

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL: SMOKING BAN IN CERTAIN WHOLLY ENCLOSED PUBLIC PLACES

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The '[Smoking, Health and Social Care \(Scotland\) Bill](#)' was introduced on 16 December 2004. Part 1 of the Bill deals with the prohibition of smoking in certain wholly enclosed places. This follows commitments made by the Scottish Executive after its consultation on '[Smoking in Public Places, a Consultation on Reducing Exposure to Second Hand Smoke](#)' (2004a).

This briefing describes current trends in smoking, it then discusses smoking within the current legislative framework, recent developments in Scotland, the main themes arising from the Scottish Executive consultation, the bills proposals and recent developments on smoking in other countries.

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KEY POINT SUMMARY

- The [‘Smoking, Health and Social Care \(Scotland\) Bill’](#) (the Bill) was introduced on 16 December 2004, by Health Minister Andy Kerr MSP. It is accompanied by a [‘Policy Memorandum’](#) (2004) and [‘Explanatory Notes’](#) (2004), which include a Financial Memorandum. Part 1 of the Bill proposes a ban on smoking in wholly enclosed public places in Scotland
- Such a ban is controversial, not only because there is a serious ongoing debate on the dangers of passive smoking – there appears to be a preponderance of scientific and medical evidence which supports the case for a ban on health grounds - but because it will make illegal, in certain places, an activity which is itself legal.
- Further, it has been argued that such a ban will have an adverse economic impact on the licensed trade and hospitality sector which is unnecessary when there are other solutions available.
- For some, a ban is seen as ‘nanny state’ politics and an infringement of civil or personal rights. For others, the public good and the right of individuals not to be subjected to dangerous and unpleasant substances overrides the right to smoke in enclosed public spaces.
- In 2003, about 28% or 1.14 million adults (aged 16+) were regular smokers in Scotland. Long term trends for GB show a steady reduction in smoking rates from about 46% in 1974 to 28% in 2003, with Scotland following a similar trend. The number of people who smoke in Scotland varies greatly between areas of differing levels of deprivation.
- In 2004, 5% of boys and 7% of girls aged 13 reported smoking one or more cigarettes per week. For 15 year olds the rate was 14% for boys and 24% for girls and in 2002/03, 26% or about 50,000 Scottish women smoked during pregnancy.
- The only current legislation on the restrictions of smoking in the workplace is the Workplace (Health, Safety and Welfare) Regulations 1992, which places a duty on employers to ensure staff are not affected by tobacco smoke in rest areas.
- Recent policy developments in Scotland have included endorsement of ‘Smoking Kills: a White Paper on Tobacco’, the Scottish Voluntary Charter on Smoking in Public Places, ‘Scottish Executive Action Plan on Tobacco Control’ the introduction of the ‘Prohibition of Smoking in Regulated Areas (Scotland) Bill’.
- The Scottish Executive launched their consultation Smoking in Public Places on 7 June 2004. The process contained 4 key elements. A programme of awareness raising activity, research and evidence gathering, the public consultation and a final evidence report. As part of consultation the Executive commissioned an Omnibus Survey to gain information on public opinion on smoking in public places.

- Key findings of the Scottish Executive included that 82% of the consultation responses and 53% in the omnibus survey supported the view that further action is needed to reduce exposure to second hand smoke, and 80% of the consultation responses and 54% of the Omnibus Survey supported making all enclosed public places smoke-free.
- Several key themes arose from the consultation including health and passive smoking, civil and personal liberties, ventilation and smoke free areas, possible exemptions, enforcement and economic impact.
- The Bill proposes to prohibit smoking in wholly enclosed areas to which the public or a section of the public have access.
- Partial or full bans of smoking in public places have been proposed or introduced in various other countries, cities and regions including England, Ireland and New York.

INTRODUCTION

The '[Smoking, Health and Social Care \(Scotland\) Bill](#)' (the Bill) was introduced on 16 December 2004, by Health Minister Andy Kerr MSP. It is accompanied by a '[Policy Memorandum](#)' (2004) and '[Explanatory Notes](#)' (2004), which include a Financial Memorandum. Part 1 of the Bill proposes a ban on smoking in wholly enclosed public places in Scotland

Such a ban is controversial, not only because there is a serious ongoing debate on the dangers of passive smoking – there appears to be a preponderance of scientific and medical evidence which supports the case for a ban on health grounds - but because it will make illegal, in certain places, an activity which is itself legal. Further, it has been argued that such a ban will have an adverse economic impact on the licensed trade and hospitality sector which is unnecessary when there are other solutions available. For some, a ban is seen as 'nanny state' politics and an infringement of civil or personal rights. For others, the public good and the right of individuals not to be subjected to dangerous and unpleasant substances overrides the right to smoke in enclosed public spaces.

This briefing outlines the debate surrounding smoking in public places. It looks at trends in, and prevalence of, smoking in Scotland and at recent policy developments in this area. In particular, the briefing considers the recent Scottish Executive (the Executive) consultation [Smoking in Public Places: A Consultation](#) (2004a) (the consultation paper), which ran from 7 June 2004 to 30 September 2004, and at the issues raised by the consultation, together with research that has been commissioned by the Executive in this area. These issues include the health, civil rights and economic arguments put forward by respondents on both sides of the debate. Finally and briefly, the paper considers recent policy developments in England and the operation of smoking bans in other countries and states.

TRENDS IN SMOKING

Number of Smokers in Scotland

In 2003, about 28% or 1.14 million adults (aged 16+) were regular smokers in Scotland. Long term trends for GB show a steady reduction in smoking rates from about 46% in 1974 to 28% in 2003, with Scotland following a similar trend. In 2003, the smoking rate in Scotland for Males was 28%, the same as for GB, for Females the Scottish rate of 28% was higher than the GB average of 24%. In comparison, Scotland has a higher smoking rate than countries such as Canada, United States, Sweden and Australia where the overall rates are below 20%, but Scotland has a lower rate than countries such as Greece, Netherlands, Spain and Japan, where the rate is above 30%. (Scottish Executive. (2003b and 2004ad), Office of National Statistics (2003))

Prevalence of Smoking in Scotland by Deprivation Categories

The number of people who smoke in Scotland varies greatly between areas of differing levels of deprivation. In 2001-03, the adult (16+) smoking rate in the 20% most deprived areas in Scotland, defined by the Carstairs Index of Deprivation, was 41.9%. This is more than twice the rate of 19.2% in the 20% most affluent areas. Smoking rates are also particularly high among heavy drinkers, homeless people, prisoners and people with serious mental health problems. ((Scottish Executive 2004ad, NHS Health Scotland & ASH Scotland 2003)

Prevalence of Smoking in Scotland in Children and Adolescents

In 2004, 5% of boys and 7% of girls aged 13 reported smoking one or more cigarettes per week. For 15 year olds the rate was 14% for boys and 24% for girls. It is estimated that in 2002 there were almost 26,000 children smoking under the age of 16 in Scotland. (Drug Misuse and Information Scotland 2004).

Prevalence of Smoking During Pregnancy

In 2002/03, 26% or about 50,000 Scottish women smoked during pregnancy. Up to a quarter of women stop smoking during pregnancy, while a further quarter or more try to cut down. However, most who stop during pregnancy restart after their baby is born. Pregnant teenagers are most likely to smoke. This is partly because teenage pregnancies are most common in the most deprived areas, where smoking rates are also the highest. In 2000-02, the smoking rate during pregnancy in the 20% most deprived areas in Scotland was 37.5%, over two and a half times greater than 14.3% in the 20% most affluent areas. Smoking during pregnancy is also associated with early school-leaving age, being unmarried, living with other smokers and unemployment. (NHS Health Scotland & ASH Scotland 2003, Scottish Executive 2004ad)

CURRENT LEGISLATIVE FRAMEWORK

The only current legislation on the restrictions of smoking in the workplace is the Workplace (Health, Safety and Welfare) Regulations 1992, which places a duty on employers to ensure staff are not affected by tobacco smoke in rest areas. Employers have a general duty to protect the health and safety of their staff under the Health and Safety at Work etc Scotland Act 1974. The Scottish Executive have issued policy advice to several major organisations such as NHSScotland and COSLA that the legislation does include protecting staff and visitors alike from the effects of smoking (Scottish Executive 2004ad).

RECENT DEVELOPMENTS IN SCOTLAND

The Executive endorsed '[Smoking Kills: a White Paper on Tobacco](#)' (UK Government 1998) (the white paper), which set out a comprehensive tobacco control programme. Since 1999, the Scottish Executive has been implementing the programme in a Scottish context. This has included a ban on tobacco advertising, enhanced health warnings on cigarette packets, making nicotine replacement therapy available on prescription from April 2001 and tobacco test purchasing pilots.

THE SCOTTISH VOLUNTARY CHARTER ON SMOKING IN PUBLIC PLACES

As a result of the white paper the Executive launched a voluntary charter on Smoking in Public Places in May 2000. The charter aimed to increase by 10% the number of sites with written smoking policies, signage and non-smoking areas.

There have been mixed findings on the success of the voluntary charter. The Executive (2004a) found that there had been an increase in the amount of businesses in the Scottish leisure industry which had some form of non-smoking provision, rising from 39% in 2000 to 61% in 2003. It also found that there had been an increase in the number of businesses with a written smoking policy, rising from 25% in 2000 to 34% in 2003. A smoking policy does not necessarily impose smoking restrictions, it may also permit smoking throughout the premises. The Executive (2004a) estimate that 7 out of 10 pubs still allow smoking throughout their premises. In a review of the hospitality sector less than half of all businesses in Scotland surveyed knew

about the Voluntary Charter and 23% of respondents believed that they complied with the voluntary charter (only 11% did).

ACTION PLAN ON TOBACCO CONTROL

Following the '[Reducing Smoking and Tobacco-related Harm: a Key to Transforming Scotland's Health](#)' (NHS Health Scotland & ASH Scotland 2003) the Scottish Executive published '[A Breath of Fresh Air for Scotland](#)' (2004b), an action plan on tobacco control in Scotland. The document offered a programme of action covering prevention and education, protection and controls and the expansion of high quality cessation services. The action plan:

- included proposals to carry out a major public debate on actions to minimise the impact of second-hand smoke and extend smoke-free zones in enclosed public places
- indicated the need for more public education on the health risks associated with environmental tobacco smoke (ETS)
- upgraded the Tobacco Control Strategy Group to a Ministerial Working Group, to provide expert advice on the health impact of tobacco and a forum for the dissemination of best practice to health and other professionals throughout Scotland
- committed additional funding to smoking cessation services of £1 million in 2003/04 and 2004/05 and £5 million in 2005/06
- amended the Executive's target for smoking rates amongst adults (aged 16-64) from 31% to 29% by 2010
- confirmed the Executive's commitment to reducing smoking amongst young people (aged 12-15) from 14% to 12% between 1995 and 2005 and to 11% by 2010
- committed the Executive to reduce the proportion of women who smoke in pregnancy to 23% by 2005 and 20% by 2010

THE PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL

[The Prohibition of Smoking in Regulated Areas \(Scotland\) Bill \[as introduced\]](#) Session 2 (2004) was introduced in the Scottish Parliament as a Member's Bill by Stewart Maxwell MSP on 3 February 2004. The Bill proposed to ban smoking in areas in which food is served or will be served within the next 5 days. The Bill would make it an offence to smoke in a regulated area, to permit smoking in a regulated area and to fail to display signs inside and outside regulated areas. These offences would carry a penalty of a fine up to £1,000.

The Health Committee has been designated the lead committee for the Bill. As well as receiving over 200 written evidence submissions, the Health Committee held 4 oral evidence sessions in June 2004. Witnesses who gave oral evidence included representatives from the Centre for Tobacco Control Research from Cancer Research UK, the New York City Dept of Health and Mental Hygiene, the Freedom Organisation for the Right to Enjoy Smoking Tobacco (FOREST) and Action on Smoking and Health Scotland (ASH). In his oral evidence session to the Health Committee on 29 June, Stewart Maxwell stated that there was scope in the Bill for it to be amended to a full ban on smoking in enclosed places in Scotland. In order to allow the Committee to take the findings of the Scottish Executive's consultation on smoking in public places into account the Committee has extended its consideration of the Bill at Stage 1 until the end of January 2005. At the time of writing the Committee's Stage 1 report had not been published.

SCOTTISH EXECUTIVE CONSULTATION

The '[Smoking in Public Places: a Consultation](#)' (Scottish Executive 2004a) (the consultation) aims to take forward commitments made in several Executive policy documents. In '[Improving](#)

[Health in Scotland: The Challenge](#)' (2003a p 32) a commitment was made to review national tobacco control policy, in conjunction with key interests, and to set out a new plan for action. In ['A Partnership for a Better Scotland: Partnership Agreement](#) (Scottish Labour & Scottish Liberal Democrats 2003 p23) a commitment was made to consult on how to achieve considerably more smoke-free bars and restaurants and to consult transport operators on further measures to improve enforcement of restrictions on smoking on public transport. The Executive states that this commitment was reaffirmed in ['A Breath of Fresh Air for Scotland'](#) (2004 p 23), which outlined plans for a major public debate on actions to minimise the impact of second-hand smoke.

The consultation was launched on 7 June 2004. The Scottish Executive consultation process contained 4 key elements:

- a programme of awareness raising activity, carried out by NHSScotland
- research and evidence gathering. This included 3 pieces of research commissioned by NHS Health Scotland, on behalf of the Executive:
 - University of Glasgow ['Passive Smoking and Associated Causes of death in Adults in Scotland'](#) (2004)
 - University of Aberdeen [International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places](#) (2004a)
 - University of Aberdeen [International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places: Summary Report](#) (2004b)
 - BMRB Social Research [Workplace Smoking Policies in Scotland](#) (2004)
- the public consultation which in addition to the consultation document included:
 - a series of focus groups with targeted sections of the population
 - a number of regional public seminars throughout Scotland
 - activities conducted with young people by the Young Scot organisation
 - an opinion survey of a representative sample of the Scottish population
 - a national conference held on 9 September 2004
- a final evidence report on assessment and conclusions from this work. [Smoking in Public Places: A Consultation on Reducing Exposure to Second Hand Smoke Evidence Report](#) (evidence report) (Scottish Executive 2004h) The Executive has also produced an individual report for each strand of research and evidence gathering and consultation activity, Scottish Executive 2004c-h).

Throughout the consultation the Executive requested views on smoking in public places and possible approaches that might be taken to reduce potential exposure to second-hand smoke. The preface to the questionnaire outlines the Executive's current policy and a strong emphasis on the health risks of passive smoking. The consultation document posed six questions:

1. Having considered the health risks associated with passive smoking, do you think that further action needs to be taken to reduce people's exposure to second-hand smoke?
2. Would you support a law that would make enclosed public places smoke-free? (Public places include workplaces and public transport)
3. If a law was introduced, do you think there should be any exemptions to it? (i.e. any enclosed public places where smoking should be allowed)
4. If we decide not to introduce a law, what more could be done to encourage individual businesses to take voluntary action to become smoke-free or to provide more smoke-free provision?
5. What else could we do to reduce people's exposure to second-hand smoke?
6. Please let us know any other views you have about smoking in public places.

Criticism has been made by organisations including the Scottish Licensed Trade Association (SLTA) (Scottish Executive, 2004i p 3), that the consultation should have focused more specifically on pubs as they indicate that the main concerns and controversy regarding a smoking ban lie there. There was concern that the consultation did not contain specific questions regarding how a potential smoking ban would operate or ask specifically for information on any detrimental affects imposing such a ban could have.

The consultation received the largest number of responses of any consultation carried out by the Scottish Executive with a total of 53,474 responses of which 52,441 were personal responses and 1,033 were responses from groups, organisations or businesses a further 'free-flowing' 179 written responses from business and organisations.

KEY FINDINGS OF THE SCOTTISH EXECUTIVE CONSULTATION

As part of the consultation, the Executive commissioned an Omnibus Survey, based on 1,026 interviews with a representative sample of the population, to gain information on public opinions on smoking in public places. The main findings of the Executive's consultation (Scottish Executive 2004h) include:

- 82% of the consultation responses and 53% in the omnibus survey supported the view that further action is needed to reduce exposure to second hand smoke
- 80% of the consultation responses and 54% of the Omnibus Survey supported making all enclosed public places smoke-free
- 35% of the consultation responses thought that some public places should be exempt from the law. 56% thought there should be no exemptions. Of those supporting legislation for a complete ban on smoking in enclosed public places only 24% said that there should be exemptions
- in the Omnibus Survey of those expressing support for a ban 66% also believed there should be exemptions. 57% of those in support of legislation spontaneously mentioned pubs when asked which public places should be exempt.

COMMON THEMES ARISING FROM THE CONSULTATION

This section draws together the main themes drawn from a variety of sources, including the responses from the main respondent organisations to the consultation made available on the Executive website and the Evidence Report (2004h). It should be noted that this paper outlines the main arguments that have been being expressed regarding these themes. It is

recommended that these be read alongside the individual responses, the research quoted and the various publications that have been published through the Executive, outlined above.

HEALTH AND PASSIVE SMOKING

Passive smoking is described in many different ways given many names, including exposure to second hand smoke (SHS), environmental tobacco smoke (ETS) and involuntary smoking, to denote exposure to both exhaled mainstream smoke and side-stream smoke released from a smouldering cigarette.

As discussed in an editorial in the British Medical Journal (2003), there have been studies regarding the health effects of passive smoking since 1928, when Schönherr et al proposed that lung cancers among non-smoking women could be caused by inhalation of their husbands' smoke. Although disputed by the tobacco lobby in terms of extent, the evidence of negative health impact of second hand smoke is in the majority.

Health effects of passive smoking

ASH Scotland (Scottish Executive 2004k p1) highlight that there are around 4,000 chemicals in tobacco smoke, of which 60 are known or suspected carcinogens such as arsenic and benzene. Arguments for introducing a smoking ban included that exposure to other toxins at work is regulated by law, but there is no mandatory right to protection from ETS in the UK and Scotland.

The Evidence Report (2004h, p i) outlines that there is “robust scientific evidence” to show that passive smoking has a detrimental effect on health. This has been highlighted in many consultation responses. Prominent amongst the epidemiological and meta-analytical studies mentioned are two studies carried out by the UK Scientific Committee on Tobacco and Health (1998 and 2004) and a joint study by the World Health Organisation (WHO) and International Agency for Research on Cancer (IRAC) (2002).

The UK Scientific Committee on Tobacco and Health (SCOTH) published its first report in 1998. It embarked on a programme of scientific review and appraisal of a range of issues related to tobacco and health. In its [‘Summary of Conclusions and Recommendations’](#) (1998) it found that:

- exposure to environmental tobacco smoke is a cause of lung cancer and, in those with long term exposure, the increased risk is in the order of 20-30%
- exposure to environmental tobacco smoke is a cause of ischaemic heart disease and, if current published estimates of magnitude of relative risk are validated, such exposure represents a substantial public health hazard
- smoking in the presence of infants and children is a cause of serious respiratory illness and asthmatic attacks
- sudden infant death syndrome, the main cause of post-neonatal death in the first year of life, is associated with exposure to environmental tobacco smoke. The association is judged to be one of cause and effect
- middle ear disease in children is linked with parental smoking and this association is likely to be causal

One of its recommendations included that smoking in public places should be restricted on the grounds of public health, though it did believe there should be varying degrees of restriction according to different categories of public place.

SCOTH (2004) reviewed the evidence on SHS in its report '[Secondhand Smoke: Review of Evidence Since 1998: Update of Evidence on Health Effects of Secondhand Smoke](#)' (2004). In this report, SCOTH (2004, p 3) concluded that:

"...knowledge of the hazardous nature of SHS has consolidated over the last five years, and this evidence strengthens earlier estimates of the size of the health risks. This is a controllable and preventable form of indoor air pollution. It is evident that no infant, child or adult should be exposed to SHS. This update confirms that SHS represents a substantial public health hazard."

In particular SCOTH (2004, p 2-3) found:

- increased risk to non-smokers of lung cancer from secondhand smoke (SHS) was estimated at 24% in the overview of 37 studies and 4626 cases commissioned by SCOTH in 1998
- that new studies on SHS exposure and the risk of heart disease have strengthened the findings of the 1998 SCOTH overview which estimated that the excess risk in non smokers exposed to SHS compared to those not exposed was 23%
- that a number of new studies have confirmed the range and extent of health damage in infancy and childhood. children are at greatest risk in their homes and the evidence strongly links SHS with an increased risk of pneumonia and bronchitis, asthma attacks, middle ear disease, decreased lung function and sudden infant death syndrome. It has also been shown that babies born to mothers who come into contact with SHS have lower birth weights
- that overall exposure to secondhand tobacco smoke in the population has declined somewhat as cigarette smoking prevalence has continued to come down. However, some groups, for example bar staff, are heavily exposed at their place of work and almost half of all children still live in households with at least one smoker

The WHO/IRAC report, '[Monographs on the Evaluation of Carcinogenic Risk of Chemicals to Humans - Tobacco Smoking and Tobacco Smoke](#)' (2002) reviewed all significant published evidence related to tobacco smoking and cancer, both active and involuntary. Its conclusions confirmed the cancer-causing effects of active smoking. It also concluded its evaluation of the carcinogenic risks associated with involuntary smoking and classified second-hand smoke as carcinogenic to humans.

As discussed above, the Scottish Executive also commissioned research from the University of Aberdeen (2004a), which combined a literature review with a modelling exercise to determine the likely impacts of restrictions on smoking in public places in a Scottish context. As regards the health impacts of ETS/SHS in Scotland, the report (2004a, p 11) found:

- the excess risks of lung cancer associated with domestic exposure to ETS is about 25%. The range of estimates for workplace exposure is similar to domestic exposure
- the excess risk of CHD associated with domestic exposure to ETS is about 25%. The range of estimates for workplace exposure is similar to domestic exposure
- there is some evidence to suggest a relationship between exposure to ETS and stroke. Although recent studies report an excess risk of about 34%, further research is required
- exposure to ETS has a detrimental effect on lung function and may be associated with poorer respiratory health
- exposure to ETS in pregnancy can lead to low birth weight and poor gestational growth
- studies that have examined the impact of ETS on health can be affected by bias and confounding. However, good quality studies that have adjusted for these factors still find significant effects

Deaths relating to Environmental Tobacco Smoke (ETS)

NHS Health Scotland and ASH Scotland (2003, p 11) estimate that the annual number of deaths from passive smoking in the UK is over 12,000, which equates to around 1,200 deaths a year in Scotland. .

The University of Glasgow published '[Passive Smoking and Associated Causes of Death in Adults in Scotland](#)' in November 2004. The objective of the report was to estimate how much past ETS exposure impacts on current levels of deaths caused by lung cancer, ischemic heart disease, stroke and respiratory disease. Estimates of the number of deaths were calculated using local data on the distribution of exposure, where possible, and international estimates of the level of risk posed. Its main findings were that:

- ETS exposure is associated with 865 deaths per year in Scotland among lifelong non-smokers from the four main causes listed
- individually, this divides into 295 IHD deaths, 335 stroke deaths, 91 respiratory deaths and 44 lung cancer deaths
- over 75% of the ETS-related deaths occur amongst women
- including other deaths known to be related to smoking, up to 1000 deaths per year might be attributed to ETS exposure among lifelong non-smokers
- although extremely difficult to quantify the risk of ETS exposure to ex-smokers as no reliable information exists, there would appear to be as many ex-smoking men and women exposed to ETS as there are lifelong smokers. It would not be unreasonable to assume that they are at a similar risk after a suitable latent period and that the numbers of ETS related deaths would be similar to that seen for lifelong non-smokers. This would imply that some 1,500 to 2,000 deaths per year in Scotland are related to ETS exposure among non-smokers (lifelong or quitters)
- passive smoking represents the greatest risk to public health when compared to other forms of involuntary environmental exposure
- a ban on smoking in the workplace might be considered to be capable of reducing the number of ETS-related deaths by however much it reduces the total ETS exposure in individuals (eg 50% reduction in total ETS exposure might lead to a 50% reduction in ETS related deaths)
- a modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally

ARGUMENTS FOR THE LIMITATIONS OF PASSIVE SMOKING RESEARCH

As noted above, there is much international evidence showing that passive smoking does have a detrimental effect on health. However, there are those, including the tobacco lobby, that dispute, at least in terms of the extent and seriousness of that impact, the evidence of the negative health impact of ETS.

The Tobacco Manufacturers Association (TMA) (Scottish Executive 2004m p8–12) argues that the public are led to believe that evidence that ETS causes serious diseases is clear and incontrovertible when this is not the case. It believes the balance of evidence taken as a whole does not demonstrate a causal link between ETS and serious disease. TMA point to the findings of ETS epidemiological studies as being inconclusive and inconsistent. Where an elevated level of relative risk has been reported, the TMA argues, it is of a very low order, and could be accounted for by bias or inadequate statistical adjustment. Essentially, it believes that the majority of studies do not meet the crucial test of statistical significance. Reviews which use meta-analysis are deemed unreliable by TMA as, it argues, they compare studies which do not have a similar design or methodology. TMA believe that interpretation of systematic reviews is

as prone to errors as the interpretation of data in individual studies. In both cases interpretations offer subjective, not objective judgements. However, as discussed above, the University of Aberdeen research (2004a) found that good quality studies, which have adjusted for such factors, still find significant correlation between passive smoking and ill health.

Debate has also surrounded the question of whether research which uses studies focusing on ETS exposure in the home can be used to give an indication of the impact of ETS exposure in public places when exposure rates are likely to be less frequent or prolonged. Brian Monteith MSP (2004) argues that surveys of ETS exposure in the home do not take into account that non-smoking partners are likely to have similar lifestyles to their smoking partners including drinking, eating and health patterns which will contribute to their chances of CHD and other diseases attributed to smoking.

Stuart Ross, Chief Executive of Belhaven Brewers and Chair of Against an Outright Ban (AOB) (Ross 2004) argues that figures for the number of lives that could be saved by banning smoking in public places fail to take into account the fact that a ban may lead to a displacement of smoking. He argues that smokers may move from smoking in public places to increased smoking in the home which is likely to be in more confined spaces with no ventilation system. Children would be more likely to be adversely affected and a smoking ban would merely transfer the health problems associated with smoking from public places to the family home.

CIVIL/PERSONAL LIBERTIES

A number of arguments have been raised in the consultation responses and wider debate on civil and personal liberties.

Arguments have been made that introducing a ban on smoking is an example of the 'nanny state', restricting the freedom of choice and rights of the individual to smoke. Brian Monteith MSP (2004), believes that there should be choice both for smokers and non-smokers and premises should introduce smoking restrictions where there is the commercial pressure to do so:

'An outright ban, as in Scotland and Ireland is to that extent illiberal – an attempt to outlaw, by backdoor methods something which is perfectly legal in itself.' (Sunday Telegraph 2004).

The alternative viewpoint is expressed by Asthma UK Scotland (Scottish Executive 2004n p3) which sees the current policy as impacting on the personal liberty of people with asthma. Cigarette smoke can trigger asthma attacks in some asthmatics and they can feel excluded from pubs and restaurants where smoking is permitted. It is also argued that introducing a ban would be respecting people's rights, particularly those of workers to work in a healthy environment.

John Reid, UK Health Minister, argued (Telegraph Online 2004) that one of the few pleasures for people in lower socio-economic categories is being able to smoke.

'Let me play devil's advocate. What enjoyment does a 21-year old mother of 3 living on a sink estate get? The only enjoyment sometimes they get is having a cigarette.' (Telegraph 2004)

Thus it could be argued that imposing a ban on smoking in public places is further stigmatising those experiencing disadvantage and denying them the enjoyment they get from smoking.

VENTILATION/SMOKE FREE AREAS

One of the alternatives suggested to imposing a smoking ban in public places is the installation of ventilation systems. Ventilation is the dilution or removal of unwanted indoor air constituents, including smoke or odours, with fresh outdoor air. There are two distinct arguments - that ventilation systems do not work and should not be used and the opposing view that ventilation systems should be used as they do remove the health risks associated with passive smoking.

The consultation (2004a) states that the air-flows possible with current ventilation systems are not sufficient to eliminate the health risks associated with second-hand smoke. East Ayrshire Council's consultation response (Scottish Executive 2004q p2) argues that air conditioning systems merely circulate the air and even in restricted areas, do not offer protection to staff, who require entry to the area to serve patrons. It is also claimed in some of the consultation responses including ASH Scotland (Scottish Executive 2004k p2-3) that there is no safe level of exposure to tobacco smoke, ventilation systems do not remove all the harmful contaminants in cigarette smoke and, even if ventilation worked smoke is inhaled before passing through the ventilation systems. Consultation responses opposed to the use of ventilation systems use evidence from Philip Morris, the largest cigarette company in the USA, which recognises such systems have limitations:

“while not shown to address the health effects of second-hand smoke, ventilation can help improve the air quality of an establishment by reducing the sight and smell of smoke and by controlling smoke drift.” (Philip Morris 2004)

It is also argued in some of the consultation responses that ventilation systems are expensive to purchase, install, run and maintain. The British Airport Authority (BAA) (Scottish Executive 2004r p 2-3) has installed tornex ventilated smoking units in terminal areas at Edinburgh, Glasgow and Aberdeen Airport at a total cost of £650,000. As well as the cost, the BAA state that the ventilation system has not led to the desired reduction in the level of complaints from customers regarding smoking in the terminal buildings. An estimate of £30,000 has been suggested for the installation of ventilation systems in individual pubs and bars (Ross 2004). Whilst Ross (2004) believes that pubs and bars would be willing to pay for ventilation systems he suggested that the Executive should offer some funding assistance or tax incentive for those wishing to install ventilation systems.

Arguments against smoke free rooms are highlighted by Glasgow City Council Policy and Resources Committee (Scottish Executive 2004o p 5) it argues that smoke free rooms make an un-level playing field. Larger bars and restaurants, including chains, are more likely to have the resources needed to install ventilation measures. This leaves smaller independent businesses, which may not be able to afford such large-scale investments at a competitive disadvantage. Glasgow City Council Policy and Resources Committee (Scottish Executive 2004o p 5) also argues that it may raise potential problems regarding occupancy crowd control issues in the different smoking or non-smoking areas. Asthma UK Scotland (Scottish Executive 2004n p2) state that:

“Smoke free areas have been compared to swimming in the chlorine free-half of a swimming pool. It simply does not exist. Smoke free areas are still contaminated by cigarette smoke and the carcinogens and toxins that it contains.”

Brian Monteith MSP (2004) believes that there should be minimum air quality standards in pubs, clubs etc, which should be enforced through inspection. He argues that ventilation systems are

a way of controlling air quality in public places. Supporters of the use of ventilation systems point to studies such as that conducted by the University of Glamorgan, sponsored by the SLTA, which tested the use of ventilation systems in a small pub (Atmosphere Improves Results 2004). They state that the results show that an inexpensive ventilation system can clear carbon monoxide from the air to a level where it is too low to be easily measured, and cut the particles in the air by around 90%. Paul Waterson, Chief Executive of the Scottish Licensed Trade Association stated:

'The University of Glamorgan tests are independent and provide a robust answer to those who believe ventilation to be a purely cosmetic exercise. We want to keep our staff comfortable and our customers coming back – and ventilation is an excellent way to do this. We don't say ventilation is the only answer, but it has a role to play and we are working hard to deliver clean air environments for all'. (Atmosphere Improves Results 2004)

Those who support the use of ventilation systems also use the wider argument that identifying and measuring the components of ETS and assessing the exposure of non-smokers to them in real-life situations, present very great difficulties. The TMA (Scottish Executive 2004m p 8) states that various substances that make up ETS are generally only present in extremely low concentrations, some below any meaningful measurement. Some of these are likely to be present in the air anyway, emanating from other sources and inseparable from the ETS contribution.

POSSIBLE EXEMPTION TO SMOKING BAN: HOSPITALITY SECTOR

Proposals were made by the Scottish Voluntary Charter Signatory Group, comprising the Scottish Licensed Trade Association, the Scottish Beer and Pub Association, the British Hospitality Association and the Scottish Tourism Forum, to the Health Minister in May 2004. They proposed that if the voluntary approach to restrictions on smoking was not acceptable a five point plan over a three year period could be introduced , which would be reviewed after that time. The proposals included measures for all licensed premises that:

- smoking should be banned at the bar counter in all licensed premises
- smoking should not be permitted in any area where and when hot food is being served
- all licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be increased to 40% in year 2 and 50% in year 3.
- every licensed premise should have a smoking policy sign at the entrance
- smoking should not be permitted in any area of licensed premises from which the public are excluded (ie back of house)

No direct official response to these proposals was made by the Scottish Executive. AOB believe that the public favour a gradualist approach to a ban on smoking in public places. AOB argue that further support is given to their argument in the Scottish Executive Omnibus Survey where 66% of those surveyed, who expressed support for the ban believed there should be some exemptions, and 57% mentioned pubs as public places that should be exempt. However, when the Omnibus Survey is compared with the Executive consultation responses, figures for exemptions are much lower with only 24% wanting exemptions.

The Executive emphasises that an estimated 70% of the population are non-smokers and that 77% of respondents claimed to be non-smokers in its consultation. The AOB argues that people who volunteer to participate in surveys such as the Executive's consultation are more passionate in their opinions than most, and what is true of them is unlikely to be true of the

wider population. The Executive highlight (Scottish Executive 2004ad) that although the Omnibus Survey was based on a representative sample, a disproportionately high number of those interviewed were smokers (47%) compared to a national average of 28%.

POSSIBLE EXEMPTION TO SMOKING BAN: INCLUDING NURSING AND RESIDENTIAL HOMES, PRISONS, RAILWAY STATIONS

A number of consultation responses discussed specific establishments other than pub and restaurants that should be considered for exemption to the smoking ban. These included people's own homes, residential homes, nursing homes, sheltered housing, hotel, guest room or B & B bedrooms, prisons, residential facilities in further or higher educational establishments and psychiatric wards.

Fife Health and Wellbeing Alliance (Scottish Executive 2004l p4) says that residential homes, nursing homes and sheltered housing communal areas, kitchens, sitting rooms, waiting areas etc should be classified as 'enclosed public spaces' and, therefore, should be included in the legislation. Fife Council Liberal Democrats (Scottish Executive 2004s p 3l) highlight in their response that Fife Council have a smoking policy that prohibits smoking on council premises and transport. However, one of its current exemptions is for situations where a council employee is interviewing clients. If the interviewer believes that permitting the client to smoke or offering them a cigarette will have a significant calming effect and smooth the progress of the interview the smoking is permitted.

Chest, Heart and Stroke Scotland (Scottish Executive 2004t p 5) argues that institutions where people live might be excluded, on the grounds that others have the right to smoke in their own home. However it contends that this ignores the health and safety considerations applying to staff who work in residential establishments. One of the individual responses received by Equality Scotland (Scottish Executive 2004u p 4) states that there should be no exceptions to the ban as *'non smokers should not be subjected to smoke at any stage in their life.'*

The Rail Passengers Committee (Scottish Executive 2004v p 2) says that if the enclosed public space is of sufficient size to accommodate in comfort all those who do not wish to be subjected to second-hand smoke, it should be a commercial decision for the operator of that railway station whether to allow smoking in another enclosed space, provided there was no possibility under any circumstances of 'leakage' of second-hand smoke into the non-smoking area. In semi-enclosed areas such as partially covered railway stations there should be segregated and well-separated, smoking and non-smoking standing and seating areas. Otherwise it is difficult for non-smokers to avoid second-hand smoke. Its response also considers that the fire hazards linked to smoking must be taken into account with regard to issues of safety and potential loss of life. Strathclyde Passenger Transport (Scottish Executive 2004w p2) says that smoking on public transport vehicles, in subway, rail and bus stations and at bus stops reduces the attractiveness of public transport.

RESPONSIBILITY AND ENFORCEMENT OF A PROPOSED BAN ON SMOKING IN PUBLIC PLACES

Although the Executive did consult on whether there was support for legislation the consultation document did not ask any specific question on how the legislation should be enforced. However, several consultation responses did discuss issues surrounding responsibility and enforcement of the ban.

The British Hospitality Association (Scottish Executive 2004x p2) wants responsibility and penalties for not adhering to a smoking ban to be split equally between the proprietor and

customer. The Federation of Small Businesses (Scottish Executive 2004y p 4) highlights that hospitality businesses are 4 times more likely than other business sectors to have suffered assaults on business owners and staff in the past year, which may make enforcement of legislation difficult. For licensed premises it could be appropriate to report offences to the licensing board.

The Royal Environmental Health Institute of Scotland (Scottish Executive 2004z), which represents Environmental Health Officers (EHOs), argues that they are well placed to play a major part in ensuring any future ban is understood and complied with. EHOs regularly inspect premises to which the public have access, such as bars and restaurants, on a daily basis to monitor compliance with, for food safety and occupational health and safety legislation. If EHOs were to have responsibility for enforcement, significant additional resources would be required. Aberdeen City Council (Scottish Executive 2004aa p4) believe that gathering the necessary evidence would be difficult and time consuming and likely to require an element of covert surveillance and a large proportion of work undertaken out with normal working hours. If Environmental Health officers were given responsibility for enforcing the ban, Aberdeen City Council argues that, because they do not have powers of arrest, obtaining information from members of the public could be difficult and therefore could require police involvement.

Responses from several local authorities claim that extra resources would be required to effectively enforce the provisions. Gordon Greenhill (2004), from the Society for Chief Officers in Environmental Health, estimates that to carry out the additional work a smoking ban would require 100 additional EHOs across Scotland at the cost of around £3 million. He indicates that the role of EHOs is changing. There are proposals in the Nicholson Report to extend the role EHOs play in licensed premises. EHOs have become involved in enforcing the Antisocial Behaviour etc. (Scotland) Act 2004 (asp 8), including issuing fixed penalties for noise disruption. Greenhill (2004) points to these changes as leading to an increasing number of EHOs working more flexible hours and in licensed premises making the addition of enforcing a smoking ban easier to fit into the increasingly dynamic role of EHOs. Greenhill believes that fixed penalties are the best way to enforce legislation on smoking in public places. He notes that the general public are used to fixed penalties for other types of offences with EHOs in the City of Edinburgh Council issuing over 2000 fixed penalty notices in 2003 and over 95% paying the fines.

The role of EHOs is reinforced by the consultation response from the Association of Chief Police Officers in Scotland (ACPOS) (Scottish Executive 2004ab p 1) which argues that the police should play no direct role in monitoring or enforcing the ban. ACPOS believe the system should operate on a similar basis to the Irish system of enforcement. However, the recent Antisocial Behaviour etc. (Scotland) Act 2004 (asp 8) highlights that the police can be given the power to issue fixed penalty notices for offences.

ENVIRONMENTAL IMPACT

A number of consultation responses highlight the potential negative environmental impact a ban on smoking in public places may have on society. Aberdeen City Council (Scottish Executive 2004aa p 10) fears that it may lead to an increase in litter as smokers who are forced outside public places to smoke dispose of their cigarette butts on pavements. There are also concerns expressed regarding an increase in noise nuisance and public disorder as people are encouraged to congregate outside to smoke. AOB (2004) identifies this as a particular problem as a third of pubs in Scotland are part of tenements and therefore are in close proximity to residential areas.

ECONOMIC IMPACT

Some consultation responses argue that introducing a smoking ban will have a negative economic impact on the hospitality industry. This view is supported by research commissioned by BDO Stoy Hayward (2004), which identifies that a higher percentage of smokers go to pubs than the percentage of smokers in the population, 46% of licensed trade customers in Scotland smoke whilst only 26% of the population in Scotland smoke. Visits to licensed premises by smokers are likely to decline by 19.2%. However it also argues that there will be an increase in visits by ex-regular smokers to 11.3% and pub-goers who have never smoked regularly by 14.5%. However, this will still cause an overall decline in the number of visits to licensed premises of 6.3%. BDO Stoy Hayward argue that this will cause an increase in business failures of 1.7% and that employment in the licensed trade will decline from 38,900 in 2004 to 36,600 by 2006. AOB (2004) estimates that a smoking ban in Scotland would result in approximately 1 in every 6 licensed premises closing, which equates to losing 2,000 small businesses. BDO Stoy Hayward argues that employment in the licensed trade will decline by 38,900 in 2004 to 36,600 by 2006, should the ban come into force.

If Scotland experienced a similar downturn in cigarette sales to that which has occurred in Ireland since the introduction of a ban on smoking in public places it would lead to a significant decrease in revenue generated from tobacco. Currently the taxation of tobacco products raises substantial revenue for the UK Government: £9,510 million in revenue from tobacco tax for the financial year 2000-2001; £7,648 million in excise duty; and £1,860 million in VAT (NHS Scotland & ASH Scotland 2003 p 12). Those in favour of a smoking ban believe that duty on tobacco should not be seen primarily as a way of generating revenue but as a way to discourage people from buying cigarettes and that replacement revenue would be generated from elsewhere in the economy.

Some consultation responses argued that smoking is currently having a negative impact on the economy. '[Towards a Healthier Scotland](#)' (The Scottish Office 1999 p20) had highlighted that NHSScotland spends £140m on treating smoking-related disease. The Executive (2004b p11) estimate that at current prices this would amount to over £200 million annually. Some consultation responses point to the payment of welfare benefits to those unable to work due to smoking-related illnesses. A study carried out by Parrot, Godfrey and Raw (2000) estimate that the annual cost of smoking-related time off work in Scotland is £40 million and total productivity losses are put at £450 million. The University of Aberdeen (2004b p 9) says that the Health and Safety Executive estimated costs for sickness absence relating to exposure to ETS for those with asthma and chronic bronchitis at around £83 million to £166 million per year in Great Britain as a whole. They also point to research that estimates the cost of fire damage relating to smoking on business premises as being £4.5 million for Scotland.

The University of Aberdeen (2004b p 16) estimate that the cost of employee smoking breaks is £73,707,000. However it highlights that this figure is an estimate based on a previous cost of smoking study in Scotland reduced to take account of research that indicates that most of the cigarettes smoked at work are smoked during normal breaks. It accepted there is little satisfactory data on the effect of smoking restrictions on the cost of employee smoking breaks at work. The Scottish Executive (2004h p45) highlights from its workplace policies study during the consultation process that alternative views were expressed regarding whether productivity in the workplace could be compromised by denying smokers their 'nicotine fix' to enable them to concentrate and work effectively. It was also suggested that, by obliging smokers to leave work premises to have a cigarette, more time could be lost.

The financial impact on the individual smoker is also raised as an important consideration. NHS Health Scotland & ASH Scotland (2003 p11) point out that a 20-a-day smoker will smoke 7,300

cigarettes a year and will currently spend around £ 1,500 doing so. Over 70% of two-parent households on income support smoke, spending on average about 15% of their disposable income on tobacco. NHS Health Scotland & ASH Scotland (2003 p 11) believe that smoking deepens economic inequalities highlighting research findings that children of low income smokers are three times more likely to go without essential items than children of non-smokers with a comparable income.

THE BILL'S PROPOSALS

The Bill (Part 1) proposes to prohibit smoking in wholly enclosed areas to which the public or a section of the public has access. The likely timescale for implementation of Part 1 of the Bill is March 2006 (Scottish Executive 2004 ac).

The Policy Memorandum (p 3) argues that whilst there is support for separate smoking or non smoking areas within leisure and hospitality premises, it is difficult to justify this on public health grounds. Also, a complete ban would provide the most comprehensive protection and has the advantage of being simpler to implement.

The Policy Memorandum (p 3) notes that the overarching objective of the Bill is: *'to increase smoke-free places in order to protect public health.'* and details the health risks associated with ETS. The Policy Memorandum (p 3-4) also states that there is no safe level of exposure to second-hand smoke and that restrictions help to encourage existing smokers to give up or reduce consumption, and children and young people not to start in the first place.

The Bill sets out the powers of enforcement officers to enter no-smoking premises, the Policy Memorandum (p 4) explains that the principal enforcement authority will be local authority environmental health officers. Schedule 1 of the Bill says that the police will also be given the authority to issue fixed penalty notices.

The Explanatory Notes (p 2) notes that the Bill creates a number of offences:

- permitting others to smoke in and on no-smoking premises
- smoking in no-smoking premises
- failing to display warning notices in no-smoking premises
- failing without reasonable excuse to give one's name and address on request by an authorised officer

SECTIONS OF THE BILL

Section 1 – Offence of permitting others to smoke in no-smoking premises

Section 1 of the Bill would make it an offence for a person who manages or has control of non-smoking premises to knowingly permit another person to smoke there. The Explanatory Notes (p 3) detail that the fine for such an offence would be up to £2,500. It is a defence for an accused if they can prove that they had no lawful means to stop or prevent the person from smoking and had taken all reasonable precautions to prevent the person from smoking in their premises.

Section 2 – Offence of smoking in no-smoking premises

Section 2 of the Bill would make it an offence to smoke in no-smoking premises. The Explanatory Notes (p 4) explain that a fine for such an offence would be up to £1000. It would

be a defence for an accused that they did not or could not have known the premises were no-smoking.

Section 3 – Display of warning notices in and on no-smoking premises

Section 3 of the Bill would make it an offence not to display warning notices inside and outside no-smoking premises, which state that they are no-smoking premises and that it is an offence to smoke. The Explanatory Notes (p 4) propose that a fine for such a draft would be up to £1000. Scottish Ministers would be given powers to make regulations on further details as to the manner of display, form and content of the no-smoking signs. Regulations under this provision would be made under the affirmative resolution procedure, so that they cannot be made until the Parliament has approved a draft.

Section 4- Meaning of ‘smoke’ and ‘no-smoking premises’

Section 4 of the Bill provides definitions for the use of the word ‘smoke’ and ‘no-smoking’ premises. Smoke is defined as smoking tobacco or any substance or mixture which includes it. A person is to be taken as smoking if the person holds or is otherwise in possession or control of lit tobacco or any lit substance or mixture which includes tobacco.

Section 4 of the Bill also defines no-smoking premises as those which are wholly enclosed and to which the public or a section of the public has access. No definition is provided in the Bill for what is meant by the term ‘wholly enclosed’. Premises are defined as those used wholly or mainly as a place of work by persons who are employees or/and those used by and for the purpose of a club or other unincorporated association and those used wholly or mainly for the provision of education or of health or care services. The Explanatory Notes (p 4-5) detail that provisions, including exemptions, would be prescribed through regulations which will be subject to affirmative procedures. Scottish Ministers would have the power to define or elaborate by means of regulations on the meaning of certain expressions. This includes the meaning of ‘premises’ by reference to the person or class of person who owns or occupies the premises and the meaning of ‘premises’ to include specific forms of public transport.

Section 5- Fixed penalties

Section 5 of the Bill provides a fixed penalty scheme for offences committed under sections 1, 2 and 3 of the Bill. Schedule 1 of the Bill states how the fixed penalty scheme would operate. The fixed penalty scheme would not extend to the offence of permitting others to smoke in no-smoking premises or failure to display notices in or on no-smoking premises committed otherwise than by a natural person.

Section 6- Powers to enter and require identification

Section 6 of the Bill would empower a local authority officer to enter no-smoking premises in order to check whether an offence has taken place. The local authority that authorises the officer under this subsection would be the council in the area where the premises are situated. Local Authority Officers would in general terms have access to premises to which the public has access, this additional power is therefore a back-up power. Local Authority Officers exercising a power of entry would be able to gain entry if necessary and would be able to search the premises. Section 6 also makes it an offence to fail without reasonable excuse to give one’s name and address on request by an authorised officer.

Section 7 – Bodies corporate etc.

The Explanatory Notes (2004 p 6) explain that Section 7 of the Bill provides that officers of companies and other corporations and members of partnerships can be held personally liable,

in certain circumstances, for offences under Part 1 of the Bill that their companies or partnerships commit.

Section 8 – Crown application

The Explanatory Notes (p 6) explain that many enclosed public places are operated and controlled by the Crown. Section 8 details that whilst the Crown would not be criminally liable for any contravention under Part 1 of the Bill, the Court of Session may declare unlawful any act or omission of the Crown which constitutes a contravention. The provisions in Part 1 of the Bill would apply to people in the public service of the Crown.

Financial Implications

Costs on the Scottish Administration

The Financial Memorandum states that Scottish Ministers will establish a communications programme in advance of the regulations coming into force. Costs are anticipated to be in the region of £2 million 2005/06 and a further £1 million per year for the following 3 years following the introduction of smoke-free places (Explanatory Notes p 27).

The Financial Memorandum considers that, if compliance rates are high as has been achieved in New York and Ireland there will be relatively few prosecutions and therefore cost to the criminal justice system would be low (Explanatory Notes p 27-28). It also estimates that if a Smoke-free Compliance Help-Line was established to report alleged breaches of the ban this could cost between £50,000 to £100,000 to establish, with running costs being dependent on compliance with the ban in future years.

The Financial Memorandum notes that there is likely to be an increase in demand for smoking cessation services as the smoking ban is likely to lead to significant numbers of smokers quitting. There has already been increased funding by £4 million 2005/06 bringing the total amount available to smoking cessation services to £7 million. The presumption is that any increase in demand can be funded from existing planned provision (Explanatory Notes p 28)

Costs on local authorities

Councils will have principal responsibility for enforcement. The Financial Memorandum explains that initially there will be a high level of inspections resulting in additional cost in the early years to local authorities. After discussions between Ministers and COSLA full details of anticipated costs will be produced and included in the regulatory assessment (Explanatory Notes p 28).

Savings to NHSScotland

The Financial Memorandum considers that a reduction in the number of smokers would lead to significant savings for NHSScotland over time on the treatment of smoking-related diseases and reduce the number of smoking related deaths. In 1999 it was estimated that Scotland spent up to £140 million every year on treating 35,000 people for smoking-related diseases and at current prices this would amount to over £200 million per year. Using the University of Aberdeen estimates that reduced exposure to ETS will lead to a decrease in mortality rates, the Executive estimates that there will be gross savings to NHSScotland of between £5.7 million and £15.7 million per annum based on best and worst case outcomes (Explanatory Notes p 29).

Costs to business

The Financial Memorandum considers that a ban on smoking in public places is likely to have the greatest impact in the hospitality sector where the highest number of businesses without

existing smoking policies are found. The hospitality sector in Scotland in 2003 employed 150,000 people and had an annual turnover of £5,113 million. The Financial Memorandum also highlights concern from the hospitality sector that a ban on smoking in public places will mean that a quarter of licensed premises will cease trading with a loss of 30,000 jobs. The Financial Memorandum notes research from the University of Aberdeen (2004a) on the potential economic impact of a smoking ban with central estimates representing a conservative estimate of the most likely impact whilst low and high estimates show a range of possible impacts. The Financial Memorandum considers that the table reproduced below incorporates more conservative assumptions on the estimates of the impact on the pub sector than that contained in the published paper (Explanatory Notes p 30):

Potential economic impact on hospitality sector per annum

	Central estimate £ million	Low estimate £ million	High estimate £ million
Hotels	-10	-26	5
Restaurants	4	-21	28
Bars	0	-58	104
Total	-6	-104	137

RECENT DEVELOPMENTS IN OTHER COUNTRIES

ENGLAND

On 16 November 2004 the UK Department of Health (2004) published [‘Choosing Health: Making Healthier Choices Easier’](#). The White Paper (p 97-100) details the UK Department of Health’s legislative proposals on smoke-free public places in England. The proposals set out a timetable for a phased-in approach to smoking restrictions which would make enclosed public places and workplaces other than licensed premises smoke-free by the end of 2007. Restaurants, pubs and bars preparing and serving food would be smoke free by 2008 and smoking would be prohibited in all bar areas. Pubs and bars which do not prepare or serve food, and members’ clubs would be free to choose their smoking policy.

The White Paper (p 98-99) states that the policy has been arrived at after taking into consideration surveys showing that whilst 86% of people are in favour of workforce restrictions on smoking, only 56% are in favour of restrictions in pubs and only 20% would choose a total ban on smoking in pubs.

THE REPUBLIC OF IRELAND

There have been limited prohibitions on smoking in the workplace, advertising and sponsorship in Ireland since 1990. Further restrictions came into force on 29 March 2004 with the [Public Health \(Tobacco\) \(Amendment\) Act 2004](#). The Act bans smoking in licensed premises including bars, restaurants and hotels. The legislation creates smoke-free enclosed workplaces. The key aim of the legislation is to protect third parties, particularly workers, from the harmful effects of exposure to second-hand smoke. Liability is on those responsible for management of the premises.

Enforcement of the controls in Ireland is primarily undertaken by 40 Tobacco Control Officers (TCOs). TCOs are supported by Environmental Health Officers and Health & Safety Officers. They are charged with checking that the ban is enforced whilst carrying out their normal duties. The public and workers are being encouraged to challenge illegal smoking and, if an adequate

response is not forthcoming, to report this to the TCOs through a 'Smoke Free Compliance Phone Line'.

It is difficult to gain an overall view of the long term impact of the legislation because it has only been in force for nine months. However, research from the Office of Tobacco Control (2004a p 3) puts compliance with the smoking ban as very high, with 94% of premises inspected being compliant in respect of the smoking prohibition ie no-one smoking and no evidence of smoking in contravention of the law. The Office of Tobacco Control (2004b p 5) states that since the introduction of the legislation, visiting patterns to pubs and restaurants have remained constant. It found that 71% of the population surveyed after the introduction of the smoking ban stated that they had visited a pub within the previous fortnight, the corresponding figure prior to the smoke-free workplace legislation coming into effect was 68% of the population. The Office of Tobacco Control (2004b p 5) puts the increase in pub visits down to an increase in the numbers of non-smokers from 67% to 70%. The rate of pub visiting by smokers has remained steady at 74%.

According to the Irish Government's Department of Finance, Irish tobacco sales have fallen by 17.6% in the first 10 months of 2004 as a direct result of the smoking ban in the workplace. This is expected to lead to a full year cost to the public purse of 128 million Euros or £89 million against predicted revenue (Public Health News 2004).

The Licensed Vintners Association (LVA) (2004), which represents 95% of publicans in Dublin, reported that in July 2004 there had been a serious economic downturn for the Dublin licensed trade. It found that since the introduction of the total ban average Dublin pub sales had decreased by 16% and that Dublin pub employment levels had fallen by 14%. The LVA claim that 2000 full and part-time jobs had been lost to the Dublin pub trade.

The Scottish Executive (2004ad) highlight that official statistics suggest that the volume of bar sales were down 1.3% in the first three months following the ban. However bar sales had been declining for the last three years before the smoke-free law was introduced. Beer sales were down 3% between 2002 and 2003 and spirit consumption down by 21% in the same period – before the ban was introduced. In addition there was a price rise in the cost of alcohol introduced in July 2004, which may also have influenced alcohol sales.

NEW YORK

Smoking was banned in restaurants and bars in New York in March 2003, by the [Smoke Free Air Act of 2002](#). It is claimed this measure has not damaged businesses (Scottish Press Association 2004), but increased employment in restaurants and bars, by increasing patronage. It has also been accompanied by an 11% reduction in rates of smoking, which has been attributed to the legislation, along with other initiatives such as the raising of tobacco tax and the nicotine patch programme (Gottleib 2004). The Act is also linked to employment law and provides exemptions in respect of tobacco bars that were in existence on 31 December 2001, and non-profit membership associations with no employees. The workings of the legislation were the subject of a one-year review. It concluded, that

'Since the law went into effect, business receipts for restaurants and bars have increased, employment has risen, virtually all establishments are complying with the law, and the number of new liquor licenses issued has increased – all signs that New York City bars and restaurants are prospering.' (New York City Departments of Finance, Health & Mental Hygiene, Small Business Services and Economic Development Corporation 2004).

FOREST highlights evidence from the United Restaurant and Tavern Owners of New York (URTONY), which represents 3,000 on-premise beverage alcohol licensees, which refuted these claims. It believes that the figures used are a distortion of reality as they relate to returns made by the entire industry, including restaurants, fast food outlets, coffee shops and bars. It points to figures from the City's Wholesale Beer and Liquor Distributors which indicate that on-premise deliveries were down by 20% in the year from April 2003. Brian Nolan, Chief Executive of URTONY stated:

'The fact is that almost all bars, and some restaurants in New York City and State, have experienced a radical downturn in bar business and that downturn is directly related to the smoking ban.' (Freedom Organisation for the Right to Enjoy Smoking Tobacco 2004)

OTHER COUNTRIES, REGIONS AND CITIES

Some regions in Canada and some American states have enacted similar legislation, as have countries such as Norway, Australia, Singapore and South Africa and cities such as Boston, Victoria and Ottawa. For example:

- Norway became the second nation in Europe to impose a countrywide ban on smoking in all public places, including all restaurants and bars in June 2004.
- In New Zealand, on 10 December 2004, legislation came into force to make all workplaces, including bars, cafes and restaurants smoke-free. As well as tobacco, herbal smoking products are prohibited under the ban.
- Halifax in Canada has enacted by-law S-200, cited as the "[Smoking By-law](#)", which bans smoking in drinking establishments (a lounge, cabaret or beverage room) licensed under the Liquor Control Act, and in places of public assembly such as shopping centres and civic government buildings. It also bans smoking within 5 metres of the entrance to prohibited areas.
- Occupational Health and Safety Regulation in British Columbia requires employers to designate separate areas for smoking. Amendments in 2002 apply to public entertainment facilities, including bars, bingo halls, bowling alleys, cocktail lounges, restaurants, gambling casinos, nightclubs and pubs.
- In South Africa, the Tobacco Products Control Act makes it illegal to smoke tobacco products in public places. Private dwellings are exempt, except if run as a commercial child care or schooling facility. Smoking is permitted in designated smoking areas within bars, pubs, taverns, night clubs, casinos, restaurants, hotels, guest houses, bed and breakfasts, game lodges, passenger trains, passenger ships, workplaces, and airports. This, too, forms part of employment legislation.
- In Australia, bans on smoking are done on a territorial basis. The Australian Capital Territory banned smoking from most restaurants in 2000; New South Wales passed a ban in September 2000: Victoria in July 2001: and Queensland and Tasmania in 2002. The Australian Capital Territory and the State of South Australia have announced their intention to introduce legislation to ban smoking in restaurants and bars, as well as the workplace generally.
- In Singapore smoking is banned on public transport, domestic and international flights, in cinemas and theatres, public places, outdoor bus stops and places where people queue, enclosed offices and factories. There are also restrictions on smoking in restaurants and cafes and private and public workplaces.

Further information on Tobacco Control Country Profiles 2003 is available through [GLOBALink](#) and through the World Health Organisation's [European Report on Tobacco Control Policy](#) (2002).

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