

A CONSULTATION ON REDUCING EXPOSURE TO SECOND-HAND SMOKE

SMOKING IN PUBLIC PLACES

RESPONSE FORM

This submission is on behalf of the Scottish Parliament's Cross Party Group on Tobacco Control. This Cross Party Group has membership of more than 20 MSPs from all the main parties, and was established by SCCOT (the Scottish Cancer Coalition on Tobacco). Its purpose is to take forward an effective tobacco control agenda and monitor the implementation of the UK White Paper on tobacco, Smoking Kills, in Scotland. The submission does not necessarily reflect the views of individual member's parties or organisations (see end of response form for full list of current members).

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? YES

Please provide any other comments here:

There is a wealth of robust medical and scientific evidence that documents the health risks associated with environmental tobacco smoke (ETS):

Environmental Tobacco Smoke and Adult Health

A recent European Respiratory Society report, the European Lung White Book, demonstrates that respiratory diseases such as lung cancer, asthma, pneumonia and chronic obstructive pulmonary disease are killing more people in the UK than in any other EU country except the Irish Republic (who have recently taken decisive action by banning smoking in the workplace)ⁱ. The UK death rate for these diseases is running at 105 per 100,000 people – twice the average for the EU.

Exposure to ETS has been established as a cause of heart diseaseⁱⁱ and lung cancer.ⁱⁱⁱ Research has demonstrated a 50-60% increased risk of an acute coronary heart disease event^{iv}, and a 20-30% increased risk of lung cancer^v associated with passive smoking in both men and women. Even brief exposure to ETS can affect the coronary circulation in non-smokers^{vi}, and a recent Scottish study demonstrated that non-smokers exposed to ETS in the workplace may have their lung function reduced by up to 10%.^{vii} It has also been estimated that ETS in the workplace poses 200 times the acceptable risk for lung cancer and 2000 times the acceptable risk for heart disease.^{viii}

Exposure to ETS could also account for bouts of respiratory damage in non-smokers especially as ventilation systems are not able to effectively control ETS pollution. Recent controlled experiments have shown that the air pollution emitted by cigarettes is 10 times greater than diesel exhaust. The comparative pollution levels for the tiniest particles in cigarette smoke – the most dangerous to health, are even greater.^{ix}

Individuals who work on low incomes, or in small businesses, and in the hospitality industry are at greatest risk.^x A US study showed hospitality workers had a 50% higher risk of lung cancer than the general population – after controlling for active smoking.^{xi} Konrad Jamrozik^{xii} also states that in the general population, 30% of individuals smoke, leading to an estimated 42% of younger adults (age <65 years) being exposed to tobacco smoke at home and 11% at work. Domestic exposure is estimated to cause at least 3,600 deaths annually from lung cancer, heart,

disease and stroke combined, while exposure at work leads to approximately 700 deaths annually from these causes.

Currently, virtually all employees in the hospitality industry are exposed to tobacco smoke at work. The exposure of those in pubs and bars is approximately three times greater than that of the average non-smoker living with a smoker. Bar personnel may spend up to 40 hours a week exposed to ETS, and round 4 in 10 have been in the business for over 10 years.^{xxv} A significant number of people in the hospitality industry face decades of exposure to ETS. Passive smoking at work is estimated to be responsible for almost twice as many deaths from heart disease, stroke and lung cancer among hospitality employees than is their domestic exposure (49 deaths annually *versus* 29). In simple terms, passive smoking at work is killing one hospitality industry employee in the UK each week.^{xiii}

Environmental Tobacco Smoke and Child Health

Exposure to ETS can cause asthma in children^{xv} and may increase the severity of the condition in children who are already affected^{xvi}. Recent research suggests that corticosteroid drugs used to treat asthma are ineffective when given to children who are exposed to ETS as a result of their parent's smoking^{xvii}. Children are also at a higher risk of developing an atopic eczema when exposed to ETS, and genetically predisposed children are at higher risk of developing allergic sensitisation against house dust mites.^{xviii}

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

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

Ventilation

The installation of ventilation equipment is often promoted as the solution to the health risks associated with exposure to ETS. However, there is no ventilation system that *fully* removes the harmful gases that are present in ETS.^{xxvii} Tobacco smoke contains over 4000 chemicals either in the form of particles or gases. Particles include tar, nicotine, benzene and benzo(a)pyrene. Some of the chemicals have marked irritant properties and 60 of them are known or suspected carcinogens.^{xxviii} The use of ventilation would not be considered for any other class A human carcinogen, and it cannot be considered an acceptable solution to the health risks associated with exposure to ETS.

Because only the particulate matter in smoke is visible, ventilation filtration systems can give the non-smoker the impression that they are safe from exposure to ETS. Ventilation systems may increase comfort levels, and as a result, many people underestimate the extent to which they are exposed to ETS. In one US study for example, 40% of people questioned reported exposure to

ETS. However, the U.S. Centre for Disease Control measured cotinine (a product formed by the body breaking down nicotine) in the blood of 88% of the non-smoking population.^{xxxix}

The current ventilation standards promoted by AIR (Atmosphere Improves Results)^{xxx} are simply inadequate. They state that a minimum of 12 air changes per hour is required for an average sized room, in order to judge ventilated air as 'safe'. However, based on this recommended ventilation rate for a pub at full occupancy, it is estimated that 5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer during his or her working life.^{xxxi}

The UK Health and Safety Commission states "A ventilation rate of 8 litres per second (30m³/hour) of outdoor air per person is adequate for non-smoking rooms. But where smoking is allowed this rate needs to be increased to reduce the concentration of environmental tobacco smoke to levels that do not cause discomfort."^{xxxii} However, preliminary evidence from the Joint Research Centre (JRC), one of the EU's most prestigious scientific institutions, shows that changes in ventilation rates during smoking do not have a significant influence on the air concentration of tobacco components. This means, in effect, that efforts to reduce indoor air pollution through higher ventilation rates in buildings and homes would hardly lead to a measurable improvement of indoor air quality^{xxxiii}. In fact, ETS and ventilation expert Prof. James Repace has estimated that it would require in excess of 10,000 air changes per hour to produce levels of risk acceptable to bar staff from ETS.^{xxxiv} This would be equivalent to a tornado-like wind, and as Repace and the JRC both conclude, this is clearly unachievable.

A challenge based on ventilation as a solution to the problems relating to ETS exposure was recently reported as rejected in Malta.^{xxxv} The Malta Standards Authority Technical Committee on Air Quality in Bars and Restaurants concluded there was insufficient evidence to show that any air cleaning system is effective enough to purify the air so that it would not pose a health hazard. Similarly, the Irish Office for Tobacco Control and Health and Safety Authority dismisses ventilation as a solution to ETS, saying, "even new technologies would still mean exposure levels of 1500 to 2500 times the acceptable level of risk for hazardous air pollutants"^{xxxvi}. The Scottish Executive have recently acknowledged that "research suggests the air-flows possible with current ventilation systems are not sufficient to eliminate the health risks associated with second-hand smoke"^{xxxvii}. Ventilation systems are simply not the solution. Smoke-free enclosed public places remain the only viable way to ensure that workers, members of the public and children are fully protected from the hazardous effects of ETS.

Employer's Duty of Care

Any belief that ventilation systems protect staff and the public from the ill effects of ETS is mistaken. As the World Health Organisation has concluded, "Since there is no evidence for a safe exposure level (to second-hand smoke), legislation limited to ventilation design and standards cannot achieve smoke-free workplaces and public places."^{xxxviii} Employers should be aware that buying a costly ventilation system does not remove the threat of litigation from employees exposed to ETS. The Health and Safety at Work Act (1974) implies that employers have a duty to control smoking in the workplace. Case law also requires employers to provide a safe workplace, so that they may be sued for negligence where exposure to passive smoke damages the health of employees. It is therefore not only in the interests of non-smokers, but also in the interests of employers to provide an adequate no smoking policy. It is the employer's responsibility under the Management of Health and Safety At Work Regulations 1999 to assess and remove where possible the hazards to which their employees are exposed and which may place their health and safety at risk. The risks of litigation for exposing workers to known risks and damaging health should not be underestimated. A number of UK cases have been settled out of court, with businesses compensating workers for damage to health. In the Irish Republic 50 bar staff are

currently taking a legal action against their employers over damage to their health caused by exposure to ETS^{xviii}.

The Voluntary Charter

The current Voluntary Charter on Smoking in Public Places is failing to deliver significant protection to hospitality workers in Scotland. It is not based on evidence on how to protect health, either for staff in the leisure industry, or for the public who use these facilities. It is possible to put up a sign and comply, without doing anything to provide smoke-free areas.

Even where designated smoking areas are provided, they often continue to expose people in the vicinity to ETS, and they increase the exposure to smokers by concentrating them in the one place. The results of the recent audit of the impact of the Voluntary Charter show how flawed the scheme is. After nearly three years since its introduction, more than 7 in 10 pubs still permitted smoking throughout, as did nearly 4 in every 10 leisure industry sites. Only 1 in 7 of all leisure industry sites - including superstores, sports grounds, sports centres, as well as pubs and restaurants - complied with all key aspects of the Charter. Furthermore, awareness of the scheme was disappointingly low - fewer than half of businesses knew about the scheme - suggesting that the changes that had taken place would have happened anyway.^{xi} Seventy percent of the Scottish public do not smoke, and yet only 18% of public places are currently smoke free^{xii}. Scotland has fewer smoke-free workplaces than the rest of the UK^{xiii}; 31% of working women and 21% of working men had been exposed to other people's smoke at work in the week preceding the most recent Scottish Health Survey.^{xiii}

Exposure to ETS presents a significant health risk for every Scot, and pregnant women, hospitality workers, children and many individuals with existing health problems face an even greater risk associated with exposure to ETS. ETS has been labelled "**carcinogenic to humans**" by the World Health Organisation's International Agency for Research on Cancer (IARC).^{xiv} It has also been labelled a "**class A human carcinogen**" by the US Environmental Protection Agency^{xv}, along with asbestos, arsenic, benzene and radon gas. While exposure to other toxins at work is regulated by law, there is no mandatory right to protection from ETS in the UK and Scotland. Ventilation systems may increase comfort, but cannot achieve smoke-free, healthy workplaces and public places.^{xvi} Voluntary agreements have proved ineffective in other areas of tobacco control policy, such as advertising, and likewise, the Voluntary Charter simply hasn't worked. **It is time to take decisive action to protect the Scottish workforce, and members of the general public, from the hazardous health effects of ETS, by introducing legislation to make enclosed public places smoke-free.**

2. Would you support a law that would make enclosed public places smoke free? (Public places include workplaces and public transport) YES

Tobacco is the biggest cause of death and ill-health in Scotland, claiming over 13,000 lives each year^{xvii} and costing the NHS in Scotland an estimated £200 million on hospital treatment annually.^{xviii} The annual cost of employee smoking in Scotland is estimated to be more than £500 million - £450 million for lost productivity (smoking breaks), £40 million from higher absenteeism among smokers and £4 million as a result of fire damage^{xix}.

Impact on Cessation Rates

A number of studies show that smoke-free environments support smokers who are trying to give up. Employees in workplaces with smoking bans have higher rates of smoking cessation than employees where smoking is permittedⁱ. Total workplace bans in the UK may also reduce cigarette consumption by individuals who smokeⁱⁱ. A recent British Medical Journal study used data from other countries to show that, if all UK workplaces were smoke-free, we could expect smoking rates to fall by 4%, and overall tobacco consumption by 7.6%ⁱⁱⁱ.

Evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and public places may also have the effect of enhancing protection from ETS in the home. For example, in Australia, the introduction of legislation for smoke-free workplaces during the 1990s was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at home. Among households with children, the proportion with smoking restrictions more than doubled, from 25% in 1989 to 59% in 1997. The increase among households where parents smoked was even more dramatic: among homes where one adult smoked, the proportion with smoking restrictions rose from 17% to 53%; among those where all adults smoked, it increased from 2% to 32%.^{liii}

For the sake of current smokers attempting to quit, and to denormalise smoking in society so that future generations don't get hooked on smoking, we must act now to rid our public places of tobacco smoke. There is a culture change going on. Public attitudes to smoking are changing. People are becoming more aware of the serious health risks faced by smokers themselves, and are increasingly concerned about the health effects and discomfort of breathing other people's smoke. The majority of Scots now don't smoke, either because they have quit or because they never started. Many of our tourists come from stricter regulations and expect more than we can currently offer in terms of eating, drinking and sleeping smoke-free.

The Tobacco Industry

The tobacco companies have identified smoke free places as a major threat to their profits since the 1970s.^{liv} As a result, they continue to lobby against any measures to restrict smoking in public places. Additionally, the tobacco industry actively supports initiatives that encourage the use of air cleaning and ventilation as a proposed solution to the problem of ETS. They have funded the development of a number of 'information' initiatives on smoking aimed at the hospitality trade. For example AIR (Atmosphere Improves Results) is mainly funded by the Tobacco Manufacturer's Association.^{lv} Courtesy of Choice, which is run by the international federation of hoteliers, has also been directly implicated in other countries as a conduit for tobacco industry funding and lobbying in particular against smoke free legislation.^{lv}

The tobacco industry has been known to work behind the scene in other countries to influence the public and defeat public health efforts to control tobacco. For example, the 2004 'Tobacco Industry Involvement in Colorado' report^{lvii} documents evidence gathered through examination of internal tobacco industry documents, Colorado Secretary of State records, local campaign contribution records and various other sources. It concludes that the tobacco industry's involvement in opposing public health initiatives has grown, but at the same time has become less clear to the public. The industry's efforts have slowed the progression of public health efforts to address tobacco issues in Colorado, primarily through derailing efforts to enact an end to smoking in enclosed public places.

Economic Impacts

Some UK businesses have concerns that putting a total end to smoking in enclosed public places would have a negative impact on business. In advance of legislation to restrict drinking and driving in the UK, similar fears were expressed concerning the demise of the rural pub or small freehold following legislation. By and large, society accommodated the changes and few would now campaign for a return of unlimited alcohol consumption combined with driving.

There is a wealth of international evidence to demonstrate that ending smoking in public places does not have a negative impact on business. For example, a recent report on the first 12 months since the smoke-free legislation in New York was introduced has documented clear financial benefits to comprehensive legislation; 10,000 new jobs have been created (2,800 seasonally adjusted jobs), air pollution levels have reduced six fold, and business tax receipts in restaurants and bars are up 8.7%. There has been an 11% decline in the number of smokers in New York

City over the previous year – the fastest drop in smoking rates ever nationally recorded. This drop represents 100,000 fewer New Yorkers smoking in 2003 compared to 2002. It is also estimated that 150,000 fewer New Yorkers have been exposed to second-hand smoke at work since the Smoke-Free Air Act took effect, and in non-smoking workers in bars and restaurants an 85% reduction in cotinine levels has been noted.^{bvii}

A recent report from the Republic of Ireland also suggests that smoke-free public places may have a positive impact on business. On the 31st May 2004, the Office of Tobacco Control in Ireland published its first report on compliance for one month after the smoke free workplace legislation was introduced. The report found that 97% of premises inspected were compliant with the new law. Levels of visits to pubs and restaurants remained constant, with 1 in 5 smokers choosing not to smoke at all when out socialising. The rate of smokers visiting pubs has remained steady at 74% since the legislation was introduced. The frequency of non-smokers visiting pubs has increased from 67% to 70%.^{ix}

Recent research has compared the quality and funding sources of 97 studies concluding either a negative effect, no effect, or positive effect of smoke-free legislation on the hospitality industry. The best designed most rigorous studies consistently report no impact or a positive impact of smoke-free restaurant and bar laws on sales and employment. It is noteworthy that all the studies concluding a negative impact have been funded by the tobacco industry^x.

Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland's appalling rates of cancer, heart and lung disease, both by cutting smoking rates and by reducing people's exposure to unwanted smoke.

An Approved Code of Practice

In July 1999, the Health and Safety Commission (HSC) produced a draft Approved Code of Practice (ACoP) to clarify the implementation of the Health & Safety at Work Act as it applies to passive smoking in the workplace. The Act states that employers have a duty "to provide and maintain a safe working environment which is, so far as is reasonably practicable, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work." The intention of the ACoP was to show what would be considered as 'good practice' in dealing with ETS at work. The ACoP was issued for consultation by the Health and Safety Commission in 1999. In September 2000, the Commission decided to go ahead and it was passed for Ministerial approval. However, a decision was then made to demit the proposed ACoP for further consultation, apparently due to lobbying from the hospitality sector^{xi}. This process has caused the ACoP to disappear from the political agenda.

Even if implemented, it is likely that the ACoP will be too weak to have any real impact on the provision of smoke-free areas in the future. This is unfortunate, as the principle of using the ACoP to standardise workplace restrictions on exposure to ETS has the potential to be very effective. Although general requirements exist there is a lack of any specific guidance and regulation in relation to exposure to ETS. Properly introduced, the ACoP could have been an opportunity to increase smoke-free provision to protect workers exposed to ETS through their work in the hospitality industry as well as other sectors. As it stands, it represents a missed opportunity for culture change in the workplace. In the absence of the ACoP, legislation to protect employees from exposure to ETS is vital, and must be a priority.

There are a number of possible options for legislation, other than introducing smoke-free enclosed public places. One option, for example, is to target only specific areas where food is being served or where children have access. The problem with this is that it would not apply in the majority of enclosed public places where ETS causes harm. Those working on low incomes, or in small businesses and in the hospitality industry would still remain at greatest risk.^{bviii} We are

concerned that, if such legislation were introduced, the explicit relationship between food and smoke-free places would reinforce the view that ETS is primarily a comfort issue, rather than a health issue. A recent study showed that this was the predominant perception in Scotland.^{lxvii} However, research clearly demonstrates that ETS causes a range of serious health conditions.

A key message from those opposing smoke free legislation is that it 'removes choice' – for business and for customers. But the status quo actually denies the option of smoke free air to many people, including those with asthma or other existing health conditions who are barred from smoky atmospheres. People in deprived communities, where smoking rates are highest, are least likely to be able to enjoy smoke-free facilities. Many employees cannot choose to work in smoke-free conditions without losing their jobs. We do not accept that people can choose to be exposed to serious toxins like asbestos. And people can choose to drink, and to drive, but not to do both because of the potential harm to other people. The 'choice' argument is just too weak to stand up.

Scotland has an opportunity to lead the way in the UK by introducing smoke-free enclosed public places. It is estimated that 1,000 lives each year would be saved in the UK if workplaces were smoke-free^{lxviii}. Now is the time for the Scottish Parliament to act to protect the Scottish workforce and members of the general public, from the hazardous effects of ETS, by introducing smoke-free public places.

3. If a law was introduced, do you think there should be any exemptions to it?

Please provide any suggestions, reasons or other comments here:

Exemptions to any law introduced on smoke-free enclosed public places may result in only partial protection of the general public – smokers and non-smokers - from the health risks of passive smoking already documented. Effective smoke-free legislation in many other countries is framed to apply in almost *all* public places, for example in New Zealand, the Republic of Ireland, Norway, Sweden and in parts of the US. The health benefits of introducing comprehensive no-smoking policies are clearly documented.

We believe that if any exemptions *are* to be considered, they should be minimal exemptions for evidence-based reasons, and be time limited or with defined and monitored criteria. For example, prisons, nursing homes and psychiatric hospitals are exempt from smoke-free legislation in the Republic of Ireland. However, all employers (even those who are exempt) still have the right to enforce the legislation. In other words, even though these exempt institutions are not obliged to enforce the ban, they are free to do so if they wish.

UK public opinion clearly demonstrates that it is time to end smoking both in the workplace and in other public places. The most recent Office of National Statistics survey shows steadily increasing public support for smoking restrictions at work, including 88% in favour of restrictions on smoking in restaurants, 54% in pubs and 87% in other public places^{lxix}. Similarly, a recent poll by MORI shows strong support for smoke free environments for hospitality staff. Three-quarters (76%) of British people polled agreed that waiters and waitresses in cafes and restaurants should be able to work in a smoke-free work environment. 61% believed bar staff in pubs should also be able to work in a smoke-free environment, and more than half of British people (53%) said they would rather eat in a smoke-free restaurant^{lxx}. Most recently, a survey conducted by law firm Peninsula shows that 90% of UK employers would welcome a workplace smoking ban^{lxxi}. **The wealth of existing research literature, combined with public opinion clearly demonstrate that it is now time to increase efforts to protect the Scottish workforce and members of the general public, by introducing legislation for smoke-free public places.**

4. If we decide not to introduce a law, what could be done to encourage individual businesses to take voluntary action to become smoke-free or to provide more smoke-free provision?

We believe that encouraging voluntary action by businesses, in place of a law on smoke-free enclosed public places, could only be described as Scotland failing to seize the unique opportunity to move forward on the issue of smoking in public places. In order for tobacco control measures to be most effective, they must be standardised across establishments. There are also issues of enforcement to consider. Transparent legislation, which applies to everyone, is easier to enforce than legislation that applies only to some types of buildings or applies differently at different times of the day. Smoking restrictions in pubs and bars have lower levels of public support than other public places^{ixv}. On this basis it will be easier to enforce if legislation is introduced that applies in all enclosed public places. If voluntary action is encouraged rather than introducing legislation, individuals will be no closer to obtaining freedom of choice concerning exposure to ETS, and nor will hospitality workers, children and other members of the public be protected from the harmful health-effects of ETS. As already outlined, the current Voluntary Charter isn't working. Any efforts to provide partial protection from ETS remain flawed, as there is no safe level of exposure to second-hand smoke^{ixviii}.

5. What else could be done to reduce people's exposure to second-hand smoke?

It is a basic tenet of occupational health and safety law that workers should be protected from substances that might affect their health. For example, under the new Control of Asbestos at Work Regulations (2002)^{ixx}, duty holders have a legal obligation to assess risk from asbestos in non-domestic properties, and where applicable, adopt a risk management plan accordingly. The Health and Safety at Work Act (1974) and Control of Substances Hazardous to Health (COSHH) Regulations 1994, employers have a duty "to ensure that the exposure of his employees to substances hazardous to health is either prevented or...adequately controlled." COSHH Regulations include a list of substances that are established as being hazardous to health. Tobacco is currently not included in this list, despite the fact that ETS has been labelled "carcinogenic to humans" by the WHO's International Agency for Research on Cancer (IARC)^{ixx}. It has also been labelled a "class A human carcinogen" by the US Environmental Protection Agency^{ixxi}, along with asbestos, arsenic, benzene and radon gas. ETS should be explicitly added to the COSHH Regulations 2002^{ixxii}, and should be explicitly listed in the forthcoming EU Carcinogens Directive.

Tobacco control is a complex issue, and requires sustained effort from various sources in order to achieve positive outcomes. A substantial amount of money has been invested in Scottish smoking cessation services, and these services must continue to be supported and maintained in order to assist in reducing individual's exposure to ETS.

6. Please let us know any other views you have about smoking in public places.

One hundred and fifty years ago, it was commonplace to send primary school age children up chimneys, or to have them working in factories for 14 hours per day, 6 days per week, with horrendous casualty and injury rates. Fifty years ago it was commonplace for shipyard workers to work all day long with asbestos products, then go home, without even changing their overalls, and pass the deadly dust on to their families. As recently as 20 years ago, it was commonplace for workmen on building sites not to wear hard hats. But our culture is changing, and safety standards are quite rightly rising.

Any restrictions introduced to prevent exposure to environmental tobacco smoke in enclosed public places will require specific legislative requirements. To ensure compliance, provision for enforcement must be in place which will identify what the offences are, who enforcement action may be taken against and who the legislation will be enforced by. This legislative provision should be adequately resourced, to ensure the effectiveness of any controls. A good example of such provision is the Republic of Ireland's Office of Tobacco Control. The role of the Office of Tobacco Control is to support the Republic's smoke-free policy by discharging a variety of functions which includes enforcing the tobacco control laws, conducting research into tobacco and communicating the findings, and organising a national inspection programme.

The scientific and medical evidence is clear, and the health benefits of introducing smoke-free enclosed public places are clearly documented. The dangers associated with exposure to ETS are also clear. Attitudes to smoking are changing, and people are becoming more aware of the health effects associated with passive smoking. It is now time to act decisively in Scotland and protect workers, children and members of the general public from the hazardous impacts of environmental tobacco smoke. The only viable way to do this is to introduce smoke-free enclosed public places.

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INFORMATION TO HELP US UNDERSTAND YOUR VIEWS

Are your views personal or are you representing those of an organisation?

This submission is on behalf of the Scottish Parliament's Cross Party Group on Tobacco Control.

Respondee Information Form

Name: Brian Adam (Convenor)

Address: The Scottish Parliament, Edinburgh, EH99 1SP

Consultation Title: Smoking in Public Places

Your name and address as respoondees will be made available to the public (in the SE library and/or on the SEW website). Are you content for your response to be made available too? Yes

The current membership of the Cross Party Group on Tobacco Control is as follows:

Brian Adam MSP (Convener) (SNP)
Bill Aitken MSP (Treasurer) (Con)
Shiona Baird MSP (Vice Convener) (Green)
Mark Ballard MSP (Green)
Ted Brocklebank MSP (Con)
Robert Brown MSP (Vice Convener) (Lib Dem)
Donald Gorrie MSP (Lib Dem)
Pauline McNeill MSP (Lab)
Stewart Maxwell MSP (SNP)
Irene Oldfather MSP (Vice Convener) (Lab)
Keith Raffan MSP (Lib Dem)
Eleanor Scott MSP (Green)
Nicola Sturgeon MSP (SNP)
John Swinburne MSP (SSCUP)
ASH Scotland (Maureen Moore)
British Lung Foundation (Andrew Powrie-Smith)
BMA (Gail Grant, Beatrice Kennedy, Dr Bill O'Neill)
Cancer BACUP (Jenny Whelan)
Cancer Research UK (Lesley Conway)
Centre for Tobacco Control Research (Elinor Devlin, Prof Gerard Hastings)
Macmillan Cancer Relief (Lorraine Alstead; Ian Gibson; Kate Seymour; Kirsty Tomassi)
Marie Curie Cancer Care (James Wells)
National Asthma Campaign (Marjory O'Donnell)
Roy Castle Lung Cancer Foundation (Dr Jesme Baird, Chris Owens)
The Royal Environmental Health Institute of Scotland (Tom Bell)