OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 14 November 2023

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
34th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Emily Banks (University of Oxford)
Professor John Britton (University of Nottingham)
Sheila Duffy (ASH Scotland)
Dr Garth Reid (Public Health Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 14 November 2023

[The Convener opened the meeting at 10:30]

Interests

The Convener (Clare Haughey): Good morning, and welcome to the 34th meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies.

The first item on our agenda is to invite Ruth Maguire to declare any interests that are relevant to the committee's remit.

Ruth Maguire (Cunninghame South) (SNP): I have no interests to declare, convener.

The Convener: Thank you, Ms Maguire, and welcome to the committee.

Decision on Taking Business in Private

10:30

The Convener: The second item on our agenda is to decide whether to take item 4 in private. Do members agree to do so?

Members *indicated agreement.*

Vaping (Public Health Impact)

10:30

The Convener: The third item on our agenda is an evidence session on the public health impact of vaping. We will hear from representatives of Public Health Scotland, anti-smoking charities and academics with expertise in tobacco control and vaping. I welcome to the meeting Professor Emily Banks, head of the centre of epidemiology for policy and practice at the Australian National University and visiting professor in the Nuffield department of population health at the University of Oxford; and Professor John Britton, emeritus professor of epidemiology at the University of Nottingham. Both are joining us remotely. With us here are Sheila Duffy, the chief executive of ASH Scotland; and Dr Garth Reid, consultant in public health at Public Health Scotland.

We will move straight to questions.

Ivan McKee (Glasgow Provan) (SNP): Good morning, panel. I would like to explore the prevalence of vaping among young people. We have been given data that sort of shows a picture, but, to be honest, there are lots of different data points taken at different times from different cohorts who were asked different questions. I would like to get a sense of what the data tells us about the prevalence of vaping among young people, what that prevalence looks like by different age cohorts and how that is moving over time. Is it increasing over time?

Dr Garth Reid (Public Health Scotland): I will make a start on that. Some of the other panel members may then want to chip in.

As you say, there is no single survey that asks children about vaping every year. However, we have three representative surveys of 13-year-olds and 15-year-olds. We have had those data since 2015. I will break things down into 13-year-olds and 15-year-olds. In 2015, 1 per cent of 13-year-olds reported that they were currently vaping. That figure rose to 10 per cent in 2022. There is a similar picture for 15-year-olds. In 2015, 2 per cent of 15-year-olds reported that they were currently vaping. That figure rose to 25 per cent in 2022. The biggest increases have been in the most recent years.

We are seeing an increase in youth vaping from a very low level. For context, we are seeing a flatter picture for adult vaping, which varies around 5 per cent. It seems to me that we have different pictures for adults and children.

I do not know whether any of my colleagues want to come in.

Ivan McKee: It seems that they do not. You have given a comprehensive answer and nobody feels the need to add to it.

To follow on from that, I believe that the number of young people who smoke is still reducing, but you can clarify that. Does the data suggest—obviously, this is hard to know in absolute terms—that young people who would perhaps in the past have smoked are vaping instead, or is the increase in vaping much more substantial than the reduction in young people smoking over that time period?

Dr Reid: We are seeing in children a much better picture in respect of smoking. Youth smoking has been dropping consistently for probably over a decade. That is a really positive picture. I think that the percentage has dropped to about 4 per cent for 15-year-olds. Therefore, really low numbers of kids are smoking and that is excellent. Obviously, we want more of that in public health. We want fewer kids smoking and stopping kids starting to smoke is an absolute priority.

To answer your question, if 25 per cent of 15-year-olds are vaping compared with 4 per cent who are smoking, we are not seeing a picture of smokers just switching. There is obviously a big group of kids taking up vaping who were not smoking. I think that it would be fair to say that. I hope that my colleagues would agree. Okay, I see that they do.

Ivan McKee: I suppose that the missing number is the percentage of 15-year-olds who were smoking in 2015. I assume that it was a lot less than 25 per cent.

Dr Reid: It was a lot less. We could come back to the committee with the exact figure.

Ivan McKee: Thank you—that would help to fill out the data picture. Are you comfortable that enough data is being collected, or is there a need for more data collection to give us a better picture?

Dr Reid: You could always have more data. The excellent thing about the Scottish health survey is that it is collected annually, which gives us not a real-time picture but a really current picture of what is going on for adults in terms of their smoking and vaping. For young people we do not have that picture any more, so we rely on different surveys that are running in slightly different sequences in order to collect that data, as you said earlier.

Ivan McKee: Okay. Just to be clear, when you talk about young people vaping, are those people who have ever used it, who occasionally use it or who use it on a very regular basis?

Dr Reid: The question is about current use of vaping, so the numbers who have ever tried it would be higher than that.

Ivan McKee: Right, so it is people who are using vapes on a regular basis.

Dr Reid: Yes.

Ivan McKee: Is there any breakdown beyond that in terms of the characteristics of young people, such as socio-economic background, gender, whether their parents smoked or anything like that?

Dr Reid: Yes. The health and wellbeing census study has looked at vaping and there is some detail within that. For example, in youth vaping we see that higher numbers of children across all the different quintiles—the different socioeconomic groups—are vaping. The smoking picture is very socially patterned and, sadly, we have the highest levels of smoking in the most deprived areas, in adults and in kids. We are seeing a flatter picture with vaping. More kids are vaping in more affluent areas compared with the number who are smoking, if that makes sense, but it is still the same picture in terms of inequality.

Ivan McKee: That is really helpful. Does anyone else want to contribute on any of that?

Professor Emily Banks (University of Oxford): I am pleased to be here speaking to you.

First, I support the comments made by my colleague Garth Reid. What we are seeing, both in the data from Scotland but also more generally, internationally, is an increase in overall nicotine use in young people—in teenagers—so the pattern is not consistent with people moving from smoking to vaping. It is more of a picture of continuing declines in smoking but quite rapid increases in vaping, which exceed smoking prevalence and mean that there is an overall increase in nicotine use.

The other comment, about the differences in social patterning, is also something that is seen in other places. There is a more general distribution of the use of e-cigarettes or vaping and less of a social gradient compared with smoking.

Ivan McKee: That is really helpful. Thank you very much.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I want to pick up on a question from Ivan McKee about data. As a registered nurse, I understand that when somebody comes into the hospital through a medical assessment unit they are asked, “Do you smoke—yes or no?” If it is yes, they are offered a smoking cessation pathway. Is that question extended to ask, “Do you smoke or vape?”, with smoking cessation then offered in that way?

Also, what do we do in paediatric admissions? It is rather difficult to ask paediatric patients that question, especially if their mum or dad is sitting there. For example, when they come in with shortness of breath, the first thing that we think is that it might be an asthma attack, but it might not be; it might be as a result of high doses of nicotine in vaping, for instance. Are we pursuing that now? I understand that people in some health boards ask about that, but others do not.

Dr Reid: That area is the subject of a live investigation. It is not clear how consistently health professionals are asking the question that you raised. The issue is relatively new and emerging. Its importance is now being recognised more in a clinical setting, but we are investigating that. It is one of the factors that we would need to be confident about before we could publish official statistics; we need to know how the question is being handled in a clinical setting.

The Medicines and Healthcare products Regulatory Agency has issued guidance that all healthcare professionals should ask consistently about vaping. That is a useful message and asking about that would help. We are looking at the question with colleagues in hospitals and with general practitioners.

Paul Sweeney (Glasgow) (Lab): The Scottish Government’s health and wellbeing census found that young people who live in the most deprived areas are more likely to regularly vape than are those who live in the least deprived areas. The risk is that that could compound the health inequalities that already exist in Scotland.

How can we ensure that the socioeconomic context and the disparity in health outcomes are part of the evidence on the chronic health harms of vaping? Has that evidence featured so far?

Sheila Duffy (ASH Scotland): We see from the health behaviour in school-age children survey in Scotland that, with tobacco, there is a period of uptake that does not necessarily settle into regular use quickly, whereas we are hearing reports of a huge rise in children and teenagers vaping, which has been driven by the easy availability of highly coloured, sweetie-flavoured cheap products in the past couple of years.

From the 2021 Scottish health survey data, we see that e-cigarette use is four times higher in Scottish index of multiple deprivation quintile 1 areas—the more deprived areas—than in SIMD quintile 5 areas, and dual use with lit smoked tobacco is six times more common in more deprived communities. I agree that that is a huge concern in relation to widening inequalities and health inequalities.

The Convener: Will you clarify something? What you said seems to contradict what Garth

Reid and Professor Banks said about vaping rates being similar across socioeconomic groups.

Sheila Duffy: I was talking about the Scottish health survey, which covers adult use. In all deprivation categories, the rate of experimentation and use tends to be fairly similar among children who smoke but, when we fast-forward a few years, the disparity and inequality are clear.

The Convener: Thank you for clarifying that.

Paul Sweeney: That was a helpful clarification. How do we monitor the links between vaping and certain health conditions? Should GPs or other medical professionals ask patients whether they vape and record that in their medical records? Is the data being monitored or gathered in another way?

Dr Reid: That is a good question, which we are looking at. The advice is that all healthcare professionals, including GPs, should ask consistently about vaping and record the position. It is important to collect that information clinically.

No country has cracked this; Emily Banks might talk about the health harms later. The area is new and emerging, but we in Scotland have the opportunity to look at it and at clinical practice. The country is small enough that we can get the key people together to consider how we will tackle the matter. That is key and Scotland has a good track record of doing it. Therefore, although it is a worry and a problem, I am hopeful that we can tackle it with clinicians.

10:45

Paul Sweeney: That is helpful. Has any data been gathered about accident and emergency presentations or people who have sought medical assistance due to concerns that may be linked to vaping? Do you know of any data?

Dr Reid: We have examined the A and E data and there does not seem to be information that is coded as vaping-related disorder within it. That shows you how new the issue is. There is uncertainty about much of it and there are probably inconsistencies in the vaping histories that are being taken. A and E is extremely busy and a lot of things have to be done, so we need to collect the data in a way that is constructive and mindful of the service’s other pressures.

Paul Sweeney: Professor Banks, the review of public health evidence that you published last year found evidence of acute harm such as seizure, poisoning and nausea associated with vaping. Does the evidence show whether the harms that we are seeing improve if and when a person stops vaping or whether the damage might be permanent, with the complications persisting even after vaping is stopped?

Professor Banks: We found evidence of e-cigarette harms particularly for non-smokers and young people. They included intentional and unintentional poisoning, as well as toxicity from inhalation, which can include loss of consciousness, seizures and less serious effects. Vaping is also associated with lung injury, predominantly because of tetrahydrocannabinol and vitamin E acetate. Then there is increased uptake of smoking, which we will talk about.

Most of those effects are acute and short term and will resolve once the person stops. The single most common and serious side effect for young people and non-smokers is addiction to nicotine, which can be hard to kick but, although people can have lifelong cravings, in general, once somebody stops and is past that addiction the harm will not be long term.

The other issue is burns and trauma. There have been deaths from exploding batteries. Serious burns can have lasting effects. Lung injury can also have lasting effects but most of the effects that we see, including addiction, will resolve after the person ceases use.

One of the major issues that we identified in our review is uncertainty about a lot of the effects of electronic cigarettes. We do not know what they do to cancer, cardiovascular disease or reproductive health so, if you do not know what the overall effects are, it is quite hard to say whether those effects are lasting. There is a lot of uncertainty.

Paul Sweeney: Will it be decades before that full data series is available to fully assess the life cycle of the effects on a human lifespan?

Professor Banks: I am optimistic. We have an international community and national communities who are committed to finding out more about electronic cigarettes’ effects, so we will probably get more information much more rapidly than in decades. It can take decades before we know what some exposures do but we already know a lot more about e-cigarettes than we knew about, for example, smoking in the given time frame just because we understand a lot more about how to assess risk.

The Convener: Professor Britton wants to comment.

Professor John Britton (University of Nottingham): Thank you for inviting me. I am sorry that I could not send a message to say that I wanted to speak because, for some reason, I cannot type into the message box, so I had to wave my arm around.

I will add a little bit of context to Professor Banks’s comments. She is right that the magnitude of the harm effects of e-cigarettes are

unknown but all the early indications are that they are modest.

Since 2010, the MHRA—the United Kingdom drug regulator—has collected what are called yellow-card reports on adverse effects from vaping. That is where doctors fill in a report because they have just seen a patient with something that the doctor thinks could have been caused by vaping. Not everybody does that—it is far from a complete reporting system. It operates as a sentinel system—a bit like monitoring infectious disease. It tells us when something is happening. Since 2010, five fatalities in the UK linked to vaping have been reported on the system, and about 1,000 adverse effects. For context, since 2010, about 1 million people have been killed by smoking. So, while it is unequivocal that vaping is not harmless, the magnitude of its adverse effects is extremely small.

Professor Banks referred to acute lung injury caused by vaping tetrahydrocannabinol and vitamin E acetate. In the United States, in the year before the Covid pandemic, there was a serious epidemic of a major disease that killed hundreds of people. It was linked to the use of illicit cannabis vaping fluids produced illegally in a garage somewhere in middle America. Because the practice of vaping cannabis oil had become so popular, there was a shortage of the oil, so vitamin E acetate was being used to cut the cannabis oil in the vaping fluids. It was vitamin E acetate that was causing the illness. There is no vitamin E acetate in nicotine vapes. When the cause was identified, the epidemic disappeared. It is not true to say that vaping causes major lung injury when we are talking about nicotine vaping and vaping licit contents.

Sheila Duffy: We have conclusive evidence that e-cigarette aerosol contains particulate matter of the kind that has been implicated in mechanisms such as lung inflammation and DNA damage, and subsequent risk of lung cancer. A lot of the evidence that we have is from air pollution, but it tells us to be wary about saying, “These things are safe.” If we make a comparison with smoking tobacco, I absolutely agree with Professor Britton about the relative harms. However, we could also make a comparison with not using anything and breathing fresh air.

If we are talking about people’s initial use of vapes—particularly young people—there are huge question marks that we should not be complacent about. Tobacco was popularised by being given free to the troops around the time of the first world war. From the 1920s to the 1950s, some doctors were actively recommending smoking to patients because of the short-term benefits and were not aware of the long-term harms. We need to keep that caution in mind.

Professor Banks: It is really important that we pay attention to both the nature of the harms that have been identified and the magnitude. I served for seven years as the chair of the Advisory Committee on the Safety of Medicines in Australia, so I am very familiar with the reporting systems, which are important for medicines and for particular adverse events that doctors will see and that they can link to a specific exposure.

Reporting systems are more problematic when we are looking at a moderate increase in risk. If we wanted to ask whether regular vaping among young people was linked to increased asthma risk, it would be difficult for a doctor to link cause and effect.

We know that addiction to nicotine is a serious harm for young people and that, because the brain is plastic at that age, addiction in youth tends to set the scene for and increase the risk of addiction later in life. We know that 52.1 per cent of the e-cigarette users who were 11 to 17 in the most recent ASH survey said that they had moderate to extremely strong urges to vape, and we certainly hear plenty of case reports of addiction.

We underestimate addiction. My kids say, “I’m addicted to chocolate or I’m addicted to this particular television program,” but if you are addicted to nicotine in particular, which is a highly addictive substance, you will be going through a cycle of withdrawal and craving and irritability before you satisfy that urge. You can be going through that many times a day, because nicotine is quite rapidly metabolised. We have kids who are experiencing addiction who have difficulty sitting through a lesson or sitting through a meal with a family.

We have to be careful about what we can know from reporting systems and where we need other kinds of data, and we also need to appreciate the breadth of health effects that nicotine and the other things in e-cigarettes can have.

I have a more technical point regarding the EVALI—e-cigarette or vaping product use-associated lung injury—outbreak, which peaked in September 2019 and which Professor Britton spoke about. It was absolutely largely attributed to illicit substances in vapes, but in the Centers for Disease Control and Prevention reports, one in eight cases was actually linked to reported use of standard vapes. We have certainly seen intermittent cases of lung injury where illicit substances were not indicated, but they are obviously not of the magnitude of the EVALI outbreak, which caused 68 deaths and 2,800 hospitalizations.

David Torrance (Kirkcaldy) (SNP): Good morning, witnesses. Can you provide an overview of the strength of the association between

nicotine, brain development and mental health problems? Who would like to go first?

The Convener: Professor Banks, do you want to come in first? Then we will go to Professor Britton.

Professor Banks: I would be quite happy for Professor Britton to go first, because I spoke quite a bit just then. I will be happy to speak after that.

Professor Britton: Okay. There is evidence, particularly from animal models, that exposure to nicotine during brain development leads to adverse effects in mature animals. In humans, nearly all of the available evidence is derived from studies of smokers, and we know that smokers have impaired cognitive development. There is the theory, which Professor Banks has alluded to, that that might set the scene for a greater predilection to other addictions in later life. However, studies of pure nicotine in humans are pretty few and far between, and it is extremely difficult to disentangle statistically the effect of vaping from the concurrent or preceding effect of tobacco smoke.

I agree entirely with the earlier comments that what you are seeing in Scotland, and what we are seeing in England and elsewhere in the world, is a big increase in young people vaping who would not otherwise have smoked, and that needs to be addressed. Nevertheless, the majority of people who vape regularly were smokers or are at very high risk of becoming smokers if they do not vape, and they come from families in which people do or did smoke. It is very hard to separate out the effects of vaping nicotine in those human populations.

I am not writing them off, but I would say that the risks of future mental health disease, which the question was about, are more theoretical than real. If they did exist, they would be unlikely to be substantially different from the status quo of about 20 years ago, when smoking was so much more common.

11:00

Professor Banks: One of the difficulties is in disentangling nicotine-related and smoking-related issues. We know that nicotine itself is highly addictive and that e-cigarettes, and particularly the nicotine salt products in those, are capable of delivering very high concentrations of nicotine very rapidly.

We are seeing nicotine addiction in children, and we have clear evidence that nicotine addiction in childhood predisposes people to nicotine addiction in later life. That is one reason why the tobacco industry and related industries are aggressively targeting children and adolescents with their marketing: they do it to create lifelong customers.

We know from reports from children that they are experiencing issues with e-cigarette addiction and that there is a lot of distress and stigma related to becoming addicted to e-cigarettes. The idea is that people will use that highly addictive product socially, so becoming addicted is seen as a failure by some people.

We also know that there is a close and complex relationship between nicotine addiction and mental health problems. Some people say that they vape to relieve mental health problems, but we know that addiction creates mental health problems and that cessation—particularly cessation of smoking, although we are getting more evidence about vaping—can improve mental health.

There are things that we do know, but there is also a lot of long-term uncertainty. It is important to remember that, when people inhale the aerosol or emissions from an electronic cigarette, they are generally getting nicotine but they are also getting the products in the e-liquid, which include propylene glycol, vegetable glycerine and, usually, flavourings and other additives. The most recent analyses of just four brands of e-cigarette showed the presence of between 900 and 2,000 distinct chemical entities, many of which are unknown while a number of those that are known are hazardous. This is not just about nicotine; there are lots of other emissions and particulate matter in what is being inhaled.

David Torrance: Professor Britton, in your work as a respiratory consultant are you seeing an increasing number of younger patients as a result of vaping, and how are they presenting?

Professor Britton: I should say that I am a former respiratory consultant—I did that for 30 years and am now retired—and that I was an adult physician.

During my career, which finished in 2020, I did not see a single admission to hospital of anyone who was there because they vaped. Smokers who come to hospital with lung disease and who are still smoking are hard-core smokers, so we would very much encourage any method of quitting smoking, including conventional medicines and electronic cigarettes. Electronic cigarettes were the most widely used method.

There have been anecdotal reports of increasing admissions to hospital of children in the UK, or certainly in England, and one or two very serious cases of lung disease have been written up in the literature. Once again, that is a big problem in that at least some of those people were smokers and have come into hospital with diseases or lung infections that are certainly more common in smokers but that might also have been

triggered by vaping. The numbers remain very small; they are growing, but they are very small.

I have one other point to make, which is about the content of the toxins in vapour. I agree with Professor Banks that there is a lot of stuff in there. We analysed the data from 2016-17, which was the first year of reporting of emissions that were registered with the MHRA. By law, manufacturers and suppliers have to submit an analysis of vape content to the MHRA. That is their own analysis—nobody checks it—and we have no idea how reliable those numbers are. They could be made up, for all I know. Taking them at face value as reasonable and valid, we found that there was a very wide range of chemicals in the vapour. However, estimates of the level of concentration of most of those constituents in the lung after inhalation of the vapour were typically below European occupational health standards. A lot is in there, but the levels are very low.

We have no idea what long-term exposure to those things will mean. I suspect that, in 50 years, some cases of lung cancer, pulmonary fibrosis, chronic obstructive pulmonary disease and heart disease will have been caused by vaping. However, whereas lung cancer cases are currently in the tens of thousands, I expect the numbers of those cases to be in the tens, or in the hundreds at most. There is a wide range of toxicants in the vapour, but the levels of those are—not exclusively, but typically—very low.

Paul Sweeney: Comments have been made about illicit substances in vapes that may produce harmful outcomes for vape users. It has been put to me that the nicotine level in some vapes that are sold in the UK exceeds the legal limit. Does the panel have any knowledge of that? How can we monitor product safety more robustly and strengthen regulation—in particular, when it comes to imported vape products from China, for example?

Professor Britton: You are right that illicit vapes are getting into the UK. Some contain very high levels of nicotine. In and of itself, that may not be such a bad thing, if the vapes are being used by smokers. The 20mg upper limit in the European directive of 2014 always struck me as being an arbitrary level.

When it comes to how to stop those products, we should enforce the laws that are already in place. Those products should not be on the market at all. To be on the market, they should have been registered with the MHRA. If that has not been done, a product is illegal and it is illegal to sell it to people. It is illegal to sell vapes to people aged under 18, and it is illegal to sell vapes that are not registered with the MHRA. Those are illicit products. When asked about what we can do, my first answer is that we can police what is on the market and close down retailers and suppliers that are not registering their products. We can then beef up our trading standards to make sure that sales to children do not happen.

That leads to the possibility of somehow prohibiting vapes. Australia has gone down that policy route. Professor Banks may differ on this, but it seems to me that vaping levels among children in Australia are not remarkably lower than those in the UK, despite the fact that the products are illegal.

It comes down to policing and enforcing compliance with the law rather than thinking about what else we could do. We have laws; we are just not enforcing them.

Sheila Duffy: I agree that illicit products are an issue and that there is a problem. I have heard from the Society of Chief Officers of Trading Standards in Scotland that it is aware of a regularly used route into Scotland for illicit products, which come from the Republic of Ireland, through Belfast to Cairnryan, and end up in the north of England. At the moment, there is no easy mechanism for controlling that trade, because trading standards officers do not have the powers that police have—and, apparently, His Majesty's Revenue and Customs does not deal with illicit e-cigarettes in the way that it deals with illicit tobacco. We need to join up some of our enforcement.

"Illicit" is always the go-to argument for tobacco companies against any meaningful health regulation. However, the fact that an illicit product may or may not kill faster than a legally sold product does not reassure. Someone in Europe described it as jumping from the 23rd floor of a tower block rather than from the 21st.

I note that e-cigarettes include a range of products; they are not one thing. They include four or five different types of device, some of which have been modified in different ways. There are more than 30,000 e-liquids registered on the MHRA's site, but, as Professor Britton said, those liquids are not tested. The MHRA is simply informed of what is in them, and then they can be sold legally. The US Food and Drug Administration decided that that was not good enough. It decided that it would look at and scrutinise what could be sold legally. It received 6.7 million applications for authorisation, but, so far, it has authorised only 23, and none of those has flavourings.

We need to make it clear that we are not talking about a pharmaceutical, medicinal product, because nowhere in the world is there a positive medicinal product that is an e-cigarette.

Professor Banks: I support the idea that, if we are talking about illicit trade and illicit products, the

main thing to do is have better enforcement, because enforcement is critical there.

In Australia, e-cigarettes are legal on prescription, so, unless you think that antibiotics are prohibited, in the sense that they are available only on prescription, e-cigarettes are not prohibited in Australia. They are available on prescription. In addition, the current statistics show that use among 15-year-olds is lower in Australia than it is in many other parts of the world. However, we have a problem with enforcement. We face similar issues with enforcement although we have the regulations in place, so we are now working to enforce them.

It is important to note that many of the issues that we see with e-cigarettes are similar across those products that are legally available and those that are illicit in that they largely relate to nicotine and to inhaling the products of heating propylene glycol, vegetable glycerine and flavours to a high temperature. We know that higher concentrations of the nicotine salt products, in particular, are more addictive, especially among young people.

The other issue that is probably worth talking about is that there is a recognised issue with open and refillable systems being used to deliver illicit drugs, including opioids. Therefore, we are talking about not only illicit nicotine products but other illicit substances.

Dr Reid: I absolutely agree with the point about the need for tougher controls—I think that that is a really good point.

I also want to note that the MHRA, which is the regulatory authority for medicines in the UK, has a yellow-card system, which people can use for any products that they have concerns about and that appear to be illegal. All healthcare professionals should use that system. We can send a link to it. That is a really useful function that the MHRA provides, along with the work that is done by trading standards. They work together to provide different types of surveillance.

Sheila Duffy: I have a point of clarification. I think that, in Australia, the Government has followed through on what was in the consensus statement, which said that such products are of interest to health in so far as they could help smokers to move away from lit, smoked tobacco.

The system in Australia does not involve a positive medicinal prescription; it involves a check that people have had the chance to be fully advised of the options that are available to them for quitting smoking before they are allowed to buy e-cigarettes, which are not then regarded as permitted recreational products in the way that they are here.

Paul Sweeney: What about the risk of particulate inhalation? There are some products that have no nicotine in them and that might be perceived as being risk free as a result of that. Do you consider that there are still risks associated with those?

11:15

Sheila Duffy: To be honest, I am not sure that particulates are linked with nicotine. When various studies have tested a lot of the products that have been advertised as being nicotine free, those products have been found to contain nicotine. When tested, some illicitly sold products have been found not to contain what they were notified as containing. There are an awful lot of unknowns.

Emma Harper: Sheila Duffy will know that Dr Jonathan Coutts came to a meeting of the cross-party group on lung health, which I co-convene. We had a presentation on vaping, especially among young people. Given the targeting, I am really concerned about a raft of new interstitial lung diseases—I raise that because I have close links with Phyllis Murphie, who is a nurse consultant in respiratory medicine and who happens to be my sister.

We have explored future lung ill health among young people. Dr Coutts talked about the alarming rise in the number of teens who are using e-cigarettes, from 3 to 43 per cent, which has reversed a lot of the work to eliminate nicotine exposure and then addiction. Whether or not use is illicit, how concerned are you that young people are being exposed directly to nicotine, which will harm them?

Sheila Duffy: I am very concerned by the massive uptake that we have seen and heard reports of since about autumn 2021. That is being driven by products that are marketed pretty much entirely at children through brightly coloured designs, sweetie flavours, price points and availability. According to the Society of Chief Officers of Trading Standards in Scotland, the failure rate for underage sales of e-cigarettes—at about 20 per cent—is twice that for tobacco.

The disposables, which have driven the massive uptake among children, are highly addictive. Pretty much universally, they have the highest permitted level of nicotine for the UK, and they use nicotine salts, which are smooth on the throat and make the products easier to use and therefore to become addicted to. Sweetie flavours are used, which bring their own concerns about health harms. My experience is that paediatricians are extremely concerned and are warning us that there are huge risks and that we should get on top of the massive rise in youth uptake.

Emma Harper: Jonathan Coutts's work shows that a lot of companies quote research by Nutt et al that says that e-cigarettes are 95 per cent safer than standard cigarettes, but that study involved 12 people who were invited to take part and it was not peer reviewed. Two of the people who participated also had financial links with the vaping industry. Will you jog my memory on the argument that e-cigarettes are 95 per cent safer?

Sheila Duffy: The argument is probably irrelevant, because it was from the early days of cigalikes. Since then, there have been many more iterations and devices. When the Scottish consensus statement was produced, the study was considered and universally rejected by the panel, which included people with a range of views, because it was felt to be methodologically and scientifically unsound. Professor Coutts gave a comprehensive explanation of that.

The figure is also unhelpful, because it gives the impression that e-cigarettes are safe. We know that lit, smoked tobacco is lethal and will reliably kill between half and two thirds of its consumers when it is used in the long term as intended, but that is not an excuse for encouraging people to think that e-cigarettes are safe when there are serious concerns about them and huge question marks over long-term health.

Emma Harper: Earlier, I talked about smoking cessation and questions that are asked when people are admitted to hospital, for example. Do the colours and the sweetie flavours that you have talked about inhibit cessation of nicotine device use? How can we support a better transition to help people to move away from cigarettes? I know that some people use e-cigarettes to help smoking cessation, but where are we now with regard to the way that flavours and colours have been used to encourage people to pick up e-cigarettes?

Sheila Duffy: There are products that are available on national health service prescription, for free, for people in Scotland who want to quit smoking. The evidence that I have seen is not yet a clear endorsement that e-cigarettes will help everyone to quit but pertains to a very narrow slice of smokers who might find them helpful. The commercial impetus, and the marketing and promotion behind those devices, are absolutely driving their uptake by people who might previously have used nicotine replacement therapy, which is pretty much in the same ballpark for effectiveness.

The goal that we have not yet fully explored is how to strengthen people's motivation and readiness to quit, their ability to quit and the environments that support attempts at quitting. People in low-income communities in Scotland are telling us that cigarettes are highly addictive and habit-forming and that e-cigarettes also feel pretty addictive. People want to move away from addiction and to be free from it.

Emma Harper: Is there a danger that a flavour ban could deter adult smokers from switching to vapes? I know that encouraging people to stop smoking is very complicated. If we banned flavours, would that make it harder for people to stop smoking?

Sheila Duffy: We heard arguments about flavours in the past when we thought about alcopops. The question is who those flavours are mainly being targeted at. The names of some flavours that out there, such as blue lemonade, use sweetie flavours as part of the marketing. New Zealand has restricted flavours so that vapes can use only the flavours that are available in tobacco, and Denmark has banned all flavours because they cause too much of an added health risk. If someone wants to get off tobacco, the flavour is not a particular plus for them, so why would moving to something flavourless be unacceptable?

Once again, we are getting into whether a vape is a recreational product or a medicinal option. Most medicines are flavoured only very carefully and for good reason.

The Convener: Professor Britton and Professor Banks both want to come in.

Professor Britton: I will preface what I am going to say by stating again that the rise in vaping among adolescents and people who would not otherwise have smoked is an issue that must be addressed and that there are ways that we can go about that.

Sheila Duffy asked why HMRC does not get involved with illicit supplies of e-cigarettes. As I understand it, HMRC gets involved with tobacco because there is an excise duty that HMRC does not want to lose, but there is no excise duty on vapes so there is no interest in policing their import.

I will comment on a number of things. Emma Harper asked about nicotine and pulmonary fibrosis. To my knowledge, there is no evidence linking nicotine inhalation with pulmonary fibrosis. That is a very rare condition and one that is increased in smokers, but to a very small extent. I would not suggest focusing on the risk of pulmonary fibrosis.

Emma Harper: I said interstitial lung disease, not pulmonary fibrosis, and I was not talking about nicotine but the other inhalable substances or components that are in there.

Professor Britton: That is fine, but that is not nicotine. You said that you were worried about the association between nicotine and interstitial lung disease, which results in pulmonary fibrosis.

I think that Sheila Duffy is right about cessation. The Cochrane review, the review by the National Institute for Health and Care Excellence and the MHRA's 2010 determination that anything that contains nicotine is likely to be an effective stop-smoking aid mean that e-cigarettes are about as effective as combination nicotine replacement therapy or varenicline, which is the best of the non-nicotine drugs.

The difference with e-cigarettes is that they are available over the counter as a consumer product. A smoker who has probably tried to stop smoking umpteen times and failed, and who does not want to put his or her head above the parapet and say, "Look I'm going to try again and I'm probably going to fail", does not have to make it public or go to a GP or a pharmacist to get help. They can just walk into a shop and make a discreet choice for themselves. The population reach of a consumer product eclipses the population reach of the services that we have been promoting so hard for 30 years. It is not just a matter of efficacy; it has to do with population reach, and the reach of e-cigarettes is much greater than that of other stop-smoking products.

The final thing about the flavours is that, among other sources, the ASH data for the UK strongly suggests that smokers find unflavoured nicotine and even tobacco-flavoured nicotine intolerable to inhale. As a non-smoker, I find that very hard to believe. The flavours are what make it tolerable. You are absolutely right if you say that, if we ban flavours, we will discourage the use of e-cigarettes by smokers. What is wrong is the kind of marketing that Sheila Duffy alluded to, which makes those flavours attractive to children. If we look at what is on cigarette packs in the UK and Australia, it is the name of the brand and one descriptor in a single standard font on a plain background. If we do that with flavours, and they become generic flavours—orange, vanilla or whatever—smokers will still be able to access them, but children will not be bombarded with attractive images, akin to the alcopop problem.

Emma Harper: Do we need to revise how we support people to quit smoking? The NHS "Quit Your Way Scotland" service is part of that support.

Dr Reid: Yes, absolutely. You can hear from this discussion that a lot of evidence is emerging. A lot of things are contested—there are different opinions on them. If we focus on things such as cessation, it is sort of too late. We need to focus on prevention. We need to turn off the drivers that cause kids to start vaping or smoking. We know that that is to do with price. If products are dirt cheap, kids will be able to afford them.

There is also the availability of products. If you can get them in every shop that kids go to and it is easy to get hold of them, that will drive kids to use them. These are not products for children—kids know that. Because it is illegal, kids are having to go out of their way to get hold of the products. We need more enforcement, but we also need to ensure that we are addressing the broader drivers. There might be differences of opinion around flavours, but I think that there would be a lot of agreement on some of the other drivers. As John Britton said, you can have flavours, but you do not call them names that children will find appealing. It is the same with the colours. There is no reason why these products need to be the colours that they are—colours that are appealing to children.

Pre-pandemic—if you can remember that far back, because it feels like a lifetime ago—these products were black and chrome. They were big and quite technical—you had to know how to use them. Now, the products are small, brightly coloured and very cheap, and they are in every shop. It is easy for kids to hold them in their hand and conceal them in their pocket.

In terms of what we can do, if we get hung up on the problems and the things that we do not agree on, it distracts us from the things that we can do. We are proposing having a round-table discussion on e-cigarettes, including Emily Banks—it would be great if John Britton, Sheila Duffy and the Scottish Government could be part of that, too—where we look at what we can do in Scotland. It is about bringing together all the different stakeholders to look at how we move forward on this. If we do that, there will be a lot of things that we agree on. It is very easy to get distracted into fighting about differences on little bits of evidence. If we are talking about cessation, I think that it is too late.

11:30

Finally, we must always remember to focus on tobacco control and tobacco smoking, because the latter is still what kills 8,000 people every year in Scotland. We must ensure that anything we do on e-cigarettes complements and builds on what we have already done on tobacco.

Ruth Maguire: I have a brief supplementary question, convener. Dr Reid, I acknowledge everything that you have said about the importance of prevention. Professor Britton mentioned population reach and the lack of stigma around adults—although I know that we are specifically talking about children—being able to go in and buy vapes. Does that not perhaps tell us more about how we should approach smoking cessation and health services for adults? That is not really a pro-vaping point, is it? It is perhaps for us to reflect on in the context of how we provide assistance to citizens to make choices that are healthier for them.

Dr Reid: Absolutely. The "Quit Your Way" approach, which was mentioned earlier, is a really good example of person-centred care. It puts the person who wants help at the centre of that journey and asks them how they want to quit. Within that, we would want to have the longest-standing evidence, which others have mentioned already, promoted first—for example, NRT patches and gum, and behavioural support. However, the current view in Scotland is that, if someone wants to use an e-cigarette to help them to quit, we do not turn them away and they are enabled to do that. We want to have a person-centred approach to care, as opposed to saying, "Oh well, we're not going to do that for you. We know better." It is really all about putting the person at the centre of the process.

The Convener: I believe that Professor Banks wants to come in on that point.

Professor Banks: I support 100 per cent what has just been said. When we think about tobacco control, people often immediately go to products to help individuals to cease smoking. However, if we look more broadly at what we are trying to do, the most effective tobacco control measures are reducing smoking uptake, increasing cessation and reducing harms.

Once we get to a lower smoking prevalence—happily, that is what we are trending towards in Scotland—it is increasingly driven by young people not taking up smoking. The measures that work at population level are those such as price, advertising bans, plain packaging, health warnings and smoke-free spaces, and going as hard as possible on those. Such measures motivate people to quit, as well as reducing general uptake. Individual smoking cessation is a relatively small part of that picture. I understand that, for people who deal with individuals face to face, it is meaningful. However, at population level, those broader drivers are more important in many ways. When we examined those and asked people who had succeeded in quitting smoking what they had done, the majority said that they had quit unaided. Therefore, the number of people who need a specific aid to help them to quit are not the majority of smokers. As we have heard, approved products such as varenicline are available, and those are appropriate in such cases.

We have to be careful that we do not magnify the importance of measures such as e-cigarettes. We are looking at there being about 15 per cent or fewer current daily smokers in the whole population of Scotland, which means that 85 per cent are not. Having got that picture of the population, we still have to look after both those groups of people. If a product is harmful for the 85 per cent but beneficial for a minority, being the 15 or so per cent, we have to think very carefully about how we tread the balance there. Quite often, if we suggest doing anything to reduce the availability of e-cigarettes for smokers, that is portrayed as being a really big problem. We cannot take measures that will protect young people but also might disadvantage smokers.

As a community, we are all struggling with that. We have an industry that is very interested in aggressively marketing such products to young people. E-cigarettes are a bit of a Trojan horse, or a cross between a Trojan horse and a Pandora's box—a Pandora's horse, if you like—in that it has been brought into the community as a measure that will help adults to quit, but when we open it up, out come bubble-gum-flavoured vapes, which are being used by children in the toilets. That is not what any community wants.

Internationally, there is a lot of variation in how the issue is being dealt with. There are 35 countries where e-cigarettes are not available as consumer products. That covers about 41 per cent of the world's population. A further 25 per cent or more of the world's population are in countries that heavily restrict flavours. Those countries include China, which only allows tobacco-flavoured e-cigarettes for its internal market, and the Netherlands and Finland. Therefore, it is not out of the question to think about what balance you want to strike.

Gillian Mackay (Central Scotland) (Green): I want to build on what we have just heard from Professor Banks. I have hosted a couple of round-table discussions on vaping, at which parents and professionals have raised concerns about flavours, price promotions and the fact that vapes are being marketed to children, and how those issues interlink in the context of marketing to children.

From a very quick look at a vape-selling website—to access which, incidentally, it takes only one click on a button to say, "Yes, I'm 18"—I found that the flavours available include Rainbow, Orange Gummy Bear, Grape Gummy Bear and Prime; any parent who is watching will know how popular that soft drink is with children and young people. Other flavours include Vimto Crush, which, of course, is a brand of juice that is often given to children, and Supermix, which shares its name with the Haribo sweets. There are even Christmas flavour special editions popping up. There are also multibuy and cashback offers on disposable vapes.

To what extent does the panel believe that a ban on disposable vapes would make a difference to children and young people and stop some of that marketing?

Sheila Duffy: I think that the rise that we saw in children's experimentation and use was a direct

result of disposables or limited-use e-cigarettes. Before that, it was mainly adults who used vapes. There was some experimentation by children, but very little. That was the case for about seven years. Therefore, I would say that disposables or limited-use e-cigarettes are responsible for the massive rise in children's uptake. We have an opportunity to address that.

We also have an opportunity to recognise that the products that we are talking about are uniquely dangerous environmental products. There are very few throwaway electronic products, and most of those do not contain toxic-chemical-soaked sponges, plastics, metals, particulates, tiny electronic components and lithium batteries, which present a further health risk and health hazard. I think that the Scottish Parliament has an opportunity to move fast on limited-use disposable e-cigarettes. Other countries, such as France, the Netherlands and Ireland, are very interested in doing so.

A unique opportunity also exists for regulations to be laid before this committee to enact legislation that was debated and passed by the Scottish Parliament that would allow for the shutting down of the colourful, bright displays in shops; the billboard and bus shelter advertising; the free samples; and sponsorship and brand sharing.

Those are two things that the committee could consider recommending. Another thing that is needed is more frequent and better data so that we can understand what is happening and how the situation can change.

Dr Reid: I agree with Sheila Duffy's points on that. Laura Young has done excellent work in shining a light on the issue of disposables and the environmental damage that they are doing.

As Sheila said, there are two reasons for us to consider action on disposables. One is the fact that children are using them, and the other relates to the environmental damage that they are doing. Those are two strong pillars to support such action.

There is no magic bullet to reduce youth vaping. We need a combination of approaches. On the website that Gillian Mackay talked about, the disposables will be the cheapest product, I guess. The tanks will be more expensive. I support a ban on disposables, for those reasons, but that should be part of a broader package of measures that will also tackle those other drivers. If we leave those still in place, it is unlikely that legislation to ban disposables alone would be successful.

Gillian Mackay: The pervasiveness of marketing and product placement has also been raised. The Advertising Standards Authority website says that

"ads for nicotine-containing e-cigarettes that are not licensed as medicines ... are prohibited"

on

"On-demand television"

as well as newspapers and magazines, the internet and advertising by email and text message. In reality, however, young people are exposed through product placement on TV shows and seeing people use vapes in YouTube videos, on Instagram and in Twitch streams. On top of that, I am sure that we have all seen shops with windows full of vapes, and signs on doors advertising that vapes are back in stock. Back in the day, they would have been advertising that Pokémon cards were back in stock—which definitely shows my age.

What it means is repeated exposure for young people every day as they walk around their local environment. Could more be done to limit that exposure, and do social media companies in particular need to take action to make sure either that there is a content warning on videos that nicotine products are being used or that it becomes against community guidelines to use them on Twitch streams or in YouTube videos?

Dr Reid: That would be an excellent thing to do, but again, this will involve a combination of things. Marketing is a key thing to tackle, too. There might be areas on which the Scottish Parliament could legislate, but areas such as marketing are probably dealt with on a UK basis. It is important to work across the different countries to protect children. There is no reason why vapes should be advertised in content that is designed for children—I do not think that anyone wants to see that—so I support action in that respect.

The idea of plain packaging and displays is also part of the picture, with the aim of denormalising such products so that children do not think that they are for them. We need to send that message to children. We have done that by making those products illegal for them, but the fact is that they are everywhere and are so cheap that they can be picked up at pocket-money prices. Children pick up on those cues. We need to make sure that we are consistent in our messages to our children.

The Convener: I see that Professor Banks wants to come in. I must ask her to be very brief, as we do not have a lot of time left, and a lot of members still want to ask questions.

Professor Banks: I agree that the disposable high-concentration nicotine salt products have clearly driven youth use—indeed, the US surgeon general and the Canadian health authorities have said so. The marketing of those products to children is really quite aggressive, and brands need to be quite creative in how they stay ahead and get around a lot of the restrictions. I, too,

support Scotland not only in thinking about how to restrict advertising but in keeping abreast of the tactics that the industry is using to market the products and in thinking about how to maintain innovation and regulation alongside innovation in the industry.

Tess White: I have a question for Sheila Duffy. The branding and sales tactics used for single-use vapes are prolific compared with those for cigarettes, and these things are now clogging drains and littering town centres. Will you comment on that, please?

11:45

Sheila Duffy: You are absolutely correct that the tobacco industry playbook is being played out with e-cigarettes. The industry is carefully targeting young people, including through targeted social media and influencers whom we will never see unless we know someone in the target age group.

We need to think ahead because, as Professor Banks has said, the industry is constantly reinventing itself and innovating, so it is hard to keep up. We are seeing a rise in concerns about nicotine pouches being targeted at young people. Snus, which cannot be legally sold in this country, is turning up and being used among influencers of young people.

Tess White: I have a follow-up question. Should the sale of vapes be brought in line with cigarettes and hidden behind the counter?

Sheila Duffy: We would support that, because we are hearing from enforcement officers that clear category regulation makes it easier for them to do their job.

The Convener: I call Carol Mochan.

Carol Mochan (South Scotland) (Lab): I know that we are tight for time, convener, but I am interested in the issue of regulation and the link with public health, which we have already discussed and which Professor Banks has talked about.

Under the marketing theme, we talked about the industry's heavy influence. I want to be clear about where we in the Scottish Parliament are and should be going on public health. Are you aware of undue influence from the tobacco companies or similar companies on our public health intentions?

Sheila Duffy: We are definitely seeing tobacco companies bouncing messages that favour commercial addictive health-harming products and their whole portfolio of products, including cigarettes. The predominant pattern in Scotland is dual use, as 42 per cent of vapers also use tobacco.

From my experience of working in the field, what is new is the huge rise in third-party influencing through so-called consumer groups, which are massively funded and operate internationally, and through third parties that are funded by tobacco companies, although it is not always apparent where their funding is coming from. We have to think that through and adapt, because the issue is not as straightforward as just tobacco company influence.

Dr Reid: I agree. Article 5.3 of the Framework Convention on Tobacco Control, which is about making sure that the tobacco industry is not influencing political decision making and legislation, is a cornerstone of public health and a good example of making sure that we are not influenced by the tobacco industry. That is positive and important.

Sheila Duffy: I should have added that the tobacco industry interference index, which covers 90 countries, was published at 10 o'clock today. The UK has always been exemplary in that. In year 1, the UK started in first place, and in years 2 and 3, it was in fourth and then third place. We are still not bad, but we have now plummeted to 21st place, because we are not protecting health policy as effectively as we used to, and that needs to be addressed.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS GP.

I have a couple of quick questions. I have listened to what has been said, and my question, which is for Professor Britton, is: do you think that vaping is safe?

Professor Britton: No, and I do not think that any serious academic or practitioner who has taken any interest in vaping would say otherwise. It is definitely not safe—it is just not as harmful as smoking.

Sandesh Gulhane: Absolutely—I could not agree more. Although vaping is safer than smoking, it is still not safe, but I have to wonder whether a lot of people think that it is.

The Prime Minister has spoken about wanting to prevent 14-year-olds from smoking in the future, which is something that I strongly support. Should we be looking to introduce such an approach for vaping?

Professor Britton: That is a good and difficult question, in so far as vaping is an alternative to and a way out of smoking. I take issue with Professor Banks's comment that most people quit without any help at all, because far more of them would quit if they used help. E-cigarettes do help, so I would not want to cut off smokers' access to them.

We could do a great deal more to prevent adolescents who have never smoked from using vapes in the first place, by making them less attractive to look at, putting them out of sight, and putting excise duty on disposable vapes. Then we could take stock. I do not know whether bringing in a minimum age would work—and, to be honest, no one knows whether it will work for tobacco, either. However, I am pleased that Rishi Sunak has taken the plunge and is following that policy, because it makes sense.

Sandesh Gulhane: I have a question for Sheila Duffy from ASH Scotland. If you were to vape where you are sitting right now, you would be advised that you were not allowed to do so, but you would not actually be breaking the law. Should we bring in regulation that puts tobacco and vapes in the same piece of legislation, so that we would categorise vaping in the same way in law?

Sheila Duffy: On matters of clean air and public spaces, the move at European level as well as all the evidence suggests that we should be considering safe spaces and smoke-free and aerosol-free environments, which would include heated tobacco products as well as e-cigarettes and lit smoked tobacco products.

Sandesh Gulhane: My question was specifically about legislation. Should we put vaping on the same level as cigarettes and tobacco in legislation?

Sheila Duffy: It would be helpful for enforcement purposes to have category legislation for all tobacco and related products. I recognise that tobacco is by far the most lethal product. One of the ways in which New Zealand is dealing with that, as well as encouraging a rise in prohibition on sale to young people, is by mandating only nicotine-free combustible tobacco products so as to take away from the addiction that people experience with tobacco. It is also massively reducing the number of outlets that can sell tobacco products, which is supportive for people who are trying to quit.

Sandesh Gulhane: My final question is for Dr Reid. My big concern is that there seems to be a subgenre of vaping, in which people like to see huge clouds going out into the air. There might also be lights on the products. I am also concerned about the effect on people walking past shops, which Gillian Mackay talked about. I have walked past a sweet shop where vapes are sold—or, at least, where vapes are put next to the sweets. I do not think that a smoker will necessarily want to go into a sweet shop to buy their vapes, but should we be absolutely clamping down on such approaches? If we want vapes to be there for people to stop smoking—that is, as a smoking cessation aid—why do we need to have all the other factors that I have just described?

Dr Reid: I absolutely agree. Putting vapes at children's eye level is not happening by mistake. There is no reason to have such products available in every shop. I agree that we could have a measure similar to the display ban for tobacco. Putting vapes out of sight would play a part in denormalising the product, and it would also mean that children would not be exposed to them and see their appealing colours. As we have heard, the names that are used for such products, some of which have been read out this morning, are also appealing to them and are, in fact, products that are used almost exclusively by children. Again, those acts are not done by mistake; they really are intentional. Therefore we need to be intentional in what we do to protect children.

We need a combination of approaches, but I would absolutely support a ban on displaying vapes or a move to put them out of sight. We might want to consider whether we really need to have all those retailers selling such products if they are for smoking cessation. That has been considered in Australia, where it was decided to make them available through prescription.

We need to think about what we want in Scotland and to make sure that we act. I do not think that we are limited in what we can do, just because doing anything will put smokers off—I think that that is slightly misleading. We can take positive actions, such as a display ban, without putting off people who want to quit using the product, and that is a good thing.

The Convener: Thank you.

All the witnesses have contributed a lot of helpful suggestions about things that could be done either to reduce the use and availability of vapes or to discourage children and young people from taking up vaping. Do the witnesses wish to bring to the committee's attention anything else that they think it would be helpful to ask the Scottish Government to do in order to reduce vape usage, particularly amongst children and young people?

Dr Reid: The measures that we have talked about are the ones that are really worth considering, but we should take them together with experts, and also learn from what has happened in Australia and other countries. It is all about taking a collaborative approach. That is one of the good things that we have in Scotland. In some countries, the issue has been really divisive and has pulled the public health community apart, but that has not happened in Scotland. We have the consensus statement, which was made quite a few years ago before the pandemic and provides a template when working to address the issue. Those measures should be put up for discussion.

Other issues might come out of work with an expert group. Because the field is growing rapidly, we need to be quite flexible in our own approach to tackling it, particularly with regard to issues such as marketing. We need to think about how we can work with, for example, the UK Government on dealing with that.

Professor Banks: It is important that we maintain our strong action against conventional tobacco and that, whatever we do about e-cigarettes, we are not being distracted from that. The matter was considered extensively in Australia, and we think that it is appropriate to think of the two things together. This is not about one or the other—we should really be going as hard as possible on both. There is a risk that, because vaping is so new, we will put more emphasis on it.

The industry has done a good job of making us think that tobacco is not such a big problem any more, but it is. It causes 8.7 million deaths a year and, as we have said, many thousands of those deaths are in Scotland. The main thing, therefore, is for everybody to maintain the emphasis on tobacco control and go as hard as they can on that while, at the same time, controlling e-cigarettes.

The Convener: I thank the panel for joining us. The committee has found this to be an interesting and informative session that will help us develop our thinking as we move forward, and we will take on board Professor Banks's point about taking vaping and tobacco together. Thank you for your attendance today.

At our next meeting, we will hold the first oral evidence-taking session for our inquiry into health and care in remote and rural areas, to be followed by an evidence session with the women's health champion.

That concludes the public part of our meeting.

11:59

Meeting continued in private until 12:20.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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