Health Committee

1st Report 2005

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

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1st Report, 2005 (Session 2)

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Other written evidence received by the Health Committee can be found on the Committee’s webpage at:

http://www.scottish.parliament.uk/business/committees/health/index.htm

Hard copies of this evidence are available from the clerks to the Committee upon request to health@scottish.parliament.uk or on 0131 348 5224.
Health Committee

Remit and membership

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 areas.
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](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.
25. 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.

26. 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)

27. 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.

28. 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)

29. 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

30. 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.

31. 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 indicated 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]\(^2\). 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

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 charter3 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,

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 Ireland⁴ 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 2002⁵, 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

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’.6

**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.

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’.
section 5 of the bill. He went on to suggest that whether or not an area is to be used for food service within 5 days is a matter of fact that should be known to the proprietor. 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.

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\(^8\) 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 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
Mr Stewart Maxwell, MSP, Member in Charge; and David Cullum, Clerk, Non-Executive Bills Unit.

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.
7 Ted Brocklebank, Official Report, 1 June 2004, col. 1479
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.
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\(^{27}\) 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

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\(^{27}\) 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 × 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

**THE PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL**

**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>
</tr>
<tr>
<td>Hotels, Restaurants, Others</td>
<td>3,300</td>
<td>500</td>
<td>4,000,000</td>
<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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Convener
Finance Committee
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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 Jeromy 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
Subordinate Legislation Committee

Prohibition of Smoking in Regulated Areas (Scotland) Bill

Delegated Powers Scrutiny

Stage 1 Report

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.
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
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

12th 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
Helen Eadie
Kate Maclean
Shona Robison
Dr Jean Turner

Christine Grahame (Convener)
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
Mike Rumbles

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
Helen Eadie
Kate Maclean
Shona Robison

Christine Grahame (Convener)
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
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
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
Helen Eadie
Kate Maclean
Shona Robison
Christine Grahame (Convener)
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
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
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}.

**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.

**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{xxii}. 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{xxiii, 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. 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%. The findings of this poll are similar to those of 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%). 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. 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.

The Voluntary Charter

An estimated 1,000 lives would be saved each year if workplaces were smoke-free. 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. Seventy percent of the public do not smoke, but only 18% of public places are currently smoke free.

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.
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 concerns\textsuperscript{v}. In health terms, the California ban on smoking in bars has provided both immediate and longer-term respiratory benefits for smoking and non-smoking bartenders\textsuperscript{vi}. Furthermore, a recent report\textsuperscript{vii} 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 effect\textsuperscript{viii}.

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.

\textsuperscript{5} Reducing Smoking and Tobacco-Related Harm. NHS Scotland and ASH Scotland. 2003.
\textsuperscript{6} Pearce, J., Boyle, P. and Flowerdew, R. (2003). Predicting smoking behaviour in census output areas across Scotland. Health and Place, 9, 139-149.
\textsuperscript{xii} Bonita, R. et al. (1999). Passive smoking as well as active smoking increases the risk of acute stroke. Tobacco Control, 8, 156-160. Online at: http://tc.bmjournals.com/cgi/content/full/82/156 (Accessed 22/04/04)
\textsuperscript{xiii} See Footnote 12
\textsuperscript{xv} See Footnote 14
xxviii 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.
xxii 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.
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 workplaces. 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 work-places from the Helsinki metropolitan area, Finland.

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

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 work-place law. We found that such legislation is associated with steadily reducing ETS exposure at work, particularly at work-places, 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 work-place as the norm.
SUBMISSION FROM FOREST

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.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

14:02

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: I see. Sorry.

Dr Gruer: 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:

“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”.

"International Persp ective", you say that, in Glasgow,
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.

14:45

**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 this 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 have a social life. I am thinking of the Disability Discrimination Act 1995. Are you saying that such people can go somewhere else?

Simon Clark: Of course I have sympathy. I loved the way in which you dropped in the word “discrimination”. If the bill were to be passed, you would be discriminating against the quarter of the Scottish population who smoke. You would be preventing them from going out and enjoying themselves socially.

Of course I have sympathy. We are saying that 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.

One of the other options that we have not discussed is having separate smoking and no-smoking rooms in pubs and restaurants. A person would have to be an anti-smoking fanatic to object to there being a smoking room and a non-smoking room. It is extraordinary that, in relation to public transport, for example, there used to be the perfect compromise in the form of smoking compartments on trains. I am pleased that Great North Eastern Railway still offers such a choice. One out of 12 coaches is for smokers and the other 11 coaches are for non-smokers. That provides choice and smokers are kept away from non-smokers. The argument is about providing choice and the sad thing about the anti-smoking lobby is that it does not want to compromise in any way, shape or form. However, we do and we want to come up with an acceptable compromise.

I have sympathy with the example that Mr Rumbles gave and I think that we will see more no-smoking pubs and restaurants over the next few years. It is clear that there is a niche market and I hope that people such as those whom Mr Rumbles mentioned will have more places to which they can go. Many places to which people can go now have no-smoking areas. We should put matters in perspective. Some 86 per cent of companies in the United Kingdom now have a smoking policy that involves either severe restrictions on smoking or a total smoking ban. Smoking is banned in most workplaces and offices, on most forms of public transport, in most shops and in cinemas and theatres. It is not impossible for a person to go out and avoid a smoky atmosphere. I am happy to stand by what I said about the 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 antismoking 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?

15:15

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: Of 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 JD 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 airlock, 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 airlock—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 McNeill: 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 McNeill: 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 in 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?

16:00

Arun Randev: I have had no problems at all in implementing such areas in my business. My restaurant is 100 per cent non-smoking, and people are not allowed to smoke within three feet of the bar.

Mr Davidson: Is there a direct connection between the dining area and the drinking area?

Arun Randev: There is a void area, or a passing area.

Mr Davidson: Is there a physical gap?

Arun Randev: There is no physical gap—it is just a void area.

Mr Davidson: The bill suggests that there should be physical barriers and physically distinct spaces between non-smoking areas where food is served and smoking bar areas. How would the practicalities of that affect you?

Arun Randev: I would have to consider that at the relevant time and place but, like most people in the trade, I would find that difficult to implement because it could—depending on the logistics of the premises—be difficult to create separate areas.

Mr Davidson: So the matter depends on the practicalities of individual premises.

Arun Randev: Yes.

Stephen Leckie (British Hospitality Association Scotland Committee): I represent the British Hospitality Association in Scotland, but I
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 is 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?

16:15

Stephen Leckie: The chief executive and deputy chief executive of the British Hospitality Association—of which I am the part-time, not full-time, chairman in Scotland—communicate verbally, by letter and in whatever way with the guys in Dublin. They also attend regional meetings around Britain, which happen four times a year.

Helen Eadie: Are you aware that politicians in the Republic of Ireland have said that switchboards there were jammed with international calls from people who wanted to visit southern Ireland as a consequence of the legislation?

Stephen Leckie: I was not aware of that and I am intrigued to hear it. I think that you refer to a total ban, whereas I understood that this afternoon’s debate was about the Maxwell bill. Perhaps the debate has moved on a bit. If it was decided that the bill was not appropriate and that a total ban would be implemented, and if that was all that was left, the BHA’s view would be that that was the case.

Mike Rumbles: Commendably, Arun Randev has a no-smoking restaurant, which has signs that say that the restaurant does not allow smoking, so that people know what they are doing. That obviously works well and you have had good feedback from your customers. I will ask whether you understand the differences that are involved. A non-smoker does not inflict anything on anybody else, whereas a smoker inflicts smoke on people who do not want to have smoke inflicted on them. I do not understand why your submission says: “Your proposals would be impossible for me to comply with” as you would have to build a wall, because the bill would not necessarily mean that you had to build anything. However, if smoke travels from the bar area to the restaurant area, why not make the bar smoke free, too? It would cost you nothing to have a completely smoke-free environment.

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. I will allow Stewart Maxwell a chance to ask questions.

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.
Meeting suspended.
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."

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. 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."

The report was later also challenged in the courts 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, the National Health & Medical Research Council of Australia, and the UK’s Scientific Committee on Tobacco and Health (SCOTH). 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.”

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”\(^{18}\). 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”\(^{19}\); 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.”\(^{20}\)

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.”\(^{21}\)
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...\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{28}

Yet, in the case of lung cancer and ETS, a 1997 meta-analysis\textsuperscript{29} 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 report\textsuperscript{30} 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 practice.

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 study 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 study 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”.

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.\(^35\).

The factors mentioned in that important Parliamentary answer are included in the criteria that were proposed by Bradford Hill\(^36\) 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\(^37\). 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 workplace. 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>
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<tbody>
<tr>
<td>1</td>
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<td>1981</td>
<td>USA</td>
<td>153*</td>
<td>1.17</td>
<td>0.85 – 1.61</td>
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<td>0.43 – 1.30</td>
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<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>
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<td>1984</td>
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<td>0.80</td>
<td>0.34 – 1.90</td>
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<tr>
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<td>1984</td>
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<td>200*</td>
<td>1.45</td>
<td>1.02 – 2.08</td>
</tr>
<tr>
<td>7</td>
<td>Kabat 1</td>
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<td>USA</td>
<td>53</td>
<td>0.79</td>
<td>0.25 – 2.45</td>
</tr>
<tr>
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<td>Garfinkel 2</td>
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<td>1.09 – 3.72</td>
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<td>31</td>
<td>1.20</td>
<td>0.50 – 3.30</td>
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<td>1986</td>
<td>Japan</td>
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<td>1.50</td>
<td>0.93 – 2.76</td>
</tr>
<tr>
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<td>UK</td>
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<td>1.00</td>
<td>0.37 – 2.71</td>
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<td>0.39 – 6.90</td>
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<td>USA</td>
<td>35*</td>
<td>1.50</td>
<td>0.30 – 6.30</td>
</tr>
<tr>
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<td>Zhong</td>
<td>1999</td>
<td>China</td>
<td>504</td>
<td>1.10</td>
<td>0.80 – 1.50</td>
</tr>
<tr>
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<td>Lee C-H</td>
<td>2000</td>
<td>Taiwan</td>
<td>268</td>
<td>1.87</td>
<td>1.29 – 2.71</td>
</tr>
<tr>
<td>55</td>
<td>Malats</td>
<td>2000</td>
<td>Europe/Brazil</td>
<td>105</td>
<td>1.50</td>
<td>0.77 – 2.91</td>
</tr>
<tr>
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<td>China</td>
<td>200</td>
<td>1.03</td>
<td>0.60 – 1.70</td>
</tr>
<tr>
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<td>71</td>
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<td>0.62 – 2.30</td>
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<tr>
<td>58</td>
<td>Lagarde</td>
<td>2001</td>
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<td>242</td>
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<td>0.84 – 1.58</td>
</tr>
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<td>Nishino</td>
<td>2001</td>
<td>Japan</td>
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<td>1.80</td>
<td>0.67 – 4.60</td>
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<tr>
<td>60</td>
<td>Ohno</td>
<td>2002</td>
<td>Japan</td>
<td>191</td>
<td>1.00</td>
<td>0.67 – 1.49</td>
</tr>
<tr>
<td>62</td>
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<td>2002</td>
<td>Singapore</td>
<td>176</td>
<td>1.29</td>
<td>0.93 – 1.80</td>
</tr>
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<td>177*</td>
<td>0.94</td>
<td>0.66 – 1.33</td>
</tr>
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<td>Czech Republic</td>
<td>84</td>
<td>0.48</td>
<td>0.21 – 1.09</td>
</tr>
</tbody>
</table>
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**

<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>
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<td>3</td>
<td>Correa</td>
<td>1983</td>
<td>USA</td>
<td>10</td>
<td>1.97</td>
<td>0.38 – 10.32</td>
</tr>
<tr>
<td>5</td>
<td>Buffler</td>
<td>1984</td>
<td>USA</td>
<td>11</td>
<td>0.52</td>
<td>0.14 – 1.79</td>
</tr>
<tr>
<td>6</td>
<td>Hirayama</td>
<td>1984</td>
<td>Japan</td>
<td>64*</td>
<td>2.25</td>
<td>1.05 – 4.76</td>
</tr>
<tr>
<td>7</td>
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<td>1984</td>
<td>USA</td>
<td>25</td>
<td>1.00</td>
<td>0.20 – 5.07</td>
</tr>
<tr>
<td>11</td>
<td>Akiba</td>
<td>1986</td>
<td>Japan</td>
<td>19</td>
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<td>0.39 – 6.96</td>
</tr>
<tr>
<td>12</td>
<td>Lee</td>
<td>1986</td>
<td>UK</td>
<td>15</td>
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<td>0.38 – 4.39</td>
</tr>
<tr>
<td>15</td>
<td>Humble</td>
<td>1987</td>
<td>USA</td>
<td>8</td>
<td>4.08</td>
<td>0.70 – 23.91</td>
</tr>
<tr>
<td>23</td>
<td>Choi</td>
<td>1989</td>
<td>Korea</td>
<td>13</td>
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<td>0.49 – 15.21</td>
</tr>
<tr>
<td>24</td>
<td>Hole</td>
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<td>Scotland</td>
<td>3*</td>
<td>3.52</td>
<td>0.32 – 38.65</td>
</tr>
<tr>
<td>26</td>
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<td>1990</td>
<td>USA</td>
<td>45</td>
<td>0.75</td>
<td>0.31 – 1.78</td>
</tr>
<tr>
<td>Ref</td>
<td>Author</td>
<td>Publication</td>
<td>Location</td>
<td>Sex</td>
<td>Relative Risk</td>
<td>Confidence Interval at 95%</td>
</tr>
<tr>
<td>-----</td>
<td>--------------</td>
<td>-------------</td>
<td>--------------</td>
<td>-----</td>
<td>---------------</td>
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</tr>
<tr>
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<td>1984</td>
<td>USA</td>
<td>M</td>
<td>3.27</td>
<td>1.01 – 10.62</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>F</td>
<td>0.68</td>
<td>0.32 – 1.47</td>
</tr>
<tr>
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<td>Garfinkel</td>
<td>1985</td>
<td>USA</td>
<td>F</td>
<td>0.93</td>
<td>0.55 – 1.55</td>
</tr>
<tr>
<td>10</td>
<td>Wu</td>
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<td>USA</td>
<td>F</td>
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<td>0.50 – 3.30</td>
</tr>
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<td>UK</td>
<td>M</td>
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<td>0.39 – 6.60</td>
</tr>
<tr>
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<td>F</td>
<td>0.63</td>
<td>0.17 – 2.33</td>
</tr>
<tr>
<td>16</td>
<td>Koo</td>
<td>1987</td>
<td>Hong Kong</td>
<td>F</td>
<td>1.19</td>
<td>0.48 – 2.95</td>
</tr>
<tr>
<td>22</td>
<td>Shimzu</td>
<td>1988</td>
<td>Japan</td>
<td>F</td>
<td>1.18</td>
<td>0.70 – 2.01</td>
</tr>
<tr>
<td>26</td>
<td>Janerich</td>
<td>1990</td>
<td>USA</td>
<td>C</td>
<td>0.91</td>
<td>0.61 – 1.35</td>
</tr>
<tr>
<td>27</td>
<td>Kalandidi</td>
<td>1990</td>
<td>Greece</td>
<td>F</td>
<td>1.70</td>
<td>0.69 – 4.18</td>
</tr>
<tr>
<td>29</td>
<td>Wu-Williams</td>
<td>1990</td>
<td>China</td>
<td>F</td>
<td>1.06</td>
<td>0.80 – 1.40</td>
</tr>
<tr>
<td>31</td>
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<td>1992</td>
<td>USA</td>
<td>F</td>
<td>0.98</td>
<td>0.74 – 1.31</td>
</tr>
<tr>
<td>35</td>
<td>Fontham</td>
<td>1994</td>
<td>USA</td>
<td>F</td>
<td>1.56</td>
<td>1.21 – 2.02</td>
</tr>
<tr>
<td>38</td>
<td>Kabat 2</td>
<td>1995</td>
<td>USA</td>
<td>M</td>
<td>1.02</td>
<td>0.50 – 2.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>1.15</td>
<td>0.62 – 2.13</td>
</tr>
<tr>
<td>39</td>
<td>Schwartz</td>
<td>1996</td>
<td>USA</td>
<td>C</td>
<td>1.50</td>
<td>1.00 – 2.00</td>
</tr>
<tr>
<td>40</td>
<td>Sun</td>
<td>1996</td>
<td>China</td>
<td>F</td>
<td>1.38</td>
<td>0.94 – 2.04</td>
</tr>
<tr>
<td>42</td>
<td>Wang T-J</td>
<td>1996</td>
<td>China</td>
<td>F</td>
<td>0.89</td>
<td>0.46 – 1.73</td>
</tr>
<tr>
<td>43b</td>
<td>Cardenas</td>
<td>1997</td>
<td>USA</td>
<td>M</td>
<td>1.09</td>
<td>0.62 – 1.91</td>
</tr>
<tr>
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<td></td>
<td>F</td>
<td>1.00</td>
<td>0.65 – 1.54</td>
</tr>
<tr>
<td>46</td>
<td>Boffetta 1</td>
<td>1998</td>
<td>Western Europe</td>
<td>M</td>
<td>1.13</td>
<td>0.68 – 1.86</td>
</tr>
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<td>F</td>
<td>1.19</td>
<td>0.94 – 1.51</td>
</tr>
<tr>
<td>48</td>
<td>Zaridze</td>
<td>1998</td>
<td>Russia</td>
<td>F</td>
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<td>0.55 – 1.41</td>
</tr>
</tbody>
</table>

**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**
### 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>
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<td>8</td>
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<td>F</td>
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<td>0.58 – 1.42</td>
</tr>
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<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>
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<td>USA</td>
<td>F</td>
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<td>0.72 – 1.10</td>
</tr>
<tr>
<td>38</td>
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<td>USA</td>
<td>M</td>
<td>0.90</td>
<td>0.43 – 1.89</td>
</tr>
<tr>
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<td></td>
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<td>F</td>
<td>1.63</td>
<td>0.91 – 2.92</td>
</tr>
<tr>
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<td>Sun</td>
<td>China</td>
<td>F</td>
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<td>1.56 – 3.37</td>
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<tr>
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<td>Wang T-J</td>
<td>China</td>
<td>F</td>
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<td>0.56 – 1.48</td>
</tr>
<tr>
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<td>M</td>
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<td>0.77</td>
<td>0.61 – 0.98</td>
</tr>
<tr>
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<td>Zamarinze</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>
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<td>51</td>
<td>Rapiti</td>
<td>India</td>
<td>M</td>
<td>1.09</td>
<td>0.38 – 3.18</td>
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<td>China</td>
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<td>0.93</td>
<td>0.72 – 1.20</td>
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<td>F</td>
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<td>1.40 – 3.14</td>
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<td>China</td>
<td>M</td>
<td>1.46</td>
<td>0.60 – 3.70</td>
</tr>
<tr>
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<td>F</td>
<td>1.51</td>
<td>1.00 – 2.20</td>
</tr>
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<td>Johnson</td>
<td>Canada</td>
<td>F</td>
<td>1.38</td>
<td>0.81 – 2.34</td>
</tr>
<tr>
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<td>Ohno</td>
<td>Japan</td>
<td>F</td>
<td>1.00</td>
<td>0.51 – 1.98</td>
</tr>
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<td>Czech Republic</td>
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<td>1.01 – 2.57</td>
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</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>
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<td>M</td>
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<td>0.26 –1.87</td>
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<td>USA</td>
<td>M</td>
<td>1.40</td>
<td>0.80 – 2.50</td>
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<tr>
<td>9</td>
<td>Jackson</td>
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<td>New Zealand</td>
<td>M</td>
<td>1.80</td>
<td>0.94 – 3.46</td>
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<td>0.48 – 5.03</td>
</tr>
<tr>
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<td>M</td>
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<td>0.17 – 2.62</td>
</tr>
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<td>Muscat</td>
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<td>USA</td>
<td>M</td>
<td>1.20</td>
<td>0.60 – 2.20</td>
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</tr>
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<td>Steenland</td>
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<td>M</td>
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<td>0.89 – 1.19</td>
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<td>0.86 – 4.00</td>
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<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>1.18</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>
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.


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
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.
15 June 2004 (16th Meeting Session 2 (2004)) – Written Evidence

**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 women 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 everybody 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 not 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 let’s stop people smoking in regulated areas.

**Submission by Elizabeth Butler**

At school we had a debate about the bill being passed or 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 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 forwards.

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 peoples 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 breathe 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 if 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 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.
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\(^1\) 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\(^2\).

In addition, exposure to ETS during pregnancy has been conclusively linked to reduced foetal growth and premature birth\(^3\). Almost one in three pregnant women are exposed to ETS in the workplace\(^4\). 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\(^5\). 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\(^6\).

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.

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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.

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 hostleries – 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.\(^5\)

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.\(^6\) Smoke free regulations also do not appear to adversely affect tourist business and may, in fact, increase it.\(^7\)

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.\(^2\)

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.\(^8\)

**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.\(^9\)

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.

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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.
Prohibition of Smoking in Regulated Areas (Scotland) Bill: Stage 1

14:04

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: 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: 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 Rutherglen) (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 shoggly 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 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. Banning smoking in public places is a crucial weapon in the armoury, but it is only one weapon; we must take other measures.

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 ballpark 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
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, Strathcathro 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 Robinson: 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
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:** 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 Robinson:** 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.

16:00

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: I wish to ask a question of the RCN. We have heard the evidence today that, for humanitarian reasons, the health boards have allowed smoking in psychiatric wards and places that people see as their home. Given your evidence about workplace bans, and your support for such a ban, what is the RCN doing to protect nurses in that situation?

Geoff Earl (Royal College of Nursing): The RCN policy is that all workers, including nurses, have a right to work in a smoke-free environment. We argue that nurses should not be forced to work in areas that are set aside for certain groups to smoke, if they do not wish to. We envisage a similar policy being extended to all workers. We support the bill because workers in the service 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.

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
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 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 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 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 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.

**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. In public places people are not sure in which rooms or corridors smoking is not permitted, the situation becomes difficult. If someone had put 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 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 have only a global figure for the cost to the NHS of caring for an individual patient with a form of cancer? Can you provide us with that figure?

**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 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?

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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 diabetics—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 in the home. There is good evidence from Australia that, when Governments take smoke-free public places seriously by introducing laws, parents recognise the effects of smoking on their children’s health and are more likely to curtail smoking in their own homes, which brings down exposure. If parents do not smoke, their children are less likely to take it up. Therefore, introducing laws on smoking has many benefits.

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?

**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.

16:30

**The Convener:** David Davidson wants to address the voluntary charter.
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 exercise because we cannot get the message across. The public acceptance is not there. If you are saying that it is accepted that smoking and passive smoking are bad things, why do people frequent places that allow smoking and not use their power in the marketplace?

Dr Jones: That is a sign that this is one area in which only a law will do. Market forces will not protect health. The approach is flawed.

Mr Davidson: Do any other witnesses wish to comment?

Geoff Earl: I am not sure how market forces would work in areas of the Highlands where there is only one pub. Also, markets do not work purely by demand; there is also a fear factor. Publicans say that the reason why they do not introduce smoking bans is because they fear that if they do, everybody will go down the road. Whether that is true or not, that is what people feel will happen, which is why the voluntary code has not achieved anything—there is a fear factor within the market. Markets respond to fear as well as to public purchasing. Everybody is worried. They are all standing at the edge of the water and until somebody dips their toe in and runs in, nobody will go in.

Mr Davidson: We heard evidence from publicans that they would rather have a level playing field one way or the other. You raised the issue of a small hostelry in the Highlands serving food, which is what we are considering today. You seek to introduce a ban that may not be acceptable to a community—perhaps the Highlands is the wrong example to choose, given the figures we heard about earlier. Are you trying to use legislation as a blunderbuss against a population that will probably simply go to the off-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

Also a link to the IARC monograph on involuntary smoking: 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.

(reference: http://www.archive.official-documents.co.uk/document/doh/tobacco/part-2.htm#2.9)

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, the 1986 Report of the US Surgeon General, the National Health and Medical Research Council of Australia and the UK Independent Scientific Committee on Smoking and Health. This culminated in a major review by the US Environmental Protection Agency 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. 28

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.” 29 According to the Tobacco Manufacturers’ Association, “the health risk claims are all too often based on a selective view of the evidence”. 30

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. 31

A decade earlier, Philip Morris began a campaign dubbed ‘Project Whitecoat’ to “co-ordinate and pay so many scientists on an international basis to keep the environmental tobacco smoke controversy alive.” 32 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. 33 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

US California

Population (million) 265 32

Low birthweight
(max) 18,600 2,200
(min) 9,700 1,200

Cot death - SIDS
(max) 2,700 120
(min) 1,900 -

Middle ear infection
(max) 1,600,000 188,700
(min) 700,000 78,600

Asthma induction –new cases
(max) 26,000 3,120
(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 status, both in 1998 and now, in keeping with the international literature. Again there is a consistent downward trend in reported rates in those with least level of education, though that is not true of younger respondents with completed secondary level education, the only group where the trend appears upwards.
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 “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.

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 of 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 | Children in Scotland | Royal College of Physicians |
| Beatson Oncology Centre | Health at Work | Royal College of Physicians & Surgeons |
| British Lung Foundation | Macmillan Cancer Relief | Royal College of Surgeons |
| Department of Public Health Fast Forward | Marie Curie Cancer Care | Royal Environmental Health |
| Smoking Concerns | National Asthma Campaign | Scottish Tobacco Control Alliance |
| Cancer BACUP | NHS Health Scotland | STUC |
| Cancer Research UK | Path House Medical Practice | West Lothian Drug & Alcohol Service |
| Chest, Heart and Stroke | Roy Castle Lung Cancer | |
| Centre of Tobacco Control | Foundation | |
| Royal College of Nursing | |

**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 health 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 Faulknor 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 vulnerable.

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 adult.

3 million people in the UK are exposed to environmental tobacco smoke in the workplace and latest estimates suggest that 12,000 U.K. non-smokers die annually as a result of exposure to secondhand smoke.

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 less.

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-smokers

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%. 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; 286:436-41
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 the 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 an operations manager in the policy and performance unit of Dundee City 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 remotest 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 building sites 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 janey 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 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
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 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—

Professor Hastings: 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 that the public has a strong interest in the comfort factor associated with reducing environmental tobacco smoke; there is no doubt about that. However, it is also clear that a high percentage of people make the connection between second-hand smoke and damage to their health. The benefits of reducing environmental tobacco smoke and the potential health gain are clear to many people.

Janis Hughes: Some organisations, including your own, make it clear in evidence that there should be a ban on smoking in the workplace, which would come under the heading of 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, cruelly, 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 mumblings. 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 Edie: 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.

The Convener: It might be a five-minute question for all I know.

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\(^1\)
- 26% increased risk of lung cancer in adults\(^2\)
- 23% increased risk of heart disease in adults\(^2\)
- respiratory disease in childhood (such as cot death, middle ear disease and asthma)\(^2\)
- 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\(^3\)
- immediate negative effects on adults including eye irritation, headache, cough, sore throat, dizziness and nausea\(^4\)

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.\(^5\)
- 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.\(^6\)
- 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%
• Irritated eyes 21%
• Made them cough 23%
• Made them feel sick 9%
• Gave them headaches 7%

**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 areas. 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]. 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.  

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 stroke.  

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%.

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
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


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 SFM 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.
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\(^1\) 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.
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—that 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.
We felt that the law would, in its licence. After the third violation, an establishment can lose not less than $1,000 but not more than $2,000. 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 $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.

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.

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?

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.

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.

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 Robinson: 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 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 hires, 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.

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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 into 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 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
into a smoky bar, it can protect everyone. That is not true. No company that has developed and which produces the devices can assure us that they can protect individuals from the harmful substances in second-hand smoke.

We are not talking about clouds of smoke, irritation or odour—although those affect people in a negative way and in some cases simple devices can cut back on some of that. We are talking about tiny particles that cannot be detected by existing filtration devices and which contain the cancer-causing substances that get deep into the lungs and cause havoc. Generally, the larger substances cause the odour, eye irritation and so on. Those are the alarm bells that indicate to people that they should get out of a smoky environment, because what is behind those are the very small particles that existing filtration devices cannot prevent. In a smoky bar where people are smoking all night it is impossible for a small filtration device to clear the air sufficiently to protect the workers—let alone the public. We think that such devices are essentially a fraud; they do not protect health and they give the impression that workers are protected when the reality is that they are not.

15:45

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. The law does not apply in a private home or in any private establishment. 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 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 precede 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?

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 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 form 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 that 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 act-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 people with us. 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 McNeill:** 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 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 provision in the bill that we are discussing. The provision in the bill is clear and unequivocal: it is to prevent people from smoking in regulated areas, which is not the intention.

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.

Bearing in mind the committee’s endurance levels and the fact that we have thoroughly aired many issues, I think that our question-and-answer session with our next panel might be shorter than the other ones. Heaven forbid that I should suggest that it is also almost the end of term.

In our next panel, we have Stewart Maxwell MSP, David Cullum, of the Scottish Parliament’s non-Executive bills unit, and Catherine Scott, of the Scottish Parliament’s directorate of legal services. I was about to ask them to take the stand, but they are not in a witness box. I ask them to take their seats.

Dr Turner: I will ask what I hope will be a quick question. I would like to know, having heard all the evidence so far, whether the bill can be changed to make the provisions compulsory and to even out the inequalities that have been mentioned. Can it be changed in order to create a blanket ban?

Can you explain the connection that has been made in the bill between food and a ban on smoking? Why has the ban not been extended to all licensed premises, including those serving only alcohol? Perhaps it is naive to ask this question, but could the bill be changed to include all licensed premises? As a doctor, I have waited all my life for something like this bill, which would help people and cut costs to the health service. Would it be possible to change the bill reasonably quickly if we had a mind to do so? The evidence is overwhelming—

The Convener: I was hoping for short questions, Jean.

Dr Turner: Sorry.

Mr Maxwell: The short answer to your question is yes. It is possible to change the bill in the way that you describe. There is no doubt that a full ban on smoking in public places can be achieved through the bill. That was agreed with the parliamentary authorities when scope issues were discussed when the bill was introduced. 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 (Scottish Parliament Directorate of Legal Services): I agree absolutely with Stewart Maxwell—there is no problem with amending the bill in the way that he has suggested.

The Convener: My comments will also be short because I could tell that people thought it was like watching paint dry when I asked about the section on enforcement.
Scott will respond. corporate veil, as you put it. Perhaps Catherine corporations or businesses from hiding behind the intention of the bill, which was to prevent questions to the Crown Office followed exactly the need for that phrase.

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 premises, 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.
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.
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.
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?

14:30

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.
problem. The ground has shifted in that regard, that gives me a problem about 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 Provision 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?

14:45

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.
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