HEALTH COMMITTEE

Tuesday 6 February 2007

Session 2

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HEALTH COMMITTEE
2nd Meeting 2007, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Dave Petrie (Highlands and Islands) (Con)
Margaret Smith (Edinburgh West) (LD)
Stewart Stevenson (Banff and Buchan) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Stewart Maxwell (West of Scotland) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Professor Jon Ayres (University of Aberdeen)
Mary Cuthbert (Scottish Executive Health Department)
Dr Laurence Gruer (NHS Health Scotland)
Mr Andy Kerr (Minister for Health and Community Care)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 6 February 2007

[THE CONVENER *opened the meeting at 14:00*]

Smoking Ban (Public Health Impacts)

The Convener (Roseanna Cunningham): I bring the meeting to order. No apologies have been received, although one member is running a little late; they will join us as soon as possible.

Item 1 on the agenda is the impact of the smoking ban on public health. What we are doing today is a small amount of post-legislative scrutiny. The legislation that introduced the smoking ban was probably one of the biggest pieces of legislation passed by the Parliament this session; it was certainly the biggest piece of legislation that the committee has had to deal with this session.

We will hear evidence from Professor Jon Ayres, who is head of the department of environmental and occupational medicine at the University of Aberdeen. We will then hear from Dr Laurence Gruer, director of public health science at NHS Health Scotland. The minister will join us at about 3 pm. We are also joined by Stewart Maxwell MSP, who I shall bring in on any questioning once committee members have had an opportunity to ask questions. That is normal practice on the Health Committee.

It is early in the process to be undertaking post-legislative scrutiny, because most of the findings of the commissioned research have yet to be published, but we thought that it would be useful to get an interim report before this session of Parliament comes to a close. One of the few pieces of research that has been published is the study on the health of bar workers by Professor Ayres at the University of Aberdeen.

This afternoon's session is specifically on the issue of impacts on health. I know that members might be interested in a great many other areas, including the economic and social impacts, which are not necessarily directly to do with health. I ask members not to allow themselves to stray into questions about private clubs, noise nuisance outside pubs and so on, because our witnesses today are not really in a position to answer questions on those areas.

I welcome Professor Ayres to the meeting. A summary of his study is included in the committee papers. I ask him to make a short opening statement of no more than about four minutes, after which we will move to questions.

Professor Jon Ayres (University of Aberdeen): Thank you for asking me to give evidence.

Our study, which is one of a range of studies sponsored by NHS Health Scotland, considered 370-odd bar workers in Aberdeen, Aberdeenshire, the Borders, Edinburgh and Glasgow, to give a full spread of urban and rural communities with different socioeconomic strata. The aim has been to measure the respiratory and general health of those bar workers at about this time last year, before the ban; two to three months after the ban; and again around now. We are completing our final bits of health data at the moment. That is why we do not have health data to show the committee—we need them to account for the seasonality effect.

What we have shown, however, is that in 41 of the bars that we went into, there has been a rather dramatic fall in levels of particles in the air. We have used as our measure of particles $PM_{2.5}$—PM being particulate matter and 2.5 being 2.5 micrometres in diameter. A micrometer is one millionth of a metre, to give you an idea of how small it is. $PM_{2.5}$ particulates are respirable—they get down into the respiratory tract—and they are one of the best measures of second-hand smoke. What we showed was an 86 per cent fall from a baseline of about 250 micrograms per cubic metre—that is, micrograms per cubic metre of air. We can compare that to a $PM_{2.5}$ outside this building today of about 15 micrograms per cubic metre. Post-ban, the levels fell to about 20 micrograms per cubic metre. Apart from environmental tobacco smoke, there are of course other contributors to indoor smoke, such as outdoor air pollution that gets inside and dust that is disturbed as people walk around.

Many of the levels that we found before the ban were way above the levels in air quality standards in the United States that are regarded as a serious threat to health. The average level is now down to 20 micrograms per cubic metre, which is similar to the level in outdoor air pollution. The data are comparable to those that were found in other places where similar legislation has been instituted, such as parts of the United States and, notably, Ireland. Those places have found improvements in health outcomes to match the improvements in air quality. However, to find out about the health effects here, we will have to wait until later in the year, when the full health data will be available to us.

The Convener: To clarify, are you saying that not all particulate matter is cigarette related and that there will never be a figure of zero, apart from in a sterile environment?

Professor Ayres: That is absolutely right.

Mrs Nanette Milne (North East Scotland) (Con): My question follows on from that. Were the pubs that you visited before the ban ventilated?

Professor Ayres: Some were and some were not—there was a range. The highest concentration was nearly 1,000 micrograms per cubic metre, which is huge, and the lowest was 8 micrograms per cubic metre, which, as the convener suggested, is about as low as possible. The pubs that had lower baseline levels had a smaller percentage reduction. The average reduction of 86 per cent means that some—well, half of them—had greater reductions, because the levels were falling from a greater height.

Kate Maclean (Dundee West) (Lab): In the post-ban visits, the level of micrograms per cubic metre ranged from 6 to 104. What accounts for that difference?

Professor Ayres: That is a good question. The higher levels may be due partly to non-compliance in some areas and partly to the siting of the bars. For instance, if a bar is on a busy road, there may be entrainment of particles from outside. There are other issues. For example, cooking in a bar might result in fugitive cooking fumes and, I have to say, some bars are just very dirty and when one tramples around in them one disturbs a lot of dust.

The Convener: So anything from a toastie machine to a microwave could contribute to the level of particulate matter.

Professor Ayres: Yes, although less so with microwaves. The issue is usually with machines such as panini heaters, which open up.

The Convener: So those all contribute. If there are two or three such machines on the go behind a bar, the level of particulate matter will likely increase.

Professor Ayres: Absolutely. Other factors are involved, such as the size of the room, the height of the ceiling and the presence of ventilation.

The Convener: Even the number of doors would be relevant.

Professor Ayres: For sure.

Euan Robson (Roxburgh and Berwickshire) (LD): Did you adjust the results of the research to take into account the number of people who were in the bars when the measurements were taken? I presume that different readings would be obtained if there were a lot or a few people in a bar.

Professor Ayres: Absolutely. Covertly, we assessed the number of smokers in the bars. Our measurements were done as covertly as possible.

The Convener: How did you do that?

Professor Ayres: Our machine is not huge. We had the agreement of the bar managers to carry out the measurements, but we were concerned that if everybody knew that we were measuring the number of smokers and the amount of particles in the air, people would modify their behaviour. For example, some bar managers might have turned off the ventilation or some might have turned it on, depending on their views of the proposed legislation, and other individuals might have behaved differently. That is why we worked covertly. That is an interesting methodological issue that raises scientific issues.

We will be able to sub-analyse the data to account for source strength, to use the jargon—in other words, how many people were puffing away.

The Convener: Okay. Are the results that you have got so far pretty much what you expected, or did you set out with no preconceived notions of what would happen?

Professor Ayres: We knew what had happened in the United States. As we were conducting our study, the data from Dublin were published, so we knew roughly where we were going. Our results are in that ball park. Although the change in level is remarkable, it is pretty uniform.

There is a range of reduction. Some pubs had lower levels of environmental tobacco smoke to start with, but others will have seen a big percentage improvement, which means that there has been a huge reduction in absolute exposure—as opposed to a percentage reduction. We should be able to match those reductions to measurable changes in health. We might be able to look for what is called a dose-response effect—in other words, do the people who have experienced the greater improvement in air quality show the greater improvement in health? That has not been done previously, but the size of our study—it is the largest study of its type that has been conducted to date—

The Convener: In the world?

Professor Ayres: Yes.

The size of our study will enable us to pick out that information and we may be able to use it to inform studies that are planned for the English ban.

Helen Eadie (Dunfermline East) (Lab): What collaboration are you involved in with other universities around the world? Is there anything notable that you would like to share with us, arising from work that might be being done elsewhere? Also, is there anything that you would like to be doing but cannot do—either because of funding constraints or because of other practicalities—on quality issues around the research?

The Convener: You have just asked him whether he thinks that he has enough money to do his research. I am almost sure that the answer will be no.

Professor Ayres: Got it in one.

Helen Eadie: I asked him to be specific, though.

Professor Ayres: In terms of collaboration, we have kept close tabs on the folk in Dublin. We worked up our study design learning from some of the things that they did and said that they would do again. In the same way, we are feeding the results of our study to those who are working on the Welsh ban. Sean Semple, my occupational hygienist, who has been doing a lot of the work here, is advising the Welsh on their ban. Also, we are in discussions with the Department of Health down south about the English ban. We think that we are improving the methodology.

The English ban will come into force in July, not in March, so there will be a different pattern of seasonality. Seasonality is a real issue. If people's chestiness in January and February is compared with their chestiness in May and June, you can bet your bottom dollar that they will be more chesty in January and February than they are in May and June. That is why we are doing our one-year post-baseline assessment now. That is not to say that the information from May and June is wrong; it just means that we must learn how to interpret the data.

As well as our involvement with the folk in Dublin, we have had some discussion—although less—with folk in the United States. I will probably know more about what we would like to do once we have analysed the health data. I have lots of ideas, but once we have started to unpick the health data there will be lots of scientific questions that we will want to ask, some of which may be relevant to policy but many of which will not. That data will at least give us some information on how the body—especially the lungs—responds to an adverse exposure such as exposure to environmental tobacco smoke.

You are correct about the bottom line: we need lots of money.

The Convener: Strange, that.

Am I right in saying that the English ban will not be as extensive as the Scottish ban?

Professor Ayres: That is correct.

The Convener: So, the research that you undertake will also be a useful comparator for any subsequent research that is done on the English ban.

Professor Ayres: Absolutely. There are lots of other issues. In England, they are much exercised by ethnicity as an issue. There are certain establishments—

The Convener: Cafes and things.

Professor Ayres: Yes, and smoking houses, where smoking is positively encouraged. One has almost to eat one's way through the air to get in.

The issues that arise seem to be social and cultural. People in England are concerned about such issues, and we have not had that experience here.

14:15

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I know that you have not yet analysed the data for salivary cotinine, but will you divide them between bar staff who have never smoked and people who smoke but who might not be able to smoke at work and who may smoke more cigarettes when they are not working?

Professor Ayres: I will explain what salivary cotinine is. Cotinine is a breakdown product of nicotine that we can measure in saliva. It is quite a good index of smoking activity, but it can also pick up passive smoke exposure, although it does so less effectively. It is a marker of a person having smoked cigarettes in the past 24 to 48 hours. If people have smoked in the past 24 to 48 hours, salivary cotinine will reflect that.

We are dividing the data on salivary cotinine between non-smokers, smokers and people who have changed their habits as a result of the ban—perhaps that is going a bit far; I mean people who changed their smoking habits after the ban. We can create several sub-groups. That is one issue that we were concerned about. We needed to study fairly large numbers to unpick that, but we will be able to do so.

Dr Turner: Will the data be similar to those that are being collected in New York and other places? Have people elsewhere split the data in the same way, so that you can make comparisons?

Professor Ayres: We will operate similarly. I would have to refresh my memory on exactly how the Americans operated in New York and California; my memory is that they operated differently in each site. We are aware of the different combinations and permutations. The assay is fairly straightforward.

Mrs Milne: Do you plan to do repeated seasonal follow-up? There was quite a lot of viral infection around over Christmas and the new year and I presume that that varies from year to year. Will you cover several years?

Professor Ayres: We did not plan to do so, but that is a good point. As I am sure many will bear witness to, January has been pretty grim from a respiratory point of view, because one or two pretty violent bugs have gone around. We might

find that that compounds the issue—we will just have to wait and see.

There may well be merit in following the bar staff. However, one must bear it in mind that such staff are—how shall I put it?—often transient. For example, students do such work as an extra job, although a core group of permanent bar staff exists. We lost a percentage of people at the initial follow-up and we are losing more one year on. We expected that, which is why we picked the sample size that we did. However, we may be reaching the core group, which could be followed year on year. We had not thought that we would do such follow-ups, but the point will be important to consider once we have analysed the health data.

The Convener: What is the timescale for producing what might turn out to be the first year's study? I leave aside any potential follow-up years, but you must publish the health data from the first year.

Professor Ayres: We are doing pretty well on our one-year data collection. I reckon that, with a bit of luck, we should be finished in early March.

The Convener: When will you publish?

Professor Ayres: Data analysis will take two to three months. As the committee well knows, the data will be available, but the question is publishing them. Some journal editors will not publish data that have got out into a wider forum first. Those issues are sensitive.

Nevertheless, our approach is that we know that the data are important and that some journal editors will be prepared to push through the peer-review process quickly papers that have been submitted, so that they are not delayed. Dr Gruer might tell the committee about the meeting that is planned for September. That meeting will bring together the results of all the studies, so we hope to have papers accepted or at least in press by September, when we will present the data.

The Convener: So we are talking about autumn or early winter before that information comes into the public domain.

Professor Ayres: The meeting will be in September, so the data will effectively be in the public domain then. We hope—although one can never be sure—that we might have the information in published form by then.

The Convener: Our successor committee will find that helpful.

Euan Robson: I note the figure of 371 bar workers in the study. Roughly what percentage is that of the total number of bar workers? Is it 1, 2 or 3 per cent, perhaps?

Professor Ayres: I cannot give you a genuine answer to that, but it is less than 5 per cent.

Helen Eadie: I do not know whether you will have seen the *Journal of Public Health* article that was included in our papers, but it makes a point about a dramatic reduction in the incidence of coronary heart disease, which was certainly one of the hopes of politicians in Scotland. The article states:

> "An analysis of routine hospital admission data from Helena, Montana found a dramatic reduction in the incidence of acute myocardial infarction following the introduction of smoke-free legislation."

Do you know about that analysis? Would you like to comment on that point? Has similar evidence begun to grow in Scotland?

Professor Ayres: I dare say that Dr Gruer will tell you about on-going studies that are looking into precisely that point. The paper from the United States to which you refer is important. In a way, it is surprising. Those of us who are involved in this area were not expecting the evidence of health benefits that has been coming through from the States and Ireland. It really is a good-news story, it seems to me. We shall see—we will find out in September.

The Convener: Stewart Maxwell introduced the original bill in this area. His member's bill, the Prohibition of Smoking in Regulated Areas (Scotland) Bill, was somewhat overtaken by events.

Mr Stewart Maxwell (West of Scotland) (SNP): In many ways, I was very pleased that it ended up where it did.

Some people have claimed that other factors pollute the workplace, so it is difficult to tell how much improvement is down to the smoking ban. I presume that you would say that those other factors would be the same before and after the ban—I am referring to the number of panini bought, the concentration of traffic or whatever.

Professor Ayres: That is absolutely right. Such situations are very interesting, because they are what we might call natural experiments. If you were to tell me to design an experiment or study to show the effects of a reduction in smoking, I would almost certainly not have designed it in the way that Parliament has done, but thank you very much. Natural experiments are terribly important, and one has to take advantage of them. NHS Health Scotland has done very well in taking advantage of the ban, through a collection of studies.

As you rightly point out, just one thing is changing: the contribution of cigarette smoke to indoor air quality. Everything else is effectively staying the same. The only other thing that changed between January-February 2006 and May-June 2006 was, of course, the weather. Things change with the weather—that is the seasonality issue.

However, in another natural experiment, there was a dramatic fall in the amount of particles in the outdoor air when coal was no longer sold in Dublin. That had a beneficial effect on deaths from cardiovascular disease and total mortality. The same thing happened in Hong Kong. There are issues around other confounding factors but, in general, you are right to say that this is about exposure to a single factor. There has been a big change, and such a dramatic fall is reassuring. If, say, we had shown only a 20 per cent fall, things would have been made much more difficult.

Mr Maxwell: Are you saying that we can be sure that the results are because of the ban?

Professor Ayres: More and more studies are being carried out now. If we come up with the same answer as Dublin, California or New York city, it adds to the believability of the result.

Mr Maxwell: You visited 41 bars on 53 occasions. Can you explain why you did that?

The Convener: Did it depend on how good the beer was?

Professor Ayres: We wanted to visit all the bars if we could but there are research issues about lone working, and two of the workers who were going into the pubs quite rightly said, "I am not going to go into that pub and sit there for an hour measuring levels." That was absolutely right and proper—a few pubs were like that.

Some pubs were measured only during quiet times—Monday to Thursday before 5 o'clock. We measured some during busy times—Thursday to Saturday after 5 o'clock. Some bars were measured twice: once during a quiet time and once during a busy time. That explains why the numbers do not add up.

Mr Maxwell: It is huge fall, obviously. Did any of the bars show no fall at all or was there consistency?

Professor Ayres: There was only one bar where the fall was under 50 per cent. The rest all showed falls that were greater than that.

Mr Maxwell: You mentioned the $PM_{2.5}$ concentration. After the ban, the levels were between 6 and 104, and the average was 20. My maths is not great but, given the average, I assume that the vast majority of the bars were at the low end of the scale. Is there a range of bars above the average of 20? Is there an even spread between 6 and 104 or are one or two at the top end, skewing the figures?

Professor Ayres: There is a really good spread. If you like, I can show you a diagram that will explain that quite nicely, but it would be difficult to do so without a projector.

Kate Maclean: I am looking for clarification following Stewart Maxwell's first question about other factors. How do you know that there were no changes in those other factors? After the smoking ban, when the smell of smoke went away from the pubs, other smells started to emerge. Perhaps pub managers cleaned their premises more often or more food was eaten—there might be more particulates in the air because more panini are being cooked. Did you clarify that there were no changes in relation to such factors?

Professor Ayres: Of course, the particle levels would be pushed in the opposite direction if there was an increase in panini cooking, so there would have been less of a fall. We did not formally count the number of panini cooked or anything like that, but—

Kate Maclean: Cleaning would send the levels in the opposite direction.

Professor Ayres: All we got on cleaning was a rather subjective view from the researcher about whether things were different, but we did not ask the pubs specifically about their cleaning regimes. Personally, I do not think that that is a big issue.

The Convener: Thank you, Professor Ayres. That was quite interesting, and we have an indication of the timescale so that our successor committee can request a repeat visit.

Dr Laurence Gruer is director of public health at NHS Health Scotland. He is responsible for managing the evaluation of the smoking ban on behalf of the Executive, and he chaired the Scottish Executive's working group on smoking prevention, which published a report in November 2006 called "Towards a future without tobacco". A copy of the summary and recommendations is included in the committee papers, which committee members have, but it is also on the website for anyone else who wants to look at them.

I invite Dr Gruer to make a brief opening statement of about four minutes, after which we will go straight to questions.

14:30

Dr Laurence Gruer (NHS Health Scotland): First, I will talk about the studies that have been carried out to evaluate the smoking ban. NHS Health Scotland has been co-ordinating those studies, and I pay particular tribute to Sally Haw, our principal adviser, who has masterminded and co-ordinated the whole programme. I also thank the Scottish Executive, which has played a major part in enabling the work to be carried out.

A large part of the information that I will give you is carried in an article in the *Journal of Public Health*, of which I think you all have a copy. The evaluation examines the impact of the ban on eight different outcomes, of which six are directly

related to health. I will talk about those six, which are: attitudes towards exposure to environmental tobacco smoke; actual exposure to environmental tobacco smoke; whether there has been a change in the smoking culture in Scotland; whether there has been a change in the levels of smoking in the population and the amount of tobacco consumed in Scotland; the impact on tobacco-related illness and mortality that might or might not have occurred; and whether there has been an impact on health inequalities.

We have used two types of data to carry out the work. One is what we call routinely collected health data, which we get anyway, on admissions to hospital for coronary heart disease and asthma, and deaths due to coronary heart disease. We have looked at primary care data on people with symptoms of coronary heart disease, chronic obstructive pulmonary disease and asthma. We have also received routine data on smoking prevalence in Scotland. We have collected new data from seven distinct research studies, which I can talk about in more detail if the committee wishes. A large part of our ability to determine the impact of the ban will come from those seven studies, which all use a before-and-after design.

Data were collected rapidly between the legislation being passed and the ban being introduced before the end of March last year, and data have been collected since then. Given the seasonality that Professor Ayres talked about, some of the crucial data are being collected only now, to enable us to compare the same periods before and after the ban. Partly for that reason, apart from the work that we have already had from Professor Ayres, one or two pieces of the health work will be placed in the public domain in May at the earliest. The intention is to try to publish all the data that we can on the first year of the ban in September, before the international conference that we are organising in Edinburgh on 10 and 11 September. We also hope that we will be able to publish many of the papers in reputable journals at about the same time. It is our intention to have the climax of the unique set of studies in September.

The Convener: As I indicated, we want to confine the discussion to what we know so far about the impact of the ban on public health. I appreciate that you might find it difficult to answer on certain aspects because of the limitations of the research.

Dr Turner: We have heard a bit about the impact on bar staff. In the evidence that we took I was interested in the worry that cutting down on smoking in certain places might increase it at home, thereby exposing children to an environment in which they inhale more smoke. In addition, young people seem to smoke in relation to drugs. I noticed in the summary of commissioned research in the *Journal of Public Health* article that the first study is called changes in child exposure to environmental tobacco smoke. How are you doing that study and is any other work in the offing that might establish whether children are being exposed to more tobacco smoke?

Dr Gruer: The childhood exposure study is using two samples of children at the primary 7 level in a sample of schools around the country. About 2,500 children are in the study, which is roughly 5 per cent of all Scottish kids at that level. The first part was done about a year ago and the second part is being done now. In both instances the children are asked to complete a questionnaire about their own smoking and their impressions and experiences of the smoke that they are exposed to, both at home and in other places. They are also asked to provide a saliva sample so that we can determine the cotinine level, to which Professor Ayres referred. That is a much more objective indicator of whether they have smoked and the extent to which they are exposed to tobacco smoke in the environment.

The children in the two samples are different. The aim is to get children of the same age in the two samples, so we will compare two different groups of children but the sample size should be sufficiently big to enable us to ascertain whether there is a statistically significant change in the exposure to tobacco smoke between the two groups. Given the sample size, we should be able to ascertain from what they say whether there is any real difference in the exposure to smoke in the home and whether there is any objective evidence for that in the cotinine levels that are found in the saliva samples.

The Convener: Just to clarify, you are not following the same cohort.

Dr Gruer: No, the two samples are different. The problem with following the same cohort is that the kids would be of a different age and would have gone into secondary school, where it is potentially more difficult to follow them up, resulting in lower response rates. There is also the confounding factor that kids start smoking a lot more in secondary school, and they may be exposed to different levels of smoke. We therefore opted to compare two different groups, but at the same stage and from the same parts of the country.

Helen Eadie: Are you comfortable that the appropriate statistical framework—in other words, benchmarking—was in place at the beginning to give us all the basic and sound information that we need to properly analyse and evaluate the information that will arise from the studies that are mentioned in the *Journal of Public Health* article? I notice that the aim is to ensure that the analysis

"will focus on trends in consultations for CHD, chronic obstructive pulmonary disease (COPD) and asthma."

Are you confident that when we come to the evaluation the basic information will enable there to be a good analysis?

Dr Gruer: Yes. One of the strengths of the work in Scotland is that we were able to collect a large amount of data. We are generally pleased with the quality of the data that were collected before the ban. With the range of studies that we are carrying out we should be in a good position to make strong comparisons between the situation before the ban and what has happened since. That places us at an advantage over a number of other countries, where the data are not nearly so coherent and there is no clear ability to compare the situations before and after bans.

Aside from the new research studies, Scotland can also benefit from our good routine statistics on hospital admissions and deaths and—to a lesser extent, when it comes to data quality—from primary care information. Those data will give us a good background against which we can put the research studies in context.

Shona Robison (Dundee East) (SNP): Yesterday, I had a meeting with a pharmacist from Dundee who is involved in the smoking cessation programme, and we discussed those who came forward for that programme in the immediate aftermath of the smoking ban. Her anecdotal evidence was that a high number of young women came forward. How does that anecdotal evidence fit with the report by the smoking prevention working group, which seems to say that the pilot smoking cessation services for young people in Scotland have had poor outcomes? The pharmacist was talking about the 16-to-30 age group of young women. I was pleasantly surprised by what she said, but is it consistent with the findings that you have come across? Do you have such a level of information?

Dr Gruer: The studies on smoking cessation services for young people have largely focused on teenagers, and the results have been disappointing. A relatively small number of young people came forward for the studies—indeed, I think that only seven came forward throughout the country. Of those, only a small number successfully managed to quit smoking during the time of the studies, which reflects the general finding that, for various reasons, teenagers have great difficulty in giving up cigarettes. Many teenagers are seriously addicted to them, and by the time that many of them start to think about giving them up they are not interested in doing so, as they do not see giving them up as a major issue. That important problem has not been cracked. How can we stop young people becoming serious long-term smokers once they have become addicted to cigarettes? The evidence suggests that cigarette addiction can develop within only a few weeks or months of starting to smoke—that may particularly be the case for young women.

We would have to look closely at the information that you were given by the pharmacist. The young women may have been in their late twenties. However, it is clear that a disproportionate number of women go to smoking cessation services. In fact, the crucial problem later on is that fewer men succeed in giving up smoking. The data suggest that men suffer more than women do from the effects of cigarette smoke. That is a major issue that contributes to the gulfs in mortality and illness rates between men and women, which are, to a large extent, smoking driven.

The Convener: Can you identify the percentage of smoking cessation service clients who are clients as a result of the smoking ban?

Dr Gruer: I do not think that that is possible.

The Convener: So you cannot draw a conclusion.

Dr Gruer: No, it is too difficult. However, we noticed a sharp increase in the uptake of nicotine replacement therapy through pharmacies in particular in the lead-up to the ban. That uptake climaxed in March last year, but it has fallen sharply since then and the levels are now similar to those for the previous autumn. Therefore, the ban may not have a sustained effect on smoking cessation.

Mrs Milne: Was any consideration given to studying children younger than the primary 7 age group to try to segregate the effects of domestic passive smoking and to determine whether smoking was increasing in the home? That matter concerned me when the bill was going through the Parliament. I am talking about studying children who had not started smoking, as few children of that age would have started. Is there any way of studying that? I do not know how young children can be when they are studied.

14:45

Dr Gruer: There is no way we could study a younger group at the moment. One of the reasons why we chose primary 7 was that probably less than 5 per cent of primary 7 kids are regular smokers, whereas the rates become higher as soon as children get into secondary school. At the same time, we felt that we would be more likely to get good co-operation from the primary 7 group and permission from their parents for them to take part in the study. We felt that primary 7 was the optimum age to get a good result for the research and to deal with some of the issues that you have mentioned.

Mrs Milne: Would it have been possible to follow the same cohort if the study had started when the children were a little bit younger? You say that it is difficult to follow children once they are in secondary school, but nine-year-olds could have been followed at 10 and 11.

Dr Gruer: That is a good point, but other factors made us veer in the direction of primary 7.

Mr Maxwell: The smoking prevention working group's report says:

"new targets should be set for 16-24 year olds".

From the figures that are in front of us it seems that, roughly speaking, the smoking rates in that age group were declining by about 1 per cent a year before the ban. However, the post-ban target is for a 1 per cent reduction in smoking rates per year among that age group. I would have thought that you would set more onerous targets, given the hoped-for effects of the ban, the raising of the legal age for buying tobacco—which might come into force this year and will mean that a smaller group is able to buy tobacco legally—increased enforcement and other measures that might be introduced, such as plain packaging and photographic warnings. I would have expected all that work to lead to a steeper decline in smoking rates for 16 to 24-year-olds, not that the pre-ban and estimated post-ban declines would be roughly the same. Will you explain that?

Dr Gruer: What you say is a possibility. However, in many ways setting targets is more of an art than a science. If we consider California in the United States, we find that the rates of decline might be somewhat steeper than the targets suggest in the first couple of years but that things become more difficult after that. That is because one has to tackle a population with a high proportion of highly addicted people—as we said earlier, it is hard to get young people off cigarettes once they have started—so one begins to get diminishing returns, even if the enforcement is strict and there is strong health education.

In producing the targets, we have sought to be realistic but nevertheless give ourselves something serious to aim for in that we want to see year-on-year declines in the percentage of young people who smoke. I would be extremely pleased if we reached the target for 2020. That would be a major step forward that would bear good comparison with virtually everywhere else in the world.

Mr Maxwell: I understand what you say, but I do not understand your explanation that the group will become tougher and tougher to deal with because you get to a core addicted group. Surely anybody who starts at the bottom end of the age group—16 years old—will be out the other end of it by 2020 so, if the age range that you are measuring is 16 to 24, the target for 2020 will not apply to the same people. It will not be a smaller, core addicted group. New people will come into the group all the time, so the nature of the group that you start with in 1998 will be no different from that of the one that you finish up with in 2020. I would have thought that the ban's cumulative effects on new people coming into that age range would roll on. It is not as if you will measure the smoking rates among 16 to 24-year-old people and move with them as they grow older.

Dr Gruer: That is why they go into a new group. However, the statistics show that, over the past 14 or 15 years, the prevalence of smoking among girls has remained unchanged at about one in four. We have simply not cracked that problem. Far from highlighting a relative decline in smoking rates in the 16 to 24-year-old age group, I am pointing out that there has been no improvement in the group of young people who will come into the older age group in the years to come.

Mr Maxwell: Exactly. I realise that we have not yet seen any improvement in the group that you mentioned—I think that most of the decline in smoking rates is among young men—but surely one purpose not only of the ban but of many of the other recommendations that have been implemented is to crack the problems with that age group. Surely if you were confident that you could do so through all that work, the decline in smoking rates would be steeper post-ban than before the ban came into effect.

Dr Gruer: That might be the case; if so, we would be absolutely delighted. We would, for once, meet our health targets, which would make us feel very good. However, we still need to carry out a huge amount of work to implement our recommendations, a number of which depend not only on what we can do in Scotland but on our ability to persuade people to make changes at United Kingdom and European levels with regard to pricing, clamping down on advertising, images in the media and so on.

The Convener: It seems that social pressures, for example, can lead girls to take up smoking. Notoriously, young women smoke so that they do not have to eat and they are terrified that, if they give it up, they will put on weight. Has any research been carried out on those issues that we could use to get a handle on some of the reasons why it might be harder to tackle the problem of smoking among teenage girls?

Dr Gruer: You are right to suggest that a lot of women smoke to keep their weight down; they also smoke to deal with stress and help them to calm down. A study that was published either last year or at the end of 2005 focused on the issue of smoking and weight. After examining a large number of girls, the researchers concluded that

there was no difference in the weight of smoking and non-smoking girls and suggested that there was a real misconception among girls on this matter. However, we should bear it in mind that, if a regular smoker stops smoking, their weight will shoot up.

The Convener: It is certainly a big disincentive to stop smoking.

Dr Gruer: Indeed, and the girls who try to stop smoking often get caught in a bind.

Euan Robson: I want to ask about the qualitative bar study that involves three communities and the qualitative community study that involves four communities. How many people are involved?

On measuring behaviour, there is reference to reported behaviour and observed behaviour. Given that the interviews were carried out before the ban came in, in full knowledge of what it would do, I presume that you have to separate out what people were doing from what they said they were doing. What is your methodology for separating what people said and what they actually did in advance of the ban?

Dr Gruer: As part of the study, the researchers carry out what is known as participant observation, which involves sitting around in bars—

The Convener: That is some job.

Dr Gruer: Actually, I think that the researchers find it quite difficult, because they are not the sort of people who are used to spending a lot of time in bars. Also, many pubs have a regular clientele, and any newcomer can stick out like a sore thumb. As a result, the researchers have tried to find ways of looking as anonymous as possible.

The Convener: You are drawing wonderful pictures for us.

Dr Gruer: Part of the work is to be present, to assess what the situation was before the ban and to compare it with how people behave after its introduction. The researchers talk to people to gauge their opinions, in so far as that is possible. Unfortunately, I cannot provide members with the number of people who are interviewed. It is relatively small. Studies of this kind tend to involve trying to get a significant amount of information from small groups. We are attempting to cover a range of situations and communities, to get a better cross-section of people's reactions.

Euan Robson: Presumably, the idea is to determine whether the ban per se has been a trigger for people to give up smoking or whether it has just altered their behaviour and they are smoking elsewhere.

Dr Gruer: The study deals with all of those issues. It is probably picking up a variety of reactions. Some people may volunteer the fact that they have tried to stop smoking. Some may not like the ban, whereas others may have found it difficult in winter to have to go outside to smoke. Some people may have reacted to the ban by ceasing to go to the pub. Obviously, we cannot pick them up, because they may be drinking at home instead.

Euan Robson: It would be interesting to find out a little more about the people who have just changed where they smoke, especially if they are now smoking more in front of their family and children than hitherto.

The Convener: The issue might be picked up in the study of children that we discussed earlier.

Euan Robson: I am asking about the methodology that is being used.

Dr Gruer: Our methodology is not very good at doing what the member suggests. However, we expect to get that information from the 1,800 adults who are included in the health education population study. We will ask the smokers among them where they smoked before the ban and where they are smoking now.

Euan Robson: But that issue is not covered by the bar study or the community study.

The Convener: We want to take evidence from the minister in a few minutes, so I ask Jean Turner and Duncan McNeil to make their questions brief. Dr Gruer's answers should also be relatively brief.

Dr Turner: The report of the smoking prevention working group states:

"Among 13 year olds, 48% of smokers had used other drugs in the past month compared with 1% of never smokers. Among current smokers at age 23, the majority have used other drugs in the last year."

There is also a connection between smoking and alcohol. We may not get the number of consistent smokers down until we deal with the other drugs.

The Convener: Let us not go down that road. We are talking about the impact of the anti-smoking legislation. I do not want us to reopen the issue of drug prevention treatments. Although that may be part and parcel of the problem, we cannot encompass it in this afternoon's discussion.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): My question is about displacement and follows on from Euan Robson's point. Critics of the ban may say that people are now smoking at home. Is work being done—or could work be done—on the quality of air in smokers' homes, and could that be developed into some sort of guidance? The key is to raise awareness. Parents who smoke outside, at the back door and when their children are in bed think that they are making a contribution, but they are still polluting the air in

their homes, which can damage their children. If they only have a cigarette late at night, they do not associate that with the smoke in their house. How easily could work be done to enable the non-smoker in a house to win the argument about the damage that smoking in the home is doing to their child?

The Convener: I asked you to keep your question short.

Mr McNeil: You kept me until last.

The Convener: You put your hand up late.

Mr McNeil: The other issue that I want to raise is that of girls' smoking. Did you say that girls become addicted earlier?

Dr Gruer: There is evidence from American studies that, on average, girls become addicted more quickly than boys.

Mr McNeil: You said that in the past 15 years there has been no significant movement in the prevalence of smoking among girls. In that time, prices have gone up tenfold and advertising has been restricted. In other countries that are engaging with that group, is there real innovation that has not been tried and tested here, unlike many of the measures that are discussed in the paper?

15:00

Dr Gruer: It would be difficult to carry out a study of smoking in the home, because the home is a complicated place. There is a real risk that, once we started to measure the amount of smoke—which could be done in the same way as in bars—people would behave differently, because they would know that they were being measured. We cannot measure the amount of smoke surreptitiously.

The Convener: Do not put ideas into people's heads.

Dr Gruer: It is a nice idea in theory, but it would be hard to put into practice.

The Convener: So it will always be difficult to measure the amount of smoke in people's homes.

Dr Gruer: Duncan McNeil raised the issue of innovation. I am not aware that any country has had great success in tackling girls' smoking, but we are always open to new ideas. If there is evidence that something works, we are keen to try it in Scotland. We want to be at the forefront of attacking this massive problem.

The Convener: Thank you, Dr Gruer. I will suspend the meeting for five minutes while we get the minister and his officials in. We will reconvene at 15:06.

15:01

Meeting suspended.

15:05

On resuming—

The Convener: We are all here, so we will restart the meeting a little earlier than I said. To conclude the session, I welcome the Minister for Health and Community Care, who is accompanied by Mary Cuthbert from the Scottish Executive Health Department. I invite the minister to make a short opening statement of no more than eight minutes. Thereafter, we will have questions from members.

The Minister for Health and Community Care (Mr Andy Kerr): Thank you. I have listened with interest to the proceedings for the past hour or so. I am delighted to reflect on the implementation of the smoking elements of the Smoking, Health and Social Care (Scotland) Act 2005. As I said when it was passed, it is undeniably the most important piece of public health legislation for a generation.

One of the founding principles of the national health service, back in 1948, was the desire to improve the health of the Scottish population. I believe that that is what we are about, although we sometimes forget that, given the daily rigours and demands of the job. The NHS is about running the health service, but it is also about national health, and I strongly believe that that is what the legislation is about—national health. "Delivering for Health" shifts the balance of care and the way in which we approach health in Scotland. Given the toll that smoking takes on Scotland's health, the early indications are that the successful introduction of the law banning smoking in public places on 26 March 2006 has been a major step towards achieving that shift.

Looking ahead—others have reflected on this today—the increased emphasis that we are placing on smoking prevention, including our intention, subject to consultation, to raise the age at which tobacco can be purchased from 16 to 18, will continue that shift in our approach to public health in Scotland. As has been said in previous conversations, it is a win-win situation for the people of Scotland. Even a small drop in the incidence of smoking in a health board area—say, 1 to 2 per cent—has a marked effect on hospital admissions and premature deaths. I therefore view the legislation on smoking as positive in all ways.

As others have said today, it is too early to say precisely what the health and economic impacts of the new law on smoke-free areas have been. The research and evaluation programme that has been put in place to assess the expected short-term, intermediate and long-term outcomes of the legislation is widely regarded as one of the most

complex and comprehensive of its kind. That reflects my ambition when the act was introduced. I felt that, as we learned from other parts of the world, it was incumbent on Scotland to contribute to the wealth of international data on laws on smoke-free areas. From what I have heard today and from the comprehensive understanding of it, I am very pleased with the research programme to date.

As Dr Gruer explained, using routine health, behavioural and economic data as well as commissioned research, we will assess the impact of the legislation in eight key outcome areas: knowledge and attitudes; environmental tobacco smoke exposure; compliance; culture; smoking prevalence and tobacco consumption; tobacco-related morbidity and mortality; economic impacts on the hospitality sector; and health inequalities. Understandably, there will be keen interest in the findings of that assessment, which will become available throughout the year, as you have heard, and will be showcased at a major international conference in Edinburgh in September.

Although it may be too early to look for hard data, it is appropriate to reflect on what we know already. First and foremost, I have no hesitation in saying that the introduction of the smoking ban, under the 2005 act, has been extremely successful. It is also satisfying to note that—as in so many other ways—we are leading the UK in health policy. We have also led the way in smoking cessation. The implementation of the legislation has been smooth, compliance levels have been high and the public support for the ban has been extremely positive. There were people who said that we would have civil unrest, that the ban would not work and that it would create widespread problems—the committee heard from them at the time—but I am pleased to say that that has not been the case. I believe that credit for the success of the legislation—which has been embraced by smokers and non-smokers alike—should go to the Scottish people.

Let us reflect on what we know. Compliance levels are high—returns from local authorities throughout Scotland reveal that almost 53,000 inspections were carried out between March and September and that 98 per cent of the premises that were inspected were found to be compliant. Compliance was even higher—99 per cent—in the licensed and hospitality sector. As for fixed-penalty notices, 210 have been issued to individuals and 11 to premises for failure to comply. There have been two prosecutions, one in Aberdeen and the other in Falkirk.

It has been suggested in the media that the comparatively small number of fines and prosecutions means that the Executive is not getting value for money from local authority enforcement. However, I take the opposite view. To my mind, it demonstrates that the Scottish environmental health profession has excelled itself. Through its compliance-building exercise, it has helped businesses to comply with the law and, as we wanted, has not been heavy handed about implementation.

We know that public opinion is on our side. I have not yet met anyone who would like us to turn the clock back to before 26 March 2006. There is anecdotal evidence of folk who have been down south on business or on holiday, who notice the difference when they come back and say what a pleasure it is to be back in a country that has anti-smoking legislation. A poll by Cancer Research UK showed that 84 per cent of Scots between the ages of 18 and 24 think that a smoke-free Scotland is something to be proud of.

We have had early indications that significant health benefits will flow from the ban. Although it is too early to be precise about what those benefits will be, many people have used the ban as an incentive to stop smoking. Anecdotal evidence suggests that in the three months leading up to the ban's introduction, there was an increase of roughly 40 per cent in the number of people who sought support from smoking cessation services. Moreover, there was a threefold increase in the number of calls to smokeline, a significant increase in nicotine replacement therapy sales and a decline in cigarette sales. Imperial Tobacco's figures show that there was a 5 per cent drop in sales at time of the ban and that sales continue to be between 2 and 3 per cent down.

The national smoking cessation management information system, to which all NHS boards will contribute, was set up in 2005 to track smoking cessation activity. As with any new database, it will take time for ISD Scotland to be confident about the robustness of the data, but I understand that it expects shortly to be in a position to publish an analysis of the data held.

A study by the University of Dundee has shown that, within just two months of the ban's introduction, there was a significant reduction in the respiratory problems experienced by bar workers and the committee has already heard from the good Professor Ayres about the qualitative bar study, which is part of the official monitoring and evaluation exercise.

We know that there have not been widespread closures in the licensed trade. The figures remain positive in what is a fluid industry. Some businesses might be being affected more than others, but so far there is nothing to suggest that the smoking ban will create long-term economic problems for the sector. Indeed, some pub companies have said that the ban has had no significant impact on sales, while others have

reported growth in the number of new customers and in food sales. We are tracking that closely.

We know that some issues have arisen to do with the practical application of the new law, such as increased noise and littering. However, no insurmountable problems have been created, and across the piece the picture is highly positive.

I turn to the future prevention of tobacco use. In addition to the law banning smoking in public places, we have a network of smoking cessation services throughout Scotland to help people to quit, which are receiving record levels of funding from the Executive, but we now need to up the ante on smoking prevention. As has been mentioned, although the number of teenagers between the ages of 13 and 15 who smoke is falling, the situation is still unacceptable, especially given that there has been very little decline in smoking among 15-year-old girls, almost a quarter of whom are regular smokers. That has implications not only for their own health, but for that of any children they might have.

We need to take bold steps. As Laurence Gruer said, the smoking prevention working group has identified a range of measures that must be taken. As the committee knows, we are consulting on the group's recommendations with a view to developing an action plan for consideration by the new Administration. One of the group's key recommendations was that the age at which tobacco can be purchased should be raised from 16 to 18 as part of a comprehensive smoking prevention strategy. We are minded to accept that recommendation and, subject to the outcome of the consultations that are taking place, we propose to lay an order before the Parliament before dissolution.

It is early days, but I think that the Scottish Parliament is to be applauded for its bold decision to legislate on the issue. We have led the way in the UK. The Scottish people should be applauded, too, for embracing the new legislation so confidently and so effectively. I am clear that when the history of the Scottish Parliament is written, the passing of the Smoking, Health and Social Care (Scotland) Act 2005 will be viewed—quite rightly—as a defining moment in devolution.

15:15

The Convener: Thank you, minister. You said a lot about enforcement, the social effects and so on. However, this afternoon, we want to concentrate on the health impacts of the law banning smoking in public places. We are conscious that there are a number of more wide-ranging issues that can be considered, but we are sticking with health today.

Before I invite committee members to indicate whether they want to ask a question, I remind them that, if they are the very last person to put their hand up they will, as night follows day, be the last person to be called.

Mr Kerr: That was a bit scary.

The Convener: Could I get an indication from committee members as to who wishes to speak? The idea is that we will get through all the committee members' questions before we invite Stewart Maxwell to ask his questions.

Dr Turner: The smoking ban has worked well and everyone is proud of their involvement in it. However, there is still a small group of people who are difficult to deal with. Obviously, there will be on-going work by the Scottish Executive to put in money and people to try to help them. How do you think that the Scottish Executive will be able to continue the work with the 13 to 16-year-olds and, perhaps, younger people?

Mr Kerr: First, I point to the comprehensive work that we are doing around our schools in relation to health improvement generally and smoking in particular. That is to be commended. Secondly, we have focused some of our media work around those age groups, which is important. Thirdly, there is an enforcement issue around the way in which young people access tobacco in our shops and communities. We are working on that through the successful pilot project in Fife. So there is a range of initiatives around education, support and encouragement, and enforcement—it is important to ensure that young people cannot get access to tobacco. We are also consulting on raising the age of purchase.

Lastly, I would say that there is a genuine community effort at work. The more smoke-free homes we have, the less of a smoking culture we will have. I was impressed by the project that I saw in the east end of Glasgow, which runs a gold and silver award scheme that recognises parents who decide to have a smoke-free home. That sort of initiative, as well as the work on smoking that football clubs such as Rangers and Celtic are doing, is part of what needs to be done to change the culture around smoking.

Across the piece, initiatives such as those will lead to greater awareness of the health effects of smoking and will create a culture in which our young people are not encouraged to start smoking in the first place. That is important because, as Laurence Gruer said, it is more difficult to break the nicotine addiction of those who were gripped by it early in their lives.

Mary Cuthbert (Scottish Executive Health Department): The smoking prevention working group report is broadly based and has 31 recommendations. The people you are asking about will be helped by comprehensive measures rather than a single measure.

The Convener: Will it be easy to tease out the impact of the ban in respect of the knock-on effect on the amount of smoking in the country, and compare it to the impact of the other measures that might have been in place regardless of whether there was a ban, or will there come a point at which you will simply cease to bother to separate things out and, instead, consider everything as a single picture?

Mr Kerr: I would leave that to the researchers, but I would want to be able to add to our knowledge and understanding of the impact of the ban. Therefore, with regard to the work that we are doing with people in primary 7 and other work that we are doing with young people, we would want to refer to the law banning smoking in public places.

The Convener: You would want to keep that separate, if possible.

Mr Kerr: Yes, if we can do that. However, in relation to all health issues—alcohol, diet, exercise and so on—there are many factors at play in any one person's life with regard to the decisions that they make. Therefore, what we do in our schools is as important as what we do in the media and in enforcing the smoking ban. Nonetheless, I take your point. I want to be able to add to the international evidence base on the impact of a smoking ban.

Janis Hughes (Glasgow Rutherglen) (Lab): You talked about the health impacts of the ban and in your written evidence you mention the increased number of calls to smokeline and the fact that 1 million prescriptions for smoking cessation products were written in March 2006 alone. Perhaps this will be part of the monitoring and evaluation programme, but are you monitoring the efficacy of those prescriptions? I am conscious that a lot of people seek help with smoking cessation but are not successful in following it through.

Mr Kerr: The cessation study should monitor the impact of that. We acknowledge that people might not always achieve a positive outcome the first time they seek such help and we would want to continue to work with them. There are smoking groups where people get together, smoking buddies and volunteer support workers, so it is not just about getting hold of patches or gum, but having people to talk to who share the desire to stop smoking and who can console you when you are low. The combination of therapy, moral support and the work done by our cessation teams in all our communities offers the best chance of success.

There is evidence that, although the smoker who just walks into Boots and buys nicotine replacement therapy products might have a positive outcome, they have a much better chance of giving up smoking if they are part of a smoking cessation group. I had my surgery in Strathaven at the weekend and noticed that, on the wall, there was an offer from NHS Lanarkshire for folk to join the smoking cessation group or club—or whatever it was described as. We have to consider what appropriate support we can provide for people, outwith the simple and straightforward—but nonetheless effective—nicotine replacement therapy.

Euan Robson: I note from your submission that Cancer Research UK's poll found widespread support for the ban among young Scots, which is reflected in my constituency. I have always found it difficult to understand why there is a continuing recruitment of young girls to smoking. I presume that the survey of young Scots that Cancer Research UK produced covered a fair sample of both genders. I have always found it difficult to understand the slight dichotomy that exists. In the consultation on raising to 18 the age at which people can buy cigarettes, have you asked young people whether they can explain that dichotomy and whether they have any views on the recruitment of the next generation of smokers?

Mr Kerr: There are big issues involved in that. Fashion, peer groups and media icons—

The Convener: Kate Moss.

Mr Kerr: Indeed; media icons such as Kate Moss and others influence our young people—positively and negatively. The movies that kids, particularly young girls, are watching and the iconic figures to whom they pay undue attention have an influence on them, which is disturbing. Such figures should be more responsible about how they are seen by the wider public. There is also a peer group issue.

There is also an issue with weight management and the appetite suppressor concept. There are deep issues with self-image and confidence among young people. We are aware of those and are working to try to approach the problem from many different angles.

We are involving young people in our comprehensive consultation on raising the smoking age from 16 to 18, which is right. We will involve in our research the sector of our population for which smoking cessation is a more difficult issue. I do not want to sound like an old fuddy-duddy, but a lot of messages are taken from the media and from iconic figures who are there to set examples, and sometimes those examples are not appropriate.

Euan Robson: In the consultation about increasing the age to 18, can we ask young people themselves to reflect on what you said about the ways in which people are recruited so that we find out whether they validate those observations?

Mr Kerr: We are doing that. We have segmented the consultation on the 16 to 18 issue to include as representative a group as possible of those young people.

Shona Robison: The report of the smoking prevention working group states:

"While raising the age of purchase of tobacco has not been shown to reduce youth smoking rates on its own, it may well do so as part of a comprehensive package of control measures".

I thought that there was some evidence from the Guernsey experience that linked raising the smoking age to falling rates of smoking, or was that more to do with the package of reforms that was introduced?

Mr Kerr: I concede to my expert on the Guernsey experience.

Mary Cuthbert: Guernsey not only increased the smoking age but introduced a package of other measures that affect young people, so it is difficult to isolate the effect of increasing the age. We had a presentation here in the Parliament from those who were involved.

Mr Kerr: If we can give you any other information on that, we will happily supply it.

Mr McNeil: They were certainly confident that the increase in the smoking age and their work with retailers were significant factors in dramatically reducing the number of young smokers.

We heard earlier that the price of cigarettes and tobacco products is a significant factor. You mention that in your submission, where you state that you have written to the UK Government on the matter and you mention EU tobacco taxation. I am worried that, as we increase the price of tobacco, gangsterism and smuggling will increase. Tobacco products are freely available at car boot sales and markets every week. We do not need to write to the UK Government or Europe to tackle that.

Do you agree that, if we are to argue for an increase in the cost of tobacco products, we must tackle the smuggling and gangsterism that happen every week?

Mr Kerr: We certainly recognise the problem. That is part of the work of Laurence Gruer and the team, but we are also taking advice on the matter and I have corresponded with the Treasury on it. There might come a point at which we increase the cost of cigarettes so much that we perhaps drive the community into further illegal activity. We need to be careful about the disincentive around that.

The price of cigarettes is a key determinant of the number of people who smoke. For many of the smoking champions who took part in our adverts in the lead-up to the legislation, a substantial reason for giving up was the increased cost. Price plays, and will continue to play, a significant role in people's access to cigarettes and their willingness to give up.

However, I take your point. There will come a point at which the Treasury-driven customs and excise issues will become important in relation to what happens in the illegal market. I have written to the Chief Secretary to the Treasury about that and I will ensure that we continue to work on the matter in Europe to protect our population.

Mr McNeil: What work is your department doing with HM Revenue and Customs to tackle the enforcement issues with local government, which has a role in relation to markets, and with the police? How can they ensure that there is enforcement now? I hear that it has become more profitable to sell tobacco than marijuana.

15:30

Mr Kerr: Directly, the implementation of policy on those issues is a reserved matter, but we have made known our views—and will continue to do so—about the need to ensure that we get the balance right. We certainly want increased enforcement activity in relation to illegally imported tobacco products. Such products are not always genuine and can contain extremely dangerous products. Normal cigarettes carry 4,000 toxins, but illegal ones can carry other extremely dangerous products if they are made inappropriately.

Mr McNeil: Cannot the police and the local authorities impact on that now?

Mr Kerr: Trading standards officers should be doing so. I am happy to get back to the committee with information on the measures that are being taken on that. However, I have not had direct engagement with the issue as yet.

The Convener: We are all aware of the huge number of enforcement issues that arise as a result of the smoking ban and other aspects of smoking-related policy. Nanette Milne has a question—is it back on to the health issues?

Mrs Milne: Kind of—it is about enforcement as well, as we have got on to that.

The Convener: I do not want to go down the enforcement road. I said specifically to the committee that we are not discussing that. We all have enforcement issues that we could raise. I ask members to desist and stick to the health impacts, because that is what we are meant to be considering.

Mrs Milne: We know that smoking is bad for people and we want to persuade young people not

to start. The minister mentioned work that has been done on that, which I welcome. However, how realistic is the proposal to raise to 18 the age at which people can purchase tobacco, given that we know that people start smoking a lot earlier than age 16? That is where the enforcement issue comes in, in the interests of health.

The Convener: We could consider whether there is a potential measurable impact. When the minister talked about raising the price of cigarettes, it occurred to me that more expensive cigarettes could have a greater impact on teenagers than raising the smoking age, because teenagers probably do not have so much money. However, I may be wrong about that. I am not sure whether the Executive has considered the potential results of raising prices and of raising the age at which people can buy cigarettes.

Mr Kerr: I believe that raising the bar from 16 to 18 will have an effect, although I am not sure whether we will be able to single out what difference it makes. On enforcement, life will become a lot simpler for those who sell cigarettes, as better forms of identification are available for those who are 18 than are available for other ages and those who sell tobacco products will have an easier judgment to make. We have the Young Scot card and standard proof-of-age and identification schemes, which are much more sophisticated at that age. Raising the bar to 18 will exclude younger people, such as 11 to 14-year-olds, and will make age identification easier for licensees and shopkeepers. Therefore, it will reduce smoking and provide a positive health outcome.

On enforcement, I am keen to see the evidence from the test purchasing pilot in Fife, so that we can understand its effects. We need to consider how to deal with shopkeepers who, bluntly, choose to disobey the law and give our children dangerous products. We need to deal with those people more severely.

The Convener: We have not circulated to committee members information on the issues and statistics in relation to enforcement and other matters, such as complaints about noise nuisance, which is why I am trying to steer members away from those issues.

If no other committee member has questions, I will go to Stewart Maxwell, who is meant to be asked to speak once committee members have asked their questions. That is not meant to provoke another forest of hands.

Mr Maxwell: In the debates that we had on the proposed legislation, one great positive of the proposal was said to be that it would contribute to denormalising smoking in society, which was a phrase that arose several times.

Do you think that there is much that the Executive can do on that in relation to films, TV and advertising? Clearly, there is a ban on advertising tobacco products, but many films and TV dramas and programmes use smoking as a prop. Could the Executive do anything about that? I understand that broadcasting is a reserved matter.

The Convener: The minister can answer that but only briefly, because it is rather outwith the scope of what we are meant to be discussing.

Mr Kerr: The UK Government is responsible for those matters, but we have made our views known. The more corrosive dynamic is the lifestyle picture. Film and TV could do much better, but the media's capturing of icons in their normal daily life is more corrosive.

The Convener: It is the picture of Kate Moss with the fag in her hand at the rock festivals.

Mr Kerr: That and many others.

Mr Maxwell: I agree about the iconic figures, and that is why some of us are disappointed by the fact that, for example, Pete Doherty was not fined for smoking on stage in Inverness.

I will move on to cessation services. You mentioned that smokeline had received many more calls in the run-up to March than it had previously—I think that the number was 27,000 between January 2006 and March 2006. Can you tell us how many it has received post-March?

Mr Kerr: Perhaps I can—the figures might be in this pile of papers.

I have a bit of paper that will help us out, including a table that I can forward to the committee. There was a peak period around the ban, with 2,405 calls on 10 February 2006. The figure goes from 2,000 to 3,000 to 3,500 by early March. It starts to reduce at the end of March and then tails off to just over 1,000 by April 2006, and it is now running at about 700 calls a month. I am very happy to share the table of figures with the committee.

The Convener: Could those figures be explained by the publicity surrounding the introduction of the ban?

Mr Kerr: I think that, as well as publicity, it could be explained by people using the ban as a vehicle for a final push to give up. I met so many people—in the strangest of circumstances, I must say—who used the ban as motivation to give up smoking. That relates to the point that many people had the intention to give up, had perhaps tried a couple of times in the past, and used the introduction of the ban as the day to give up. As well as the publicity, that explains the peak in smokeline activity at that time.

Mr Maxwell: The prescribing figures, which the Scottish Parliament information centre has produced, show a big peak around the ban date, but they also show another peak just less than a year earlier, which probably coincides with our stage 2 and 3 debates. I think that the convener is correct that publicity has an impact on those seeking cessation services.

In light of that and the impact on giving-up rates, what detailed plans do you have to keep the momentum going? Clearly, you cannot have that rate all the time. As we can see from the figures, new measures that come to public attention have an impact.

Mr Kerr: I would make a couple of points about that. First, we will want to reflect on all the Gruer group's findings, and as we accept them—or otherwise—we will need to find ways to implement the conclusions. That will produce useful work.

Secondly, NHS Health Scotland, which has produced campaigns that have been borrowed by many around the world, has shown itself to be extremely creative in the mechanisms that it has used to encourage people to give up. It will continue that work as part of its daily activities.

It is a combination of the need to respond to the Gruer group report and the work on public health and smoking that NHS Health Scotland is required to do by me. That will continue to see our efforts played out, and there will be other campaigns.

My experience is that this is about a combination of factors. Yes, there is the campaign, but, as I made clear to health chiefs, if anybody wants to give up smoking and turns to the NHS—wherever they find us—we should be ready to help them. For example, there are the smoking cessation workers, who are out there doing a great job in our communities, and there will be further, innovative approaches involving the media, as well as other initiatives to ensure that we keep the momentum.

Mr Maxwell: I agree that the package of measures is essential, but I am sure that you would also agree that—although it is early days for evidence—the peaks match the publicity. Publicity effectively gives us the opportunity to bring more people into the cessation services.

Mr Kerr: We also have the annual opportunity of national no smoking day, to which we will continue to give substantial support.

The Convener: I have a final question about the on-going work with primary 7 children to tease out whether there is the potential for an increase in domestic smoking. I appreciate that we do not know what the results will be, but if they show that there has been an increase in smoking at home that would impact on the health of the primary 7s, would you want to revisit the situation with a view to tackling that increase?

Mr Kerr: Evidence on Australia's smoking legislation was that there was no apparent effect; therefore there is some evidence that smoking bans—

The Convener: That is a different climate though.

Mr Kerr: I appreciate that. That evidence is there, though, so it is worth putting on the table as supporting the case. We would have to address that matter candidly. We would not go backwards and undo the ban. What we would need to do is to work with those families and try to encourage lifestyles that do not expose their children and young people to environmental tobacco smoke. Children breathe in and out more frequently than adults, which means that if they are exposed to environmental tobacco smoke they take in much more of it. If evidence suggests that there has been an increase in domestic smoking, we would need to respond to that. We would do so in ways that are as creative as those we have used to date in relation to the smoking ban. Let us wait to see what the evidence says. I would be alarmed if there had been such an increase. If that is the case, I reassure the Health Committee that the Executive would want to deal with that.

The Convener: Thank you, minister. It looks as if we have exhausted our questions. You are free to watch the last couple of minutes of the committee if you wish.

Subordinate Legislation

Food Hygiene (Scotland) Amendment Regulations 2007 (SSI 2007/11)

15:42

The Convener: Item 2 on the agenda is subordinate legislation. The instrument is negative. The Subordinate Legislation Committee has raised no issues in relation to the regulations, no comments have been received from members, and no motions to annul have been lodged. Do we therefore agree that the committee does not wish to make any recommendation in relation to the regulations?

Members *indicated agreement*.

Meeting closed at 15:43.

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