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Public Bill Committee

TOBACCO AND VAPES BILL

Fourth Sitting

Wednesday 1 May 2024

(Afternoon)

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Sunday 5 May 2024

The Committee consisted of the following Members:

Chairs: † Gordon Henderson, Sir George Howarth, Sir Gary Streeter, Dame Siobhain McDonagh

† Aiken, Nickie *(Cities of London and Westminster)* (Con)
† Baker, Duncan *(North Norfolk)* (Con)
† Bell, Aaron *(Newcastle-under-Lyme)* (Con)
† Blackman, Bob *(Harrow East)* (Con)
† Cameron, Dr Lisa *(East Kilbride, Strathaven and Lesmahagow)* (Con)
† Charalambous, Bambos *(Enfield, Southgate)* (Lab)
† Foy, Mary Kelly *(City of Durham)* (Lab)
† Gill, Preet Kaur *(Birmingham, Edgbaston)* (Lab/Co-op)
† Glindon, Mary *(North Tyneside)* (Lab)
† Harrison, Trudy *(Copeland)* (Con)
† Johnson, Dr Caroline *(Sleaford and North Hykeham)* (Con)
† Leadsom, Dame Andrea *(Parliamentary Under-Secretary of State for Health and Social Care)*
† Maskell, Rachael *(York Central)* (Lab/Co-op)
† Oswald, Kirsten *(East Renfrewshire)* (SNP)
† Richardson, Angela *(Guildford)* (Con)
† Tuckwell, Steve *(Uxbridge and South Ruislip)* (Con)
† Wakeford, Christian *(Bury South)* (Lab)

Katya Cassidy, Kevin Maddison, Lucinda Maer, *Committee Clerks*

† **attended the Committee**

Witnesses

Professor Sanjay Agrawal, RCP's special adviser on tobacco, Royal College of Physicians

Tim Mitchell, President, Royal College of Surgeons

Mark Rowland, Chief Executive, Mental Health Foundation

Dr Laura Squire OBE, Chief Healthcare Quality and Access Officer, The Medicines and Healthcare Products Regulatory Agency

Mr David Lawson, Director, Inter Scientific Ltd

Professor Allison Ford, Associate Professor, University of Stirling

Dr Rob Branston, Senior Lecturer, University of Bath

Professor Anna Gilmore, Professor of Public Health, University of Bath

Professor Robert West, Professor Emeritus of Health Psychology, University College London

Professor Ann McNeill, Professor of Tobacco Addiction, King's College London

Public Bill Committee

Wednesday 1 May 2024

(Afternoon)

[Gordon Henderson *in the Chair*]

Tobacco and Vapes Bill

2 pm

The Chair: Before we begin, Dr Johnson wants to declare an interest.

Dr Caroline Johnson (Sleaford and North Hykeham) (Con): I am a consultant paediatrician in the NHS and a member of the Royal College of Paediatrics and Child Health, and one of the witnesses this afternoon—Mark Rowland—is known to me.

The Chair: If anyone else wants to declare an interest, please do so now.

Mary Glindon (North Tyneside) (Lab): I declare an interest as a member of the responsible vaping all-party parliamentary group.

The Chair: Thank you.

Examination of Witnesses

Professor Sanjay Agrawal and Tim Mitchell gave evidence.

2.1 pm

Q154 The Chair: We will now hear from Professor Sanjay Agrawal, the Royal College of Physicians specialist adviser on tobacco, and Tim Mitchell, president of the Royal College of Surgeons We have until 2.40 pm for this panel. Would the witnesses please introduce themselves for the record?

Professor Agrawal: My name is Sanjay Agrawal. I am the specialist adviser for the Royal College of Physicians. To give a bit of background, the RCP has produced reports over the past 60 years on a whole variety of facets of tobacco control. Most recently, we published a report on e-cigarettes and an evidence review that looked at the trends of e-cigarette use, safety, efficacy and regulations.

As my day job, I am a consultant in intensive care and respiratory medicine in Leicester. Perhaps it is worth saying that in my lung cancer clinics and in the intensive care unit, I see week after week, year after year the impact of tobacco on my patients. In my lung cancer clinic, I frequently have to deliver bad news about lung cancer. Oftentimes I am left sitting there, thinking, "Why haven't we as a society and a country done more about this? We have known about the harms for the past 60 years. Why haven't we done more?"

I am really pleased to be here today, because it feels to me that this Bill is a momentous occasion where, once and for all, we can do something for people along their whole life course, whether that is people who are pregnant and are affected by tobacco smoking or their unborn children who are affected, or people with dementia, hearing loss or sight loss—diseases in old age related to tobacco.

The RCP supports the Bill. It is really well balanced. As a clinician in the medical profession, I, along with the RCP, which represents at least 30 different medical specialties, support the Bill. We know it will prevent ill health for future generations and reduce poverty and disparity.

Tim Mitchell: I am Tim Mitchell, president of the Royal College of Surgeons of England, which hosts a number of national cancer audits, including lung cancer audits, so we are very familiar with the impacts of smoking. I and my colleagues across all surgical specialties see the impact of smoking on a daily basis. Lung cancer particularly is seen as being associated with smoking, but the risk of all cancers is increased by smoking, particularly in my field as an ear, nose and throat surgeon—mouth and throat cancer, for example. There is also a range of benign diseases, particularly those that affect blood vessels—so people who need to have coronary artery surgery or surgery to improve blood flow to the brain if they have had a stroke. Diabetics are affected, and the risk of diabetes is increased by smoking. There are vascular problems, such as with blood flow to the legs, which can result in amputations.

Aside from that, all patients undergoing surgery are affected by smoking. They may have specific disease processes affecting their heart and lungs that will have an impact on them having a general anaesthetic. Even if they do not have defined disease processes, we know that smoking affects healing. The other thing we are also very aware of is the impact of passive smoking, particularly on children.

Q155 Preet Kaur Gill (Birmingham, Edgbaston) (Lab/Co-op): Tim, coming to you first, from a surgeon's perspective, why do you think that it is important to decrease the rates of smoking and vaping?

Tim Mitchell: As I have alluded to, the burden of disease caused by smoking is huge, and there is no doubt that smoking is very bad for people's health. As surgeons, we see that on a daily basis. We have talked about cancers and other disease processes. As I think you heard, the estimated cost to the health service is £2.5 billion a year, and the burden on surgeons across all surgical specialties, because of the impact of smoking, is huge.

In addition, as I said, smoking has an impact on all patients undergoing surgery under general anaesthetic. It increases the risk of complications and has an impact on wound healing, the risk of infection after surgery and, particularly, respiratory complications after surgery. It has been estimated that there may be an increase of as much as 40% in major complications after surgery in people who smoke. Decreasing the rate of smoking will have a massive impact on surgical activity.

Q156 Preet Kaur Gill: Sanjay, the Royal College of Physicians has called for regulation to protect young people from vaping while still allowing smokers to use e-cigarettes to quit. Do you think that the Bill strikes the right balance in that regard?

Professor Agrawal: I do, actually; I think that it is a very well thought-through Bill that absolutely gets the balance right. For example, we have 6.4 million people who smoke in this country. As Professor Sir Chris Whitty said today, they are doing that not out of free choice but because they became addicted to tobacco while they were children, as designed by the tobacco industry. Those 6.4 million people need a way out of smoking. I speak to patients in clinic who have successfully stopped smoking and ask them, "How did you do it?" I cannot remember the last one who did not say that they did it with vaping. We know that vaping is a very popular way to quit smoking among people who are addicted to tobacco; it allows them a sense of control about how they quit smoking.

I think the balance in the Bill is just right: it recognises that vapes are important in helping people to quit smoking, but, by the same token, we all recognise that we do not want to see our children and grandchildren—young people—take up vaping. I was listening to the Committee proceedings yesterday, and I was struck by what the group representing schoolteachers said about the impact that it is having on children's learning. It is important that we address young people vaping and do as much as we can to reduce the appeal of vapes, as well as access to them.

The Government have already outlined other measures: for example, raising excise tax and making vapes less affordable, as well as banning disposables, which have really fuelled the rise in youth vaping. We would hope that the whole package of measures, as well as this Bill, should see a significant reduction in youth vaping.

Q157 Preet Kaur Gill: The Royal College of Physicians has also called for manufacturers to limit the production of toxic substances from vapes and for the Medicines and Healthcare products Regulatory Agency to be required to independently verify the contents of e-cigarettes. That is something I have taken a real interest in—you make a really good point. Whereas the notification scheme for tobacco tests products, the vaping scheme does not. Do you think we need to do more in the Bill to address that?

Professor Agrawal: It is important that we make sure that these products are notified well, and I know that there is a colleague speaking after me today about the MHRA process. Independent verification will be an important thing to do, whether that is part of the Bill or something that comes about as part of the consultation process that the Bill and the regulations will go through.

One thing that is really important is that this Bill passes through this Parliament, so that we stop the 350 young people who take up smoking every day from doing so as soon as we possibly can. We know that two out of three of them will die as a result of smoking. What I do not want to happen is for the Bill to be slowed down in any way by a series of amendments. We need to get this Bill and the law on the statute book. The consultation process should hopefully take care of some of the finer details, which are really important, too.

Q158 The Parliamentary Under-Secretary of State for Health and Social Care (Dame Andrea Leadsom): Thank you both so much for being here today. As you will know, what witnesses are providing are the words and the arguments to enable the smooth passage of the Bill. Professor Agrawal, you have just said that you want this to go through smoothly, as do all of us here, so what you say is incredibly important.

As physicians and surgeons, what would you not have to do if people were not smoking? Could we say you would be writing yourselves out of a job? What are some of the things that are specifically on your day-to-day list that you think would be removed if people were not smoking?

Tim Mitchell: I referred to the national cancer audits. For example, 37,000 people a year develop lung cancer, many of whom will need surgery. On the survival rate for lung cancer, fewer than 50% of people survive one year. There is a whole range of other cancers related to smoking, so the burden of that disease and the burden on the health service would reduce dramatically if we had a smoke-free society. I have alluded to other forms of surgery that are required—amputations and so forth. So the impact on society at large would be huge if we had a smoke-free society. In terms of other surgery, the complications would be avoided.

I know very much from my own personal experience how important this is. My mother died from lung cancer caused by smoking when I was seven years of age. My grandfather died from mouth cancer caused by pipe smoking when I was eight years of age. If we had a smoke-free society and there was one small boy or girl who grew up knowing and being loved by their mother or their grandfather, that would be very powerful.

However, that pales into insignificance compared with the impact that the Bill could have on society at large. Millions of people's health would be improved. The impact on millions of families would be dramatically improved and the health of the nation would be significantly greater. We as a college fully support the Bill and, as my colleague said, we very much hope that it will pass through smoothly and get on to the statute book.

Professor Agrawal: Just to add to that, for my clinical practice in the intensive care unit, I see people with life-changing illnesses, whether that is ruptured aneurysms, heart attacks, kidney failure, the need for mechanical ventilation in people who have severe lung infections or chronic obstructive pulmonary disease exacerbations. There is also my lung cancer clinic—really, the list goes on.

One of the other things that I am often struck by in our multidisciplinary meetings where we look at things like CT scans of people who have smoked all their lives—through no free choice, by the way, because they have become addicted to tobacco through means of the tobacco industry encouraging young people to take up smoking—is that they have multi-morbidity. So as well as having lung cancer, they may have a kidney cancer, they may have heart disease, as well as COPD. If they have one of those things, we can manage that, but unfortunately, the combination makes people multi-morbid and frail, and it impacts their ability to have treatment for the most serious of those conditions.

By eliminating smoking and creating a smoke-free generation, we will transform aspects of our medical care and our NHS. We heard this morning that there is

a person admitted every minute to hospital with smoking-related disease, and there are 100 people seen by GPs every hour with tobacco-related disease. So I think we can alleviate all that extra pressure on the NHS from tobacco addiction and use those resources differently.

Q159 Dame Andrea Leadsom: Thank you both. You have alluded to the fact that this is not a choice, but an addiction. Can you explain how that impacts on your patients? What do they say when you tell them, "I'm sorry, you are going to die." How do they respond? Do they feel, "This was my choice and therefore it is great for me"?

Professor Agrawal: This is awful. One of the things I am struck by in my lung cancer clinic is that at least a third of the people we look after are still smoking despite the diagnosis of lung cancer, because they have no free choice and are addicted. They became addicted as young children. I know there are other panellists that you will hear from later on who may talk about the business model of the tobacco companies, but the sad reality of their business model is that two out of three people will die from smoking-related disease, and to maintain their profits they need to replace those smokers. They do that with young people. That is what we need to stop so that it is not just a production line for corporate profit.

Q160 Dame Andrea Leadsom: Mr Mitchell, what do patients say to you when you tell them, "I am very sorry, but you're going to die"?

Tim Mitchell: Very often, when I see patients who smoke, I encourage them to stop smoking. A very large proportion say, "I would love to stop smoking. I have tried previously." They might have been successful for a period of time. Many of them simply regret the fact that they ever started smoking in the first place. If we can stop them getting on to that ladder in the first place, one does not have that problem. Stopping smoking, as I think we are all aware, is an incredibly difficult thing to do. That is where I see vapes as certainly having a useful role in smoking cessation, but trying to stop people smoking in the first place is absolutely key.

Q161 Dame Andrea Leadsom: Could I ask you both to agree that it is therefore not a matter of free choice? This is an addiction that removes people's choice; would you both be willing to agree with that?

Professor Agrawal: I think it is a lethal addiction.

Tim Mitchell: Undoubtedly, I would agree with that.

Q162 Kirsten Oswald (East Renfrewshire) (SNP): I know that the Royal College of Physicians has called for regulation to protect young people from vaping. I thought that what Professor Agrawal said about the importance of helping people to stop smoking was very interesting. At the same time, that balance is really important.

I am interested, however, in the harms of vaping to those who have never smoked, particularly young people, and the challenges we have heard about with them being advertised to in various ways, including on sports kits and in online spaces. What are your thoughts on how we best deal with that?

Professor Agrawal: I agree that it is awful and that we need to restrict it. The tobacco industry has a playbook on how it attracts young people to smoking, and it is not dissimilar to vaping. Billboards, influencers on social media, brightly coloured, garish packaging and the names of flavours are all used to appeal to young people. The provisions in the Bill will provide the powers to restrict that. That is really important and is exactly what we should be doing.

There is also the influence of social media, and we should not forget that. Whether this Bill will deal with that or whether it will be some secondary legislation that does that, that is fine, but we certainly need to curb the impact of social media and other influences on young people starting to take up vaping.

Q163 Kirsten Oswald: Do you have anything to add?

Tim Mitchell: Just that the scientific evidence in relation to surgery and vaping is very limited. Clearly, as I have said, we see vaping as being much less of a risk to people than smoking, and from that perspective, it is very good. But otherwise, I would defer to Professor Agrawal and what he said.

Q164 Nickie Aiken (Cities of London and Westminster) (Con): I absolutely accept what you both have said about wanting to get the Bill through as quickly as possible with no amendments. However, is there anything in the Bill that you think we have missed and that you would like, if this was possible—I am not saying it is—to add in? What have we missed, if anything?

Professor Agrawal: I thought it was such a well-balanced Bill, with all the objectives, whether that is making sure they are available to help people quit, or really focusing on preventing young people from being attracted to vaping. The Bill is not in isolation, as I have alluded to. The ban on disposables is undergoing consultation, and there is the excise tax. All of those measures form a whole. Yesterday, we heard about the potential for track and tracing, for example, to be used with vapes, which would therefore mean that things like retail licensing are probably not needed because a good track and tracing system will actually do the job. I think the Bill has been well thought through, not by accident, and I cannot think of anything that will not get picked up in the consultation. I suppose the one thing that is not in there is interference from the tobacco industry, front groups and lobbyists with any part of tobacco regulation, and making sure that that does not occur.

Nickie Aiken: Mr Mitchell?

Tim Mitchell: I have nothing more to add.

Nickie Aiken: Excellent.

Q165 Mary Glindon: There are still 6.4 million people who smoke. With this Bill, how do we prevent future generations from smoking and become a smoke-free country? What incentive is there in this Bill for persistent smokers to stop smoking now? Are there physical health benefits for long-term smokers to quit that could be an incentive if they have not tipped over the edge and have an incurable disease?

Professor Agrawal: It is never too late—that is what I say to patients who are currently smoking. I see people in their 60s, 70s and 80s, so it is never too late to quit. There are always benefits. Even when people have been diagnosed with lung cancer, we can provide treatment in the form of surgery, radiotherapy and so on, and quitting smoking still helps. I think the Bill sends a clear message that we recognise that there are 6.4 million smokers and we need to support them to quit. Vaping is one means of doing that, and we are not trying to take it away from them if that is the only way they have been able to quit smoking. The Bill contain provisions to help all groups. It is not just about stopping young people taking up smoking; it recognises the need to do something for the people who are still currently smoking.

Tim Mitchell: I would say that there is still an imperative to encourage people who smoke to stop smoking, and vaping can be a mechanism for helping with that. Certainly, as surgeons, when we see people who smoke who require surgery, we encourage them to stop smoking. We know that their risk profile through surgery is improved if they can stop smoking, even just a few weeks before they have surgery. Even if they do not smoke on the day they have their operation, that has some benefits. Encouraging people who smoke to stop smoking remains a very good thing to do, in addition to the provisions in the Bill.

Q166 Dr Johnson: Professor, you talked about choice, and about business and the need to maintain profits by addicting a new generation of people to a nicotine-based product that will be hard for them to quit. That applies to vaping as much as it does to smoking, although one may be more harmful than the other. Could you talk about the effects of vaping on those who have never smoked—particularly things such as e-cigarette or vaping use-associated lung injury, and the effects of nicotine on their lungs?

Professor Agrawal: In the report we have just published, we looked at a range of studies related to safety. Ann McNeill, who will be talking this afternoon, is in a much better position to talk about that work. We measured the range of toxins and the degree of exposure. E-cigarettes expose people who use them for a short time to quit smoking—which is the only thing we advocate them for—to a much narrower band of toxin, and the degree of exposure is lower. In comparison with tobacco, it is much lower, but in comparison with not using either, unsurprisingly the levels of toxins are higher. The RCP is very clear about that: if you do not smoke, do not vape.

Q167 Dr Johnson: Do you have any more details about the medical effects of vaping on non-smokers?

Professor Agrawal: Nicotine itself can raise the heart rate and raise blood pressure, although usually less so than tobacco. As I said, we do not advocate vaping for anybody who does not smoke.

Q168 Mary Kelly Foy (City of Durham) (Lab): Good afternoon to you both. You have explained to us the horrors and the multitude of harms that tobacco smoke can have on an adult who smokes. Can you explain a bit about the effects that second-hand tobacco smoke has on children, who have even less choice in the matter?

Professor Agrawal: We know that second-hand smoke causes a range of diseases for children, whether that is triggering asthma exacerbations or infections, such as middle-ear infections. There is a bunch of infections that are much more likely in children whose parents, carers or siblings smoke, and they are exposed to that second-hand smoke. By treating adults who smoke and helping them quit, you will also help their children.

One thing I did not talk about earlier was the impact on poverty. Helping adults to stop smoking increases household income and reduces child poverty. Action on Smoking and Health has estimated that something like 250,000 children live in households that are below the poverty line because of adults spending on smoking. Stopping smoking has myriad benefits, whether helping children, reducing poverty or reducing health inequality. That is why this Bill is so pleasing.

Tim Mitchell: From a surgical point of view, in my practice as an ear, nose and throat surgeon, one of the commonest conditions we see is glue ear in children. That is a condition where fluid behind the eardrum affects hearing, and potentially affects speech. That is the condition for which children sometimes have grommets or ventilation tubes put in their ears. It is one of the commonest operations that children undergo. The risk of that is significantly increased in children who live in households with smokers. There are other disease pressures as well, as my colleague alluded to. It has a significant impact.

Q169 Rachael Maskell (York Central) (Lab/Co-op): Are we missing an opportunity to create a nicotine-free generation, alongside a smoke-free generation? We heard earlier that GPs were not able to prescribe vapes. Would that help your practice and help people quit, if you had those tools in your hands when seeing your patients, to encourage them to transition from smoking, which is so dangerous, to vaping?

Professor Agrawal: The first question was?

Rachael Maskell: It was about a nicotine-free generation.

Professor Agrawal: Because people are addicted to nicotine, often at an early age, they find it impossible not to have some nicotine. The danger of banning nicotine altogether is that it will perpetuate smoking. People will go to the only form of nicotine they can buy, let us say, and if that is tobacco, they will just carry on smoking. I would worry about banning nicotine and all nicotine products, because it means that the 6.4 million smokers will not have anything else to go to.

Q170 Rachael Maskell: It will rise in line with the smoke-free generation. These would be people who are non-smokers, because they would be children born after 1 January 2009.

Professor Agrawal: Oh, I see. I do not know, is the answer to that question. The second question—

Rachael Maskell: About prescribing.

Professor Agrawal: Prescription, yes. That might be a helpful adjunct, inasmuch as it would give healthcare professionals safety in the knowledge that a product has been tried and tested and could be prescribed. If they

were unsure about e-cigarettes and which to recommend to patients, having a prescribable e-cigarette could be helpful.

The only downside is that, as I am sure the Committee knows, the e-cigarette market changes at lightning speed. What is licensed one day, the very next day would not attract anybody, or nobody would want to use it. That is the only con, as it were. It certainly might have a role in helping medical professionals prescribe and have confidence in using a product that has been deemed to be safe.

Q171 Dame Andrea Leadsom: Further to that, I would like to probe a bit on that, because it has been put forward that some colleagues would prefer prescription-only vapes. However, from speaking to vapers myself and having done some visits to meet with enforcement officers and so on, it seems that users of vapes like the variety. They say, "I don't want to vape tobacco flavour; I want to vape strawberry flavour." There is another side to this argument, which is that you should keep different flavours in order to avoid people who are smokers going back to smoking because they are not getting enough choice. You just said that it would be good to have prescription-only vapes, but would that not fly in the face of how people use them? That is why that is not in the Bill at the moment. I do not want to set hares running where, in fact, the practical reason for not saying that vapes should be prescription-only is exactly that of consumer choice and trying to avoid people going back to smoking.

Professor Agrawal: Maybe I was not clear. I do not think that we should have just prescription-only vapes. It would be an adjunct to all the other vapes out there to give that choice to people who want to use vapes to quit and access all those flavours and different types of vapes. There are several different types of vapes as well as the flavours and so on, and that choice has driven people who smoked to use them to help them to quit. They can do it themselves, they have the hand-to-mouth movement—a whole combination of things attracts them to vapes to help them to quit smoking. Having only one product would be a disaster.

Q172 Dame Andrea Leadsom: The chief medical officer said earlier that he would encourage the vaping sector to perhaps try for registration for a particular vape for prescription. Nobody has done that as yet, because it is a complete free-for-all out there. We are all really keen to see better, safer products and help adult quitters to quit. The CMO said that they could be prescription-only for people who are both in poverty and deprivation and trying to quit smoking, but not to in effect prescribe in a Bill such as this, "You shall now have only prescription vapes." Would you agree with the CMO?

Professor Agrawal: I completely agree with that. I completely agree with what the CMO said.

Q173 Dr Johnson: In order to be a prescribable drug, an e-cigarette or vape would need to go through an awful lot of testing to demonstrate its effectiveness in what it does, the safety of its components and the safety of the product as a whole. Are you aware of any vape that has gone through the safety testing to demonstrate that it is safe in that way that can currently be prescribed?

Professor Agrawal: I think a colleague from the MHRA is on after me who might be able to answer. I believe there are products that industry has taken to the MHRA and got to the point of licensing, but it has not marketed them or wanted to take them further. I do not think that it is impossible. In fact, as the CMO said this morning, I think manufacturers should be encouraged to go through that process.

Q174 Dr Johnson: So you think vapes are available that could be prescribable in the United Kingdom.

Professor Agrawal: No, I am not saying that there are: I am saying that companies have started to go down that route, but they have not proceeded.

Q175 Dr Johnson: Why do you think that is?

Professor Agrawal: I do not know. Presumably it is related to what they feel is a good commercial bet or not.

The Chair: If there are no further questions, can I thank the witnesses? We will move on to the next panel.

Examination of Witness

Mark Rowland gave evidence.

2.34 pm

The Chair: We will now hear from Mark Rowland, chief executive of the Mental Health Foundation. We have until 3 pm for this panel. Would the witness please introduce himself for the record?

Mark Rowland: Thank you, Chair, and I thank the Committee very much for inviting me. I am really happy to be here. My name is Mark Rowland and I am the chief executive of the Mental Health Foundation, which has been around for just about 75 years—not quite as old as the NHS. I am also the co-chair of the Mental Health and Smoking Partnership, which brings together 25 or so academic institutions and charities to look at the relationship between smoking and mental health, and is organised by ASH.

Q176 Preet Kaur Gill: In popular culture, there is this pervasive myth that smoking relieves stress and anxiety, when we all know that it does not. We know how damaging thinking like that has been. There was a school in my constituency that decided to give a young person a leaflet about how to address anxiety, which I was quite dismayed to see said, "smoke a cigarette". Do you think that this Bill addresses those concerns?

Mark Rowland: I was saying earlier on that this myth about smoking appeasing the symptoms of anxiety and stress does not come about by accident. It has been purported by the tobacco industry. The tobacco industry has deliberately commissioned research into the proposed impacts of smoking, looking for some sort of consequence for relieving long-term stress. You are absolutely right that it is not just a myth, but a pernicious myth, because it does exactly the opposite. The only thing that smoking does is relieve the immediate symptoms of nicotine withdrawal, deepening the addiction. We know now that it exacerbates the symptoms of poor mental health across the population, particularly for common mental

health disorders, as well as serious mental illness. We now see that there is a causal relationship between smoking and mental health.

You asked whether the Bill does enough; the Bill does not directly address the myth. I am very grateful that this Committee has called me to specifically talk about the relationship between smoking and mental health, because it is often not in the public conversation. I feel really strongly that there is a generation who have been let down and deceived, and that has unfortunately seeped into the practice and perception of mental health professionals over the years as well. In 2008, which was the first time that smoke-free policies were made mandatory in mental health settings, we looked at the attitudes of mental health professionals compared with other medical professionals. We found that one in three had serious reservations about introducing smoke-free policies into mental health settings, versus one in 10 for other medical professions.

It has let down people who have then become addicted and experienced the poor mental health and physical health consequences. This Bill will make an important contribution. I think there is an amendment to put an insert into cigarette packages that directly takes on that myth. Given the long history of deception and misinformation, we would strongly take the opportunity to support that amendment to this Bill, so that future generations can be in no doubt that it has no mental health benefits whatsoever.

Q177 Preet Kaur Gill: Thank you. It is an amendment that I tabled based on the concerns raised by young people in a school near me. There is a generation of children who are addicted to nicotine, because there have been clear loopholes on marketing and giving free vapes. Do you think that there is enough support within communities to help children who are addicted to quit? Does that actually exist for young people?

Mark Rowland: For nicotine or smoking?

Q178 Preet Kaur Gill: Nicotine, whether by smoking or vapes.

Mark Rowland: The commitments that were made in relation to the long-term NHS plan—the five-year forward view for mental health—were really important, but our NHS colleagues say that they are not well-funded. We are roughly £10 million to £20 million short of completing the opt-in in mental health settings. It is currently an opt-out, and that has been hugely successful. About nine in 10 inpatient services are now adopting the smoking cessation offer, but you are right to say that it has not extended anywhere near far enough in terms of community settings.

Community mental health services, for example, have only had a pilot for smoking cessation. It is on an opt-out as well, but there are only seven pilot sites. It is relatively cheap; £10 million to £20 million could expand community smoking cessation to mental health services and integrate it within that. That would be a really smart thing to do.

We can also see that most people who experience distress, depression or anxiety will go through talking therapies. There is a really big opportunity there—my wife is a therapist—but there is no standard mechanism for therapists to check smoking status as they are coming forward to help. One of the things on which we have really accrued evidence, through Cochrane and systematic reviews, is the mental health benefits of stopping smoking. We think there is much more that could be done at those access points, such as talking therapies. Why not think about a holistic approach to stopping smoking alongside the psychological talking therapies assistance that is being offered to about 1.6 million people? There is more to do.

In relation to young people, I think that could be added to that component in child and adolescent mental health services as well to understanding. Let us have a whole picture of what our young people are facing, because we know that the causes of mental ill health are often multi-varied, so we need to understand what the causes are and also what the coping mechanisms are. One of the reasons we are so passionate about this Bill is that what smoking does is provide an out for young people and adults to be able to really look at the emotional distress that they are experiencing and manage those difficult emotions in a healthy, life-affirming way, so there is much more to do.

Q179 Dame Andrea Leadsom: Thank you so much for being here this afternoon. It is incredibly helpful. Can I ask you the chicken-and-egg question? Does smoking make you depressed, does depression cause you to smoke or is it both? I think you are possibly saying both.

Mark Rowland: I think five or 10 years ago we would probably have said that it is more likely that, if you are depressed or anxious, you will reach for a cigarette to appease the emotional distress in the short term. The work from academics at the University of Bristol has found that there are now good population studies looking at the impact of smoking leading to a first instance of mental health problems and the fact that there is a causal relationship between smoking and mental health. We are already facing, as this Committee will be aware, a mental health crisis in this country, and 23% of the health burden is a result of mental ill health—one in four in any year, one in six in any week. The efforts to reduce smoking will, we think, have both an impact in reducing prevalence and in reducing acuity of mental ill health.

On the chicken and the egg, it is difficult to disaggregate exactly for many people, but we know that both are a real issue. We talk about this cycle of smoking increasing the risk of poor mental health and poor mental health increasing the chances of smoking and the number of cigarettes someone smokes. People with mental health problems smoke far more, and that addiction then exacerbates psychiatric symptoms. Those psychiatric symptoms also then lead to increased poverty and increased chances of being unemployed, and that leads to poorer mental health. It is a complex picture, but we are really starting to see the causal drivers of mental ill health.

I will finish by saying that this Government should be applauded for introducing this progressive, bold and far-sighted piece of legislation. We have called for a long time for a cross-Government approach to mental health, and we would have been calling for exactly this type of legislation in that approach to give young people—give us all—a fighting chance for better mental health, so that we can reap all those benefits.

Q180 Dame Andrea Leadsom: We have seen that the number of 11 to 17-year-olds vaping has trebled in the last three years, which is terrifying. We have also seen the mental health of young people fall off a cliff. A lot of people would argue that that is to do with social media and the act of scrolling and what that does to the brain and so on, but would you say that smoking is another factor that should be taken into the mix of what is happening to young people's mental health, or would you say that it is not proven yet?

Mark Rowland: Are you asking whether increased smoking and vaping is a driver of young people's mental ill health?

Dame Andrea Leadsom: Very specifically the increase in children vaping, which is nicotine as well. It is the same addiction.

Mark Rowland: The causes of the deterioration of young people's mental health are really complex. There are a number of different factors, and it is difficult to disaggregate them all. There is social media and what we call the social evaluative threat, which emerges from being in a context where you are able to see how you are doing in life against everyone else in the world. It is the first time we have had that in human history, so no doubt we need greater protections in the use of social media for young people.

In terms of the evidence of vaping and young people's mental health, we have not seen a causal relationship between vaping and poorer mental health. We know that all addiction is bad for all of us, especially young people. We did a Delphi study a couple of years ago looking at the most important protective factors for people's mental health, and No. 1 was, "Don't become addicted to drugs." That had the most deleterious impact. It is not going to help if more young people are addicted to nicotine, for absolute sure. It comes back to the original point that we need to equip our young people with skills to be able to manage difficult emotions and not look for the quick dopamine hit that nicotine provides. So it is not helping, but is it the major driver of children's mental ill health? We do not have the evidence to be able to point to that right now.

Q181 Kirsten Oswald: I am interested in the exchange that has just taken place. You have said that all addiction is bad for us, which makes sense to me. We heard evidence yesterday about the impact of young people vaping in schools. Some of that impact is the disruption to education and the challenge for young people if they a need to go out of the classroom to vape because the pull of the addiction is so strong. I wonder what your thoughts are on the mental health impact of the addiction in the education setting. I would also welcome your thoughts on the connections with sports; I am particularly interested in sports organisations advertising vapes, which I think is a poor choice. I think sport should have a positive impact on the mental health of young people, but I am not sure that connects properly when these vapes are being advertised.

Mark Rowland: I really support the Bill's efforts to regulate and protect young people from ever engaging in vaping. As you say, it is about the unintended consequences. We are not quite clear on the mental health consequences of vaping for young people. We know that young people who have lower levels of mental wellbeing are more likely to vape. We know that the targeting of young people drives them into addictive behaviour, so we need to protect young people from that. We need a regulatory environment that does not allow young people to be exposed to advertising that is particularly targeted at them. I would support such a measure.

I think the unintended consequence of children missing out on education due to vaping cannot be underestimated. We also have an issue around the mental health of young people who are not attending school—the school rejectors. We need to bring them into an education environment in which we can see what that young person needs and what the consequences for their mental health have been from not being in school. I would rather kids were in school and that that educational setting was protected for them.

Q182 Dr Lisa Cameron (East Kilbride, Strathaven and Lesmahagow) (Con): When I worked in mental health services, we often found that there was an association between people who were smoking cigarettes and also cannabis and having aggravated psychotic symptoms. Do you think that the measures in the Bill will help people to avoid smoking in general and therefore be less likely to move on to smoking cannabis as well and aggravating those psychotic episodes?

Mark Rowland: The evidence around cannabis use and the increased risk around psychosis is really clear and strong. I have personal experience of the absolutely devastating experience of friends who have experimented casually with cannabis and the consequences for their mental health.

It is a fair supposition to make for you as legislators that a Bill that makes such a symbolic and strong stand against young people getting addicted to smoking, reducing the rates and preventing young people from getting addicted to vaping will set a fantastic context for preventing addiction to other substances. Would it not be great if we also saw some delay in the first experience of young people drinking? We could be on the cusp of doing something really fantastic for young people if we look at the range of addictive or self-soothing products, and cannabis would be one of them. If you break the chain and teach people how to manage their mental health and distress in a positive way, you will reduce the risk of people choosing addictive and damaging products to do that for them.

The Chair: If there are no further questions, can I thank the witness? We will move on to the next panel.

Examination of Witness

Dr Laura Squire gave evidence.

2.52 pm

Q183 The Chair: We will now hear from Dr Laura Squire, the chief healthcare quality and access officer for the Medicines and Healthcare products Regulatory Agency. We have until 3.25 pm for this session. Will the witness please introduce herself for the record?

Dr Squire: Good afternoon. My name is Laura Squire, and I am the chief healthcare quality and access officer for the Medicines and Healthcare products Regulatory

Agency. The objectives of the MHRA are to protect public health and, in connection with that, we have a number of different roles connected with e-cigarettes. We have no role at all with tobacco.

Q184 Preet Kaur Gill: Can you briefly describe the regulatory approach taken by the MHRA regarding vaping products? Will this Bill change anything that you currently do?

Dr Squire: Yes, I can. We have three very distinct roles connected with vaping products. The first is in connection with medical products, which we talked about earlier and I can explain a bit more. That is something that might be prescribed for someone to give up smoking. We have a very different role on consumer vapes—the sort of things that you will find in your local vape shop. For all those products, we also have a role in monitoring their safety once they are on the market.

I will start with the role for vapes as medical products. The Human Medicines Regulations 2012 govern that and define what a medical product is, which is essentially a substance used for preventing or treating disease in human beings or diagnosis. MHRA is responsible for regulating medical products; that includes nicotine-containing products that are used in a therapeutic way, and which would help people give up smoking. That would include the licensing of electronic cigarettes that allow the inhalation of nicotine. In addition, where an e-cigarette is in a reusable form, it needs to conform with the UK's Medical Device Regulations 2002.

To explain that a little bit more, as with all medical products, before a medical nicotine-containing product can be marketed in the UK we do a robust assessment of that product. We always say that no medicines are entirely without risk, and the question that we ask ourselves as regulators is, are the risks outweighed by the benefits of that product for the patient who is using it? This is done by the examination of evidence provided by the manufacturer of the quality, safety and efficacy of that product. We have mentioned earlier this afternoon the possibility of licensing e-cigarettes. There was one product licensed in 2015, which was an electronic nicotine inhaler. It was never marketed in the UK.

The evidence is really clear—and a lot of people have said it—that e-cigarettes are less harmful to health than tobacco, and that nicotine-containing e-cigarettes can help people stop smoking for good. That was restated very clearly in the recent report by the Royal College of Physicians, which advocates cigarettes being offered as part of a treatment pathway by the NHS. Treating those products as medical products and licensing them would enable that. For that reason, we continue to encourage manufacturers to come forward to us to seek licensing as a medical product. Quite recently—a couple of years ago—we put out some really detailed guidance, because we recognise that not all manufacturers of e-cigarettes would be particularly familiar with the Human Medicines Regulations, so there is specific guidance out there at the moment. The Bill does not change any of that; we would continue doing the same thing.

The second role is our role on vapes as consumer products, which as I have said is different. The MHRA is the competent authority for the notification scheme for e-cigarettes and refill containers, and that covers Great Britain and Northern Ireland. The e-cigarettes covered by the Bill and by the notification scheme are not medical products, and that is very important. It means they are not entitled to make medical claims, so we do not test them for that.

The role in consumer products and the notification scheme is given to us by the Department of Health and Social Care and it derives from the UK's Tobacco and Related Products Regulations 2016, which were designed to put in place some product standards for e-cigarettes such as nicotine strength, the size of the tank and so on. The checks we undertake for that are really just to make sure that the data fields have been completed, and that a fee has been paid for those products. In contrast to medical products, we do not do a full assessment of the safety, quality and efficacy of those products, nor would we undertake a consideration of whether the benefits of those are outweighed by the risks. Our competent authority role does not include the testing of those products either.

Q185 Preet Kaur Gill: Just on that point, the notification scheme is essentially a paper-based process, so anyone sitting in Germany, say, or anywhere in the world, if they want to supply the United Kingdom, simply has to fill out a form, send you a notification form and pay the fee. No physical products are examined or tested to make sure that they are compliant with what is required before they can be sold. Do you think the MHRA should be given the powers to use the notification fee for more than just the administration of the scheme, and request some sampling and testing of products—of course, not all—before they go on the market? I say that because we have seen the evidence of the increase in illicit vapes and we have heard from trading standards as well on that volume increase.

Dr Squire: Sampling and testing can be done—it is done by trading standards—but you are quite right that that is not before it goes on the market. I think at the moment it is difficult for me to say what the Bill should or should not be. The policy sits with the Department of Health and Social Care, and as we work through the process of consultation and putting the regulations in place, we will continue to work closely with them on what that means for the notification scheme and our role in it.

I was going to talk about our post-market surveillance role, which covers everything. There are requirements for manufacturers of both medical and consumer e-cigarettes regarding post-market surveillance; they have to ensure the safety and quality of their products when they are being used in the intended way. Those requirements include reporting to the MHRA. They are much more stringent for the medical products.

The MHRA yellow card system is a spontaneous reporting system, which anybody can use to report a problem with a product. In 2016, we extended that to enable people to report on e-cigarettes as well. Our vigilance team, when they get those reports in, look at them all to identify any safety concerns, and if a concern is identified they work with trading standards to enable them to do what they need to do, which is sometimes taking the product off the market. They do not just use the spontaneous reporting; they use other parts of intelligence, including literature review, to take these products off the market.

What we are thinking about at the moment is the challenges, particularly with spontaneous reporting, of identifying longer term effects or effects that have a longer lead-in time. That is something our safety and surveillance teams are really thinking about.

Q186 Preet Kaur Gill: In terms of your notification process as a regulator, of course there is enforcement, with trading standards removing products, but do you have the powers, and have you used your powers, to remove products from that notification process?

Dr Squire: At the moment, no; it does not allow us to take things off the register, although I notice in the Bill there is something about exceptions to publication. At the moment we cannot do that, but the exceptions to publication in the Bill—again, this is DHSC legislation rather than ours—look as if they might give an opportunity for that.

Q187 Preet Kaur Gill: It seems to me that there needs to be some sort of triangulation between trading standards' enforcing and removing illicit products from the market and your register. Surely, given your role, you should have the powers to be able to pull that product off the register.

Dr Squire: Yes. There is a lot of triangulation and a lot of work with trading standards, and the evidence we have gained through the notification is used to support them to do their enforcement activity. But you are quite right that we cannot take things off the actual notification list at the moment, though the Bill has some exceptions to publication.

Q188 Preet Kaur Gill: If a product is not compliant—if it is illicit, illegal and so on—does it stay on your register? What happens?

Dr Squire: Nothing happens on the register, but trading standards will take it off the market. Trading standards take that enforcement activity. We provide them with support from an intelligence perspective and with expert input, and with things such as telephone support if they are doing operations, so we do work very closely with them. The key objective, when these products are found, is to get them out of the shops.

Q189 Preet Kaur Gill: Does that mean that you communicate with every trading standards department in the country and get them to go out and remove the product? Is that how it is done?

Dr Squire: That depends on where it starts. They get their own intelligence as well, so they would lead on enforcement operations. That is their role, not ours, within the UK tobacco products regulations. They do that and they ask for our help to support them, and we will give them intelligence when we do that.

Q190 Dame Andrea Leadsom: Thank you very much for being here this afternoon. Can you talk us through the work you do with some vape companies in order to take non-compliant vapes off the market?

Dr Squire: The work that is done with vape companies to take products off the market would be done by trading standards.

Q191 Dame Andrea Leadsom: So you do not work directly with vape companies?

Dr Squire: We do not have the powers, no. Our work with vape companies would be from the perspective of their wanting to get a product licensed as a medical product. We would have discussions with them on that, as we would with anybody else who is bringing a medical product to the market for licensing, but we do not have a role in enforcement or in withdrawing products from the market. If we were to identify a safety concern, there would be a collaboration with trading standards to get the products off the market.

Q192 Dame Andrea Leadsom: I think there is still some slight confusion among colleagues about the exact relationship between the MHRA and trading standards vis-à-vis the huge rise in illicit vapes. Could you have another go at explaining it from start to finish? You get a—well, you do not get a request through if it is an illicit vape, presumably.

Dr Squire: No, if it was an illicit vape, they would not put it on our list. We might work with them if they found a product that had a problem with it—often products are under different brand names but they are the same product—and our notification system would help to understand what products are affected by that. We do not have any powers to do enforcement activity. That is not a power given to us under the tobacco products rules at the moment; it is just a notification scheme. It was never designed as an enforcement tool; it was designed really as a single version of the truth of what is out there. That then enables enforcement because it is information, but we are not the enforcing authority; trading standards are.

Q193 Dame Andrea Leadsom: Thank you—that is clear. Can you also explain the process? You said that you published some guidance for vape companies that want to produce a prescription-only type of vape. You said that one was produced, but then was not marketed in England. Do you know why that is, and whether that might change in the future?

Dr Squire: I do not know why that is, but I products agree with what was said earlier: those products move and develop very fast. The requirements to obtain a medicines licence under the Human Medicines Regulations 2012 go a long way beyond those to produce a consumer vape. You have to produce evidence of the quality of the product; we also look at the quality of manufacturer, and have requirements around that.

In terms of efficacy, while nicotine is a well understood substance, so there are some things that producers do not have to do, we still need to ensure that the product works in the way we would expect equivalent products to work. We have clinical assessors and quality assessors, and we think about manufacturing as well. To get a product licence, producers have to put together a dossier of all that evidence. Putting together that dossier is both costly and time consuming, because they have to demonstrate that the risks of the product are outweighed by the benefits. The dossier will also describe what we call the indication—that is, how they expect the product to be used. It would be licensed only for a particular use, which would be smoking cessation. Producers would have to go through all that in order to get the product on to the market.

It is difficult to say how the Bill would affect that. When you have two systems, one of which is an awful lot easier than the other, I can see why there was a commercial attractiveness to going down the consumer route, but I think that anything that introduces more controls over consumer vapes has to be a good thing.

Q194 Dame Andrea Leadsom: Would it be reasonable for those of us who are suspicious about, for example, the marketing of vapes to children to suspect that the reason we do not see vape companies coming forward to try to license a medicinal prescription vape is that the products and the manufacturing processes are not good enough, and it would be very hard to meet the bar for a medicinal product, or would that be unfair?

Dr Squire: I would be speculating if I said that. It takes time and money to collate the dossier to prove the products' quality. The products are not necessarily worse, but they have to go through quite a process to prove it, so I think it is that, rather than anything else.

Q195 Rachael Maskell: I have just one question, which is a particular concern of mine. Vapes are a delivery product for a liquid. I am concerned about the illicit market, which is now utilising vapes for Spice, cannabis and a new generation of synthetics as well. Is there work going on to produce testing kits, so that the liquid can be tested? I understand that testing kits would have to go through a regulatory process with you as well. If not, why not? Surely we need to get ahead of the curve in keeping people safe from a new generation of illicit drugs.

Dr Squire: I think that would probably be under the consumer products regulations. If it was testing the actual product, that is not something that the MHRA would do as it is not a medical product. What we test is medical products and whether they are safe, effective and made to the right quality, but testing part of the device—

Q196 Rachael Maskell: But the testing kit would have to come through you?

Dr Squire: It would depend on what it was defined as. I think we could be going into the medical device regulations. I am thinking on my feet, but I would say that a testing kit to test a product would probably not be "for a medical purpose". It probably would not be under the medical device regulations because the testing kit itself does not have a medical purpose, but it is quite a fine line. We would need to look at the actual testing kit and its purpose.

Q197 Dr Johnson: I want to make sure I have it clear in my head. If someone wants to license something as a medicine or a medical product, they have to go through the more complicated, more expensive process and show you that it is safe, properly made and works as it says it will, and that the risks are outweighed by the benefits of the product. If they want to list something as a product for sale, do they just tell you that they are going to do it and you do not test any of those things?

Dr Squire: No, they are under different pieces of legislation.

Q198 Dr Johnson: Would they count as listed with and notified to the MHRA?

Dr Squire: They are notified to the MHRA, and that notification is under the tobacco and related products rules. That is different from the human medicines regulations, which govern medical products. We do not deal with that notification scheme. That is set out by those regulations and the responsibility was given to us as the competent authority. We cannot go beyond those rules.

Q199 Dr Johnson: I understand that. Do you think that it is the right authority to do that? Could it be misleading to members of the public, who see that the vaping devices they buy have been listed by the MHRA and presume, because the MHRA is the medicines and healthcare products regulatory authority, that somehow you have tested them? Might it be more practical to say that this has been notified and we call the competent authority something else, to make what you have actually done with the product more transparent to the public?

Dr Squire: That is an interesting question. As I said at the beginning, our objective as the MHRA is to protect public health. Most of the time we do that by making a decision on whether the risks of a product are outweighed by the benefits. For medicines and medical products, they very often are, and they are if an e-cigarette is licensed and is being used for smoking cessation. However, for vapes, I think we have all said, "If you don't smoke, don't vape." The benefit-risk decision on a lot of products would be that the benefits are not outweighed by the risks. It is an interesting question. I cannot really answer it today, but I would be interested in the public perception of whether having medical and healthcare in the title gives a misleading impression.

Q200 Dr Johnson: Could you clarify something else? If I were a vape manufacturer wanting to get full registration as a medical product for one of my vapes, and I did an apple flavour and a gummy bear flavour, would I have to put those products through separately because the apple flavour is a different chemical to the gummy bear flavour?

Dr Squire: Any product that has different constituents would have to be put through separately, because we would have to test everything. I can see the issue around flavouring is about making it attractive to children, and we are not interested in that, but we look at what the chemicals and substances are in a product, which will be different for different flavours, so we would have to look at those separately and make sure that they all came up to scratch.

Q201 Bambos Charalambous (Enfield, Southgate) (Lab): I ask more for clarification, if a GP wanted to offer a patient a vape as a means of reducing smoking, would that have to be licensed by the MHRA as a medical device? Would it have to be licensed through your organisation?

Dr Squire: Yes, if you want a licensed product that can be prescribed, that would be a medical product. I know, because I was talking to one earlier, that GPs do recommend that their patients go and buy a vape. They do not have any choices at the moment, because there are no licensed products available on the market in the UK.

Q202 Bambos Charalambous: So they would just suggest that someone go and buy a vape in a shop to help them to reduce their smoking, rather than suggest one that had been through your rigorous process?

Dr Squire: At the moment, the limiting factor on the availability of licensed products is that we need manufacturers to come forward and apply for a medical licence. We continue to encourage that, including putting out the guidance. If anyone wanted to talk to us about bringing a product to market, we would talk to them about that, but they are not out there at the moment.

Q203 Bambos Charalambous: So there is no obligation on the vape manufacturers to come to you to check the vape?

Dr Squire: Not if they are putting a product on the market that is not making any medical claims. If they are putting it on the market and not making medical claims, it is a consumer product and they do not have to come to us. If they start to make medical claims, including that it will help you to give up smoking, they need to come and talk to us. They should not be making medical claims without having it as a licensed product.

Q204 Trudy Harrison (Copeland) (Con): We have heard various accounts of the impacts of vapes on children and young people—that there are limited direct consequences of vaping on children and young people's bodies, but plentiful and multiple different indirect impacts of that behaviour in schools and such like. I am starting to hear that it almost feels like an unbearable choice between whether we protect children and young people from vaping, or prevent older people from being able to stop smoking through the use of vapes. I am struggling with making that choice; I can see both sides of the argument. Do you have a view? Could you help the parliamentarians here to understand the choice we are faced with?

Dr Squire: The Bill helps in all ways. The Bill is very clear on tobacco and, as I say, we do not have a role on that, but the proposal is to put more requirements on vapes, and in our experience more requirements add to the barrier to something getting on to the market, which is helpful. One of the problems we have with e-cigarettes is their availability.

I am not sure I see the choice between the two. We are seeing here a Bill that, as people have said before, is balanced. It recognises that vapes are useful for people who already smoke, and it puts in some very big restrictions on people who already smoke, but it also tightens the rules around vapes. I think that is what gives it the balance, which is helpful. The problem, which others are more qualified than I am to talk about, is: if we did not have vapes at all, where would people who smoke go? It is not a good answer, but if you do not smoke, don't vape. That has been said a number of times, and we definitely agree with it.

Q205 Preet Kaur Gill: How many products that have gone through the notification process have been deemed illicit and have therefore been removed by trading standards?

Dr Squire: I think I have some figures about that—can I write to you? I do not have them in front of me, but I think they are quite high numbers. We have about 67,000 on the list at the moment, and quite a high proportion have come off as a result of the activities of trading standards.

Q206 Preet Kaur Gill: It is the process that we are trying to understand. You have a register and a notification process—

Dr Squire: Yes.

Preet Kaur Gill: But because we are not testing a product before it comes to the market, we are allowing a lot of illicit substances to come in and flood the market. Do you think that companies submit data about their products and say, "Yes, they will meet the regulations," so that they can get their European community identification, but then actually send to the market products that are potentially illicit and have high nicotine strengths?

Dr Squire: Yes, so the product that goes on to the market is not the product that is on the notifications—yes, that does happen. That is why I think it would be helpful to have the exceptions that are coming in through the Bill in order to take some of those products off the market.

Q207 Preet Kaur Gill: Do you think those exceptions are strong enough?

Dr Squire: What the exceptions are is not defined yet. The ability to make exceptions is in the Bill, but what the exceptions are would be a Department of Health and Social Care policy decision, and we will work with it on the development of those regulations.

Q208 Preet Kaur Gill: Have you ever asked a Secretary of State to use powers to recall or remove products from the register?

Dr Squire: Have we?

Preet Kaur Gill: Yes.

Dr Squire: No, I do not believe we have.

Q209 Preet Kaur Gill: Where you were given the role of being the register in the notification process, it says that the powers can sit with the Secretary of State, and I am just wondering, given that we have a growing number of illicit substances, how that information has been shared with the Secretary of State so that they can utilise those powers. I appreciate that we have in the Bill the opportunity to try to look at whether we should be testing products. I suppose my other question to you is this: what happens if, after a product has been notified, the company decides to send notifications of other products? Is it allowed to do so even though it has already supplied illicit substances?

Dr Squire: There is illicit and there is non-compliant—those are two different things. If a company provided something that turned out to be non-compliant, provided that what they then send us is compliant, there is no reason why we should stop that. I have tried to bring the contrast between the levels of control that we have on medical e-cigarettes and the levels of control that we have on notification. The notification scheme is just that and was designed as just that. The MHRA does with it what we are required to do under the tobacco

rules, and that was assigned to us when we left the EU. The strengthening that comes through these regulations—or through the Bill, which will then lead to the regulations—is something that the Department of Health will develop, and we will work with it on that. However, I am not sitting here saying that this is an absolutely robust system that keeps everybody safe. That is why the Bill is important.

Preet Kaur Gill: Thank you.

The Chair: If there are no further questions, I thank our witness. We will move on to the next panel.

Examination of Witness

Mr David Lawson gave evidence.

3.24 pm

The Chair: We will now hear from David Lawson, director of Inter Scientific Ltd. We have until 3.45 pm for this session. Will the witness please introduce himself?

Mr Lawson: Hello, my name is David Lawson. I am director of Inter Scientific. I am also director of another company called Ventus Medical, which sits on the other side of regulation in the development of pharmaceutically regulated nicotine-containing products.

Q210 Preet Kaur Gill: In 2023, your company identified shops selling vapes with illegal capacities and nicotine strengths. What have you found through some of your work?

Mr Lawson: We looked at stores in Liverpool, Manchester and London. We did this with a few different media outlets—the BBC, Sky News and *The Guardian*. We found that you could buy illegal products quite easily on the market and that they were available in almost every store you go into. Some of those were post office stores that were selling those products, so there was no way for customers to determine which products would be legal or illegal.

We were able to expand on testing in relation to trading standards, and we found that around 77% of products that we tested exceeded the 2 ml limits in the Tobacco and Related Products Regulations 2016, which set the UK limit on volume. Some 33% of products contained more than 20 mg/ml of nicotine, so over the legal limit for nicotine, but 19% of products that were marketed as being nicotine-free contained nicotine, generally at the full maximum strength for the UK. Overall, 78% of products tested were deemed to be illegal in accordance with TRPR 2016.

Q211 Preet Kaur Gill: Were those vapes being marketed to children or to adults, or was it a mixture?

Mr Lawson: I think it is quite easy to characterise the products. They are generally quite large in size. They normally have cartoon figures on them, such as Rick and Morty from Netflix. A lot of them are branded with cartoons like that— sometimes The Simpsons are used. Generally, they have flavours characterised by trademarked brands, such as Skittles. These are all prohibited under the tobacco and related products regulations as they resemble food products, but they also exceed tank volume and nicotine content, too.

Q212 Preet Kaur Gill: In your opinion, does the Bill do enough to address the sale of vapes with illegal capacities and nicotine strengths? Will it give Government the powers they need to address future trends in this area?

Mr Lawson: From the products we have tested, 78% of those are already deemed illegal based on the tobacco and related products regulations, which are the current regulations in the UK, so enforcing those regulations more stringently would have removed most of the products that people are now using. Implementing new regulations on top of regulations that are not currently enforced may not be effective in reducing the number of those products being sold on the market.

Q213 Trudy Harrison: I am the very proud mum of four daughters, aged between 21 and 25. When I think back to them as teenagers, I do not think they would have found a unicorn, a cartoon character or a bubble gum flavour particularly trendy—when they were four or five, yes—so I do not buy the idea that teenagers are attracted to such things. I worry that whatever we manage to do to avoid cartoon characters or bubble gum flavours being prevalent just will not work. For example, cigarettes are still attracting many young people, which is why the Bill is needed. I think they taste absolutely revolting, but that is not putting children off. What are your thoughts on what needs to be done to prevent teenagers from finding vapes attractive?

Mr Lawson: I am not sure we can ever prevent any youth getting access to vapes—that is an impossibility. Youth are known to engage in risky behaviours, so they will drink alcohol under age and engage in risk-taking behaviour. What we can do is limit the drivers that bring youth to using vape products, such as flavours that are appealing or cartoons they are familiar with. These are small factors that play into the overall picture as to why somebody may pick up a vape when they did not previously smoke. That needs to be balanced with the question of adults quitting smoking. If you restrict flavours to only tobacco flavour, as we see in the US pretty much at the moment, adults are then limited to flavours that remind them of smoking, and that is probably less likely to reduce the smoking prevalence in the population.

Q214 Kirsten Oswald: To extend that conversation a bit, the issue of youth vaping is particularly concerning to me and obviously to many others around the table. You spoke to the Committee about how easy it is to buy products that are illegal but that may look to the unexpert eye as if they are legal products—even to the shopkeepers, one presumes. That must be much more difficult for children and young people—even people who are at the lower age of legally buying vapes—so I wonder what your thoughts are on how that might be acted upon. I also wonder whether you think that vape manufacturing is likely to be impacted by the measures in the Bill.

Mr Lawson: I can answer that anecdotally for you. Of my friends and peer groups who vape, despite what I do for a living, they do not listen to me that the products they are using are illegal, so I think the only way to prevent those products being used is to enforce action against them being on the market to begin with. I think there is a complete lack of awareness and knowledge of

the current regulations among shopkeepers, and among the population. Many people may choose to buy an illegal product despite it being illegal, but many people might not have made that decision had they known otherwise.

What we are seeing more recently in that category of illegal products is that the safety of those products is less well known than for products that have gone through the MHRA's notification process. We have done research into their metals content, for example, and we see elevated levels that you would not normally see in a product that has been notified to the MHRA. There are a few layers of this, but I think that if consumers are not aware of the safety of the products they are using—which they are not—that is a bigger concern. Whether youth use them or not is a separate thing to that.

Q215 Dr Johnson: Mr Lawson, you talked about how many of these products exceed the level, and those figures you presented were quite shocking, but how do people tell? You might think that if you went to a reputable major supermarket, the products there would be the right thing to buy, but we know that in February last year, Elf Bars were removed from Tesco, Morrisons and Sainsbury's because their products—the Elf Bar 600s, I believe—were found to contain over 50% more than the legal limit of nicotine liquid.

I have three questions: how can a consumer tell if they are buying a legal product? How can a shop, particularly a smaller shop with fewer resources, tell that they are buying a legal product—as we have already heard, the MHRA does not actually test them? And are the penalties for getting this wrong enough?

Mr Lawson: With respect to Elf Bar, the industry itself has tried to take some level of leadership. Distributors are now doing testing on products before they go to the shops, before they stock them or sell them on. My company is registered for testing with UKAS—the United Kingdom Accreditation Service. We work with trading standards, and we work with the industry in testing products like these, so I think this Elf Bar issue has been a bit of a wake-up for industry to take more action.

With respect to smaller stores, I mentioned post offices earlier, because you would assume that going into a post office, you would be able to purchase a legal and reputable product, but I think there is a lack of awareness among the people purchasing these products in stores about what is and is not illegal. I would assume that you should not be able to buy an illegal product; if I owned a store and I was able to buy these products somewhere, I would assume that the only things I could buy were legal. You do not go into a store and buy alcohol, for example, that is illegal, so I guess there is an assumption that products should be legal.

Q216 Dr Johnson: The final part of that question was whether you think the penalties are enough of a deterrent, and whether you think the Bill does anything that will really resolve this.

Mr Lawson: At the moment, there is little enforcement, so I guess anything is an improvement on the current status quo. The question is whether or not retailers make more money and can pay off the penalties due to the profits they are making from illegal products. It is a positive that some action is being taken, but it needs the enforcement behind that, too.

Q217 Dr Johnson: Do you think the penalties should fall on the person who sold the good, rather than the person who produced and made the illegal product and released it for sale?

Mr Lawson: You would find it very difficult to enforce it if you were trying to take action against a manufacturer in China, where you do not have jurisdiction. I think the only way of addressing this is in the UK, where the stores are purchasing products and then selling them on illegally.

Q218 Mary Glindon: The UK Vaping Industry Association, which represents the vaping sector but not any of the tobacco companies that produce vapes—I note that John Dunne, the CEO, is in the Gallery today—has suggested that the Government should include a vape retailer and distributor licensing scheme in the Bill. The industry has itself developed a comprehensive framework for such a scheme, which it claims is designed to, once and for all, deal effectively with the issue of underage and illicit vaping sales. Would that be a big step forward to cut out illicit vape sales?

Mr Lawson: The evidence I have seen is mainly from Spain, where tobacconists must be registered and licensed before they can sell products. In Spain traditionally, vape products have been sold only through licensed tobacconists. More recently, you can see them in convenience stores. I think we are seeing issues in Europe beyond the UK where products are now being sold illegally. Where they are sold in licensed outlets, you generally see much better compliance with the regulations. Obviously the licence can be removed, so it is a deterrent to the retailer to selling any of the products. That would be a good step in the right direction.

Q219 Preet Kaur Gill: You mentioned that your company is doing testing of products. One of the things that we heard just before your evidence was that what comes into the UK market obviously is not tested before it comes out, and we know that the illicit and non-compliant market is growing hugely. Can you talk us through what you do when you test your product? Where does it go?

Mr Lawson: The main driver behind testing has been to support trading standards in taking enforcement action against illegal products in the market. The testing has therefore focused on two main areas. One is the tank volume, the 2 ml, and the other is the nicotine strength, the 20 mg/ml, so the testing looks entirely at whether products are simply complying with the regulations. I did hear some of the last answers, but there is a very simple step: when it is applied, the MHRA notification scheme works fairly well. Most of the products that we test are not on the notification system—they are not on the MHRA's portal. There is no check from a retailer or an importer that the products must be on that portal, so there is a bit of an issue there; you can effectively bypass the entire notification process by importing products and selling. Additionally, if the products do not contain nicotine, they are not subject to MHRA regulations.

Q220 Preet Kaur Gill: How are those products coming into the market?

Mr Lawson: They are being illegally imported. The majority of products are not produced in the UK; I would imagine that most products, if not every product

produced here, would be compliant. These are products coming in from Shenzhen in China, generally. They are being illegally imported and illegally sold, so the question around taking enforcement action against the manufacturer may be fruitless, because you will not be able to enforce penalties against a Chinese manufacturer.

Q221 Preet Kaur Gill: Are they imported illegally in bulk?

Mr Lawson: I assume so. I am not sure whether Kate Pike from trading standards has given evidence, but trading standards has been involved in seizing quite a lot of products, particularly in Manchester, where there are container-loads coming straight in from China.

The other thing to mention is that vaping has been around in the UK for 14 or 15 years. It is only in the past two years that youth use has been a concern. This has come from the US, where youth use has been a concern for five or six years. The US has implemented new regulation that has prohibited almost all flavours. What we see now is a circumvention of products from the US to the UK, so these large tank sizes, cartoons and characterising flavours are products that were in, or were generated in, the US market and which are now coming to the UK, because the UK is a bit more of an open market for products to be sold. We can see that happening in Europe and some other countries as well, where products are now being trickled into the countries that have less stringent enforcement action.

Q222 Preet Kaur Gill: We heard yesterday that with tobacco, you have track and trace. Do you foresee that if we had a track and trace system for vapes, it should largely address some of this?

Mr Lawson: My personal opinion is that if the current regulations were enforced thoroughly, most of the issues we see today would not be a problem. If we go back two or three years, I would say that almost all products on the market would be compliant. We did not see large tanks or these characteristic products that are now illegal. If the Tobacco and Related Products Regulations 2016, which are the current UK regulations, were implemented or enforced properly, we would see a huge reduction in youth use, because those products that appeal to the youth would not be on the market.

Q223 Dame Andrea Leadsom: Thank you very much for coming today. Would you support an excise duty on vapes?

Mr Lawson: I am not sure that that is an appropriate question for me. I am a scientist, rather than a policymaker.

Q224 Dame Andrea Leadsom: But in terms of behaviour, you have been talking about the targeting of children and so on, so I am asking you for your opinion. Are you also employed by the vaping industry?

Mr Lawson: No. I work in pharmaceuticals and medical devices. The issue around excise duty is that the illegal products that we see youth buy are actually a lot more expensive than legal products. You might buy a legal product for £5 or £6, and an illegal product is probably £10 or £15. The cost does not seem to be a deterrent; larger products with these characterising flavours are what they are looking for. I think you may penalise adult smokers switching more than you would benefit children by preventing them from using products, if you applied a tax on vaping.

Q225 Dame Andrea Leadsom: Okay, but obviously an excise duty then enables more enforcement and the track and trace scheme to which the hon. Member for Birmingham, Edgbaston referred to come into play for vapes, which could then mean better knowledge of which are legal and which are illicit. Would that be true?

Mr Lawson: I guess the source of funding is a separate question, but if there was enforcement of the current regulations there would be a lot of revenue generated from the enforcement and penalties under the current regulations, which may fund track and trace or other policies.

Q226 Mary Kelly Foy: To follow on from Andrea, most of the experts we have heard from to date have been from the NHS or the medical profession—people with skin in the game and promoting good health and tobacco cessation. Who funds you to do your work?

Mr Lawson: We are self-funded. We work with trading standards, so they fund part of our work. We work with the industry ensuring products are compliant. My other company develops medical products for quitting smoking and vaping. We straddle both sides—the tobacco side and the medical side.

Q227 Mary Kelly Foy: So it is self-funded.

Mr Lawson: I set the business up, yes.

Q228 Mary Kelly Foy: And you work with trading standards in the local authority?

Mr Lawson: We work with trading standards across England and Wales currently. Almost without exception all the testing that has been conducted on vaping in the UK would have come through our lab. The data that trading standards has is from the testing that we do for it, and from the enforcement that it has taken as well. The MHRA, as far as I know, does not conduct any testing.

The Chair: If there are no more questions, we thank you for coming. We will move on to the next panel.

Examination of Witnesses

Professor Allison Ford, Dr Rob Branston and Professor Anna Gilmore gave evidence.

3.42 pm

The Chair: We will now hear from Professor Allison Ford from the University of Stirling; Dr Rob Branston, senior lecturer at the University of Bath; and Professor Anna Gilmore, professor of public health at the University of Bath, who will talk to us via Zoom. We have until 4.25 pm for this session. Will the witnesses introduce themselves for the record?

Professor Ford: Thank you for inviting me to attend today. I am Dr Allison Ford, an associate professor at the Institute for Social Marketing and Health at the University of Stirling. I have worked in research in the area of tobacco control since 2009. Currently I am working on a large package of work on youth vaping,

looking at youth responses to vaping products and the marketing environment of those products. More recently, I have been looking at their responses to other nicotine and tobacco products such as nicotine pouches and heated tobacco. We conduct large surveys with young people across the UK. We also speak qualitatively with smaller groups of young people.

Dr Branston: Thank you for inviting me. My name is Dr Rob Branston, and I am a senior lecturer in business economics at the University of Bath where I am part of the tobacco control research group. My interest in the tobacco industry is on the economic side, so I do research on industry taxation, responses to taxation, profitability, and responses to regulation more generally. That includes work on the illicit tobacco market. In the interests of transparency I should flag that I own 10 shares in Imperial Brands for research purposes. I do not get any financial interest from the company, but owning shares allows me to attend the AGM and ask questions that are useful in my research.

Professor Gilmore: Hi, I am Anna Gilmore, and I am a professor of public health at the University of Bath. I apologise as I cannot be there in person. I am currently on work travel and camped out at a colleague's house in Copenhagen. My background is in medicine and public health. My work focuses on what we now call the commercial determinants of health, which is the way in which corporations influence health. I have a particular interest in this area and therefore in the tobacco industry.

Q229 Preet Kaur Gill: My question is to you, Anna. You and your colleagues have examined the ways in which what you term "unhealthy commodity industries", such as tobacco companies, achieve their aims. Can you tell us a bit more about that, and how it relates to the measures in the Bill?

Professor Gilmore: We do work on unhealthy commodity industries, which include tobacco, alcohol, fossil fuels and ultra-processed foods. This is increasingly an issue, because what kills us, increasingly, are the products and practices of these corporations. The products of just those four industries account for at least a third of global deaths every year.

Obviously, their aims are to maximise profits, and we now know that their practices are incredibly similar in the way in which they lobby, market, use public relations to massage reputations and buy access to Governments. That is not only a direct problem, but, in a way, a wider system problem. Those industries cause this huge harm, but they do not actually meet the costs of that harm; instead, the individuals who are affected, we as taxpayers and Governments end up paying for those healthcare costs, and so on. We know that even the tobacco industry, despite high excise rates, does not fully meet the costs of the harm it causes, and this incentivises further harm. I would love to talk in detail about that—perhaps another time.

In relation to this Bill specifically, it helps us to understand a few issues. It helps to explain why we have a problem with smoking and youth vaping, because tobacco and vaping companies will market to children and make their products as attractive as possible. We know that the tobacco industry has historically manipulated cigarettes to make them as addictive as possible. In fact, if you look at tobacco industry documents, they are quite clear on that:

"The base of our business is the high school student."

We know that the key reason we are facing these problems with new products such as vapes is that tobacco companies were under threat. We had done a good job on tobacco control globally, and smoking rates and cigarette sales were coming down; now, globally, those sales and rates are stagnating. The industry is fighting back, if you like. That is why we are seeing a whole host of new addictive products.

What is really worrying is the emerging evidence, both from animal models and human studies, that exposure to nicotine at a young age, such as vaping in teenagers, can effectively rewire the brain and increase the risk of addiction in the long term. For these companies, it is the perfect business model: they can addict them young, and then move them on from one product to another. We need to be very concerned about that.

What is perhaps most relevant is the overwhelming evidence that these companies will fight the legislation at every stage. We refer to this simply as block, amend, delay: they will try to block the legislation; if it goes further, as it is doing now, they will push to amend it and weaken it; and then they will push to delay it, including through litigation. Once it is implemented, they will also work to circumvent it and find loopholes, so we need to ensure that the legislation is watertight. We know that from past work we have done, such as with the ban on menthol, when the industry tried to introduce menthol cigarillos as a replacement for cigarettes by bringing in menthol accessories such as menthol cigarette papers and filters.

In terms of recommendations, I would say that you really need to be on guard against the arguments of the tobacco industry. Having looked at these over many pieces of legislation and in many jurisdictions, we can tell you that the tobacco industry's arguments do not come true. They may be plausible on the surface, and I am happy to talk about them in more detail, but they do not come true. We also need to be aware of the third parties and front groups through which the industry operates. The tobacco industry has lost its credibility, so it works through third parties—organisations such as the Institute of Economic Affairs, and often through retail groups. I urge you to be cautious about who is approaching you, and to ask who really funds them. We need to be aware of amendments, too. I think we can be certain that the industry is working quite quietly this time, because, over the past few years, it has claimed to have changed. I think we need to be careful of the amendments that are coming in. Push against any industry efforts to delay the legislation. I would also urge you to be really cautious with any evidence or data that is presented to you, because we know from our past work—we did detailed work on standardised packaging when that came in, for example—that the industry will manipulate the evidence and data in its favour. Finally, I urge you to make the legislation as watertight as possible.

Q230 Preet Kaur Gill: On that, do you think that Government regulation in the Bill is sufficient, and will it improve public health?

Professor Gilmore: Yes, absolutely. I think the primary legislation is important for the smoke-free generation and to help address smoking, particularly among young people, and to de-normalise smoking. We know from past measures that de-normalising smoking can be important. What is useful are the powers to introduce

secondary legislation. We are dealing with quite a lot of uncertainty in this area, and evidence is emerging all the time. What is useful is the ability to introduce some legislation and then further legislation later depending on the impacts and as new evidence emerges.

What is key is getting that secondary legislation right. Obviously, it has the potential to reduce smoking and vaping. There is some balance to be had on vaping because we need to reduce vaping in never-smokers, particularly young people, but still allow e-cigarettes to be available for smokers who are using e-cigarettes to quit. It is important to remember that they are obviously not the only quit product. It is important that we do not lose sight of the role of pharmaceuticals, which are actually more important, but there are some smokers who do quit with vaping products. There is that balance. I am happy to talk in detail about some of the things that I think could or should be in those secondary regulations, if that helps.

Preet Kaur Gill: That is great—thank you.

Q231 Dame Andrea Leadsom: Thank you all very much for being here today. Are any of you able to talk through the economics of the smoking industry, the vaping industry and, in particular, the illicit vaping industry? Do any of you have information on that?

Dr Branston: I can speak to at least some of your questions, so thank you for them. I think the starting point for understanding the tobacco industry is to understand that it is incredibly profitable. It is profitable like almost no other industry that we currently face. Not only are those profits large in total—I can tell you the world's six largest cigarette manufacturers made profits totalling about $55 billion in the most recent year that I was able to track, which was 2018—but they make large profits in the UK. I last estimated that for 2022, and it was about £900 million annually. Equally, they make a large amount of profit for each unit sold. Their profit margins are in the region of 70%, meaning that for every £100 they get to keep, having paid all excise duty, £70 of that is just pure profit. The actions of the industry are entirely guided by wanting to maintain and expand those profits going forward.

The interesting facet is that big tobacco currently does not make much, if any, profit on its new-generation products, which include e-cigarettes and other products, such as heated tobacco products. The vested interest of big tobacco is to maintain the status quo. The issue of profitability in e-cigarettes is more difficult to talk about for the private companies because many of them are based in China and do not publish their accounts, so it is difficult to tell how much, if any, profit they are making. Ultimately, companies cannot continue in existence if they are losing money, so it is a reasonable presumption that they are making some levels of profit, because they want to continue selling these products. Hopefully that gives you some background.

Q232 Dame Andrea Leadsom: That is helpful. Do you have any information—a guestimate—of what the illicit vape industry is worth?

Dr Branston: I would not like to speculate on that because, as we heard earlier today, the illicit sector has increased significantly in the past two years. It is difficult to work out what is licit and what is illicit, so I think it would be inappropriate to speculate. Given the number being sold, however, it would be reasonable to think that a significant amount of money is being made by those illicit products.

Q233 Dame Andrea Leadsom: We have seen youth vaping treble between the ages of 11 and 17 in just the last three years. It has already been mentioned that the vaping and tobacco industry seeks to prevaricate and keep hold of its young customers in a number of ways. Can you tell us some of the ways in which it will argue during the passage of the Bill? Do not forget that we are trying to get you on record today giving us some answers that we can then put to colleagues who challenge us because the sector has given them some lines to take. What should we be looking out for, and what should we be saying to our colleagues?

Dr Branston: I am fairly sure that the first thing it will say is that this is a charter for the illicit market and will lead to a big explosion in the rate of illicit tobacco in particular. I know that the industry always trots out that line whenever a tax increase, or any other regulation, is suggested. However, the facts simply do not support that line of argument. When the age of sale was increased from 16 to 18 in 2007, the rate of illicit actually went down in 2007-08. Illicit tobacco is driven by a whole host of reasons. It is very complicated, but ultimately it is an issue of enforcement, as we heard before. We need to ensure that we have the rules in place to make sure that products on the market comply with the law and all the regulations therein. I do not feel that illicit is a particular concern at this stage.

The idea of the generational ban is that it will only increase by one year every year. We are not going to suddenly outlaw a habit that millions of people currently have. It is something that many young people will be unable to do going forward, but they are not currently smokers, so we do not have to worry about all those people wanting to buy these products. The fact that they are banned will go a long way towards addressing the issue in and of itself.

The new excise duty due to come in on e-liquid will go a long way to addressing some of the concerns on illicit vapes. Having the products within the excise system means that more enforcement powers will be available, which will in itself help to reduce the rate of illicit. We can be reasonably confident that there will not be a big wave of illicit products in the future.

Q234 Dame Andrea Leadsom: Professor Ford, do you want to add anything on what we should be looking out for?

Professor Ford: I think Professor Gilmore is the expert on tobacco industry strategies.

Professor Gilmore: I am happy to speak on that if it helps. The model that we developed to understand how the industry argues about policy is called the policy dystopia model, because the industry will argue for a whole host of dystopian outcomes: "The regulation will not work"; "There is no evidence"; weirdly, "It will increase youth smoking"; "It will increase illicit", as Dr Branston has said.

The other key thing the industry will always claim is that it will be bad for business, but it will never admit that it will be bad for its own business, which is obviously

its key concern. It is always trying to claim that the negative impacts will be on others, such as retailers. We are seeing those arguments now: "It is impractical"; "It is untested"; "It will be impossible to enforce"—that is the other favourite argument; "It reduces freedoms".

Those are the typical industry arguments. It might present them quietly itself, but it acts directly less and less—increasingly, it acts through the third parties I flagged. I would be careful of all those arguments, and of approaches from people who might seem credible but, very often, have industry links behind them or are meeting with industry and simply believing those arguments without question. Generally, the arguments have some plausibility, but they have never materialised with any previous policy. They simply have not come true.

On illicit cigarettes, it is worth remembering that the tobacco industry has a very long history of orchestrating the smuggling of its own products on a vast scale, which is well documented through its own documents, which it had to release through litigation. That may sound counter-intuitive, but the more expensive the product, the less is sold; the cheaper the product, the more is sold. If the product is illicit and the excise duties on it are not paid, it sells more cheaply and more is sold. That also enables the industry to make the illicit argument: if there are illicit products on the market, it makes the illicit argument stronger.

It is also worth noting that the last time we looked at rates of illicit and published on that, the biggest share of the illicit cigarette market in the UK was the tobacco industry's own products. At best, that means that it is failing to control its supply chain. It makes a big song and dance about counterfeit and illicit whites, but there remains a problem with the tobacco industry's own products ending up in the illicit market. That is really important to bear in mind.

Q235 Kirsten Oswald: I have a question for Professor Ford. Can you describe for us how the packaging of vapes attracts young people to purchase them, and how the visuals advertising vaping that young people might see on social media or sports kits, for instance, might attract them and influence their desire to purchase them?

Professor Ford: Packaging in the UK just now is doing two things: first, it is communicating a message to young people, and secondly it is having a huge impact in the retail setting. I will deal with those separately.

First, we recently conducted a pack analysis of a representative sample of vape packaging that was legally available for purchase in the UK. We found that 85% of those packs are really brightly coloured. A proportion of them have a childish cartoon font on the pack, and the language and terminology on a proportion of the packs utilised youth language and slang, so it is tapping into something that young people could be receptive to.

There is also an issue with how the nicotine content is displayed on the front of the pack. There is no consistency. Some of the packs say that the nicotine content is 2%. We know from our qualitative work that young people misinterpret that as a low percentage, but it is actually the maximum legally allowable amount in the UK. All of that together is communicating to young people that this product is for them; in our qualitative work, that is what they have told us that they believe. We have also spoken to adult smokers, and they also believe that a lot of this colourful packaging is targeting young people. At the moment, there is a mismatch between what we would ideally like vape packaging to do—we want it to speak to adult smokers—and what it is doing. It is not speaking to adult smokers; it is communicating to young people.

The second part is the impact of the packs in the retail setting. I am sure you have noticed that in the retail setting—within the store, but also in the shop front—the display made up of brightly coloured packs is vast. We did a youth tobacco policy survey in 2020 and followed that up with the youth e-cigarettes policy survey last year, in July 2023. We are finding an increased awareness of vape displays in shops among 11 to 16-year-olds across the UK, from 40% up to 68%. That is a substantial increase.

We asked those 11 to 16-year-olds last year what they think about these displays in the retail setting. Some 58% think they are colourful, 36% think they are attractive, 36% think they are eye-catching and nearly a quarter think they are attractive. That shows not only how the display feeds into the appeal but, perhaps even more importantly, how it feeds into the social norm around this product and this behaviour. To give you just a couple of other statistics, nearly a third of our sample reported that displays make them think it is okay to vape, and 64% reported that vape displays make them think that a lot of people vape, so they are really feeding into this social norm. Thankfully, the Bill covers those aspects of promotion.

There has also been an increase in young people reporting seeing vapes and vaping imagery on social media: 25% of 11 to 16-year-olds reported that in 2020, and 41% reported it last year. On your final point about sponsorships, we are seeing quite a lot of sports-associated imagery with nicotine pouches. I know that nicotine pouches should be included in the Bill, because that is another nicotine product. We are starting to see the terminology, awareness and imagery of nicotine pouches take off among young people. This is concerning, and it is one to watch. The imagery is of it being a hit or a boost that helps you to focus. There is a big association with professional footballers; we definitely saw a gender difference in terms of the males picking up on that. For nicotine pouches, there is also sponsorship on Formula 1.

Q236 Nickie Aiken: Are they the ones that you put on your gums?

Professor Ford: Yes, it is a little white pouch. You put it underneath your lip and leave it there for up to an hour. For some of these products on the market, their displays are becoming more elaborate. The packaging is very childlike and the number of those childish packs is increasing.

The products can be incredibly strong. We have seen some for sale that contain up to 150 mg of nicotine. In terms of future-proofing the Bill and having the powers to regulate a range of products, the market is so innovative and developing so quickly that it is important to stay on top of that kind of thing.

Q237 Dr Johnson: This is very interesting evidence. I want to ask you about flavours. I note that more recently we have started to see flavours among the nicotine pouches that you have just described. I introduced a

ten-minute rule Bill last year to ban disposable vapes, because I am concerned about their attractiveness to children and their environmental impact. As part of that, I met representatives of the vaping industry, who told me that the reason they have flavours is essentially to maintain an addiction.

If a person uses a standard stop smoking device, such as a nicotine patch or nicotine gum, the natural history is that they smoke, they use the said gum or patch, they wean themselves off the gum or patch, and then they are no longer a customer providing the industry with revenue. If a person uses vapes, however, they have a choice of flavours that help to maintain the addiction. One thing we have seen with the Bill, which contains powers for the Government to potentially regulate the flavours, is that people are using the argument that it will prevent smokers from stopping smoking. They are trying to argue that flavours do not attract children, but the evidence says otherwise. Do any of you have any comments on that?

Professor Ford: It is true that the flavours are part of the appeal of these products for young people. That appeal is made up of a whole marketing mix of things, and flavours are one element of that. We know that adults like flavours as well, and they might help some adult smokers to migrate away from tobacco, so that is also a factor.

The concern is the vast number of flavours that are available—there are thousands. The way they are described is also an issue. In our pack analysis, we looked at how all the flavours are described: you have a basic flavour such as strawberry, or a flavour blend, but you also have what we call flavour concepts, which do not denote a flavour at all. We had examples such as tiger blood and koala drool. I do not know what they taste like, but they are certainly not flavours that I am aware of.

We believe that those descriptors are tapping into this youth culture and youth slang—some other kind of imagery. They go beyond the factual content of a flavour. One easy way to help to restrict the appeal around flavours would be to restrict those flavour descriptors in the first instance. I think it is great that the Bill would contain the power to go on to restrict flavours if that is the right thing to do.

Dr Branston: Can I add that these are profit-seeking companies? They will do what they can to continue to make the profits that they are making. The profits are as addictive as the products that they make, so it is not in any way surprising to me that they design their products to be as appealing as possible to consumers, as well as being as addictive as possible to consumers.

Q238 Rachael Maskell: I want to come back to the point about advertising. Should the legislation bring tobacco advertising and vaping advertising into line so that the same standards are applied across all products?

Professor Ford: That is something to consider. As I said in my previous answer, it is the whole marketing mix of the current vaping products that has led to the rapid rise in youth use. That includes not only the packaging, the retail displays, which we have spoken about, and the flavours, but the actual product design: the price, the promotion, the price promotion, the images on social media, the posters in the shop window—there are a lot of youth cues and messages in some of those—the accessibility, because of the wide variety of retailers that sell these products, and the user imagery. We find when we speak to young people that they associate vapes not with cessation, but with social vaping.

It is important for the Bill to be mindful of all of the marketing mix, and I would put sponsorship in there as well. We know that there has recently been investment from tobacco companies in outdoor advertising for their vapes, and we are seeing a lot of sponsorship of nicotine products at music festivals and music events and in the sports sponsorship that I mentioned earlier. It is really important to be mindful of all those marketing avenues.

Q239 Rachael Maskell: You have talked about alternative products. We know that the industry is very adept at switching products to avoid regulation. Should we be creating a nicotine-free generation alongside a smoke-free generation, so that people who have never smoked will also not have access to nicotine products?

Professor Ford: We do need nicotine products on the market, because we know that they can be helpful for adult smokers.

Q240 Rachael Maskell: But these people have never smoked, because, having been born from 1 January 2009, they would not have been introduced to smoking. That would be unlawful.

Professor Ford: Given the potential harm that nicotine can cause to young people, and the fact that generally everyone is in agreement that if you have never smoked, you should never vape, yes. I do not see an argument why we would need young people to use nicotine. That is my personal view.

Professor Gilmore: I would support that. These measures have been put in place in some cities in the US in Massachusetts and California, where they have implemented both smoke-free and nicotine-free generations. They have not been evaluated yet, but I know that other cities are now implementing the same policies, so I think they must have been going reasonably well. I am in touch with colleagues in the US to try to get any evidence from those measures as they emerge.

You are right: nicotine, as I mentioned, is harmful to the developing brain, so ideally we should be aiming for smoke-free and nicotine-free generations in future, in line with the smoke-free generation legislation, while making sure that current smokers are able to quit using nicotine. But that is recreational nicotine, not pharmaceutical nicotine.

Q241 Mary Kelly Foy: I think a lot of people will be quite shocked at the statistics that you have just outlined to us on the profits big tobacco is making and the shocking tactics it uses to keep users addicted, ultimately killing half the people who buy its products. I know that this is not in the Bill, but would you support a "polluter pays" levy, so that at least the tobacco industry could give something back to society for the harm it is causing at an individual level, by killing people, and at the societal level, at the expense of our NHS? Do you think that that could be added to the Bill? I do not want to put you on the spot with that question, but in principle would you support a levy on the tobacco industry?

Dr Branston: Absolutely. I would very much welcome that. It is obscene that the industry can make so much profit by killing up to two thirds of its long-term users.

Addressing that profit incentive will go a long way to stopping the interest that the industry has in selling these deadly products. As you know, those products cause massive costs to society, so I think it is entirely reasonable that the companies make a bigger contribution.

In that regard, I know that the excise tax that is currently levied on tobacco products is not directly paid by the tobacco firms—it is passed on to smokers who are addicted to those products—so the "polluter pays" levy is an idea that I would strongly support. I encourage others to do so as well. Not only does it have the economic advantage of raising money that could be used to address the harms caused by smoking, but it would restrict the industry's ability to price its products as it is currently able to. We know that it uses clever pricing tactics to make tobacco both affordable and profitable for the industry. On every level, a "polluter pays" levy would be a win-win for society, so I absolutely support it.

Professor Gilmore: I would support that 100%. If I go back to my response to the earlier question about how we have a system problem, that is the sort of measure that can help us to address that system problem. Dr Branston and I have published on the idea of "polluter pays" or using a price cap system, so there is some evidence out there, and some evaluations or modelling of the impacts it might have and the revenue it would bring in. I would really support that.

Q242 Trudy Harrison: Has anybody on the panel made any assessment of any kind of business association between the tobacco companies and the vaping companies, and also the ultra-processed food companies? The common denominator seems to be addiction. Is there any connection between those three industries, and perhaps even the pharmaceutical companies, which may be part of the solution for people who have become addicted to those three products?

Professor Gilmore: I can talk a little bit about this. We run a website called tobaccotactics.org, which you can use to look up the organisations that might be lobbying on behalf of the tobacco industry. It identifies the front groups and third parties that are lobbying for it. We know that at least some of those third parties also lobby for the ultra-processed food and alcohol industries and take money from all those industries. That certainly goes on. We also know that they use the same practices, and that sometimes all those unhealthy commodity industries have worked collectively to change whole systems of policymaking. They pushed for the better regulation agenda, for example, because they thought it would make it harder to pass public health policies and environmental policies. We have gone on to show that systems such as better regulation make it harder to pass public health policies, because they provide those powerful industries with a route to feed in their misleading evidence and data.

There is also a revolving door. You see a lot of movement of staff—executives—from one of those unhealthy commodity industries to another. The investors also link them, so there are links at all sorts of levels. To be honest, I do not know the extent to which they learn from each other about addiction and the manipulation of products to make them addictive, but it would make sense.

Q243 Rachael Maskell: I would like to ask one further question, if time will allow, about the locations where people can vape. Smoking has now been banned in indoor places, cars travelling and cars with children present. Would the same impact around deterring people from vaping occur if the same statutory requirements were put in place?

Professor Gilmore: Smoke-free legislation had a number of impacts. It was primarily there to protect non-smokers from the effects of second-hand smoke, which we know is harmful, and it was successful in that: we evaluated it and showed reductions in admissions to hospital for heart attacks, asthma and so on. We know far less about second-hand vape, if you like, but smoke-free legislation also de-normalised smoking. I think that having vape-free public places would go towards de-normalising vaping, which is also really important, particularly among younger people.

The other thing, of course, is that the more you vape, the more nicotine you are taking in and the more you are addicted. If you can do it in public places and in workplaces, you can get more and more addicted; some ex-smokers have said to me that they find that a problem, because they can just keep vaping in some places, so they are now using more nicotine than ever before. I suppose it is theoretically possible that if they were not able to vape, they might shift back to smoking, but I do not think they would: we do not have any evidence for that and I do not think that that even really makes sense. Certainly, in terms of de-normalising vaping and reducing addiction, there would be benefits.

The Chair: There are no further questions. I thank the witnesses on behalf of Committee members.

Examination of Witnesses

Professor Robert West and Professor Ann McNeill gave evidence.

4.21 pm

Q244 The Chair: We will now hear from Professor Ann McNeill from King's College London and Professor Robert West from University College London. Before we begin, I thank the witnesses for their flexibility in accommodating our rearranged schedule. We have until 4.55 pm. Would the witnesses please introduce themselves for the record?

Professor West: I am Robert West, professor emeritus of health psychology at University College London. I have been working in the field of tobacco and smoking since 1982. Most of my work involves clinical trials and large-scale surveillance of things such as smoking, vaping, quitting and so on.

Professor McNeill: Good afternoon, everyone. My name is Ann McNeill. I am a professor of tobacco addiction at King's College London. Sheila Duffy yesterday referred to me as just a psychologist. I wasn't quite sure what she meant by that. Just for the record, my first degree was in psychology and zoology and my PhD was on dependence on smoking. That included biomarker research, which I think was the context in which she made that comment, but for nearly 40 years—not quite as long as Robert—I have devoted my career to reducing the harmfulness of tobacco smoking and covered prevention, cessation and harm reduction.

I welcome the Bill, but I have a few comments on it. The smoke-free generation will, if properly enforced, remove smoking as the anomaly that it is, because we should not have cigarettes in our society, given that they are so uniquely dangerous. It will not do anything directly for the 6.4 million smokers that we have heard about. However, the Bill has helped to put smoking back centre stage in terms of its unique harmful properties. There has been a lot of noise about vaping over the past few years, so it is really good to be discussing smoking and its unique harmfulness.

It is really important, moving forward, that the Bill is in the context of a comprehensive tobacco control strategy, for which there continue to be mass media campaigns about the dangers of smoking and other smoking control strategies. That will really help to drive down health inequalities, given that we know that smoking is higher among the more disadvantaged. We have heard about that during these hearings.

To add to what Mark Rowland said, because mental health is an area I have worked in quite a bit, most of the 15 to 20-year life expectancy gap is because of the fact that people with mental health conditions are more likely to smoke. But the reason I mentioned smokers is that I think we have got to be really careful not to have any unintended consequences from the Bill that keep smokers smoking or drive people who are vaping to relapse to smoking. Though I welcome things such as putting electronic cigarettes behind the counter in shops and removing some of the packaging and branding of e-cigarettes, one area we do need to be careful of is flavours, because we know from research that they are important for smokers when they are trying to stop.

Q245 Preet Kaur Gill: Robert, can you talk about the UCL smoking and alcohol toolkit studies' findings on public views on smoking cessation and measures in the Bill?

Professor West: Yes. Probably even better is the ASH survey, particularly in relation to public views on the policies being proposed. What is interesting about both surveys is that, as many of you will be aware, there is widespread support for what some in years gone past might have seen as quite a draconian Bill that phases out smoking. That is testimony to how far we have come with the policies we have adopted, with credit to successive Governments—all Governments have kept their foot on the accelerator in addressing the issue, and it has paid off. Probably for the first time in any country in history, we are in a position where this is a serious, viable option in terms of public sentiment.

If you have not had a chance to look at the smoking toolkit study, go to smokinginengland.info. The study gives you a month-by-month analysis of key parameters, including things such as vaping and vaping in particular age groups. I do not want to bang on about vaping too much, because the key thing is smoking; but as is often the case with what they call a diffusion of innovation, when you look at the data you will see an acceleration and things look as though they are going in a terrible direction, and then at some point other factors kick in. For the last couple of months, vaping rates, particularly among never-smokers—the key people we are interested in—and young never-smokers have plateaued. We do not know whether the rates would go up again, but I think that means that if we can put a lid on it through the Bill, there is a very good chance that we could get the vaping rates down again.

Q246 Preet Kaur Gill: Ann, do the measures in the Bill equitably benefit all people affected by tobacco and vaping products?

Professor McNeill: As I mentioned in my opening comments, the people affected by the Bill will be people who are vaping and/or smoking, people who might take them up, and people around them. It will certainly drag down smoking uptake. My main issue is around encouraging people who smoke to stop, given that more people from disadvantaged groups smoke. As long as we maintain the focus on smoking with the Bill and provide support for smokers to stop—that includes vapes, which are effective tools—then yes, it can drive down the health inequalities caused by smoking.

Q247 Dame Andrea Leadsom: Thank you both very much for being here. As I have said to other health professionals, what you say can be incredibly helpful in allowing the Bill to pass through smoothly, because people make some very big challenges, namely that this is all just about freedom of choice, vaping is fine and there is nothing wrong with it. With that in mind, I would be grateful if you could try to ensure that you give us material with which to address some of those challenges.

Professor McNeill, we heard earlier that there is no evidence on what happens to a baby born addicted to nicotine or what the impacts are for that baby. I was advised that you might have a view on that.

Professor McNeill: We can certainly ensure that we provide written evidence afterwards. The more concerning issue is some of the other constituents that go through to the foetus, such as carbon monoxide, which can have a devastating effect on the baby. On vaping in relation to pregnancy, we have seen in research that when people have used vaping, it is an effective tool for stopping smoking, which is really important, and it does not have any more adverse effects than nicotine-replacement therapies. My concern would be about smoke constituents more than nicotine addiction, which is highly unlikely if nicotine is used during pregnancy. I hope that makes sense.

Q248 Dame Andrea Leadsom: To push back slightly, we know that babies are born addicted to crack cocaine or heroin. Does nicotine pass through as an addiction for the newborn baby in the same way?

Professor McNeill: I do not have the evidence for that.

Professor West: There are a lot of misconceptions about what addiction is and how it operates. We need to distinguish some of it from what we might consider to be physical addiction, which is a physiological adaptation —for example, with a baby born to a mother who has been drinking heavily, that baby's physiology will have got used to alcohol, and there will be things like foetal alcohol syndrome and so on. There are those physiological adaptations.

In the case of nicotine, as far as we can tell from the studies of people who have used nicotine replacement therapy, such as e-cigarettes or, in other countries, things

like snus—a form of smokeless tobacco with pretty high nicotine levels—we do not really see evidence of that sort of syndrome. In fact, those kinds of physical withdrawal symptoms that we see with alcohol—potentially fatal—and with heroin and so on, are more often a feature of sedative or opiate-type drugs than of stimulant drugs and are not so much a feature of nicotine.

The addiction to nicotine some people think of as psychological, but it is not really psychological; it is the impact of nicotine on our motivational system, which causes people to feel an impulse for whatever it was they were doing when they got that nicotine in the system. It forges an association in the brain. What that means is that the craving for nicotine is the thing that is driving the behaviour, rather than the need to escape the withdrawal symptoms.

That means that, for example, even non-daily smokers —in the UK, that figure has gone up quite a bit, with about 25% of smokers being non-daily—find it very hard to stop smoking. That would be odd if it were just a physiological adaptation. The craving is the big issue there. In terms of damage to the foetus from nicotine per se, the trials that have been done have not shown the kind of serious damage that we would be worried about.

Q249 Dame Andrea Leadsom: So it is other damage from smoking that is caused to newborn babies. For the record, it is important to say, in answer to those who say smoking is about freedom of choice, that a newborn baby does not choose to be impacted, or killed indeed—stillborn. What thoughts do you have about that argument of freedom of choice versus freedom of addiction?

Professor West: I think it is nonsense. One can get philosophical, so let us not do that, but the issue is that a choice is something that you make in situations where the forces operating on you are not so compelling that you end up going down a particular road. In a way, if someone puts a gun to my head and says, "You can choose to do this, but if you do it, I will shoot you," that is not really freedom of choice, although in a way it is. What addiction does is to limit your freedom of choice. If you market a product that causes people to be addicted, the only people who really have the choice in the matter are the people who use the product for the very first time and the companies that are marketing the product. Once you have a level of addiction, that level of choice becomes constrained. That is my view.

Q250 Dame Andrea Leadsom: Thank you; that is very helpful. Professor McNeill, may I ask you again about the vape flavours? The Bill takes powers to restrict packaging, location in store, and flavours. I would like to get your views on the record. Some say, "Let's choose and put the actual flavours on the face of the Bill," while other medics say, "No, you can't do that, because you will never stay ahead of the vape industry." What would your view be?

Professor McNeill: My view would be that it is quite a complex issue. As I have said, there are dangers of unintended consequences by removing flavours. Certain research that I have been involved in has shown that the flavours were important in people transitioning out of cigarette smoking, so I think one has to be quite careful about doing it. We also know that it is very difficult to characterise flavours, and that has happened with tobacco cigarettes. That is something for the secondary regulations, where it can be properly thought through. However, I think that removing flavoured descriptors from cigarette packs—as I think Dr Ford said in the last session—would be a really important measure. Our group at King's has done some work showing that that would have an impact in reducing interest in young people, while being unlikely—we think—to affect adult smokers.

Q251 Dr Johnson: I want to ask about this tension that you have kept coming back to throughout the past couple of days. Particularly on flavours, it is the idea that we need to help grown-ups who may have made the choice, have the conviction, and have some purpose to quit—bearing in mind that we know the average person takes 30 times in total to quit, so they are likely to relapse at some point—versus the need to prevent children from starting to vape. We know, and we have heard today and yesterday, that they are particularly vulnerable to addiction in their mid-teens, and that those who develop addiction to nicotine in their mid-teens—whether that be vaping or smoking—are highly likely to get their choice removed, because they will be unable to stop it. We also heard that some of those who vape will then go on to smoke. If the Government are to choose, and it may be that we have to make a choice in this matter, do you think it is more important to prevent relapse to smoking in adult smokers, or to protect children from starting on a lifetime of nicotine addiction?

Professor McNeill: I don't think it has to be a choice of one or the other; you can do both. It is a difficult balancing act to achieve, but it is important to do so. It is not about just avoiding relapse to smoking among adult vapers; it is about the 6.7 million smokers who we need to support to stop smoking quickly. They are in disadvantaged groups, and we know that children will also emulate what their parents do, so it is cyclical in disadvantaged communities. I don't think it has to be a choice. It is a delicate balancing act that we have to get right, and this Bill is trying to do that. I want to pick up on one comment—you implied that vaping is a gateway to smoking.

Dr Johnson: That is what we heard from the doctors earlier.

Professor McNeill: I think the jury is out on that. I would say that the gateway hypothesis is highly contested. It used to be invoked quite a lot in the drugs field but was abandoned because it is quite difficult to test. You cannot randomise children to environments where there either are cigarettes and vapes or are not. It has been contested, and our research and other research has shown that it goes both ways. An argument against the gateway theory is the common liability theory, which says children who take risks will try different products. That said, we obviously want to try to stop young people from vaping.

The other thing I would look at is the epidemiological evidence. In the UK, when vaping was increasing among young people, smoking was declining, and that has happened in the US and Canada, which is the opposite of what you would expect with the gateway theory. I think we can get that balance right. It should not be an either/or, and it would be detrimental to think about it in that way. Adult smoking will continue to influence generations to come, if we do not support them to stop smoking as quickly as possible.

Professor West: I agree with what Ann has said. I would put it like this: I think we can have our cake and eat it, and we have. Until the advent of disposables, the UK had a very rational policy, and it was working. The prevalence of vaping and e-cigarette use among never-smokers of all ages was very low, and it was not really going anywhere. If we look at the course of time when these new products came in and the particular rise in youth vaping, the game changer has been the disposables. The key is addressing that. I even think, if we look at the evidence, that it may be an interaction with disposables—flavours per se have been around for a long time. On their own, they were not doing much in the UK to drive vaping prevalence up. The way the Bill is crafted at the moment—if I may say so, though it is not my area of expertise—means that from an implementation point of view, it is well crafted to allow Governments to adjust their policies on vaping as might be required.

As we saw in the rapid rise in new vaping with the advent of disposables, we need to be agile. The industry is constantly coming up with things, and we need to be able to figure out how we are going to deal with that quickly, before things start to get out of hand. For example, and I agree with Ann, on a population level, we do not see a population gateway effect, in the sense that as vaping has increased, we do not see a knock-on effect on smoking—but we could. We could have a situation where, if we have loads of vapers out there who have never smoked, and somehow we discourage them from vaping, smoking becomes the easiest thing to do. These are difficult balancing acts—there is no question about it—but the fact that we have achieved a pretty successful strategy in the past gives me confidence that we could do so again.

Q252 Dr Johnson: I find what you say about the disposables interesting. A year ago last February I proposed a ten-minute rule Bill to ban disposable vapes to protect the environment and children, and the Government now have a statutory instrument to do just that. I heard today from representatives who have been to those meetings that the industry is already working around those many pages of regulations to find a way to create something that just sneaks in under the balance.

Professor West: That is the tricky thing. We can ban disposables as currently construed, but once the genie is out of the bottle, as it were, and with humans being innovative, as they tend to be, especially when they can make money out of it, it will be terribly hard to nail it so that, basically, we can put the genie back in the bottle. That is why the sort of approach that is being adopted makes good sense to me so that we can respond quickly, or so Governments can do what is necessary.

Q253 Trudy Harrison: Professor West, I found your introduction on addiction absolutely fascinating. One of the things that people have said to me—I am sure it has been said to all of us here—is that could be a slippery slope, the thin end of the wedge, because there are other addictive things in society, such as alcohol, ultra-processed foods or gambling. Where do we start? What is it about tobacco products, uniquely, that gives such a compelling reason for the Bill being so necessary?

Professor West: That is a really good question. The wedge issue comes up a lot. Essentially, what is unique about tobacco is the significant degree of harm at low levels of use. With alcohol, it has been and could be argued, there is at least some degree of harm from so-called moderate use, the level of harm is of an order such that, I think, most people in society would say, "Well, you know, this is okay." Even non-daily smoking, however—even smoking one, two or three cigarettes a week—can present significant harm, particularly of cardiovascular disease, for example, which has a very nonlinear function relating the exposure to the risk. So there is that, the unique harm.

The other unique thing about tobacco is the proportion of users who become addicted. With alcohol, alcohol dependence as it would normally be measured is present —depending on your definition—in between 5% and 10% of users. With tobacco and cigarettes in particular—not all tobacco or nicotine products are identical, but with cigarettes in particular—it is much higher than that. A majority of people who use any amount, and any form, of smoked tobacco probably have a significant level of addiction. That would be my response.

Q254 Mary Glindon: We know that in deprived areas there is high incidence of smoking. Professor West, you have been talking about the fact that disposable vapes becoming more readily available has perhaps made more people vape. Is that in any way linked to people in deprived areas being able to afford vaping more than they could if they have to buy a unit, vials, batteries and everything else? Although the Bill does not ban disposable vapes, how valuable and important is the economic value to people in deprived areas of being able to vape cheaply as opposed to smoking?

Professor McNeill: Very. Keeping vapes accessible, both in terms of price and where they can be purchased, is really important for smokers to stop.

Professor West: I was going to reinforce the point about young people, smoking and disposables. It is about the unit cost, or having a low start-up cost. With disposables, if you look at it over the long run they are more expensive than having a tank device and refilling it with the liquid, but the upfront cost is greater. We do not know for sure, but certain bits of evidence point in particular directions. If you put the unit cost, or the start-up cost, together with the potential ease of use, the appeal and all the rest of the things in the package, you reach a point at which arguably you cross a threshold and then it begins to take off. Then it becomes a self-fulfilling thing, because it becomes fashionable and faddy. It is possible, if the plateau we are seeing now carries on or if it starts to go down in the absence of what we might do, that will also be testament to the social norm side of it. Running against that is the fact that nicotine is addictive, so that will drive it up. However, I think you make a good point.

Q255 Dr Cameron: I am interested in the psychology of vaping. Do you see that as being somewhat different, particularly for younger people, from smoking? Is it seen as more fashionable because of the packaging and the social media around it, perhaps because of the flavours and so on, or is the psychology for both much the same?

Professor McNeill: I certainly think the cartoon packaging and names are inappropriate and clearly targeted, at young people, as I think the previous speaker said, and they are unnecessary. As she said, they are

probably not having the effect we want with adult smokers in making them feel that these products are for them, so I do think about reducing that branding. The promotions on social media seem to be important and influential, so if something can be done about that, that would be good. I also think the easy accessibility in shops is a factor.

Q256 Dr Cameron: But is it more fashionable to use vapes for young people than to smoke?

Professor West: I think that is right. What was interesting is that I talked about having your cake and eating it, and we were doing pretty well until recently. A key factor there, if you look at the sentiment among young people and what they thought of vaping, was that it was an old person's thing to do to help them stop smoking. That is what we want; we want people to think of vapes as a thing you use to help you stop smoking. Unfashionable, but useful.

The Chair: Rachel Maskell. Yours will probably be the last question.

Q257 Rachael Maskell: I want to follow on from that theme on advertising and to take your opinion about advertising, promotion and sponsorship. We have seen the vaping industry very much following the lines of how the tobacco industry evolved in the way that it is very adept at promoting its products. Should there be a ban on advertising as there is for tobacco? First, for simplicity, so everyone knows what the rules are, and secondly, for effectiveness—that is, to discourage a new generation of vapers?

Professor McNeill: My view is that there is a bit of a danger if we put smoking and vaping on exactly the same footing. One problem we have behind the perception about the relative risks of the two products is that, for example, fewer than one in 10 smokers knows that vaping is a lot less harmful than smoking, so I would be wary of putting them on exactly the same footing. It is important that we try to distinguish the relative risks through what we do. I think we can further reduce the advertising of e-cigarettes, particularly, as I have said, in shops, because that seems to be one area where young people can buy these products that are heavily promoted, and the branding is in itself a form of advertisement.

Professor West: I agree. I think the key thing is the messaging in the advertising. It is already the case, if I understand it right, that you are not allowed to advertise e-cigarettes as a fashion item or leisure product.

Q258 Rachael Maskell: They are on football shirts. When we pressed a company that came to our Select Committee, they said, "This is a public health message." They did not have "do not smoke" on the shirts, so I did not buy that, because they are trying the same tactics.

Professor West: That, in a way, is a question of implementation. I agree with you. Just putting a brand on a shirt is not a message saying, "This can help you stop smoking." If they had put, "Use this to help you stop smoking" on the football shirt, maybe it would be a different thing. Ann's point is also a very important one.

The weirdest sort of miscommunication that we have had over recent years is that as evidence has accrued that e-cigarettes are less harmful than smoking, the perception that they are more harmful than smoking has increased. Obviously, there is a whole bunch of things going on, but it is a deterrent. Not only do we know this from the surveys, but I have been talking to a lot of people—intelligent academics even—who say, "Why would you switch to e-cigarettes? They are just as harmful as smoking." We are not getting that message across.

Whatever we do in relation to indirect messaging that might create a sense of equalisation or equality between e-cigarettes and smoking, we have a big comms job to do to make sure the message gets across that it is not the only method of stopping smoking, but it is an important one that a lot of people can use even if they do not, for example, use stop smoking services.

The Chair: Mary Kelly Foy has the final question.

Q259 Mary Kelly Foy: When I was first involved in tobacco control over a decade ago, at the advent of vapes it was said, "This is shocking. It's awful. It will keep that normalisation of smoking, because it is that habit of putting something in your mouth and it is cool. Let's not use vapes." But over time I have come to learn that that habit is great for people who are trying to quit smoking, so vapes are seen as a positive tool. Has that put back the denormalisation of smoking for young people? I do not think they would go around saying "Let's get a nicotine patch". You have not seen any aspect of that? It has not slowed down that denormalisation?

Professor McNeill: No, and that is why it is important to keep them separate, and their relative risks.

Professor West: What is really interesting about the concern that people had, which is perfectly reasonable a priori, is that people can tell the difference. There has been no sense in which the increase in vaping has led to an increase in the sense that all smoking is okay.

The Chair: On behalf of the Committee, thank you. That brings us to the end of this afternoon's sitting.

Ordered, That further consideration be now adjourned. *—(Aaron Bell.)*

4.55 pm

Adjourned till Thursday 9 May at half-past Eleven o'clock.

Written evidence reported to the House

TVB 19 Japan Tobacco International (JTI)

TVB 20 Nishi Patel

TVB 21 New Nicotine Alliance

TVB 22 Hunters & Frankau Ltd.

TVB 23 David Francis, Senior Enforcement Officer, Aberdeen City Council

TVB 24 European Smoking Tobacco Association (ESTA)

TVB 25 Andrej Kuttruf, CEO, Evapo

TVB 26 The Asian Trader, Asian Media Group

TVB 27 Carol Fraser, Senior Trading Standards Officer, North Lanarkshire Council

TVB 28 UK Vaping Industry Association (UKVIA)

TVB 29 Hon. Wan Saiful Wan Jan, Member of Parliament for Tasek Gelugor, Malaysia