HEALTH COMMITTEE

Tuesday 15 June 2004
(*Afternoon*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Tuesday 15 June 2004

HEALTH COMMITTEE
16th Meeting 2004, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Stewart Maxwell (West of Scotland) (SNP)
Mr Tom McCabe (Deputy Minister for Health and Community Care)
Mrs Nanette Milne (North East Scotland) (Con)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

THE FOLLOWING GAVE EVIDENCE:

Paul Ballard (Tayside NHS Board)
Garry Coutts (Highland NHS Board)
Geoff Earl (Royal College of Nursing)
Shona Hogg (Firrhill High School)
Simon Hunter (Firrhill High School)
Dr Helene Irvine (Greater Glasgow NHS Board)
Dr Sinead Jones (British Medical Association)
Gillian Lee (Grampian NHS Board)
Findlay Masson (Mile-End School)
Callum McPherson (Mile-End School)
Dr Malcolm McWhirter (Faculty of Public Health)
Claire Repper (Mile-End School)
Dr Peter Terry (British Medical Association)
Lea Tsui (Firrhill High School)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Chamber

Scottish Parliament

Health Committee

Tuesday 15 June 2004

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:03*]

The Convener (Christine Grahame): I welcome everyone to the Health Committee's 16th meeting in 2004. We have a heavy agenda, so I would like to start. I ask everyone to switch off their phones and pagers.

Does the committee give me leave to defer agenda item 1 and to start with item 2? The minister is detained but will be here after 3 o'clock, so I intend to start with item 2 and move straight on to item 3, with our panel from two schools. Does the committee agree to that?

Members *indicated agreement*.

Subordinate Legislation

General Medical Services and the General Medical Services and Section 17C Agreements (Transitional and Other Ancillary Provisions Orders) (Scotland) Amendment Order 2004 (SSI 2004/223)

Kava-kava in Food (Scotland) Amendment Regulations (SSI 2004/244)

The Convener: We have two instruments to consider under the negative procedure. The Subordinate Legislation Committee made no comment on the order or the regulations. No members' comments have been received and no motions to annul have been lodged. Does the committee agree that it wishes to make no recommendation on these Scottish statutory instruments?

Members *indicated agreement*.

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: Passive smoking definitely kills people. We did research and we found out that being in a smoky environment for just half an hour can reduce the blood flow to the heart. That was quite a scary thing to read and it made us take a step back. If that is what happens to adults, what must it do to wee children and pregnant women? The smoke that pregnant women breathe in will go directly to their unborn baby. That does not sound right. It is unjust that someone should suffer for what someone else has done.

Mike Rumbles: Do we not have a duty to protect people?

Lea Tsui: Yes. We can always take actions to help to protect other people from illnesses.

Mr David Davidson (North East Scotland) (Con): Having listened to the comments from the Firrhill High School students, I want to ask about smoking at home. You have been very strong on the effects that smoking has on a range of people. Do you think that the bill goes far enough or should it cover other areas? Should people have some freedoms?

Lea Tsui: In private homes, people should make their own choice and it should be up to the family. In a public place, not everyone can get their say, whereas families in private households can make their own decision on whether to allow smoking in the house.

Mr Davidson: Does Mile-End School have any views on that?

Claire Repper: As the people from Firrhill said, it should be the family's view. If the whole family smokes, that might be their choice. If they want to quit and other people are smoking, they have to fight back against other smokers in the house.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Would the bill lead to more people giving up smoking?

Claire Repper: It might not lead to more people giving up, but fewer people might start smoking because of the inconvenience that would be caused if the bill was passed in full. People who already smoke might also cut down on the amount that they smoke each day.

Lea Tsui: When our teacher and his wife went to California, where smoking in public has been banned, they found that finding somewhere to smoke was such an inconvenience that they stopped smoking.

The bill might also prevent peer pressure. If everyone is smoking on a work staff night out, you might feel a wee bit encouraged to smoke. As the girl from Mile-End said, if smoking was banned in public places, that might prevent people from starting to smoke.

The Convener: We wrote to Governor Arnold Schwarzenegger but he has not replied yet. When he does, I will keep the autograph.

Janis Hughes (Glasgow 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 shoogly pegs.

The Deputy Minister for Health and Community Care is now available. I suggest that we return to item 1 after which we will resume our evidence taking. Are members content to do so?

Members *indicated agreement*.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 3) (Scotland) Order 2004 (SSI 2004/237)

14:28

The Convener: We have an affirmative instrument to consider under item 1. I welcome Tom McCabe, the Deputy Minister for Health and Community Care, who will speak to the order. I have no doubt that, before the minister moves the motion on the order, David Davidson will want to comment on it.

Mr Davidson: Quite simply, convener, I will not support the motion for reasons that I have stated clearly in the past.

The Convener: The Subordinate Legislation Committee had no comments on the order, and no comments have been received in advance from members of the Health Committee. If no member wishes to debate the order, I ask the minister to move motion S2M-1398.

The Deputy Minister for Health and Community Care (Mr Tom McCabe): Before moving the motion, I thank the convener for her indulgence in accommodating us. We were a bit late coming back from Ayrshire this morning and got held up in traffic.

I move,

That the Health Committee recommends that The Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.3) (Scotland) Order 2004 (SSI 2004/237) be approved.

The Convener: The question is, that motion S2M-1398 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

ABSTENTIONS

Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

The Convener: The result of the division is: For 6, Against 1, Abstentions 2.

Motion agreed to.

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

14:31

The Convener: We will take evidence from our next panel of witnesses. Their written submissions are included in members' papers after the schoolchildren's petition. I refer members to papers HC/S2/04/16/3 and following.

I welcome our witnesses: Gillian Lee is a programme manager for Grampian NHS Board; Garry Coutts is chairman of Highland NHS Board; Dr Helene Irvine is a consultant in public medicine for Greater Glasgow NHS Board; and Paul Ballard is a consultant in health promotion for Tayside NHS Board.

Shona Robison will ask the first question.

Shona Robison: Groups such as FOREST—the Freedom Organisation for the Right to Enjoy Smoking Tobacco—claim that the risk from second-hand smoke has been exaggerated. How do you answer that?

Garry Coutts (Highland NHS Board): I will kick off while the others think of a more substantive answer.

An extensive body of research shows that there is substantive risk from second-hand smoke. There are tolerances—research varies on how great the risk is—but there is no evidence that suggests that there is no risk from second-hand smoke. Health boards have a duty to protect and promote good health, so we need to try to curtail any risk from second-hand smoke.

My colleagues will speak to the specific evidence.

Paul Ballard (Tayside NHS Board): All the research papers that I have seen point markedly to the fact that passive smokers have an approximately 30 per cent increased chance of coronary heart disease and lung cancer. New evidence is emerging that suggests that there are also increased risks of type II diabetes.

Shona Robison: It would be useful if the committee could have that evidence, especially that on the link to type 2 diabetes.

Garry Coutts: The *British Medical Journal* published evidence in 1997, and the United States Environmental Protection Agency has published a lot of evidence. We can ensure that the committee has all the references. Many of them are cited in the policy memorandum to the bill, but we can provide any additional information that is required.

Dr Helene Irvine (Greater Glasgow NHS Board): When I examine the literature, my feeling is that dozens of studies refer to a wide range of conditions, such as an increased risk of cot death, of upper and lower respiratory infection, and the exacerbation and causation of asthma in children and an increased risk of lung cancer, ischaemic heart disease and stroke in adults.

None of the relative risks that are associated with those conditions is extremely high; they often do not exceed the magic number of 2. However, that does not suggest to me that we should ignore the risk from passive smoking. We see a consistent tendency towards elevated risks that are relatively small but are for a range of conditions that have biological plausibility. In other words, it makes sense that glue ear would be, and cot death might be, more common in the children of smokers because of the potent toxins, carcinogens and other substances in second-hand smoke. Several of the criteria of causality are satisfied, even though the relative risks as measured by the statisticians are not very impressive.

Statistical methods are extremely insensitive. Having worked in public health for almost 15 years, I am less impressed by the sensitivity of my own methods to pick up such links. We must bear it in mind that the methodology is not very strong. We need a range of different types of evidence to come together, one of which is statistical evidence of the type that people such as Mr Lee have denigrated in their submissions. Someone who is clever with statistics can easily find their weaknesses and denigrate the evidence, but I appeal to the committee to say, "Wait a minute—let's not throw out all that evidence when there is so much of it and it all points in one direction." The evidence is that a wide range of conditions are more common among the children of smokers, the colleagues of smokers at work and the spouses of smokers.

Shona Robison: I do not know whether you have had a chance to read the evidence that FOREST gave us last week. It dismissed the statistics as being so insignificant as to be irrelevant and said that they were propaganda. You say that we must take the evidence as a whole and consider the trends that are involved.

Dr Irvine: That is right. Many people are involved in undertaking, reviewing or criticising the research. In my experience, the vast majority of people conclude that a risk is present. It will always be possible to find an intelligent and educated professional who may be trained in medicine, statistics or epidemiology and who will denounce the evidence, especially when such huge incentives to do so exist, because the industry is powerful. I am not saying that all such

individuals are funded by the industry, but some of them are. There are reasons why people might use their knowledge to denigrate the evidence, but those people are in a tiny minority compared with the vast number of experts with other views.

All that the committee needs to do is to look at any of the reports. The bibliographies cite reports by the Department of Health, by the Independent Scientific Committee on Smoking and Health, by the Scientific Committee on Tobacco and Health and by the World Health Organisation's international agency for research on cancer, including the report that it is about to publish. The documents are overwhelming and it could take years to read all that evidence. It is astounding that somebody from FOREST should denigrate that evidence. I am disappointed that people take such criticism seriously when so many committed professionals from around the world say consistently that an excess risk of a range of conditions is associated with being in a room with a smoker.

Just by being in a small room with someone who is smoking, you will feel the symptoms of irritation to your upper airway and eyes. You must ask yourself what happens when the same smoke that irritates external bits of your body—your eyes and nose—goes into your lungs and is immediately absorbed into your bloodstream. Within seconds, it comes into contact with every organ of your body. That cannot be completely benign. If that does not show up clearly in the statistics, that is because the methodologies are not very sensitive.

The Convener: I thank you for that exposition.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We all agree that smoking kills and we probably all agree about passive smoking when someone is locked in a room with a smoker or is in a smoker's family, for example. However, we are not discussing that; we are discussing exposure to smoke for limited periods in social situations and in restaurants. I have read your submission and I know exactly where you are coming from. However, I worry that the debate is not just about a ban or a restriction, but about winning people over to the view that smoking is harmful. People are confused because both sides of the argument have been presented, although the truth is probably somewhere in the middle. As you have done, FOREST quoted the *British Medical Journal*, which claimed in a recent report that

"the link between environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed."

Quotes can be provided to support both sides of the argument. I worry that the argument is turning people off. Do you agree that simply banning and restricting smoking is only one tool that can be used in the programme?

Gillian Lee (Grampian NHS Board): I agree that banning smoking is only one element, but it is an important element. A comprehensive answer has been provided that addresses some of the issues about the mixed evidence. Given the wealth of independent evidence that is available, we must agree that smoking and exposure to environmental tobacco smoke is harmful and we must take measures to do something about that. Public places where food is served are workplaces as well as places for the public. You are right that we need to bring public opinion with us and that, because of the mixture of evidence that is promoted and the confusing messages, the public are not clear about whether environmental tobacco smoke is harmful, although the evidence is clear that it is. The Grampian NHS Board submission provides statistics on public opinion, which show that the tide is turning and that the public want premises to be smoke free. The Executive consultation that was launched last week will help to clarify some of those points.

In addition to restrictions on smoking, it is important that we provide smoking cessation services and other support and that we are clear in our messages to the public. A restriction would be part of a wider tobacco control strategy and an integral part of the tobacco control action plan.

Mr McNeil: Do you agree that the language that public health professionals use is the reason why we are here today? Health professionals have failed to communicate successfully to people a method for stopping smoking and have failed to get them not to smoke in public places, which means that we may have to legislate. Is that not caused by the failure of people such as you to get the message across?

Gillian Lee: A range of individuals other than health professionals have a responsibility to consider tobacco control and tobacco issues. The health service plays its part, but other mechanisms are available. However, the matter is difficult because of bodies such as FOREST and other agencies and the powerful advertising by the tobacco industry. That is why an overall tobacco control strategy is important. Such a strategy will have many elements and the health service must play its part. It is important that the public receives clear messages as part of the overall national tobacco action plan and any local work.

Paul Ballard: A recent survey by Action on Smoking and Health Scotland demonstrated that 75 per cent of the Scottish population supports a smoking ban, which shows that the information and education work is getting through. It is important to stress Gillian Lee's point that banning smoking in public places is only one arm of the strategy. She rightly mentioned smoking cessation services, but a wide range of other work is done,

such as work with young people in schools and peer education. The initiatives, including the ban on smoking in public places, must work together; any one of the measures will not work by itself. A partnership approach between the NHS boards and local authorities is crucial, otherwise the initiatives will not work. We have extreme poverty in Tayside, particularly in Dundee, and we are conscious that we have to work with local communities to tackle poverty issues, which are closely linked to smoking. The agenda is complex. Banning smoking in public places is a crucial weapon in the armoury, but it is only one weapon; we must take other measures.

14:45

Mr Davidson: Dr Irvine's evidence is based on damage done to young children, which happens around the home in most cases. Do the health boards feel that legislation should be a last resort after we have tackled the problem through health promotion? Is there any future in the provision of choice within adult establishments—would you support the introduction of physically distinct spaces in such establishments?

Dr Irvine: 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 smoking in public places—ideally, a ban—as far and away the most critical measure. It is in a class of its own, and it is what we are missing. That is why, despite record levels of investment in health promotion, we are not seeing the decline in prevalence that we need. It is critical that we introduce controls, because we have to stop people setting a bad example to everybody else and encouraging their colleagues to light up when they go to the pub. Until we physically prevent people from smoking, we will not be able to do anything about our high prevalence of smoking.

I am sorry if what I said suggested that I was more concerned about evidence in children. I am convinced that, if someone is chronically exposed to smoking in their home because their spouse smokes or if they are exposed for eight hours a day at work, they are bound to experience at least an exacerbation of existing respiratory disease and, I believe, a creation of disease if they are susceptible. The genetic make-up with which a person is born will always combine with environmental factors. If someone is unlucky enough to have had a father who had lung cancer, for example, and if they are then exposed to smoke for eight hours every day, there is an excess risk. That is why it is essential that we introduce effective control of smoking in public places and the workplace.

Mr Davidson: You talk about control, but what about choice? If an establishment had two physically distinct areas for smokers and non-smokers, would that satisfy what you want and balance it with civil liberties?

Dr Irvine: I have yet to see any evidence that suggests that it is possible to have one building with adequate separation of the two areas. There are other problems, such as when a party of six people consists of four non-smokers and two smokers. I had an evening like that last week. I was really keen to go out with friends of mine, two of whom are smokers. The rest of us are non-smokers and we suffered the whole evening—I had to cut the evening short because I could not cope with the smoking. Because there were smokers among us we ended up in the smoking section and it was really unpleasant. That is what happens in such situations.

One of those friends spends her day working with respiratory disease, but she still cannot give up smoking. If she had come into a no-smoking pub with us, she would have had to struggle without her cigarettes, but she would eventually have got used to it, as she did when she went to New York for five days and could not smoke—she almost gave up. Because of the way that human beings interact—smokers and non-smokers together—because we cannot physically prevent smoky air from wafting over into a no-smoking area and because ventilation systems apparently do not work to remove carcinogenic gases, I do not think that it is possible to live happily with smokers and non-smokers in the same building. I have yet to see any evidence that we can.

Kate Maclean (Dundee West) (Lab): If we agree to the bill, or go even further and introduce a total ban on smoking in public places, we will be preventing people from doing something that they want to do. Some have gone as far as to say that we would be interfering with their civil liberties. I was a smoker until quite recently, so I know that, to a certain extent, it is not something that people choose to do, because it is an addiction and it is difficult to cope with. Before we can decide, we must ensure that our decision is based on accurate information, but from the written and oral evidence that the committee has taken, it seems that there is contradictory evidence from scientific studies. Last week we heard from the Tobacco Manufacturers Association and from FOREST that they had studies that showed that the risk of lung cancer for a non-smoker who lived with a smoker was relatively small. In fact, it was insignificant enough for them to think that it was unnecessary to ban smoking in public places.

However, from the evidence that we have heard from you and others who work in the health field it seems that there are more scientific studies that

suggest that smoking-related conditions—but not necessarily lung cancer—are more prevalent in people who come into contact with second-hand smoke. Is that the case? Can you put a ball-park figure on the percentage of studies that prove there is an effect on non-smokers who come into contact with second-hand smoke, as opposed to the study that the tobacco industry likes to quote, which shows that there is no harmful effect? Before we make a decision on this important matter, it would be useful to have an idea of the percentage of the evidence on the effects of second-hand smoke on non-smokers that supports a ban.

Paul Ballard: It is interesting that you say that FOREST and the TMA provided evidence that contradicts the evidence that we have come up with.

Kate Maclean: Sorry. They did not provide evidence. As far as I am aware they did not provide us with the studies. They just said that the studies took place and quoted the results. I could not tell you what the studies were.

Paul Ballard: I have provided—as I am sure have my colleagues—a long list of evidence to support the points that we are making. It would be interesting to compare it with the list of evidence that FOREST and the TMA can come up with, and to see how much of that evidence is linked directly to funded surveys by the tobacco industry.

The Convener: I remind members that they told us that they would send that evidence. We have not received it.

Kate Maclean: That would be the tobacco industry's own evidence.

The Convener: That is right.

Kate Maclean: It would be useful if we had a list, so that we could use it as a resource to do some research on the scientific studies that have taken place. I would find that useful.

Dr Irvine: My sources suggest that we have at least 50 studies on passive smoking and lung cancer alone. Many of them are small, and some of them are old. I notice that the submissions by the tobacco industry suggest that only five are large and worth looking at, of which three showed an increased risk that was not statistically significant, one showed an excess risk that was statistically significant, and one showed a decreased risk—it is implausible that someone would be safer if they were exposed to smoke than not exposed.

That is a beautiful example of selective reference to the literature. The literature on the subject is massive. If you want to prove your case, you choose those five studies, but if you want to show that passive smoking is dangerous, you pick the other 45. It should not surprise anybody in this room that there is a huge controversy on the subject. The tobacco industry is a multibillion pound industry. It is now targeting the developing world, because it is getting trouble from the western world. It is rightly looking for other markets.

We have had decades of evidence on what they have been up to, such as suppressing and concealing evidence when they knew that smoking was a deadly habit. It has all been documented. There have been television programmes on the subject. We should not be surprised that there are clever researchers selecting the literature that they want to use to try to prove the other argument. It is overwhelmingly obvious that smoking is a suspect habit, and that it must be dangerous for the people in the room if it is dangerous for the person who is puffing on the cigarette. You do not need to be a doctor to figure that out. The way that we have to go is overwhelmingly obvious.

Garry Coutts: If there were another 100 studies on the effects of passive smoking, and they all concluded the same thing, you would still find people arguing against the evidence. We would never have legislated on the use of seatbelts or mobile phones when driving if we had had to wait for the same weight of empirical evidence that there is on the effects of second-hand smoke. We have a very powerful lobby that is selectively using evidence to stop a piece of legislation that is overwhelmingly supported by the public.

Kate Maclean: The point is that we as MSPs and members of the committee must justify our decisions and it is useful for us to be able to present hard evidence to justify them. Obviously, if a person is involved in an accident while not wearing a seat belt and their head goes through the windscreen, there will be simple and straightforward evidence and a scientific study will not be needed. A list of studies that we could consider before we reached a decision would be useful.

Dr Irvine: We can make a point of getting that for the committee.

The Convener: Sending that to the committee clerk would be fine.

I want to move on. I have a list and am taking members in turn.

Dr Turner: I would love you to elaborate on what you think about the general duty of care. Dr Irvine's submission deals with smoking in the workplace, and health and safety at work coming into play with the Health and Safety at Work etc Act 1974. Will you elaborate on that?

I have just thought of something else in relation to the previous question. There might be statistics

that I cannot draw to mind about the number of people who have to have redos in cardiac surgery and who continue to smoke after surgery. As I remember, their arteries fur up faster than those of people who do not smoke. There must be research figures on that matter, but I did not think about looking them up until now.

Dr Irvine: That is okay.

The Convener: Dr Irvine might have those figures at the tips of her fingers.

Dr Irvine: I do not, but we could certainly get hold of them.

I would like to dissect what you have asked about into two issues. The first question was about the Health and Safety at Work etc Act 1974. I am glad that you mentioned that, as I have looked at the act and it clearly states that an employer has a statutory obligation to protect the health of his employees and the health of all members of the public who use the premises. Therefore, a law exists that should prevent smoking in public places, but why is that law not enforced? That is the million dollar question that I have been unable to find anyone to answer. The answer probably relates to the fact that no precedent exists for environmental health officers and the Health and Safety Executive taking action and convincing a procurator fiscal to charge a restaurant or a pub for exposing its staff and the people using it to smoke. They have simply never tried to take action, and if there is no precedent, nobody will want to take the matter on—they will worry that the case will be thrown out. However, if we thought about the matter, there is nothing to stop an EHO from trying to prosecute at the moment on the ground that there is loads of evidence in the literature from a variety of sources throughout the world that suggests that smoking passively is a dangerous activity. Therefore, why are we encouraging it by selling cigarettes in vending machines in such places? The answer to what you ask is that the law exists, but it is not used.

Paul Ballard: There is also a—

The Convener: Please speak when the microphone comes on, if and when it comes on.

Paul Ballard: I am sorry. There is a linked issue that I have come across many times locally. Many people will use the fact that they have ventilation systems—they think that ventilation systems will get them off the hook in respect of the point that Dr Irvine made. However, we can clearly state that a considerable weight of evidence supports the fact that ventilation systems do not remove the carcinogens in the atmosphere that are caused by smoking. Many licensees say that they have ventilation systems and that they are therefore removing the risk, but the research evidence that I have come across does not point to that. Considerable traces of carcinogens are left in the atmosphere. I understand that there must be a tornado-strength ventilation system to remove the whole risk. To link up to what Dr Irvine said, there is now significant evidence to point against ventilation systems as well.

The Convener: Again, we would be grateful if you would provide us with references for that research.

Shona Robison: I have a quick question. Is the denial of any health risk from passive smoking, such as that by the tobacco industry, reminiscent of that industry's denial of the impact on health of smoking itself that it used to propagate before it was evident that what it argued was not the case and it had to accept that smoking is indeed dangerous for people's health?

Dr Irvine: Definitely. It is amazing that anybody believes the arguments, given that we have heard them all before in the context of primary smoking.

The Convener: I ask you to wait until I call your name, because the microphone operator cannot see you. If you could wait until the light comes on, that would be helpful—otherwise, you will not be in the *Official Report*.

15:00

Dr Irvine: I do not usually need a microphone to get my point across.

The Convener: There is a rule that you get into the *Official Report* only if your microphone is on, and your answers are important to us. Shona Robison is content, so I call Duncan McNeil.

Mr McNeil: The debate that we have had illustrates the problem. There are people in the tobacco industry, and there are people on the other side. The people in between need support to use legislation to encourage compliance and to encourage people to stop smoking. We deal with perceptions all the time, and I suggest that the problem is that the messages need to be simpler. On your side of the argument, people claim that primary smoking has important knock-on effects and that the bill will reduce morbidity, mortality, absenteeism at work and the number of fires; it will also improve children's health—the list goes on and on. However, we are not communicating that and nobody believes you. Some 1.2 million people in Scotland continue to smoke despite the wealth of evidence. We are asked to legislate and to encourage compliance, using all the good arguments. Can we not get to the simple messages and effectively communicate them to people, rather than making extravagant claims on both sides of the argument?

Garry Coutts: In the Highlands, only 25 per cent of adults smoke, which is slightly lower than

the Scottish average. In our lifestyle survey of 3,000 of those folks, 65 per cent of smokers said that they wanted to stop. We have overwhelming evidence that the arguments about smoking cessation have got through to all but a tiny minority of people. The job is about helping those people to stop smoking—that is becoming very important. I do not see many people out there who seriously argue that smoking is not harmful.

Mr McNeil: What about passive smoking?

Garry Coutts: The vast majority of people, including the majority of smokers, already support a ban in restaurants—in Highland, 75 per cent of people support such a ban. The public are coming with us, but we need legislation to help to support the majority of the public. At the moment, the public are a step or two ahead of the legislation. If we can take a bold step forward, that will help people who run smoking cessation classes and assist folk who want to stop smoking. It is important to take that bold step to show that we take the issue seriously.

Mr McNeil: People clearly believe that smoking kills—I believe it and I do not know anybody who would argue against it. The job is to legislate to impact on passive smoking and I do not believe that we have won the argument about that. The chief medical officer in Scotland recently suggested that Scottish public opinion is not ready for it and there have been headlines in our newspapers about it. As legislators, we are trying to take people along with us, but I do not think that the same case has been made against passive smoking as was made against smoking.

Dr Irvine: I disagree. I think that people are ready for it. I asked my secretary to print the 318 submissions to the committee—I have them in my briefcase—and I was overwhelmed by the depth of feeling from people who implore the committee to support Mr Maxwell's bill. I do not know what more you need. There were few submissions opposing the bill that did not express a fundamental conflict of interest. Even smokers have written in to ask the committee to take a ban forward. Depending on location, between a quarter and a third of the population still smokes, but that is not evidence that we must not do something about the problem, which is crippling the NHS. Should we believe that just because a lot of people still do it, we should throw in the towel and say, "On you go—keep doing it"?

The fact is that nicotine is a potent addictive agent and smokers cannot give it up, although most of them want to do so. They cannot give it up because it is addictive and because we live in a stressed society in which people rely on crutches such as cigarettes. It does not surprise me that people are having trouble giving up smoking and I think that we should be doing what we can to help people to give up. Setting an example by saying, "You don't do it in public places," is the best way forward. We have been waiting for that for decades.

Mike Rumbles: When the opponents of the bill gave evidence to us last week, they agreed that smoking kills. They also agreed that there is a danger from passive smoking, but where they disagreed was in saying that that risk was statistically insignificant. They also said that there was no evidence that passive smoking kills and I wondered whether there was indeed any evidence that passive smoking kills.

I have a question that follows on from what has just been asked. The submission from Grampian NHS Board mentions public opinion and states:

> "Two thirds of the Grampian population feel that smoking should not be allowed in public places. In Grampian, 7 out of 10 people are non-smokers and of this group, 81.5% believe that smoking should not be allowed in public places."

Could we have some more information on where that information on public opinion came from and more evidence as to its veracity?

Gillian Lee: The evidence came from the Grampian adult lifestyle surveys, which are conducted every three years among a sample of the population. It was from those surveys that we were able to get information about what restrictions people would welcome on smoking in public places.

Your first point has probably already been answered, but there is independent scientific evidence to show that exposure to environmental tobacco smoke contributes to coronary heart disease, stroke and cancers. Dr Irvine can probably provide more detail about that.

Mike Rumbles: The opponents of the bill were adamant in saying that passive smoking does not kill and that there is no evidence to show that it does. They were quite clear about that.

Dr Irvine: Lung cancer has a high case-fatality ratio. That means that, if you get lung cancer, you are probably going to die from it within a year or two. It is a nasty type of cancer and difficult to treat. As a passive smoker, you might have a 1.3 relative risk of developing lung cancer, but lung cancer is still a death sentence for you. According to the study that showed that relative risk, there is a greater risk of death if you have been passively exposed.

Mr Davidson: The witnesses have said that the statistics from their research indicate that people are ready to give up and that there is a willingness to ban smoking. Could they explain why each and every one of the four health boards does not ban smoking on its property?

Paul Ballard: Tayside NHS Board does ban smoking on all its premises.

Mr Davidson: That was not the question. I was asking about banning smoking on your property—in other words, on entering the hospital gates and from there on in.

Paul Ballard: Smoking is banned from all front entrances on all NHS sites in Tayside. The only exceptions that we have made, for humanitarian reasons, are for terminally ill patients, psychiatric in-patients and patients for whom the NHS has become their home. Other than where those exceptions apply, everywhere else is a totally smoke-free environment. If people wish to smoke within any NHS site in Tayside, they have to go to a designated area to do so.

Mr Davidson: So you provide designated areas.

Paul Ballard: We provide designated areas.

Mr Davidson: Where are they?

Paul Ballard: The criteria for a designated area are that it must be out of sight of the public and in a discreet location. Where possible, it should also be sheltered. At Ninewells hospital, for example, shelters have been constructed to the rear of the hospital where staff and patients can go to smoke. There is also an area away from the front entrance where patients only can smoke. Perth royal infirmary, Stracathro hospital and all the main hospitals have similar arrangements for designated areas. We are not able to provide shelters for all the health centres, because there are so many of them, but we are working towards identifying designated areas for all of them.

Mr Davidson: You are saying that smoking is not banned and that you have gone down the route of providing facilities to allow patients and staff to exercise choice.

Paul Ballard: My understanding is that smoking is banned in NHS buildings and their front entrances and that there are three exceptions to that, which have been identified for humanitarian reasons.

Mr Davidson: I am asking why, if the intention is to lead by example, the health boards do not have the courage to follow the evidence that they appear to have and ban smoking on their property. That would send a clear message; it would be more believable and, possibly, more effective than Mr Maxwell's partial control system would be.

Paul Ballard: We did not ban smoking on all our property because some of the hospital sites are extremely large and have extensive grounds. It would be almost impossible to police such a ban. We had to be practical; we do not have security forces to patrol the grounds. We felt that the buildings were the most important aspect, particularly in relation to the issue of passive smoking and the good example that banning smoking in the buildings would set for patients and visitors.

At a recent meeting of the Tayside health improvement committee, the representatives of three local authorities congratulated Tayside NHS Board on taking the lead and said that, because of the lead that we had taken, they would now seek assurances in their areas that they were pursuing the lines that we were pursuing. That has helped in the work that Tayside is doing towards having a smoking ban across the region and is linked closely with the national agenda.

Shona Robison: A lot of the questions in this debate are, rightly, around passive smoking. However, your policies—and one of the main arguments in favour of the bill—relate to the impact on smokers of reducing the number of cigarettes that they smoke during their working day.

Paul Ballard: That is absolutely right. We have concentrated our discussion on passive smoking because of the severe risk but, as one of the school pupils pointed out earlier, if we are to help smokers, the importance of creating a non-smoking culture cannot be overstated. In our smoking policy, we state, as a point of principle, that the policy is designed not only to tackle the issue of passive smoking but to support smokers. To back that up, as well as creating a smoke-free environment, we have put in place smoking cessation services and advice to help smokers to give up.

Garry Coutts: I support everything that has been said. There is evidence to show that the ban on smoking in public places will not only help people to stop smoking—being unable to smoke in public places when I went to America certainly helped me to stop—but decrease the amount of cigarettes smoked by those who continue to smoke. That will have an impact on the health of smokers.

Dr Irvine: The literature suggests that we would have a reduction in smoking prevalence of between 10 per cent and 15 per cent in relative terms. That means that, in Glasgow, the number of smokers would decrease by between 4 per cent and 6 per cent. That would have huge ramifications for reduced morbidity and mortality rates among smokers. More important, their children and their unborn children would be less exposed to smoke. That group has been neglected because, in the past, we have endorsed the habit. We must bear in mind the fact that decades of children have had no choice. They have been exposed to a highly toxic substance in utero and once they were born, because we have said that smoking is okay. By providing so many

public places in which people can smoke, we have given out the wrong message.

15:15

Kate Maclean: Do you have any evidence that cutting down smoking in the workplace reduces the amount that people smoke overall? When I smoked—I smoked about 20 a day—I found that, when I was not able to smoke at work, I simply smoked more at other times. I still smoked about the same number of cigarettes. I smoked for 35 years and, despite the fact that during that time there was a gradual reduction in the number of places in which people could smoke, I found that that did not mean that I smoked less.

Garry Coutts: I must admit that that was my experience when I was a smoker.

The Convener: We are hearing about shared experiences.

Garry Coutts: When I went through the literature in preparation for my attendance at today's meeting, I found that there is evidence of the benefits of smoke-free workplaces. A study in the BMJ concluded:

"Smoke-free workplaces not only protect non-smokers from the dangers of passive smoking, they also encourage smokers to quit or to reduce consumption."

That is the evidence of a BMJ study, which we will make available. I must admit that that was not my experience.

Mr McNeil: Last week, ASH said in its evidence that results such as the 30 per cent reduction in smoking that it was claimed had taken place in Finland were produced not just by a ban; they were helped by all the other measures that were implemented on top of the ban. It is vital that bans in the workplace such as that which Tayside NHS Board has imposed are not applied on their own, but that support such as patches and buddy systems are provided.

The Convener: Helen, do you have a supplementary?

Helen Eadie: I have a different question.

The Convener: I am trying to remember where I am. Shona Robison has a supplementary.

Shona Robison: I have a quick question for Paul Ballard from Tayside NHS Board on the point that we have just discussed. As you proceed with your policy on smoking, have you been monitoring the number of smokers who have given up smoking or who have reduced their smoking? If so, can you make that information available to us?

Paul Ballard: The monitoring committee is monitoring the effectiveness of the policy's implementation. There will eventually be feedback from patients and staff. We had not intended to assess the extent to which people have given up smoking as a result of the policy; our intention was to assess feedback on how effectively people felt that the policy was being implemented.

We are conducting a piece of work to measure the numbers of people who are attending smoking cessation groups throughout Tayside. From that, it should be possible to identify what motivated them to come to those groups. In due course, that information will be available.

Gillian Lee: An integral part of our tobacco policy in NHS Grampian is that we have provided smoking cessation services on site for staff and patients, so we can provide the committee with data on the number of people who have been seen in the hospital setting and who are receiving smoking cessation support through the link with our community-based service. That will be part of the ban and part of the care plan that those people have in the hospital setting. We can give you that information.

Helen Eadie: I have a different question altogether. Today, we have heard on the news that 140 deaths have been saved by the Government's measures to enforce speed restrictions on roads using a variety of measures, such as cameras. Do you know the cost of every item of care that is used to treat patients who are suffering from lung cancer or any of the variety of cancers? My point is that, for each of the 140 road deaths that are saved, £1 million is saved. That means that the Exchequer is saving £140 million. What would the Exchequer save for each person who did not have to be treated for lung cancer or any other cancer?

The Convener: I have a feeling that that is the witnesses' ink exercise for tonight, but if you feel that you can comment just now—

Garry Coutts: The cost to Highland NHS Board is £5.8 million, although I am not sure of the source of that figure. Nonetheless, it is a significant sum that could be invested in care elsewhere.

Helen Eadie: Can that be broken down to individual cases? We know what it costs when the chancellor puts up the tax on a pint of beer, but can we tell what the costs are for one individual to be cared for? Have you discussed that with your peer group?

Dr Irvine: I have not done that type of calculation, but I point out that it is cheaper for the NHS if someone drops dead from a heart attack than if they live for 30 years with peripheral vascular disease or ischaemic heart disease, for example. We have to bear in mind the fact that the morbidity is much more costly than the people who die from disease.

Helen Eadie: We know that some say that a hip replacement costs £4,000 in the NHS and others say that it costs £7,000 in the private sector. I would like to have a ball-park figure of what it costs the NHS to treat people with a different variety of cancers.

Dr Irvine: I do not have that data to hand, but we can see whether the information exists somewhere.

Janis Hughes: The bill is about the prohibition of smoking in regulated areas. The committee has received some written evidence that argues that a blanket ban on smoking in all public places would be easier to enforce than a ban in specifically regulated areas. Would a blanket ban be more beneficial or would it place an undue demand on the enforcement agencies?

Paul Ballard: As we say in our submission, although we fully support the bill, our preference is for a wider ban than just in eating places. A wider ban would be easier to enforce, because the arrangements would be less complicated—with all due respect to the bill, we think that it would lead to certain complications for enforcement. As I said, local publicans have told me that they would prefer a total ban because it would make things a lot simpler for them. In economic terms, they would prefer a system whereby the public knew right away that there was to be no smoking where food or drink was being served. We would prefer a blanket ban, whether it comes from the bill or at a later date—and I hope that it is not too much later. Looking at the evidence from around the world, we can see that there are successes in New York and I believe that that is because the city has taken a blanket-ban approach. I suspect the evidence from Ireland will be the same.

Janis Hughes: Would such a ban put an extra burden on the enforcement agencies?

Paul Ballard: No, it would make things simpler. Some provisions in the bill, such as the five-day rule, will be quite complex to enforce. There will also be questions about definitions, which might cause difficulties. A blanket ban would remove those problems and make it a lot simpler for enforcement agencies such as the police to define clearly when a breach has taken place.

The Convener: The term "public places" also applies to places such as parks. Would it be necessary to ban smoking in a large public park?

Dr Irvine: I find it annoying when I go into a park and someone sits beside me on a bench and lights up, but I think that imposing a ban to cover that situation would be going too far. We have to be reasonable and talk about enclosed public places.

The Convener: I did not know whether Paul Ballard had used that phrase—I thought that we were talking about "public places", but you are talking about "enclosed public places".

Paul Ballard: Yes. I meant places where food and drink are served.

Garry Coutts: It is interesting to note that members of the previous panel suggested that a ban on smoking in public parks might be appropriate. Indeed, in some places, a ban on smoking on beaches and in parks is being considered. However, we would be more than happy with a ban on smoking in enclosed public spaces at this time.

Shona Robison: Do you have a view on the requirement in the bill that next to a regulated area there should be an area called a "connecting space", which would also be a non-smoking area?

Dr Irvine: I can understand why the bill addresses that issue, but it reinforces the argument made by Mr Ballard that it would be easier to ban the whole kit and caboodle. It is difficult to regulate only certain areas; it is easier to ban smoking in all enclosed places.

Paul Ballard: Tayside NHS Board raised the issue in its submission. The issue around smoke drift is difficult to sort out. I know that connecting spaces are meant to prevent smoke drift but, like Dr Irvine, we felt that the situation would become too complicated and that it would be simpler to ban smoking throughout an enclosed place.

Dr Irvine: I would like to go back to the point that Mr Davidson made about smoking policies in the NHS—I agree with him 100 per cent. I am disappointed with Greater Glasgow NHS Board's history on the issue, as the line that it took was never strong enough for me. I can see why it gave in in certain areas, such as psychiatric wards and terminal care wards. The issue was made even more difficult because a lot of the porters, nurses and others smoked and, when staff do not want to comply, a ban is difficult. However, I agree with David Davidson and I think that we should insist on hospitals being 100 per cent smoke free if the policy is to have any credibility.

Mr Davidson: The point that I was trying to make was that the NHS seems to be happy to run to get legislation to deal with an issue on which it has not managed to change the culture, despite the medical knowledge and the reinforcement of the message by the various medical and health promotion professions. Do you believe that to go down the route of a partial ban would be an indictment of the fact that the health service has not been strong enough?

Dr Irvine: It is evidence that the Scots are compassionate. They say to somebody who is

dying of lung cancer and asks for a cigarette, "On you go." Perhaps I would not be so compassionate, but the Scots are. If all that somebody with mental illness has in the way of pleasure is smoking cigarettes all day long, the Scots will say, "On you go." The fact is that psychiatric nurses and psychiatrists—I was in psychiatry for six months and I had to inhale all that smoke for the duration—have to put up with smoking, because we are looking after mentally ill patients. However, that is the biggest cop-out. We are effectively saying, "You are mentally ill, you have schizophrenia—on you go, ruin your heart and lungs. Here is a pack of cigarettes." In fact, there was a drawer in the nurses' station full of cigarettes for that purpose. That must come to an end. I agree with David Davidson's point, but it is not simply an indictment of the fact that we have failed—we have just not had enough courage. I am saying that we should all have courage and bite the bullet, not only in the NHS but everywhere else.

Mr Davidson: However, you still think that that can be done only through legislation.

Dr Irvine: Yes. The submissions that you have received overwhelmingly state the case. The best argument that I saw was from the Scottish Consumer Council. I do not know whether members have been able to read every submission—there are an awful lot of them—but they must read that one, as it is a beautifully articulated explanation of why we need legislation. The voluntary charter will never work; even the pub owners would tell you that. None of them will volunteer to restrict smoking unless everybody else is forced to do it at the same time.

Paul Ballard: We need to be clear about the issue. What we are saying—and NHS Tayside is not the only one—is that there will be specific designated areas for the three exception groups of patients, which I identified earlier, to smoke. As Dr Irvine pointed out, those exceptions are made for humanitarian reasons; it is not a question of failure. The point is that those are highly vulnerable people who have an addiction and have less choice and less opportunity than other groups to do anything about it. I fundamentally support the whole no-smoking policy agenda, but I also fundamentally defend the human rights of those three groups to have an area—specifically for them—where they can smoke. It would be a serious mistake for us to say to people who are in an institution for a considerable period, who may be dying and for whom whether they smoke or not will make no difference to the final outcome that smoking is not allowed anywhere, by anyone, and that the fact that they are in a vulnerable category is just hard luck.

Over time, the number of people who smoke, even in the groups to which the exception applies, will reduce. However, in these early days, as we start to roll out radical and important initiatives, we must remember the vulnerable in society. One or two points were made about choice. As I said earlier, vulnerable groups in our society live in areas of high deprivation and have little choice about many things. We must be sensitive to their needs. The smoking agenda does not mean saying that smoking should be banned in all circumstances. We should pursue a ban on smoking in public places, because of all the important points that have been made, but we must recognise that the smoking agenda is complex and that not every group is the same. Not every member of society can make the same choices as others. In the work that we do, we must take into account poverty and vulnerability.

15:30

Dr Turner: What are your views on using the criminal law partly to reduce passive smoking? Do you think that the penalties that would be faced by those convicted under the bill are appropriate? Have you thought about the fact that the bill will make smoking in public places a criminal offence?

The Convener: Paul Ballard's light is on. I do not know whether that is involuntary, but now he will have to answer the question whether he likes it or not.

Paul Ballard: I have certainly thought about the fact that the bill would make smoking in public places a criminal offence. If the bill becomes law, that will happen automatically. A long time ago, drink driving was the norm. Now we would not think twice about saying that someone who knocks another person down with their car while they are drunk should be prosecuted. If we have legislation that recognises formally the dangers of passive smoking and the fact that it makes people ill and kills them, and an owner is irresponsible enough to allow passive smoking to continue on their premises, in spite of the law, of course that owner should be prosecuted. That is the issue. Without that sanction, we will not have the effective ban that we need.

The Convener: Does anyone else want to take up the cudgels, although perhaps that is the wrong word?

Garry Coutts: People are agonising over the issue of penalties and enforcement, but that is a secondary argument. Evidence from other parts of the world indicates that enforcement has not been a big issue once a ban has been put in place. We can sort out those matters over time. The only aspect of the bill about which I am concerned is that it relates both to the smoker and to the holder

of premises. In my view, owners of premises have the principal responsibility. There is also an equality issue, because whether people can afford to pay a fine depends on their income. However, the principal issue is the need for legislation. The number of prosecutions in other parts of the world is small. In the vast majority of cases, people obey the law. Rather than worrying about the detail, we should aim for that outcome.

Mr Maxwell: I am interested in your comments about enforcement. Do you know of any other law that was designed to protect the public and in which specific provision for enforcement, rather than the usual provision for enforcement through the police, was made?

Dr Irvine: I am sorry—whom are you asking?

Mr Maxwell: Anybody. Does anybody know of any laws to protect the public for which we use not the police but some kind of special force?

Garry Coutts: I cannot think of any special force.

Dr Irvine: Traffic wardens?

The Convener: I think that Mr Maxwell's question is for the Crown Office rather than for health professionals.

Mr Maxwell: The point about enforcement has been raised before. People have said that enforcement will be a problem and that we will need special smoke police, or whatever you want to call them. However, we do not use special drink-driving police or special other kinds of police; we just use the police.

Dr Irvine: Good point.

Mr Maxwell: Last week, FOREST tried to give the impression that the scientific evidence was balanced at 50:50. FOREST suggested that there was a reasonable debate to be had between the two sides of the argument—for and against. Do you agree that the evidence suggests a 50:50 split? If not, what is the split?

The Convener: I think that the witnesses have already answered that, but they may respond briefly if they want.

Dr Irvine: People can make it look as if the split is 50:50 when they select evidence to suit their argument. However, if you did a review of the literature on the subject, printed off every study and counted them all up, for and against, you would find that the vast majority of them suggest that there is an effect.

Mr Maxwell: I am trying to elicit an estimate from you. Is the split 50:50, or 90:10?

Dr Irvine: I would suggest that it is more like 90:10. However, the only way in which you could be sure would be by printing off all the pieces of evidence, of which there are hundreds. You would have to consider all the evidence.

The Convener: We must also consider the quality of the evidence, not just the quantity.

I wanted to ask one more thing about enforcement. Two of you have been to the United States. Have there been problems with prosecutions in New York?

Garry Coutts: I was not aware that enforcement was an issue. However, just before the law came into force in Ireland, the one issue that we heard about time and again—almost sneeringly—was that enforcement would be a nightmare. I do not hear a murmur about it now and I think that that is what will happen when the measures are introduced here.

Dr Irvine: I want to turn the argument on its head. My relatives live in British Columbia and, when I visit them, it is wonderful to be in all the places where there is no smoking. When they came to visit me last summer, they complained bitterly about the amount of smoking here. If you are worried about your tourism, you should worry about the amount of smoking in restaurants and pubs and about the fact that you cannot get away from it. Moreover, public toilets are non-existent, being closed down or in an appalling condition.

The Convener: I am not sure that that comes within the remit of the bill, but you have made your point.

That brings us to the end of what has been a most useful evidence session, for which I thank the witnesses very much. The session was quite long, so are members happy to take a 10-minute break now?

Members *indicated agreement*.

15:38

Meeting suspended.

15:53

On resuming—

The Convener: I reconvene the meeting. Before we move on to the next panel of witnesses, I have a question for members. I am aware of the pressure of business in what is a long agenda today. Would the committee agree to deal with item 4, on our work force planning inquiry, at next week's meeting? The issue is already on the agenda for then. I ask members to ensure that they have plenty of time for that meeting because we must also deal with stage 1 of the Breastfeeding etc (Scotland) Bill next week. Does the committee agree to my suggestion?

Members *indicated agreement*.

The Convener: That means that we will take our panel of witnesses and then move straight on to agenda item 5, which should not take too long.

I welcome to the committee Dr Peter Terry, deputy chairman of the Scottish council of the British Medical Association, and Dr Sinead Jones, director of the tobacco control resource centre of the BMA. May I ask you to turn your name-plates towards me? It is difficult to see them from where I am sitting. Thank you—you did that like ballroom dancers in formation.

I also welcome Geoff Earl, who is the Lothian member of the Scotland board of the Royal College of Nursing, and Dr Malcolm McWhirter, who is the convener of the Scottish affairs committee of the Faculty of Public Health.

Shona Robison: FOREST and others say that the risk from second-hand smoke has been exaggerated. Indeed, I think that they have gone as far as to say that the existence of such a risk has not been established. How do you answer that?

Dr Peter Terry (British Medical Association): Those sources are trying—not very effectively—to put up a smokescreen, if I may use that term.

The Convener: You have used it.

Dr Terry: I regret that now.

The evidence is overwhelming. I listened to the earlier part of the meeting and it seems that the committee is concerned about the evidence for and against the risk from passive smoking. There are fairly weighty tomes that are full of evidence and Sinead Jones might comment on a specific study, which concludes overwhelmingly that passive smoking has a harmful effect. There is no doubt about that in my mind or in that of most other health professionals.

FOREST clearly has a vested interest in its selection and presentation of evidence to the committee, because it is trying to protect an industry. However, that industry causes disease and death, not only in Scotland but throughout the world and we have a duty to meet it head on. The evidence that FOREST produces is overwhelmingly outweighed by the evidence that smoke is harmful.

Dr Malcolm McWhirter (Faculty of Public Health): It is wrong to portray the arguments as being split 50:50, as if there were two sides to the argument. Most health professionals consider public health in the population in Scotland as a whole and in the health board areas in which they work, whereas the tobacco industry and FOREST should be regarded as a marginal group, although it is a lobbying group.

I have passed to the official reporters a briefing paper from the Faculty of Public Health entitled "Tobacco Smoke: Pollution and Health", which was prepared in the past two weeks. It is a well-referenced document and I hope that the committee will find it useful.

Shona Robison: I put this question to the previous panel of witnesses: are the arguments that the tobacco industry puts forward about passive smoking similar to those that it used to make about the absence of proven health effects of direct smoking?

Dr Sinead Jones (British Medical Association): The record shows that that is the case. For many years, the tobacco industry denied that active smoking was harmful to health, although there was a mounting body of scientific evidence and a scientific consensus that smoking does indeed kill. The industry now knows that it cannot win the argument about active smoking, but it is desperately trying to instil insecurity in policy makers about the evidence base on passive smoking.

I strongly encourage the committee to read the International Agency for Research on Cancer monograph to which my colleague Dr Terry alluded. That United Nations agency is the scientific and technical body of the World Health Organisation and has a remit to consider cancer prevention. It considered the evidence on active and passive smoking by considering every published study—whether negative or positive—and it made a balanced judgment, not just on the basis of the statistics but on the basis of the biological evidence, animal studies and post mortem data. The agency concluded very clearly that passive smoking increases the risk of lung cancer by between 20 and 30 per cent. That is a significant increased risk. If there are high levels of exposure, the risk will be higher. When that exposure is removed, the risk goes down. The study has all the commonsense features of cause and effect. It is an excellent summary and I commend it to the committee.

Mr McNeil: Does the study refer to the danger of passive smoking in public areas, or to the danger of passive smoking in the home?

Dr Jones: It considers all the studies that have been published on passive smoking. It refers both to studies that have been carried out on passive smoking in the home, and studies of passive smoking in the workplace.

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 theme in our attempts to control tobacco, which is the major cause of health inequalities in Scotland.

Dr Terry: Clearly, the primary purpose of the bill is to protect the non-smoking public when they are in public places. That does not mean that we cannot welcome all the other spin-offs from it. Those benefits include comfort, the fact that people may smoke less and possibly even stop and the fact that the bill may make smoking less socially acceptable than it is at the moment and encourage people to give up. However, we should be clear about the primary purpose of the bill.

Dr Jones: I will summarise some of the international evidence. When workplaces become smoke free, there is a reduction of about 30 per cent in overall tobacco consumption. On average, people who continue to smoke smoke three cigarettes fewer per day and the overall rate of smoking drops by about 4 per cent. Obviously, there is a significant gain to be had. Making workplaces smoke free encourages people to give up and supports them if they are trying to do so. It cuts their tobacco consumption, even if they continue to smoke. Besides protecting non-smokers, which is the principal purpose of the measure, it is helpful to smokers. Let us not forget that 70 per cent of smokers want to stop smoking and find that hard to do.

16:15

The Convener: A few members of the committee have succeeded, some quite recently.

Dr Jones: Congratulations.

The Convener: We are all coming out the closet.

Helen Eadie: I have never been a smoker. It has been suggested in written evidence from ASH and in the great volume of submissions that have been made to the committee that a blanket ban on smoking in all public places would be easier to enforce than the proposed ban on smoking in regulated areas. Do you think that a blanket ban would place an undue demand on the enforcement agencies?

Dr Jones: The evidence from countries that have introduced blanket bans is that they are relatively easy to enforce, provided that certain conditions are in place. First, there needs to be a reasonable level of public acceptance that passive smoking is a health risk. In the UK, we already have that. About 80 per cent of adults accept that passive smoking is a cause of lung cancer, so we have a sound body of evidence on which to build.

Secondly, there need to be meaningful regulations that are properly enforced. If the regulations can be coupled with measures to help smokers to stop smoking, that is so much the better. If nicotine replacement programmes and the associated health services are introduced, there is a real improvement. In Ireland, smoking prevalence dropped by 4 per cent in four years during the preparation phase, after the legislation was announced. In Scotland, the target is a drop of 4 per cent over 14 years. That gives the committee some idea of the progress that can be made.

Dr McWhirter: I came here today from Stirling by train—I use the train regularly. No one was smoking in the carriage and no police were present. That is a good example of people accepting that they should not smoke. The bill would act as a deterrent, but I do not see why the situation that I have described cannot apply across the board, as long as there is clarity. Everyone knows that on ScotRail trains the whole train is a no-smoking zone. If in public places people are not sure in which rooms or corridors smoking is not permitted, the situation becomes difficult. If someone had lit up on the train on which I was travelling today, the enforcer would probably have been me—I would have told them that they were not supposed to smoke on the train. Enforcement is not just about the police—we can all enforce legislation and remind others of the law.

Helen Eadie: I will put the same question to you that I put to the previous witnesses. Do you know the cost to the NHS of caring for an individual patient with a form of cancer? Can you provide us with that figure?

Dr Jones: I have only a global figure for the treatment of tobacco-related illnesses by the NHS in Scotland, which is about £200 million a year.

Mr Davidson: In the bottom paragraph on page 1 of its submission, the Faculty of Public Health cites the fact that

"£200 million will be used in the treatment of tobacco related disease in Scotland alone."

The submission goes on to give evidence about the use of statins and suggests that people are prescribed those drugs

"because the additional risk of their tobacco smoking brings their total risk of CHD to a level requiring treatment."

Can you give us the statistics please? What percentage of statins use at the moment is for other reasons? I am thinking of the treatment of long-term diabetics over 50 and so on. The situation is not as simple as has been described. Could you firm up on the evidence please?

Dr McWhirter: Statins are used for cardiovascular disease including stroke or coronary heart disease. Several different factors can produce the effect of furring up of the arteries. Those factors include tobacco smoking, high blood pressure, high blood sugar—for example, in cases of diabetes—and diet. There is no single cause; all the causes come together.

In respect of coronary heart disease, the causes do not add up; they multiply. That is why Scotland has a particular problem in this regard: the diet is poor and blood fats are high and smoking and high blood pressure are also involved. The point that I was trying to make is that it is not possible to look at one cause in isolation from another. We have a tendency to look at some of those diseases and think that a drug is the treatment when in fact one of the treatments is to stop smoking. That is a very effective and—dare I say it—a very cheap treatment.

Mr Davidson: I just wanted clarification on your evidence, as your submission does not quite read like that.

Shona Robison: Does any member of the panel have a view on the requirement in the bill that next to a regulated area there should be an area called a "connecting space", which would also be a non-smoking area?

Dr Terry: As we suggested earlier, those areas make the situation a little bit more complicated. As my colleague Dr Jones mentioned, the legislation needs to be as clear as possible. If signage is also clear, everybody will know where they can and cannot smoke and that will make things easier. We would prefer to see a ban on smoking in all enclosed public spaces. The proposal for the "connecting space" areas is confusing. I can see exactly why one would want to remove the smokers from the non-smokers, which is presumably the reason for having the connecting spaces, but I agree that the provision will confuse more than it will help the situation.

Geoff Earl: Notwithstanding what has been said, I can see the logic in the provision. The problem in not going for a prohibition on smoking in enclosed public spaces is that we are getting into these difficult areas. I understand that a barrier is needed between the smoking and the non-smoking areas as smoke would otherwise drift between them.

Dr Turner: Apart from the question that I asked the last lot, if—

The Convener: "The last lot" is a bit of a casual remark. I am sure that Dr Turner does not wish to leave it at that for the *Official Report*.

Dr Turner: Yes. I did not mean it that way; I should have said "the last panel". I have been thinking about all the experience that the panel members have. If you had a magic wand, what would you do to save the health of the public of Scotland and save money for the health service? What is the biggest single thing that you could do in relation to the discussion that we have just had on the bill? Are there any doubts in your mind about what would save the most money and, at the same time, save the nation's health?

Dr Jones: Again, if one looks at the research evidence on the tobacco control measures that work, one can see clearly that the measure that we have not taken as yet in this country is to make indoor public places smoke free. There is now a good body of evidence that smoking in those places is harmful to health.

A ban on smoking in enclosed public spaces works in a number of ways, the first of which is the important fact that it protects non-smokers. At the moment in this country, the only substance that has been proven to cause human cancer and that is not regulated in the workplace is second-hand smoke. We are the only country in Europe not to have any such legislation, which is rather shameful.

We also know that a ban works—it helps smokers to give up. When smokers give up, fewer parents smoke and that means that fewer children are exposed to second-hand smoke 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?

Geoff Earl: From a nursing perspective and given the spirit in which the question was asked, I know that nurses would want to take all the people who are against a restriction on smoking in public places to meet people who suffer from the effects of smoking tobacco and to see the pain that they and their families go through. Nurses would say that although a person might have made the personal choice to smoke an addictive substance, they should not be allowed to force that killer on non-smokers. I would like to think that, once they had seen the effects of smoking tobacco, all those who oppose restrictions on smoking tobacco in public places would understand why we need them. The issue is about the choice of non-smokers not to develop smoking-related illnesses.

Dr McWhirter: Reducing tobacco smoking in the Scottish population is the one thing that will have a major impact on Scotland's health. Smoking is one of the reasons why Scotland's health is worse than that of the rest of the United Kingdom and why inequalities in Scotland are so much greater. The poorer someone is, the more they are likely to smoke and the more that impacts on their income. The bill is just one element of addressing the problem. We should also try to ensure that young people do not start smoking. Certainly, the young people who gave evidence earlier made their views very clear. We do work with schools within Forth valley and there have been many positive initiatives.

The proposed act would be only one arm in managing smoking, but it would be an important one. Over the past 15 years, smoking rates in Forth valley have gone down from 44 per cent to 29 per cent, but it is getting more difficult to get the rate down further. The 29 per cent of people who still smoke are finding it harder to stop. We must do everything that we can to make it easier for them.

Dr Terry: We can use all sorts of mechanisms to reduce smoking—for example, education, banning tobacco advertising and providing support for people who are trying to give up smoking. The bill is an aspect that we need to get in place, but other mechanisms are also important and will have an effect. I do not want the committee to think that enacting the bill is the only thing that has to be done and that things will then suddenly get better—that is far from being the case. We need to do all the other things as well.

Dr Turner: So you do not have any difficulty with the fact that we would be using a measure in criminal law to reduce passive smoking. Do you have any difficulties with that? That was the question that I was supposed to ask.

The Convener: No, you are not supposed to ask any question; you ask what you want.

Dr Turner: So many questions go through one's mind when one listens to others. Does the panel have any difficulty with the penalties that people who would be convicted under the bill would face?

The Convener: I may be wrong, but the smile on Dr Terry's face seems to say no. Perhaps he will tell us.

Dr Terry: You are absolutely right—I have no problem with people facing penalties. That is the only way in which the proposed act will work. There is not much point in having legislation and then allowing people to carry on smoking in restaurants because we will not do anything about it. That would send completely the wrong message. I thought that the whole point of legislation was to outlaw something and change the rules within society.

Geoff Earl: We use legislation to control different types of behaviour all the time. The speed controls that are being introduced in built-up areas—the speed limit has been reduced to 20mph on a number of estates—has nothing to do with controlling speed on the roads; it is about the fact that a child who is hit by the bumper of a car travelling at 20mph may well survive, but they will not survive if they are hit by the bumper of a car travelling at 30mph. In that case, criminal law has been introduced purely as a protective measure and not as something to outlaw behaviour. Banning smoking in public places is also a protective measure, for which we need legislation.

Dr Jones: The other thing to point out is that the evidence from throughout the world shows that voluntary approaches are worth trying, but they do not work. We have had 15 years of voluntary approaches in this country, the last one being the public places charter. After five years of that charter, less than 1 per cent of pubs in Scotland are smoke free. Three months after bringing in legislation in Ireland, 96 per cent of pubs are smoke free. Where laws are cleverly designed and carefully enforced, they make a difference.

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.

Timescales and Stages of Bills

16:40

The Convener: We move on briskly to agenda item 5. I refer to paper HC/S2/04/16/11. With the leave of the committee, we will focus only on the parts of the paper that are in bold, as the rest is narrative. Are members content with that?

Members *indicated agreement*.

The Convener: The first part in bold is on page 3. Could I have members' comments so that we can come to some kind of agreement? We want to finalise the response today.

The draft response suggests that there should be

"a **minimum period of eight weeks** in which to gather evidence prior to taking a decision as to oral witnesses."

Are members content with that?

Members *indicated agreement*.

The Convener: The next bit states:

"We have no experience this session of acting in the capacity of a secondary committee.

It is suggested that the following factors should be taken into consideration when the timetable for Stage 1 is agreed—

The Bill's length and the complexity of the issues."

Do members agree? That is common sense.

Members *indicated agreement*.

The Convener: The next two factors are:

"The number of different subject areas covered by a Bill."

and

"The number of other committees which may require to contribute to the process."

I think that those are obvious. The next factor is:

"Politically sensitivity; is the Bill contentious? Reports may take longer to draft, discuss and agree."

Mr Davidson: Will you remind me of the comment that I sent to the clerks? I had a very hectic weekend.

The Convener: The comment that you sent us was:

"May I propose that the Business Bureau along with the propose of any Bill meet with the lead and secondary committees to negotiate the timetabling once the scale of the proposed legislation is made available."

Mr Davidson: Thank you.

The Convener: We could add that at the end of the list as a further bullet point. At the moment, the final point is:

"The workload of the lead and secondary committees – other referred work can include SSIs and petitions together with the Committee's own inquiry work."

We could add that the proposer of a bill—your email says "propose", but I think that it should be "proposer"—should meet the lead and secondary committees to negotiate the timetables, presumably, in many cases, with the minister. However, is it not the bureau that does that?

Kate Maclean: That was my question. Is it not the bureau that decides that?

The Convener: Yes. I do not think that the suggestion is appropriate, but perhaps we need more input at an early stage from the lead committee and the secondary committees, before the bureau takes over. We want the bureau to make contact with the lead and secondary committees—

Kate Maclean: To consult them.

The Convener: That is the word that I am looking for. The bureau should consult the committees before setting the timetable.

Mr Davidson: Quite simply, I do not understand how, with its work load, the business bureau would be able to anticipate certain nuances that would lead the committee to decide how deeply it would want to dig into a matter. It would save a lot of time and argument if that was done early on. Some bills might be simple, but others might be more complex.

The Convener: Will you give us the wording that you want?

Mr Davidson: Perhaps someone could refresh members' memories of what I sent to the clerks. In any case, I think that it contains a typing error.

The Convener: So you have the wording with you.

Mr Davidson: The e-mail says:

"May I propose that the Business Bureau along with the"

proposer

"of any Bill meet with the lead and secondary committees to negotiate the timetabling once the scale of the proposed legislation is made available."

I went on to say:

"It is quite ridiculous that a standard timetable is set-up as Bills can range from simple to complex"

and so on.

16:45

The Convener: We have already dealt with the point in the paper about

"The Bill's length and the complexity of the issues".

Kate Maclean: That would be covered by the reference to consultation. After all, in the consultation, the lead committee or any other committee could comment on the amount of time that might be needed to consider a bill. Instead of saying that there should be a meeting with the bureau to discuss the matter, which might be difficult, we could have a pro forma which might be used to submit comments.

Mr McNeil: Does that not already happen through the clerks?

The Convener: No.

Mr McNeil: Then how do they feed into the bureau at that point? Is the matter directed by the business manager of the Parliament?

The Convener: I think that that is correct. To the best of my knowledge, I do not think that we have any input.

Mr McNeil: I presume that she receives advice about how long things are likely to take.

The Convener: I think that some clerks have discussions.

Mr McNeil: I know that if there is a problem, the conveners go along to the bureau. I believe that that approach has worked up to now.

Tracey White (Clerk): I understand that, at the moment, representations are made, but not formally.

The Convener: In that case, should we say something about formalising current practice to ensure that there is consultation with the lead and secondary committees prior to setting a timetable?

Mr Davidson: I am certainly not hung up on my wording. I just think that my suggestion would simplify matters.

The Convener: We will send members a form of wording about consultation prior to setting a timetable.

On page 4, the paper says:

"For both Stage 2 and Stage 3 members are invited to consider the following … The timing of the daily deadline—should it be the same time on every lodging day? Should it be 2pm as set down in standing orders for the final day on which notice of amendments may be given before Stage 2?"

I think that, for the sake of simplicity, the time should be the same on every lodging day, as it means that we do not miss anything. Therefore, the question is: what should that time be? I believe that it is 4.30 pm at the moment. Should we say that it should be 4.30 pm for all lodging days?

Members *indicated agreement*.

The Convener: The paper then goes on to ask our views about the number of days before the day of consideration by the committee by which amendments should be lodged. At present, the deadline is two sitting days.

Janis Hughes: I do not think that that is long enough.

The Convener: Neither do I. Should we suggest that the deadline is five sitting days? After all, that is a working week.

Janis Hughes: It should be five working days. After all, that is the deadline for Executive amendments.

The Convener: On the lodging of Executive amendments, the paper asks for our views on the number of days prior to the deadline for members' amendments, and says:

"At present the agreement is 5 sitting days with Standing Orders allowing lodging up to 2 sitting days".

I believe that we want that deadline to be formalised to five or more sitting days. Do we want more of a deadline for Executive amendments?

Shona Robison: Would that not require standing orders to be changed?

The Convener: Yes, but the Procedures Committee is considering changes to standing orders in this respect. Do members agree that the deadline should be five sitting days for Executive and members' amendments?

Members *indicated agreement*.

Janis Hughes: I know that it is not in bold type, but the conclusion of the paper states in relation to the work of the former Health and Community Care Committee on the Mental Health (Scotland) Bill:

"The members of the Committee at that time felt that the passage of this Bill was extremely unsatisfactory and the quality of scrutiny was severely compromised."

As a member of the previous committee, I have to say that members were very unhappy about what happened with the Mental Health (Scotland) Bill. Indeed, it is noted earlier in the paper that the bill took longer to come before the committee than we had been led to believe. However, I do not want people to think that the legislation that we passed was compromised in any way. Although it is correct that we found it difficult to get the bill through in time, the committee worked very hard and gave the bill a lot of scrutiny. Certainly, we should make it clear that we need to learn lessons for the future from what happened, but I feel that the phrases "extremely unsatisfactory" and "severely compromised" do not reflect previous committee members' work on the bill.

The Convener: I cannot comment on that, because I was not a member of the committee. I

seek comments from the other member who was on the committee at the time.

Shona Robison: I am not going to go to the wire on this matter, but I must say that it is possible that the bill was compromised. After all, the fact that the Executive has had to fix some of the legislation as a result of certain problems suggests that, due to the rush and lack of time for scrutiny, things were not done as they should have been. Whether that means that the bill was compromised or "severely compromised" is a matter of wording. However, the legislation was not as good as it should have been.

The Convener: The huge problem was that 480 amendments were lodged at stage 3. Janis, would you be content to say that the quality of parliamentary scrutiny was compromised? After all, it is terribly hard for MSPs to give any thorough consideration to amendments at stage 3. We rely on what the committee does at stage 2.

Janis Hughes: I would be happy to say that the passage of the bill was unsatisfactory and that the quality of scrutiny may have been compromised. I am not suggesting that we ignore that fact completely. I just feel that the wording as it stands—

The Convener: Do you want to say that the quality of scrutiny by Parliament may have been compromised because so many amendments were lodged at stage 3?

Janis Hughes: I am happy with the phrase "may have been compromised".

The Convener: If we include the phrase "scrutiny by Parliament", it gives some focus to the problems at stage 3. Are members happy with that?

Members *indicated agreement*.

The Convener: Thank you. That concludes the meeting.

Meeting closed at 16:51.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Thursday 24 June 2004

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £3.75
Special issue price: £5
Annual subscriptions: £150.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

RNID Typetalk calls welcome on
18001 0131 348 5412
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178