
serious about changing people’s smoking habits.

16:27

Robert Brown (Glasgow) (LD): Before I came
into the debate, somebody said to me that it was
terribly boring, that it had no motion and that it
would be full of platitudes. In fact, it has been one
of the Parliament’s best debates. The quality of
speeches, which have been largely non-partisan,
has been high.

I was going to wax lyrical about the Liberal
Democrat commitment to health promotion until
my colleague John Farquhar Munro spoke; then I
thought I should tone down the moralistic bit just a
little. Nevertheless, the Liberal Democrats have
had a considerable commitment to health
promotion. Cigarette addiction and smoking is a
key target in health promotion. The fact that in the
promotion. The fact that in the
parliamentary circle smoking is a cause of heart disease and increases
the risk of lung cancer by 20 to 30 per cent. The
committee spoke in graphic terms of the risk to
passive smokers, who may face 25 per cent of the
risk that active smokers face, even though they
take in only 1 per cent of the smoke—that is
another interesting aspect of the matter. Passive
smoking also increases the risk of stroke in non-
smokers by 82 per cent in men and 66 per cent in
women, and Asthma UK said that tobacco smoke
is a common trigger for asthma attacks for 80 per
cent of the 3.4 million people with asthma in the
UK.
Are we really saying that the right to smoke in so-called public places and the right to have smoke-free environments are equivalent? I do not think that we are; we are talking about two different situations. Who do we believe: the vested interests of the industry and its front organisation, or the British Medical Association, the Royal College of Nursing and organisations such as Asthma UK Scotland? That is not much of a choice.

I did not think much of the private place argument that the Conservatives used. We are talking not about private places, but about public places or places to which the public have access, which is a different matter. Nobody seriously suggests that because a restaurant is a private place, we can poison people who eat there by giving them adulterated food or by allowing health hazards. Society is entitled to regulate matters in the interests of the majority of people if there is an appropriate reason to do so, and I do not think that the market argument stands up. As Nora Radcliffe and other members said, nobody is proposing to ban smoking. People have a perfectly free choice to smoke if they wish, but that is not the same as saying that they have the right to smoke in public places. We must make progress on those issues.

We are going through a consultation process. There are issues about effects on businesses—marginal businesses in some areas, such as rural areas—and those issues must be examined. There are also issues about the public acceptability of a ban, which is an important point. I detect a shift of public opinion on the matter, as evidenced by Johann Lamont and other members who have changed their minds on the matter over time, as I have to a degree.

My final point concerns smoking and culture. Young people probably go into pubs more than other age groups, and if there are smokers among them, the non-smokers will, on the whole, go with the smokers. The smokers will continue to smoke during the lengthy period that they are in pubs and the non-smokers with them will be exposed to the public effects of the smoking. The end result is that there is a cultural acceptance of people smoking and of exposure to smoke. If we had many more non-smoking areas, the culture would change and it would be normal not to have smoking in pubs.

Let us move on with the consultation and gather public opinion, but let us make a significant difference on this important issue.

16:35

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): It was Mark Twain who said that stopping smoking was the easiest thing he ever did—he had already done it thousands of times. As somebody else remarked, cigarettes are killers that travel in packs. Perhaps the most sobering smoking anecdote is that when CBS radio announced the death—reportedly from lung cancer—of the American broadcaster Ed Murrow, the announcement was followed by a cigarette commercial.

I agree with Robert Brown that we have had a good, wide-ranging debate this afternoon. The issues of health, choice and civil liberties have been well aired. Few of us can be unaware of the direct links between smoking and various cancers. It is not just a matter of the harm that smokers do to themselves; there is also the effect of so-called passive smoking on others, as many members have described.

The Executive approach seems to involve sending a mixed message about second-hand smoking. Despite Tom McCabe's dire warnings of the dangers, Jack McConnell appeared to rule out an all-out passive smoking ban when he and Jim Wallace gave a joint briefing on the subject, saying that such a ban was “impractical”. Today, Tom McCabe tells us that nothing is ruled out and nothing is ruled in. The Executive is clearly struggling to find a way of squaring business realities with the demands of the health lobby.

If the Labour Party is sending out mixed messages, so are the Liberal Democrats, especially to Scotland’s children. The party of Donald Gorrie and Robert Brown has a national policy of non-prosecution for the possession, cultivation for own use and social supply of cannabis. At the same time, it wants to ban smoking in public places. During his tenure as Minister for Justice, Jim Wallace abandoned the just say no policy, changing it to know the score. Well, what is the score, Jim? Are we really saying that the consequences for a licensee who tolerates tobacco use in a pub might at some point be worse than the penalty for possessing and blatantly smoking a joint outside that pub? As a lifelong non-smoker, I defend the rights of individuals to smoke. As David Davidson rightly pointed out, smoking is not illegal. Scotland has an age-old tradition of live and let live. Sadly, in the case of smoking, that often turns out to be live and let die. Murdo Fraser is right: it is a matter of personal choice.

I had sympathy with John Farquhar Munro’s recollections as a lifelong pipe smoker.

Mark Ballard: Following the logic of the libertarian argument that Murdo Fraser advanced, why is smoking a joint not a matter of personal choice if it is done in a way that does not harm others?
Mr Brocklebank: I was talking about a matter of degree. Why should only one be espoused by the Liberals as being subject to freedom of choice? They decided that smoking was to be banned.

As Nicola Sturgeon and others have pointed out, there is a world of difference between defending the rights of smokers and allowing their actions to damage the health of others. Personally, I am broadly in favour of Stewart Maxwell’s Prohibition of Smoking in Regulated Areas (Scotland) Bill, and I have sympathy for its aims. Like Stewart Maxwell, David Davidson, Brian Adam and others, I believe that smoke and food should not mix and that, eventually, pubs should declare themselves either smoking pubs or non-smoking pubs. Similarly, in private clubs and entertainment venues, smoking should be banned where food is served.

Conservatives accept that we live in the real world. Our beleaguered hospitality industry is one of the most regulated in the world. The last Conservative Government had a good record on reducing smoking through a combination of the price mechanism, education and voluntary controls on advertising. Scott Barrie rightly drew attention to the fact that, between 1971 and 1996, the United Kingdom was one of the most successful countries at reducing tobacco consumption—it did so by nearly 40 per cent. We welcome progress made under the voluntary charter approach.

Stuart Ross of the Belhaven Group recently gave evidence to the Finance Committee. Belhaven is currently working towards a non-smoking policy where food is served. I believe that its approach is the right one. Let us proceed with the voluntary charter until it has had time to deliver meaningful results. If the industry fails to meet its targets in persuading smokers that their habit is antisocial, legislation should set tougher targets.

We have heard much about the Irish example this afternoon. Ireland has a different drinking culture from Scotland. Regrettably, Scots no longer go out to socialise in the numbers that the Irish do. More than 40 per cent of all beer sold in Scotland is consumed off the premises. In Scotland, a ban on smoking would simply exacerbate an existing couch-potato syndrome. Moreover, the impact of a total smoking ban on small businesses, jobs and the civic purse could be enormous. Kate Maclean and others tried to minimise the effect on businesses but, according to the Irish Licensed Vintners Association this week, Dublin pub revenues have been hit by the ban by between 12 and 15 per cent. Donall O’Keefe, the association’s chief executive, said:

“Make no mistake about it the smoking ban is having a serious financial impact … which has clear implications for jobs and the Exchequer … the Ban is hurting.”

Kate Maclean: Does the member accept that people will quote whichever statistics suit their case? I will quote another piece of evidence, as it suits my case. In New York a year after the ban, business tax receipts in restaurants and bars were up by 8.7 per cent, despite the fact that 150,000 fewer New Yorkers were exposed to second-hand smoke at work, and there was an increase in jobs.

Mr Brocklebank: I accept the broad thrust of Kate Maclean’s argument that different sides will present different arguments, although there is evidence that the statistics to which she referred might have been affected by the aftermath of 9/11.

Although I am in broad agreement with the broad aims of Stewart Maxwell’s bill, I oppose it at this stage for the following reasons. First, its timing is not good. There is little point in the bill going through its first stage when the Executive’s major consultation is being undertaken simultaneously. Secondly, although I have said that I agree with many of the bill’s objectives relating to food being separated from smoke, I believe that it is hugely naive in relation to the costs of implementation. Thirdly, I believe that the bill would have a serious effect on small businesses that might be able to make the necessary changes over time, but which would not be able to do so in the short term.

Many people talked about the difficulties around smoking in the workplace. However, that is a reserved matter and although the UK Government has had ample opportunity to address it, it has failed utterly to do so. In principle, the Conservatives believe that everyone, including bar staff, should be able to work in a smoke-free environment, although we acknowledge the difficulties that that poses for the hospitality sector.

16:41

Stewart Stevenson (Banff and Buchan) (SNP): This afternoon we have heard from the moderates on the smoking issue, but there will be no more Mr Nice Guy, because I am not moderate on this subject. The Government has told us a number of things in its consultation on reducing exposure to second-hand smoke, such as that exposure to second-hand smoke is a cause of heart disease and represents a substantial public health hazard. It has also told us that exposure to second-hand smoke is a cause of lung cancer and can cause childhood asthma. However, colleagues should not imagine that those insights are anything new.

I will share with members some other quotes. First:

“smoking is dangerous to the lungs.”

Secondly, it is

“hurtfull and dangerous to youth.”
Thirdly, it is
"very pernicious to the heart."

Those quotations were published respectively in 1604, 1606 and 1637, by James VI, Eleazar Duncon and Tobias Venner.

James VI got it spot on when he wrote in “A Counter-blaste to Tobacco”, to which my colleague Stewart Maxwell and our friend Scott Barrie referred,

"This filthy smoke makes a kitchen oftentimes in the inward parts of men, soiling and infecting them with an unctuous and oily kinde of soote, as hath bene found … that after their death were opened."

He did not just know about the effect of smoking in theory; he went to dissections and examined the state of the inner man after exposure to this pernicious evil. Are we so short of knowledge that our deliberations must begin anew 400 years after James so correctly described smoking as "lothesome to the eye" and "hateful to the nose"?

At the heart—and lungs and brain—of the issue is addiction. I do not criticise addicts; they are captured by their addiction. As James VI said, the smoker is "piece by piece allured" until he craves it like

"a drunkard will have as great a thirst to be drunk."

However, James was wrong to compare smoking to alcohol, because drink is addictive to a small minority of its users, albeit that the abuse of alcohol is one of our most widespread social ills. By contrast, smoking is generally thought to be as addictive as heroin, which I imagine the free marketeers on the Conservative benches would, like the SSP, liberalise and make available to marketeers on the Conservative benches would, like the SSP, liberalise and make available to anyone with the money to buy it. Like heroin, smoking captures the majority of its users in its deadly embrace.

I find it baffling that, after 400 years of knowing the evils of this wicked weed, we are still supporting the evil tobacco companies who prey on the addictive misery of our citizens. We are faced across the chamber by a Government that wants to listen rather than lead. We should be absolutely aware that, if tobacco were a new product today, there is not the faintest chance on earth that permission would be given for it to be sold freely across any counter in any shop in any country in the world. We have heard about personal choice, but the tobacco companies, with their pernicious recruitment of new generations of addicts, remove choice from the people whom they ensnare.

During the two and a half hours of this debate, five of our citizens have died as a result of tobacco addiction. Our lack of urgency does us no credit. Every day that we postpone engaging in a meaningful response to what is one of the great issues of modern times, we all share responsibility for 52 deaths. We view Iraq as a dangerous place. We see turmoil and death there nightly on our televisions. However, tobacco kills at a far higher rate in Scotland than is being experienced in Iraq, even in these dangerous and turbulent times.

James VI recognised the evils of tobacco. In 1603, when he took over from Elizabeth as the monarch in England, one of his first acts was to increase the taxation on a pound of tobacco from 2d to £6 10/-—41 times more. If we had the same level of taxation that James introduced to discourage the consumption of tobacco, a pound of tobacco would cost—by comparing the then average earnings with today’s—between £30,000 and £40,000. In that case, price would be a bit of a discouragement. [Interruption.] As the minister has just observed, discussion of the issue of tobacco taxation is academic because we are denied the powers that a normal country has to take the action that would enable us to exercise fiscal powers to reduce the consumption of this pernicious weed. That is why I support my colleague’s excellent Prohibition of Smoking in Regulated Areas (Scotland) Bill. I was delighted to see support from other members, such as Scott Barrie and Helen Eadie, and I look forward to their stage 2 amendments, which will strengthen its implementation, extend its remit and deliver cleaner air for people in Scotland.

In the 20th century, with 13,000 people dying every year as a result of tobacco addiction, we have lost—pro rata—1 million Scots to this pernicious addiction. That is more than were killed in all the wars in the millennium from 1000 to 2000. We might soon run out of tombstones for those killed by our tobacco barons. After 400 years of relative inaction, we are quite simply out of time to fail to engage meaningfully with this scourge on our society.

16:49

The Minister for Health and Community Care (Malcolm Chisholm): In this important debate, we have heard passionate and important speeches from all sides of the argument, such as those who favour legislation and those who want to see a more voluntary or market-based approach.

The debate has reinforced my conviction that we were right to commit ourselves to a policy that stimulates and welcomes an open and informed discussion on passive smoking, right to look at the evidence through the fog of claim and counter-claim, right to look at international experience and right to look at the facts.

Those facts, which were outlined so passionately by Tom McCabe and others during the debate, make us begin to appreciate the
importance of action to reduce exposure to second-hand smoke and the role that such action can play in improving Scotland’s health and tackling the health inequalities that continue to scar our nation.

We must acknowledge the fact that second-hand smoke contains more than 4,000 chemicals, many of which are known to cause cancer; that exposure to second-hand smoke can be a cause of asthma and respiratory disease in children; and that exposure to second-hand smoke increases the risk of heart disease as well as the risk of cancer. Faced with those facts, I assure Nicola Sturgeon that I entirely agree with her that doing nothing is not an option. Smoke-free workplaces and public places are the direction of travel, but the process of getting there and ensuring that action that we take is effective are important.

Action on Smoking and Health—ASH—is the leading campaigning charity in the field. It passionately believes in action to tackle passive smoking and it has clearly said:

“The process of reaching entirely smoke-free workplaces requires broad-based public support and increased awareness of the dangers of passive smoking. Resources must be allocated to building awareness of the risks and showing that the economic consequences would be minimal”.

That is what ASH has said and that is what we are doing. It is therefore wrong for Stewart Maxwell to complain about delay and prevarication. We will make our proposals before the end of the year and they will be better and more effective proposals as a result of the consultation.

Christine Grahame: I asked whether, if the Executive was moving towards legislation, the minister could give an idea of the timetable for when legislation might be in place.

Malcolm Chisholm: I have already said that we will come forward with proposals before the end of the year.

Tom McCabe outlined the process of consultation that will take place over the next few months. I hope that that process will prove to be the most successful and engaging public debate in the history of the Parliament. As we have heard, there were 950 responses in one day. With all due respect to Stewart Maxwell, his bill’s policy memorandum mentions 39 responses.

Mr Maxwell: I think that the minister is referring to Kenneth Gibson’s consultation rather than mine.

I wonder whether the minister could explain to me and other members what the thought processes were behind the design of the Executive’s consultation document, which uses a picture of a young, glamorous, attractive and well-dressed woman lighting a cigarette. Is that really the message that the minister wants to send out about smoking? The advertising industry is not allowed to use such images because they promote smoking in young people. Why was that image put on the front of the document?

Malcolm Chisholm: I was referring to the policy memorandum for Stewart Maxwell’s bill. I understand that the second point that he made can be debated. I imagine that the reason for the image was the prevalence of smoking among young women, but I understand the point that he is making.

We will encourage responses to our consultation through our website and hard copies of consultation documents will be distributed through surgeries, libraries and other places throughout Scotland. We will encourage employers from the public, private and voluntary sectors to raise awareness of the consultation process among their staff and we will welcome action by pubs and other businesses to encourage their customers to send us their views.

We are also putting a strong emphasis on research. We will consider public opinion in Scotland and conduct research among Scottish businesses in a variety of sectors. We have commissioned an expert look at the impact of passive smoking on mortality and morbidity in Scotland and we are taking time to have an in-depth look at the experience of other countries. We will consider the emerging evidence from Ireland. Johann Lamont’s speech was one of the most interesting speeches in the debate. As she said, she is a converted sceptic as a result of visiting Ireland. We will also consider the experience of Canada, in which 11 out of 13 provinces now have byelaws that deal in some way with passive smoking. We will consider the experience of New York city, where smoke-free-air legislation was introduced in a blaze of publicity in March 2003.

Mr Davidson: The minister talks about research on the effects of passive smoking. Will that research also cover the effects of smoking in the home?

Malcolm Chisholm: No—I think that it will concentrate on public places.

The process of gathering international evidence will culminate in a conference that will be held in Edinburgh on 9 September.

Murdo Fraser simplified and distorted the issue of freedom. By contrast, Nora Radcliffe said that there were issues relating to individual rights, but that those rights should not be at someone else’s expense. We are not going to force people to stop smoking, but we want them to recognise the potential impact that their decision has on others. We want them to think about how they can modify
their behaviour to reduce the harm that is caused to those around them; to recognise the importance of good citizenship; and to play their part in promoting the cause of health improvement in Scotland. Good citizenship involves respect for the right of smokers to smoke and the right of everyone to have their health protected from second-hand smoke. It is about recognising the health risks from passive smoking and taking action to ensure that we minimise those risks.

This is a genuine and open debate in which nothing is ruled out. Ted Brocklebank focused on that and suggested that there was a conflict between health and business interests in this matter. However, we also heard several remarks about the positive business opportunities that flow from smoke-free environments. There may not be the conflict that Ted Brocklebank identified.

There are a number of options. We have the ability to legislate to protect public health and we will consider all the options. We will look at the potential for a total, Scotland-wide ban and whether we should consider exemptions for places such as residential care homes. We will consider the option of a more targeted ban, as is proposed in Stewart Maxwell’s bill. Several interesting comments were made about that bill. Nicola Sturgeon said that it did not go far enough. Helen Eadie also felt that it was partial and did not deal with the whole issue. There were also issues of timing to which Ted Brocklebank referred. We need to wait until the end of the consultation process before we take a view on the issue as a whole and on Stewart Maxwell’s bill in particular. I hope that that is widely accepted in the Parliament.

Another option is to put the onus on local action and local decision making by local authorities. Whether that can be achieved without the kind of confusion and market distortion that many in the licensed trade seem to fear is very much an open question. Mention has also been made of the voluntary charter on smoking in public places. Progress on that has been disappointing, but we are prepared to listen to ideas for reinvigorating the voluntary approach.

The Executive’s action plan on tobacco control signalled a new determination to tackle smoking throughout Scotland. Since its launch in January, we have made new money available to support services for those who want to give up smoking. David Davidson emphasised the importance of that, but he should have acknowledged the considerable resources that are already being invested and the big increases in resources for that effort that will come on stream soon. We fully support helping individuals to give up smoking. That is a key part of our strategy. No one is saying that smoke-free environments in themselves will solve the problem; nevertheless, moving towards smoke-free environments has an important contribution to make.

We have worked with NHS Health Scotland to launch new and powerful advertising to raise awareness of the dangers of second-hand smoke and we have put together the comprehensive programme of public consultation that we have heard about today. Back in January, we committed ourselves to providing a breath of fresh air for Scotland and we now have our best-ever opportunity to demonstrate that commitment. I know that there are different opinions in Parliament and in the country; that is right and understandable. However, I ask everybody—whatever their opinion—to commit themselves to taking part in the national discussion on smoking in public places.

This is not about delay or prevarication. I was disappointed that Stewart Maxwell and several of his colleagues made that charge. This is about taking more effective action to move towards smoke-free places. The conclusions of the consultation will be announced before the end of the year—nobody can seriously call that delay or prevarication. This is about ensuring that the action that we take is effective and that we make progress on this important issue.
Ministerial Statement: The First Minister (Mr Jack McConnell) made a statement and answered questions on smoking.

Smoking: The Parliament debated the ministerial statement by the First Minister (Mr Jack McConnell) on smoking.
Smoking

The Deputy Presiding Officer (Murray Tosh):
The next item of business is a statement by Jack McConnell on smoking. The First Minister will take questions at the end of his statement, therefore there should be no interventions.

14:35

The First Minister (Mr Jack McConnell): This is a great time in Scotland’s history. Our Parliament grows in confidence and effectiveness, our economy is strong and employment rates are high, our public services are improving lives, with higher levels of achievement in education and more lives being saved by our health services, and poverty is decreasing, particularly among children and pensioners. Internationally, we have an increasingly positive profile. Our universities are admired, our artists are celebrated and visitors to Scotland increase in number and spend more money when they are here.

Scotland is a country of great talent, of enterprise, compassion and tolerance, but there are still national habits that hold us back. The time has come for Parliament to accelerate our action on health improvement. In comparison with the rest of the United Kingdom, with Europe and with too many countries worldwide, our mortality and morbidity rates across far too many indicators are lamentable. Poor diet, excessive drinking, lack of exercise and drug abuse all contribute to making us one of the unhealthiest nations in Europe. Too many people smoke and too many people die or fall ill from cancer, stroke and heart disease—the top three killer conditions that blight our country.

Since devolution, our action, investment and focus have been on tackling those three killers, and we are making progress. Rates of death from heart disease have fallen by 14.1 per cent, rates of death from stroke have fallen by 15.3 per cent and rates of death from cancer among people under 75 have fallen by 5.7 per cent. We have also taken action on diet and exercise and on alcohol and drug misuse; I believe that we are making progress on those, but the single largest cause of preventable premature death in Scotland is smoking. Smoking levels in Scotland are falling, but smoking among young women is increasing at a worrying level and it is becoming increasingly clear that passive smoking affects us all.

We made, in our partnership agreement, a clear commitment to increase the number of smoke-free areas in Scotland. In support of that, we launched our tobacco action plan in January 2004 and we embarked on a comprehensive consultation on smoking in public places. We conducted an opinion poll and commissioned research on passive smoking and on the impact of smoking legislation in other countries. We held public meetings all over Scotland, surveyed young Scots and hosted an international conference in Edinburgh to consider international expertise. I and others visited Ireland to see at first hand the effects of the smoking legislation there.

It was a comprehensive consultation, which sought views, sparked debate and gave all sides in the debate the opportunity to put their cases. I want to record my appreciation of the early steps that Tom McCabe took to take that consultation forward, and I also record my appreciation of Stewart Maxwell’s efforts in raising the issue here in Parliament. We conducted those assessments of impact and of opinion fairly, thoroughly and thoughtfully. We have consulted more widely than on any other issue since devolution, and few issues have generated so much sustained debate.

We know that the case for reducing smoking and exposure to second-hand smoke is indisputable. Every year, 13,000 families in Scotland lose loved ones through smoking-related death and about 1,000 of those deaths are associated with passive smoking. Every year, 35,000 Scots are treated for smoking-related diseases and across the UK 17,000 children under the age of five are admitted to hospital each year because of the effects of passive smoking.

The consultation has provided new evidence on the impact of smoking bans and a greater range of information on public opinion. Here is the evidence. The smoking bans in Ireland and in New York have helped smokers to give up quicker and have encouraged smokers to smoke less. Cigarette sales have dropped by 13 per cent in New York and by 16 per cent in Ireland. Our research estimates that there will be a net economic benefit—not a disadvantage—for the Scottish economy as a result of any ban. Tax revenues from bars and restaurants in New York have increased by almost 9 per cent since the ban was introduced there and despite the dire warnings, the first official figures from Ireland show that volume sales are down by only 1.3 per cent and were falling before the ban became law.

The majority of Scots do not smoke; of those who do, the majority want to give up. There is widespread support throughout Scotland for a ban on smoking in public places, but there is also support for exemptions. However, the international evidence shows that a comprehensive and clear-cut law to create smoke-free areas is more enforceable and more effective.

Crucially, medical opinion highlights the impact that active and passive smoking have on our national health; medical bodies, cancer charities and others want us to take a clear and decisive step forward.
After having consulted more widely than ever, the Scottish Cabinet met this morning to consider the action that we will take on smoking in public places. We had in front of us reports on the consultation and on the impacts of smoking legislation—those have been placed in the Scottish Parliament information centre today. We noted the strong support for a comprehensive ban and we noted the reservations of many on the detail. We also noted the unequivocal evidence that smoke-free public areas will save lives and improve Scotland’s national health. We noted the evidence that productivity will increase and the expectation that we will be a more confident and attractive country if we take action on smoking in enclosed public places.

We have considered the arguments and the evidence and we are clear that Scotland must not be held back by our poor public health. The single biggest contribution that our devolved Government and we elected members of the Scottish Parliament can make to improving public health in Scotland would be to reduce the toll of preventable premature deaths from smoking. Therefore, I am proud to announce to Parliament today that we will, with Parliament’s support, introduce a comprehensive ban on smoking in enclosed public places.

A comprehensive ban will be a clear signal that Scotland has changed. The ban will reduce smoking, save lives and help transform our national health. A comprehensive ban will be easier to enforce and simpler to understand than other options that fall short of it. Private clubs will not be exempt; the only exemptions will be in private and specific circumstances.

There will be opposition to the decision, but Parliament must do what is right in the national interest and we must persuade those who have reservations to embrace the opportunities that the decision will create. For individuals, the ban will offer the opportunity to cut down or to stop smoking and it will create the opportunity for our children and grandchildren to grow up with less pressure to smoke and less likelihood of their dying early.

For the hospitality industries, the comprehensive ban will create opportunities for improved productivity, for a whole new positive image and for more, not fewer, customers. For Scotland, the ban will give us the opportunity to transform our national health.

We will take steps to implement the decision together with those who will be affected by it, rather than seek simply to impose it on those who are addicted or on those who are worried about their business. We will establish a national smoke-free areas implementation group, which will be chaired by the Minister for Health and Community Care, and we will invite the licensed trade and others to join that group and assist us in the task. We will double our health service support for those who want to stop smoking but who need help to do so. We will also prepare an international marketing campaign to promote Scotland as a country where tourists can enjoy a smoke-free environment, where business can expect improved health and productivity and where our sick man of Europe image is firmly in the past.

On enforcement, we have seen the scare stories and the attempts to portray our chosen way forward as draconian and as an infringement of personal liberty. However, the Scottish people are proud of the Scottish legal system. Scots do not need the threat of fines of more than £3,000 to obey the law and our police officers should, of course, be catching serious criminals and keeping our communities safe as their first priority. Our decisions reflect that. All the experience in San Francisco, New York, Dublin and elsewhere—in cities and countries that have been brave enough to take the same decision—suggests that members of the public enforce smoke-free areas themselves.

However, we must be clear about the penalties and responsibilities. Licensees or employers who fail to enforce the law in their premises will face fines up to a maximum of £2,500 and licensees who persistently refuse to comply with Scottish law will face the ultimate sanction of their licence being withdrawn by the local licensing board. In consultation with those who will be charged with enforcing the legislation, we will examine a system for issuing fixed-penalty notices for individuals who smoke in enclosed public areas. We will introduce a maximum fine of £1,000 for persistent offenders. Environmental health and local licensing standards officers will be responsible for enforcement and the Convention of Scottish Local Authorities and its professional bodies will be invited to join the implementation group to prepare local authorities for that responsibility.

We have made a decision and we must lay out a timetable. If it is the right decision for Scotland, as we believe it is, there should be the minimum delay. We need to act quickly, but we also need to give those who will be affected time to prepare. We have considered the legislative options and balanced those two objectives and we will introduce the necessary legislative proposals in the health service (miscellaneous provisions) bill, which is due to be introduced before Christmas. We will set a target date for full implementation in spring 2006.

Devolution has provided us with the means to make a difference that is suited to the specific needs of Scotland. There is no greater action that we can take to improve the well-being of children
and families in Scotland for generations to come than to secure legislation to make Scotland's public places smoke-free.

However, more than anything else, the reason why smoking in public places should be illegal is the message that that will send to our nation. No longer will Scotland be the place in Europe that is most associated with poor health. No longer is Scotland prepared to sit back and let cultural traits prevent national progress. No longer does Scotland need to wait for someone else to take responsibility for difficult decisions. The greatest rewards for our country can be achieved by taking the toughest decisions. The prize is not a new set of laws or the restriction of personal freedoms; it is much greater than that. We in Parliament have a chance to take the most significant step to improve Scotland's public health for a generation. That is a chance that this Government is willing to take and an opportunity that Parliament should not miss. I do not believe that the Parliament will miss the opportunity.

The Deputy Presiding Officer: The First Minister will now take questions on his statement. I intend to allow 35 minutes for questions before we move on to the debate.

Nicola Sturgeon (Glasgow) (SNP): I welcome the First Minister's statement and join him in congratulating Stewart Maxwell on the work that he has done on the issue. I also welcome the fact that the Scottish Executive has opted for a consistent ban on smoking in public places and has ruled out unfair exemptions for private clubs.

I believe, as does the Scottish National Party, that the time has come for a ban on smoking in public places. There is evidence that a ban will cut deaths from passive smoking and make it easier to give up smoking for the 70 per cent of smokers who desperately want to kick the habit. We must also recognise, as the First Minister acknowledged, that many people have concerns and reservations—many people are yet to be persuaded.

Does the First Minister agree that the process of moving towards a ban must involve as clear a public debate as possible, so that the concerns that many people have can properly be addressed? Will he, on reflection, agree that it would be quite wrong and would simply confuse debate to introduce a ban on smoking as part of a miscellaneous provisions bill that will also address big, controversial issues such as organ donation and, as I understand it, perhaps the fluoridation of water? Will the First Minister think again and, in the interests of a full debate, give an assurance that he will introduce a bill that will deal specifically and exclusively with smoking in public places within the timescale for implementation that he set out?

The First Minister: I welcome the Scottish National Party’s support for the measures that I outlined. Some issues in this country transcend the boundaries between our parties—this is one of them. I hope that we can work together to secure effective and well-implemented legislation that makes the difference that we all want it to make in Scotland.

We must choose a legislative route for the proposals that causes the minimum delay and that is firmly rooted in the Parliament's health legislation. Therefore, I believe very strongly that the right route is to introduce to Parliament next month a bill that includes the provisions. That route will give Parliament the chance not only to consider the primary legislation, but to see the important draft regulations. Parliament should be able to debate the proposals as openly as possible and to legislate for them as quickly as possible. That is the right thing for us to do and that is the route that we have chosen.

David McLetchie (Edinburgh Pentlands) (Con): I thank the First Minister for the courtesy of providing us with advance notice of his statement. As he is aware, because of the health hazards that smoking poses, all parties share a desire to see a reduction in the incidence of smoking in Scotland.

As I am sure the First Minister will acknowledge, he does not have a monopoly of concern in such matters. The Conservatives welcome the substantial progress that has been made to date thanks to public health campaigns that have been run by successive Governments over many years. It is fair to say that Conservative members have legitimate concerns—as I am sure many other members do—about the First Minister’s plans and proposals to achieve further progress in this area. I have several questions to put to him.

First, is the First Minister’s approach to the issue of banning smoking in public places based on objective analysis of available evidence about environmental tobacco smoke—or passive smoking, as it is better known—or is his approach based on the unscientific assertions that have characterised much of the debate on both sides of the argument?

Secondly, the First Minister said in his statement that there was “widespread support” for the ban. However, press reports at the weekend indicated that as part of its consultation exercise the Scottish Executive conducted an opinion survey, which demonstrated that three quarters of Scots do not want a total ban. Whether they were smokers or non-smokers, people said that a more reasonable and balanced approach should be taken to the issue. Will the First Minister confirm the Executive’s poll’s findings? As a supporter of freedom of information, will he publish the findings in full so that we can all see them for ourselves?
Thirdly, the First Minister’s proposals in respect of exemptions, to which he referred in his statement, will be of interest to many people. Are prisons to be exempt from the ban, as is the case in Ireland? If prisons are to be exempted, is not it ironic—and, indeed, entirely typical of the First Minister’s brave new Scotland—that criminals can be smokers while smokers will become criminals?

The First Minister: The decisions that the Cabinet took this morning were based not only on the most widespread consultation ever by Government in Scotland, but on the analysis and evidence that we compiled at the same time as the consultation was taking place. When the Cabinet made its decisions today, it made them based on all the evidence that was placed in front of it. The decisions were based on the clear and consistent evidence that is accepted by everyone apart from those who have a vested interest in retaining the status quo or who seem to want to appear to be the spokespersons for those interest groups.

Passive smoking kills. It also significantly worsens medical conditions and affects young children in particular. We need to take this stand not only for employees, as is the position in Ireland, but for the public health of Scotland. It is within our competence as a Parliament to do so and we intend to act on the matter.

We conducted an opinion poll as part of our wide-ranging consultation. As I said in my statement, one of the most interesting things about opinion surveys on this issue is the way in which the answers that people give to the questions that are posed differ depending on the questions that are posed. If people are asked whether they want an all-out ban, huge numbers of them say, “Yes”. If people are asked whether they want exemptions, and if specific exemptions like pubs or other examples are mentioned, a huge majority of people again say that they are in favour. That is why there is a duty and a responsibility on this Parliament and this Government to show leadership. We need to ensure that the right decision is made in the national interest of Scotland. Although we will be guided by public opinion, by popularity, by the surveys that we have conducted and by the consultation, we need to make the right decision; I believe that we have done so.

Finally, let me make it clear that although Ireland has a number of exemptions that are specific in some senses, but which are also fairly broad, it is important that we protect the rights of non-smokers and smokers who want to give up in our prisons and in other places, as well as protect the rights of people out in the street and in their own homes. This is about Parliament taking a firm stand for the non-smoking majority of Scotland and for those who smoke and want to give up. It is important to find a solution that does that, so we intend to find it. Although there will be exemptions, and although we have to ensure that the rights of people in their own bedrooms or their own homes are secure, we will at the same time have to ensure that in public places—which includes public establishments such as those that are exempt in Ireland—smoking is banned.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The Liberal Democrats are delighted that this health promotion measure, which is so important to us and to Scotland, is to be introduced so comprehensively. However, the First Minister said that private clubs will not be exempt. The only exemptions will be in “private and specific circumstances”, which the First Minister elaborated on a second ago. Can the First Minister elaborate further and give us the reasons for including private clubs within the scope of the proposed legislation? Is it to close supposed loopholes? Could we have more detail on that?

The First Minister: As I said, our decisions were based on the evidence and on proper analysis of the effectiveness of action in other countries, such as Australia, and in states in the United States of America. The reality is that the best way forward is a comprehensive and consistent ban that not only the people who live in a country but those who visit it can clearly understand. It is best in terms of implementation and it is best in terms of acceptance among the general population.

I recognise that there will be real sensitivities in relation to private members clubs, but members of the public visit private members clubs, and non-smokers in private members clubs have rights, too. We want to ensure that the ban is as comprehensive as possible. We want the maximum number of enclosed smoke-free areas in Scotland, which is why we intend to introduce the measures. However, we will ensure that the proposed legislation that we bring to Parliament has been properly scrutinised and that we have received the proper advice. We need the combination of health legislation and licensing legislation that we will put to Parliament next year to be properly enforced in all areas.

Paul Martin (Glasgow Springburn) (Lab): As an MSP who represents a constituency where the incidence of lung cancer is 93 per cent above the Scottish average, I welcome the First Minister’s statement.

In respect of future generations, Patricia Ferguson and I were joined by pupils from Chirnside Primary School and St Philomena’s Primary RC School, and a straw poll of those pupils made it clear that they would also like to see a ban. Today we are reflecting public opinion, young and old.
The First Minister wants people to give up smoking, but there have been no specifics on how he will direct resources. Helplines and glossy leaflets do not work in this area, so how will the First Minister ensure that we assist people to give up smoking?

The First Minister: I thank Paul Martin for those points. I have seen much of the correspondence from young people throughout Scotland that has come in as part of the consultation. Today, I met pupils from four schools who took part in the consultation. The views of young people in Scotland are clear—a clear majority want a comprehensive effort to secure smoke-free areas that they can enjoy as they grow older.

I also know about the importance of supporting people who have started to smoke and who want to give up. The reality in Scotland today is that 70 per cent of people do not smoke. Of the 30 per cent of people who smoke, two thirds want to give up, but they find it hardest not to smoke in public places where they socialise. The areas where people find it harder still to give up are the most deprived areas that face the greatest economic and social challenges. That is why we will not only double our efforts through the health service to support individuals in Scotland to give up smoking, but will ensure that money is targeted at the constituencies or areas of Scotland that most require assistance. The gap in life expectancy between some of the constituencies that are represented in Parliament is far too large and far too much of it is attributable to smoking. We want to assist those who are in the greatest danger with the maximum effort to help them to stop smoking and secure a longer life.

Eleanor Scott (Highlands and Islands) (Green): I will follow on from the previous question. How will the health promotion initiatives and information be targeted specifically at young women? I share the First Minister’s concern about the increasing level of smoking among young women—they are the one group in Scotland among whom smoking levels are not reducing.

I support the ban and the proposals and I welcome the First Minister’s statement. He said that environmental health and local licensing officers will be responsible for enforcement. What additional resources will be provided to local authorities to enable those officers to fulfil that role?

The First Minister: We expect that the implementation group’s discussions will involve discussion with local authorities about additional resources that might be required. We will have an open mind on the issue and ensure that local authorities and environmental health officers are well enough resourced to perform their important task.

I welcome the support of the Green group of MSPs for the proposed legislation. I welcome the cross-party support that we have received. I hope that we will secure a large majority on the issue in the Parliament, which I am sure will help us to unite the country.

I fully understand the point about young women in Scotland. The social pressures that have led to increases in smoking levels among young women in Scotland do not cause immediate problems only for them, but problems that can come back to haunt them in later life. I am absolutely determined that, when we focus the resources that I mentioned to help people give up smoking, we will take into account the particular challenge that we face with young women. On a lighter note, we should also realise that the proposed legislation will generate a lighter and positive response from the many young women throughout Scotland who are sick and tired of going out on a Friday or Saturday night and coming home absolutely stinking of smoke and finding that they cannot go out the next night wearing the same gear or without washing their hair and cleaning up. It is high time that we gave people in Scotland a chance to enjoy their leisure and social time in a clean, smoke-free atmosphere, which is what we intend to do.

Mr Duncan McNeill (Greenock and Inverclyde) (Lab): Does the First Minister agree that it would be counterproductive to have fewer people smoking in public, surrounded by adults who choose to be there, but more people smoking in their living rooms, surrounded by their kids? I am pleased that resources and support will be targeted at the deprived communities that suffer greatly from the incidence of smoking. How much money will be used to reduce smoking overall, rather than just to switch the situation round?

The First Minister: The current spend in the health service on smoking cessation services is about £3 million a year throughout Scotland. We intend to more than double that and we will do so by the time that the proposed legislation comes into force.

Shona Robison (Dundee East) (SNP): Some of us would never dream of leaving the house without washing our hair.

I sincerely welcome the First Minister’s statement, which is a landmark for the Parliament. The First Minister referred to the proposed system of fines and he will be aware that Ireland’s system of fines is directed towards licensees rather than individuals. Why has the Executive decided to go down the road of fining individuals as well as licensees? Will the First Minister clarify what persistently breaking the law means, and how many breaches of the law would be required for the £1,000 fine to kick in?
The First Minister: One of the key discussions that we need to have over the coming weeks—we will produce proposals on it in due course that can be well scrutinised by Parliament—relates to the potential for fixed-penalty notices. Such systems work in many similar areas and should be able to work in this case. However, before we come forward with definite proposals, we should discuss with those who might have to implement the notices the provisions that would be required and the impact that those provisions might have.

We believe that it is important that, rather than have a draconian piece of legislation, which goes over the top as far as fines are concerned, there should be a firm disincentive for everybody in relation to the legislation. There should be not only a firm disincentive for the licensees and those who are responsible for property in which smoke-free areas are created, but a responsibility on the part of individuals. I am sure that that matter will be debated at great length in the committee over the next few months. We believe that we have found the right balance. We believe that the prosecuting authorities in Scotland are well able to judge when, and in what circumstances, it would be right to move towards a prosecution and towards the potential of a fine at that level. However, there will be further advice and guidance in the course of the discussion in committee.

Irene Oldfather (Cunninghame South) (Lab): I warmly welcome the First Minister's statement and assure him of the support of the cross-party group on tobacco control in pursuing this radical action, which will save Scottish lives. While recognising the humanitarian arguments that exist for specific exemptions, will the First Minister give an assurance that frail elderly people in day centres, residential homes and nursing homes who do not smoke—or have given up smoking—will be protected from the harmful effects of passive smoke—or have given up smoking—will be protected from the harmful effects of passive smoking? Does the First Minister envisage that exemptions may be phased out over time?

The First Minister: In the short term—and, I suspect, in the medium term and possibly the long term—there will be circumstances in which, for humanitarian reasons and reasons of consistency with other laws, we will need to ensure that people have the opportunity to smoke. However, in designing the laws that we bring before the Parliament we need to protect, in as many establishments as possible, the rights of those who do not smoke or who do not want to be in public areas where smoking is taking place. In relation to care homes, we require to make a very sensitive and challenging decision. However, when we come to Parliament with our detailed proposals—the details that would be included in the regulations that would follow from primary legislation—we will outline to the committee the way in which we intend to deal with that matter in advance of Parliament being asked to vote.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I congratulate the First Minister on his statement. Having spent most of my life looking after people who are suffering the adverse effects of cigarette smoking, I found it to be wonderful news. Some stroke and cancer figures have been reduced, but despite the fact that lung cancer kills more people than breast cancer and prostate cancer put together, and despite the fact that most lung cancer patients are ex-smokers, researchers into lung cancer still feel that it is a Cinderella area of research. Will the First Minister give more money to research on lung cancer?

The First Minister: My understanding is that research into lung cancer is particularly difficult, but I am happy to take on board that point and respond to it at a later date. I agree absolutely that the impact of lung cancer, which Dr Turner has seen throughout her working life, is one that far too many people in Scotland experience in their families, among their friends and in their neighbourhoods. Anyone in the chamber who has had a member of their family dying of lung cancer will know just how traumatic and awful that experience is, not just for the person who is dying of lung cancer but for their family.

Karen Gillon (Clydesdale) (Lab): As an asthmatic I very much welcome the opportunity that the ban will provide, once it is in place, for me to socialise without requiring additional medication. Given that I represent Carstairs state hospital, I want to ask the First Minister about the situation for psychiatric patients. How will we get the balance right between allowing exemptions and protecting the rights of people in the wards who do not want to smoke?

The First Minister: That is the third in a trio of points, to which I will give a consistent answer. In Ireland the exemption covers prisons, care homes, which were mentioned earlier, and the psychiatric services. We need to be clear that we have a duty and responsibility to protect those who are in the psychiatric hospital who are non-smokers and who would like a smoke-free environment. It is therefore important that, in relation to the psychiatric hospital, we try to achieve the balance...
that I talked about earlier in relation to prisons and care homes.

Mr Stewart Maxwell (West of Scotland) (SNP):
I join others in welcoming the statement. I am delighted to be here in the Parliament as we take the first steps towards a smoke-free, healthier Scotland. I want to press the First Minister on the timetable that he mentioned in his statement. He said:

“If it is the right decision for Scotland ... there should be the minimum delay. We need to act quickly, but we also need to give those who will be affected time to prepare.”

Although I agree absolutely with that statement and the sentiments behind it, I am not sure how the leap was made from it to the health service (miscellaneous provisions) bill. The opposition will mount a particularly fierce campaign, which is one of the reasons why we should have minimum delay. However, we also want to give those in the industries that will be affected the maximum time to prepare for the enactment of the bill. Given that the Prohibition of Smoking in Regulated Areas (Scotland) Bill—my bill—would be passed by the Parliament before Easter if it continued through the normal parliamentary process, while the miscellaneous provisions bill will take longer as it has not yet been published and will cover a number of other contentious issues, how has the First Minister taken the sentiment about minimum delay and created the idea that we should act through the miscellaneous provisions bill, rather than through the dedicated bill on smoking that I introduced earlier this year?

The First Minister: I mentioned one of the reasons earlier: we believe that the provision should be rooted firmly in health legislation, because, as Stewart Maxwell said, those with a vested interest who oppose the ban will mount a vociferous challenge to it. I am sure that one of the things that they will challenge—they have already threatened to do so—is the Parliament’s competency to legislate in this area. We are clear that the position on the Parliament’s competency to legislate will be stronger if we legislate on the ban as part of a bill on health provisions. That is one of a number of reasons for our legislating in that way.

It is important that we get the provisions before Parliament before Christmas, which is what we intend to do. We rejected the other options that were available to us. We have plans to introduce a public health bill at some stage in this session, but leaving the provision until then would have meant that we had to wait too long. It would not be appropriate to include the provisions in the proposed liquor licensing bill, but it is appropriate to include them in a health bill, which is what we intend to do.

Murdo Fraser (Mid Scotland and Fife) (Con):
The First Minister made it clear in his statement that he considers that issues of public health should take precedence over issues of personal liberty. Given that that is his stance, what other areas and aspects of human behaviour that are injurious to public health does he plan to legislate against?

The First Minister: There will be other debates at other times on other areas of legislation and there are, of course, many areas of public legislation in this country that have an impact on people’s personal liberty and impose on them duties and responsibilities. The issue of seatbelts is an obvious example, but there are many others.

To be frank, Murdo Fraser’s question misses the point. Absolutely nobody in this chamber, to my knowledge, wants to ban people from smoking. Smoking is a matter of personal liberty and is a choice that people have. However, it is wrong for our country and for the individuals who are affected for us to have a situation in which the actions of one person can cause a great deal of damage to another. We need to show leadership in this Parliament and to change the nature of our country. I believe that that is possible.

There are those who say that it will not be possible to introduce such a ban in a country like Scotland, but I do not accept that. Ireland has many similarities to Scotland and, in Ireland, the ban is not only enforced but is an absolute success. There are those who say that, in Ireland, the ban will cause problems in the winter. That is not true either—the ban in New York works in the winter and every month of the year is wetter in New York than it is in Edinburgh. Further, in New York, although the summers are warmer, the winters are colder than they are here. Nevertheless, in New York, people adhere to the ban and respect the law. For hundreds of years, people in Scotland have respected the basic laws against?...

Margaret Smith (Edinburgh West) (LD): I very much welcome the First Minister’s statement, bearing it in mind that passive smoking is associated with 865 deaths in Scotland every year. However, I will play devil’s advocate in relation to a justice issue. Does the First Minister have any thoughts on what the impact of the displacement of people from public houses into our public streets will be? What has been the impact of numbers of people congregating outside public houses in countries that have introduced a similar ban?
The First Minister: We have to consider the evidence from elsewhere. When issues are taken in isolation, they can be worrying, but when we look at what has happened in cities, states and countries around the world that have been brave enough to take the decision that we are discussing, we can see that the legislation on smoke-free areas has worked in practice. People do not cause trouble or public nuisance out on the street; they respect their duty as citizens to obey the law inside the public houses and to behave reasonably outside.

I recognise the worry that Margaret Smith expresses, but I also recognise that, where bans are in place across the world, those bans are enforced effectively and people do not cause a public nuisance in the areas outside the enclosed spaces that are affected by the bans.

Christine May (Central Fife) (Lab): I, too, welcome the First Minister's statement. However, I draw his attention to the fact that, today, Radio Telefís Éireann is reporting the first prosecution of a publican on the charge of failing to enforce the ban. The publican, who is in Waterford, did not enforce the ban on the grounds that many of his customers were elderly and found it difficult to change.

I welcome the First Minister's assurance that a committee will be set up to consider the actions that can be taken to help business prepare for the ban. What discussions has the First Minister had with the trade unions, health boards and others who have worked hard to improve public health on the subject of activities that might be supported by the Executive, such as the issuing of free nicotine patches on a trial basis in pubs? That sort of initiative would ensure that publicans were assisted to enforce the ban.

The First Minister: A range of services and support initiatives can be put in place for individuals and businesses. It is important that we engage with the business community to involve businesses in the process of delivering the legislation and, more important, preparing for its implementation. I believe that businesses have nothing to fear. I do not believe that they should be terrified of this change. They should seize the opportunities that exist. If we get the implementation of the legislation right, those businesses will have more customers, not fewer; their business premises will be better environments; and their staff will be looked after properly.

Businesses will have a real opportunity and I hope that, not only in the education and support programmes that Christine May mentioned but in the work that we can do to promote Scottish businesses in the hospitality sector, we can use the implementation group as an opportunity to come together, discuss ideas and go forward together rather than being at loggerheads over a decision that I am sure will be controversial but which is right.

The Deputy Presiding Officer: That concludes questions. My regrets go to the seven members whom I have not been able to call, but I must go to the next item, which is a debate on the ministerial statement on smoking. No question will be put at the end of the debate.

15:20

Mr Stewart Maxwell (West of Scotland) (SNP): I thank the First Minister for his statement and for his personal comments on the work that I have done since I was elected on trying to achieve a smoking ban in Scotland.

Today, Scotland is the sick man of Europe. Scotland has the highest rate of female lung cancer in the world and the lowest life expectancy at birth in the European Union. Scotland is only now achieving the levels of life expectancy that were seen in other European countries in 1970. Other countries have made progress with health improvements while we have been left behind. In Scotland, our diet is poor, we drink too much and, most important, we have some of the highest smoking rates in Europe. Smoking is the single biggest cause of preventable premature death and ill health in Scotland. Ireland and Norway have implemented full smoking bans, and with the introduction of those bans health in those countries will take another leap forward. Without a similar ban here, Scotland will fall even further behind.

Without a ban, it is not only in health that we will lag behind the rest of Europe. A young family that wishes to go on holiday is far more likely to choose Ireland, with its healthy, forward-thinking image and its smoke-free bars and restaurants, than a smoky Scotland. We must not let that happen. If someone wanted to emigrate for a better life, where would they choose: a country that has a reputation as the sick man of Europe, or a vibrant country with a young population and a proven commitment to passing and enforcing public health policies to protect the health of its population? If we do not introduce a full ban, we will endanger our tourism industry, our chances of attracting new, young immigrants, our image in the eyes of the world and the economic benefits that all those things bring.

Scotland has to make up lost ground in health, tourism and self-belief. It is time for us, as the policy makers of Scotland, to stand up for the health of the people of Scotland. We must not be intimidated by the blustering of vested interests in the tobacco industry, who have no interest in the
health of Scotland’s citizens. Great advances in health are made by legislators who have the courage to act. In the 19th century, Glasgow undertook the massive engineering project to pipe clean water from Loch Katrine. In the middle of the 20th century, the Clean Air Act 1956 was passed, saving many lives in Scotland. Now, we have a Scottish Parliament and we must take responsibility for our health and have the courage to act. By implementing a ban on smoking in public places, we will place ourselves firmly in the footsteps of the great reformers of the past who did so much for public health.

However, I sound a note of caution and concern. In this week’s newspapers there have been leaks stating that the Executive will cave in to pressure from the pro-tobacco lobby during the passage of the legislation by introducing exemptions for certain places. I hope that that is not true; I hoped that the First Minister would make the matter clear today, but I still have slight concerns and I hope that clarity will be forthcoming, perhaps when the Minister for Health and Community Care speaks later. It is entirely unacceptable for certain clubs to be exempt from the ban and I hope that the First Minister will dismiss that proposal out of hand. It is not acceptable for certain groups to be allowed to use their money to avoid the law. People should not be exempt from a ban just because they pay to join an upmarket club. Money should not be the deciding factor, and I agree with the Scottish Licensed Trade Association when it says that there must be a level playing field.

**Mr Brian Monteith (Mid Scotland and Fife) (Con):** The member has often cited New York as an example of a place where a smoking ban has worked. Is he aware that in New York there are exemptions for cigar clubs? They are not just bars or cafes, but have a substantial turnover of cigar sales and they are given exemptions as long as they can prove that that turnover continues month on month.

**Mr Maxwell:** It is true that New York has such exemptions, which I do not support. America has a different society from ours. We do not allow people to buy their way out of complying with the law or with regulations that are enforced for poorer people in society. To do so is wrong, unfair and unjust.

I am disappointed that the Executive intends to make this important and culture-changing provision a section in a miscellaneous provisions bill. Choosing that route will appear to the people of Scotland, and will be portrayed by some, to be underhand and aimed solely at stifling debate, because the matter will be mixed with many other contentious issues. I urge the Executive to reconsider and not to take that road. The measure is the single most important piece of public health legislation that the Parliament can enact and it is far too important to be mixed with other issues in a general bill. We must have a bill that deals exclusively with smoking.

The Parliament has a duty to ensure that Scotland’s health is protected as speedily as possible—the First Minister mentioned that in his statement. If we fail to do that, the ban’s opponents will have more time to scaremonger and to frighten the people of Scotland with lurid and nonsensical tales of job losses and economic meltdown. They will use their financial strength to mount hysterical opposition, which we must prevent.

How does the Parliament introduce a dedicated smoking bill quickly? That is easy. My Prohibition of Smoking in Regulated Areas (Scotland) Bill is already with the Health Committee. Its stage 1 debate is due in January and it could pass stages 2 and 3 and complete the parliamentary process by Easter 2005. That would be the quickest, simplest and best route to achieving a full ban.

**Kate Maclean (Dundee West) (Lab):** The Health Committee heard evidence about the partial ban that the bill would introduce in places where food was served, so does the member agree that we would have to take evidence again? I know that many people gave evidence about a full ban, but we did not call for evidence on that, so we would have to issue another call for evidence. That means that the timescale could not be as truncated as the member suggests.

**Mr Maxwell:** I agree that the Health Committee took evidence in relation to food, but virtually every witness—and certainly every Health Committee member—talked and asked questions about a full ban. If the committee wished to take evidence at stage 2, I am sure that that would be perfectly acceptable, but it would not take as long to pass that bill as it will take to pass the health service (miscellaneous provisions) bill. The Executive’s proposals will drag on well into 2005, as the miscellaneous provisions bill will be published only by the end of this year, so it will take time to be passed.

A few simple amendments are all that would be required to bring my bill into line with the objective that the First Minister announced: a full ban. I have told the Health Committee of the small number of amendments that would be required. Since we moved to the new Parliament, the First Minister has talked much about raising our game. In imposing a full ban on smoking in public places, we would be at the top of our game on public health.

We must work together to introduce successfully a full public-places ban. By supporting my bill, the First Minister, the Executive and the Parliament
would take a great opportunity to show political maturity and a willingness to participate in a cross-party way for the good of all the people of Scotland. However, instead of working with other parties, the Executive has been unable to put aside party-political differences on the matter for the benefit of the people of Scotland.

I urge the Parliament again to show our country and the world that the health of the people of Scotland comes above all else. We can do that by working together to put in place a full public-places ban as soon as possible by supporting and amending my bill.

15:28

Mr David Davidson (North East Scotland) (Con): It is interesting that we have started a public debate. No vote will take place after our debate—this is another stage in a public debate that we are willing to participate in.

I do not smoke and have never smoked and I would like tobacco consumption to be reduced. That has been the aim of Governments in the past few decades, although Chancellors of the Exchequer seem to have a vested interest in the continuation of consumption. Equally, I do not want cannabis or ecstasy to be legalised and I do not want alcohol use to increase through binge drinking. Public health does not have only a single front.

We must educate our people to make healthy lifestyle choices and to take responsibility for their health. That is not the same as merely saying that the state will do that for people. In particular, we must engage our young people in how they live their lives, what the risks are and what choices they have.

Many of us do not argue with the idea that smoking and tobacco consumption should be reduced.

Shona Robison: Will the member take an intervention?

Mr Davidson: In a minute.

The debate is about how we get there. People have freedoms and we have to treat them as adults and ensure that they have the tools to do the job. It is not just a case of someone making a decision and that is it; that would make for poor legislation and is a misuse of legislative power.

Shona Robison: Last night, the member’s colleague, Brian Monteith, seemed to question whether passive smoking was harmful to people. Does the member think that there is evidence—I think of what he has heard in the Health Committee—that passive smoking can be dangerous to health?

Mr Davidson: I do not argue with that point. As a health professional I know that very well. Passive smoking can exacerbate certain conditions. However, we need real, internationally reputable evidence that people die from passive smoking. I would welcome research into that area because that would add to the public debate; it would not be just an opinion of one or two in Government.

In other countries, decisions of state bodies have been reversed because of the lack of quality in the debate. When Sir Richard Doll first came out with his passive smoking research, he was on one side of the argument. He looked at the issue again, recanted and withdrew.

We need clear and substantial evidence from the medical community on passive smoking. If the evidence shows that it is dangerous, we should deal with it then.

Mike Rumbles: Will the member give way?

Mr Davidson: I will move on.

No one is arguing about the health risks of smoking, the deaths that it causes and the cost to the national health service. However, I am afraid that I am a gradualist when it comes to changing public opinion and behaviour. The Irish took 14 years to bring in a ban. I met members of the Irish Government and we discussed the issue at length. They thought that their minister responsible for health had jumped the gun on what they thought was going to be a progressive change of policy that included education.

As I have said before, from 1971 to 1996 in this country tobacco consumption fell by more than 37 per cent, which is one of the best records in the world. That was due to a mixture of price mechanisms, education and voluntary controls on advertising. Other systems are coming in. The voluntary charter was short-lived but was very successful, except for the issue of signs on premises. We needed a stage 2 voluntary charter, stiffened up with better targets, then a stage 3 charter. That is the way to take people with us. Trains, planes, buses, cinemas, theatres, shopping malls and most workplaces have all become smoke-free on a voluntary basis. There has been no compulsion.

Choice is promoted by this Parliament and there is provision in the building for those who choose to smoke here. Will that be copied in hospitals? There have been queries from Labour backbenchers about care homes, prisons and so on.

Helen Eadie (Dunfermline East) (Lab): Will David Davidson take an intervention?

Mr Davidson: In a moment.
What about the freedom to choose? Why are we not approaching the legislation on the basis that suitable premises can offer choice for the non-smoker? I would like to have that choice, as would smokers, and with progressive legislation, people would have choice. As Duncan McNeil said, there will be displacement.

The main issue is whether we are looking after the health of our young people and children. If people move away from pubs completely and go to the off licence, they will buy twice as much alcohol probably for less money, they will drink it two or three times as fast, they will do it at home and their children will be affected by smoking. Bodies that are concerned about alcohol consumption are worried about that.

I see that Mr Maxwell is desperate to make a point.

Mr Maxwell: The member seems to be giving us a litany of mere speculation, not evidence. Has he any evidence to back up what he suggests? Research evidence from Australia shows that the opposite happens: when a ban is introduced, people smoke less at home, not more. What evidence does he have to suggest that what he says is true?

Mr Davidson: I am saying that that is the risk that we are taking.

We have to ensure that the people of Scotland have a choice. We cannot ban activities such as hill-climbing because an element of risk is involved. We have to educate people about the difficulties and the risks that they take.

I am disturbed about the way in which the provisions are going to be sneaked into an all-purpose bill. I believe that the issue is so important that it should be discussed straightforwardly as a stand-alone piece of legislation—I think that I have the SNP’s support on that point. What we are discussing and how we arrive at our conclusions should be clear so that the debate is proper and fair. I am afraid that there are many questions and I do not think that the First Minister went down a clear route on the options that are going to come up. I look forward to seeing the quality of the proposed legislation. I hope that the bill will not be rushed through the Parliament’s Health Committee and other committees. Until we see the proposal in full, the Conservatives will support moves to reduce tobacco consumption but we will not do so at the price of freedom of choice.

15:35

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The Scottish Liberal Democrats were the first major party in Scotland to support a ban on smoking in enclosed public places. We did that because we wanted to put health promotion at the heart of the Government’s health agenda. The Executive is delivering a radical change to improve the nation’s health.

The voluntary approach has failed miserably. Only a handful of pubs across the country offer a smoke-free environment. We must take action now to protect the public from the harmful effects of so-called passive smoking. We now know beyond doubt that passive smoking kills. We also know that ventilation cannot protect non-smokers from passive smoking.

The proposal to ban smoking in enclosed public places is not about social authoritarianism. We do not want to ban smoking in public places because we do not like it, because it would be good for the health of smokers or because we want to ban people from smoking. We want to ban smoking in enclosed public places to protect non-smokers from the clear harm that passive smoking causes.

Murdo Fraser: If that indeed is his objective, why does the member not support legislation to require both smoking and non-smoking areas in licensed premises?

Mike Rumbles: That is an interesting argument, but ventilation does not work, as I will explain in a moment.

Murdo Fraser: We have a smoking room in the Parliament.

Mike Rumbles: Exactly. We should not have that either.

Mr Monteith: Aah.

Mike Rumbles: We need to set an example.

We want to liberate non-smokers from the harm of passive smoking. Currently, non-smokers have no choice. It is not good enough to say, as some do, that non-smokers have the choice not to go into smoke-filled pubs. That is ridiculous.

That great liberal, John Stuart Mill, said that “the only purpose for which power can be rightfully exercised over a member of a civilised community, against his will, is to prevent harm to others”.

That is what the debate is about, but the opponents of this important and essential health-protection measure fail to recognise that.

John Farquhar Munro (Ross, Skye and Inverness West) (LD): None of us was elected simply to ban smoking in Scotland’s pubs and clubs. To my mind, the proposed ban is incoherent and unreasonable. It is simply politically correct nonsense—

The Deputy Presiding Officer (Trish Godman): Mr Farquhar Munro, you must ask a question.
**John Farquhar Munro:** The proposal has been reached without any discussion.

**The Deputy Presiding Officer:** I am sorry. You are interrupting a member's speech.

**Mike Rumbles:** I know that John Farquhar Munro is very much an individual. He is entitled to his view, but he knows that the Liberal Democrat conference confirmed our policy by a margin of eight to one. As he will be aware, all 16 of his MSP colleagues support the party's policy.

The test of whether society is justified in restricting the liberty of the individual is whether that individual's actions cause significant harm to others. According to the research that was carried out by Professor David Hole from the University of Glasgow—I advise David Davidson to examine that research—up to 2,000 deaths per year in Scotland could be related to environmental tobacco smoke exposure. I believe that the weight of evidence about passive smoking is now so significant that the test of harm has been met.

Despite the spin from the tobacco companies, the facts about passive smoking are clear.

“Smoking is the single biggest cause of preventable ... death ... in Scotland.”

Those are not my words, but the words of the chief medical officer for Scotland.

“Public health officials have concluded that secondhand smoke from cigarettes causes disease, including lung cancer and heart disease, in non-smoking adults, as well as causes conditions in children such as asthma, respiratory infections, cough, wheeze ... middle ear infection ... and Sudden Infant Death Syndrome.”

Those are not my words, but the words of Philip Morris USA, which is America's largest tobacco company. When even Philip Morris admits that passive smoking causes harm, we should act. Indeed, Philip Morris goes on to say that the health concerns are

"sufficient to warrant measures that regulate smoking in public places".

At last, we have some truth from the tobacco giants. However, that is the least that we should expect, given the fact that the World Health Organisation's recent classification of second-hand smoke as a human carcinogen puts it on a par with asbestos, radon gas, benzene and arsenic.

What else do we now know? We know that ventilation and filtration do not protect non-smokers from passive smoking. That is the crucial point, but few people have been aware of it because, until now—

**Mr Monteith:** Will the member give way?

**Mike Rumbles:** Unfortunately, I do not have the time.

Until now we have had only the skewed science of the pro-ventilation tobacco lobby. For many years, that lobby has pushed ventilation as the solution to the passive smoking problem of how to allow smokers to smoke while protecting non-smokers from smoke. Let us kill that myth.

“Partial restrictions on smoking in public places and the use of ventilation are inadequate and do not protect the non-smoker from the harmful effect of second-hand smoke. There are more than 50 cancer causing substances in tobacco smoke and many of these are odourless, invisible gases, which are not removed by ventilation systems.”

Those are the words of the British Medical Association. Put simply, ventilation does not work. The air will look and smell cleaner, but it is just as deadly.

With its so-called compromise proposals, the Scottish Licensed Trade Association would allow pub owners to disregard the harm that passive smoking does to their customers and, more important, to their staff. A partial ban as advocated by the SLTA would be like allowing one lane in a swimming pool to be used as a public toilet, if members will forgive the comparison. It would be no ban at all.

We must act to protect the health of non-smokers. The Liberal Democrats will continue to put health promotion at the top of the health agenda. We can follow the successful examples of Ireland, California and New York here in Scotland. Passive smoking kills people. The appropriate and liberal thing to do is to act now to end this harm to others.

**The Deputy Presiding Officer:** We move to open debate. I want to ensure that every back bencher has an opportunity to speak, so speeches will be strictly limited to five minutes.

**Janis Hughes (Glasgow Rutherglen) (Lab):**

Today is a very important day for the Scottish Parliament. It is a day when we can be seen to take serious action to tackle Scotland's abysmal health record. I support a ban on smoking in public places, so this is a day of which I am very proud.

The problems associated with smoking are understood by everyone in the chamber. We know that smoking kills. As the First Minister said, 13,000 people die every year from smoking-related diseases. We know that smoking is a major contributory factor to cancer and heart disease and that standing idly by and doing nothing to tackle the issue is not an option. However, I appreciate that that is where the consensus ends.

At the outset of the consultation on a potential smoking ban, I was unconvinced by the merits of a total ban. We must ensure that any decision that
we take weighs up the potential effects on individual liberty, as well as the benefits to public health. However, as time has passed and as I have listened to the evidence from both sides of the argument, I have become increasingly convinced that a total ban would have potentially immeasurable benefits for Scottish society. That conviction has been informed by experiences elsewhere, about which we have heard today.

In New York, a ban has helped to reduce the number of smokers by 11 per cent in two years. In Montana, during a six-month ban, the number of heart attacks fell by 50 per cent. Perhaps the ban that people are watching most closely is that in the Republic of Ireland. Although there are clearly teething problems, the fact that cigarette sales in Ireland have fallen by 16 per cent is a clear sign that progress is being made.

It is right for us to look to the experience of other countries, but we must have the courage of our convictions and do what devotion is all about—finding Scottish solutions to Scottish problems. That is why what ultimately happens in Scotland may be different from what happens elsewhere. Today the First Minister was asked many questions about possible exemptions from the legislation. It is vital that we have wide consultation and discussion on the issue to ensure that we reach the best solution for Scotland, which may be different from what happens elsewhere.

As Mike Rumbles said, it is important to remember that a ban on smoking in public places would not prevent people from smoking in their homes, if they wished. However, it would almost certainly encourage them to try to give up and, most crucially, would discourage young people from starting to smoke in the first place.

Margo MacDonald (Lothians) (Ind): My question relates to the member’s last point. This morning I heard a spokesman say that people had every right to do what they wanted in their homes, and on the face of it that seems to be true. However, that may mean that they breathe smoke all over their children, and I do not think that they have the right to do that. I am interested to know whether, like me, the member wants to hear from the minister what he is going to do about that.

Janis Hughes: That is an important point—Duncan McNeil made the same point earlier in his question to the First Minister. We are talking about smoking in public places. We have looked at Stewart Maxwell’s bill, which calls for a restricted ban on smoking in public places; it is important that we get the right ban. I would be as pleased as Margo MacDonald to hear what the minister has to say about the implications for children of smoking in the home.

The proposed legislation is not an attack on civil liberties; it is an attack on one of the major causes of ill health for both smokers and non-smokers. The knock-on effects of a reduction in smoking are obvious. For the millions of non-smoking Scots, a ban would permit a healthier, smoke-free environment and limit their exposure to passive smoking. The benefits to the NHS are also clear. Any reduction in smoking would save the health service millions of pounds, as smoking-related illnesses cost the NHS £200 million a year.

Nonetheless, a ban will not in itself be a panacea for Scotland’s appalling health record, nor will it be without its problems. In the minister’s summing-up speech, I am keen to hear further details of how he intends to ensure that any legislation is enforced. Perhaps he will address the specific concerns of some in the trade union movement who are concerned that their members who work in the hospitality industry might be used to enforce the legislation.

This is an opportunity for the Scottish Parliament to take the lead in the fight against ill health. I disagree with Stewart Maxwell’s comments about the vehicle for the legislation. It is important that we get the legislation on to the statute books as soon as possible. As my colleague Kate Maclean said, 54,000 replies to the Scottish Executive’s consultation called for a total ban, and surely that is the best basis on which to proceed with the legislation.

Today’s statement marks the first step in moving towards a healthier future for all Scots and I am pleased to give it my full support today.

15:47

Stewart Stevenson (Banff and Buchan) (SNP): To seek an improvement in the health of Scotland’s people is to seek something that no one in the chamber opposes. If there is any surprise in public life, it is that generations of politicians have dithered before engaging with the single measure that can deliver an unambiguous uplift in the quality of life of our people.

We lost more people to smoking in the 20th century than we did to all the wars of that century—more than a million people died from smoking. A successful public health policy would deliver a Scotland prepared for a competitive 21st century. The elimination of smoking in the long term is the single biggest gift that we can bequeath to future generations of Scots.

Helping those who have become trapped by their nicotine addiction is a health challenge. Protecting those who remain free from the scourge of that addiction is a moral imperative. Therefore, even if the Executive has taken a significant step today—and it deserves the heartiest
congratulations on its announcement—it is but the first major step on a long and difficult journey.

Being a monarch need not separate the individual from common sense, intellectual achievement or scientific endeavour. Some 400 years ago, Scotland’s James VI illustrated that well. For example, he said that because some smokers suffered no visible ill-effects from tobacco use, the illnesses of the majority could not therefore be due to smoking. He made his case through logic then; today we can examine the scientific evidence.

There are 400 separate chemicals in tobacco smoke, including—I inform Mike Rumbles—polonium-210, or radon. In 1989, the surgeon general of the United States identified more than 40 of those chemicals as carcinogens, and the number is rising. Few of the remaining chemicals have ever been demonstrated to be safe in the way that they are used; they have merely not yet been shown to be unsafe.

The effects of the chemicals are various. Besides the 40 or more carcinogens, there are many mutagens—substances that promote genetic changes in cells. Others are developmental toxicants—substances that interfere with normal cell development. The taking of that potent mixture has uncertain specific effects in individuals but a catastrophic effect on the population as a whole.

The debate is primarily about environmental tobacco smoke, half of which comes from the smoke of cigarettes left to smoulder between puffs and half from exhaled smoke. Let us be clear: we can each choose our own personal road to hell. Smokers are held captive by their addiction and they must not be personally stigmatised. As James VI said, man “by custome is piece and piece allured”.

We must support smokers’ efforts to break free from the best efforts of the evil parasites that are today’s tobacco companies.

The inhaler of smoke by accident must also be protected. David Davidson asked for evidence. He has obviously never put the arguments into the Google search engine. If he did so, he would find more than 1 million hits on the subject. I choose but a single example, from the United States. In 1986, a study was carried out there that unanimously had the scientists, who had been appointed by the US Government, deciding that second-hand smoke was a group A carcinogen.

We must do what we can. That does not mean that we are saying that we are not doing enough, although we have to do more. Rather, it is a reflection of the fact that we can legislate on the matter in the Scottish Parliament, and therefore we must.

There will be no Tory gerrymandering of the proposal, because we will not let them do that. The illusion of choice is actually the denial of choice for those whose health is being affected by second-hand smoke.

James VI ends “A Counter-blaste to Tobacco” in a way that remains appropriate 400 years later. He said that smoking was

“A custome lothsome to the eye, hatefull to the Nose, harnefull to the braine, dangerous to the Lungs, and in the blacke stinking fume thereof, nearest resembling the horrible Stigian smoke of the pit that is bottomlesse.”

We must end the scourge of smoking now.

15:52

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): How can I follow that, Presiding Officer?

A ban on smoking in public places is a small start. If that is what it takes to reduce smoking, I am for it. The tragedy is that smoking is an addiction that so many people do not believe will kill them.

Nearly 40 years ago, I worked in a thoracic unit. As a young doctor, I was in do doubt about the tragic consequences of smoking. I once had to tell the wives of two 40-year-olds that their husbands had inoperable cancer of the lung, and both those ladies had children under 12. That was traumatic for me, but it was absolutely tragic for them. It is the tragedies in families on which we hope to begin to have some sort of effect.

I am a non-smoker, but I was a passive smoker for many years, because both my parents smoked. As a child, I always thought that my respiratory illnesses were due to the smog; I never thought for one minute that they were due to my parents smoking. If they had thought that they were doing anything to harm me, I am sure that they would have stopped. I do not know whether members know what it is like to cough all night, but many children do. The commonest cause of coughing is parental smoking. Despite the fact that people will open their windows and spray air freshener all over the place before the doctor comes, we can tell that cigarettes have been smoked in those houses. Margo MacDonald and other members made an important point about effects on children. In banning smoking in public places, we are not going to prevent the terrible ills that will still exist in the background. If we could stop people smoking, there would still be an epidemic incidence of lung cancer. People should also pay attention to the other things that I had to deal with as a general practitioner, such as all the respiratory and vascular illnesses.
On a lighter note, a gentleman who had lost his leg due to vascular disease and smoking chose not to wear his prosthesis and went around on his double crutches with a cigarette dangling from his lips; his wife died of lung cancer. We can see how difficult it is to get the message across to people; they do not believe that smoking kills.

My mother and many of my patients had emphysema, and members must believe me when I say, "You don't want it." Sufferers cannot walk on the slightest incline once it begins to affect them. There are lots of illnesses that pertain to smoking. It caused our health centre an awful lot of work, but the cost to the health service is certainly balanced out by any problems that may arise due to loss of earnings.

The proposal may be a price worth paying. I think that it is nice to be able to go out of an evening and not have one's eyes smart and one's throat burn. I do not go to places now because I cannot stand the smoke, even though many of my friends who smoke do their very best to ensure that their smoke does not go in my direction. Even in an open-air restaurant in Thailand, my friend's cigarette smoke went along to the next table; the people at that table could not stand it so much that eventually there was nearly a stand-up fight.

I was speaking to a chap who was smoking outside while I waited for a taxi. I jokingly said to him, "Well, what do you think about a ban?" He said, "I'm for it. I've been in Ireland with my family and we had a very pleasurable holiday, because all the children wanted to go out with Mum and Dad and enjoy a meal."

We need to spend a lot more money on research. It is dreadful that a leading cancer expert is quoted in *The Herald* today as saying that lung cancer is a Cinderella subject in research. Tariq Sethi, a professor at the University of Edinburgh, blamed the shortage of research into the illness on the public perception that victims brought it on themselves. I would think that there is more to it than that. I do not think that people should not be treated just because they smoke. Smoking is an addiction and they jolly well need help, and we need to put as many resources into helping them as possible.

I feel sorry for the people who are put into rooms to smoke. Ventilation does not work, and we could start with a little research into that matter to prove our point. If one goes to Singapore airport one can see how bad such rooms are. My cigarette-smoking friends could not bear it; they were in and out of the room in seconds. Such rooms do not stop the smell of smoke. In the MSP building, the smell of smoke permeates the lift shaft. I am for a ban if it helps anybody to stop, and there is evidence to prove that it does.
we received referred to a full ban, although I think
that we would still need to take evidence again,
because people offered to give evidence on the
basis of a proposal for a partial ban and other
people might have come forward if the proposal
had been for a full ban. Members should take the
opportunity to read the evidence before they come
to a final decision. I know that some members are
firmly on one side of the argument or the other, but
I suspect that there are many members in the
middle who are, like I was, confused by the
statements that are made, because they all sound
plausible and convincing.

I do not underestimate the opposition that there
will be to a ban and I have a great deal of
sympathy for some of the points that smokers and
owners of businesses might be affected by
the ban have put forward. However, we should not
lose sight of the fact that there is far more support
across the board for a comprehensive ban on
smoking: from the 70 per cent of people who do
not smoke, from health professionals and, perhaps
more surprisingly, from the hospitality industry. In
some of the evidence that the Health Committee
took, representatives of the hospitality industry
said that they would support a total ban rather
than a partial ban, because it would create a level
playing field in the industry that is not currently
present.

Many people who run pubs also support a total
ban on smoking in them. An example of that was
highlighted on “Newsdrive” this morning. I have to
say that I was impressed that John Morrison from
the BBC had managed to find a pub that opened
at 6 am—that was very resourceful of him. It is
interesting that the three customers whom he
interviewed in the pub—who were all having a
cigarette with whatever refreshment they were
having—very much opposed the ban, but the
owner was in favour of it, even though he
recognised that it might affect his business.

The First Minister said that the licensed trade
and the hospitality industry must have a positive
attitude towards the ban. I agree with that. It will
not be easy for pubs and clubs, but the people
who are involved in the hospitality industry should
now turn their minds to how they can appeal to a
hitherto untapped source of custom—non-smokers
who currently avoid pubs because of the smoke—
and, at the same time, think of ways of getting
smoking customers to continue to come to their
establishments.

I strongly believe that, whatever happens with
the legislation, it is a case of when, not if, we have
a total smoking ban. When we consider the
distance that we have already travelled, it seems
inevitable that we are heading for a full ban in
Scotland at some time in the future. I hope that the
Parliament takes the lead and brings the ban
about sooner rather than later.

16:03

Rob Gibson (Highlands and Islands) (SNP):
To take up the theme of the previous member, the
whole process has been going on for decades and
Parliament is about to clinch the change that will
allow us to move forward in a different way.

I stopped lighting up cigarettes in 1979—I did
not give Mrs Thatcher any taxes from my tobacco
consumption. I think that I am still smoking, as we
all know we are.

When someone is a sociable animal—most
people are—they want to mix with folk and enjoy
music and so on in public places. Over the past 20
years, when I have organised traditional music
festivals, it has been interesting to see how
attitudes have changed to smoking in places
where musicians are playing. Some of the change
in attitudes has come from the Americans who
come to visit us, who are appalled that people still
smoke where a concert is taking place or at a
session in the pub.

When I was in Ireland in October, it was a
delight to see the improvements in the places
where people would expect to get good craic.
There were still huge numbers of people in the
pubs in Westport, Dublin and other places that are
famed for music, but it was possible to see across
the crowded rooms. We are reaching a point at
which there is potential not only for vision, but for
making the vision a reality for everyone in such
places.

I encountered some interesting anomalies in the
approach in Ireland, which we must take into
account. People seem to be allowed to smoke at
outdoor tables in restaurants. The people who
serve the food or who sit at neighbouring tables—
as Jean Turner described—are affected by the
smoke. That approach seems to be inconsistent,
given that people are not allowed to smoke on
station concourses in Ireland. I have to queue for
the 5.40 pm north-bound train from Edinburgh to
Inverness with people who are desperately puffing
away before they board the train, so it was a
delight to find that the concourse of Heuston
station in Dublin was smoke free. We must take
account of such matters when we consider how to
protect the public in Scotland.

Margo MacDonald: Does the member agree
that we will tackle such apparent inconsistencies
more successfully if we decide fundamentally why
we are adopting the measure? Are we doing so to
protect people from smokers or to persuade
smokers not to smoke? The two approaches are
different and involve two campaigns.
Rob Gibson: As I said, the measures are part of a process. We are sending a major signal that we recognise that the majority of people in Scotland want the situation to move forward. By introducing the measure, we will be able to provide more cash to help to persuade smokers who have difficulty in giving up smoking to do so. Given that smoking-related illnesses account for some 35,000 hospital admissions each year, which cost the NHS an estimated £200 million, I would expect some of the cash that will be saved to be directed towards endowed research to help people to give up smoking and to deal with the generations of problems that will arise in the future. By introducing the measure, we will be taking the first step towards the removal of smoke from people's homes.

We want the Parliament to show maturity and there are signs that that is possible. However, I am annoyed about the way in which Stewart Maxwell's work on the matter has been pushed aside.

Helen Eadie: Will the member give way?

Rob Gibson: Not at the moment. I am in my final minute.

It would have been a good idea if the Executive had adopted Stewart Maxwell's bill and adapted it to suit its purpose. That would have demonstrated an inclusive approach that is currently lacking. People's attitudes are changing and they expect the Executive to change, too. I welcome the measure and the debate, but I hope that cross-party solidarity is not simply a one-way process.

16:08

Mr Brian Monteith (Mid Scotland and Fife) (Con): I was not able to get in to ask questions after the First Minister's statement, so I want to make a number of points to which I hope the Minister for Health and Community Care will respond. The First Minister said that the proposed bill will introduce

"a comprehensive ban on smoking in enclosed public spaces".

Will the minister define an enclosed public space? As we start the process of having a proper debate about the proposed legislation, objective evidence and the terms and definitions in the bill will become important.

For example, the reception area, the chamber gallery and the committee rooms of the Parliament are surely public places, and I happily agree to the smoking ban that already applies in those areas. However, are the working environment of the Parliament and other offices a public space? Surely the Parliament's smoking room is not a public space but a private room for staff—

[Interruption.] I make an important point. Can the minister confirm that such a room would not fall within the scope of the bill? I ask the question because members will be aware that the Parliament can legislate on public health but not on workplace and employment matters. We need to tease out the detail of just how far the Executive's approach can go. If we do not, the Executive runs the risk of judicial review.

Earlier in the debate, in an intervention on Stewart Maxwell, I raised the example of the private cigar clubs in New York. Will the Minister for Health and Community Care allow exemptions for private cigar clubs? The First Minister said that the legislation will be evidence based and the evidence is that cigar clubs work in New York. I am sorry to see the minister shaking his head. Stewart Maxwell said that exemptions should not be for the rich. I agree, but cigar smoking is not exclusive to the rich; someone can choose to smoke either an inexpensive Hamlet or a mortgage-busting Cohiba. Smoking cigars is a joy that rich and poor alike can enjoy.

Another question that will help us to tease out the detail is whether the ban is to be one on smoked tobacco—in a cigarette, cigar or pipe—or will extend to other tobacco products that have no passive-smoking attributes, such as snuff. The point is a serious one. We need to determine the extent of the legislation. We are talking about changing our civil liberties on the basis of public health concerns.

I want to discuss the evidence on the link between environmental tobacco smoke and death. The figure is put at 865 a year in Scotland and sometimes at 1,000. I agree with the sentiments of many members that smoking is an irritant. I agree that it causes one's clothes to smell and that it can trigger asthma attacks—I do not refute those aspects of smoking. That said, I agree with Dr Ken Denson, of the Thame Thrombosis and Haemostasis Research Foundation, who has said:

"The scientific evidence for any deleterious effect of passive smoking is so tenuous, that similar evidence would not be seriously considered, let alone published in any other medical discipline."

Mike Rumbles: Will the member take an intervention?

Mr Monteith: No, I must carry on; I want to discuss the evidence. I might be able to take one intervention later.

The most comprehensive study that the scientific committee on tobacco and health—SCOTH—used showed a 24 per cent increase in the risk of contracting lung cancer. However, that is 24 per cent of the 10 deaths in 100,000 that could have been expected to result from lung cancer without any smoke—passive or direct. That
is 12.4 deaths in 100,000 instead of 10. For Scotland, that means a possible extra 14 deaths from lung cancer.

**Margaret Smith:** Will the member take an intervention?

**Mr Monteith:** No.

Given that lung cancer is by far the easiest disease to contract, the possibility of the number of deaths in Scotland being 1,000 or 865 is pure fantasy. The figures are based on a mathematical extrapolation of unsound science. In the spirit of objective debating, will the minister ensure that he publishes all the evidence that shows the calculations of how the figures were arrived at? Time and again, although the figures are reported, the detail of how they are arrived at is not made available.

I recognise that I am running out of time, Presiding Officer, although I have much more to say. I would have been pleased to have taken interventions if I had had the time to do so.

It is clear that the evidence, if one accepts it, is based on surveys in the home and not on surveys in public places. The likely effect of a ban would be to encourage the displacement of smokers from the places that no research has shown to be a real threat, to the place where the Executive believes the real threat to be—the home, which is where the children are. The Executive says that the proposed legislation will protect children. I say that it will threaten them.

16:14

**Mr Alasdair Morrison (Western Isles) (Lab):**

One of the great privileges of this job is being asked to visit schools in my constituency. Indeed, I am taking up such an invitation this week at Lionel School in Ness. It is always refreshing to witness pupils’ abilities, enthusiasm and zest for life. It is always instructive to see for myself how pupils, teachers and staff are benefiting from the policies of the Scottish Executive.

I ask members to reflect on the past seven years. Since 1 May 1997 and the advent of the Scottish Parliament, we have ensured that renewed and proper emphasis has been placed on the investment in school buildings. We have invested not only in school buildings but in the recruitment of school staff, finding the resources for additional support staff, and in transforming the food that is available in our school canteens. It has been out with the old stodge and in with nutritious food.

We have also ensured that children now have at least two hours of physical education each week. Sports co-ordinators are being trained and placed in our schools to ensure that children will have structured physical activity for at least two hours per week.

**Margo MacDonald:** I do not want to interrupt Alasdair Morrison’s flow, but he should stick to the subject of the debate and not go into the realms of fantasy about two hours of physical education for every child. It is not happening.

**Mr Morrison:** It is certainly going to happen, and it is the reality in many of the schools that I visit in my constituency.

It is clear that all those measures have been introduced not only to help to improve educational attainment, but to ensure that our young people grow and reach maturity in a healthier state than many of their parents and grandparents did. Government at all levels must work in a co-ordinated manner to improve the health of our nation. Thankfully, today, the Scottish Executive’s Cabinet has ensured that we will continue on that trajectory of reform—reform that will see us transforming the life chances of many in Scotland.

Notwithstanding the Cabinet’s important decision, over the years we have realised much progress in relation to smoking. Travel in Scotland is mostly now smoke-free on buses, trains, planes and ferries. The time is right to take that to the next level and to legislate for further action over and above what has been achieved on a voluntary basis.

As members will appreciate, ferries are an important part of my life and work. Four years ago, the state-owned ferry company, Caledonian MacBrayne, put in place a smoking ban on a trial basis. On 20 October 2002 that trial ended. CalMac’s managing director and his board decreed that the ban would extend to all vessels and be permanent. It was a courageous decision, which was taken because, as responsible employers, Caledonian MacBrayne’s management recognised that exposing their crews to secondary smoke was harmful.

Now, our ferries are cleaner and safer places in which to work and travel. The managing director of Caledonian MacBrayne, Laurie Sinclair, and RMT representative, George Lonie, today agreed that the ban has improved working conditions for all CalMac crew. What was necessary and appropriate for catering crew on CalMac ferries is certainly appropriate for the staff of Scotland’s pubs, clubs and restaurants.

I fully appreciate, as my colleague Kate Maclean recognised, that there might be difficulties for patrons and some landlords who at this stage are not convinced of the merits of the forthcoming legislation. However, our duty as legislators is to remain focused on the need to improve the nation’s appalling health record. As has again been demonstrated in the chamber today, that
appalling health record is uneven throughout Scotland. I refer specifically to Paul Martin’s depressing statistics on the incidence of lung cancer in his constituency, which is 93 per cent above the national average.

A smoking ban in public places will help us to realise the aim of improving our health record; however, let us not believe for one moment that a ban in itself will be sufficient. Government thinking and decision taking must appreciate that assistance for those in poorer areas of the country is and must remain a priority. It is in those areas that smoking has its greatest impact, not only on those who are exposed to secondary smoke, but on those who, unfortunately, are addicted to nicotine in disproportionate numbers.

Finally Presiding Officer, on a lighter note, you might have noticed that today a very special person was sitting in the VIP gallery. The gallery has been graced by dignitaries from all over the world, from ambassadors to speakers of legislatures from across the Commonwealth. Today we had royalty in the gallery, in the shape of Kenny Dalglish. If the measure articulated by the First Minister enjoys the support of Kenny Dalglish, it will certainly be supported by the member for the Western Isles.

16:19

**Eleanor Scott (Highlands and Islands) (Green):** I start by saying for the record that I continue to be a member of the British Medical Association.

I am happy to speak in today’s debate in support of the Executive’s proposals to protect workers and non-smokers from the harmful effects of environmental tobacco smoke. The majority of people in Scotland—72 per cent of us—do not smoke, and I believe that most of us want to be able to go out and enjoy ourselves without having to breathe in harmful tobacco smoke.

There are now examples of the successful implementation of smoking restrictions in New York and Ireland. It is important to monitor and learn from experiences in other countries, but a lot of conflicting information seems to be going around. For example, the licensed trade tells us that the ban in Ireland has led to the loss of earnings and jobs, yet a report by the Irish Central Statistics Office states that sales went down by just 1.3 per cent in a three-month period. I know who I believe.

Oddly enough, I was in Ireland during the recess and, purely in the interests of research, I had occasion to visit a few pubs, which were brilliant. I cannot say that it was a scientific sample, but the pubs that I visited were busy and in some cases packed. They were much more pleasant for everyone to be in than pubs that allow smoking are. People went outside to smoke, but smokers told me that they smoke a lot less as a result of the ban and that they are really happy about that. Ireland has a few lessons to teach us, whether on smoking in pubs, the third-party right of appeal in planning matters or the polythene bag tax.

It has been said that people will be driven to do their drinking and smoking at home and so children will be exposed to more smoke. However, Australian legislation on smoke-free workplaces in the 1990s resulted in adults avoiding exposing children to tobacco smoke at home. We should not underestimate the potential awareness-raising effect of the proposed legislation and the possible carry-over of behavioural changes to other situations.

We have also heard about choices. I question whether people have a real choice when they are exposed to the might of the tobacco companies and their advertising and to the cultural norms and traits to which the First Minister referred in his statement. The only longer-term losers from a ban on smoking in public places will be the tobacco companies. Good. I hope and believe that the ban will reduce smoking and cut sales. Those companies are campaigning vigorously against the ban because they believe the same.

My one concern about reducing levels of smoking in Scotland is that the tobacco companies, which have shown that they are unscrupulous, will redouble their already considerable efforts to sell their products in the third world. Given that 5 million people die of smoking-related diseases annually, British American Tobacco, with 15 per cent of the global tobacco market share, is implicated in up to 750,000 deaths every year. The figures are set to double in the next 20 years, with the developing world bearing the brunt of the escalating rate of smoking-related deaths, as it presently bears the considerable environmental costs of tobacco production.

Tobacco is the only legally available consumer product that kills people when it is used entirely as intended. Scotland suffers particularly from its effects. The measure will go some way towards protecting workers and non-smokers from the effects of other people’s smoke and, for human rights and human health reasons, we should support it.

16:22

**Mr John Swinney (North Tayside) (SNP):** It is my pleasure to speak in the debate and to add my congratulations to the First Minister on the decision that he has taken today, which is a bold and wise decision that is worthy of support from all
members. I also pay tribute to Stewart Maxwell’s trenchant efforts in pursuing the issue through the parliamentary system. To echo my colleague Rob Gibson’s remarks, I hope that the Executive will take seriously the work that Stewart Maxwell has undertaken in pursuing the issue and will use that legislative vehicle to implement the measures. I will return to that issue in due course.

All the critics of the Parliament make the point that this institution has little impact on people’s lives. I am pleased to welcome the First Minister’s proposal, which will have a strong impact on people’s lives and, into the bargain, will be for the better.

Many serious and well-tabulated health problems in our society arise from the dependence of a proportion of our population on smoking. Unless I misheard him, David McLetchie, in his questioning of the First Minister, made an absolutely ludicrous and unsustainable argument that there is somehow no problem with passive smoking. I have read enough evidence and seen enough information that is in the public domain to persuade me that passive smoking is an issue of the most enormous concern. For David McLetchie to hinge his arguments on such a baseless point of view is an exercise in missing the seriousness of the issue that society faces.

In an intervention, Margo MacDonald posed the question whether the proposals are intended to persuade smokers to give up or to protect other people from smokers. Of course, it is a bit of both, because if we just protect people like me, who have never been a smoker, from smokers, we are not doing a service to those in Scotland whose health is damaged by smoking. I welcome the Government’s proposal to intensify support and encouragement to motivate people to give up smoking. None of us can seriously argue that smoking is good for an individual; therefore, the Government is introducing an effective two-pronged strategy to tackle the issue in Scotland.

We must be mindful of the fact that if we support a comprehensive ban on smoking in public places, we should also protect those who are most vulnerable to passive smoking in their homes. That is why the education exercise that the Government is talking about, to try to persuade more people to give up smoking full stop, rather than just to give up smoking in public places, is so significant. We have a duty to enable our children and the young people of Scotland to be free of the impact and the after-effects of smoking in their homes. If the product of this debate is that it says to everybody in Scotland, more forcefully, more fully and more effectively than it has ever been said before, that smoking is bad for individuals, for families and for society, Parliament will have achieved a great deal and will have made a convincing impact on people’s lives.

However, the debate must be followed up by the action required to persuade individuals to change their habits and their behaviour. I have never been a smoker and I do not know how tough it is to give up smoking—although I can imagine that it is very tough—but I believe that the Government must ensure that, through the wider public health agenda, the exercise agenda and the healthy eating agenda, we take dramatic steps to transform people’s lives and their prospects.

My final point relates to the legislative vehicle that has been chosen for the implementation of the ban. I am concerned that the Government has chosen to introduce the ban as part of a wider miscellaneous provisions bill. I do not know what the full content of that bill will be, but while I would unreservedly and enthusiastically support the inclusion of a ban on smoking, if the miscellaneous provisions bill also contains a provision to introduce fluoridation in the water system, I will have a big problem when it comes to voting on it at stage 3. There is sufficient complexity and debate, and scrutiny required, in introducing an effective provision to ban smoking in public places for it to be a stand-alone bill. Stewart Maxwell’s bill gives us a vehicle that is already making its way through the parliamentary system, which could be revised to bring into force the necessary provisions, for which there is widespread support across the political spectrum.

I hope that ministers will express nothing but contempt and will have no patience whatever for some of the Conservatives’ arguments, which are baseless and which will undermine the health of people in Scotland. We need bold actions to improve the public health of people in Scotland and to improve the quality of life of some of the most vulnerable individuals in Scotland today.

16:28

John Swinburne (Central Scotland) (SSCUP):
I welcome the debate as an early example of near cross-party consensus on a health issue. The electorate will welcome that consensus, too, which must be taken even further in future. It is proper to declare an interest, as I am still addicted to nicotine, despite having given up cigarettes 47 years ago. I smoked my first cigarette when I was 13, which was some 61 years ago. Non-smokers have no conception of the addictive power of tobacco. It is evil and it must be banished from society.

In the Parliament there is a smoking room—or rather an apology for a smoking room—which must go now. I am talking as a smoker. I used it on only one occasion but vowed never to go back
inside it because it was absolutely honking—that is a Lanarkshire word that means very unpleasant and smelly. Señor Miralles was obviously a brilliant architect, but it appears that he did not know a great deal about ventilation. I am blaming him and no one else for that place. The BBC in Glasgow has a smoking room that boasts clean fresh air, which is probably less polluted than the air in Sauchiehall Street, which is not too good.

Today we are debating a ban on smoking in public places, which I, as a smoker, support 100 per cent. There has been an outcry from the licensed trade, which claims that the ban could hurt its business. My answer to that is, “Tough.”

It is arguable that alcohol costs the NHS as much as tobacco does. The drink laws have been liberalised to a tremendous extent. We hear constantly about people being killed by drunk drivers and the number of alcohol-dependent people in the United Kingdom has now reached 2.8 million.

The most recent available figure on the annual societal cost of alcohol misuse in Scotland, which is from 2001, is a frightening £1,071 million. The number of deaths caused by alcohol is escalating—in 1991 there were 452, a figure that by 1999 had risen to 1,032. According to the statistics, alcohol gave rise to 275,575 hospitalisation days, 187,951 accident and emergency attendances, 93,999 out-patient visits and 64,382 ambulance journeys. Moreover, 26 per cent of all crime recorded by the police in 2000 was alcohol related. Need I go further? Those figures are five years out of date.

Taking into consideration the binge-drinking culture that is now affecting vulnerable under-age drinkers, I suggest that, if a ban on smoking has a detrimental effect on alcohol sales, that is no bad thing. There is absolutely nothing wrong with civilised social drinking but, sadly, overindulgence seems to be the acceptable norm in far too many areas. Perhaps after nicotine has been tackled, alcohol will be the next point of attack for any educated Parliament.

On smoking, I would go further than the Executive has gone. I suggest that it ask Chancellor Gordon Brown to introduce a new tax directed squarely at the tobacco companies, which manufacture cigarettes and make obscene profits. We should make them pay for a good percentage of the costs incurred by the NHS from tobacco-related health problems.

Mr Monteith: Is the member aware that, according to the Government’s own figures, the tax revenues from tobacco already account for 30 times more than the cost of tobacco-related diseases that the NHS treats?

John Swinburne: Mr Monteith is putting a monetary value on a person’s life when he talks like that. How do we value one life, far less the thousands that are lost because of tobacco?

I admit that unfortunate addicted smokers are already paying a phenomenal amount in tax to the Treasury. An additional tax on the tobacco companies would help to ease the burden on the rest of society and alleviate pressure on the NHS. I expect that suggestion to be greeted with extreme hostility in certain quarters, as we have just heard. However, if the Government deems it acceptable that senior citizens can have their home requisitioned by the state to pay for their residential care after they have paid a mortgage for 25 years, why not tax the hugely profitable tobacco companies to help to pay for some of the grief and problems that they have foisted on society by manufacturing death? I support the Executive’s proposal.

16:34

Margaret Smith (Edinburgh West) (LD): We have had an interesting debate this afternoon. On behalf of the Liberal Democrats, I welcome the First Minister’s announcement. What has been announced is a bold step, it is the right thing to do and it represents the single biggest health policy commitment that the Executive and the Parliament could make to the people of Scotland. It has the support of the Liberal Democrat group and the party conference.

As part of an Equal Opportunities Committee trip, I recently visited Dublin, as Rob Gibson, Eleanor Scott and others, including the First Minister, have done. I went into the same pubs as I had been in before—when I could hardly see 20ft in front of me—and the difference in the atmosphere, the number of people who were eating with their families was striking. Because I knew that similar legislation was on the cards in Scotland, thanks to the work done by Stewart Maxwell and others, I made a point of speaking to some of the people in those pubs and discovered that they were enjoying the atmosphere, which, as I said, was very different from the one that I encountered when I had previously been in Dublin.

The proposed legislation represents a challenge to the licensing trade and the hospitality industry in Scotland, but they should not approach that challenge with a feeling of fear. Today, we have seen some of the figures from the international review of the economic impacts of the regulation of smoking in public places that was conducted by the University of Aberdeen. Using data on sales taxes and employment, for example, the study failed to find any statistically significant effect on the hospitality sector of smoking restrictions. We
have heard about the 1.3 per cent fall in the consumption of alcohol in Ireland but, as John Swinburne pointed out, that brings with it certain benefits as well.

The vast majority of people in Scotland do not smoke and do not want to inhale their neighbour’s smoke when they are eating a meal. In particular, they do not want to be one of the 865 or so people who die every year as a result of four diseases that are affected by passive smoking, according to the University of Glasgow’s statistics. Depending on which evidence one reads, that figure is as high as 2,000 people a year.

We have tried the voluntary approach but, frankly, it was not going far enough fast enough. After five years, only 1 per cent of British pubs were smoke free. I am happy to say that the business of at least one of those, Lauriston Farm in my constituency, has improved as a result of its decision to become smoke free. That demonstrates what I was saying about the challenge that the licensed trade faces.

Mr Swinney: Will the member take an intervention?

Margaret Smith: Not just now.

Some people have said that the proposal represents an attack on individuals’ freedoms. However, as a Liberal Democrat, I—like Mike Rumbles and the vast majority of my colleagues—am content to say that we should not be supporting somebody’s right to kill somebody else or damage somebody else’s health. We should be doing what we can to protect non-smokers from the actions of smokers and the impact of their addiction.

Many speakers have raised the issue of health. Stewart Maxwell, Jean Turner and just about every other speaker have catalogued our unhealthy record. Macmillan Cancer Relief has said that 13,000 lives are lost to smoking-related diseases every year.

I agree with what John Swinney said in what I thought was a good speech. The ban should be taken forward as part of a wider smoking-cessation package and I welcome the doubling of support for cessation policies that the First Minister outlined. I agree with John Swinney and David Davidson about the importance of education, but we should not underestimate the importance of the message that the ban will send to children and young people that smoking is not acceptable in public places. The fact that the Parliament is saying that is an education in itself.

David Davidson said that we need clear evidence. There is clear evidence. We could stand here for the next three months and recite the evidence. The World Health Organisation has classified environmental tobacco smoke as a human carcinogen and the United States Environmental Protection Agency has classified it as a class A human carcinogen for which there is no safe level of exposure, as Stewart Stevenson told us. To hear Brian Monteith refer to that evidence as a “fantasy” was incredible. I must have blinked and missed the point at which he became a bigger expert on these issues than most of the doctors in this country, the British Medical Association and Professor David Hole of the University of Glasgow.

David Davidson said that no one is arguing about the impact of smoking, but he should look behind him. Moreover, I will tell him who else has been arguing about the impact of smoking for the past 50 years: the multinational tobacco companies. We have listened to the tobacco lobby for 50 years as it has argued that cigarette smoke is not harmful, whether it is taken in by a smoker or by passive smokers. We should have no truck with the tobacco lobby or the apologists for the tobacco lobby in the Conservative party.

We heard a bit about ventilation, but the international research says that only 10 to 20 per cent of smoke is removed as a result of ventilation. I am not dismissing the views and concerns of the licensed trade, as others have perhaps done, and I think that there is a place for trade representatives on the implementation group. I asked the First Minister about the impact of people spilling out from public houses on to the street, which might create a public-order issue and intimidate some members of the public who walk past or live beside public houses. However, the effect of a ban on public health is so positive that it outweighs those concerns from the licensed trade. The ban will certainly benefit workers in pubs and the hospitality industry, as I think all members will agree.

I believe that we are right to go for a total ban because that will bring clarity and a level playing field. Exemptions for private clubs would have had an even bigger impact on our pubs and our hospitality industry and would be downright unfair. To have introduced the ban by stealth, either through a timetable or in progressively larger areas, would have been a nightmare to enforce and open to misinterpretation. It is right to go for a total ban. The legislation will be clear, it will be bold and, most of all, it will be right.

16:41

Mrs Nanette Milne (North East Scotland) (Con): Clearly, no one in the chamber does not acknowledge that smoking is a major cause of ill health in Scotland. The morbidity that is associated with pulmonary and cardiovascular disease in smokers is a serious burden on NHS
resources and the resultant high mortality is of the utmost concern to everyone in the medical profession and beyond.

My first hospital post after graduation was in a thoracic unit where the majority of patients were suffering from the long-term effects of smoking. The look in the eyes of the lung cancer patients on Christmas eve that year—patients who knew in their hearts that it would be their last Christmas—has stayed with me ever since. As Jean Turner said, at that time—the mid-1960s—the majority of adults were smokers and the risks were not appreciated. My dad continued to smoke, despite medical advice, when he developed serious arterial disease and he died from his second coronary when he was only 58 years old and I was 19. Like most of my contemporaries, I was exposed to cigarette and pipe smoking throughout most of my young life by caring but ignorant parents who had picked up the popular habit before the war years. Many of my generation started smoking in their teens and early 20s, following the example that they had seen at home.

Thankfully, times have moved on. The risks of smoking are now well known and only a minority of adults indulge in the habit.

Mike Rumbles: Will the member take an intervention?

Mrs Milne: I am not sure whether I have time—perhaps later.

For young people, the risks of smoking seem remote and, worryingly, girls in particular ignore them and pick up the habit in their early teens.

The arguments about passive smoking rage on, with some researchers denying that serious harm comes from inhaling smoke in the atmosphere and others claiming that doing so has lethal consequences. Whatever the health implications, an increasing number of people agree that exposure to environmental tobacco smoke is unpleasant and people with respiratory conditions such as asthma find it hard to endure.

Mike Rumbles: It kills.

Mrs Milne: That is arguable, according to research.

Whatever the arguments, there clearly has to be a public health policy objective to reduce tobacco consumption and the prevalence of smoking in the population and to help smokers to give up the habit. As David Davidson said, there has been a reduction of about 40 per cent in the prevalence of smoking since the early 1970s. That has resulted largely from pricing, education and the voluntary controls on advertising that were introduced under Conservative and other Governments.

Margo MacDonald: I am extremely interested in what the member has just said. I ran the national AIDS helpline and introduced Smokeline and I am not at all sure that the reasons she instanced for the reduction in smoking are the correct ones. She might find that shock tactics worked, particularly in the case of AIDS.

Mrs Milne: I am sure that the member is right that there are many ways of influencing whether people give up smoking and other public health issues, but I believe that the factors that I instanced had some influence.

In the past few years, an increasing number of businesses have voluntarily provided smoke-free environments. Smoking in restaurants and on public transport, for example, has become increasingly unacceptable to people. As we know, many restaurants and airlines now provide smoke-free facilities, as do some trains. The point that is at issue is whether that voluntary approach should be stepped up, alongside better education of children and young people on the risks of starting the smoking habit, until public demand results in the provision of smoke-free facilities in all sectors of Scottish business, or whether the state should legislate now to force smokers out of all enclosed public places.

We have had a good debate that aired issues on both sides of the argument. We have heard much about the dangers of passive smoking, but no one cited the findings of the World Health Organisation, which six years ago concluded after a seven-year investigation that the link between environmental tobacco smoke and lung cancer was not statistically significant. Research results are not clear cut.

I have sympathy with Stewart Stevenson’s desire to eliminate smoking altogether, but the fact is that tobacco is not a banned substance and he did not propose that, to pursue his end, it should be.

I have not yet read the evidence that was presented to the Health Committee, but I assure Kate Maclean that I will do so. Both sides of the debate have convincing arguments, as we have heard. The Parliament will have to decide in due course what will best achieve the desired public health outcome in practice. Will that be enforced legislation that might be difficult to police, or will it be the emerging public will to influence the market? In common with my Conservative colleagues, I would infinitely prefer people to take responsibility for their own health and force the business world to take appropriate action by choosing to support smoke-free premises.

The jury is still out. The debate will undoubtedly continue until Parliament decides on the best way
forward to achieve the desired result for Scotland’s public health.

16:47

Shona Robison (Dundee East) (SNP): I will refer to some issues that Stewart Maxwell raised in his speech. We should consider the bigger picture—the opportunities that the proposal will bring to Scotland—rather than the threats and problems. One benefit that he highlighted and which is worth repeating is that of Scotland becoming a tourist destination because of the healthy atmosphere and its public health achievements. To change our record of being the sick man of Europe, as we are always described, to one of being at the cutting edge of public health and public health policy would be an achievement for Scotland and for the Parliament.

The concerns about the process that Stewart Maxwell expressed are worth repeating. This opportunity should be handled with great care. I suggest that the Minister for Health and Community Care examine closely what else goes into the miscellaneous provisions bill. Members of different parties are concerned about organ donation, fluoridation or whatever else will be in the bill. If we have only one opportunity to vote for or against the bill and many other controversial issues are lumped into it, barriers will lie in front of that important legislation. Those barriers do not have to exist. I plead with the minister to take that on board.

David Davidson has a difficult job. I know that he is sympathetic—perhaps more so than some of his colleagues—to tackling smoking and smoking in public places. Like us all, he must endure Brian Monteith on the television and in other sections of the media undermining some of the arguments that he makes.

Mr Davidson: As Brian Monteith said over my shoulder, the member has the power to switch off the television.

I am a gradualist. I would like to have heard from the minister about a stepping-stone system—not an overnight ban—to take the public with us. That would be a gradual approach that provided choice. If publicans had been allowed to continue and had been given a bit of encouragement, they might have taken us to the goal.

Shona Robison: Unlike David Davidson, I do not believe that we have the luxury of time to allow more people to die of smoking and passive smoking. He talks about choice, but there is no choice for non-smokers or the staff who are working behind the bars. As other members have said, minimal progress was made with the voluntary code—Margaret Smith mentioned the figure of 1 per cent. An opportunity was given to move forward but it was not taken, so we are where we are and further action is required. The proposed ban is the action that is required.

No other comparable activity so affects those around the people who do it and spurious comparisons do not stack up. Mike Rumbles, as always, claims the entire credit for the proposal for the Liberal Democrats, but I point out that the Scottish National Party has put the issue firmly on the parliamentary agenda.

Mike Rumbles: Will the member give way?

Shona Robison: No.

However, Mike Rumbles made an important point that is worth reiterating. The research into passive smoking exists, if members want to read it, and I advise some of the Tories to have a good look at it. Smoking is the major preventable cause of death in Scotland and that is why we have to take this action. I know that some in the tobacco industry have acknowledged that passive smoking is detrimental to health, but many others continue to argue that it is not. That is reminiscent of the arguments that people from the industry put forward previously that smoking was good for health. Those are the arguments that we heard 40 and 50 years ago, but time has moved on and we know that smoking is bad and that Government action is required.

Margo MacDonald made an important point about what else needs to be achieved to address the issue of people smoking at home. I believe that the bill will go some way towards addressing that issue, because it will de-normalise smoking as an activity. In too many communities, smoking is seen as a normal activity. Removing smoking from public places sends out a message to children throughout our society that smoking is not a normal activity. That can only be good for future generations in this country.

16:52

The Minister for Health and Community Care (Mr Andy Kerr): Winding up will be a difficult task, because we have had such an extensive, passionate and—in parts—informative debate. I thank members for their support for the Executive’s proposed action.

We have a one-off chance to make a substantial difference to the health of Scotland, which is a reason why many of us came to the Parliament. It will be a long and interesting journey between now and the legislation going through the Parliament.

For me, the issue is health improvement and, as some of my colleagues have said during the debate, health inequalities. My colleague Paul Martin represents Springburn and my colleague Frank McAveety represents Shettleston. It is
frightening to note that Richard Peto, professor of medical statistics and epidemiology at the University of Oxford, has estimated that smoking accounts for about half the deaths that separate the richest from the poorest in this country. In other words, those who are least well-off in our communities are dying because of cigarettes and passive smoking.

We have to address those difficult issues. The incidence of smoking is down and we are doing our best to deal with the problem, but we have to be more assertive in taking action. It is about time that the Parliament shut down its smoking room.

Stewart Maxwell spoke about the continuum of public health measures over the centuries and decades. There has been immunisation; there have been public health acts and clean air acts; there has been legislation on the wearing of seat belts in cars and in the back of cars; and the Health and Safety Executive has been set up. People will look back in five or 10 years’ time and say, "What a normal thing the Parliament did with the smoking debate to try to improve the health of our nation."

I was embarrassed for Nanette Milne when she referred to environmental tobacco smoke as “unpleasant”. I am surprised that someone of her stature in the community and her experience would say that. I might expect it from Brian Monteith, who clearly has a vested interest, but not from Nanette Milne.

Mr Monteith: Will the minister give way?

Mr Kerr: On the effects of passive smoking on non-smokers and the causes of lung cancer—

Mr Monteith: Will the minister give way? He made a comment about my having vested interests.

Mr Kerr: There are increased risks from long-term exposure of 20 to 30 per cent—

Mr Monteith: Will the minister take an intervention?

The Deputy Presiding Officer (Murray Tosh): Order.

Mr Monteith: Will the minister give way?

Mr Kerr: The member has already said that he is a cigar smoker—

Mr Monteith: On a point of order, Presiding Officer. The minister has made a serious accusation that I have a vested interest, but there is nothing in my entry in the register of members’ interests to suggest that. I would like him to retract what he said or to explain why he believes that I have a vested interest.

The Deputy Presiding Officer: That is a point of order, as there is an issue of courtesy. The minister must either substantiate, qualify, explain or withdraw his remark.

Mr Kerr: I will take the Presiding Officer’s advice on whether I should withdraw my remark. Brian Monteith is on record as—and has a profile as—a cigar smoker. He has advocated cigar-smoking establishments as being one way round the proposed ban. In my view, that is a vested interest. However, I will take the Presiding Officer’s advice on the matter. If the remark offends the member, I will withdraw it. However, that is the basis for my remark.

The member said that those who have the resources and the financial means should have the right to be able to step away from the proposed legislation. That would undermine the Executive’s approach, which is for a comprehensive ban. David Hole’s studies support the Executive’s position.

Rob Gibson made an interesting point, which is also made in one of the many letters that I received on the subject:

“I am a 53 year old male with chronic obstructive pulmonary disease. I do not smoke but for many years was a musician in clubs and pubs.”

That is evidence of the effect that passive smoking can have on people’s lives. The letter goes on to explain the dire situation in which that individual now finds himself.

Let me address some of the substantial issues that were raised in the debate. Stewart Maxwell pointed out that he has promoted a similar member’s bill. However, his bill is narrower and it requires substantial amendment. I believe that our bill will be more robust and that, with the health improvements that will be embedded in the bill, the ban will be less open to challenge. We have received 54,000 responses to our consultation, whereas he received only 34.

I respect all the work that Stewart Maxwell has done on his bill—I do not take anything away from that—but let me respond to his question on the manner in which the Executive has sought to implement a ban. Our bill will be not just for the coalition parties or for the SNP, but for the whole Parliament and for the whole of Scotland. The advice that we have received is that our bill is the best way of delivering a ban without difficult challenges from those outside the Parliament who have a vested interest in the matter.

Mr Maxwell: Like the First Minister earlier, the Minister for Health and Community Care has suggested that an Executive bill is somehow more legally robust than a member’s bill. I fail to understand the logic behind that argument.
The minister also suggested that my bill “requires substantial amendment”. However, the evidence that I and the Parliament’s legal services provided to the Health Committee was that the bill would require just six amendments. That is not a substantial number.

Mr Kerr: I do not want to go over all those points, which we can discuss in more detail later. However, as Stewart Maxwell’s bill is so much narrower in its scope, it would require such substantial amendment—not so much in terms of the number of amendments as in terms of their scope—that we believe that our legislation would be less open to challenge.

Mr Swinney: Will the minister give way?

Mr Kerr: No, I want to refer to some of the other points that have been made, such as those by David Davidson, who perhaps needs to discuss the medical evidence on passive smoking with his Conservative colleagues.

Now is the time for this work, but we cannot do it in isolation from smokers. We want to support smokers, not to stigmatise them. We want to try to help them to kick the smoking habit. The First Minister announced some measures to that end, such as a doubling of our support for smoking-cessation measures. Moreover, our tobacco action plan has been working for many months now.

Some members have suggested that any ban should be voluntary. However, the voluntary ban has been around for a long time and the industry has not taken the opportunity to make any substantial changes because of it.

As Mike Rumbles pointed out, ventilation does not remove the poisons from the atmosphere. People might get a false sense of security because the pub smells nicer, but passive smoking still kills people in that environment. That is why we want to address the issue in a clear and unequivocal fashion through legislation. Janis Hughes raised the issue of enforcement. We are discussing that issue with the Convention of Scottish Local Authorities at the moment.

Stewart Stevenson made an interesting and valuable contribution—perhaps he was around when James VI made those statements—and I will be interested to see what he comes up with when he does his next Google search. However, we seek not to stigmatise but to support the smoker. More people have died from smoking-related illness and disease than died during the world wars.

Jean Turner mentioned research. We invest some £12 million in cancer research, which is one of the Executive’s biggest research spends. As I told cancer charities and cancer organisations, although we support lung cancer research, lung cancer is an extremely difficult and particular issue, whereas other research is more productive in terms of outcomes. That is not to say that no productive work is being done on lung cancer; it is to say that the issue is extremely difficult.

From Brian Monteith we got red herrings and a head-in-the-sand approach. Some of his comments were embarrassing. Yes, we will have a comprehensive ban. We can and we will define it. We will include clubs, smoking rooms and cigar clubs, because we want to ensure that there is a comprehensive, unequivocal ban and that everyone understands the situation. If members visit the Scottish Executive website or ask Stewart Maxwell about the work that he has done on the issue, they will see that there is a wealth of evidence on environmental tobacco smoke.

Alasdair Morrison made a good point about the other health improvement measures that the Executive is taking. That is what this measure is about. The Executive takes a long-term perspective on Scotland’s health. We are trying to deal with some of the issues in Scottish society that are hardest to crack.

The debate has been interesting. It has been comfortable discussing the matter in the chamber, but we have a long, challenging time ahead of us. Powerful, rich forces are marshalled against the measure, so we must ensure that we stick to our guns and focus on the evidence. We have the evidence and a commitment to public health. We have the chance to change Scotland. Let us not just say how bad the figures are, but let us do something about them by supporting the legislation.
Smoking, Health and Social Care (Scotland) Bill
[AS INTRODUCED]

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Smoking, Health and Social Care (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to prohibit smoking in certain wholly enclosed places; to make provision in relation to general dental services, general ophthalmic services, personal dental services and pharmaceutical care services; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council and the provision of information to the Council; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; and to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust.

PART 1

PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

1 Offence of permitting others to smoke in no-smoking premises

(1) A person who, having the management or control of no-smoking premises, knowingly permits another to smoke there commits an offence.

(2) A person accused of an offence under this section is to be regarded as having knowingly permitted another to smoke in no-smoking premises if that person ought to have known that the other person was smoking there.

(3) It is a defence for an accused charged with an offence under this section to prove—

(a) that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence; or

(b) that there were no lawful and reasonably practicable means by which the accused could prevent the other person from smoking in the no-smoking premises.
(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 4 on the standard scale.

2 **Offence of smoking in no-smoking premises**

(1) A person who smokes in no-smoking premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged that the accused was smoking was no-smoking premises.

(3) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

3 **Display of warning notices in and on no-smoking premises**

(1) If notices are not conspicuously displayed—

(a) inside and outside no-smoking premises;

(b) stating—

(i) that the premises are no-smoking premises; and

(ii) that it is an offence to smoke there or knowingly to permit smoking there, the person having the management or control of the premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence.

(3) The Scottish Ministers may, by regulations provide further as to the manner of display, form and content of the notices referred to in subsection (1).

(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4 **Meaning of “smoke” and “no-smoking premises”**

(1) In this Part, “smoke” means smoke tobacco or any substance or mixture which includes it; and a person is to be taken as smoking if the person is holding or otherwise in possession or control of lit tobacco or any lit substance or mixture which includes tobacco.

(2) In this Part, “no-smoking premises” means such premises or such classes of premises, being premises of a kind mentioned in subsection (4), as are prescribed by regulations made by the Scottish Ministers.

(3) Regulations under subsection (2) may prescribe premises or parts of premises or classes of premises or parts of premises which are excluded from the definition of “no-smoking premises”.

(4) The kind of premises referred to in subsection (2) is premises which are wholly enclosed and—

(a) to which the public or a section of the public has access;

(b) which are being used wholly or mainly as a place of work by persons who are employees;
(c) which are being used by and for the purposes of a club or other unincorporated association; or
(d) which are being used wholly or mainly for the provision of education or of health or care services.

5 (5) Regulations under subsection (2) may, for the purposes of that subsection, define or elaborate the meaning of any of the expressions—
   (a) “premises”; 
   (b) “wholly enclosed”; 
   (c) “the public”; and 
   (d) “has access”.

10 (6) Regulations under subsection (2) may define or elaborate the meaning of “premises”—
   (a) by reference to the person or class of person who owns or occupies them;
   (b) so as to include vehicles, vessels, trains and other means of transport (except aircraft), or such, or such classes, of them as are specified in the regulations.

15 (7) The Scottish Ministers may, by regulations, modify subsection (4) so as—
   (a) to add a kind of premises to; or
   (b) remove a kind of premises (but not the kind referred to in paragraph (a) of that subsection) from,

those in that subsection.

20 (8) Regulations made by virtue of subsection (6)(b) may provide as to how the statement referred to in section 3(1)(b) is to be expressed in the case of each of the means of transport referred to in the regulations.

5 Fixed penalties

(1) Schedule 1 (which provides as to fixed penalties for offences under this Part) has effect.

25 (2) Schedule 1 does not extend to an offence under section 1 or 3 committed otherwise than by a natural person.

6 Powers to enter and require identification

(1) An authorised officer of the appropriate council may enter and search any no-smoking premises in order to ascertain whether an offence under section 1, 2 or 3 has been or is being committed there.

30 (2) A power under this section may be exercised, if need be, by force.

(3) A person who—
   (a) an authorised officer of a council reasonably believes—
      (i) is committing or has committed an offence under section 1, 2 or 3; or
      (ii) has information relating to such an offence; and
   (b) fails without reasonable excuse to supply the officer with the person’s name and address on being so required by the officer,

commits an offence.
(4) A person guilty of an offence under subsection (3) is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

(5) In this section—

“authorised” means authorised for the purposes of this section by the appropriate council;

“the appropriate council” means, in relation to no-smoking premises, the council of the area in which those premises are.

7 Bodies corporate etc.

(1) Where an offence under this Part which has been committed by a body corporate other than a council is proved to have been committed with the consent or connivance of, or to be attributable to, any neglect on the part of—

(a) a director, manager or secretary, member or other similar officer of the body corporate; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the body corporate, is guilty of the offence and liable to be proceeded against and punished accordingly.

(2) Where an offence under this Part which has been committed by a council is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) an officer or member of the council; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the council, is guilty of the offence and liable to be proceeded against and punished accordingly.

(3) Where an offence under this Part which has been committed by a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a partner; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the partnership, is guilty of the offence and liable to be proceeded against and punished accordingly.

(4) Where an offence under this Part which has been committed by an unincorporated association other than a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a person who is concerned in the management or control of the association; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the unincorporated association, is guilty of the offence and liable to be proceeded against and punished accordingly.

8 Crown application

(1) This Part binds the Crown.
(2) No contravention by the Crown of this Part or any regulations under it makes the Crown criminally liable; but the Court of Session may, on the application of a council in the area of which the contravention is alleged to have taken place, declare unlawful any act or omission of the Crown which would, but for this subsection, have been an offence.

(3) Subsection (2) does not extend to persons in the public service of the Crown.

PART 2

GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

9 Free oral health assessments and dental examinations

(1) Oral health assessments and dental examinations carried out on or after 1st April 2006 in accordance with arrangements made under section 17C of the 1978 Act, arrangements for the provision of general dental services under Part II of that Act or a pilot scheme under Part I of the National Health Service (Primary Care) Act 1997 (c.46) (the “1997 Act”) are to be free of charge; and accordingly those Acts are amended as follows.

(2) In the 1978 Act—

(a) in section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “other than those” substitute “except—

(a) oral health assessments and dental examinations carried out on or after 1st April 2006; and

(b) those services”;

(b) in section 71 (charges for general dental services under Part II)—

(i) in subsection (1), after the words “not being—” insert—

“(a) oral health assessments and dental examinations carried out on or after 1st April 2006;”;

(ii) in subsection (2), after “services” where it first occurs insert “(but not being oral health assessments or dental examinations carried out on or after 1st April 2006)”.

(3) In the 1997 Act, in section 20 (charges for dental treatment in accordance with pilot schemes)—

(a) in subsection (1), for the words from “dental” to the end substitute “personal dental services provided in accordance with pilot schemes except—

(a) those services to which section 78(1A) of the 1977 Act or (as the case may be) section 70(1A) of the 1978 Act applies; and

(b) oral health assessments and dental examinations carried out on or after 1st April 2006.”;

(b) subsection (2) is repealed.
Free eye examinations and sight tests

(1) Arrangements under section 26(1) of the 1978 Act for the provision of general ophthalmic services are to include eye examinations and the provision of free eye examinations and sight tests in accordance with such arrangements is to be extended on and after 1st April 2006; and accordingly that Act is amended as follows.

(2) In section 26 (arrangements for the provision of general ophthalmic services)—
   (a) in subsection (1), for the words from “the testing” to the end substitute “the carrying out of eye examinations including where clinically necessary testing of sight.”;
   (b) subsections (1A) to (1E) are repealed.

(3) In paragraph 2A of Schedule 11 (additional provision as to regulations under section 70(1) on charges for optical appliances), sub-paragraph (3)(a) is repealed.

Charges for certain dental appliances and general dental services

(1) The 1978 Act is amended as follows.

(2) In section 70 (regulations as to charges for dental or optical appliances)—
   (a) in subsection (1), for the words “optical appliances” substitute “dental or optical appliances”;
   (b) subsection (1A) is repealed;
   (c) in subsection (2), for the words “(1A)” substitute “(1)”.

(3) In section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “70(1A)” substitute “70(1)”.

(4) In section 71(1) (charges for certain general dental services), for the words “an amount calculated in accordance with section 71A” substitute “the amount authorised by this section”.

(5) Section 71A (regulations as respects amount of any charge authorised by section 70(1A) for supply of dental appliances or by section 71 for certain general dental services) is repealed.

(6) In paragraph 2 of Schedule 11 (additional provision as to regulations under section 70)—
   (a) after sub-paragraph (1), insert—
       “(1A) The dental appliances referred to in that section are dentures, bridges, crowns and orthodontic appliances.”;
   (b) in sub-paragraph (2)(a), for the words “optical appliance” substitute “dental or optical appliance”;
   (c) in sub-paragraph (3), the words “or (1A)” are repealed;
   (d) in sub-paragraph (4), for the words “70(1A)” substitute “70(1)”.
12 **Arrangements for provision of general dental services**

In section 25 of the 1978 Act (arrangements for provision of general dental services)—

(a) in subsection (1), after the words “dental practitioners” insert “or bodies corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(b) for subsection (3), substitute—

“(3) In subsection (1), the reference to “carrying on the business of dentistry” is to be construed in accordance with section 40 of the Dentists Act 1984.”.

13 **Assistance and support: general dental services**

After section 28C of the 1978 Act, insert—

“Assistance and support: general dental services

28D Assistance and support: general dental services

(1) A Health Board may provide assistance and support to any person providing, or proposing to provide, general dental services.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.

14 **Provision of certain dental services under NHS contracts**

(1) Section 17AA of the 1978 Act (arrangements for provision of certain services to be treated as NHS contract for certain purposes) is amended as follows.

(2) In subsection (1), for the words from “to”, where it first occurs, to the end of paragraph (b) substitute “to—

(a) any arrangement under which a Health Board or such other health service body as may be prescribed arrange for the provision to them—

(ii) by a person on a pharmaceutical list, or

(b) any arrangement under which a Health Board arrange for the provision to them by a person on a dental list,”.

(3) In subsection (3), after the word “section—” insert—

““dental list” means, in relation to a list published in accordance with regulations made under subsection (2) of section 25 of this Act, the first part of the list which is referred to in paragraph (a) of that subsection;”.

15 **Lists of persons undertaking to provide or approved to assist in the provision of general dental services**

In section 25 of the 1978 Act (arrangements for provision of general dental services), for subsections (2) to (2B), substitute—
“(2) Regulations may make provision as to the arrangements to be made under subsection (1), and shall include provision as to the preparation, maintenance and publication by every Health Board of a list—

(a) the first part of which shall be of dental practitioners who, and bodies corporate referred to in that subsection which, undertake to provide general dental services under arrangements with the Board;

(b) the second part of which shall be of persons who do not undertake to provide such services under such arrangements but who are approved by the Board to assist in the provision of such services provided under such arrangements.

(2A) In making provision as to the preparation, maintenance and publication of a list referred to in subsection (2), the regulations may include in particular provision as to—

(a) the division of the first part of a list into further sub-parts within the part;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that a person who does not undertake to provide general dental services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(b).”.

16 Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

After section 17E of the 1978 Act, insert—
"17F Lists of persons performing personal dental services

(1) Regulations may provide that a person may not perform personal dental services under section 17C arrangements or a pilot scheme with a Health Board unless his name is included in a list maintained under the regulations by the Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;
(b) eligibility for inclusion in a list;
(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);
(d) the grounds on which an application for inclusion must be granted or refused;
(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);
(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);
(g) circumstances in which a person included in a list may not withdraw from it;
(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);
(i) criteria to be applied in making decisions under the regulations;
(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.”.

17 Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

In section 26 of the 1978 Act (arrangements for provision of general ophthalmic services), for subsection (2), substitute—

“(2) Regulations may make provision as to the arrangements to be made under subsection (1), and shall include provision—

(a) as to the preparation, maintenance and publication by every Health Board of a list—

(i) the first part of which shall be of medical practitioners and ophthalmic opticians who undertake to provide general ophthalmic services under arrangements with the Board;
(ii) the second part of which shall be of persons who do not undertake to provide such services under such arrangements but who are approved by the Board to assist in the provision of such services provided under such arrangements;

(b) conferring on any person a right to choose in accordance with the prescribed procedure the medical practitioner or ophthalmic optician by whom his eyes are to be examined, his sight is to be tested or from whom any prescription for the supply of optical appliances is to be obtained.

(2A) In making provision as to the matters referred to in subsection (2)(a), the regulations may include in particular provision as to—

(a) the division of the first part of a list into further sub-parts within the part;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that a person who does not undertake to provide general ophthalmic services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(a)(ii).”.

PART 3

PHARMACEUTICAL CARE SERVICES ETC.

18 Health Boards’ functions: provision and planning of pharmaceutical care services

(1) The 1978 Act is amended as follows.
(2) After section 2C (functions of Health Boards: primary medical services), insert—

**“2CA Functions of Health Boards: pharmaceutical care services**

(1) Every Health Board—

(a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of pharmaceutical care services as respects the Board’s area; and

(b) may, to such extent, provide or secure the provision of pharmaceutical care services as respects the area of another Health Board, and pharmaceutical care services provided, or the provision of which is secured, by a Health Board under or by virtue of this subsection may be performed outside their area.

(2) For the purpose of securing the provision of pharmaceutical care services under subsection (1), a Health Board may make such arrangements for the provision of the services as they think fit (and may in particular make contractual arrangements with any person).

(3) A Health Board must publish information about such matters as may be prescribed in relation to the pharmaceutical care services provided under this Part.

(4) Without prejudice to section 13, Health Boards must co-operate with one another in discharging their respective functions relating to the provision of pharmaceutical care services under this Part.

(5) Regulations may provide that services of a prescribed description are, or are not, to be regarded as pharmaceutical care services for the purposes of this Act.

(6) Regulations under subsection (5) may in particular—

(a) classify services as services which are to be regarded as essential services or which are to be regarded as additional services;

(b) describe services by reference to the manner or circumstances in which they are provided;

(c) provide that pharmaceutical care services for the purposes of this Act include the provision, in circumstances specified in directions given by the Scottish Ministers, of drugs, medicines and appliances included in a list specified in such directions;

(d) describe services which involve the ordering of a drug, medicine or appliance included in such a list by reference to the description of person by whom the drug, medicine or appliance is ordered.

(7) The Scottish Ministers must publish directions given by them under regulations under subsection (5) in a document to be known as the “Drug Tariff” or in such other manner as they consider appropriate.

(8) Arrangements made under this Part by a Health Board for the provision of pharmaceutical care services may provide for such services to be performed outside Scotland.

(9) Anything done by a Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on the Health Board by an order under section 2(1)(a).
2CB Functions of Health Boards: planning of pharmaceutical care services

(1) Regulations may make provision requiring every Health Board, in accordance with the regulations, to—

(a) prepare a plan for the discharge of their duty under section 2CA(1);

(b) keep a plan prepared under paragraph (a) under review;

(c) prepare a revised plan; and

(d) without prejudice to section 2CA(3), publish a plan so prepared or revised.

(2) Regulations under subsection (1) may in particular make provision as to—

(a) identification by a Health Board in any such plan prepared by them of—

(i) what pharmaceutical care services they consider are necessary in order to discharge their duty under section 2CA(1);

(ii) whether as respects their area there is convenient access (as regards location and opening hours) to pharmaceutical care services; and

(iii) any under-provision of pharmaceutical care services as respects their area;

(b) the period within which a plan is to be prepared and published;

(c) consultation which a Health Board must undertake in relation to the preparation of a plan;

(d) the duration of a plan;

(e) the frequency with which a plan must be reviewed and revised by a Health Board;

(f) the availability and accessibility of a plan to persons who are resident in a Health Board’s area; and

(g) such other matters as the Scottish Ministers consider appropriate.

(3) Regulations making provision as to a matter referred to in subsection (2)(a) may provide that the matter is to be identified in accordance with such criteria as may be specified in directions given by the Scottish Ministers.”.

(3) In section 18 (duty of the Scottish Ministers), the words “, and of pharmaceutical services,” are repealed.

19 Pharmaceutical care services contracts

For section 17Q of the 1978 Act (assistance and support), substitute—

“Pharmaceutical care services contracts

17Q Health Boards’ power to enter into pharmaceutical care services contracts

(1) A Health Board may enter into a contract under which pharmaceutical care services are provided (whether directly or indirectly) by a contractor in accordance with the provisions of this Part.
A contract under this section is referred to in this Act as a “pharmaceutical care services contract”.

Subject to any provision made by or under this Part, a pharmaceutical care services contract may make such provision as may be agreed between the Health Board and the contractor as respects—

(a) the services to be provided under the contract;
(b) the remuneration to be paid under the contract; and
(c) any other matters.

The services to be provided under a pharmaceutical care services contract may include services which are not pharmaceutical care services; and the contract may provide for such other services to be performed in any place where, by virtue of section 2CA(1), pharmaceutical care services may be performed.

In this Part, “contractor”, in relation to a pharmaceutical care services contract with a Health Board, means the other party to the contract.

A pharmaceutical care services contract must require the contractor to provide as respects the area of the Health Board pharmaceutical care services of such descriptions as may be prescribed.

Regulations under subsection (1) may in particular describe the pharmaceutical care services by reference to the manner or circumstances in which they are provided.

A Health Board may, subject to such conditions as may be prescribed, enter into a pharmaceutical care services contract with—

(a) a registered pharmacist; or
(b) a person other than a registered pharmacist who, by virtue of section 69 of the Medicines Act 1968 (c.67), is taken to be a person lawfully conducting a retail pharmacy business in accordance with that section, who undertakes that all pharmaceutical care services provided under the contract will be provided by, or under the supervision of, a registered pharmacist.

Regulations may make provision as to the effect on a pharmaceutical care services contract entered into with a partnership of a change in the membership of the partnership.

The Scottish Ministers may give directions as to payments to be made under pharmaceutical care services contracts.

A pharmaceutical care services contract must require payments to be made under it in accordance with directions for the time being in force under this section.
Part 3—Pharmaceutical care services etc.

(3) A direction under subsection (1) may in particular—

(a) provide for payments to be made by reference to compliance with standards or the achievement of levels of performance;

(b) provide for payments to be made by reference to—

(i) any scheme or scale specified in the direction;

(ii) a determination made by any person in accordance with factors specified in the direction;

(c) provide that the whole or any part of a payment is subject to conditions (including a condition that the whole or any part of a payment is liable to be paid by a Health Board only if they are satisfied as to such conditions as may be specified in the direction);

(d) make provision having effect from a date before the date of the direction, provided that, having regard to the direction as a whole, the provision is not detrimental to the persons to whose remuneration it relates.

(4) Before giving a direction under subsection (1), the Scottish Ministers—

(a) must consult any body appearing to them to be representative of persons to whose remuneration the direction would relate; and

(b) may consult such other persons as they think appropriate.

(5) References in this section to payments include fees, allowances and reimbursements.

17U Other mandatory contract terms: pharmaceutical care services contracts

(1) A pharmaceutical care services contract must include (in addition to provisions required by or under other provisions of this Part) such provision as may be prescribed.

(2) Regulations under subsection (1) may in particular make provision as to—

(a) the manner in which, and the standards to which, services must be provided;

(b) the persons who are to perform services;

(c) the area in which services are to be provided;

(d) the persons to whom services are to be provided;

(e) requirements to be complied with where a contractor provides any pharmaceutical care services indirectly (including requirements as to the pharmaceutical care services which may or may not be so provided);

(f) the variation of terms of the contract (except terms required by or under this Part);

(g) rights of entry and inspection (including inspection of clinical records and other documents);

(h) the circumstances in which, and the manner in which, the contract may be terminated;

(i) enforcement;

(j) the adjudication of disputes.
Part 3—Pharmaceutical care services etc.

(3) Regulations making provision in pursuance of subsection (2)(d) may make provision as to the circumstances in which a contractor—

(a) must, or may, accept a person as a person to whom services are provided under the contract;

(b) may decline to accept a person as such a person; or

(c) may terminate the contractor’s responsibility for a person.

(4) Regulations making provision in pursuance of subsection (2)(f) may—

(a) make provision as to the circumstances in which a Health Board may unilaterally vary the terms of a contract;

(b) make provision suspending or terminating any duty under the contract to provide services of a prescribed description.

(5) Regulations making provision of the kind described in subsection (4)(b) may prescribe services by reference to the manner or circumstances in which they are provided.

(6) A pharmaceutical care services contract must contain provision requiring the contractor to comply with any directions given by the Scottish Ministers for the purposes of this section as to the drugs, medicines or other substances which may, or may not, be dispensed in the provision of pharmaceutical care services under the contract.

17V Resolution of disputes and entry into NHS contracts: pharmaceutical care services contracts

(1) Regulations may make provision for the resolution of disputes as to the terms of a proposed pharmaceutical care services contract, including, without prejudice to that generality, provision for—

(a) the referral of the terms of the proposed contract to the Scottish Ministers; and

(b) the Scottish Ministers, or a person or panel of persons appointed by them, to determine the terms on which the contract may be entered into.

(2) Regulations may make provision for any person entering, or who has entered, into a pharmaceutical care services contract to be regarded as a health service body for any purposes of section 17A, in circumstances where the person so elects.

(3) Where a person is to be regarded as a health service body for any purposes of section 17A by reason only of an election by virtue of subsection (2) of this section, that section has effect in relation to that person with the omission of the words “under any enactment” in subsection (1) and with such other modifications (if any) as may be prescribed.

(4) Regulations under subsection (2) may include provision as to the application of section 17A in cases where—

(a) a partnership is to be regarded as a health service body; and

(b) there is a change in the membership of the partnership.”. 
Persons performing pharmaceutical care services

After section 17V of the 1978 Act (as inserted by section 19 above), insert—

“Persons performing pharmaceutical care services

(1) Regulations may provide that a registered pharmacist may not perform any pharmaceutical care service which a Health Board is, under section 2CA(1), under a duty to provide or secure the provision of unless that pharmacist is included in a list maintained under the regulations by the Health Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from the list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal.

(3) Regulations making provision as to the matters referred to in subsection (2)(j) may in particular authorise the disclosure of information—

(a) by a Health Board to the Scottish Ministers; and

(b) by the Scottish Ministers to a Health Board.”.

Assistance and support: primary medical services and pharmaceutical care services

After section 17W of the 1978 Act (as inserted by section 20 above), insert—

“Assistance and support: primary medical services and pharmaceutical care services

(1) A Health Board may provide assistance and support to—
(a) any person providing, or proposing to provide, primary medical services under a general medical services contract;
(b) any person providing, or proposing to provide, such services in accordance with section 17C arrangements;
(c) any person providing, or proposing to provide, pharmaceutical care services under a pharmaceutical care services contract.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.

PART 4
DISCIPLINE

22 Disqualification by the NHS Tribunal

(1) The 1978 Act is amended as follows.

(2) In section 29 (conditions of disqualification and persons subject to jurisdiction of NHS Tribunal)—
(a) for subsection (2) substitute—
“(2) If the Tribunal receive from a Health Board representations that a person—
(a) who has applied to be included; or
(b) who is included,
in any list meets any of the conditions for disqualification, the Tribunal shall inquire into the case.”;
(b) in subsection (4)(b), the words “the representations are that the second condition for disqualification is met and” are repealed;
(c) in subsection (6)—
(i) for the word “continued” substitute “inclusion or continued”;
(ii) for the words from “list”, where it second occurs, to the end substitute “list—
(a) in relation to a list referred to in subsection (8)(a), (cc) or (e), perform;
(b) in relation to a list referred to in subsection (8)(c) or (d), undertake to provide or are approved to assist in providing;”;
(d) after subsection (7), insert—
“(7A) The third condition for disqualification is that the person concerned is unsuitable (by virtue of professional or personal conduct) to be included, or to continue to be included, in the list.”;
(e) in subsection (8)—
(i) paragraph (b) is repealed;
(ii) for paragraphs (c) to (e) substitute—
“(c) a list of dental practitioners and bodies corporate referred to in section 25(1) undertaking to provide, and of persons who are approved to assist in providing, general dental services;

(cc) a list of persons performing personal dental services;

d) a list of medical practitioners and ophthalmic opticians undertaking to provide, and of persons who are approved to assist in providing, general ophthalmic services;

e) a list of registered pharmacists performing pharmaceutical care services,”;

(f) in subsection (11)—

(i) the word “and” is repealed;

(ii) at the end insert “; and cases in which representations are made that the third condition for disqualification is met are referred to below as unsuitability cases”.

(3) In section 29A (cases before Tribunal: supplementary provision)—

(a) in subsection (1), after “the second condition for disqualification” insert “or, as the case may be, the third condition for disqualification”;

(b) after subsection (1), insert—

“(1A) A body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry is to be treated for the purposes of this group of sections as meeting the second condition for disqualification or, as the case may be, the third condition for disqualification if any director meets that condition (whether or not he first met that condition when he was a director).”;

(c) in subsection (5), for the words “a fraud case” substitute “an unsuitability case, a fraud case or an efficiency case”;

(d) in subsection (6), after the word “in” insert “an unsuitability,”;

(e) after subsection (7), insert—

“(8) In subsection (1A), the reference to “carrying on the business of dentistry” is to be construed in accordance with section 40 of the Dentists Act 1984.”.

(4) In section 29B (disqualification by Tribunal)—

(a) in subsection (1), after paragraph (b) insert “;

(c) on inquiring into an unsuitability case, that the person meets the third condition for disqualification”;

(b) for subsection (2), substitute—

“(2) The Tribunal shall disqualify him for inclusion in—

(a) the list to which the case relates;

(b) all lists within the same paragraph of subsection (8) of section 29 as that list; and

(c) where the list to which the case relates is a list referred to in—

(i) paragraph (c) of that subsection, all lists within paragraph (cc) of that subsection;
(ii) that paragraph (cc), all lists within that paragraph (c).”;

(c) in subsection (4), for the word “any” substitute “a”.

(5) In section 29C (conditional disqualification)—

(a) in subsection (2)—

(i) the word “or” following paragraph (a) is repealed;

(ii) after paragraph (b), insert “;

(c) ensuring that the person—

(i) performs, undertakes to provide or assists in providing only services specified (or of a description specified) in the condition;

(ii) undertakes an activity (or course of activity) of a personal or professional nature, or refrains from conduct of a personal or professional nature, so specified (or of a description so specified)”;

(b) in subsection (5)(aa), for the words “17P” substitute “17F, 17P or 17W or this Part”.

(6) In section 32(2) (regulations: inquiry into more than one category of case), for the words “both an efficiency case and a fraud case” substitute “an efficiency case and a fraud case or an unsuitability case or any other combination of more than one such category of case”.

(7) In section 32A (interim suspension by the Tribunal)—

(a) in subsection (2), for the words from “services” to the end substitute “—

(a) services of the kind to which the case in question, or the case to which the review in question, relates; and

(b) if the services are either general dental services or personal dental services, both general dental services and personal dental services.”;

(b) in subsection (2A)—

(i) in paragraph (a), after the words “primary medical services” insert “, pharmaceutical care services”;

(ii) for paragraph (b), substitute “or

(b) that it is otherwise in the public interest to do so.”;

(c) in subsection (6)(a), for the words from “a list” to “services” substitute—

“(i) a list of persons performing;

(ii) a list of persons undertaking to provide and of persons approved to assist in providing,

services”;

(d) after subsection (6), insert—

“(7) Regulations may provide that where a Health Board, in accordance with regulations made under section 17F, 17P, 17W, 25(2) or 26(2), suspend a person from a list prepared under regulations made under the section in question and the Board apply to the Tribunal for a direction to be made under subsection (2) in relation to the person to whom the suspension applies, the suspension may continue until the Tribunal determine the application.”.
Corresponding provision in England or Wales or Northern Ireland

For section 32D of the 1978 Act (suspension provisions in England and Wales or Northern Ireland), substitute—

“32D Corresponding provision in England or Wales or Northern Ireland

(1) This section applies where it appears to the Scottish Ministers that there is provision in England or Wales or Northern Ireland under which a person may be dealt with in any way which corresponds (whether or not exactly) with a way in which a person may be dealt with under sections 29 to 32B.

(2) A decision in England or Wales or Northern Ireland to deal with such a person in such a way is referred to in this section as a “corresponding decision”.

(3) If this section applies, the Scottish Ministers may make regulations providing for the effect to be given in Scotland to a corresponding decision; and where the decision corresponds (whether or not exactly) with a decision which may be made under section 29C or (so far as relating to conditional disqualification) the regulations may provide for the effect to be given to be determined in the prescribed manner by the Scottish Ministers.

(4) That effect need not be the same as the effect of the corresponding decision in the place where it was made.”.

PART 5

MISCELLANEOUS

Infection with hepatitis C as a result of NHS treatment

Payments to certain persons infected with hepatitis C as a result of NHS treatment

(1) The Scottish Ministers may make a scheme for the making of payments by them, or out of money provided by them, to, or in respect of, persons who—

(a) before 1st September 1991, were treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product;

(b) as a result of that treatment, became infected with the hepatitis C virus; and

(c) did not die before 29th August 2003.

(2) A scheme under this section must—

(a) provide that the question of whether a person became infected with the hepatitis C virus as a result of treatment such as is mentioned in subsection (1)(a) before the date mentioned there is to be determined on the balance of probabilities;

(b) provide that a person is not eligible for the making of a payment under the scheme unless, when the claim for the payment is made or, in the case of a claim made in respect of a dead person, when the person died, the person’s sole or main residence is or was in Scotland; and

(c) provide for the procedure to be followed in relation to claims under the scheme (including the time within which claims must be made and matters relating to the provision of information) and the determination of such claims.
(3) Without prejudice to the generality of subsection (1), a scheme under this section may—

(a) specify conditions for eligibility for the making of a payment under the scheme (and may specify different conditions in relation to different payments);

(b) provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings in relation to the matter which is the subject of the claim or payment (but may also provide for the taking account of payments under the scheme in such proceedings);

(c) appoint a person (other than a Minister of the Crown) to manage the scheme on behalf of the Scottish Ministers;

(d) confer functions on the Scottish Ministers or any person appointed under paragraph (c);

(e) provide for any function so conferred on the Scottish Ministers to be carried out on their behalf by any person appointed under paragraph (c); and

(f) make transitional, transitory or saving provision.

(4) Provision such as is mentioned in subsection (3)(c) or (e) does not affect the responsibility of the Scottish Ministers for the management of the scheme or the carrying out of the functions.

(5) The Scottish Ministers may revoke or amend a scheme under this section.

(6) The Scottish Ministers must publish a scheme under this section in such manner as they consider appropriate.

**Amendment of Regulation of Care (Scotland) Act 2001**

25 **Independent health care services**

In section 2(5) of the 2001 Act (meaning of “independent health care service”), after paragraph (d) insert “,

but a service may be excepted from this definition by regulations”.

26 **Implementation of certain decisions under the 2001 Act**

(1) The 2001 Act is amended as follows.

(2) In section 16 (right to make representations to Scottish Commission for the Regulation of Care as respects proposals under Part 1), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) that person notifies the Commission in writing that such representations will not be made;
(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(3) In section 48 (right to make representations to Scottish Social Services Council as respects proposal in notice under section 46(2) or 47(1)), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Council may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) that person notifies the Council in writing that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Council receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Council shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(4) In section 51(1) (appeal against decision of Council), for the words from “section” to “proposal” substitute “subsection (2) of section 50 of this Act of a decision mentioned in that subsection”.

27 Provision of information to the Scottish Social Services Council

After section 57 of the 2001 Act, insert—

“Notification of dismissal etc. for misconduct and provision of other information to Council

57A Notification of dismissal etc. to Council

The employer of a social service worker shall—

(a) on dismissing the social service worker on grounds of misconduct; or

(b) on the social service worker resigning or abandoning the worker’s position in circumstances where, but for the resignation or abandonment—

(i) the worker would have been dismissed on grounds of misconduct; or

(ii) dismissal on such grounds would have been considered by the employer,

forthwith notify the Council of the dismissal, resignation or abandonment; and the employer shall in doing so provide the Council with an account of the
circumstances which led to the dismissal or which were present when the resignation or abandonment took place.

57B Provision of other information to Council by employer

The employer of a social service worker shall, when requested to do so by the Council, provide it with such information as respects the worker as it may reasonably require in connection with the exercise of the functions assigned to it under this Act or any other enactment.”.

Child care agencies and housing support services

28 Registration of child care agencies and housing support services

(1) Subsections (2) to (4) apply where—

(a) on 1st April 2003 a person was providing a care service to which the 2003 Order applies;

(b) the service—

(i) was, by virtue of article 3(1) of the 2003 Order, treated as if it were registered on that date; and

(ii) by virtue of article 3(2) of that Order, ceased on 1st October 2003 or on 1st April 2004 to be treated as if it were registered; and

(c) the person continued (or continues) to provide the service after it ceased to be so treated as if it were registered at any time during which it was not registered.

(2) If any of the circumstances mentioned in subsection (3) apply, the service is, subject to subsection (4), to be treated for all purposes as if it were registered—

(a) on 1st October 2003 or, as the case may be, 1st April 2004; and

(b) for the period during which there was (or is) a continuation of service as mentioned in subsection (1)(c).

(3) The circumstances are—

(a) that an application for registration of the service was made by the person before 30th September 2004;

(b) that—

(i) no application for registration of the service was made by the person before that date; and

(ii) the person ceased to provide the service before that date.

(4) The service ceases to be so treated as registered by virtue of subsection (2) on whichever of the following first occurs—

(a) where the Commission decides to refuse the application and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;

(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;
(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(b) where the Commission decides (other than in accordance with an application under section 14(1)(b) of the 2001 Act) to cancel the registration of the service effected by virtue of subsection (2) and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;

(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;

(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(c) where the sheriff grants an application by the Commission under section 18 of that Act for cancellation of the registration of the service, the day on which the sheriff does so;

(d) the day on which the person ceases to provide the service;

(e) 1st April 2006 or such later day as may be substituted for it by order made by the Scottish Ministers.

(5) In this section—

“the 2003 Order” means the Regulation of Care (Scotland) Act 2001 (Commencement No. 3 and Transitional Provisions) Order 2003 (SSI 2003 No. 205 (C.9));

“the Commission” means the Scottish Commission for the Regulation of Care;

“registered” means registered under Part 1 of the 2001 Act; and references to “registration” are to be construed accordingly.

29 Grants in respect of housing support services

Payments by a local authority—

(a) made out of sums, or descriptions of sum, received by it from the Scottish Ministers under section 91(1) of the Housing (Scotland) Act 2001 (asp 10); and

(b) purportedly made in compliance with the condition specified in paragraph 2 of the Schedule to the Housing (Scotland) Act 2001 (Payments out of Grants for Housing Support Services) Order 2003 (SSI 2003 No. 140),

which were not validly made merely by virtue of the condition not having been complied with are to be treated as having been validly made notwithstanding the non-compliance with the condition.
Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

(1) The Adults with Incapacity (Scotland) Act 2000 (asp 4) is amended as follows.

(2) In section 47 (authorisation of medical treatment)—

(a) in subsection (1)—

(i) for the words “the medical practitioner primarily responsible for the medical treatment of an adult” substitute “any of the persons mentioned in subsection (1A)”; 

(ii) in paragraph (a), for the words “the adult” substitute “an adult”;

(b) after that subsection, insert—

“(1A) The persons are—

(a) the medical practitioner primarily responsible for the medical treatment of the adult;

(b) a person who is—

(i) a dental practitioner;

(ii) an ophthalmic optician;

(iii) a registered nurse; or

(iv) a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed, and who is primarily responsible for medical treatment of the kind in question.”;

(c) in subsection (2)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who by virtue of subsection (1) has issued a certificate for the purposes of that subsection”;

(ii) for the words “medical treatment” where they second occur substitute “the medical treatment in question”;

(d) in subsection (3)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom that authority is conferred”;

(ii) for the words “medical treatment”, where they second occur, substitute “the medical treatment in question”;

(e) in subsection (5)—

(i) in paragraph (a), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issues the certificate”; 

(ii) in paragraph (b), for the words “does not exceed one year from” substitute “does not exceed—
(i) one year; or

(ii) if, in the opinion of the person issuing the certificate any of the conditions or circumstances prescribed by the Scottish Ministers applies as respects the adult, 3 years,

from”;

(f) in subsection (6)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued it”;

(ii) in paragraph (b), for the words “not exceeding one year from” substitute “not exceeding—

(i) one year; or

(ii) if, in the opinion of that person any of the conditions or circumstances prescribed by the Scottish Ministers apply as respects the adult, 3 years,

from”.

(3) In section 49(1) (medical treatment where there is an application for intervention or guardianship order)—

(a) for the words “Section 47(2)” substitute “Subsection (2) of section 47”;

(b) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom authority is conferred by that subsection”.

(4) In section 50 (medical treatment where guardian etc. has been appointed)—

(a) in subsection (2)—

(i) in paragraph (b), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) in paragraph (c), for the words “medical practitioner” substitute “person”;

(b) in subsection (3)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “any person having an interest” substitute “the medical practitioner primarily responsible for the medical treatment of the adult or any person having an interest”;

(c) in subsection (4)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “medical practitioner”, where they second occur, substitute “person who issued the certificate”;

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(iii) for the words “a medical practitioner (the “nominated medical practitioner”))” substitute “a practitioner who the Commission consider has professional knowledge or expertise relevant to medical treatment of the kind in question (the “nominated practitioner”))”;

5

(d) in subsection (5)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;

(ii) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

10

(e) in subsection (6)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;

(ii) after the words “personal welfare of the adult” insert “(including, where the certificate issued for the purposes of section 47(1) was issued by another person, that person)”;

15

(f) in subsection (9)—

(i) for the words “medical practitioners” substitute “practitioners”;

(ii) for the words “medical practitioner” substitute “practitioner”.

31 Joint ventures

(1) After section 84A of the 1978 Act, insert—

“Joint ventures

84B Joint ventures

(1) The Scottish Ministers may do any (or all) of the following—

(a) form or participate in forming companies to provide facilities or services for persons or groups of persons exercising functions, or otherwise providing services, under this Act;

(b) participate in companies providing facilities or services for persons or groups of persons falling within paragraph (a);

(c) with a view to securing or facilitating the provision by companies of facilities or services for persons or groups of persons falling within paragraph (a)—

(i) invest in the companies (whether by acquiring assets, securities or rights or otherwise);

(ii) provide loans and guarantees and make other kinds of financial provision to or in respect of them.

(2) For the purpose of subsection (1), it is immaterial that the facilities or services provided or to be provided by a company are not provided or to be provided—

(a) only to persons or groups of persons exercising functions, or otherwise providing services, under this Act; or
(b) to such persons or groups of persons only in that capacity.

(3) In this section—

“companies” means companies within the meaning of the Companies Act 1985 (c.6);

“facilities” includes the provision of (or the use of) premises, goods, equipment, materials, vehicles, plant or apparatus.”.

(2) After section 7(7B) of the Health and Medicines Act 1988 (c.49) (powers of the Secretary of State for financing the health service), insert—

“(7C) The power specified in paragraph (g) of subsection (2) above includes power for the Scottish Ministers—

(a) to form or participate in forming companies,

(b) to—

(i) participate in companies,

(ii) invest in companies (whether by acquiring assets, securities or rights or otherwise),

(iii) provide loans and guarantees and make other kinds of financial provision to or in respect of companies,

where it appears to them that to do so is calculated to facilitate, or to be conducive or incidental to, the exercise of any power conferred by that subsection.

(7D) In subsection (7C) above “companies” means companies within the meaning of the Companies Act 1985; and that subsection is without prejudice to the generality of subsection (2) above.”.

Scottish Hospital Endowments Research Trust

(1) The 1978 Act is amended as follows.

(2) In section 12 (establishment and functions of the Trust)—

(a) subsections (1) and (2) are repealed;

(b) in subsection (3), for the words “the Research Trust” substitute “the Scottish Hospital Endowments Research Trust (referred to in this Act as “the Research Trust”)”;

(c) in subsection (4B), the words from “Subject to” to “activity,” are repealed;

(d) subsection (5) is repealed;

(e) in subsection (6), the words from “, and shall send” to the end are repealed;

(f) subsection (6A) is repealed;

(g) for subsection (7), substitute—

“(7) The Research Trust shall prepare an annual report of their proceedings which shall include an abstract of their accounts.”;

(h) after that subsection, insert—
“(8) Schedule 7 shall have effect in relation to the Research Trust.

(3) In Schedule 7 (further provision as respects the Trust)—

(a) paragraph 1 is repealed;

(b) for paragraph 3, substitute—

“Members

3 Subject to paragraph 3A, the Research Trust shall consist of such number of members appointed by the Trust as the Trust may determine.

3A(1) The persons who are the members of the Research Trust immediately before the day on which section 32 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00) comes into force shall, on that day, continue to be members (the “continuing members”).

(2) The terms and conditions of appointment of the continuing members shall, on the 90th day after whichever of the following occurs first—

(a) the day on which that section comes into force; or

(b) the day on which the Research Trust first make standing orders under paragraph 3F,

be the terms and conditions of appointment the Research Trust determine for the members appointed by them under paragraph 3B(1).

(3) The provisions of paragraphs 3B(2) and (3) to 3D and 3F shall apply to the continuing members as they apply to members appointed under paragraph 3; and in the application of paragraph 3C any period of appointment of a continuing member as a member (before he became a continuing member by virtue of sub-paragraph (1)) shall count for the purposes of determining eligibility for re-appointment in accordance with paragraph 3C.

Terms of office etc.

3B(1) Subject to the provisions of this Schedule, the appointment of a member under paragraph 3 shall be on such terms and conditions as the Research Trust may determine, but shall not be for a period exceeding 4 years.

(2) A person holds and vacates office as member in accordance with the person’s terms of appointment.

(3) A person may resign office as member at any time by notice in writing to the Research Trust.

Eligibility for re-appointment

3C A person who ceases to be a member of the Research Trust shall be eligible for re-appointment, but only once.

Payments to members

3D The Research Trust may make payments from their funds to their members in respect of any loss of earnings the members would otherwise have made or any additional expenses to which they would not otherwise have been subject, being loss of expenses necessarily suffered or incurred for the purpose of enabling the members to discharge their duties as members of the Trust.
Staff

3E(1) The Research Trust may appoint such staff, on such terms and conditions (including as to remuneration and allowances), as they consider appropriate.

(2) The Research Trust may—

(a) pay, or make arrangements for the payment of;

(b) make payments towards the provision of; and

(c) provide and maintain schemes (whether contributory or not) for the payment of,

such pensions, allowances and gratuities to or in respect of such of their employees, or former employees, as they may determine.

(3) The reference in sub-paragraph (1) to pensions, allowances and gratuities includes a reference to pensions, allowances and gratuities by way of compensation for loss of employment or reduction in remuneration.

Standing orders

3F (1) The Research Trust—

(a) shall make and maintain standing orders regulating—

(i) the appointment by them of members;

(ii) the appointment of a member as convener;

(iii) the terms and conditions of office of members and convener;

(iv) their procedure;

(v) such other matters as the Research Trust consider appropriate;

(b) may, subject to sub-sub-paragraph (a), amend such standing orders from time to time.

(2) The first set of standing orders under this paragraph shall be made before the expiry of the period of 90 days beginning with the day on which section 32 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00) comes into force.

(3) Subject to the provisions of this Schedule, the Research Trust may regulate their own procedure.

(4) The validity of any proceedings of the Research Trust shall not be affected by any vacancy in membership nor by any defect in the appointment of a member.

Powers etc.

3G The Research Trust may do anything which appears to them to be necessary or expedient for the purpose of, or in connection with, the exercise of their functions.”;

(c) in paragraph 6, the words from “, unless” to “case,”, where it first occurs, are repealed;

(d) paragraph 7 is repealed.
PART 6
GENERAL

33 Ancillary provision
(1) The Scottish Ministers may by order make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—
(a) make different provision for different purposes;
(b) modify any enactment, instrument or document.

34 Regulations or orders
(1) Any power conferred by this Act on the Scottish Ministers to make orders or regulations—
(a) must be exercised by statutory instrument;
(b) may be exercised so as to make different provision for different purposes.

(2) A statutory instrument containing an order or regulations made under this Act (except an order under section 37(3)) is, subject to subsection (3), subject to annulment in pursuance of a resolution of the Parliament.

(3) A statutory instrument containing—
(a) regulations under section 3(3) or 4(2) or (7) or paragraph 2, 4(1), 5(2), 12 or 13 of schedule 1 or an order under section 28(4)(e);
(b) an order under section 33 containing provisions which add to, replace or omit any part of the text of an Act,
is not to be made unless a draft of the instrument has been laid before, and approved by resolution of, the Parliament.

(4) The Scottish Ministers must consult such persons as they consider appropriate before laying a draft of a statutory instrument containing regulations under section 3(3) or 4(2) or (7).

35 Interpretation
In this Act—
“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c.29);
“the 2001 Act” means the Regulation of Care (Scotland) Act 2001 (asp 8);
“council” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994 (c.39);
“prescribed” means prescribed by regulations made by the Scottish Ministers.

36 Minor and consequential amendments and repeals
(1) Schedule 2 contains minor amendments and amendments consequential on the provisions of this Act.
(2) The enactments specified in column 1 of schedule 3 are repealed to the extent specified in column 2.

37 Short title and commencement

(1) This Act may be cited as the Smoking, Health and Social Care (Scotland) Act 2005.

(2) Sections 1 to 8, 28, 29 and 35 and schedule 1 come into force on the day after Royal Assent.

(3) The remaining provisions of this Act, except this section and sections 33 and 34, come into force on such day as the Scottish Ministers may by order appoint.

(4) Different days may be appointed under subsection (3) for different purposes.
SCHEDULE 1
(introduced by section 5)

FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, AND 3

Power to give fixed penalty notices

1 (1) An authorised officer of a council may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3 in no-smoking premises within the area of the council, give that person a fixed penalty notice in relation to that offence.

(2) A constable may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3, give that person a fixed penalty notice in relation to that offence.

(3) In this schedule, “fixed penalty notice” means a notice offering a person the opportunity of discharging any liability to conviction for an offence under section 1, 2 or 3 by payment of a fixed penalty.

2 A fixed penalty notice for an offence under section 1, 2 or 3 may not be given after such time relating to the offence as may be prescribed.

Contents of fixed penalty notice

3 (1) A fixed penalty notice must identify the offence to which it relates and give reasonable particulars of the circumstances alleged to constitute that offence.

(2) A fixed penalty notice must also state—
   (a) the amount of the penalty and the period within which it may be paid;
   (b) the discounted amount and the period within which it may be paid;
   (c) the person to whom and the address at which payment may be made;
   (d) the method or methods by which payment may be made;
   (e) the person to whom and the address at which any representations relating to the notice may be made;
   (f) the consequences of not making a payment within the period for payment.

(3) The person specified under sub-paragraph (2)(c) must be the council in the area of which the offence was alleged to have been committed or a person acting on its behalf.

The amount of the penalty and the period for payment

4 (1) The fixed penalty for an offence under section 1, 2 or 3 is (subject to paragraph 5) such amount as may be prescribed.

(2) The period for payment of the fixed penalty is the period of 29 days beginning with the day on which the notice is given.

(3) The council may extend the period for paying the fixed penalty in any particular case if it considers it appropriate to do so.
The discounted amount

5 (1) A discounted amount is payable instead of the amount prescribed under paragraph 4(1) if payment is made before the end of the period of 15 days beginning with the day on which the notice is given.

5 (2) The discounted amount for a fixed penalty offence is such amount as may be prescribed.

5 (3) If the last day of the period specified in sub-paragraph (1) does not fall on a working day, the period for payment of the discounted amount is extended until the end of the next working day.

Effect of notice and payment of penalty

6 (1) This paragraph applies where a person is served with a fixed penalty notice in respect of a fixed penalty offence.

6 (2) No proceedings for the offence may be commenced before the end of the period for payment of the penalty.

6 (3) No such proceedings may be commenced or continued if payment of the penalty is made before the end of that period or is accepted by the council after that time.

6 (4) Payment of the discounted amount counts for the purposes of sub-paragraph (3) only if it is made before the end of the period for payment of the discounted amount.

6 (5) In proceedings for the offence, a certificate which—

(a) purports to be signed by or on behalf of a person having responsibility for the financial affairs of the council; and

(b) states that payment of an amount specified in the certificate was or was not received by a date so specified,

is sufficient evidence of the facts stated.

Request for hearing

7 (1) A person to whom a fixed penalty notice has been given may, before the expiry of the period for payment of the penalty, give notice requesting a hearing in respect of the offence to which the fixed penalty notice relates.

7 (2) A notice requesting a hearing under sub-paragraph (1) must be in writing and must be sent by post or delivered to the person specified under paragraph 3(2)(c) in the fixed penalty notice at the address so specified.

7 (3) For the purposes of this paragraph and unless the contrary is proved, the sending of a notice by post is deemed to have been effected at the time at which the notice would be delivered in the ordinary course of post.

7 (4) Where a person has requested a hearing in accordance with this section—

(a) the council must hold the hearing;

(b) a person authorised for the purpose by the council of the area in which the offence was committed must notify the procurator fiscal of the request; and
(c) the period for payment of the fixed penalty must be calculated so that the period beginning with the giving of the notice under this paragraph and ending with the receipt by the person who gave that notice of the decision reached at the hearing is left out of account.

5

**Power to withdraw notices**

8 (1) If the council considers (whether after holding a hearing under paragraph 7 or not) that a fixed penalty notice which has been given ought not to have been given, it may give to the person to whom it was given a notice withdrawing the fixed penalty notice.

(2) Where a notice under sub-paragraph (1) is given—

(a) the council must repay any amount which has been paid by way of penalty in pursuance of the fixed penalty notice; and

(b) no proceedings are to be commenced or continued against that person for the offence in question.

(3) The council must consider any representations made by or on behalf of the recipient of a fixed penalty notice and decide in all the circumstances whether to withdraw the notice.

9 Where proceedings for an offence in respect of which a fixed penalty notice has been given are commenced, the notice is to be treated as withdrawn.

10 Subject to paragraphs 8 and 9, where a fixed penalty remains unpaid after the expiry of the period for payment of the penalty it is enforceable in like manner as an extract registered decree arbitral bearing a warrant for execution issued by the sheriff for any sheriffdom.

11 (1) A person against whom a fixed penalty bears to be enforceable under paragraph 10 may apply to the sheriff by summary application for a declaration that the fixed penalty is not enforceable on the ground that—

(a) the fixed penalty was paid before the expiry of the period for paying; or

(b) the person has made a request for a hearing in accordance with paragraph 7 and no hearing has been held within a reasonable time after the request.

(2) On an application under sub-paragraph (1), the sheriff may declare—

(a) that the person has or, as the case may be, has not paid the fixed penalty within the period for payment of the penalty;

(b) that the person has or, as the case may be, has not requested a hearing in accordance with paragraph 7;

(c) that, where such a request has been made, a hearing has or, as the case may be, has not been held within a reasonable time after the request; and accordingly, that the fixed penalty is or, as the case may be, is not enforceable.
General and supplementary

12 The Scottish Ministers may make regulations about—
   (a) the application by councils of fixed penalties paid under this schedule;
   (b) the keeping of accounts, and the preparation and publication of statements of
        account, relating to fixed penalties under this schedule.

13 The Scottish Ministers may by regulations—
   (a) prescribe circumstances in which fixed penalty notices may not be given;
   (b) modify paragraph 4(2) or 5(1) so as to substitute a different period for the period
        for the time being specified there;
   (c) prescribe the method or methods by which penalties may be paid.

SCHEDULE 2
(introduced by section 36(1))

MINOR AND CONSEQUENTIAL AMENDMENTS

National Health Service (Scotland) Act 1978 (c.29)

1 (1) The 1978 Act is amended as follows.

(2) In section 17AA(3) (meaning of “ophthalmic list” for purpose of section), in the
     definition of “ophthalmic list”—
     (a) for the words from “a list” to the end of paragraph (a) substitute “—
         (a) in relation to a list published in accordance with regulations made under
         paragraph (a) of section 26(2) of this Act, the first part of the list which
         is referred to in sub-paragraph (i) of that paragraph;”;
     (b) at the beginning of each of paragraphs (b) and (c) insert “a list published in
         accordance with regulations made under”.

(3) In section 28A(1) (remuneration for provision of Part II services), for the words “,
     general ophthalmic services or pharmaceutical services” substitute “or general
     ophthalmic services”.

(4) In section 28C(3) (indemnity cover)—
     (a) in the definition of “list”, for “section 29(8)(b) to (e)” substitute “section 29(8)(c)
         or (d)”;
     (b) in the definition of “Part II services”, for the words “general dental services,
         general ophthalmic services or pharmaceutical services” substitute “general dental
         services or general ophthalmic services”.

(5) In section 29(8A) (meaning of health care professional in section 29(8)(a)), for the
     words “17D” substitute “17P”.

(6) In section 30(1) (review etc. of disqualification), for the words “any disqualification,
     conditional disqualification or declaration of unfitness” substitute “a disqualification or
     conditional disqualification”.

(7) In section 32(1)(a) (regulations as to sections 29 and 31), for the words “31” substitute
     “30”.

(8) In section 32A(3) (interim suspension), after paragraph (a) insert “and”.

(9) In section 32E(1) (payments in consequence of suspension), for the words “32D(2)” substitute “32D(3)”.

(10) In section 33 (powers of Scottish Ministers where services are inadequate), for the words from “any list” to the end of paragraph (d) substitute “—

(a) the first part of any list prepared under section 25(2), being the part which is of dental practitioners and bodies corporate referred to in section 25(1) who undertake to provide general dental services;

(b) the first part of any list prepared under section 26(2), being the part which is of medical practitioners and ophthalmic opticians who undertake to provide general ophthalmic services,”.

(11) In section 85AA (means of meeting expenditure of Health Boards out of public funds)—

(a) in subsection (2)(b), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”;

(b) in subsection (4)—

(i) in paragraph (a)(ii), for the words “paragraphs (b) or (c)” substitute “paragraph (b)”;

(ii) paragraphs (c) and (e) are repealed;

(c) in subsection (5), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”.

(12) In section 85AB (further provision as to expenditure on drugs)—

(a) in subsection (6), for the words “pharmaceutical services” substitute “pharmaceutical care services”;

(b) after that subsection insert—

“(7) In this section, “drugs” includes—

(a) medicines; and

(b) appliances included in a list specified in directions given under regulations made under section 2CA(5).”.

(13) In section 108 (interpretation)—

(a) after the definition of “general medical services contract”, insert—

““general ophthalmic services” is to be construed in accordance with section 26(1F);”;

(b) after the definition of “personal dental services”, insert—

““pharmaceutical care services” is to be construed in accordance with section 2CA(5);

“pharmaceutical care services contract” has the meaning given by section 17Q(2);”;

(c) for the definition of “the Research Trust”, substitute—

““the Research Trust” means the Scottish Hospital Endowments Research Trust constituted under subsection (1) of section 12 of this Act (before the repeal of that subsection by section 32(2)(a) of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00);”.”
Health and Medicines Act 1988 (c.49)

2 In section 17 of the Health and Medicines Act 1988—

(a) in subsection (1)—

(i) for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”;

(ii) after the words “1978” insert “(referred to in this section as “the 1978 Act”)”;

(iii) in paragraph (a), for the words from “or” to the end, substitute “or—

“(i) in relation to section 17F of the 1978 Act, personal dental services;

(ii) in relation to section 17P of that Act, primary medical services;

(iii) in relation to section 17W of that Act, pharmaceutical care services”;

(b) in subsection (2)(a)(ii), for the words from “or,” to the end substitute “or, with any requirements placed on him by regulations made under section 17F, 17P, 17W, 25(2) or, as the case may be, 26(2) of the 1978 Act”.

Police Act 1997 (c.50)

3 In section 115 of the Police Act 1997 (enhanced criminal record certificates)—

(a) in subsection (6C) (as inserted by section 70(3)(c) of the Criminal Justice (Scotland) Act 2003 (asp 7))—

(i) in paragraph (b), after the word “provide” insert “, and persons approved to assist in providing,”;

(ii) in paragraph (c), after the word “provide” insert “, and persons approved to assist in providing,”;

(iii) paragraph (d) is repealed;

(b) in subsection (6D)(a) (as inserted by the said section 70(3)(c)), for the words “(c) or (d)” substitute “(b) or (c)”;

(c) in subsection (6E) (as inserted by the said section 70(3)(c)), for the words “section 17P of the National Health Service (Scotland) Act 1978 (persons performing primary medical services)” substitute “section 17F (persons performing personal dental services), 17P (persons performing primary medical services) or 17W (persons performing pharmaceutical care services) of the National Health Service (Scotland) Act 1978”.
### SCHEDULE 3
*(introduced by section 36(2))*

#### REPEALS

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<tr>
<td>National Health Service (Scotland) Act 1978 (c.29)</td>
<td>Section 25(4) and (5). Sections 27 to 28. Section 29A(2). Section 29B(3). In section 29B(4), the words “or declaration”. In section 30(2), in paragraph (a) the words from “or” to the end of the paragraph, and the words from “, and, on a review” to the end of the subsection. Section 31. In section 32A, in subsection (3) paragraph (c) and the word “and” immediately preceding that paragraph and in subsection (6) paragraph (b) and the word “, and” immediately preceding that paragraph. In section 32B, in each of subsections (1) and (2)(a) the word “national” and subsection (3). Section 85AA(11). In section 85AB(6), the words “section 85AA and”. In Schedule 8, paragraph 8(2A).</td>
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<td>Health and Social Security Act 1984 (c.48)</td>
<td>In Schedule 1, in Part II, paragraphs 2, 3 and 4.</td>
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<td>National Health Service (Amendment) Act 1986 (c.66)</td>
<td>Section 3(3).</td>
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<tr>
<td>Health and Medicines Act 1988 (c.49)</td>
<td>Section 8. Section 11(4) to (6). In section 17(3A) the words from “or section 27A” to the end. In Schedule 2, in paragraph 15, sub-paragraphs (2) and (3). In Schedule 3, the entry concerning section 70(1) of the 1978 Act; and in the entry concerning Schedule 11, the words “the words “dental or” and”.</td>
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<td>National Health Service and Community Care Act 1990 (c.19)</td>
<td>In Schedule 9, paragraph 19(7).</td>
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<td>Public Finance and Accountability (Scotland) Act 2000 (asp 1)</td>
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<td>Ethical Standards in Public Life etc. (Scotland) Act 2000 (asp 7)</td>
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<td>Freedom of Information (Scotland) Act 2002 (asp 13)</td>
<td>In schedule 1, paragraph 43.</td>
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Smoking, Health and Social Care (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to prohibit smoking in certain wholly enclosed places; to make provision in relation to general dental services, general ophthalmic services, personal dental services and pharmaceutical care services; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council and the provision of information to the Council; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; and to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust.

Introduced by: Mr Andy Kerr
On: 16 December 2004
Supported by: Rhona Brankin
Bill type: Executive Bill
SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Smoking, Health and Social Care (Scotland) Bill introduced in the Scottish Parliament on 16 December 2004:

- Explanatory Notes;
- a Financial Memorandum;
- an Executive Statement on legislative competence; and
- the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 33–PM.
EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL – AN OVERVIEW

4. The main provisions of the Bill are set out below.

Part 1 – makes provision for a ban on smoking in certain wholly enclosed places:

- creating an offence of permitting others to smoke in and on no-smoking premises;
- creating an offence of smoking in no-smoking premises;
- creating an offence of failing to display warning notices in no-smoking premises;
- setting out the powers of enforcement officers to enter no-smoking premises.
- creating an offence of failing without reasonable excuse to give one’s name and address on request by an authorised officer.

Part 2 – provides for various matters concerning general dental services, personal dental services and general ophthalmic services:

- free oral health assessments and dental examinations;
- free eye examinations and sight tests;
- assistance and support in the provision of general dental services;
- NHS provision of certain dental services;
- listing of those persons undertaking to provide or approved to assist in the provision of general ophthalmic services;
- listing of those persons undertaking to provide or approved to assist in the provision of general dental services and those persons performing personal dental services under section 17C arrangements and pilot schemes.

Part 3 – makes a series of provisions regarding pharmaceutical care services:

- requirements on Health Boards to plan provision of pharmaceutical care services;
- contracts for provision of pharmaceutical care services;
- listing of persons performing pharmaceutical care services;
provision of assistance and support for pharmaceutical care services.

Part 4 – makes provisions for strengthening the powers of the NHS Tribunal, extending its jurisdiction and giving effect to corresponding provision made in England or Wales or Northern Ireland.

Part 5 – makes provisions for a number of miscellaneous issues:
- payments to certain persons infected with hepatitis C;
- amendment of the Regulation of Care (Scotland) Act 2001;
- registration of child care agencies and housing support services;
- amendment of the Adults with Incapacity (Scotland) Act 2000;
- the ability of Scottish Ministers and health bodies to enter into joint ventures;
- the Scottish Hospital Endowments Research Trust.

Part 6 – makes general provisions.

Schedule 1 – Fixed penalty for offences under sections 1, 2 and 3.

Schedule 2 – Minor and consequential amendments.

Schedule 3 – Repeals.

PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

Section 1 – Offence of permitting others to smoke in no-smoking premises

5. Subsections (1) and (2) make it an offence for the person who is in charge of no-smoking premises, having the management or control of those premises, to knowingly permit others to smoke there. The person in charge will be regarded as having permitted that other person to smoke if he or she knew, or ought to have known, that the other person was smoking there.

6. Two defences are provided under subsection (3). The first defence open to the accused person is to prove that they, or anyone working for them, had taken all reasonable precautions and had tried to the best of their ability to stop any other person from smoking in their premises. The second defence open to the accused is to prove that there were no lawful and reasonably practicable means by which they could prevent the other person from smoking in their premises.

7. Subsection (4) provides that the offence of permitting others to smoke in no-smoking premises is subject to a maximum penalty, on summary conviction, of a fine not exceeding level 4 on the standard scale (currently £2500).

Section 2 – Offence of smoking in no-smoking premises

8. Subsection (1) makes it an offence for a person to smoke in no-smoking premises.
9. Subsection (2) provides that it is a defence if the person accused of smoking can prove that they did not know, and could not reasonably be expected to have known, that the premises in which they were smoking were no-smoking premises. This might arise in instances where, for example, no-smoking signs had been removed or had failed to be displayed. The onus is however on the accused to prove this.

10. Subsection (3) provides that the offence of smoking in no-smoking premises is subject to a maximum penalty on summary conviction of a fine not exceeding level 3 on the standard scale (currently £1000).

Section 3 – Display of warning notices in and on no-smoking premises

11. Subsection (1) requires “no-smoking” signs to be conspicuously displayed inside and outside no-smoking premises. The person who is in charge of those no-smoking premises, having the management or control of the premises, is liable for any failure to display such signs. Failure to display signs is an offence. The signs to be displayed must state that the premises are no-smoking premises and that it is an offence to smoke there or knowingly to permit smoking there.

12. Under subsection (2) it is a defence for anyone accused of failing to display “no-smoking” signs to prove that they or anyone working for them or representing them as an agent took all reasonable precautions and exercised all due diligence to ensure that signs were in place as required.

13. Subsection (3) gives the Scottish Ministers powers to make regulations which will provide further details as to the manner of display, form and content of the no-smoking signs. Regulations under this provision will be made under the affirmative resolution procedure, so that they cannot be made until the Parliament has approved a draft.

14. Subsection (4) provides that the offence of failing to display warning notices in and on no-smoking premises is subject to a maximum penalty on summary conviction of a fine not exceeding level 3 on the standard scale (currently £1000).

Section 4 – Meaning of “smoke” and “no-smoking premises”

15. Subsection (1) provides the meaning of “smoke” which in the context of Part 1 of the Bill means to smoke tobacco or any substance or mixture which includes it. This subsection further clarifies that a person is to be taken as smoking if the person holds or is otherwise in possession or control of lit tobacco or any lit substance or mixture which includes tobacco.

16. Subsection (2) provides for “no-smoking premises” to be defined as such premises or classes of premises of a kind mentioned in subsection (4), which will be prescribed by the Scottish Ministers under regulations. Subsection (3) allows the Scottish Ministers to exclude, by means of those regulations, certain premises, or parts of premises, or classes or premises or parts of premises, from the definition of “no-smoking premises”. Regulations made under subsection (2) are to be made by affirmative procedure.

17. Subsection (4) lists the kinds of premises which are to be prescribed as “no-smoking premises” under subsection (2), being premises which are wholly enclosed and (a) to which the
public or a section of the public have access, (b) which are used wholly or mainly as a place of work by persons who are employees, (c) which are being used for the purposes of a club or an other unincorporated association and (d) which provide education, health or care services.

18. Subsection (5) gives a further power to the Scottish Ministers to define or elaborate by means of regulations on the meaning of certain expressions used under subsection (2).

19. Similarly, and as above, subsection (6)(a) empowers the Scottish Ministers to define or elaborate by means of regulations the meaning of “premises” by reference to the person or class of person who owns or occupies the premises, whilst subsection (6)(b) allows the Scottish Ministers to define or elaborate the meaning of “premises” to include specific forms of public transport as they see fit.

20. Subsection (7) allows the Scottish Ministers to make regulations to modify subsection (4) by adding to or removing from the kinds of premises listed there. Again, any such regulations will require to be made by affirmative resolution.

21. Subsection (8) relates to the “no-smoking” notices which are to be displayed under section 3(1). Subsection (8) provides that where regulations are made under subsection (2) which define or elaborate the meaning of “premises” to cover certain forms of transport, those regulations may provide how the “no-smoking” sign in relation to each form of transport is to be expressed, thus enabling bespoke “no-smoking” signs for the various forms of transport.

Section 5 – Fixed penalties

22. Subsection (1) provides for a fixed penalty scheme under Schedule 1 to have effect. Schedule 1 sets out the details of how the fixed penalty system will work for offences committed under sections 1, 2 and 3 of the Bill. An explanation of the provisions in the Schedule is given at the end of these notes.

23. Subsection (2) provides that the fixed penalty system will not extend to offences under section 1 (permitting others to smoke in no-smoking premises) or section 3 (failure to display warning notices in or on no-smoking premises) committed otherwise than by a natural person.

Section 6 – Powers to enter and require identification

24. Subsection (1) empowers an officer of a council to enter no-smoking premises in order to check whether an offence under sections 1, 2 or 3 has taken place or is being committed. The council which authorises the officer under this subsection will be the council in the area where the premises are situated. Officers of the council will, in general terms, have access to premises to which the public has access; this additional power is therefore a back-up power.

25. A council officer exercising a power of entry under subsection (1), may use force to gain entry if necessary under subsection (2) and may, under subsection (1) search the premises.
26. An offence is committed under subsection (3) if a person who an authorised officer of a council reasonably believes is committing or has committed an offence under sections 1, 2 or 3, or has information relating to the offence fails without reasonable excuse to give their name and address when requested to do so by the enforcing officer. The penalty for a person guilty of an offence under this subsection is on summary conviction a fine not exceeding level 3.

Section 7 – Bodies corporate etc.

27. Section 7 provides that officers of companies and other corporations and members of partnerships can be held personally liable, in certain circumstances, for offences under Part 1 of the Bill that their companies or partnerships commit.

Section 8 – Crown application

28. Many enclosed public places will be operated and controlled by the Crown. Section 8 provides that Part 1 of the Bill and any regulations made under it shall bind the Crown. Subsection (2) ensures that instead of making the Crown criminally liable for any contravention under this Part of the Bill, the Court of Session may declare unlawful any act or omission of the Crown which constitutes a contravention.

29. Although the Crown itself cannot be prosecuted, subsection (3) ensures that the provisions in Part 1 apply to people in the public service of the Crown.

PART 2: GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

Section 9 – Free oral health assessments and dental examinations

30. The provisions discussed in paragraphs 30 to 33 fulfil the partnership agreement of introducing free dental checks for all before 2007. In subsection (2) of section 70A of the National Health Service (Scotland) Act 1978 new wording is substituted, creating new paragraphs (a) and (b). Subsection (2) defines the dental treatment provided in accordance with section 17C arrangements for which regulations made under subsection (1) may prescribe the manner of making and recovering patient charges. New paragraph (a) excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from that definition.

31. In subsection (1) of section 71 of the 1978 Act, a new paragraph (a) is inserted. This excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from the Part II general dental services for which regulations may provide for the making of charges.

32. In subsection (2) of section 71 of the 1978 Act, new wording is substituted. This again excludes oral health assessments and dental examinations made on or after 1 April 2006 from the prescribed special dental treatment provided under general dental services for which regulations may provide for the making of charges.

33. In subsection (1) of section 20 of the National Health Service (Primary Care) Act 1997, new wording is substituted creating new paragraphs (a) and (b). New paragraph (a) replaces
subsection (2) of section 20 which is repealed. Section 20 empowers regulations to be made to prescribe the manner of making and recovering patient charges for personal dental services under a pilot scheme. New paragraph (b) excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from these powers.

Section 10 – Free eye examinations and sight tests

34. Section 10 makes provision in relation to free eye examinations and sight tests. It does so by extending the meaning of general ophthalmic services, the provision of which must be secured under section 26 of the 1978 Act. At present, general ophthalmic services to be provided free of charge are limited to the testing of sight, which would determine whether or not a person requires an optical appliance (e.g. spectacles), of certain categories of person. This section extends the duty in section 26(1) of the 1978 Act both to include eye examinations, tailored to meet the needs of the individual patient and which may, or may not, include a sight test, and to apply to all.

35. In subsection (1) of section 26 of the 1978 Act, new wording is substituted in order to provide that Health Boards are placed under a duty to make arrangements with ophthalmic opticians and ophthalmic medical practitioners for the carrying out of eye examinations which will include the testing of the patient’s sight where this is considered necessary in the clinical opinion of the ophthalmic optician or medical practitioner who is undertaking the eye examination.

36. Subsections (1A) to (1E) of section 26 of the 1978 Act are repealed. These set out the categories of patient who are currently entitled to have their sight tested free of charge under general ophthalmic services and are therefore otiose.

37. Sub-paragraph (3)(a) of paragraph 2A of Schedule 11 to the 1978 Act is repealed. This provides for Scottish Ministers or a Health Board to contribute towards the cost of sight tests for those persons whose income/capital does not exceed their requirements as calculated in accordance with regulations but falls within the regulatory parameters for help with costs.

Section 11 – Charges for certain dental appliances and general dental services

38. In section 70 of the 1978 Act, new wording is substituted in order to provide, by regulations, more flexibility for the way in which dental charges are made or recovered. In section 70, wording is expanded to add the category of dental appliances to allow for more flexibility in the charging system. Section 70(1A) is repealed as dental appliances are now included in subsection 1. Similarly, in section 70(2) the reference to subsection (1A), is amended to refer to subsection (1).

39. In section 70A(2) new wording is substituted to take account of the repeal of section 70 subsection (1A) and to refer to section 70(1) for the making and recovery of charges for dental appliances.

40. In section 71 of the 1978 Act new wording is substituted to reflect that section 71A is repealed.

41. In paragraph 2 of schedule 11 of the 1978 Act new wording is substituted. A new sub-paragraph (1A) is introduced to provide by regulations charges for dental appliances which are...
defined as dentures, bridges, crowns and orthodontic appliances. The wording in sub-paragraph (2) (a) is also amended to include dental appliance. In sub-paragraph 3 the reference to section 1A is repealed and the wording in sub-paragraph (4) is amended to reflect that section 70(1A) is repealed.

Section 12 – Arrangements for provision of general dental services

42. In section 25 of the 1978 Act, new wording is substituted to expand the categories of persons with whom Health Boards can make arrangements for the provision of dental services. In subsection (1), new wording is substituted to allow arrangements to be made with bodies corporate as defined in section 43 of the Dentists Act 1984 (the 1984 Act).

43. A new subsection (3) is introduced to further define the bodies corporate as being ones which carry on the business of dentistry in terms of section 40 of the 1984.

Section 13 – Assistance and support: general dental services

44. After section 28C of the 1978 Act a new section 28D is inserted to enable a Health Board to provide assistance, including financial assistance, to providers of general dental services in a way that the Board thinks fit.

45. A new subsection (1) is introduced which enables a Health Board to provide assistance and support to any person providing, or proposing to provide, general dental services under section 25 of the 1978 Act.

46. New subsection (2) enables the Health Board to provide such assistance and support in a way that it thinks fit, and new subsection (3) enables the assistance to include financial assistance.

Section 14 – Provision of certain dental services under NHS contracts

47. In section 17AA of the 1978 Act new wording is substituted to make provision regarding certain arrangements between dentists and Health Boards. This will facilitate the participation of dentists in co-management schemes whereby Health Boards may make arrangements with dentists to undertake functions complementary to the work of hospital departments.

48. In subsection (1) new wording is substituted to treat arrangements between a Health Board and persons on a dental list as NHS contracts. An NHS contract is an arrangement where disputes with respect to it or its proposed terms may be determined by the Scottish Ministers. New wording is inserted at subsection (3) to define a dental list.

Section 15 – Lists of persons undertaking to provide or approved to assist in the provision of general dental services

49. A new subsection (2) is substituted in section 25 of the 1978 Act for the existing subsection (2). The new subsection (2) provides a regulation-making power as to arrangements for the provision of general dental services (GDS).
50. The regulations as to arrangements shall provide for the listing of those who are approved to assist in the provision of GDS in the area of the Health Board. The subsection sets out those persons who will be listed on each part of a list to be prepared, maintained and published by each Health Board. Under paragraph (a), those persons who have undertaken to provide GDS will be named on the first part of the list. The second part will include those persons who are approved by the Health Board to assist in the provision of GDS and this is provided for in paragraph (b).

51. A new subsection (2A) is substituted for existing subsection (2A) of section 25. Paragraphs (a) to (j) of subsection (2A) set out issues that may be included in the regulations as to the preparation, maintenance and publication of the list.

52. Paragraph (a) provides that the first part of the list may be divided into further sub-parts to enable different categories of persons undertaking to provide GDS to be distinguished as necessary – for example, those who provide domiciliary visits to nursing homes and similar establishments.

53. Paragraphs (b) to (j) provide that the regulation making powers may include provision as to: eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused, or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

54. A new subsection (2B) is substituted for existing subsection (2B) of section 25. Under this, regulations may specify that a person who acts only as an assistant practitioner in a Health Board area may not assist with GDS provision unless named on the second part of the Board’s list.

Section 16 – Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

55. A new section 17F is inserted into the 1978 Act. This provides an enabling power so that regulations may be made to establish lists of persons performing personal dental services (PDS) under pilot schemes or section 17C arrangements, that is, permanent schemes.

56. New subsection (1) provides that no person may perform PDS in an area unless that person’s name is included in a list maintained by the Health Board.

57. Paragraphs (a) to (j) of new subsection (2) set out issues that may be included in the regulations and provide that the regulation making powers may in particular include provision as to: the preparation, maintenance and publication of a list by a Health Board, eligibility and applications for inclusion in such a list; the grounds on which an application must be granted, or refused, or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.
Section 17 – Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

58. A new subsection (2) is substituted in section 26 of the 1978 Act for the existing subsection (2). As with existing subsection (2) this provides a regulation-making power as to arrangements made by medical practitioners and ophthalmic opticians undertaking to provide general ophthalmic services (GOS). The regulations as to arrangements shall provide for the listing of those who are approved to assist in the provision of GOS in the area of the Health Board for the first time. Paragraph (a) sets out those persons who will be listed on each part of a list to be prepared, maintained and published by each Health Board. Under (2)(a)(i), ophthalmic contractors, i.e. those persons who undertake to provide GOS, will be named on the first part of the list. The second part will include those persons who are approved by the Board to assist in the provision of GOS and this is provided for in (2)(a)(ii).

59. A new, expanded subsection (2)(b) replaces the former subsection (2)(c). Regulations will also provide for the procedure by which patients will have a right to choose the person that examines their eyes as well as the person that tests their sight or gives a prescription. Previously, the right to choose related only to the person by whom a patient’s sight would be tested or from whom any prescription could be obtained but the Bill now proposes that GOS should include eye examinations.

60. A new subsection (2A) is inserted into section 26. Paragraphs (a) to (j) of subsection (2A) set out issues that may be included in the regulations as to the preparation, maintenance and publication of the list.

61. Paragraph (a) provides that the first part of the list may be divided into further sub-parts to enable different categories of ophthalmic opticians to be distinguished as necessary – for example, those who provide domiciliary visits to nursing homes and similar establishments.

62. Paragraphs (b) to (j) provide that the regulating making powers may include: particular provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

63. A new subsection (2B) is inserted into section 26 of the 1978 Act. Under this, regulations may provide that a person who acts only as an assistant practitioner in a Health Board area may not assist with GOS provision unless named on the second part of the Board’s list.
PART 3: PHARMACEUTICAL CARE SERVICES ETC.

Section 18 – Health Boards’ functions: provision and planning of pharmaceutical care services

64. This inserts two new sections, 2D and 2E, into the 1978 Act.

New section 2D – Functions of Health Boards: pharmaceutical care services

65. Subsection (1) of the new section 2D requires Health Boards to provide pharmaceutical care services or to secure the provision of those services by others. This gives Health Boards a new obligation to provide services themselves, in contrast to current legislation that only permits them to secure provision by others.

66. The subsection also creates a power for Health Boards to provide or secure the provision of pharmaceutical care services for persons for whom they would not be under a duty to provide. This makes it possible for Health Boards to deliver pharmaceutical care services in a location that is outwith the area they cover.

67. Subsection (2) of the new section enables a Health Board securing the provision of pharmaceutical care services by others to do so by means of such arrangements as they think fit. The main arrangement available will be a pharmaceutical care service contract under new section 17Q, which replaces the current section 27 pharmaceutical services arrangements.

68. Subsection (3) of the new section places a duty on Health Boards to publish prescribed information about the pharmaceutical care services that they secure the provision of by others, or provide themselves. The information that can be prescribed is in relation to the provision of pharmaceutical care services under Part 1 of the 1978 Act and not just section 2D.

69. Subsection (4) of the new section creates an obligation on Health Boards to co-operate with each other in discharging their functions connected with every aspect of the provision of pharmaceutical care services. This will be relevant where Health Boards choose to deliver pharmaceutical services in a location outwith their geographical area as described above. This specific duty of co-operation is in addition to the existing general duty on Health Boards and others under section 13 of the 1978 Act to co-operate with one another in exercising their functions in order to secure and advance the health of people in Scotland.

70. Subsection (5) of the new section allows regulations to be made that will define “pharmaceutical care services” for the purposes of the 1978 Act. The regulation will set out types of services that are and are not pharmaceutical care services for this purpose.

71. Subsection (6) of the new section allows the regulations made under subsection (5) to classify what services are to be regarded as essential or additional pharmaceutical care services and under paragraph (b) the manner or circumstances in which they will be provided. This would include, for example, categorising the type of premises from which different services are to be provided and the time of day during which services should be available. Subsections (c) and (d) provide that where the service provided involves dispensing it is undertaken in accordance with
directions that list drugs, medicines and appliances (i.e. the current Drug Tariff) and the circumstances in which they may be prescribed, and against orders raised by prescribed persons, for example appropriately registered medical and dental practitioners.

72. Subsection (7) provides that any directions to be issued by Scottish Ministers (by virtue of their regulation powers at subsection (5)) must be published in the ‘Drug Tariff’, or other such other manner as they consider appropriate. The Drug Tariff already exists and, inter alia, lists or details the drugs, medicines and appliances that can be ordered and dispensed as part of the provision of pharmaceutical care services.

73. Subsection (8) makes it clear that arrangements which a Health Board may make for the provision of pharmaceutical care services may provide for the delivery of those services at a location outside Scotland. For instance, this would allow a Health Board to make arrangements that would enable persons to receive pharmaceutical care services outside Scotland where it was more practical or convenient for them to do so.

74. Subsection (9) of the new section provides that while Health Boards are exercising their own statutory functions to provide or secure the provision of pharmaceutical care services, they are to be regarded in law as exercising functions of the Scottish Ministers conferred on the Health Boards.

**New section 2E – Functions of Health Boards: planning of pharmaceutical care services**

75. Subsection (1) provides the Scottish Ministers with broad regulation and direction-making powers that will prescribe the arrangements by which Health Boards will prepare, publish and keep under review plans that will enable them to discharge their duty under new section 2D(1).

76. Subsection (2) gives examples of what the regulations under subsection (1) may cover and includes identification of what pharmaceutical care services are required in a Health Board’s area, whether there is convenient access and where provision of those services is considered inadequate. It also includes the periods in which Health Boards are to prepare, publish and review their pharmaceutical care services (PCS) plan; and the consultation process by which the PCS plan is prepared and ultimately made available to public.

77. Subsection (3) gives the Scottish Ministers power to publish in directions what criteria ought to be considered in the identification by the Health Boards of the matters in subsection (2)(a) in preparing a PCS plan. For example, the directions might require Health Boards to compare the locations of NHS community pharmacies and GP surgeries relative to and the size and proximity of populations they serve and their pharmaceutical care service needs.

**Section 19 – Pharmaceutical care services contracts**

78. This section inserts new sections 17Q to 17V into the 1978 Act (in place of existing sections on pharmaceutical services). The new sections govern the terms and content of the new pharmaceutical care services (PCS) contracts and who may provide or perform PCS under the contracts. They contain regulation-making powers that will be used to set out the detail of the rights and obligations under the new contracts.
79. **New section 17Q** refers to the general content of the contract.

80. Subsection (1) allows a Health Board to enter into a PCS contract with a contractor to provide pharmaceutical care services in accordance with the provisions of Part I of the 1978 Act.

81. Subsection (3) sets out parameters for services to be provided under the contract, the remuneration for their provision and other matters. Health Boards and contractors are free to agree the terms of the contract – subject to any restrictions on this freedom contained in Part I of the 1978 Act (restrictions set out in new sections 17R to 17V and in regulations under new section 17Q and those sections).

82. Subsection (4) allows the contract to cover a range of services, such as those that are provided in other primary and acute care settings and for the services to be delivered at a location outside the Health Board’s geographical area.

83. **New section 17R** makes it compulsory for a PCS contract to require the contractor to provide pharmaceutical care services of such descriptions as may be set out in regulations under the section. The regulations may describe services by reference to the manner or circumstances in which they are to be provided. The intention is to set out in regulations that providers must provide certain essential services.

84. **New section 17S** sets out the persons with whom a Health Board may enter into a PCS contract. Subsection (1) allows a Health Board to enter into a PCS contract with a registered pharmacist or, where the statutory conditions are satisfied, a person or business lawfully conducting a retail pharmacy business (in accordance with section 69 of the Medicines Act 1968) provided that the contractor undertakes that the pharmaceutical care services are provided by, or under the supervision of, a registered pharmacist.

85. Subsection (2) enables regulations to set out the effect on the contract of a change in the membership of a partnership contracted to provide pharmaceutical care services. The intention is to allow the membership of a partnership to change without requiring a new contract to be entered into merely because such a change in partnership has taken place.

86. **New section 17T** deals with payments to be made under PCS contracts.

87. Subsection (1) enables Scottish Ministers to give directions as to payments to be made under the contracts. This follows the practice of using direction-making powers to ensure that Health Boards make payments that adhere to Scotland-wide rates and levels.

88. Subsection (2) makes it compulsory for a PCS contract to require payments to be made in accordance with the directions then in force.

89. Subsection (3) gives examples of the matters for which directions may provide.
90. Subsection (4) requires Scottish Ministers to consult before giving any direction under subsection (1).

91. New section 17U allows regulations to be made identifying those requirements that must be included in all PCS contracts.

92. Subsection (2) gives examples of the issues that the regulations may cover, such as: the manner in which and standards to which services are to be provided; the persons who may perform services; contract variation and enforcement; and the adjudication of disputes.

93. Subsection (3) provides for regulations made under subsection (2)(d) to set out prescribed circumstances in which a contractor must accept a person to whom services are to be provided and in which a contractor may decline to accept such a person or may terminate responsibility under the PCS contract for the person.

94. Subsection (4) provides that regulations varying the contract terms (by virtue of subsection (2)(f)) may include provision as to the circumstances in which a Health Board may so vary the terms or to suspend or terminate any duty under the contract to provide services of a prescribed description.

95. Subsection (6) provides that all PCS contracts include a requirement that the contractors must comply with any directions given by the Scottish Ministers as to the drugs, medicines or other substances that may or may not be ordered.

96. New section 17V essentially provides for two things.

97. Subsection (1) creates a regulation-making power to set national procedures for internal dispute resolution for the terms of proposed PCS contracts. The regulations may provide for the proposed terms to be referred to the Scottish Ministers and for the Scottish Ministers, or a person or panel of persons appointed by them, to determine what the terms of contract should be.

98. Subsection (2) creates a regulation making power to enable the parties to a PCS contract and parties who are already providing pharmaceutical care services under a PCS contract to opt to be treated as a health service body for any purposes in the existing section 17A of the 1978 Act. Section 17A allows health service bodies to enter into contracts with other health service bodies for the supply of goods and services. Such contracts are health service contracts, and are not regarded for any purpose as giving rise to contractual rights and liabilities, and they are not enforceable in courts. Section 17A instead provides for either party to a NHS contract to refer any matter in dispute to the Scottish Ministers for determination. It also provides for any determination made by the Scottish Ministers to contain directions (including directions about payments) and places a duty on the parties to the NHS contract to comply with any such directions.

99. Subsection (3) provides that if a PCS contractor or potential provider elects to become a health service body under subsection (2), section 17A of the 1978 Act applies with appropriate modifications. Where a business opts for its PCS contract to be an ordinary contract at law, it will have the option of asking the courts to resolve any resultant contractual disputes.
Section 20 – Persons performing pharmaceutical care services

100. This section inserts a new section 17W into the 1978 Act.

101. Subsection (1) provides for regulation-making powers governing the ways in which persons performing pharmaceutical care services are listed. The regulations may prevent registered pharmacists from performing pharmaceutical care services for Health Boards unless their name appears on a list held by the Health Board that has the duty to secure or provide those services. An obligation to be on the list of a Health Board before performing services in that Health Board’s area remains even if the services are carried out as part of a contract with a neighbouring Health Board that is using its powers under section 2D(1) of the Act to provide or secure the provision of pharmaceutical care services in the area of another Health Board.

102. Section 17W ends the current arrangements whereby the Health Board’s pharmaceutical list contains the names of persons or businesses with whom the Health Board has made an arrangement to provide pharmaceutical services, and under which only the principal providers of those services are listed, and thereby subject to ‘terms of service’ requirements. The need to list contractors for ‘terms of service’ requirements is no longer necessary as arrangements will be governed by the terms of arrangements which Health Boards enter into with persons to secure the provisions of pharmaceutical care services under section 2D.

103. The new listing arrangements will apply to all registered pharmacists wishing to perform pharmaceutical care services, i.e. whether contractors or employed or engaged by contractors.

104. Subsection (2) of section 17W sets out the particular issues that may be included in the regulations. These include, for example: how the list will be drawn up and maintained; what criteria an individual will have to meet to qualify to be on the list; the process by which decision on applications will be made; and mandatory grounds under which a Health Board would have to reject an application.

Section 21 – Assistance and support: primary medical services and pharmaceutical care services

105. This section inserts a new section 17X into the 1978 Act, which makes new provision in relation to PCS and does this by replacing the existing section 17Q, which is an existing provision for Primary Medical Services (PMS). The existing PMS provision (replicated in new section 17X) enables a Health Board to provide assistance and support (including financial assistance) to those providing, or proposing to provide, PMS. The new section 17X extends the provision of assistance and support to PCS. The terms on which such assistance and support are given, including terms as to payment, are a matter for the Health Board.

106. Further provision relating to financial matters are made by amendments listed in Schedule 2 (paragraphs 1(10) and (11)).
PART 4: DISCIPLINE

107. This part makes a number of changes to those sections of the 1978 Act relating to the NHS Tribunal. The Tribunal is the principal NHS disciplinary body for family health service practitioners. It is an independent body comprising a Chair appointed by the Lord President of the Court of Session, a member of the relevant profession and a lay member both appointed by the Scottish Ministers.

Section 22 – Disqualification by the NHS Tribunal

108. A new subsection (2) is substituted in section 29 of the 1978 Act for the existing subsection. The substitution, taken together with the repeal of the words “the representations are that the second condition for disqualification is met and” in subsection (4)(b), enables the Tribunal to inquire into any case referred by a Health Board or other person within prescribed time limits and involving an applicant to any Health Board lists or a person who is already listed who meets any condition for disqualification.

109. Subsection (6) sets out the first condition for disqualification by the Tribunal. In subsection (6) of section 29, the words “inclusion or continued” are substituted for “continued” so that the first condition of disqualification may be satisfied by those applying to be included in a list. Subsection (6)(a) is expanded to cover the list of persons performing personal dental services described in section (8)(cc) and performing pharmaceutical services described in subsection (8)(e).

110. Subsection (6)(b) is inserted to make similar provision for the list of persons described in subsection (8)(c) or (d) who provide, and assist in the provision of, services.

111. The new subsection (7A) inserted into section 29 adds a third condition of disqualification – unsuitability (by virtue of professional or personal conduct) – to the existing 2 disqualification conditions of fraud and prejudice to the efficiency of the relevant service. It enables disqualification of both list applicants and listed persons who meet this condition.

112. Subsection (8) is amended as follows. The reference to the list of medical practitioners providing general ophthalmic services in paragraph (8)(b) is deleted. The existing paragraphs (8)(c) to (e) are replaced with references to the lists of those who provide, and assist in providing, general dental or general ophthalmic services and perform personal dental or pharmaceutical care services.

113. In subsection (11) of section 29, the insertion of the words “and cases in which representations are made that the third condition for disqualification is met are referred to below as unsuitability cases”, taken together with the repeal of the word “and”, provides for the categorisation of cases referred by Health Boards or other persons which meet the third condition of disqualification as “unsuitability cases” and adds this category to the other 2 categories of cases regarding the 2 existing disqualification conditions.

114. In section 29A, subsection (1) is amended so that the new third condition of disqualification can be met by any body corporate carrying on business as ophthalmic opticians if a director meets that condition. A new subsection, (1A), is inserted to make similar provision to subsection (1) for any body corporate which carries out dentistry as a business. The Tribunal may
These documents relate to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

direct disqualification of the body corporate on ground of fraud or unsuitability if any director meets those conditions. Subsection (5) is amended so that this may be done in efficiency and unsuitability cases also. In subsection (6) the circumstances in which a fraud or efficiency case is finally concluded are set out. It is amended so that it also applies to an unsuitability case.

115. A new paragraph (c) is inserted into section 29B(1). This adds the new third condition of disqualification to the grounds on which the Tribunal shall make a disqualification.

116. A new subsection (2) is substituted in section 29B for the existing subsection. The effect is that the Tribunal shall disqualify a person from all lists of persons delivering those services where it determines a condition of disqualification is met, unless it would be unjust to do so. In the case of dental services, the disqualification is from all lists of persons undertaking to provide and approved to assist in providing general dental services and of persons performing personal dental services.

117. A new paragraph (c) is added to subsection 29C(2) dealing with conditional disqualification which extends the scope of the conditions which the Tribunal may place on those who are permitted to practice conditionally.

118. Subsection (5)(aa) is amended to refer to section 17F, 17W and Part II of the 1978 Act. This allows the Tribunal, for the purpose of or in connection with the imposition of conditions, to vary any requirements to which a person subject to the inquiry is subject. This is in addition to the Tribunal’s power under subsection (5)(a) to vary any terms of service the person is subject to by virtue of subsection (5)(a).

119. In section 32(2) the words “both an efficiency case and a fraud case” are replaced by “an efficiency case and a fraud case or an unsuitability case or any other combination of more than one such category of case”. Section 32(2) provides that where representations are made to the Tribunal against the same person on grounds of efficiency and fraud, regulations may provide that it may inquire into one or other matter and, when then matter is finally disposed off, it may decide to adjourn the other matter indefinitely. This allows regulations to provide, for example, for situations such as where the Tribunal has decided that a condition for disqualification was met for, say, proven fraud and there would be nothing to be gained by considering other allegations. The amendment extends the regulation-making power to take account of the new ground of unsuitability.

120. Subsection (2) of section 32A is amended so that directions by the Tribunal for suspension of a person as respects services applies, in the case of dental services to both general and personal dental services. A new paragraph (b) is substituted in subsection 32A(2A). This widens the second ground on which the Tribunal may direct interim suspension from one only related to the further perpetration of fraud/the prejudicing of investigation of a fraud case or review to a public interest ground. This includes cases where suspension is intended to ensure that further fraud is not perpetrated or evidence/witnesses in a fraud case are not interfered with. It will also enable the Tribunal to direct the interim suspension where it is otherwise in the public interest. It could include, for example, interim suspension to prevent serious disruption to the efficiency of services.

121. Subsection 6(a) is amended so that the definition of “relevant list” now covers persons providing services, and persons performing, undertaking to provide and approved to assist in providing services.
122. A new subsection (7) is inserted into section 32A. This will enable regulations to provide for the continuation of the suspension of a person whom a Health Board has suspended from one of its lists in terms of regulations under sections 17F, 17P, 17W, 25(2) or 26(2) of the 1978 Act and referred to the Tribunal until such time as the Tribunal has decided whether or not to suspend the person.

Section 23 – Corresponding provision in England or Wales or Northern Ireland

123. Section 23 substitutes a new section 32D. At present section 31 governs the effect in Scotland of decisions under provisions in force in England or Wales or Northern Ireland which correspond to provisions in force in Scotland regarding disqualification, and section 32D governs the effect in Scotland of decisions under provisions in force in England and Wales or Northern Ireland which correspond to provisions in force in Scotland regarding suspension by the Tribunal. However provisions in other parts of the UK may not correspond exactly to the provisions in force in Scotland. This new section replaces section 31 and 32D and allows regulations to provide for the effect of such decisions in Scotland, by providing for the effect that is to be given in Scotland to decisions made in other parts of the UK which correspond (whether or not exactly) with decisions made by the Tribunal.

PART 5: MISCELLANEOUS

INFECTION WITH HEPATITIS C AS A RESULT OF NHS TREATMENT

Section 24 – Payments to certain persons infected with hepatitis C as a result of NHS treatment

124. Subsection (1) provides for the Scottish Ministers to make a scheme for making payments to, or in respect of, persons who have been infected with the hepatitis C virus in certain circumstances.

125. Subsection (2) prescribes certain matters which must be included in a scheme such as the procedure to be followed in making a claim under the scheme and how claims are to be determined.

126. Subsection (3) provides that a scheme may include certain matters such as conditions for eligibility and the subsection also allows the Scottish Ministers to make provision in the scheme for other persons to undertake functions or manage the scheme on their behalf.

127. Subsection (4) provides that, where a scheme provides that it is to be managed, or functions are to be undertaken, on behalf of the Scottish Ministers, the Scottish Ministers remain responsible for those functions or the management of the scheme.

AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001

Section 25 – Independent health care services

128. Under the Regulation of Care (Scotland) Act 2001 (the 2001 Act) the Care Commission registers and inspects a range of care services, deals with complaints and, where necessary, takes
enforcement action. Section 2 of the 2001 Act lists and defines care services which are regulated by the Scottish Commission for the Regulation of Care (the Care Commission). This section of the Bill amends section 2(5) of the 2001 Act which defines “an independent healthcare service” as: an independent hospital; a private psychiatric hospital; an independent clinic; and an independent medical agency. This amendment gives Scottish Ministers the power to except services from this definition by regulations, bringing it into line with other relevant care service definitions.

Section 26 – Implementation of certain decisions under the 2001 Act

129. This section amends sections 16(2), 48(2) and 51(1) of the 2001 Act.

130. The Care Commission has powers under the 2001 Act to issue a condition notice to service providers already registered and those applying to register as providers of care services (for example to require a care home provider to keep a door closed at all times to prevent residents from having access to a busy road). When such a notice is issued the 2001 Act allows a person receiving to make representation to the Care Commission. Subsection (2) amends section 16(2) to make further provision regarding representations. In particular it ensures that where representations are made to the Care Commission about a notice given under 16(2)(a) these will be considered by the Care Commission before it decides whether or not to do the thing proposed in the notice.

131. The Scottish Social Services Council (the Council) has the power under section 46 of the 2001 Act to grant registration to a social service worker either unconditionally or give notice to the worker that registration will be granted subject to certain conditions (for example to require a worker to complete a specific training requirement within a specified period of time). Section 48 allows the person who has received notice to make representations to the Council. Subsection (3) amends section 48 to make further provision about representations. In particular it ensures that where representations are made these will be considered by the Council in deciding whether or not to do the thing proposed.

132. Subsection (4) amends section 51 to ensure that there is a right of appeal against all decisions of the Council and not just an appeal against the implementation of a proposal.

Section 27 – Provision of information to the Scottish Social Services Council

133. This section inserts new sections 57A and 57B into the Regulation of Care (Scotland) Act 2001.

134. The new section 57A requires the employer of a social service worker to inform the Scottish Social Services Council where the social service worker has been dismissed on grounds of misconduct or has resigned or abandoned their position in circumstances where there would have been grounds for their dismissal. The employer must also provide the Council with an account of the circumstances.

135. The new section 57B requires that the employer of a social service worker will provide to the Council any information as respects that worker that the Council requires in the pursuit of its functions.
CHILD CARE AGENCIES AND HOUSING SUPPORT SERVICES

Section 28 – Registration of child care agencies and housing support services

136. This section is concerned with persons providing certain child care agencies and housing support services on 1 April 2003 who were deemed to have their service registered with the Care Commission until 30 September 2003. Where a provider did not make an application to the Care Commission for registration before 1 October 2003 or did not have their application granted by 1 April 2004 their deemed registration lapsed and continuation of the service was unlawful. The effect of this provision is that where such a person applied for registration by 30 September 2004, they are to be treated as if their deemed registration had not lapsed and, subject to the earlier occurrence of certain events, they are deemed to be registered until 1 April 2006. It also provides that, where, before 1 April 2006, the application for registration is granted or refused, registration is cancelled, or if the provider ceases providing the service, the deemed registration ceases on the date that happens.

137. Subsection (1) provides that subsections (2) to (4) apply where:

- from 1 April 2003, a person was providing a housing support service or a previously unregulated child care agency which was deemed to be registered with the Care Commission under Part 1 of the 2001 Act by virtue of transitional provisions contained in subordinate legislation;
- that deemed registration lapsed, either on 1 October 2003 because the provider had not submitted an application for registration before that date, or on 1 April 2004 because registration had not been granted; and
- the provider continued to provide the service when it was no longer deemed registered.

138. Subsection (2) provides that, where the circumstances described in subsection (3) apply, such a service is to be treated as if it was registered, from the date deemed registration ran out and for the period during which the service continued to be provided until one of the events in subsection (4) occurs.

139. Subsection (3) provides that the circumstances referred to in subsection (2) are where an application for registration has been made before 30 September 2004 or no such application was made before that date and the person ceased providing the service before then.

140. Subsection (4) provides that the service ceases to be treated as if it were registered on the earliest of the following events:

- the date that the Commission refuses an application where no appeal is made under section 20(1) of the 2001 Act;
- the date that the sheriff confirms the Commission’s decision after a timeous appeal has been made;
- where an appeal is made under section 20(1) but is later abandoned, the date on which that is intimated to the sheriff clerk or, where there is no intimation, the date on which it is deemed by the Sheriff to be abandoned;
the date the Care Commission decides (other than in the case of an application from the provider) to cancel the registration effected by subsection (2);

where there is no appeal under section 17(3) of the 2001 Act from the provider against the Care Commission’s decision to cancel the registration effected by subsection (2), the fifteenth day after the day the Care Commission gave notice of that intention;

where there is such appeal and the sheriff decides to grant it, the day the sheriff decides to do so;

the day the sheriff grants an application by the Care Commission under section 18 of the 2001 Act for cancellation of registration;

where an appeal under section 17(3) is made and later abandoned, the date on which that is intimated to the sheriff clerk or, where there is no intimation, the date on which it is deemed by the court to be abandoned.

the day the person ceases to provide the service; or

1 April 2006 – unless this date has been changed to a later one in an order made by Scottish Ministers.

Section 29 – Grants in respect of housing support services

141. This section provides that payments to providers of regulated housing support services which were not registered with the Care Commission, by local authorities out of money they had received from Scottish Ministers under the Housing (Scotland) Act 2001, were made lawfully.

AUTHORISATION OF MEDICAL TREATMENT

Section 30 – Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

142. This section provides for two substantive changes, and consequent amendments, to Part 5 of the Adults with Incapacity (Scotland) Act 2000. First an extension to the range of health professionals who can sign certificates of incapacity and second extending the length of certificates from one to three years in certain prescribed circumstances.

143. Subsection (1) signposts the two main amendments to the 2000 Act.

144. Subsection (2)(a) widens the scope of who can issue a certificate under section 47 of the 2000 Act from the ‘medical practitioner primarily responsible’ for the treatment of an adult, to include other named healthcare professionals as listed in subsection 2(b) and other who meet various requirements set out by the Scottish Ministers. A certificate under section 47 of the Act confers a general authority to treat an adult with incapacity, where the medical practitioner primarily responsible for the medical treatment of the adult is of the opinion that the adult is incapable in relation to a decision about the medical treatment in question. Only a ‘registered medical practitioner’ currently has the power to complete and sign a certificate.

145. Subsection (2)(b) lists the persons who will be able to issue a certificate, they are: the medical practitioner primarily responsible for the medical treatment of the adult; a dental...
practitioner; an ophthalmic optician; a registered nurse. This section also makes provision for others to be added by regulation as and when appropriate. The additional ‘healthcare professionals’ (dentists, ophthalmic options and registered nurses) will only be allowed to certify for treatment in respect of their own specialist area.

146. Subsection (2)(c)(i) makes consequential amendments to the references in section 47(2) of the 2000 Act to the medical practitioner primarily responsible for the health of the adult.

147. Subsection (2)(c)(ii) sets out that a healthcare professional who is competent to sign a certificate of incapacity can only do so within his or her own professional area.

148. Subsection (2)(d) clarifies that treatment can be delegated to any other person authorised by the certificate signatory and acting on his or her behalf, under instructions, or with his or her approval and agreement.

149. Subsection (2)(e)(i) amends section 47(5)(a) of the 2000 Act as to who can issue the certificate from ‘medical practitioner primarily responsible for the medical treatment of the adult’ to ‘person who issues the certificate’.

150. Subsection (2)(e)(ii) amends section 47(5)(b) of the 2000 Act so that, in certain circumstances and in relation to certain conditions to be prescribed by the Scottish Ministers the maximum duration of the certificate is 3 years.

151. Subsection (2)(f)(i) amends section 47(6) of the 2000 Act as to who can issue the certificate from ‘medical practitioner primarily responsible for the medical treatment of the adult’ to ‘person who issued it’.

152. Subsection (2)(f)(ii) amends section 47(6)(b) of the 2000 Act so that, in certain circumstances to be prescribed by Scottish Ministers the maximum duration of the certificate is 3 years.

153. Subsection (3) widens the scope of subsection 49(1) of the 2000 Act to ensure that health professionals do not treat a patient where they know that an application for an intervention order or guardianship order has been made to the sheriff and has not been determined.

154. Subsection (4) widens the scope of section 50 of the 2000 Act to include all health professionals who are empowered to sign certificates of incapacity.

**JOINT VENTURES**

**Section 31 – Joint ventures**

155. Subsection (1) inserts a new section 84B after section 84A of the National Health Service (Scotland) Act 1978 and gives new powers for Scottish Ministers to form or participate in forming joint ventures for the provision of facilities or services. This will provide the basis for the long term
delivery of facilities that meet the needs of local communities, as well as encouraging more joint working, for example between the NHS, local authorities and the voluntary sector.

156. Subsection (1) of 84B defines the nature and extent of the involvement of Scottish Ministers in such companies.

157. Subsection (2) of 84B allows facilities and services to be provided to those persons or bodies exercising functions under the 1978 Act.

158. Subsection (3) of 84B provides the definitions of “companies” and “facilities” as applied under section 31(1).

159. Subsection (2) amends section 7 of the Health and Medicines Act 1988 to give Scottish Ministers powers to exploit intellectual property. The amendment inserts a new subsection (7C) to allow Scottish Ministers to form or participate in forming companies, or to participate in companies. It also allows Ministers to make financial provision to or in respect of companies, including by means of loans, guarantees and investments.

160. Subsection (2) also introduces a new subsection (7D) to the 1988 Act to provide a definition of “companies” for the purpose of subsection (7C), and provides that the new subsection (7C) is without prejudice to the powers already made available in subsection (2).

SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Section 32 – Scottish Hospital Endowments Research Trust

161. The Scottish Hospital Endowments Research Trust is a self-financing Non Departmental Public Body and a registered charity established, in 1953 by Act of Parliament, to receive and hold endowments, donations and bequests and to make grants from these funds to support medical research in Scotland. Subsection (2) repeals the Scottish Ministers’ responsibility for the Research Trust.

162. Subsection (3) substitutes paragraphs concerning the membership of the Research Trust.

163. New paragraph 3A provides for the continuation of existing members of the Research Trust, and makes them subject to the new terms and conditions of appointment of members determined by the Research Trust when those new terms and conditions are determined, or after a period of 90 days, whichever occurs first. This provision seeks to provide sufficient time within which the Research Trust can draft and agree its new terms and conditions.

164. New paragraph 3B sets out the terms of office of the membership of the Research Trust, the tenure of office - specifying that a single term of appointment shall not exceed 4 years - and vacation from office.

165. New paragraph 3C provides for single term of reappointment.
166. New paragraph 3D replaces section 12 (3(d)) of the National Health Service (Scotland) Act 1978 with new provisions for the reimbursement of expenses of the membership of the Research Trust.

167. New paragraph 3E provides for the Research Trust to appoint staff on such terms and conditions as they think appropriate.

168. New 3F provides the necessary provisions for the self regulation of the Research Trust, and requires standing orders to be made within a 90 day period.

169. New 3G provides for the Research Trust to be able to do anything necessary or expedient to enable them to exercise their functions.

PART 6: GENERAL

Section 33 – Ancillary provisions

170. This section enables the Scottish Ministers to make further provision, by order, which is incidental to or consequent on the Bill and to allow transitional or savings provisions as required in implementing the Bills’ provisions.

Section 34 – Regulations or orders

171. This section provides that powers to make orders or regulations in the Bill shall be exercisable by statutory instrument. Subsection (2) provides that except where otherwise provided, the statutory instruments containing such orders or regulations shall be subject to negative procedure in the Scottish Parliament. Subsection (3) provides that the following orders or regulations shall be the subject of affirmative resolution:

(a) regulations under sections 3(3) or 4(2) or (7) or paragraph 2, 4(1), 5(2), 12 or 13 of Schedule 1;
(b) an order under section 28(4)(e); and
(c) an order under section 33 which contains provisions which alter the text of an Act.

Subsection (4) provides that Scottish Ministers must consult such persons as they consider appropriate before laying a draft of a statutory instrument containing regulations under sections 3(3) or 4(2) or (7).

Section 35 – Interpretation

172. This section defines terms used throughout the Bill and is self-explanatory.

Section 36 – Minor and consequential amendments and repeals

173. Section 36 introduces schedule 2 (which makes minor and consequential amendments) and schedule 3 (which contains consequential repeals).
174. Sub-paragraphs (10) and (11) of paragraph 1 to schedule 2 lists amendments to section 85AA of the 1978 Act that have the effect of placing the financial resources for meeting the remuneration element of providing pharmaceutical care services (PCS) with Health Boards, as part of their unified budgets. Currently the cost of the national contract is paid by Health Boards but funded centrally; additional services are funded locally. Given the intention to make Health Boards responsible in future for planning and securing or providing all PCS requirements (under both national and local contract arrangements) it is appropriate to make them responsible for the financial management of the process too.

Section 37 – Short title and commencement

175. This section provides for the short title of the Bill. Further, the section allows the Scottish Ministers to bring the provisions of the Bill into force by order, except for sections 1 to 8, 28, 29 and 35 and Schedule 1 which will come into force on the day after Royal Assent, and sections 33, 34 and 37 which will come into force on Royal Assent by order. Different days may be appointed in the order for different provisions.

SCHEDULE 1 - FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2 AND 3

176. Paragraph 1(1) and (2) provides power for an authorised officer of a council or a constable to issue a fixed penalty notice, whilst paragraph 1(3) provides the definition of a “fixed penalty notice” for the purposes of Schedule 1.

177. Paragraph 2 provides the Scottish Ministers with the power to set via regulations a time limit between an offence being committed and an authorised officer being able to give a fixed penalty notice.

178. Paragraph 3 sets out the contents of the fixed penalty notice. It must identify the offence to which it relates and give reasonable particulars of the circumstances alleged to commit that offence. It must also state: the amount of the penalty and the period within which it may be paid; the discounted amount and the period within which it may be paid; the person to whom and the address at which payment may be made; the method or methods by which payment may be made; the person to whom and the address at which any representations relating to the notice may be made; and the consequences of not making a payment at which any representations relating to the notice may be made.

179. Paragraph 4 provides for the level of the fixed penalty notice to be prescribed and the period within which payment of the notice should be made. The council has a discretionary power to extend the period of payment.

180. Paragraph 5 enables offenders to pay a lesser amount in respect of the fixed penalty notice if they make an earlier payment.

181. Paragraph 6 sets out the effect of a fixed penalty notice, providing that no proceedings may be commenced before the end of the period for payment of the penalty, or if payment of the penalty is made before the end of that period or is accepted by the council after that time. Payment of the
discounted amount will only count in that regard if it is made before the end of the period for payment for that discounted amount.

182. Paragraph 7 enables a person in receipt of a fixed penalty notice to request a hearing in respect of the offence for which they have been given notice provided that that request is made within 29 days of receipt of the notice. The request must be made in writing to the designated person at the address shown on the fixed penalty notice. The council will hold the meeting and the procurator fiscal will be notified that a hearing is to be held. The period between a person requesting a hearing and being notified of the hearing’s decision will not count towards the 29 days for the payment of the penalty.

183. Paragraph 8 provides for a power of the council to withdraw notices, in cases where they have been erroneously issued or consider if there are extenuating circumstances. Sub-paragraph 3 provides that a council is bound to consider any representations made by or on behalf of a person given a notice, and that they must decide in all circumstances whether to withdraw the notice.

184. Paragraph 9 provides for the withdrawal of a fixed penalty notice where proceedings for an offence are commenced.

185. Paragraph 10 provides for the recovery of unpaid fixed penalty fines. After the expiry of 29 days the council is able to enforce the unpaid penalty as if it were an extract registered decree arbitral. In practice this means that the unpaid penalty can be recovered in the same way as a sum of money due under a civil court decree.

186. Paragraph 11 provides a mechanism under which disputes as to whether or not a fixed penalty has been paid or a hearing sought within the period for paying can be resolved by the courts. Subparagraph (1) enables a person who is in dispute with a council to apply to the sheriff by summary application for a declaration that the fixed penalty cannot be enforced under paragraph 10 either because the fixed penalty has been paid or a request for a hearing has been made within the period for paying.

187. Paragraph 11(2) provides that the sheriff may declare that the person has or has not paid the penalty or requested a hearing within the period for paying and that the fixed penalty is or is not enforceable under paragraph 10.

188. Paragraph 12 allows the Scottish Ministers to make regulations about the application by councils of fixed penalties under Schedule 1 and also about the keeping of accounts and the preparation and publication of statements of account, relating to fixed penalties under Schedule 1.

189. Paragraphs 13(a) and (c) provide the Scottish Ministers with powers to make regulations prescribing the circumstances in which a fixed penalty notice may not be given and the methods for the payment of penalties.
FINANCIAL MEMORANDUM

INTRODUCTION

190. As the Bill covers a number of discrete policy areas, this document sets the details of costs on the Scottish Administration, costs on local authorities, and costs on other bodies, individuals and businesses for each main policy area that appears in the Bill. The order of the subjects covered within this document is as follows:

- prohibition of smoking in certain wholly enclosed places (sections 1 - 8);
- free eye and dental examinations (sections 9 - 10);
- provision of General Dental Services (sections 11 - 14);
- listing of additional categories of General Dental Practitioners, optometrists and Ophthalmic Medical Practitioners (sections 15 - 17);
- pharmaceutical care services (sections 18 - 21);
- discipline (sections 22 - 23);
- payments to certain persons developing hepatitis C as a result of NHS treatment (section 24);
- amendment of Regulation of Care (Scotland) Act 2001, and child care agencies and housing support services (sections 25 - 29);
- authorisation of medical treatment (section 30);
- joint ventures (section 31); and
- Scottish Hospital Endowments Research Trust (Section 32).

191. A table summarising the additional costs arising from the Bill appears at the end of the document.

PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

Introduction

192. The Bill is the means by which the Executive will take measures to prohibit smoking in certain wholly enclosed places.

Costs on the Scottish Administration

193. In order to inform the public and businesses of the forthcoming legislation and the steps that should be taken, Scottish Ministers will establish a communications programme in advance of the regulations coming into force. Costs are anticipated to be in the region of £2 million in 2005/06 leading up to the regulations coming into force with a further £1 million per year and for the next 3 years 2006/07 - 2008/09 following introduction of smoke-free public places.

194. Options are currently being explored on enforcement of the regulations. Evidence from New York and Ireland suggests that compliance rates will be high at around 97%. If similar
compliance rates were achieved in Scotland we would expect that there would be relatively few prosecutions and therefore costs to the criminal justice system would be low and could reasonably be absorbed within existing budgets.

195. The further costs that may be incurred in enforcing smoke-free public places would be dependent on the complexity of the approach chosen for enforcement of the provisions, and the general acceptance and compliance levels by the public and Scottish businesses. In Ireland a Smoke-free Compliance Help-line was established which allows the public to phone and report alleged breaches of the ban. The line logged 1,524 calls in the first month, of which 827 (54%) occurred in the first week and 104 calls were logged in week 5. A broad estimate would suggest a cost of £50,000 to £100,000 to establish a Scottish compliance line, if one was established. Ongoing costs will be dependent on the level of compliance in future years which mean that these costs are not measurable at present but it is anticipated that that they will diminish to a lower constant rate over time.

196. International experience has shown that introduction of smoking bans leads to significant numbers of smokers quitting with consequential increasing demand for smoking cessation services. For example, in the first month (April 2003) following the ban on smoking in the workplace in New York 18,821 people contacted the NYC smoking cessation help line seeking assistance to quit smoking. This compares with a call rate of 420 calls for the month of January 2003. Scottish Ministers have already increased funding for smoking cessation services in 2005-06 by £4 million, making the total funds available for smoking cessation services £7 million per annum. This will enable Health Boards to expand smoking cessation services in a wide range of settings, using best practices which include one-to-one counselling and group cessation services to help smokers quit. Since 2002, nicotine replacement therapy and Zyban have been available on prescription to help smokers with their attempts to give up smoking. Consideration will be given as to whether any additional funding from 2006-07 may be required in order to meet the additional demand which a ban on smoking in public places is likely to stimulate for assistance from the Scottish Smoke-line and for smoking cessation services but at this stage the presumption is that any increase in demand can be funded from existing planned provision.

**Costs on local authorities**

197. It is intended that authorised officers of the Council will have principal responsibly for enforcement. The precise details of this approach are still to be determined, but it is anticipated that costs of enforcement will diminish over time as the smoking prohibition becomes established and self-enforcing. It is likely that there will be high levels of inspections initially and these will fall to a lower constant rate over time. Ministers will discuss with CoSLA the options for, and practicalities of, enforcement. The details of these are required to obtain a meaningful estimate of the costs of enforcement. Full details of the anticipated costs will be produced and included in the regulatory impact assessment. However, whichever of the enforcement options are chosen, there is likely to be some additional cost in the early years.

**Costs on other bodies, individuals and businesses**

198. A full regulatory impact assessment will be prepared in support of the detailed regulations, which will be subject to affirmative resolution.
199. As part of the consultation process the Executive engaged the University of Aberdeen’s Health Economic Research Unit to consider the international evidence on the health and economic impact of controls on second-hand smoke and the potential impact of such controls in Scotland. In addition Ministers commissioned research by David Hole, Professor of Epidemiology and Biostatistics at the University of Glasgow, to estimate the number of deaths of Scottish adults from smoking related diseases which can be attributed to passive smoking. These reports, along with the research on workplace smoking policies in Scotland undertaken by BMRB Social Research, are available on the Executive website1.

Number of deaths amongst “never smokers associated with” environmental tobacco smoke

200. The research by Glasgow University suggests that environmental tobacco smoke (ETS) is associated with 865 deaths per year amongst lifelong non-smokers in Scotland. Further modelling by Aberdeen University based on this research suggests that, of the 865 deaths, 120 are attributable to exposure in public places. This is a conservative estimate as it is based only on the four main causes of death for which there is the most evidence and assumes that the person never smoked, rather than including (former smokers) non-smokers.

201. The benefits from reduced exposure to ETS accrue over time. The University of Aberdeen estimate that by 2034 the number of lives saved due to a ban on smoking in public places will be 186 per year. This is a worst case scenario and only looks at the deaths attributable to lung disease and ischaemic heart disease, which have the greatest amount of evidence available.

Savings to NHS Scotland

202. The Wanless Report2, which was published earlier in 2004, estimated that if a workplace smoking ban were introduced, up to 4% of all smokers would quit smoking. Although this Bill relates to a ban on smoking in public places, many public places are also workplaces and we would expect a similar reduction in the smoking rates to occur over time. Stopping smoking has almost instant benefits to improving health, for example after 1 year’s cessation the risk of heart attack falls to about half that of a smoker. In 1999 it was estimated that Scotland spent up to £140 million every year on treating 35,000 people for smoking-related disease – at current prices this would amount to over £200 million per year.

203. A reduction in the number of smokers will lead to significant savings for NHS Scotland over time in the treatment of smoking related disease and reduce the number of smoking related deaths. The University of Aberdeen estimate that reducing exposure to ETS would reduce mortality from lung cancer by 0.64%, mortality from stroke by 2.24%, mortality from respiratory disease by 0.68% and mortality from ischaemic heart disease by 1.77%. This would equate to gross savings to NHSScotland of between £5.7 million and £15.7 million per annum based on best and worst case outcomes.

Costs to business

204. The majority of workplaces which allow different types of general public access have specific smoking policies for these areas. 55% of small to medium sized enterprises (SMEs) and

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1 [http://www.scotland.gov.uk/Topics/Health/health/smoking/publications](http://www.scotland.gov.uk/Topics/Health/health/smoking/publications)

2 [http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless03_index.cfm](http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless03_index.cfm)
64% of large enterprises do not permit smoking anywhere, while 21% of SMEs and 23% of large enterprises restrict smoking for the public to smoking rooms or designated areas. A ban on smoking in public places is likely to have the greatest impact in the hospitality sector where the highest number of businesses without existing smoking policies are found. It is currently estimated that six in ten workplaces in the leisure and hospitality sector require employees to work in areas where smoking is permitted and seven out of ten public houses allow smoking throughout.

205. The hospitality sector in Scotland in 2003 employed 150,000 and had an annual turnover of £5,113 million. Of the 13,015 enterprises in the sector 43% are restaurants, 31% are bars and 18% are hotels. Each sector accounts for about 30% of the total turnover.

206. The hospitality sector is not the only sector where the Bill will have a potential impact. However, this analysis will primarily focus on the hospitality sector as it is the largest. The other sector that could be affected is the recreational, cultural and sporting sector which accounts for less than 3% of employment or turnover. The majority of the enterprises in this sub-sector already have smoking restrictions in place.

207. The table below, based on research from the University of Aberdeen shows the potential economic impact upon the hospitality sector per annum. Central estimates represent a conservative estimate of the most likely impact whilst low and high estimates show a range of possible impacts. However, the figures quoted in the table below incorporate more conservative assumptions on the estimate of the impact on the pub sector than that contained in the published paper.

<table>
<thead>
<tr>
<th></th>
<th>Central estimate £ million</th>
<th>Low estimate £ million</th>
<th>High estimate £ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotels</td>
<td>-10</td>
<td>-26</td>
<td>5</td>
</tr>
<tr>
<td>Restaurants</td>
<td>4</td>
<td>-21</td>
<td>28</td>
</tr>
<tr>
<td>Bars</td>
<td>0</td>
<td>-58</td>
<td>104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-6</strong></td>
<td><strong>-104</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

*Totals vary due to rounding

208. The range reflects the uncertainty and limitations around some of the data available. The best case estimate is a £137 million benefit to the hospitality sector, but the range of possible benefits could be either positive or negative. It is important to note however that any potential gains or losses in this sector will not entirely be gains or losses to the Scottish economy as a whole as expenditure diverted from one sector of the economy may be taken up in others.

209. Signatories to the Scottish Voluntary Charter on Smoking in Public Places, who include the Scottish Licensed Trade Association, Scottish Beer and Pub Association, Scottish Tourism Forum and the British Hospitality Association, recognise the need for acceleration in standards and non-smoking provision in pubs and the hospitality industry. They have expressed a fear that a ban on smoking in public places that extends to pubs will mean that a quarter of licensed premises will cease trading with a loss of 30,000 jobs.
Estimated business savings

210. The research undertaken by the University of Aberdeen suggests that the most likely economic impact of a ban will be a net gain for Scottish society, with conservative estimates of savings in Scottish workplaces through reduced absenteeism, a reduction in smoking breaks, reduced fire damage and reduced redecoration costs. Additional financial gains would come from the health improvements. As these health benefits and potential costs will accrue over a long time period the Executive is undertaking research to calculate the net present value for each of the potential outcomes.

FREE EYE AND DENTAL EXAMINATIONS

Introduction

211. These provisions of the Bill provide for the introduction of free eye and dental checks for all after 1 April 2006.

Costs on the Scottish Administration

212. The costs of implementing free NHS eye and dental checks will be funded from the General Ophthalmic Services budget and General Dental Services budget respectively. The current cost of providing free NHS eye and dental checks is £15.2 million and £7.7 million respectively. The cost of extending free NHS eye and dental checks would be £7.5 - £17.9 million for eye checks and £9.1 - £12.4 million for dental checks, based on the fees paid to optometrists/ophthalmic medical practitioners and to dentists. These figures are based on the costs of £16.72 for an NHS sight test and £6.80 for a dental check and on an increase of up to 25% on the numbers of people who currently pay for checks (currently 450,000 eye checks and approximately 2 million dental checks). The Executive would provide NHS National Services Scotland with the additional funding to pay for the free eye and dental checks.

Costs on local authorities

213. The free eye and dental checks have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

Costs on Health Boards

214. There will be no additional cost for Health Boards who draw down the expenditure from the centrally held budgets.

Costs on NHS National Services Scotland (NSS)

215. NSS process and pay general dental and ophthalmic service fees for Scotland as a whole. Some amendments would be required to claim forms submitted to NSS by dentists and optometrists/ophthalmic medical practitioners and adjustments made to the relevant NSS payment systems to deal with the partnership commitment. Discussions with the professional bodies will have to be concluded in order for meaningful costs to be established.
PROVISION OF GENERAL DENTAL SERVICES

Introduction

216. This Bill is the vehicle through which the Executive will implement the new General Dental Services (GDS) arrangements for providers of primary dental services. The proposed new arrangements follow a comprehensive consultation on the future of NHS dental services in Scotland.

Costs on the Scottish Administration

Current arrangements for funding General Dental Services

217. Nearly all general dental practitioners (GDPs) are paid by the NHS as independent, self-employed contractors. They are entitled to payments in respect of patients registered and work carried out. The payments they receive cover both their expenses in providing GDS and a net income for doing so.

218. Expenditure on GDS is non-discretionary, that is, demand led and met by Health Boards. The Scottish Executive Health Department issues allocations to Health Boards, based on indicative spend.

New arrangements

219. Under the new arrangements as implemented by the Bill and its consequential regulations, funding will continue to flow from the Executive to GDPs via the Health Boards. But, in addition, Health Boards will be able to make arrangements with groups of dentists and dental corporations for the provision of NHS Dental Services. The new arrangements assume a redistribution of existing resources.

220. Current financial expenditure on general dental services in Scotland is around £200 million per year, mainly in respect of item of service fees, capitation and allowances. It is planned to simplify the item of service fee structure from over 400 items to a smaller number of items. It is proposed that the new payment arrangements would comprise a mixture of: capitation, allowances (building on existing allowances), item of service fees, and a new scheme of reimbursements to support infrastructure costs and payments to support quality. Consequently some reordering of the overall financial provision will be required, but the simplification should be cost neutral.

221. It is also anticipated that the new arrangements would be nationally agreed and would be supplemented by local arrangements for services outwith the national framework.

222. The provisions of the Bill in section 11(4) are also intended to simplify the patient charging system which raises around £50 million in patients’ contributions. The current system links the patient charge to the dentist’s item of service. To provide more flexibility for patient charges it is proposed to de-link the patient charge from the dentist’s item of service, while still generating the current level of funding achieved by the current patient charge.
Costs on local authorities

223. The general dental services provisions of the Bill have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

Cost to Health Boards for administering ‘new contract’ arrangements

224. The aim of giving greater responsibility to Health Boards for the delivery of NHS dental services will result in a higher level of administration cost than at present. It is estimated that additional support staffing (administrative and professional) in Health Boards would cost some £500,000 per annum across Scotland based on an additional 10 whole time equivalents at a cost of £50,000 each. This would be funded out of existing Health Board allocations.

Costs on NHS National Services Scotland for payment processing

225. Nothing in the new arrangements is expected to impact substantially on the current expenditure levels for payment processing in NSS (£3.3 million).

LISTING OF ADDITIONAL CATEGORIES OF GENERAL DENTAL PRACTITIONERS, OPTOMETRISTS AND OPHTHALMIC MEDICAL PRACTITIONERS

Introduction

226. The Bill extends the categories of persons who are to be named on lists held by Health Boards in relation to general dental services (GDS) and general ophthalmic services (GOS).

Costs on the Scottish Administration

227. The listing provisions of the Bill will have no financial implications for the Executive.

Costs on local authorities

228. The listing provisions of the Bill will have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

Costs on Health Boards

229. It is estimated that less than 200 additional dentists and less than 100 additional optometrists/ophthalmic medical practitioners will be listed. Health Boards will incur limited additional costs as a result of listing these groups. These will be subsumed within their overall resources.

Costs on NSS

230. NSS will be commissioned to maintain up to date databases of all those who are listed to provide or assist with the provision of GDS or GOS or to perform personal dental services, i.e. national “virtual” lists. It is the policy intention that no-one may perform personal dental services
or provide or assist with the provision of GDS or GOS unless they are named on a list and have therefore undergone the various eligibility checks. Since locums will be listed, this will be of help to practice owners seeking locum cover. NSS has estimated that initial development costs will be in the order of £10,000-£20,000.

**PHARMACEUTICAL CARE SERVICES**

**Introduction**

231. The Bill is the means by which the Executive will implement new arrangements for modernising NHS community pharmacy in Scotland

**Costs on the Scottish Administration**

232. The pharmaceutical care services (PCS) provisions of the Bill do not have financial implications for the Executive.

**Costs on local authorities**

233. The pharmaceutical care services provisions of the Bill have no financial implications for local authorities.

**Costs on other bodies, individuals and businesses**

*Cost to Health Boards for new planning and administrative processes*

234. Based on financial data provided by Health Boards, the cost for administering the current control of entry and service delivery arrangements across Scotland as a whole is less than £200,000 per annum. Under the new arrangements detailed in the Bill there will be an enhanced role for Health Boards in terms of planning and monitoring service delivery, and financial management. Whilst in part some of the administrative arrangements associated with the current regime will disappear, overall it is estimated that a further £500,000 per annum will be required across Scotland, that is an additional 10 whole time equivalents of staff (at £50,000 per head) spread across the larger Health Boards. This would be funded out of existing Health Board allocations.

*Cost to facilitate change and support new provision in service gap sites*

235. The identification of locations where new or enhanced service provision is required will be an outcome of Health Boards’ new planning responsibilities and consequently the overall requirement cannot be estimated at present. However, based on current contractor numbers and remuneration costs, the required revenue provision would be in the region of £85,000 per location per annum if a full range of pharmaceutical services were to be delivered, which may not always be necessary. In some cases it may be necessary to fund ‘set up’ costs, for example for the provision or upgrading of premises. The cost of acquiring suitable premises will be dependent on a range of factors, for example location; new or existing; build, purchase or lease which, again, cannot be estimated at present. Fitting premises to provide pharmaceutical services can range from £30,000 to £80,000 for a small to medium size site (estimate provided by Scottish Pharmaceutical General Council).
Costs on NSS for payment processing

236. The 2003-04 NSS Practitioner Services Division (PSD) cost for administering community pharmacy contractor payments on behalf of Health Boards was £12.3 million. This included staff, rent, rate and information management and technology costs, and all support and maintenance costs. The number of whole time equivalent employees was 365.

237. Nothing in the new contract arrangements as such is expected to impact significantly on the current expenditure levels for NSS payment processing.

Costs on NSS for maintenance of ‘virtual’ pharmaceutical list

238. Under the arrangements contained in the Bill, Health Boards will be required to maintain a list of all registered pharmacists who wish to perform PCS in their respective areas. In order to reduce the administration requirements on Health Boards and individual pharmacists alike, the intention is that applicants would apply to one Health Board indicating any other Health Boards they wish to be listed with. The “host” Health Board would then pass copies of any relevant documentation to each relevant Health Board for their decision on listing for their area. To facilitate the process, NSS will be commissioned to maintain an all-Scotland pharmaceutical list that Health Boards and contractors will be able to access to check and confirm individual PCS performer status. Such a list is already held and maintained by NSS for Primary Medical Services performers. NSS estimate that the addition of PCS performers to the existing system would have an initial development cost of £10,000.

Costs on NSS National Appeal Panel (NAP) for revised appeal role (national dispute resolution)

239. Over the last three full financial years the NAP costs have averaged a total of £85,000 per annum comprising £6,000 for training, £39,000 for administration and £40,000 for NAP and legal costs (including judicial reviews). Under the new planning and contract arrangements, the need for appeal procedures on control of entry decisions will no longer be required as control of entry will be managed through the contractual procedure. However, there will be a need for a panel to consider contract dispute cases that are not resolved at local Health Board level. The proposal is to meet this requirement by a change in NAP’s current role. Its activity requirements cannot be predicted at this stage but the working assumption is that the budget will fall within NAP’s current expenditure levels.

DISCIPLINE

Introduction

240. The Bill introduces measures which will help to improve the protection of patients and of NHS resources. These include strengthening the powers of the NHS Tribunal.

Costs on the Scottish Administration

241. Referrals to the NHS Tribunal are a rare event. They concern only the most serious actions or lack of action and this is expected to continue to be the case. The Executive pays fees to the Tribunal members for the case hearings they attend. The total fees paid depend on the number of days which each hearing lasts, which is variable.
These documents relate to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

Costs on local authorities

242. The discipline provisions of the Bill have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

Costs on Health Boards

243. It is generally Health Boards which refer cases involving family health service practitioners to the NHS Tribunal. In many cases, they approach the Central Legal Office of NHS National Services Scotland (NSS) to prepare the case and represent the Board at the Tribunal hearing. Recent maximum administrative costs to NSS of a Tribunal case have been around £10,000. These costs are met currently from the unified budget and it is expected that they will continue to do so.

244. Generally Health Boards will be required to make payments to suspended practitioners in accordance with any determination by Scottish Ministers.

Costs on NHS National Services Scotland (NSS)

245. NSS will be commissioned to maintain an up to date database of all suspensions and disqualifications from lists, refusals of entry to lists and list removals which take place in Scotland and elsewhere in the UK. Health Boards will be able to access this when checking whether an applicant should be on the list for their area. NSS estimate that additional set-up costs would be in the order of £15,000.

PAYMENTS TO CERTAIN PERSONS INFECTED WITH HEPATITIS C AS A RESULT OF NHS TREATMENT

Introduction

246. The Bill provides a statutory basis for making continuing payments into the UK scheme for making ex gratia payments to patients who have contracted the hepatitis C virus from NHS treatment.

Costs on the Scottish Administration

247. The UK scheme for making ex gratia payments to patients who have contracted the hepatitis C virus from NHS blood treatment prior to September 1991 states basic eligibility criteria expressed in terms of the route and nature of the infection. Claimants who satisfy these eligibility criteria receive a basic payment and are eligible for a further payment if the disease progresses to a more advanced stage. There is no time limit as to when claims can be made.

248. Estimates of the numbers of people likely to be eligible for the payments have been made for Scotland, based on predictions of the number of people infected across the UK. These make allowances for the proportion of those estimated to have died between infection and the time when a claim could be submitted and for the fact that current statistics suggest that twenty per cent of those infected with the hepatitis C virus develop cirrhosis, liver cancer or liver failure within twenty to forty years of the original infection.
249. Based on these estimates, as outlined by the Minister for Health and Community Care to the Health Committee on 9 September 2003, the Scottish Executive Health Department has made a provision of £15 million to fund payments to Scottish claimants over the life of the scheme.

250. The hepatitis C provisions of the Bill do not increase the existing costs to the Executive.

Costs on local authorities

251. The hepatitis C provisions of the Bill have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

252. The hepatitis C provisions of the Bill have no financial implications for other bodies, individuals or businesses.

AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001, AND CHILD CARE AGENCIES AND HOUSING SUPPORT SERVICES

Introduction

253. The Bill makes a number of small amendments to the Regulation of Care (Scotland) Act 2001.

Costs on the Scottish Administration

254. The regulation of care (RoC) provisions of the Bill have no financial implications for the Executive.

Costs on local authorities

255. The regulation of care provisions of the Bill have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

256. RoC (Scotland) Act 2001 Section 2(5): The use of the power to except services from the definition of independent healthcare (IHC) services in the Regulation of Care (Scotland) Act 2001 (the 2001 Act) will restrict the current scope of IHC services which would be subject to regulation by the Scottish Commission for the Regulation of Care (Care Commission) under the 2001 Act (were the definition to be commenced fully now). Services which are excepted by regulations are not required to register with the Care Commission. The services to which this exception is likely to be applied are not currently regulated by the Care Commission and are therefore not generating any income for the Care Commission. The current policy is that for those services where the provisions of the 2001 Act have commenced, the fees are charged at full cost recovery.

257. RoC (Scotland) Act Section 16(2): Both the Care Commission and service providers are already considering and making representations. This change formalises a process which the Care
Commission and providers are already carrying out, therefore, there will be no additional costs incurred.

258. **RoC (Scotland) Act Section 2**: Care Commission fees for these services are at full cost recovery levels, therefore there will be no net effect on the Care Commission.

259. **RoC Act Sections 48, 51 & 53**: These are technical amendments which clarify the original intent of the Act. There is no extra work or expense involved as a result of these amendments. The Scottish Social Services Council has always taken account of any representations made in the registration process. From its initiation, the Council has included in its annual budget a provision for legal expenses which covers any legal expense incurred by the Council in relation to its functions. This amount includes any expense incurred where an appeal is made by an applicant to the Sheriff. This amendment does not mean that there will be an increase in appeals and will not, thereby, increase the original costs associated with the 2001 Act.

260. **Child care agencies and housing support services**: The provisions of the Bill which ensure that housing support services and child care agencies were deemed to be registered from 1 April 2003 and that registration does not cease until 1 April 2006 if necessary have no financial implications other than ensuring that certain payments made by local authorities to housing support services are made lawfully.

**AUTHORISATION OF MEDICAL TREATMENT**

**Introduction**

261. Since Part 5 of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) came into effect it has been possible, in some circumstances, for a medical practitioner primarily responsible for treatment to charge another health professional (for example a dentist) for producing a certificate under section 47 of the 2000 Act. The proposed changes are likely to reduce this expenditure, as described below.

**Costs on the Scottish Administration**

262. The authorisation of medical treatment provisions of the Bill have no financial implications for the Executive.

**Costs on local authorities**

263. The authorisation of medical treatment provisions of the Bill have no financial implications for local authorities.

**Costs on other bodies, individuals and businesses**

**General Practitioners**

264. Certificates issued under section 47 of the 2000 Act in general attract no fee. Where, however, a GP has not yet issued a certificate and one is requested by an independent health professional in order to treat a patient under the NHS, or in the unlikely event that a GP is required
These documents relate to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

to undertake a second assessment and produce an additional certificate for an independent health professional, having already issued a certificate which enabled the GP to treat his own patient, then in both cases a fee can be claimed. The fee is currently set at £92.60. Where a fee is properly payable under these arrangements it is for the GP concerned to make an application for payment to the local NSS Practitioner Services Division (PSD). Since Part 5 of the 2000 Act came into force on 1 July 2002, PSD has paid approximately £80,000.

265. It has been estimated that the number of certificates required which would incur a fee would reduce over time as the provisions of the Bill, which will allow other healthcare professionals to sign certificates, take effect. There should also be a reduction in certificates required as a result of the increase in duration in some cases. These effects should lead to a decrease in the costs of certification.

JOINT VENTURES

Introduction

266. The Bill makes provision to allow Scottish Ministers and NHS bodies to form or participate in joint venture companies. It is intended that this will be for two purposes. Firstly for the provision of facilities and services and, secondly, for the exploitation of intellectual property.

Facilities and services

Costs on the Scottish Administration

267. An option being explored is for Scottish Ministers to take a direct equity stake in each joint venture in order to provide stability, co-ordination and support at national level. We would expect that equity investment would be a maximum of £0.5 million per joint venture, which is already included within the existing capital budget which has a provision for 7 projects (£3.5 million) during 2006-07 and 2007-08. There would not, therefore, be any additional expenditure as a result of using this approach. The joint venture approach is an additional tool for health boards to use, but is not mandatory. It is not possible, therefore, to estimate how many projects may use it.

268. Given the experience and costs of development of NHS LIFT in England, the development costs for the joint venture model are estimated at £300,000. This would cover the development of appropriate documentation together with technical and legal advice and is a one-off cost. Again provision has been made within existing baselines to support such a development.

Costs on local authorities

269. The Executive is of the view that there will be no impact on local authorities as a result of the creation of joint ventures. Whether public or private bodies are investors or tenants within facilities developed under the joint venture model, procedures will be in place on which value for money can be assessed and tested on an ongoing basis.
Costs on other bodies, individuals and businesses

270. The Executive is of the view that there will be no impact on other aspects of public expenditure or on the costs of the voluntary or private sectors or individuals, as a result of the creation of joint ventures.

**Intellectual property**

**Costs on the Scottish Administration**

271. The intellectual property provisions of the Bill allow Scottish Ministers to invest, or provide loans or guarantees etc.. However, the policy intention is that the powers will not be exercised in such a way. No new duties or obligations are imposed; the power will allow the Scottish Ministers an additional way to progress innovations within the NHS. It will therefore be applied in two circumstances:

- where the innovation cannot be exploited currently because participation with companies is not allowed; or
- where the innovation could be exploited other than through a company but that method of exploitation is less beneficial to the NHS.

272. In both these circumstances, where the use of the new power is authorised by the Scottish Ministers through a direction to NHS bodies, the direction will ensure that the power is only used where an evaluation of the value and viability of the proposal has been carried out to confirm that this is the most appropriate means of exploitation.

**Costs on local authorities**

273. The intellectual property provisions of the Bill have no financial implications for local authorities.

**Costs on other bodies, individuals and businesses**

274. NHS expenditure through Health Boards in support of progressing innovative products or ideas is a very small element of the NHS research and development (R&D) budget. Only £150,000 of the £35 million NHS organisations receive annually from the Chief Scientist Office (CSO) of the Scottish Executive Health Department for research and related activities is designated centrally for this purpose to Scottish Health Innovations Ltd (SHIL) and, although this figure is supplemented by local expenditure of approximately the same order, it is still an extremely low proportion of the total research expenditure. As an illustration the Scottish National Blood Transfusion Service spends approximately £200,000 per year on intellectual property protection costs, for example patents and trade marks, this is closely linked to its well established commercial activities which have generated external income of £45 million over the last 9 years primarily through product sales, contract manufacture and consultancy and testing services.

275. The use of the limited funds available to progress innovative ideas beyond their research stage and into product development is therefore very carefully considered with a view to maximising a health and financial benefit to the NHS. The introduction of this new power will therefore increase the range of ways in which these funds can be deployed, but not necessarily increase the funds themselves. It should not increase costs to the NHS as the use of this new power
is limited to circumstances where it will generate income for the NHS. The ability to transfer ownership of a technology to a spin-out company will not only increase the likelihood of investment by commercial partners, but also ensure that financial and other liabilities lie with and are limited to the liabilities of the company and not the NHS organisation. As such, the NHS risk will be both limited and circumscribed. The costs of establishing a spin out company are minimal - £20 for registering the company. If Memorandum and Articles of Association are not already available they can be purchased from a law or legal stationers or formation agent for £20 to £30. Any legal costs between the NHS and commercial partner should be no more than that for negotiating a license deal with a third party for the same product. As at present this can be up to approximately £5,000 and in all likelihood less. Therefore, across all innovations using the company mechanism, there are no additional costs of going down this route.

276. The provisions of the Bill are intended to overcome the current difficulties in attracting capital and the willingness of academic partner organisations to participate in joint venture projects. Thus it is not possible to provide predictions of future benefits at present.

277. One measure of the anticipated economic and financial benefit from NHS innovation activities might be the willingness of non-NHS organisations to provide financial support. In addition to the £150,000 paid annually from the NHS R&D budget and £75,000 directly from CSO to support SHIL, Scottish Enterprise contributes £150,000 per year, Highland and Island Enterprise £50,000 per year and the UK Department of Trade and Industry a total of £425,000 to this initiative.

278. In terms of anticipated benefit from any individual innovation, that is impossible to estimate. One well advanced NHS product currently being developed through a spin–out company created by SHIL has already attracted £305,000 of external investment with a further £250,000 to follow if milestones are met. A further £0.5 million investment is also being pursued. Although this is unlikely to be typical, it does nonetheless demonstrate the potential for this new power to attract external funding in NHS innovations and to attract income.

SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Introduction

279. The Bill provides for the ending of the Scottish Hospital Endowments Research Trust’s (SHERT) status as a non-departmental public body while preserving its continuing status as a charitable trust.

Costs on the Scottish Administration

280. There are no financial consequences on the Executive as SHERT is self financing and receives no funding from the Executive. The repeal of public body status will result in minimal savings (approximately £10,000 per annum) in terms of sponsorship costs.

Costs on local authorities

281. The provisions relating to the Scottish Hospital Endowments Research Trust of the Bill have no financial implications for Local Authorities.
Costs on other bodies, individuals and businesses

Costs on SHERT

282. The policy of the proposed adjustment to the existing legislation has relatively minor cost implications for SHERT. This approach will require SHERT to take both legal advice and advice from accountants and auditors with anticipated professional costs being in the region of £5,000.

283. By contrast, the cost associated with the alternative of transferring the functions to a new charitable trust would be considerable. In addition to detailed legislation being required to ensure that all assets and liabilities are transferred to the new body, and that legacies left to SHERT would automatically transfer to “new SHERT”, existing royalty streams and intellectual property from past grants would need to be secured. In addition, land that SHERT owns would need to be transferred. In total, the costs associated with the combined accounting, audit and legal costs of such an approach would be in the region of £40,000.

284. The administration of SHERT is undertaken by a firm of Edinburgh solicitors. The associated management, support and staff costs of this arrangement are detailed in SHERT’s Annual Reports, and for the year ended 31 July 2003 amounted to £215,286. With independence will come the reduction in time spent by the Secretaries on liaising with the Chief Scientist Office, and vice versa, on public body related issues. At most, it is considered that the ongoing cost implications for SHERT will be neutral.
These documents relate to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

Table 2. Summary of additional costs arising from the Bill

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Cost on Scottish Administration</th>
<th>Health Boards</th>
<th>Local Authorities</th>
<th>Cost on Other Bodies</th>
<th>Paragraph reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>£2m for communications ahead of implementation and £1m p.a. for 3 years following implementation. £50,000 - £100,000 in first year for compliance line. Ongoing costs not known.</td>
<td>Gross saving of £5.7m to £15.7m p.a. on NHS costs in the longer term.</td>
<td>Enforcement costs to be developed in full RIA.</td>
<td>Between £104m cost to £137m benefit to hospitality sector p.a.</td>
<td>193, 195, 197, 203, 207</td>
</tr>
<tr>
<td>Free Eye and Dental Checks</td>
<td>£7.5m - £17.9m p.a. for eye checks and £9.1m - £12.4m p.a. for dental checks</td>
<td>N/A</td>
<td>N/A</td>
<td>Not known.</td>
<td>212</td>
</tr>
<tr>
<td>Dentistry</td>
<td>N/A</td>
<td>£500,000 p.a. additional professional and administrative costs.</td>
<td>N/A</td>
<td>N/A</td>
<td>224</td>
</tr>
<tr>
<td>Listing</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>£10,000 - £20,000 one-off NSS database costs.</td>
<td>230</td>
</tr>
</tbody>
</table>
These documents relate to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Nil</th>
<th>£500,000 p.a. for Health Board planning and monitoring activities.</th>
<th>Nil</th>
<th>£10,000 one-off NSS database cost.</th>
<th>234, 238</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>£15,000 one-off NSS database cost.</td>
<td>245</td>
</tr>
<tr>
<td>Hep C</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>RoC Amendments and Child Care etc.</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Authorisation of Treatment</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Joint Ventures</td>
<td>£300,000 one-off cost of development of JV model.</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>268</td>
</tr>
<tr>
<td>SHERT</td>
<td>£10,000 p.a. saving</td>
<td>Nil</td>
<td>Nil</td>
<td>One-off £5,000 professional advice.</td>
<td>280, 282</td>
</tr>
</tbody>
</table>
EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

285. On 16 December 2004, the Minister for Health and Community Care (Mr Andy Kerr MSP) made the following statement:

“In my view, the provisions of the Smoking, Health and Social Care (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

286. On 15 December 2004, the Presiding Officer (Right Honourable George Reid MSP) made the following statement:

“In my view, the provisions of the Smoking, Health and Social Care (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

1. This document relates to the Smoking, Health and Social Care (Scotland) Bill introduced in the Scottish Parliament on 16 December 2004. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 33–EN.

POLICY OBJECTIVES OF THE BILL - GENERAL

2. This Bill will enable the Executive to continue to take action to improve the health of Scotland, to continue its programme of NHS modernisation and to improve health and care services relevant to the needs of the people of Scotland.

3. A key policy objective for improving health is taking action on the impact of smoking. The Bill’s policy is to introduce a comprehensive ban on smoking in certain wholly enclosed premises.

4. The Bill also makes provision for the introduction of free eye and dental checks for all, and modernises the frameworks for the delivery of dental and pharmaceutical services. The Bill introduces a range of measures to update legislation relating to the listing and disciplinary procedures for family health service practitioners.

5. The Bill contains provisions to allow Scottish Ministers to make a scheme authorising payments to be made to certain persons who became infected with the hepatitis C virus after having had NHS treatment involving the receipt of blood, tissue or blood products. There are provisions for amendments to the Regulation of Care (Scotland) Act 2001, provisions in relation to child care agencies and housing support services, and provisions to amend the Adults with Incapacity (Scotland) Act 2000. These will further improve the delivery of health and social care.

6. Included in the Bill are provisions to allow Scottish Ministers to set up or participate in joint venture companies. This will increase the range of options available to Health Boards for the delivery of facilities and services, and enable the Scottish Ministers and NHS bodies to make
the most of ideas and intellectual property generated by the NHS. Finally, the Bill makes provision to end the NDPB status of the Scottish Hospital Endowments Research Trust.

7. As the Bill covers a number of different policy areas, this document sets out the details of policy objectives, alternative approaches and consultation for each main policy area that appears in the Bill. The order of the subjects covered within this document is as follows:

- prohibition of smoking in certain wholly enclosed places (sections 1 - 8);
- free eye and dental examinations (sections 9 - 10);
- provision of General Dental Services (sections 11 - 14);
- listing of additional categories of general dental practitioners, optometrists and Ophthalmic Medical Practitioners (sections 15 - 17);
- pharmaceutical care services (sections 18 - 21);
- discipline (sections 22 - 23);
- payments to certain persons developing hepatitis C as a result of NHS treatment (section 24);
- amendment of Regulation of Care (Scotland) Act 2001, and child care agencies and housing support services (sections 25 - 29);
- authorisation of medical treatment (section 30);
- joint ventures (section 31); and
- Scottish Hospital Endowments Research Trust (section 32).

8. The effects of the Bill on equal opportunities, human rights, island communities, local government, sustainable development etc. is summarised at the end of the document. There is also an annex which contains a useful glossary of acronyms used in the document.

**PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES**

**Policy objectives – background**

9. Smoking has long been recognised as the most important preventable cause of ill-health and premature death in Scotland. In order to reduce the unacceptable toll smoking takes on Scotland’s health, in January 2004, the Executive published the first ever action plan on tobacco control designed specifically for Scotland: *A Breath of Fresh Air for Scotland*¹. The plan offers a comprehensive programme of action to tackle smoking. This includes a clear commitment to take firm action to extend smoke-free provision within all enclosed public places, in order to protect non-smokers from the health risks posed by exposure to second-hand smoke.

10. The scientific evidence of the health risks of second-hand smoke is clear and irrefutable. Specifically, the Report of the UK Scientific Committee on Tobacco and Health (SCOTH)², published in 1998, highlighted these risks. The report concludes that exposure to

second-hand smoke is a cause of lung cancer and, in those with long-term exposure, the increased risk is 20-30%; is a cause of heart disease and represents a substantial public health hazard; and that it can cause asthma in children and may increase the severity of the condition in children already affected. SCOTH recently reviewed the evidence to emerge since 1998 into the health risks of exposure to second-hand smoke and this report\(^3\), which was published on 16 November 2004, reinforces the earlier findings. Additionally, research commissioned by the Scottish Executive and NHS Health Scotland in 2004 suggests that second-hand smoke is associated with some 865 deaths per year among life-long non-smokers in Scotland. Taking ex-smokers into account it is estimated that some 1,500 to 2,000 deaths per year in Scotland are related to environmental tobacco smoke exposure\(^4\). Further modelling by Aberdeen University\(^5\) has suggested that, of the 865 deaths, 120 are attributable to non-domestic exposure.

11. The benefits of reduced exposure to environmental tobacco smoke accrue over time and the analysis indicates that by 2034 the number of lives saved as a consequence of a ban on smoking in public places will be 186 per year. This is based on a minimum estimate of number of lives saved and only looks at the deaths attributable to lung disease and ischaemic heart disease, which have the greatest amount of evidence available.

12. The Executive acknowledges that much progress in smoke-free provision has been made through voluntary action but this has been much less pronounced in the leisure and hospitality sector (7 out of 10 pubs still allow smoking throughout). This has led to the conclusion that legislative action is now required if we are to make any real progress in this area. The Scottish Voluntary Charter Signatory Group (comprising the Scottish Licensed Trade Association, The Scottish Beer and Pub Association, the British Hospitality Association and the Scottish Tourism Forum) has presented a series of 5 targets to increase smoke-free provision and has indicated that these would require statutory backing to be effective.

13. Although there is much support for an approach that would create separate smoking or non smoking areas within leisure and hospitality premises, such an approach is difficult to justify on public health grounds given that there is no defined safe level of exposure to second hand smoke. A complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.

**Policy objectives – specifics**

14. Given the unacceptable health impact of second-hand smoke and the need to take firm action to accelerate progress, specifically in the leisure and hospitality sector, it is clear to the Executive that statutory action is now required to increase smoke-free places in order to protect public health. The provisions of the Bill take into account that 70% of Scots do not smoke and surveys suggest that a majority of those who do smoke wish to give up. They also take into


\(^4\) David Hole, Professor of Epidemiology and Biostatistics, University of Glasgow, *Passive smoking and associated causes of death in adults in Scotland* (2004)

account that there is no safe level of exposure to second-hand smoke and that restrictions help to encourage existing smokers to give up or reduce consumption and children and young people not to start in the first place.

15. As evidence of the latter point, the number of regular smokers in New York dropped from 21.6% of adults to 19.3% and cigarette consumption by 13% from 2002 to 2003 following the introduction of the smoking prohibition. Further evidence is provided by the Irish ban, where cigarette sales are reported to have dropped by some 16% since the ban came into force in March 2004. Other evidence is also available from other parts of the world where smoking is regulated.

16. The policy intention is to prohibit smoking in premises which are fully enclosed to which the public or a section of the public has access in order to protect public health. Detailed provisions, including exemptions, will be prescribed through regulations which will be subject to affirmative procedures. However, the scope of the ban is intended to be comprehensive and to cover, for example, public transport, cafes, restaurants, bars, function suites, shops, private clubs and larger buildings such as shopping centres, hotels, railway stations, airports, offices, factories, conference centres, museums, galleries, hospitals, day centres etc. The policy will not extend to aircraft as there is already provision in UK statute (Article 66 of the Air Navigation Order 2000 (SI 1562/2000)) which prohibits smoking on UK registered aircraft. In addition to fulfilling the commitment made in the action plan, the provisions also fulfil and go beyond the Partnership Agreement\(^6\) commitment to consult on measures to achieve considerably more smoke-free restaurants and pubs and take measures to enforce restrictions on public transport.

17. The Executive’s intention is also for restrictions on smoking to be extended to prisons. The policy is to carry out these restrictions through altering the prison rules, which are governed by statutory instrument. It is intended that prison rules will be amended contemporaneously with the introduction of the prohibition of smoking provisions in the Bill.

18. The provisions of the Bill create offences, set out the penalties to be imposed, define the kind of premises which are capable of being described as no-smoking under regulations, and give police and local government officers powers of entry in order to enforce the prohibition. It will be an offence to smoke in no-smoking premises, and it will be an offence for a person who, having management or control of no-smoking premises, knowingly allows someone to smoke, or fails to display warning notices. These offences will attract penalties as set out in the Bill’s schedule. The principal enforcement authority will be local authority environmental health officers. Detailed provisions will be prescribed by regulations. These will include exemptions, detailed definitions of regulated areas, fixed penalties and content of fixed penalty notices which offer a person the opportunity of discharging any liability to conviction for an offence under 1, 2 or 3 of the Bill. These regulations will be subject to pre-legislative consultation with interested parties in the normal way.

Alternative approaches

Voluntary approach

19. Voluntary approaches are likely to impact differentially across different types of public place. As noted above, the Scottish Voluntary Charter Signatory Group has presented a series of five voluntary targets on smoking, which they acknowledge would require statutory backing to be effective. Whilst 56% of Scottish small to medium sized businesses offering access to the general public do not allow smoking in such areas, little progress has been made within the leisure and hospitality sector, although there is an element of support for split smoking and non-smoking areas. This does not, however, offer protection from the health impact of environmental tobacco smoke which permeates from smoking to non-smoking areas.

Legislation with dispensation for hospitality sector

20. Public health legislation could be used to introduce a ban on smoking in public places except in those areas, typically pubs, clubs and possibly restaurants, where there is less support for restrictions. However, excluding pubs from legislation would again be difficult to justify on public health grounds, given the level of exposure to second-hand smoke that is likely to occur there compared to other public places. A similar argument would also apply to approaches that saw smoking banned in pubs with a children’s certificate, or where food is served, or to an approach which delegates responsibility to local decision makers.

21. Licensed trade bodies and a number of businesses, particularly in the leisure sector have expressed fears about a loss of profitability and jobs as a result of a smoking ban. This, however, is not backed up by research including that commissioned by the Scottish Executive and NHS Health Scotland from Aberdeen University referred to above. The modelling they have done suggests that the most likely economic impact of a ban will be a net gain for Scottish society, with conservative estimates of savings in Scottish workplaces through reduced absenteeism, a reduction in smoking breaks, reduced fire damage and reduced redecoration costs, exceeding the worst case scenario for losses in the hospitality sector. Additional financial gains would flow from health benefits resulting from the ban. This is expanded upon in the Financial Memorandum.

22. Despite trade fears about a loss of profitability and jobs as a result of a smoking ban, international experience suggests that whilst such losses are almost invariably predicted prior to the introduction of a ban, there is little robust, published evidence to suggest that this happens in practice. In Ireland, at least one trade association continues to report a significant drop in trade, but this is based on anecdotal reports rather than verifiable sales data and official statistics suggest that bar sales (volume) were down 1.3% in the 3 months following the ban. It should be noted that bar sales were falling in Ireland before the introduction of the ban and the picture is clouded by the impact of recent alcohol price rises. Evidence from New York also suggests that there has not been the predicted impact on the licensed sectors, with bar and restaurant tax receipts up 8.7% in the 9 months following the ban compared to the same period in the previous year.
Consultation

23. The measures proposed within the Bill have been informed by widespread public consultation conducted between June and September 2004 and wider evidence-gathering on possible approaches to minimise the impact of second-hand smoke. Account has been taken of information gathered through all elements of the consultation process. This includes peer reviewed research conducted through NHS Health Scotland, including a review of international evidence on health and economic impact of controls.

24. A written public consultation\(^7\) received 52,441 personal responses to the consultation and 1,033 responses from groups, organisations and businesses. Analysis of these responses indicated that 82% of all respondents thought that further action was needed to reduce people’s exposure to second-hand smoke, 80% of all respondents would support legislation to make enclosed public spaces smoke-free, and 56% of all respondents did not think that there should be any exemptions if such legislation was introduced, although 35% indicated that there should be. Only 24% of those who indicated that they would support a law were in favour of exemptions. Whilst the general public and hospitality sector tended to focus on pubs, clubs and restaurants in terms of exemptions, organisations also referred to long-stay care facilities, prisons and workplaces that are also homes of looked after individuals.

25. A total of 15 public seminars were held throughout Scotland in order to listen directly to the views of people in their own communities. The events stimulated a broad range of views and the majority of participants supported the need to increase smoke-free provisions, although there were differing opinions about how that might be achieved. Licensed trade representatives were totally opposed to a complete smoking ban in pubs at this time, mostly on economic grounds, although some were relaxed about such restrictions in restaurants. There was strong support amongst trade representatives for better ventilation and a staged approach to greater restrictions. Health professionals in particular spoke in favour of a total ban on the basis of the health evidence, personal experiences of treating smoking-related conditions and the perceived need to de-normalise smoking within society.

26. An opinion poll conducted for the Executive by MRUK in September 2004, consisting of a total of 1026 in-home interviews, suggested that just over half of respondents would support a law to ban smoking in public places, with around a third opposing such a measure. Overall, two thirds of those that would support a law thought that exemptions should be considered, with 57% citing pubs and 21% citing restaurants as places where such exemptions should apply.

27. Additional elements of the consultation included a national conference with international speakers, a youth consultation run by Young Scot, and focus group work. There was a general consensus that the time has come for increased smoke-free provision in public places.

FREE EYE AND DENTAL EXAMINATIONS

Policy objectives

28. One of the Partnership Agreement commitments states that “we will invest in health promotion and, as a priority, we will systematically introduce free eye and dental checks for all before 2007”. The Executive’s policy is to make the necessary legislative changes for implementation of this commitment. These provisions will improve health where dental and eye examinations may detect early signs of disease, illness or injury.

29. The current legislative position regarding charges for dental and optical examinations is contained in the National Health Service (Scotland) Act 1978 (the 1978 Act). The policy intention is that it should be clear on the face of the 1978 Act that no charge shall be made for:

- oral examinations, whether provided as part of General Dental Services (GDS) under Part II of the 1978 Act or as part of dental treatment provided in accordance with section 17C arrangements; or
- eye examinations provided as part of general ophthalmic services (GOS).

30. The Bill provides for free examinations to be provided after 1 April 2006.

Alternative approaches

31. As this is a Partnership Agreement commitment, no alternative approaches were considered.

Consultation

32. The Partnership Agreement included a pledge to systematically introduce free eye and dental check ups for all by 2007 and as such has not be consulted on. However, the dental checks pledge was highlighted in the wide-ranging consultation Modernising NHS Dental Services in Scotland which ended in April 2004. Discussions are on-going with the dental and optical professions on whether the free checks should be more extensive than the current dental check and sight test. An eye care review is also currently underway to review arrangements for the provision of eye care services in the community in Scotland and to provide recommendations on good practice for effective models of care. Provision of General Dental Services

PROVISION OF GENERAL DENTAL SERVICES

Policy objectives – background

Introduction

33. General Dental Services are provided by General Dental Practitioners (GDP) under the 1978 Act. A significant amount of primary dental care is also undertaken by the Community Dental Service (CDS) and by salaried dentists employed by Health Boards and the policy also addresses these services.

8 Scottish Executive, Modernising NHS Dental Services in Scotland (2004)
34. The Bill amends the provisions of the 1978 Act relating to the arrangements currently made between Health Boards and dental practitioners for the provision of GDS and personal dental services (PDS). At its heart, this will enable the development of new arrangements between Health Boards and their constituent dentists. The policy intention is to develop a system that satisfies both national requirements and meets local needs.

General Dental Services

35. Every Health Board has a duty to make arrangements with dental practitioners under which any person for whom a dental practitioner undertakes, in accordance with the arrangements, to provide dental treatment and appliances shall receive such treatment and appliances. Under GDS, the Health Board enters into separate statutory arrangements with individual practitioners (“GDP principals”) for the provision of those services. GDPs may be independent professionals, or may be salaried dentists (either those who provide GDS as emergency dental services or as non-emergency GDS). These groups provide GDS in accordance with the National Health Services (General Dental Services) (Scotland) Regulations 1996 (the GDS Regulations).

36. The legal and financial framework has remained broadly the same since the late 1970s. There has been a shift to some capitation payments, including enhanced capitation payments for preventive measures for children, in addition to gross fees introduced in 1990 (the new contract). Since 2002, some additional allowances have been introduced in Scotland aimed at recruiting and retaining GDPs within GDS and improving services.

37. The current statutory arrangements are commonly known as the “GDS contract”. They are neither an NHS contract nor a private law contract. Fees and allowances are determined by Scottish Ministers, taking into account recommendations of the Independent Review Body. This follows consultation with the British Dental Association (BDA) and is published in the Statement of Dental Remuneration (SDR).

Payments system

38. The GDS Regulations determine the terms of service of GDPs and remuneration. The “Statement of Dental Remuneration” (SDR) sets out the scale of fees and comprises over 400 individual items of service. The SDR also includes items such as seniority payments, various allowances, long term sickness payments and re-imbursement of non-domestic rates. National Services Scotland (Practitioner Services Division) makes payments to GDPs on behalf of Health Boards.

Charging system

39. The present charging system derives from the Health and Medicines Act 1988 (the 1988 Act). This introduced a simplified charging regime where patients pay 80% of the cost of their treatment. Where a patient is subject to an extensive course of treatment the maximum patient charge is presently set at £378. Certain categories of patient are exempt from dental charges, for example people up to the age of 18 and people who fall into certain benefit categories.
40. The proposed changes to GDS will address the shortcomings of the current system. These include:

- restricted ability of Health Boards to plan, fund and deliver dental services as part of the overall provision of health services in an area;
- reduced commitment from some dentists to participate in providing NHS services;
- the complexity of the current system, including a SDR covering over 400 fee types;
- the perceived “treadmill” for dentists of maximising items of treatment provided to maintain income and incentives;
- lack of focus on preventive service because of the fee structure; and
- complexity of patient charging system.

Community Dental Service

41. A significant amount of primary dental care is provided not by GDPs, but by the Community Dental Service (CDS). The CDS is not mentioned directly in the 1978 Act as the dentists concerned are employees of Health Boards. It is the CDS who provide dental inspections of pupils attending public schools and all young persons attending other public educational establishments. They also provide education in dental health of these pupils and young people. In some areas of Scotland (usually rural and remote areas), the CDS, rather than independent GDPs, also provide for the full range of care and treatment required by pupils and other young people. They have 4 further roles set out in guidance:

- epidemiological field work for use in planning local and national dental services;
- provision of facilities for a full range of treatment to patients for whom there is evidence that they would not otherwise seek treatment from the GDS (usually patients with special needs);
- provision of facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the GDS (known as the safety net function); and
- provision of treatment on referral which is not generally available in the GDS, for example sedation.

42. In effect, the role of the CDS is similar now to that of the salaried GDS and the policy intention is to merge them administratively.

Personal dental services

43. The NHS (Primary Care) Act 1997 provided for the introduction of personal dental services (PDS) under which Health Boards could make local arrangements for the provision of dental services, similar to GDS but delivered more flexibly. There were enabling powers to allow delivery of PDS under both pilot and permanent arrangements. No PDS arrangements have been introduced in Scotland to date.
Listing

44. Section 25 of the 1978 Act provides for regulations to make provision for lists to be kept by Health Boards of dental practitioners who undertake to provide GDS. The GDS Regulations set out certain restrictions as to who is eligible to be on such a list. Removal from the dental list is provided for in the 1978 Act. Once included in the list, a dentist stays on it until he decides to leave or retires, unless he is removed.

45. Under the 1988 Act GDPs are automatically removed from the dental list, and consequently required to retire, at the age of 70. It is the intention to remove this age limit.

Policy objectives – specifics

46. It is the policy intention to allow Health Boards to take a more active role in securing and providing general dental services. This will enable Health Boards, as part of their overall planning and delivery responsibilities, to take a more holistic view of local needs and the most appropriate provision of the range of dental services required. It will help integration between types of care where it can be shown that this is in the best interests of patients and the NHS.

General Dental Services

47. The policy intention is to introduce legislative changes to allow:

- Health Boards to be able to make arrangements with individual dentists, or dental corporations to undertake to provide GDS, or provide general dental services themselves through salaried NHS staff; and
- Health Boards to be able to give financial help to support GDS providers (for example support to staff, premises, infrastructure and quality).

48. Health Boards will be able to secure or provide dental services to meet reasonable need. Such services will fall within the current GDS definition which is “all proper and necessary care and treatment which a dentist usually undertakes for a patient and which the patient is willing to undergo, including advice, planning of treatment and preventive care”.

49. Currently the patient charge is linked to a dentist’s item of service fee and unless exempt, patients pay 80% of this fee. It is the policy intention (section 11(4) of the Bill) to break the current link between the GDS item of service fees paid to dentists and the patient charges levied. It is also our policy intention that, in the future, patients who do not fall within the categories for free treatment, or who are not exempt from NHS charges, will continue to make a contribution towards the costs of their dental treatment. The proposed changes are consistent with the outcome of the consultation on making the charging system more flexible.

Summary

50. The policy intention for future delivery of NHS dental services in Scotland is that responsibility for meeting local needs for dental services will rest with Health Boards and these Boards would make arrangements with:
• individual dentists (as at present);  
• dental corporations as defined in the Dentists Act; or  
• provide the services themselves through directly employed staff.

51. The arrangements would be nationally agreed and would be supplemented by local arrangements for services outwith the national framework.

52. It is also the policy intention to simplify the patient charging system and to provide more flexibility for patient charges, the Bill (section 11(4) of the Bill) provides for de-linking the patient charge from the dentist’s item of service.

**Alternative approaches**

53. The consultation was a comprehensive process and the approaches taken were consistent with the analysis from the consultation. The consultation paper put forward a range of options for changing the current system, including simplification of the fee scale, the method of delivering NHS dental services in the future and changing the patient charging system. These ranged from a fundamental reform of dental services along the lines of England’s *Option for Change* framework to a more simplified approach to the current system. It was clear from the consultation responses that a different approach from that in England and Wales was favoured in Scotland and there was widespread support for proposals, including simplification of the feescale.

**Consultation**

54. The proposed new arrangements follow a comprehensive consultation on the future of NHS dental services in Scotland. As well as a number of consultation events across Scotland, over 200 written responses were received. The consultation responses indicated a broad consensus for the provisions addressed by these sections of the Bill. The outcome of the consultation and the Executive’s policy direction in response to this will be outlined in the formal Executive response which is expected to be announced in the New Year.

**Listing of Additional Categories of General Dental Practitioners, Optometrists and Ophthalmic Medical Practitioners**

**Policy objectives**

55. Health Boards are currently required to maintain lists of all:

• general dental practitioners who undertake to provide general dental services (GDS) in their area under the National Health Service (General Dental Services) (Scotland) Regulations 1996; and

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ophthalmic contractors who undertake to provide general ophthalmic services (GOS) in their area under the National Health Service (General Ophthalmic Services) (Scotland) Regulations 1986.

56. GDS are the range of NHS dental care provided by family dentists to patients. GOS comprise the testing of sight of eligible patients, informing general practitioners (GPs) of the results of certain tests, the completion of prescriptions (a written order giving details of lenses intended to be made up into glasses or contact lenses) and the issuing of NHS optical vouchers to eligible patients.

57. The relevant lists in a given area are known as the dental list and the ophthalmic list. Dentists, optometrists and ophthalmic medical practitioners (OMP) on these lists are commonly known as “principals” or “contractors”. A dentist has to be on the dental list before he or she can provide GDS in an area. An optometrist or OMP has to be on the ophthalmic list before he or she can provide GOS in an area.

58. To join a dental or ophthalmic list, a principal/contractor has to satisfy rules on suitability, including registration with the professional regulatory body and appropriate experience. Once on a list, a principal is subject to discipline procedures relating to statutory Discipline Committees and the NHS Tribunal.

59. The list system does not currently extend to non-principal optometrists/ophthalmic medical practitioners assisting with the provision of GOS, to non principal dentists assisting with the provision of GDS, to dentists who perform personal dental services (a sub-set of GDS) nor to dental bodies corporate. Non-principal dentists may include dentists undertaking vocational training, assistant dentists and locum dentists working in GDS who do not act as principals. Non-principal optometrists and OMPs may comprise employed assistants, deputy and locum optometrists and OMPs working in general ophthalmic services but not on a regular basis for a principal.

Policy objectives – specifics

60. The Executive’s policy is that those non-principal dentists who assist with the provision of GDS, those dentists who perform personal dental services (PDS) and those non-principal optometrists and OMPs who assist with the provision of GOS and whose names do not currently appear on the dental or ophthalmic lists held by Health Boards should now be listed for the first time. Dental bodies corporate are to be permitted to make arrangements with Health Boards for the provision of GDS and will also be listed. This will assist Health Boards to be aware of and monitor all those who are providing or assisting with the provision of GDS or GOS in their areas. This will also enable non-principals to be referred to an NHS Discipline Committee or to the NHS Tribunal where their acts or failures to act merit such a referral.

61. The policy intention is that, in order to make arrangements with a Health Board to provide GDS in its area, a principal dentist or dental body corporate will require to be on the part of the dental list for that area of those who have undertaken to provide GDS, i.e. the first part. A dentist will be unable to assist with the provision of GDS in an area unless he or she is on the second part of the dental list for that area (that is, apart from where a principal also assists
another principal with GDS provision in the same area where he is already on the first part of the list). A dentist will be unable to perform PDS in an area unless on the “PDS” list for the area. Similarly, the GOS list held by each Health Board will be divided into 2 parts – principals and non-principals who assist with GOS provision.

**Entry to, control of and operation of the lists**

62. The Executive’s policy is that the following principles will apply:

- the entry and control arrangements for principals and non-principals working in family health services should be uniform, that is, for non-principals they should mirror as far as practicable those for principals, including any requirements as to suitability;

- principals should be required to ensure that any organisation providing non-principals provide only listed non-principals;

- bureaucracy will be kept to a minimum by developing a “fast track” application procedure. The practitioner will indicate on the application the area or areas where he or she wishes to work, a “host” Health Board will check the information supplied on the application and, where this is found to be satisfactory, the practitioner will then be granted entry to the list held by the host Health Board and the other relevant Health Boards may also choose to grant him/her entry without undertaking further checks;

- statutory requirements as to NHS Discipline Committees should cover non-principals as well as principals. Reference of a principal to a Discipline Committee arises from a potential breach of the National Health Service (General Dental Services) (Scotland) Regulations 1996, or the National Health Service (General Ophthalmic Services) (Scotland) Regulations 1986, including a potential breach of the terms of service set out in Schedule 1 of these. Those terms of service and those other parts of the Regulations which concern performance should apply to non-principals, while those which relate to the performance of a principal as a contractor to the Health Board (for example registering and de-registering dental patients) should not apply to non-principals; and

- the NHS Tribunal should have the same jurisdiction in relation to listed non-principals as it has to listed principals.

63. The Executive’s policy is also to harmonise the ways in which practitioners apply to Health Boards for admission to lists. At present the information varies according to the profession and is limited in scope. Health Boards are therefore restricted in their ability to check the fitness to practice of the practitioner to join or remain on a list. The policy intention is that Scottish Ministers may make regulations to require those who apply to join a list to provide certain information, for example an enhanced criminal record certificate which is obtainable from Disclosure Scotland. Such a certificate would show if the practitioner has any criminal convictions as well as any non-conviction information provided by a Chief Constable. The Scottish Ministers may also make regulations to require such certificates from practitioners already on a list. Other requirements which may be placed on those on lists will be to declare gifts above a certain limit and financial interests which might be seen to influence the delivery of services.
Alternative approaches

64. No alternative approaches were considered. The listing of non-principal practitioners for the purposes of undergoing the same checks as principals, to enable Boards to monitor who is working in their area and to bring non-principals within the family health service disciplinary arrangements is a post-Shipman measure. Non-principal GPs are already listed.

Consultation

65. A consultation paper\textsuperscript{12} was sent to Health Boards, Primary Care Trusts and other interested parties in February 2004. Copies were also sent to all practices in Scotland providing general dental and ophthalmic services. Dental and ophthalmic contractors were asked to draw it to the attention of all non-principals who work in the practice.

66. 15 responses to the consultation paper were received and these demonstrated agreement to the principle that those who assist in the provision of GDS and GOS should be listed. The representative body for optometrists, Optometry Scotland, requested that listing should be done in the least bureaucratic way possible. They have been assured that the list entry procedure will be established with minimal bureaucracy in mind.

67. The proposal that Health Boards should be able to make arrangements with dental corporations for the provision of GDS formed part of the consultation on Dental Services. This was generally supported.

PHARMACEUTICAL CARE SERVICES

Policy objectives – background

68. The over-arching policy objective of this section of the Bill is to make the necessary legislative changes to implement new arrangements for modernising NHS community pharmacy in Scotland and, in particular, allow implementation of a new contract for providers of pharmaceutical care services. It amends the provisions of the National Health Service (Scotland) Act 1978 (the 1978 Act) relating to the arrangements currently made by Health Boards with community pharmacists for the provision of pharmaceutical services, and with appliance suppliers for the supply of listed appliances.

69. In February 2002 the Scottish Executive published its strategy for pharmaceutical care in Scotland, \textit{The Right Medicine}\textsuperscript{13}. This followed the 2001 publication of the Scottish Health Plan \textit{Our National Health: a plan for action, a plan for change}\textsuperscript{14}. Collectively these documents set an agenda for modernising and redesigning pharmacy services. The over-arching aim is to improve patient care and to better use the skills of community pharmacists and their support staff to meet local population needs.

\textsuperscript{12} Scottish Executive, \textit{Listing of Non Principal General Dental Practitioners, Optometrists and Ophthalmic Medical Practitioners} (2004)

\textsuperscript{13} Scottish Executive, \textit{The Right Medicine} (2002)

\textsuperscript{14} Scottish Executive, \textit{Our National Health: A plan for action, a plan for change} (2000)
70. In January 2003 the Office of Fair Trading (OFT) issued a report *The control of entry regulations and retail pharmacy services in the UK*\textsuperscript{15}. Its one recommendation was to abolish the controls under which NHS community pharmacy contracts are granted and so leave the delivery of NHS pharmaceutical services open to market forces.

71. Whilst competition and price regulation issues are reserved, health matters are devolved and in March 2003 Scottish Ministers decided that the OFT recommendation was not the way forward for Scotland. They did so having weighed the interests of consumers against the Executive’s public health policy and the potential impact on patients – particularly in Scotland’s remote and rural communities and deprived urban areas. In announcing their decision, Ministers advised that in implementing the pharmaceutical services strategy and negotiating the new community pharmacy contract the opportunity would be taken to consider how pharmacy services in the future could best respond to the interests and needs of both patients and consumers in Scotland. Additionally, a Partnership Agreement commitment stated that the Executive would continue to protect the status of community pharmacies.

72. The negotiation of a new community pharmacy contract is a key factor in delivering the policy aims of *The Right Medicine*. Whilst elements of those negotiations remain to be finalised, the framework for the new contract has been agreed and, in March 2004, the legislative proposals to underpin its delivery were put out to consultation in the document *Modernising NHS Community Pharmacy in Scotland*\textsuperscript{16}.

73. Separately, in June 2003, but still in the context of modernising community pharmacy, the Executive consulted on alternative options for providing listed appliance services, which can currently be provided by either community pharmacists or contracted appliances suppliers.

74. Currently, pharmaceutical services comprise the provision of dispensing services, professional services and locally negotiated additional pharmaceutical services. The policy intention is that the new contract will comprise four clinically based components, referred to as *essential* pharmaceutical care services; a fifth component covering infrastructure requirements (premises and information management and technology); and, similar to now, *additional* pharmaceutical care and support services.

**Policy objectives – specifics**

**Duties on Health Boards**

75. Current legislation places Health Boards under a duty to secure the provision of pharmaceutical services for people in their respective areas. There is no formal contract as such between Boards and the persons or businesses that provide pharmaceutical services. Instead Boards are required to make arrangements for service provision in accordance with regulations made under the 1978 Act - the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995 (the 1995 Regulations).

\textsuperscript{15} Office of Fair Trading, *The Control of Entry Regulations and Retail Pharmacy Services in the UK* (2003)

76. To reflect the increased emphasis on patient care that underpins the new community pharmacy contract, the Bill creates a new terminology referred to as “pharmaceutical care services” (PCS). It is the Executive’s intention that the public should have access to the full range of PCS irrespective of where they stay or are located in Scotland. To that end, the Bill places a duty on Health Boards to secure or provide PCS that they consider necessary to meet all reasonable needs of persons in their respective areas. Such provision will enable Boards to provide PCS directly or by means of arrangements with others according to which is most appropriate to meet local circumstances.

77. Currently, the means by which a Health Board secures the provision of pharmaceutical services is through the maintenance of a “pharmaceutical list”. Persons or businesses wishing to open or relocate a NHS community pharmacy must, in accordance with the 1995 Regulations, apply to the local Health Board for approval to be entered on its pharmaceutical list. The process is referred to as the “control of entry” arrangements. Those arrangements include a criterion that before a Health Board grants an application it must be satisfied that it is “necessary and desirable” to do so in order to secure the adequate provision of pharmaceutical services in the neighbourhood in which the premises are to be located.

78. Overall, the Health Board’s role in the current control of entry arrangements is reactive rather than proactive. As a consequence there are instances where, particularly in rural, remote or deprived areas, the public may not have full or ready access to a full range of pharmaceutical services. Therefore, as well as placing a duty on Health Boards to secure or where necessary provide PCS themselves, the policy intention is that individual Health Boards should do so in accordance with a PCS Plan that they will be required to prepare and maintain. This will allow Health Boards to take a more holistic view of local needs and the most appropriate provision and distribution of services required.

79. Placing the provision of PCS into a formal planning framework means that whilst control of entry arrangements will be retained – in line with the Executive’s decision on the OFT report – applications for entry to pharmaceutical lists will no longer be made on a speculative basis but, instead, in response to clearly identified and stated service needs.

80. To ensure that the planning and service securing process is conducted on a uniform basis across Scotland, the Bill creates powers to introduce regulations to detail what PCS Plans should provide and how they will be prepared, implemented and maintained.

Categories of Pharmaceutical Care Service

81. Under current arrangements, community pharmacists are, through the 1995 Regulations, required to provide medicine and/or appliance dispensing services and may also undertake to provide certain additional professional services.

82. The Bill will bring in powers to create a new set of Pharmaceutical Services regulations that will, amongst other things, define “essential” and “additional” services. The intention is that:

- all PCS contractors will provide “essential services”; and
• PCS contractors will be able to opt into “additional services”, which will be commissioned by Health Boards to meet locally identified needs.

83. Businesses or persons eligible and able to provide all prescribed essential PCS will be able to seek PCS contracts (see below). Providers of individual essential services and/or additional PCS will, as at present for the latter category of service, be able to enter into locally negotiated contract arrangements with NHS Boards.

**Pharmaceutical Care Service contracts**

84. The policy intention is to introduce the legislative changes required to allow the implementation of the new community pharmacy contract, negotiated between the Executive and the Scottish Pharmaceutical General Council (SPGC).

85. The contract will be between a community pharmacy business and a Health Board. This is a change from the present arrangements under which the “contract” is essentially a set of arrangements governed by regulations. Giving the responsibility for holding contracts to Health Boards accords with the Executive’s policy intention to devolve responsibility from the central to the local level. The White Paper *Partnership for Care* explicitly rejects a command and control approach and emphasises the importance of giving local systems the tools and freedom to redesign services and lead change.

86. Placing the responsibility for setting contracts on Boards will put PCS on the same footing as that for general medical services (GMS) provision. This will also allow for contracts to take an integrated approach to care and deliver a full range of services for patients. It will also allow community pharmacies to expand into other health care provision including, for example, nurse-led or other specialised services.

87. Although PCS contracts will be negotiated or set at a local level, it is the Executive’s intention to have a degree of uniformity to reflect the fact that the new contract has been agreed at a national level. The Bill creates powers to introduce secondary legislation make directions on a range of issues including who can hold a contract, mandatory contractual terms, the types of services to be provided, the manner in which they are to be provided, and the arrangements by which Health Boards will calculate and make payments under PCS contracts.

88. The intention behind the regulation making powers is to ensure that service providers and Health Boards maintain a base level of quality and organisation wherever they happen to be in Scotland. Scottish Ministers will retain the overall responsibility for ensuring that a comprehensive health service exists in Scotland. The Bill will ensure that they can discharge this over-arching duty through setting the parameters within which Health Boards must work.

**Who can hold a PCS contract?**

89. The Bill has the effect of creating a power to prescribe those who can enter into a PCS contract. The situation will remain largely as at present but with only registered pharmacists, or persons lawfully conducting a retail pharmacy business in accordance with section 69 of the

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Medicines Act 1968, being able to enter into a PCS contract. By definition Health Boards will not be able to enter into PCS contracts with businesses providing only appliance supply services. This is because they are not providing the full range of services that constitute PCS, for which there will be pharmacy specific and mandatory contract conditions. However, Health Boards will continue to be able to secure appliance supply and fitting services from the providers of such services through the Health Boards’ normal healthcare commissioning and contract arrangements.

Disputes

90. The negotiation and implementation of any contract has the potential to give rise to disagreements between the parties to the contract. The Executive intends to bring forward regulations that will set out a process for dispute resolution. The policy intention is that the vast majority of disagreements will be resolved by discussion and good working relationships at a local level. However, it is essential that all parties have access to a fair and independent dispute resolution system. In keeping with the concept of a national contract, the Executive believes the process should be common across Scotland. This will ensure that any dispute follows a single, easily understood procedure and adheres to the principles of the European Convention on Human Rights.

Listing arrangements

91. It is the policy intention to ensure that the persons providing PCS services, that is “essential” and “additional”, under a NHS contract are fit and competent to do so. This is in the public interest and is essential to retaining public confidence in the provision of family health services.

92. Under current arrangements, Health Boards are required to maintain lists of the names and addresses of the “persons, firms or bodies corporate” that provide pharmaceutical services in their area. The list, known as the “pharmaceutical list” must also detail the pharmaceutical services being provided and opening hours. The purpose of the list is in part to control where community pharmacies are located but also to tie the contractors into stated terms and conditions of service and to ensure that disciplinary action can be taken against them, that is the “principal” pharmacist, if they are found to be in breach of these conditions. There is currently no requirement to list the pharmacy contractors’ employees, that is the “non-principals”, so principals are responsible for both their own acts or omissions and also for those of the non-principals that they employ.

93. The policy intention is that the “pharmaceutical list” will be retained, but as a control mechanism for those who perform PCS and not for control of entry purposes, which will in future be addressed by the proposed service planning and provision arrangements.

94. The Executive therefore intends that there should be a single list maintained by each Health Board for all registered pharmacists providing PCS in their area, whether they are principals or non-principals. The Bill will empower Scottish Ministers to provide by regulations that a health care professional of a prescribed description may not perform any pharmaceutical care services for which a Health Board is responsible unless the pharmacist is included in a list maintained under the regulations by that Board.
Financial arrangements

95. Currently, whilst Health Boards pay their pharmaceutical services providers, the funds for all nationally negotiated services are drawn from centrally held (Executive) resources. The costs of locally negotiated services are met from the Health Boards’ own allocated resources.

96. Given the policy intention to make Health Boards responsible for planning and, thereafter, securing or providing all required PCS in their respective areas, Scottish Ministers consider that Health Boards should also assume full accountability for the financial consequences of their decisions and actions with regard to PCS. Accordingly the Bill contains amendments that will make Boards responsible for meeting all future PCS expenditure from their unified budgets/allocations. The intention is to disburse the central budget to Health Boards on a weighted capitation basis but over a period of time that enables Health Boards to adjust to any changes from historic funding levels under the current arrangements.

97. Recognising that delivery of a PCS plan that meets local needs will in some cases require Health Boards to provide new or additional services, or facilitate changes in service configuration, the Bill contains a provision that will enable Health Boards to provide assistance and support (including financial support) to those providing, or proposing to provide PCS, under a PCS contract.

Alternative approaches

98. The proposals contained within the Bill reflect the legislative requirements for implementing elements of the Executive’s pharmaceutical strategy *The Right Medicine* but notably for introducing new contract arrangements for community pharmacies. Negotiations on the latter are still ongoing but the structure and content of the contract have been agreed.

99. There are two alternative options. The first would be to leave the current contract and service provision arrangements as they are. Given the widely supported aims of *The Right Medicine*, by the public and pharmacists alike, the Executive considers that option untenable. The second would be to model the contract and service provision arrangements on the existing legislation. Whilst it would be possible to implement some changes within the current legislative framework they would be limited in scope and would not deliver the full package of patient benefits sought by *The Right Medicine*.

Consultation

100. This section of the Bill is different from many others in that it provides a legislative framework for NHS contracts to provide pharmaceutical care services. The structure and content of the new contract has been agreed by the pharmacy contractors’ representative body, the Scottish Pharmaceutical General Council, and discussions on the clinical and financial detail of the contract are ongoing.

101. The legislative proposals to underpin its delivery were put out to consultation in March 2004 in the document *Modernising NHS Community Pharmacy in Scotland*. Around 6,000 copies were distributed to key stakeholders, including all registered pharmacists in
Scotland. Some 100 responses were received and in general the principles of what was proposed were widely supported.

102. Options for changing the arrangements under which the provision of listed (in the Drug Tariff) appliance supplies and services are provided and remunerated were put out to consultation in June 2003. A total of 29 responses were received, the majority from NHS bodies and appliance manufacturers or contractors. There was general support for the objective to protect and improve the standards of service for patients, and their access to the services, but no one supply and remuneration model option emerged as the preferred one for delivering the objectives.

DISCIPLINE

Policy objectives

103. The NHS Tribunal is the principal disciplinary body for family health service practitioners (general practitioners, dentists, community pharmacists, optometrists and ophthalmic medical practitioners). It is an independent body comprising a Chair, appointed by the Lord President of the Court of Session, a member of the relevant profession and a lay member both appointed by the Scottish Ministers. At present the Tribunal may inquire into cases where the continued inclusion of a practitioner on a list held by a Health Board would prejudice the efficiency of the NHS or where a practitioner on a list, or an applicant, has committed or attempted to commit fraud against any publicly funded health service.

104. The Bill’s policy is to introduce an additional ground under which the Tribunal may deal with a practitioner who has been referred to it. This is one of unsuitability by reason of professional or personal conduct. This will apply, for example, when information comes to the attention of a Health Board that a practitioner has been convicted of an offence, the nature of which suggests he or she no longer deserves the trust which is necessary between practitioner and patient.

105. At present the Tribunal may direct, after an inquiry carried out under statutory guidelines, that a practitioner’s name should be removed from the list of the Health Board (local disqualification) or that the practitioner should be excluded from all Health Boards’ lists (national disqualification). Disqualification may be substantive or conditional. The latter provides that the practitioner’s name may remain on the list subject to conditions. In addition to a national substantive disqualification the Tribunal may direct that a practitioner is not fit to be engaged in the NHS in any capacity. This has the effect of ensuring that a practitioner may not assist another in the delivery of services.

106. The policy intention is to remove the sanction of local disqualification. Thus, if a practitioner is not fit to deliver services in one Health Board’s area he or she should not be able to do so in another. There is a right of appeal to the Court of Session on points of law against decisions of the Tribunal and disqualified practitioners may apply to the Tribunal for their disqualification to be removed. If successful with such an application a practitioner would be free to apply to any Health Board to provide services once more.

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107. Where it is necessary to protect patients, the Tribunal has the power to suspend a practitioner, on application by the relevant Health Board, while the full case is considered. This has proved unwieldy and the Bill introduces changes. The policy is for regulations to make provision to allow suspension of a listed person directly by a Health Board from its own list (local suspension), unless or until representations are made to the Tribunal. This could be on the existing ground of patient protection, or on a new ground of protection of the public interest. The latter would apply, for example, where there was suspicion of fraud being committed. The Tribunal would continue to be able to make a national suspension on either ground. Any practitioner subject to suspension proceedings will have the right to a hearing and, if suspended, will continue to be paid.

108. In the case of pharmaceutical bodies corporate and appliance suppliers the disciplinary arrangements for individual practitioners are no longer appropriate with the introduction of the new pharmacy contract. Any failure to comply with the contract with the Health Board can, however, be pursued as a breach of contract in the normal way.

109. At present a Health Board must remove practitioners from its list in certain circumstances. One of these is where the practitioner has been convicted of murder. At present this only applies to convictions of GPs and dentists in the UK. The policy is to extend this to bring in pharmacists, optometrists and ophthalmic medical practitioners. In addition, the policy is that Health Boards will be required to refuse any application for entry to its lists from a practitioner who has been convicted of murder in the UK.

110. At present Health Boards must also remove practitioners from its list where a GP or dentist is convicted of a criminal offence and sentenced to imprisonment for 6 months or longer. This rule is inflexible. Thus, the policy intention is that instead the Health Board will consider the implications of any conviction of any family health service practitioner. If necessary, the Health Board may then refer the matter to the Tribunal which could disqualify or conditionally disqualify the practitioner. The policy is for these arrangements to also apply to applications for admission to lists.

**Alternative approaches**

111. One alternative approach would be to leave the provisions relating to the Tribunal and to NHS Boards as they stand. This would not however afford patients the same level of protection as the proposed changes. Additionally, a public interest ground for suspension of family health service practitioners is already used in England and Wales (by primary care bodies) and there is an unsuitability ground under which practitioners may be de-listed.

**Consultation**

112. These proposals have been the subject of a wide ranging public consultation exercise which attracted a total of 59 responses. These were generally in favour of the policy.

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19 Scottish Executive, *Further Measures to Improve the Provision of Primary Care Services* (2004)
PAYMENTS TO CERTAIN PERSONS DEVELOPING HEPATITIS C AS A RESULT OF NHS TREATMENT

Policy objectives

113. Scottish Ministers have made a commitment to participate fully in the UK scheme for making ex gratia payments to patients who became infected with the hepatitis C virus following NHS treatment prior to September 1991, that involved receipt of blood tissue or blood products.

114. The scheme has been established and has commenced making payments. At present Scottish Ministers are making ex gratia payments to the above mentioned patients using common law powers. Since it is anticipated that there will be continuing payments over a period of time, Scottish Ministers consider it appropriate that express statutory powers to make the payments be obtained.

Alternative approaches

115. No alternative approach has been considered as statutory powers are considered the only appropriate approach to ensure that payments can continue over a period of time.

Consultation

116. The provision of financial payments to patients affected in this way was a primary recommendation of the 17th Report (2001) of the Health and Community Care Committee and this was subsequently reinforced by a similar recommendation made in March 2003 by the Expert Group on Financial and Other Support (chaired by Lord Ross). In the light of these recommendations no further consultation was deemed necessary on the issue of making the necessary legal provision to make payments of this nature.

AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001 AND CHILD CARE AGENCIES AND HOUSING SUPPORT SERVICES

Introduction

117. The Regulation of Care (Scotland) Act 2001 (the 2001 Act) established a new independent body to regulate care services in Scotland; that body is known as the Scottish Commission for the Regulation of Care (the Care Commission). It also established a system of care regulation, encompassing the registration and inspection of care services against a set of national care standards and the taking of any enforcement action.

118. It also established a further new independent body to regulate the social service workforce and to promote and regulate their education and training; that body is known as the Scottish Social Services Council (the Council).

119. This section of the policy memorandum also covers the provisions in relation to child care agencies and housing support services which are free standing provisions in the Bill.

Policy objectives

Amendments affecting the Care Commission

Independent health care services

120. The Care Commission regulates care services defined in section 2 of the 2001 Act. This includes “an independent healthcare service” which is further defined at section 2(5) of the Act. The original policy intention was that independent healthcare services including hospitals, clinics and medical agencies would be brought within the scope of regulation by the Care Commission.

121. The scope of the legislation currently goes further than the original policy intention. As it stands, once section 2(5) of the 2001 Act is fully commenced, the Care Commission’s regulatory powers would encompass a wider area of the independent health care sector than that originally envisaged. For example, the Care Commission would be responsible for regulating services from a doctor or dentist provided under arrangements by a third party such as occupational health services or medical consultations and examinations for insurance companies. Any private services being provided by NHS general practitioners would also be covered by the current definition.

122. The power to except services from a definition already exists (where relevant) for other care services defined in the 2001 Act. The Bill’s policy intention is to amend section 2(5) of the 2001 Act to give Scottish Ministers the power to define by regulations the independent healthcare services that will be regulated by the Care Commission.

Implementation of certain decisions

123. Under the 2001 Act, anyone who wants to provide a care service must register that service with the Care Commission. The Care Commission has powers to make a range of decisions both in relation to applications for registration and services which are already registered. In relation to initial applications, registration may be granted either unconditionally, subject to such conditions as the Care Commission thinks fit to impose, or refused. For services which are already registered, the Care Commission may issue a condition notice (which is a notice that the Care Commission proposes to vary, remove or impose an additional condition); propose to cancel registration; or propose to refuse an application by the provider (a) to vary or remove a condition in force in relation to the service or (b) to cancel registration. The Care Commission notifies its decision in writing. The person to whom the notice is issued can make written representation to the Care Commission concerning any matter that they wish to dispute.

124. The original policy intention was that the Care Commission would consider any representations from those who are notified and then decide whether or not to do the thing proposed. This is not reflected in the current legislation.

125. The policy intention is to amend section 16(2) of the 2001 Act to make a technical change which will ensure that where representations are made to the Care Commission, these will be considered and that the Care Commission will then decide whether or not to follow the action proposed in the notice.
Amendments affecting the Scottish Social Services Council

126. The Scottish Social Services Council’s (the Council) duties include maintaining a register of social service workers as prescribed within the 2001 Act and in any orders made by Scottish Ministers. An application for registration may be granted unconditionally or subject to conditions imposed by the Council. The Council has also, subject to Scottish Ministers’ consent, issued a Code of Practice for Social Service Workers and Employers, which employers will take into account when making any decision about the conduct and competency of a social service worker.

Implementation of certain decisions

127. The original policy intention in relation to applications for registration was, and still remains, that, where the Council intends to grant conditional registration, the applicant will be notified of the Council’s decision and be given the opportunity to make any representations before the Council implements their decision. The applicant would also have the right to appeal to the Sheriff against any decision made by the Council in relation to the application for registration.

128. The Executive believes that the 2001 Act does not fulfil the policy intention as currently drafted because, even where representations are made, the Council is obliged to implement the original proposal and it is unclear whether all decisions can be appealed against.

129. The Executive’s policy is to amend the 2001 Act to make the technical changes to fulfil the original policy intention. This will ensure that where representations are made by applicants, the Council will consider them and then decide whether or not to take the action originally proposed, and also remove any ambiguity so that there is a right of appeal against all decisions made by the Council in relation to an application for registration.

Provision of information to the Scottish Social Services Council

130. With regard to the Code of Practice, the original policy intention, which remains, is that employers would take account of the Code and its contents when dealing with conduct and competency issues relating to a social service worker. Whilst some employers appear to be doing so, recent high profile investigations into social work services highlighted a need to reinforce the original intention.

131. The proposed changes to the 2001 Act will clarify the requirements for the provision of information regarding social service workers by employers to the Council. This will remove any weakness or ambiguity of when and how an employer should take account of the requirements of the Code of Practice, including co-operating with the Council in relation to registration issues.

132. The amendments will support an individual’s right to a fair hearing and protect the users of social services.

Child care agencies and housing support services

133. The definitions at section 2 of the 2001 Act are gradually being commenced as the Care Commission takes on responsibility for regulating care services on a phased basis. The policy is
This document relates to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

to put in place for each service sector, as its definition is commenced, subordinate legislation specifying transitional provisions for registration. These provisions deem services to be registered for certain periods which it is intended will ensure that their providers have enough time to submit their applications for registration and the Care Commission in turn has enough time to consider them and either grant or refuse registration.

134. From 1 April 2003 the child care agency definition at section 2(7) of the 2001 Act was commenced in full (having been partially commenced from 1 April 2002 to ensure continued registration of the few agencies registered as childminders under the previous regulatory system) as was the definition of housing support service at section 2(27). The transitional provisions provided that persons providing those services on 1 April 2003 were deemed to be registered from that date until 30 September 2003 but where a person applies for registration before 1 October the service is deemed to be registered until 31 March 2004. Section 21 of the 2001 Act makes it an offence for a person to provide a service while it is not registered with the Care Commission.

135. Due to the complexity of services, discussions between the Care Commission and providers on the number and form of applications required under the 2001 Act took much longer than anticipated. During the course of those discussions the deemed registration period ran out by which time very few providers had applied to the Commission for registration. This had the consequence that many providers were inadvertently acting illegally under the terms of the 2001 Act. This did not come to light until it was too late to take action to extend the deemed registration period in subordinate legislation. The Lord Advocate granted the providers affected an amnesty against prosecution for providing unregistered services, provided they submitted applications before 30 September 2004.

136. The policy intention is to make retrospective provision to ensure that the providers of the services affected are treated as if they continued to provide them legally during the periods in question. It ensures that where a person was deemed to be registered on 1 April 2003 that deemed registration, where necessary, does not cease until 1 April 2006, provided applications for registration were made before 30 September 2004.

Grants in respect of housing support services

137. Grants are paid to local authorities by Scottish Ministers under section 91(1) of the Housing (Scotland) Act 2001 towards expenditure incurred by them in providing or contributing towards the provision of prescribed housing support services. In turn, local authorities pay grants to providers of these services. Terms and conditions for payment were set out in secondary legislation. Existing services were deemed to be registered until 30 September 2003 and, provided they had applied to be registered by that date, until 31 March 2004. Services which were care services in terms of the relevant order under the Housing Act, required to be registered with the Care Commission to receive housing support grant until that requirement was removed on 19 August 2004 by a further amending Order.

138. The lapsing of deemed registration of certain housing support services on 1 October 2003 due to difficulties in the registration process meant that payments were made by local authorities to service providers after that date who were not registered. The policy intention is
for a new retrospective provision to ensure the lawfulness of payments made over the period 1 October 2003 to 19 August 2004.

**Alternative approaches**

139. No alternative approach has been considered as statutory powers are considered to be the only appropriate approach to ensure that the policy intentions would be fulfilled.

**Consultation**

140. The changes to the 2001 Act are all technical and consultation was not considered to be necessary. The Care Commission and the Council are aware of, and support, the proposed changes to the 2001 Act.

141. In relation to the change to section 2(5) of the 2001 Act the policy intention is that, prior to making regulations, consultation will be carried out on which, if any, services should be excepted from the definition of an independent healthcare service before these provisions are commenced.

142. In relation to the changes with regard to the implementation of certain decisions (affecting the Care Commission and the Council), the policy intention is to advise care service providers and social service workers of the proposed changes.

143. The intended policy on provision of information to the Council is to ensure that the Council has all relevant information available to enable it to properly carry out its regulatory functions. It follows from the Minister for Education and Young People’s announcement in the Scottish Parliament in May 2004 relating to the high profile investigation into the Borders that the statutory position of the Code would be strengthened. Despite recommendations on good practice in the Code, the present inability of the Council to require information from an employer on the conduct of a social services worker and concerns of employers about possible infringement of data protection obligations if information was passed on, were recognised as matters that required to be specifically addressed by legislative change. Employers are aware of the forthcoming change and are supportive of it.

144. For the policy relating to child care agencies and housing support services, known providers of these services were informed that the Lord Advocate had granted them an amnesty against prosecution, provided they submitted an application for registration to the Care Commission by 30 September 2004; they were also told that legislative steps were being progressed to rectify the situation retrospectively. Local authorities were also informed. The Executive also announced the action being taken in a news release on 23 July 2004.

**AUTHORISATION OF MEDICAL TREATMENT**

**Policy objectives**

145. The Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) regulates the way in which decisions may be taken on behalf of adults who are incapable, either by reason of mental
disorder or physical impairment, of making such decisions themselves. It sets out a regulatory regime designed to protect welfare and property. In the case of medical treatment and research (Part 5 of the 2000 Act) it provides a clear statutory framework for regulating what may be done by medical practitioners and others acting with their authority.

146. Following concerns expressed about the workload implications for general practitioners under the new legislation, a consultation exercise was launched in March 2003. Other health professionals, especially dentists were also concerned that they were unable to treat patients attending their surgery, often in pain, because a certificate was not already in place to allow that treatment to proceed. Qualitative research was undertaken on the early operation of Part 5. As a result of this careful consideration and further engagement with health professionals and other stakeholders the intention is to amend certain aspects of Part 5.

147. The policy intention is to make two amendments to section 47 of the 2000 Act. The first will extend the authority to grant a certificate under section 47(1) to health professionals who have relevant qualifications and training to assess the capacity of patients. This group is in addition to “registered medical practitioners” who are capable of making an assessment of the patient’s capacity as required in terms of section 47. Importantly, the certificate will only be valid within their specialism, for example a dentist could only authorise dental treatment. The authority to issue a certificate will be expanded in terms of the Bill to include dentists, ophthalmic opticians and registered nurses, but there is provision also to extend to other professional groups by regulation. Consequential changes will be made to other sections in Part 5 of the Act.

148. The second amendment will extend the maximum duration of a section 47 certificate from 1 year to 3 years. This will be dependent on the nature of the illness from which the patient is suffering, for example the new maximum duration could be applied where, in the view of the registered medical practitioner, a patient was suffering from a progressive degenerative condition with no chance of improvement. This would make better use of the scarce resource of the medical practitioner’s time (and knowledge of the patient) without placing the patient at risk.

149. A principal objective in this process has been to ensure that the changes do not erode the protections the current legislation gives to a vulnerable group of people. The changes should help to ensure that those patients who cannot give consent to treatment will, none the less, receive parity of care with those who can.

Alternative approaches

150. An alternative was to give the operation of the 2000 Act a longer period to settle before taking amending action. But in the light of the written comments received and discussion with key stakeholders the balance of advantage was considered to lie in taking the steps now proposed which will improve the administrative processes without diminishing the protections conferred by the 2000 Act.
Consultation

151. The Scottish Executive conducted a wide-ranging consultation\(^{21}\) on possible amendments to the Code of Practice and changes to the Act. The Executive commissioned an analysis of the responses\(^{22}\) to the consultation exercise and commissioned qualitative research into issues arising from the implementation of Part 5\(^{23}\). The Executive also met key stakeholders (representing medical professionals, voluntary organisations and carers) to consider the outcome of the consultation and to agree a common approach to the issues. The finding of the consultation was that the general consensus among respondents was support for the two substantive changes to the 2000 Act.

**JOIN VENTURES**

**Introduction**

152. The policy intention is to allow Scottish Ministers and NHS bodies to form or participate in joint venture companies for two purposes. Firstly, for the provision of facilities and services and, secondly, for the exploitation of intellectual property.

**Facilities and services**

*Policy objectives – background*

153. The policy objective is to amend the National Health Service (Scotland) Act 1978 (the 1978 Act) to enable Scottish Ministers and NHS bodies to enter into joint venture agreements with contractors, local authorities and private sector providers to support primary and community care and joint working premises, and other infrastructure development.

154. This policy is set within a context of increasing investment in health services and reforms to deliver improved health and better integrated health services that are more responsive to the needs of patients and communities. Key initiatives include: the introduction of a new contract for GPs, involving measures to reduce the barriers for GPs needing to move or develop existing premises; the establishment of Community Health Partnerships; and the introduction of new joint working powers\(^{24}\) for Health Boards and Local Authorities. Investment currently comes from independent contractors funded through their individual contract remuneration arrangements; NHS capital; Local Authority funds; private capital; and the Primary and Community Care Premises Modernisation Programme.

155. The Bill will enable Health Boards and their public sector partners to access a greater range of sources of investment to support the development of infrastructure and better integration in service planning.


\(^{24}\) *Community Care and Health (Joint Working etc.) (Scotland) Regulations 2002*
Policy objectives – specifics

156. Provision of premises for the delivery of Primary Care is the responsibility respectively of the independent contractors concerned, in relation to the services they are contracted to deliver, or of the Health Board in respect of community health or salaried Primary Care Services. Premises tend to be owned either by contractors or the Health Board, or leased from a third party. General Medical Practitioners are eligible for direct reimbursement of the costs of premises provision. Under current contracts General Dental Practitioners and Community Pharmacists are expected to meet their premises costs from the activity based fees and allowances paid to them for provision of NHS services.

157. Work undertaken within the Executive in 2001 to assess issues around primary care premises development concluded that there is a need for greater flexibility in the provision of primary care premises and services, that must be recognised by any new investment vehicle; that premises should support greater joint working between care providers; and also measures that allow flexible tenure and occupation arrangements for users.

158. Subsequently, the Scottish Executive Short Life Working Group on Primary Care Premises Development highlighted the changing nature of the primary care premises environment and recommended action to change systems and practice to reflect service change. Its report\textsuperscript{25}, recommended adoption of the joint ventures policy objective and that this should form part of a formal consultation. The consultation would also address the suitability for Scotland of Local Improvement Finance Trusts (LIFT) being implemented by the Department of Health in England. This would be on the basis of their potential flexibility for joint premises developments. The Working Group also recommended that the Executive develop and publicise innovative procurement options. As a consequence the Executive commissioned a report on procurement focussing particularly on the suitability of implementing LIFT in NHS Scotland.

159. The Executive has concluded that the decision on the development approach most suitable for each Health Board area in Scotland is one to be taken locally in conjunction with other partners. Introduction of LIFT type entities may offer an appropriate way forward in some parts of Scotland, particularly where there is an urgent need to find a way to address the strategic planning deficit in closer collaboration with the private sector and other public sector agencies. In other areas partners may decide that their objectives for the medium term are already sufficiently well scoped and that a variety of delivery vehicles may offer an appropriate way forward. These may still involve joint ventures with the private sector or wholly within the public sector. The Executive intends that once these powers are in place all Health Boards and local authorities will be invited to confirm how they intend to deliver their respective infrastructure development strategies to identify whether joint ventures may offer an appropriate vehicle for this.

Alternative approaches

160. In the period since publication of the working group’s report Health Boards, contractors and other partners have continued to apply the financial tools available to deliver purpose built or adapted premises to address needs already identified within local strategies. These have included

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\textsuperscript{25} Scottish Executive, Joint Future Agenda: Short Life Working Group on Joint Premises Development in Primary and Community Care (2003)
projects funded wholly or mainly by NHS and other public capital, augmented or substituted by leasehold developments led by GPs.

161. This has enabled significant progress in modernising primary/community care premises and in bringing into service model premises that enable innovative joined up service delivery. For example, the Executive has spent £50m over the past 5 years to specifically address primary and community care premises development. Progress is not however uniform across Scotland and relies on a steady stream of well conceived and viable projects, with contractors willing to take on a leading role in development. These arrangements do not, however, fully promote effective forward planning, exploitation of the potential for joint working with partners, their capacity to develop complicated schemes, the role expected of contractors and the realisation of benefits of partnerships with the private sector.

Consultation

162. A formal consultation\(^{26}\) sought views on both the concept of joint ventures generally and the appropriateness of LIFT as a delivery vehicle for Scotland. In summary\(^{27}\) there was broad support for the policy objectives and the desirability of the NHS having the power to invest in joint ventures with private and public sector partners. There were, however, mixed views about whether the specific LIFT model as already deployed in England would represent an appropriate, universal way forward in Scottish circumstances. These reservations are consistent with the policy intention that joint ventures would be one of a number of delivery vehicles available to support the development of facilities.

Intellectual property

Policy objectives

163. Legislation currently provides the Scottish Ministers with a range of powers to make more income available for improving the National Health Service. Those powers, which have been extended to NHS bodies though a power of direction, include, among others, the manufacture and supply of goods and the provision of services (for example, the Scottish National Blood Transfusion Service manufactures blood products and diagnostic kits, supplying its products to over 50 countries throughout the world). However, there is currently no power in Scotland for these “income generation powers” to be exercised through the medium of a company.

164. The Executive’s policy intention is to amend the Health and Medicines Act 1988 (the 1988 Act) to make specific provision to allow Scottish Ministers to form or participate in forming companies, or to participate in companies. It also allows Ministers to make financial provision to or in respect of companies, including by means of loans, guarantees and investments. The use of this power is restricted to the purpose of making more income available for the Health Service.

\(^{26}\) Scottish Executive, Consultation on the use of Joint Ventures to deliver Primary Care/Joint Premises (2004)

\(^{27}\) Scottish Executive, Consultation on the use of Joint Ventures to deliver Primary Care/Joint Premises: Summary Report (2004)
165. The intention is to enable the Scottish Ministers and NHS bodies to make the most of the ideas and intellectual property generated by the NHS by developing and exploiting those ideas commercially. Whilst such “exploitation” could be achieved through other routes such as licensing or selling innovations using existing powers, for certain technologies requiring a further degree of development and financial investment, the more appropriate – and sometimes only possible – route to successful exploitation would be the establishment of joint venture companies to bring external finance and commercial skills to supplement the NHS expertise. This is how universities typically exploit this type of technology in partnership with the private sector. As things presently stand, however, the NHS cannot contribute its continuing scientific expertise to such a company to allow the further development of the innovation. The removal of the restriction on this type of exploitation would also allow these companies to apply for Scottish Executive business growth and innovation grants.

166. The new power is not restricted to the exploitation of intellectual property; it will extend to any of the activities listed in section 7 of the 1988 Act, such as the provision of services. The Scottish Ministers, under the power in section 7(3), intend issuing a direction to NHS bodies about the exercise of this new power. They will set out the circumstances in which the exercise of this power is appropriate along with clear directions on the issues, such as the assessment of the viability and value of the particular proposal, which must be considered in advance of its use.

Alternative approaches

167. As noted above, alternative means of exploiting NHS innovations, such as through licensing or sales, are currently available. For certain technologies, however, there will be a need for further product development and trialling in a clinical setting to determine both their scientific and commercial value. These steps can be costly and there is often a high risk of failure. Attracting commercial funding and know-how through product specific “spin out” companies is therefore often the only way to finance these steps. This new power is therefore necessary to ensure that the Scottish Ministers and through them NHS bodies can engage with and participate in such commercially funded companies for mutual scientific and financial benefit.

168. As an interim arrangement NHS bodies currently seek to progress their innovations – including through spin-outs – through a contractual arrangement with Scottish Health Innovations Ltd (SHIL), a company established by the Scottish Economic Development Agencies to support NHS innovation. This might suggest that the new powers are not needed. The limitations of such an approach, however, are evidenced by the fact that neither the Scottish Ministers nor the NHS bodies can participate directly in this company set up solely for their benefit. They only have observer status and, without the new power, cannot direct SHIL’s activities. In the case of a spin-out company, SHIL is therefore currently obliged to license technologies from NHS organisations and then enter into quite separate arrangements with commercial funders – currently the NHS body is not allowed to be directly involved in the company established to progress its own innovation. The power for the Scottish Ministers to participate directly in companies is therefore required.

Consultation

169. Following the Health and Social Care Act 2001 making a similar amendment for NHS bodies in England and Wales, the Scottish Ministers announced their intention to seek similar
changes in Scotland. This proposal was included in the draft Research Strategy which was the subject of public consultation in 2002\textsuperscript{28} and it appeared in the final Research Strategy\textsuperscript{29} published in July 2003. It commands wide support throughout the NHS.

**SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST**

**Policy objectives – background**

170. The Scottish Hospital Endowments Research Trust (SHERT) was originally constituted under the Hospital Endowments (Scotland) Act 1953 to receive and hold endowments, donations and bequests and to make grants from these funds available to support medical research in Scotland. SHERT is presently governed by the National Health Service (Scotland) Act 1978. Currently, SHERT supports research into diseases of high incidence in Scotland and is committed, in doing so, to supporting only the highest quality research.

171. SHERT is empowered by the National Health Service and Community Care Act 1990 to engage in fundraising activities for the purposes of the Trust and is required by the Health and the Medicines Act 1988 to develop and exploit ideas and intellectual property.

**Policy objectives – specifics**

172. Although a Non Departmental Public Body (NDPB), the Trust is entirely self-financing and thus receives no financial support from the Scottish Executive and members receive no fee or remuneration. Members are appointed by Scottish Ministers and operate with a large measure of autonomy.

173. Following the outcome of a Policy and Financial Management Review (PFMR) and Consultation exercise, the Executive’s view is that the work of the Scottish Hospital Endowments Research Trust, as a self financing public body, is such that it is sufficiently distant from Ministers to make continuing Ministerial involvement inappropriate. It is therefore the policy intention that SHERT’s NDPB status should be removed.

**Consultation and Policy and Financial Management Review**

174. In line with established policy, all Non-Departmental Public Bodies are subject to a comprehensive PFMR at least once every five years. SHERT’s PFMR was conducted in 2003. The PFMR examined whether the functions of SHERT are still required and whether the NDPB model continues to be the appropriate governance for delivery of the functions.

175. Subsequent to the Policy and Financial Management Review a written consultation exercise on the future status of the Research Trust was held. Parties directly consulted included SHERT grant holders, its scientific advisers and the administering institutions for SHERT funded research. In addition, consultation material was placed on both the SHERT and Scottish Executive Chief Scientist Office’s websites inviting views on SHERT’s future status.


The main thrust of the conclusions flowing from the PFMR centred on the fact that the tax benefits of charitable status are vital to the continued operation of SHERT. In noting that SHERT could exist without Ministerial control, and that such control might jeopardise its charitable status in the future, the PFMR recommended that SHERT’s status as a public body, linked and accountable to Ministers, should be removed. Those who replied to the consultation unanimously supported the recommendation of the PFMR that SHERT’s public body status should be removed.

Following the outcome of the Policy and Financial Management Review and the Consultation exercise, Ministers took the view that the work of SHERT, as a self financing public body, is such that it is sufficiently distant from Ministers to make continuing Ministerial involvement inappropriate. It was for this reason that Ministers concluded that SHERT’s NDPB status should be removed. SHERT also supported this recommendation.

Alternative approaches

In line with the position that SHERT should continue as an independent charity a number of alternatives were explored within the PFMR process.

The first option considered the donation of the funds to an existing medical research charity. In conclusion it was considered that most Scottish charities would not be well placed to manage the investments and wide ranging research portfolio on the scale undertaken by SHERT. Also, singling out one charity for such a substantial portfolio ran the risk of leading to dissatisfaction in the rest and the wider research community.

The second option considered the creation of a new organisation for SHERT’s functions. SHERT is a “virtual” Trust with no staff and no premises. Against this background it was considered unlikely that an organisation could be created that would fulfil the full range of functions at existing administrative costs. In addition, as the proportion of funds used by charities for administrative purposes is an issue under considerable scrutiny, it seemed likely that any new or existing charity could manage the SHERT portfolio without increasing overheads.

In conclusion, the approach of removing Ministerial involvement in terms of the existing legislation was considered the most appropriate means of achieving the PFMR objectives.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

The Bill’s provisions are not discriminatory on the basis of gender, race, disability, marital status, religion or sexual orientation.
Human rights

183. The Executive is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights.

184. The provisions of the Bill which prohibit smoking in certain public places will help to protect the public from the known carcinogens contained in environmental tobacco smoke. The Bill does not prohibit people from smoking, other than in certain defined no-smoking premises, and is therefore a proportionate action which balances the rights of smokers to continue smoking if they wish to do so whilst protecting the health of others.

185. In particular, the Regulation of Care provisions of the Bill will improve the transparency of the Regulation of Care (Scotland) Act 2001 and will secure the rights of individuals and bodies to make representations to the Commission or the Council, as appropriate, and to receive a fair hearing.

186. The provisions of the Bill which amend the Adults with Incapacity (Scotland) Act 2000 will help to reinforce the rights of some of the most vulnerable people in society to receive treatment to which they are entitled or which is appropriate in their circumstances.

Island communities

187. The provisions of the Bill apply equally to all communities in Scotland.

188. The dental services, pharmaceutical care services and joint ventures provisions have the potential to bring real benefit to communities in remote and rural locations. New powers for Health Boards to provide assistance and support for dental services will assist Health Boards to make provision for dental services where demand is underserved. The pharmaceutical care service provisions are, in part, targeted specifically at improving the quality and range of the services that are available. The joint ventures provisions create a new option for provision of premises to deliver public services and offers strong opportunities for close co-operation between Health Boards and Councils in these areas to work together.

Local government

189. The Executive is satisfied that the provisions in the Bill will have no impact on local government other than in the following areas.

190. For the smoking in public places provisions, options are currently being explored on enforcement of the regulations. Ministers will discuss with the Convention of Scottish Local Authorities (CoSLA) the practicalities of enforcement.

191. The lead on implementing the regulation of care legislation will fall to the Scottish Commission for the Regulation of Care and the Scottish Social Services Council with central support and guidance provided by the Executive. However, local authorities (and other employers of social services workers) will benefit from improved clarity in how the Codes of
Practice should be regarded. In addition, there will be a regularisation of the payments made by local authorities to child care agencies and housing support services.

192. The ability to enter into joint ventures should help promote greater co-operation between healthcare professionals, local authorities and private developers in the delivery of modern community based healthcare facilities. This could help local authorities in their wider activities, for example in terms of urban regeneration.

**Sustainable development**

193. *Meeting the Needs....* describes how building a national effort to improve health, reducing inequalities in health and making the NHS a ‘national health service’ and not a ‘national illness service’, is an integral part of sustainable development. The Executive has made clear that efforts to promote health, alongside programmes on social justice, crime and transport, are central to sustainable development.

194. Central to measures to improve the nation’s health are the provisions in the Bill for the prohibition of smoking in public places. The Executive is also emphasising the need for proactive planning and use of resources in identifying and meeting the needs for the delivery of pharmaceutical care and dental services across the country through this Bill.

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ANNEX

GLOSSARY

BDA British Dental Association
CDS Community Dental Service
CoSLA Convention of Scottish Local Authorities
CSO Scottish Executive Chief Scientist Office
ETS Environmental Tobacco Smoke
GDP General Dental Practitioner
GDS General Dental Services
GMS General Medical Services
GOS General Ophthalmic Services
GP General Practitioner
IHC Independent Healthcare Services
LIFT Local Improvement Finance Trust
NAP National Appeal Panel
NDPB Non-department public body
NHS National Health Service
NSS NHS National Services Scotland
OFT Office of Fair Trading
OMP Ophthalmic Medical Practitioners
PCS Pharmaceutical Care Services
PDS Personal Dental Services
PFMR Policy and Financial Management Review
PSD Practitioner Services Division (part of NSS)
R&D Research and Development
RoC Regulation of Care
SCOTH Scientific Committee on Tobacco and Health
SDR Statement of Dental Remuneration
SHERT Scottish Hospital Endowment Research Trust
SHIL Scottish Health Innovations Ltd
SME Small to Medium Sized Enterprise
SPGC Scottish Pharmaceutical General Council

1978 Act National Health Service (Scotland) Act 1978
1995 Regulations National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995
GDS Regulations National Health Service (General Dental Services) (Scotland) Regulations 1996
2000 Act Adults with Incapacity (Scotland) Act 2000
2001 Act Regulation of Care (Scotland) Act 2001