OFFICIAL REPORT
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Health and Sport Committee

Tuesday 17 April 2018

Session 5

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HEALTH AND SPORT COMMITTEE
12th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Olivia Allen (Asthma UK)
Louise Feenie (Scottish Government)
Professor Sally Haw (Clean-air Legislation Evaluation Collaboration)
Jane-Claire Judson (Chest Heart & Stroke Scotland)
Daniel Kleinberg (Scottish Government)
Dr Miranda Loh (Institute of Occupational Medicine)
Professor David Newby (University of Edinburgh)
Dr Colin Ramsay (Health Protection Scotland)
Shona Robison (Cabinet Secretary for Health and Sport)
Claire Shanks (British Lung Foundation)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 April 2018

[The Convener opened the meeting at 10:00]

Preventative Agenda (Clean Air)

The Convener (Lewis Macdonald): Good morning and welcome to the 12th meeting of the Health and Sports Committee in 2018. I ask everyone in the room to please make sure that their mobile phones are off or set to silent. While some may wish to use mobile devices for social media purposes, please do not use them for recording or photography as that is done for us by our parliamentary staff.

The first item on our agenda is our round-table evidence session looking at the health implications of clean air. This is part of our inquiry into the wider preventative agenda. It is a timely session, as there is a debate this afternoon in the chamber on the Environment, Climate Change and Land Reform Committee's inquiry into air quality in Scotland. I know that some of our witnesses today will be following that debate with interest, as our members will be, so this session will give a useful health perspective on that issue.

We invited both Edinburgh health and social care partnership and NHS Greater Glasgow and Clyde to send representatives to attend this session but, unfortunately, neither was able to do so, which is regrettable. However, we do have some excellent witnesses here today. In the usual way of round-table sessions, I will introduce myself and then we will go round the table. I am the convener of the committee.

Ash Denham (Edinburgh Eastern) (SNP): Good morning. I am the MSP for Edinburgh Eastern and I am the deputy convener.

Jane-Claire Judson (Chest Heart & Stroke Scotland): Good morning. I am the chief executive at Chest Heart & Stroke Scotland.

Miles Briggs (Lothian) (Con): Good morning. I am a Conservative MSP for Lothian and party spokesperson on health and sports.

Professor Sally Haw (Clean-air Legislation Evaluation Collaboration): Good morning. I am professor of public and population health at the University of Stirling.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning everyone. I am the Liberal Democrat MSP for Edinburgh Western and the party's health spokesperson.

Olivia Allen (Asthma UK): Good morning. I am policy officer for Asthma UK.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Good morning. I am the Scottish National Party MSP for Mid Fife and Glenrothes.

Emma Harper (South Scotland) (SNP): Good morning. I am a South Scotland region MSP and I am the convener of the lung health cross-party group.

Professor David Newby (University of Edinburgh): Good morning. I am British Heart Foundation chair of cardiovascular and cardiology at the University of Edinburgh and I have a long-standing interest in the cardiovascular effects of air pollution.

Alison Johnstone (Lothian) (Green): Good morning. I am an MSP for Lothian.

Dr Colin Ramsay (Health Protection Scotland): Good morning. I am from Health Protection Scotland and I am a consultant epidemiologist in environmental public health.

Ivan McKee (Glasgow Provan) (SNP): Good morning. I am the MSP for Glasgow Provan.

Dr Miranda Loh (Institute of Occupational Medicine): Good morning. I am a senior exposure and environmental scientist at the Institute of Occupational Medicine.

Brian Whittle (South Scotland) (Con): Good morning. I am a South Scotland MSP and party spokesperson on health education, lifestyle and sport.

Sandra White (Glasgow Kelvin) (SNP): Good morning. I am the MSP for Glasgow Kelvin.

Claire Shanks (British Lung Foundation): Good morning. I am policy and public affairs officer for the British Lung Foundation Scotland.

David Stewart (Highlands and Islands) (Lab): Good morning. I am a Labour MSP for the Highland and Islands.

The Convener: Thank you very much. We will move in a moment to questions. The routine, as is usual with parliamentary committees, is that I will invite colleagues to ask questions. Please feel free to indicate that you wish to answer; questions and answers through the chair, please.

David Stewart: Good morning colleagues. The European Court of Justice has been the guardian of air quality for almost 40 years and currently eight European countries are facing action, taken by Client Earth, for poor air quality. Once we complete the Brexit process, who, or what organisation, will be the guardian of the environment in Scotland?

The Convener: Who would like to start with that large-picture question?

Claire Shanks: As an organisation, we are calling for a clean air act that covers the whole of the United Kingdom, that is because of the confusion as to where the power is going to sit in the legislation. At the moment there are many layers. There is legislation from the European Union, there is the Department for Environment, Food and Rural Affairs, the Scottish Government, and the local authorities. When we have spoken to different decision makers, there is confusion as to where the power sits and who is responsible. For example, air quality management and local air quality guidance is interpreted very differently across local authorities. That is why we think there should be a new piece of legislation that brings it all together so that, post-Brexit, there is much greater clarity for everyone.

The Convener: Is it a widely held view that we need additional legislation? If so, where should that legislation sit? Should it be at Westminster or in the devolved Administrations, as appropriate? Have those involved taken a view on these matters?

Jane-Claire Judson: In general, we know that air quality is something that affects local communities in particular so, wherever the legislation sits and whoever holds ultimate accountability, there definitely has to be accountability at a local level, as well as the resources to be able to make decisions and to make the changes that have to happen. We know that in Scotland that has not happened in the areas where we want to see lower emissions. It is critical that we look at the accountability for that and how we could speed up that process. There is a discussion to be had as to whether the legislation is held at Westminster or in the Scottish Parliament, and that has to flow into how we empower people at a local level to be able to make the changes that they need to make.

There is a secondary issue around the involvement of the private sector and industry with regard to air pollution and clean air and how that works, whatever the devolved settlement may be. There are still some questions as to how Brexit will impact on that. There is quite a lot of detail behind it and that might affect how the legislation will pan out throughout the devolved Administrations of the United Kingdom.

David Stewart: Jane-Claire Judson makes a good point. There are obviously lots of things that we do not know about the current negotiations, but what we do know is that the UK Government is withdrawing from Euratom, which governs medical isotopes, because of the ECJ. There is also some doubt about whether the EU emissions trading scheme will continue, which is the point that Jane-Claire Judson was making. Yes, of course that could continue within the UK, but the beauty of the current scheme is its scale, as it is the scale of having 28 countries that enables the scheme to run correctly.

I promise you that I will not read this out, convener, but I had a quick glance at the leading ECJ cases on the environment and the information went to 80 pages. That is what has happened over the past 40 years. My worry is about what is going to happen post-Brexit, because who is going to enforce environmental legislation on air quality if we are not in the ECJ?

The Convener: Does David Newby have a view on these matters?

Professor Newby: I support the comments of Claire Shanks and Jane-Claire Judson. We need clarity. This is an important topic that we must address and there has to be very clear guidance. We need to keep the momentum going. There is a danger that it could slip.

Professor Haw: I agree very much with what has been said so far. This is critical from the point of view of accountability and monitoring. If it is not clear where the lines of responsibility are, it is very difficult to evaluate and monitor the impact of the policy and the legislation.

Sandra White: I want to touch on an area that Jane-Claire Judson mentioned, as what happens in local communities is crucial. Lots of local communities are not all that au fait with finding out about air quality monitoring, although some are very well educated in that regard. Jane-Claire Judson mentioned data. Do you think that data should be collected by each community and perhaps fed into health boards?

Jane-Claire Judson: You make an excellent point, which relates to work that we have been doing to look at how we empower local communities to have that information. The cleaner air for Scotland strategy mentioned having a public air quality communications campaign, but that has not come to fruition. There are always issues with those types of campaigns and I believe that they are best delivered in partnership with local communities and the third sector if they are to hit the communities where they could make the most impact.

As for data, yes, if you do not know what is happening in your own community, either as an individual or as an authority or organisation working there, it is very hard to make those decisions. One of the key things that we are concerned about is children in schools and children who have asthma; we need to manage the air quality in those areas, and we need to have the data to be able to look at that and monitor it.

I will also mention admissions to accident and emergency departments. We need to link that data to what is happening locally around air quality and look at that in relation to chronic obstructive pulmonary disease, particularly in the winter, which has been a particular issue, as about 50 per cent of admissions for COPD through the front door of the NHS are during the winter. Taking that into account and joining the data up is particularly important. I would look to the new public health body, in connection with its work with the Information Services Division, to ensure that data is available so that people can make decisions locally.

Claire Shanks: I would reiterate a lot of what Jane-Claire Judson said. This is something that the British Lung Foundation also feels very strongly about. We are calling for much better monitoring around schools, care homes and hospitals. We want to tackle air quality to protect people's health and we know that the most vulnerable people here are those who are older, those who have pre-existing health conditions, and those who are young. If we are not monitoring those areas for those people, and also those in deprived communities, we are not getting the fullest picture possible.

In England we set up a clean air parents network, which is empowering local parents to engage through schools and with their local authorities to look at local measures that can be taken for local air quality issues. That has been very popular. It has empowered the local community to make those decisions and help come up with solutions.

Emma Harper: I have a quick supplementary question about monitoring. When I was on the Environment, Climate Change and Land Reform Committee, as was David Stewart, we began the air quality inquiry. We looked at how many monitors there were in Scotland. There were only 95 and we talked about those around airports and ferry ports as well, as the people living there are also being exposed. Should we invest in more monitors, mobile or fixed, so that we can measure the quality of the air in other areas, not just around schools?

Dr Loh: I second the call for more data. There is a lack of information about the spatial distribution of pollutants. A lot of the monitors may not measure a wider range of pollutants and this kind of information would be useful.

Although mobile monitoring is useful, I would also call for long-term monitoring at various sites, which is good because it allows us to look at trends over time. Looking in the short term, we do not always know whether there is a true decrease or increase in pollution because variables such as the weather can influence air pollution concentrations.

Professor Haw: I am not sure whether the committee wants to go into this at this stage, but I think that the whole question of monitoring and evaluation is extremely complex and the first thing would be to set up an interdisciplinary group, if one does not already exist, to look at the strategy and set in train a series of actions that need to be taken to monitor and evaluate. Critically there must be baseline data before implementation and also sufficient follow-up. Often those are things that are not considered. What we are monitoring—what the metrics are, whether it is average daily or average annual—is so complex that we need to look at this in more detail and I believe that it is the place of an expert working group to do that.

Olivia Allen: Going on from what everybody has said, I believe that it is important that the data is not collected in silos. Joining the data up is key to ensuring that we have a uniform approach. As Jane-Claire Judson mentioned in connection with local authorities having some accountability, it is difficult for them to have that if there is no oversight over what they are supposed to be doing, so joining the data up would be important in order to achieve that.

Ivan McKee: The area that I want to explore, which follows on from how we measure things, is the scale of the problem. Getting a sense of that may help us focus on how we go about tackling it, because from reading through our papers, I see that there is conflicting data. At one level, there are some big numbers in there about the numbers of deaths and how they compare with road accident numbers, and how they are much worse at a societal level. That is obviously a high-profile issue in itself. Then, when you drill into some of the data points, there is something from the British Lung Foundation that says that only 3.5 per cent of emergency respiratory and cardio admissions to hospitals were due to air pollution, which means that 96.5 per cent are due to something else, which suggests that there are much bigger fish to fry if we are trying to tackle that particular issue. We need to understand that.

The second part of that is that we are talking about numbers that appear to be low and coming down. The EU standard for 2020 on $PM_{2.5}$ is 20 micrograms per cubic metre; the World Health Organization standard, which the Scottish Government has signed up to, is 10 micrograms per cubic metre. The Scottish number is now down to 5 micrograms per cubic metre and coming down, which suggests that we are not in a bad place and are going in the right direction, but that again runs counter to some of the other messages that are coming out, so we need to understand where we are in that.

Is $PM_{2.5}$ the key thing that we should be measuring, or is PM_{10} important? How important are NO_2 and NOx? Are there other things that we should be measuring as well?

10:15

The third part of it is what the biggest impacts are. We tend to focus on vehicle pollutants. Are they the lion's share of the problem? We do not have any data on that. Agriculture is mentioned. Wood-burning stoves are mentioned. Is it cars, is it buses, is it freight? Is there any data that says what has the biggest impact? If we fixed the car thing and had 100 per cent electric vehicles, would that fix the problem? What impact would that have on the numbers?

There is a lot of stuff in the data that I am not clear about. Others may have more perspective to share on that, on how big the problem is and on where we should be focused.

The Convener: There is a lot in there. Can we start with Colin Ramsay?

Dr Ramsay: There are lot of questions in there. To take the last one first, as it is the one that I remember most clearly, transport-related air pollution in general is probably the biggest contributor to preventable air pollution that we can tackle now. That relates to any combustion-engine vehicle, so it is not just cars but buses, lorries, and so on. What the major contributor is may be location specific. Glasgow, for example, has done a lot of work analysing the traffic mix in the centre and has identified that buses are contributing significantly to the excess nitrogen dioxide and the PM pollution layer, whereas outside the centre of Glasgow, cars are contributing relatively more. It is not a simple picture, by any means, but the message essentially is that combustion-engine vehicles are a significant cause of traffic-related pollution, and the targeting is currently focused on trying to reduce that.

The data issue is incredibly complex. To summarise it, the best, most robust evidence is in relation to particulate pollution and $PM_{2.5}$ especially; there is all the work that has been done by the Committee on the Medical Effects of Air Pollutants, for example. It came out with the robust estimates of the effect of excess $PM_{2.5}$ pollution on mortality, and it looked at cardiovascular fatality, lung cancer and so on. It did a review of all the information a number of years ago—I think that it was published in 2010—and came out with the estimates that are commonly bandied around now, such as the estimate that with an increase of 10 micrograms of $PM_{2.5}$, there is a 6 per cent increase in overall mortality. There will be an updated report coming from COMEAP on that, but I think that the message is going to be that that figure of 6 per cent excess mortality across the board is a robust estimate, based on newer international studies.

The evidence in relation to other pollutants is more controversial, particularly for nitrogen dioxide. Again COMEAP is in the process of finalising a report, which is a review of the evidence in relation to nitrogen dioxide and nitrogen oxides in particular, and it is much more difficult to quantify precisely what the impacts of those are because there is a very clear interrelationship between particulate pollution and nitrogen dioxide pollution, for example. There are also effects due to other pollutants, such as ozone, and again that varies, depending on the circumstances. Ozone, paradoxically, is often high in rural communities because the ozone is mopped up in urban areas by the other pollutants. It is a very complex picture in terms of the data.

We have been looking more recently at trying to get a better handle on the data in Scotland and have been working with some colleagues in the University of Glasgow and the University of Strathclyde to look at that. We have been trying to look at it on a small-area basis, trying to estimate what the impacts of low-emission zones might be. The evidence that we have looked at most recently tends to suggest that the strongest associations in terms of an identifiable impact are to do with respiratory hospital admissions and $PM_{2.5}$. The association with nitrogen dioxide is far less and that is important, because the focus of low-emission zones is on nitrogen dioxide rather than particulates.

I could go on at great length, but the short message is that it is a very complex picture. We are continuing to accumulate more data on it, but the consistent message is robust, in that particulates especially are a key issue, although other pollutants are also important and it is important that we try to reduce all of them.

Professor Newby: I support Colin Ramsay's comments. If you are going to pick one thing to measure, $PM_{2.5}$ is probably the best one to pick. We can argue about all of that, but we need better $PM_{2.5}$ monitoring, certainly in Scotland, because often it is just PM_{10} that is recorded. We need better monitoring because $PM_{2.5}$ is the key thing to measure.

The second point that I want to flag up is the traffic issue—that is the biggest issue. Air pollution exposure all maps to the transport corridors. A lot of air pollution is down to traffic, and where there is traffic, there are people, so the traffic issue should be the main focus.

Ivan McKee's first question was whether air pollution is that important. If we look at the global assessment of avoidable causes of death—and there are many of those, including obesity—the

top 10 causes include three that are to do with air pollution; in the top five causes, there are two, and one of those is mostly to do with traffic-derived air pollution. Air pollution is definitely up there as an avoidable cause of death.

That is a global perspective. What about Scotland and the UK? It is still just as relevant here. We need to sort this problem out. We need cleaner cars and cleaner engines; they are coming, but we need to encourage that. I have an electric car but I have trouble plugging it in. What is going on?

As you saw, I walked in with my cycle kit. Why do I have to cycle in diesel-infested traffic? For my self-righteousness, I get to be pushed into the bus lane with the taxis, which are all diesel. What is going on? We need to do better than that, surely. We need to be encouraging people to cycle. Why do people not cycle on the roads? Because it is dangerous and because of the pollution. We need to sort that out.

Of course, it is not an instant fix. There are many barriers to getting people to choose active travel, but these are the sorts of things that we need to fix and we need legislation to help us encourage people to do the right thing.

Claire Shanks: To pick up on Professor Newby's point about active travel, it is absolutely crucial because it means getting cars off the road. Not only are cars the biggest emitters of pollution in the urban areas, but if we tackle car use, that has bigger public health benefits. If we get people outside, walking and moving, it goes across different health policies as that helps to tackle obesity and mental health issues.

There are much bigger benefits here. That is why things such as low-emission zones and clean-air zones have to be ambitious because there is no point in just adding a few electric vehicle charging points, although they are important. We need to be ambitious. We need to talk about changing cities so that it is much easier for people to walk and cycle to work. We need to tackle private car use. The approach has to be all-encompassing. Glasgow City Council's first attempt at a low-emission zone has been quite disappointing because it does not seem to go as far as it needs to.

Jane-Claire Judson: I totally accept Ivan McKee's point that when you look at the figures, it is sometimes difficult to understand what we should be doing; it is difficult to compare different figures and work out what the biggest problem is. As a charity, we have been looking at it from a slightly different standpoint. If we count up the number of people with COPD and the number of people who have any sort of chest condition—idiopathic pulmonary fibrosis, for example—we are looking at about 600,000 people in Scotland. If we look at asthma alone, over 350,000 people will have had it at some point. People might grow out of childhood asthma but they will have been affected by it.

Those numbers are big and they are quite scary. Even if those people are not admitted to hospital through A and E, or even if what they have does not show up as an acute condition, they will be affected by it day to day. Those 600,000 or so people are not sitting in clean air all the time. There may be some who are, but most people will not be. For us, that is a big issue.

There is a second issue around stroke and heart disease. We know that particulate matter affects that as well. We tend to think about clean air in relation to people with chest conditions, but it is broader than that, and we have to take that into account. There are other effects on people's health. If we start to add those numbers up, probably one in five of the population is directly affected by air quality every day.

There is something else to consider. I totally agree with Colin Ramsay and David Newby's comments and I quite like the fact that David Newby is also bringing just a little bit of temperate anger to the discussion in relation to his particular situation. That is absolutely right; we have to take quite a big step in order to tackle this issue. In terms of active travel, I used to cycle but I do not anymore, because it is far too dangerous. We have a culture in Scotland that is not replicated in northern Europe. For example, Copenhagen has weather similar to ours, so we cannot use the excuse of rain. Transport is the biggest problem in terms of encouraging active travel.

Transport is also the biggest problem in relation to people accessing employment and the health service. The health service itself, as the submissions to the committee have said, is part of the problem because it is one of the biggest employers, so we have to look at that matter in the round.

There also needs to be a shift in thinking. When we look at what happened with tobacco, it was about a shift away from the rights of an industry to sell an addictive product towards the rights of people to have access to clean air. That was difficult to achieve—it took a long time—and this Parliament took a great stand and showed great leadership on the issue. We have to move towards a similar position in this case. We also need to move away from just talking about it from an environmental perspective—important though that is—to talking about it in relation to disease prevention and thinking about it in a more holistic manner.

Air pollution affects everybody in Scotland at some point because ultimately, one thing that we all do is breathe, and we cannot get away from that—that has to happen for us to continue to live. We need to put that level of importance on the issue and make sure that we see it as a priority.

Professor Haw: My comment follows on very nicely from what Jane-Claire Judson said. She mentioned tobacco. I was involved in evaluating the impact of the Smoking, Health and Social Care (Scotland) Act 2005, and the effect was really quite dramatic. It was estimated that prior to the introduction of the legislation, there were 865 deaths per annum from second-hand smoke. The dynamics are a little bit different in the case of air pollution, but an estimated 2,000 deaths a year in Scotland are associated with air pollution, so the potential impact of legislation is quite considerable.

The evaluation of the health consequences of the 2005 act showed an improvement in respiratory health, a 15 per cent reduction in childhood asthmas and, dramatically, a 17 per cent reduction in acute coronary syndrome—that is essentially a heart attack. That improvement was really across the board. We saw a population-level fall in exposure and also, quite unexpectedly, an improvement in perinatal outcomes. This has also been measured in terms of improvements in air quality and outdoor air pollution, so the potential here is considerable but it needs to have a structure for implementation, enforcement and evaluation.

I also want to pick up on a question that Ivan McKee asked, some time ago now. The very first question that he asked was about how we can understand this. We have sudden acute admissions as a result of air pollution but we need to differentiate between the acute effects of exposure to air pollution and the longer-term effects. In a sense, the longer-term effects of long-term exposure, which relate to the earlier points about community, are really quite considerable. We need to bear in mind those two things.

Olivia Allen: David Newby mentioned behavioural change. It is key to be able to facilitate that behavioural change. Individuals cannot manage it on their own. Although electric cars are important, it would be great to get more cars off the road overall, electric or otherwise, so creating an environment where people can cycle, walk and run outside is really important.

As it stands, people with asthma have to make their own behavioural change when it comes to things such as air pollution by avoiding going outside. That is a really drastic decision—it affects their ability to work or to attend school, and it creates social isolation. It would be much easier for everybody if we could create an environment that we could all live in quite comfortably as opposed to individuals from the more vulnerable sections of society having to stay inside all day.

David Stewart: I have a quick supplementary—it is an observation rather than a question. We also need to look at the role that freight plays in our cities. Freight is very polluting. When I was on a previous committee, I went to the Netherlands to see consolidation centres—freight goes to outside the cities, and low-emission electric vehicles are then used to take freight from the large warehouses. I was on an electric bike, for example, to take freight, which was fascinating. However, that requires a step change and, as Olivia Allen said, a change in attitudes.

Let us remember that, as Alex Cole-Hamilton will know, when we had a referendum on congestion zones in Edinburgh, it was defeated. We have to take the public with us, and that includes hauliers. I agree that we have to give up something to get a longer-term gain, similar to the smoking ban, but that does not mean that the public are necessarily with us on that currently. The worry that I have, as a politician, is how we make that step change.

10:30

The Convener: That is a very fair point.

Ivan McKee: That was an excellent discussion and I thank all of the contributors to it. You have clarified a lot of things for me. I was a bit concerned to hear Colin Ramsay's comment that low-emission zones are focused on NO_2 rather than $PM_{2.5}$, whereas $PM_{2.5}$ is considered the biggest issue.

To follow up on the point about electric vehicles, what I also heard was that it is the internal combustion engine that is the problem. Does that mean that if tomorrow, we had 100 per cent electric vehicles, it would largely fix the pollution issue? I completely understand the active travel issue and I am not dismissing that, but that is a different debate that we can deal with separately; nobody is more supportive of active travel than I am, but if we could wave a magic wand so that tomorrow, we had 100 per cent electric vehicles, would that largely fix the $PM_{2.5}$ air pollution issue?

Dr Ramsay: It would certainly help to reduce it further. You have to bear in mind that not all $PM_{2.5}$ is associated with transport. There is $PM_{2.5}$ from other sources, which we can do nothing about—transboundary airflow, and so on. Also, even if you have vehicles that do not have combustion engines, you have tyre wear and brake wear, which contribute to fine particulates as well, so unless you get rid of vehicular transport altogether, it is unlikely that you would massively reduce $PM_{2.5}$.

We have to bear in mind the current context in Scotland. The fact of the matter is that if you look at the levels and the trends, although all of us want to try to improve things, we have to acknowledge that Scotland has one of the lowest levels of $PM_{2.5}$, based on current monitoring. We have to be realistic about the scope for reducing it further. Clearly, the area that we can tackle is the preventable use of combustion-engine transport. However, we have to be realistic about what the ultimate target might be and how much more room there is for reduction.

The Convener: Presumably, on buses and freight, which have been mentioned, hydrogen power is equally effective in removing that impact.

Dr Ramsay: Yes.

Professor Newby: Not all $PM_{2.5}$ is made equal so although I completely agree with Colin Ramsay, I would add that the combustion-derived $PM_{2.5}$ from traffic is the one that causes the health problems. There is some evidence around the effect of tyre wear, but the predominant adverse effect is from the pollution. If you said to me that traffic was all electric—lorries, cars, and buses—that would be absolutely brilliant, and I believe that it would make an impact and reduce pollution.

Our air pollution levels may be brilliant, but where are we monitoring pollution and where are the people? Some of these monitoring stations are not on Sauchiehall Street or Princes Street, so you are getting background levels. The monitoring stations are designed to look for background levels but when you are actually on the road, the levels are very high and of course they exponentially decay as you move from the roadside because they disperse very rapidly.

What someone will experience at the roadside will not be reflected by the monitoring stations. The trend might be reflected, but overall, the actual level at the roadside will be very different. Of course, if we think about vulnerable groups, children are in buggies right down where the exhaust pipes are. People need to remember these issues before being too complacent that we have some of the best air quality in the world.

Of course, Scotland is a rural country, so there are issues about traffic dispersion as well. We should not be too complacent about this. We touched on the need for more monitoring and perhaps we also need to be monitoring in more appropriate places, where people live and work.

Brian Whittle: I associate myself with some of the comments that David Newby made about active travel and how difficult it is to get on your bike. I am doing it less and less these days for exactly the reasons he gave—because of the pollutants and also the state of some of the roads.

Something that strikes me about electric cars is that if we manage to get many more electric cars on the road, we will be more likely to travel on our bikes because there will be less pollution. However, active travel requires a big shift change in planning. Are we aggressive enough in our transport infrastructure planning? When there is major transport infrastructure redesign, is enough cognisance given to active travel? What role should planning play in that environment?

Professor Newby: Sorry to bring the trams into this but if, instead of spending that amount of money on an electric thing that goes on one track, we had spent it on making the centre of Edinburgh a cycle-laned, pedestrian area, and adding protected cycle lanes across the city, what a difference that would have made. Planning is key to this. We have inherited beautiful historic cities across Scotland and creating cycle lanes is not easy, but many places in the world have done it. Europe has done it. Europe has an historic past and yet it still manages to deliver that. We definitely need better planning.

Dr Loh: Colin Ramsay mentioned the issue of low-emission zones being based on NO_2. There is this idea of meeting regulations and then there is the idea of making a better place for people—a better place is what we would all like to see. You can always do better, even if you meet the regulations. You do not want to just stop there. We can do things such as get more cars off the road—it is great to have no-emission cars but there are still issues around that.

We want to make a place that is healthier for everybody, so taking a broader approach is important—that is really the way to address this. It is not just about targeting one thing—it is not just about having low-emission zones or about targeting freight, for example. However, by addressing freight issues, you are making the city a nicer place to be in. It requires a very broad approach and things that do not necessarily seem very obvious ways to address air pollution may also have an impact.

There is another thing that we need to be concerned about. We do not want to just move air pollution; we want to make sure that everybody is positively impacted, and avoid some unintended consequences of policies such as shifting bus routes, or just moving more polluting vehicles to another community.

The Convener: Alex Cole-Hamilton has a question on the same theme.

Alex Cole-Hamilton: My question picks up very nicely on the last two contributions. As things stand, 5 per cent of my constituents in Edinburgh Western will die because of air pollution. Edinburgh is top of the pops in that rather

macabre league table of preventable deaths that are caused by poor air quality. My constituency has two of Scotland's top 10 most polluted streets in St John's Road in Corstorphine and Queensferry Road, so the issue is really important to me. Of course, it is important to everybody.

From what we have heard about planning, air pollution is not considered in whether planning decisions are granted. For example, we have had a proliferation of housing developments in west Edinburgh, which are feeding the arterial routes and adding traffic, which Professor Newby described as being key to the problem.

In finding a whole-place solution, do we need to change planning legislation so that planning permission will be refused if a development would compound those really toxic zones? Are we ambitious enough on the switchover to electric vehicles when it comes to the dates that the Governments here and at Westminster have set for ending internal combustion production? Should we take some radical decisions about freight? One of the problems that we have in our constituency is with lorries going through very narrow arterial corridors. Should we start to get radical about moving freight to different modes of transport? Could you talk about the whole-place solution, please?

Claire Shanks: On your first point, the cleaner air for Scotland strategy makes points and recommendations with regard to placemaking and planning policy. I do not have them in front of me but, from memory, many suggestions are made about future placemaking plans taking air quality into consideration, although as far as I can remember, there is nothing concrete on planning decisions.

I come back to a point that a number of us made in our submissions, which was also raised in the Environment, Climate Change and Land Reform Committee's air quality inquiry, about the progress report and the updates that we get on the extent to which we are meeting the recommendations and action points in CAFS. I absolutely agree that there is a lot more to be done in that respect, but it is not really clear who is doing what.

Dr Ramsay: I echo some of those points. Planners are represented on the CAFS governance group, and I believe that there is an increasing understanding in the planning community of the need to understand the impacts of development on air pollution. Evidence was taken from Holland, for example, where there is a different system of planning whereby, with any new development, an air pollution budget associated with that development has to be calculated, and if the new level of air pollution exceeds the existing levels, mitigating measures have to be designed in to mop up that extra air pollution.

People are aware that there are lessons to be learned from other countries. Efforts have been made though the CAFS governance group to promote those, and I know that efforts are being made, through education and so on, to emphasise the need for the planning community to be more aware of the issue. The work that NHS Health Scotland has done in designing an audit tool on placemaking is an example of the ways in which we are trying to encourage members of the planning community to understand their role, which is absolutely key.

Jane-Claire Judson: I am really interested in the planning angle and the adoption of a holistic approach to placemaking. I feel that the approach needs to be toughened up a bit. At the moment, tackling air pollution feels like an optional extra—something that we might do if we manage to fit it in—rather than a basic element of planning.

I love a bit of anecdotal data. It is really good to give an anecdote when you are sitting in front of people who deal in evidence every day. A few weeks ago, I supported a friend who was deciding whether to buy a house and we went to a new housing estate that is being built, which will remain nameless. I noticed that it had a pavement on only one side of the road, and I asked whether that was because we were in the show home part of the estate, but I was told that the whole estate will be like that. I was really surprised, because I did not understand how people could walk about without having pavements on both sides of the road. I was very critical and said that that was terrible and that I did not understand how such a layout could have been approved. The person said, "I thought I was just showing you a house, but now we are having a whole debate about placemaking."

It was an interesting discussion. The answer was that the developers were trying to build in some of the planning that has been done in Holland and in other parts of Europe, but they have planned it in without the culture change having been achieved. That will not work for us at the moment, because when people such as me look at it, they will think, "How will I walk about? How will I get my buggy down the road?" We are not yet in a position to be able to say that people should be able to wander down the street because pedestrians have a right of way over traffic in a housing estate. It is definitely the case that some things are being tried out, but we have not made the necessary culture change.

I also want to make a point about areas of deprivation. To my mind—I am going to be a bit bold here—a lot of the work and the planning activity on active transport fit into a middle-class bracket. I am going to use the term "MAMIL"—

middle-aged men in Lycra—to illustrate the point. There might be some of them here.

In many countries in Europe, although they have not got things fully right when it comes to active transport, it is a lot more accessible. At the moment, if you want to be a cyclist here, you have to go to a cycle shop and buy a specialist bike and specialist equipment, and that is not the case in cities in other countries. Even walking, which we think of as a free activity, is not that free. We need to build in accessibility. When we are looking at planning, we need to consider how accessible what we are asking people to do is. Olivia Allen is absolutely right. We are asking people to make changes that, as a society, we are not making alongside them, so we must integrate those two things.

Professor Haw: Jane-Claire Judson mentioned culture change. Culture shift and behaviour change are terribly difficult.

I return to the approach that was taken to the smoke-free legislation. One of the most striking things about it was the gradual build-up of information, first about the dangers of second-hand smoke exposure, then about what the legislation might do and then about what people's responsibilities were. It was very broad brush. It included leaflet drops to every household and a high-profile mass media campaign. Such campaigns are important, because they hit everybody. They are expensive, but their hit on the population is really quite large. That communication campaign was part of the success of the smoke-free legislation.

What was striking was that, before the legislation was introduced, it was primarily the non-smokers who were supportive, but as the date came nearer, the smokers began to switch and, after the legislation was introduced, the smokers changed their attitude—they became very positive. Because car ownership is the dominant theme here—car owners are the majority—we have to hit car owners and shift their opinion. We might have to move before opinion has completely changed. We might well find that, once things are in place, there is a much more positive attitude.

10:45

Emma Harper: In the chamber this afternoon, there will be a debate on the Environment, Climate Change and Land Reform Committee's inquiry into air quality. A point that is made in the committee's report is that tackling air quality is a cross-portfolio issue, which must involve the ministers for transport and the environment, as well as the housing minister. Calls have been made for a more joined-up approach across all the portfolios.

I assume that the panel would support the strengthening of that. The Cabinet Secretary for Environment, Climate Change and Land Reform, Roseanna Cunningham, said that her concern was to ensure that, when new housing developments are put in place, an understanding of transport issues is part and parcel of that. We seem to be heading in the right direction with regard to what the ECCLR Committee's report says, but the question is whether the approach that is being taken is strong enough when it comes to planning and policy.

Professor Newby: I confess that I do not own any Lycra. Changing views and attitudes is challenging, and I do not want to belittle that. The perception of people cycling around in Lycra is very common.

When I talk to people about going to work—I probably cycle about 40 miles a week just going to and from the hospitals around Edinburgh—I tell them that I go in my suit, which I am wearing today, and they cannot believe that I cycle in a suit. They ask, "Don't your patients complain of you smelling?" Well, they have not complained about it yet; maybe they are just being polite. There is a perception that it is not possible to cycle and do some kind of job.

I had a very cheap, rusty old bike, which I recently replaced with another cheap bike. They are not expensive. It is all about views and perceptions. Most journeys are incredibly short and do not need to be made in a car. Some of my patients get upset when they lose their driving licence, and I point out that I travel all over Scotland on the train with my bike. It is about attitude. I have always done that—it has been part of my mentality. Perhaps I am just a bit odd. It is a case of making it easier for people. Jane-Claire Judson made a comment about the pavements in the new estate that she visited. Were there any cycle paths in that new estate? I suspect not.

Jane-Claire Judson: No.

Professor Newby: Why not? Having cycle lanes ought to be the norm for a new estate. Why is that not the case? What is going on?

Claire Shanks: We would really like there to be a public health campaign. It is a case of telling people that they do not need to be a professional cyclist to get to work and showing them how they can take a different approach. It is also about dispelling myths that exist. I have heard a number of people say that they are not cycling as much because of safety concerns—that is fair enough—and because of the pollution, when increasing evidence shows that people are exposed to much higher levels of pollution when they are inside a car. People do not want to walk their children along the side of the road because of the pollution,

so they put them in their cars, but there is up to 12 times more pollution inside the car. We get calls from people asking whether face masks will protect them. They think that masks provide protection, whereas most of the time they do not, because the particulates are so small that they get through anyway. There is a lot of misinformation and misunderstanding out there, and I think that a really big campaign would help with that.

The Convener: I want to move now to the wider question of air quality in relation to health inequality. I will start with Jenny Gilruth.

Jenny Gilruth: I want to pick up on Olivia Allen's point about behaviour change. Her submission says:

"A reduction in the number of all types of cars is necessary to further lower the health risks posed by particulate matter."

Jane-Claire Judson's submission points to health inequalities, which have mentioned previously, and says:

"The right to health is a fundamental human right and the impact of poor air quality should be treated as an infringement of that right."

Levenmouth, in my constituency, is the largest urban conurbation in Scotland with no direct rail link. Health inequalities and child poverty in general are high in that part of Scotland. Do you think, therefore, that there is a disconnect between our aspirations in terms of health and transport?

Jane-Claire Judson: The short answer to that would be yes. It goes back to the point about the integration of portfolios that Emma Harper mentioned. The issue is very complex and I absolutely understand why it is hard to look at the transport policy in one area of Government and then to look at health in another area of Government, and then to take into account the fact that there are health inequalities, which are affected by factors that do not always start with health. I absolutely accept the structural issues that exist around that. However, we are a small nation of only roughly 5 million people, and it should not be beyond our wit to consider that situation and work out how to work better in that regard.

Olivia Allen will have more to say on that.

Olivia Allen: What we have been discussing about planning and involving the public is a really important avenue to take. Copenhagen is quite a good example of that, as the city got people who cycle to point out routes on a map that are problematic and to say where other useful routes would be. I am not entirely sure how much involvement the public has in your planning procedures, but if there could be a public consultation involving people who are living in more marginalised communities, perhaps there would be improvement in terms of getting rail links out there and offering those alternatives.

Jenny Gilruth: Absolutely, and that would be helpful in terms of facilitating the behavioural change that we are talking about, because people cannot use a rail link that is not there.

I have a broader interest with regard to my constituency. Jane-Claire, you also highlight that air pollution must be seen not purely as an environmental issue. Your submission states that

"we need to urgently address poor air quality as a priority in targeted areas where people who are more vulnerable are at greater risk."

That is a point in relation to health inequalities. Claire Shanks's submission quotes what "Cleaner Air for Scotland" says about the requirement for national health service boards and their local authority partners

"to include reference to air quality and health in the next revision of their joint health protection plans, which should identify and address specific local priority issues".

To what extent do you believe that air quality should be strategically linked to the outcomes of health and social care partnerships nationally and at a local level? Should it be embedded in those outcomes? Are any of you aware of any good practice that is happening currently across the country in that respect?

Jane-Claire Judson: Yes. The joint plans have a responsibility to reference air quality, which I do not feel goes far enough—I could reference anything, but it would not mean that I would have to act on it. I think that we should toughen that up a little and that we should be creating better outcomes-based targets in health that cut across all of the portfolios that we have. The integration joint boards should go some way to helping us with that, but we know that there is a challenge there as well, in that that integration needs to be supported through a change in their own culture, as well.

In terms of good practice, Glasgow has done a huge amount of work through Glasgow Life on city-wide approaches and admission rates. The academics around the table might be better than I am with regard to this issue, but I feel that the pockets of best practice are so small at the moment that they are not scalable enough. They involve small projects with personality leadership, as it were—that is, people who are committed to the cause—rather than there being a strategic commitment to change the situation across Scotland. We see that with the clean air strategy, which has not gone as far as we all hoped that it would.

There is definitely something to think about in terms of how we build in those outcomes. I will declare a bit of a conflict of interest, as I sit on the board of NHS Health Scotland, which has also given a submission to this committee. With regard to public health reform, there is a clear commitment to change the approach to public health in Scotland into something that is very different from an approach that simply views it as an issue for the NHS and the health sector. Of course, that work is happening at the moment, but I urge people to look towards that and to influence that process so that the public health outcomes have to address clean air quality. Further, investment has to be made in preventative spend in relation to vulnerable groups.

Jenny Gilruth: The reason I raise this issue today is that, over the Easter recess, the health and social care partnership in Fife took the decision to close out-of-hours services in Glenrothes in my constituency, and in St Andrews and Dunfermline. I thought that that was really interesting with regard to air pollution because the decision of the HSCP is going to directly increase emissions because all patients will now be directed to the Victoria hospital in Kirkcaldy as a result. The strategic decision of that health and social care partnership goes against all our aspirations in terms of air pollution.

Jane-Claire Judson's submission says:

"Most lung diseases are chronic, meaning that people living with these conditions can become heavily dependent on health and care services."

However, the people in the towns that I am talking about are now further away from those services. Claire Shanks's submission makes an interesting point when it says:

"However, as England's chief medical officer has recently highlighted in her annual report, the NHS itself is a high polluter and should take action."

The NHS has obviously taken action, but in a way that is encouraging people to use more transport. That shows that there is a disconnect between the strategic aspirations and what is actually happening. What are the panel's views with regard to how those strategic actions can help to increase or decrease health inequalities?

The Convener: I see that Jane-Claire Judson wants to speak, but the other witnesses may also comment.

Jane-Claire Judson: I would not want to comment on an individual situation within a health board—I do not think that the health board would appreciate that—but the quick point that I would make is that there has to be an understanding of connectivity across the different sectors in Scotland. That should be accepted at a strategic level and at a local level. There is definitely an issue about local community planning in that regard and how people are consulted, which connects to the panel-based place-making approach, which would help in that regard.

I take the point that you make, but I think that it is a local issue that it would not be entirely appropriate for me to comment on.

Claire Shanks: It comes back to what I said in my submission about the fact that CAFS says that health boards should simply reference air quality. There is just not enough guidance there. It all falls under the idea of better education that we have been talking about—that involves education not only for the public but for people in the health services as well.

If you look at the different references through joint health protection plans, you can see that some really get the need to consider prevention and the need to guide people towards active travel and better health choices. However, some of them just say that they are going to manage acute episodes. There needs to be better guidance for health boards when they are making those decisions. When health boards make strategic decisions, they should know what effect they might have on air quality. I do not think that they have that information at the moment.

Sandra White: I am still getting over the comment about middle-aged men in Lycra. It was a bit of a shock, and I am trying to get that image out of my head.

When we are talking about health inequalities, the issue of the most disadvantaged areas seems to be mentioned constantly—it has come up in our discussion today and is mentioned in the submissions. In my constituency there are some areas that are not disadvantaged, such as the west end of Glasgow—they call it the leafy west end. However, Byres Road in that area is among the worst roads for air pollution, as is Hope Street in Glasgow city centre, which is absolutely full of traffic.

I know that we have some very good, educated people in these areas who monitor the air quality in the high-up tenement buildings. I agree with Professor Newby about kids in buggies being exposed to air pollution, but I would like to make the point that you also get traffic-related air pollution higher up in those tenement buildings. Does the panel agree that the issue is not just one of deprivation but is also one of the heaviness of traffic, which can be an issue anywhere? I know that there is a long-term issue of education in that regard, but I would like to hear the panel's views on that.

I would also like to hear the panel's views on the issue of green lungs within the city. Glasgow City Council has been very good on that issue.

However, what can we do to improve some of the quality of that policy? Should we be planting more trees to create more green lungs in areas such as Sauchiehall Street in Glasgow city centre and so on? That policy will take a long time to come to fruition, unfortunately. Is there anything that we can do if not immediately then certainly in the short term to improve the situation for people who are living in city centres, and in places such as Byres Road and similar areas in Edinburgh, too?

Dr Ramsay: There is quite a lot of guidance available to local authorities and other bodies on effective interventions to reduce air pollution. I was a member of the public health advisory committee for the National Institute for Health and Care Excellence, which developed such guidelines. It considered the literature on interventions and did an economic analysis before publishing a reasonably thorough report that analysed potential interventions, and greening of cities was one of the areas that it examined. Again, the evidence for that is somewhat equivocal, and it very much again depends on the nature of the situation in which the policy is implemented.

Quite a lot of work has been done in regard to the issue and what we are doing is trying to ensure that people are aware of that evidence and can access it. I think that local authorities are aware of the policy, which is why, for example, Glasgow is not only introducing the low-emission zone but is also working on the avenues project—you will know more about it than I do—which is an attempt to recreate the street landscape and to improve greening in relation to it and also to totally transform the street pattern. Progressively, that is the kind of thing that will make a difference in terms of encouraging people to get out of their cars and make use of alternative means of transport.

As I said, there is quite a lot of evidence about that approach, and local authorities should be aware of it. Later in the year, we hope to produce a briefing that will highlight all the sources of evidence so that people can access them more readily.

11:00

Professor Haw: One of the things that struck me in the previous conversation was the issue of the complexity around all of the components coming together. I was thinking about whether a systems analysis has been conducted to look at how those different elements relate. That is a useful tool for bringing together all the different interventions and approaches.

My second thought concerned the fact that effective interventions might work differently in different areas, depending on the nature of the situation. In a sense, in addition to effective interventions, there is a need for a system of option appraisal that allows areas to make judgments about what the best way would be to take the intervention forward.

Those two approaches are used in academic research for working out how to take things forward.

The Convener: That is a fair point.

Professor Newby: On Sandra White's question about homes and the associations with illness, there is certainly a canyon effect and, of course, Glasgow and Edinburgh have lots of lovely tenements, which tend to exacerbate the situation. Further, the closer that people with cardiovascular disease live to a road, the more they suffer from that cardiovascular disease. There is a clear relationship—almost dose dependent—between illness and distance. Of course, that plays into issues around social deprivation, as poor people tend to be able to afford housing only in deprived areas that are very polluted and are close to roads and so on. The issues are all interlinked.

I cannot really speak to how town and country planning could be improved. We have inherited these things but radical solutions such as making people park their car on the periphery of a city and having transport into the city might encourage them to disengage from being completely wedded to their car in terms of whether they decide to get into their car to go 50 yards down the road to the shop, which is just crackers. That is part of the answer but I accept that it is not easy to deliver.

Miles Briggs: I will follow on from Sandra White's question and ask about how health boards and local authorities can lead by example. Two years ago, I asked the Government what it was doing to encourage the fitting of filters, for example. The response was that the Scottish Government provides an air-quality grant scheme to support retrofitting of vehicles, but the take-up of that has been incredibly low. What should the approach be to those sorts of interventions? In that case, should the retrofitting of vehicles be compulsory? What can we do based on the work that we are doing now to try to tackle the issue?

Professor Newby: The University of Edinburgh has done research showing that retrofitting with particle traps has a benefit in that it prevents some of the adverse health effects of air pollution. If that is voluntary, it does not happen. Grant schemes are helpful, but the legislative angle is important. One argument against that approach is that it makes engines less efficient and so produces more hothouse gases, although ultimately engines are generally more efficient now anyway. It is a trade-off.

Speaking for my health authority, I get frustrated sometimes. There are cycle paths to the Royal infirmary, which I will be taking on my way back, but it is a new site with lots of new buildings, and how many electrical charge points are there? Zero. The Western general hospital has two but, if I ever take my car, as I did at the weekend because I had to go to St John's hospital afterwards, I struggle to get it charged, because everyone is parked around the charge point but not using it. There are things that health authorities can do more imaginatively and better to lead by example.

Alison Johnstone: I would like to focus on the comments from the British Lung Foundation and Chest Heart & Stroke Scotland on CAFS, the cleaner air for Scotland strategy. Chest Heart & Stroke Scotland suggests that we need to treat the issue as a national emergency. We have got to grips with passive smoking and treat it very seriously, but we seem a lot more relaxed about air pollution. Even if it is not killing people, it is certainly not doing us any good and it is costing us all a fortune. I ask Professor Newby please not to temper his anger, as we really need to develop a sense of urgency on the matter.

The Government is looking to deliver 10 per cent of all journeys by bike by 2020, but here we are in 2018 and we are probably sitting at about 2 per cent. In my view, the proportion of the transport budget that is spent on active travel is simply not fit for purpose. What might we do to encourage the Parliament and the Government to take the issue more seriously?

Jane-Claire Judson: With areas such as tobacco or alcohol, we have a product and something that we can visualise when we talk about it. When we talk about cigarette smoking, we know what that is, and the same is true of drinking. We might all have a different vision in our minds of what a drink might be—it might be a cocktail or a pint—but we know what we are talking about. With clean air, people cannot get a handle on it. The scientists will tell us what the issue is but, although it is there around us, we cannot label it. We cannot market the issue in a way that we can with other things that impact on health. I think that that is why there is sometimes not a sense of urgency about the issue. Clean air is not something that we can take away from or give to people in the same sense.

There is an issue about changing the culture and the narrative around clean air. As I mentioned earlier, when I talk to people who have chest conditions about this, I say that breathing is an activity that we are all doing right now. It is about bringing it right back into the moment and saying that we are breathing air in and out now and that could be affecting people. For example, people in Lochee in Dundee—I have a huge amount of affection for Dundee, and I used to live near Lochee, so I am very aware of the issues there—are living with the issue and it is affecting their health.

There is definitely a need for urgent decision making. To reflect on Jenny Gilruth's point about decisions that are being made, and to go back to David Stewart's point about the difficulties of being a politician and picking the moment when public opinion is going with you, there is something that the Parliament and Government can do to start to generate that and to support the third sector to be bold on the issue. It is a bit frightening for us to take that step forward and say that the issue is a national emergency and a high priority when we know that people have so many other priorities and that politicians face many other decisions.

From the research that is coming through, we know about the impact on Scotland's health of decisions that were made 30 years ago on housing, poverty and employment. Those decisions are coming home to roost. We can see the trajectory and, if we do not take action now, where will we be in 30 years' time? We cannot get away from the fact that the NHS is under strain, but the way to resolve that is not to keep sending people there to be treated for conditions that they have developed as a result of things such as air pollution. We have to bring that spend forward.

The main challenge with upstream investment is that we are not set up to do it. The financial systems and funding systems are currently not there to enable us to do that. An example that I have used recently is that, as a charity, if we were really taking forward the messaging on preventative spend, we would take out all the services that we deliver as a charity and work only on prevention upstream. If we were to do that, I can only imagine what our stakeholders and service users would say. I understand the boldness that is needed in that decision making, but we have to get the conversation to that stage. Part of that is about my work and Claire Shanks's work, but part of it relates to Claire's point that, a lot of the time, people do not have access to the right information and options appraisal to decide whether closing one thing and opening another or moving something here or there is integrating with other measures. That goes back to Sally Haw's point about the need for a systems analysis and an understanding of the system that we are in. That is really complex, but it is attainable if we are ambitious about it.

Claire Shanks: I absolutely back up Alison Johnstone's points on active travel. I think that a lot more needs to be done on that. I keep coming back to the point about communications, awareness and education. The British Lung

Foundation is a small charity. In Scotland, we are doing what we can to raise awareness, but we just do not have sufficient resources or, admittedly, the clout. We work as well as we can with other third sector organisations. That is why we set up the cross-party group on lung health with Chest Heart & Stroke Scotland and why we try to get things into the press. It is why we have been going to the CAFS communications sub-group to ask the Government what it is going to do about national clean air day and what campaigns it is going to have, and to say that we would love to help with that. The Scottish Government has done some brilliant awareness campaigns.

As Jane-Claire Judson said, we need to bring the public along with us. We need to let people know that, if you live in a severely polluted area, your child is five times more likely to develop a lung condition or that, if you live in a deprived area, you are already two and a half times more likely to have a lung condition and you will probably end up in hospital. We need to use real-life examples from the people who we know and our supporters. We have people who say that they just do not go to the cities anymore. We have someone who wants to visit her daughter in Edinburgh, but the impact of that will knock her off her feet for maybe five days afterwards. She might not end up in hospital that time, but over the course of her day's visit it will get worse and worse, and then she will be wiped out for the next week. Those are the real-life impacts and the stories that we want to get out there. It is really important to get those stories out there to make the issue real for people. If we could get some funding and a real boost behind a public health campaign on the issue, that would be really valuable.

Alison Johnstone: Professor Newby, I came to visit you in the Royal infirmary maybe two or three years ago with Ian Murray MP and Deidre Brock MP. We saw your research at first hand, and I was struck by the fact that people who have a major heart incident are likely to have been sitting in heavy traffic in the hours before. Has that evidence been accepted, and are we acting on it?

Professor Newby: There is sometimes a lack of visibility of it. Obviously, I do not want to take anything away from the lung issues arising from air pollution, which people can readily visualise, but, actually, the biggest mortality risk from air pollution is from heart disease and strokes. It is the cardiovascular consequences of air pollution that are killing people—those are the main driver of the deaths attributable to air pollution.

There is a visibility issue. The British Heart Foundation has funded a lot of my work to investigate the issue, and we have demonstrated that, if you breathe in particles, they can indeed get into your bloodstream and cause problems with heart disease and stroke. People just think about lungs and asthma, and I do not detract from that as it is important, but the issue is more far reaching than that, and I do not think that people acknowledge that.

Dr Loh: To add to what David Newby said, there is a lot of research now that shows that it is likely that air pollution exposures when your mother was pregnant or when you were a child can have an impact that does not show up until later life. We do not necessarily know what will happen later on, so it is important to be preventative now.

Another issue that has come up in my work is that it is difficult to get people to be enthusiastic about air pollution, partly because, unless someone is a vulnerable person such as an asthmatic who feels the effects at first hand, they may not think that it applies to them. There are also competing priorities, and people may be concerned about other things. This is not really my area of expertise, but we need to understand the motivations for people to change their perceptions of air pollution as a risk. As Sally Haw said, we need to look at the larger picture and try to address it, perhaps through more indirect means.

Professor Haw: Making air pollution meaningful is problematic because, as Miranda Loh said, for people who are asymptomatic, it is difficult to understand that it has an impact. When we looked at how people reduce smoking in the home, we found that one of the biggest and most effective ways of dealing with that for people who smoke is to monitor the differing $PM_{2.5}$ levels and show them the graph trace of that. That was also instrumental in monitoring in bars and, from an advocacy point of view, in promoting the danger. A visual representation of air pollution levels can be extremely effective feedback. However, I am not sure whether that has ever been used in relation to air pollution specifically.

Olivia Allen: To add to what Sally Haw said, risk assessment is really important. Generally, people are really poor at figuring out how much risk they are at from something. Claire Shanks mentioned the importance of the public health campaigns on smoking. Those have been fairly successful at helping people to measure risk and to figure out exactly what risk is posed to them by continuing to smoke. If we could have campaigns to demonstrate the risks of air pollution more clearly to the public, that would address David Stewart's point about getting the public on side in trying to make air pollution-related changes. If people knew more about how air pollution impacted their health, they would be a lot more involved in pushing for change.

The Convener: Thank you. We will move on to the final line of questioning.

11:15

Ash Denham: When I was reading through the written submissions, I was particularly surprised by something that Claire Shanks mentioned a few questions ago, which is that the level of pollution is much higher inside cars than outside cars. As a driver, I was quite surprised by that. I do not know whether I am unusual in not knowing that, or whether that is a commonly held misconception among drivers. We look at cyclists and think, "Oh, they must be breathing in the fumes from the cars going by" when actually we are sitting breathing in the fumes in our own vehicles.

We are talking about transport and, in particular, drivers contributing quite a lot to pollution levels and we want to create behavioural change. In your submission, you said that you thought that that might be an area for a national campaign by the Scottish Government. Obviously, the Government has run some really successful campaigns before—the take it right outside campaign was a good example. If we link together public health, pollution, behaviour change and preventative spending, do you think that a public health campaign on this issue, which might get drivers out of their cars on to public transport, or perhaps using active travel or even electric vehicles, would be the right place to spend the money? If we cannot spend the money on everything, would that be a good place to spend the money?

Claire Shanks: The short answer is yes. There is a real benefit in making sure that a public health campaign is properly resourced. I am conscious that this is not all about telling people to make changes and then not giving them the tools to do so. A campaign has to be backed up by greater investment in active travel; by people being enabled to switch to low-emission vehicles; and by a targeted diesel scrappage scheme to allow the people who are most affected to get cleaner vehicles. It cannot just be about telling people that it is entirely their responsibility to make the change.

So long as a campaign is backed up by those other policies and the policies in CAFS are enacted, I think that there would be real benefit in putting a lot more resource into public health awareness.

Dr Loh: On the point about pollution inside cars, while it is possible that exposure inside the car can be higher, that is not always the case. Studies have been done and various results have been found. It is possible for higher exposures to be found inside a vehicle such as a bus or a car in heavy traffic, but some studies have found that how air circulation is set in the car can also have an impact.

I agree that you do not want to rely on people changing their own behaviour and that you want the whole system to change, but if people understand their level of exposure that might help to raise awareness because they will be able to see the impact. In studies that I have done in the past, we have monitored participants for various environmental exposures and fed that information back to them, along with information about what it means. On an individual level, that can be very useful, but we are also looking at the population-level change that needs to be addressed.

Sandra White: Reference has been made to people travelling in public transport such as buses. I seem to recollect a report that found that people can breathe in a higher level of fumes while they are sitting on a bus than they would even when they were walking in traffic. Is that correct? We really need to look at that as well.

Dr Loh: I think that there have been studies that have shown that. Those findings do not necessarily apply universally to buses, but there are situations in which it has been found that part of it is self-pollution, and infiltration from traffic round about can also increase the levels inside. When people are inside a vehicle—Olivia Allen might have mentioned this—they are not necessarily protected from air pollution. Inside levels can depend on many things, such as whether you have the windows open or whether you have more of a draughty house. Pollution from outdoors can still be found inside. Of course, there are also sources of pollution inside that cannot so easily be regulated.

Emma Harper: We are talking about transport being the biggest contributor to air pollution, but other sources such as wood-burning stoves are emerging. Agricultural emissions are also something to consider. There are issues of increased rates of COPD for people who work in fish processing or in sawmills.

I guess that our main focus should be transportation because that is the biggest issue that we face that affects our lung health. Should we be focusing on transport?

The Convener: Can I widen that out with a supplementary question? We are approaching the end of this evidence session on preventative health interventions, in which we have covered some areas in considerable depth and others less so. If there is any one thing that has not yet been raised but which you think is important in terms of prevention in this field, please let us know now. Who would like to answer Emma Harper's question with that wider supplementary?

Claire Shanks: I admit that my knowledge on wood-burning stoves is not as great as it is on transport emissions; I know that the stoves are an increasing area of concern. Collectively, industrial, commercial and residential emissions are the biggest contributor but, as I said before, if you look at transport you are tackling other public health issues. As Professor Newby said, the worst pollution tends to be in urban centres and to be related to transport; that is where pollution is highest. That is also where you find people who tend to be already unwell, so I think that that is where we should prioritise first.

More generally, as an organisation we are very keen that preventative spend increases. We think that we need to move away from the acute agenda and just managing disease, because more and more people are going to be living with chronic lung conditions and comorbidities and chronic heart conditions. It is best that we try to prevent that in the first instance, because if we just manage and manage and manage the cost is huge. Last year, there were 100,000 hospital admissions as a result of respiratory conditions, and respiratory conditions were the second-highest reason for emergency admission. If we do a lot more on pulmonary rehabilitation and self-management programmes—things that enable people to self-manage their condition—and preventative spend that stops people getting those conditions in the first place, there will be huge savings down the line.

Dr Loh: I can say definitely that transport is a very important contributor to air quality. For Scotland, I do not know what the contribution of wood burning is. It is not necessarily something that people need to do, but it is contributing to air pollution. Air pollution often tends to be worse in the winter because of meteorological conditions, and that is when a lot of wood burning happens.

It is important that we do not focus only on transportation because there are other sources of pollution, but transportation is very widespread and it impacts just about everybody. We all walk on the road. Some of us drive cars; I do not. We are all impacted by transportation, but we should not focus on it alone. As we have said before, the pollution from transportation cannot be removed completely, but other sources can be tackled as well.

Dr Ramsay: I think that the consensus is that combustion engine transport is the thing that should be focused on when it comes to preventable air pollution. There are other sources of air pollution, but by and large they have been reduced, partly by accident because of significant deindustrialisation but also because of changing patterns in industry.

Wood-burning stoves are not an enormous problem at the moment, but anecdotally plenty of people have suffered the consequences of their neighbours deciding to invest in a wood-burning stove and not necessarily adopting the appropriate techniques to control the pollution. There has been evidence from London—I mentioned this at the Environment, Climate Change and Land Reform Committee when it was considering this issue—that particulate pollution levels have been starting to creep up, particularly at weekends when the wood-burning stoves are being used excessively. People are aware of and concerned about that phenomenon. Certainly, environmental health departments are aware of that in their local areas.

Perhaps the bigger issue is the use of biomass more generally and the incentives that have been created to encourage biomass burning, sometimes as an alternative to cleaner carbon-based fuels such as gas. We can argue the case for whether or not that is desirable, but we cannot afford to be complacent about the unintended consequences of trying to be greener in some circumstances. We have to be well aware of that. We do not want to make improvements in one area only to end up having problems that are created by our attempts to remedy the situation. I think that that is worth noting.

The Convener: Indeed. Thank you very much. There is a final supplementary from David Stewart.

David Stewart: It is a general point on low-emission zones. I know that we have some questions on that subject later, but I would just make a general point that there have been great examples of LEZs across the world. That has worked well where we have had Euro 6 buses, which are adapted to be lower emitting, and adequate fares. From evidence that I heard at a previous committee, my slight concern is that non-LEZ areas might get more of the polluting buses and that, because bus companies have to invest highly, there is a danger that fares might go up. One word of caution is that we need to get the timing of LEZs right, because that has been the evidence from other parts of Europe.

The Convener: Thank you very much. The point on LEZs is fair and a good one on which to end. The question of burning biomass was also raised. Initiatives that are taken in this area may have unintended consequences—that has become clear from the evidence session.

I thank all our witnesses very much indeed for their evidence this morning, which has been extremely helpful.

11:26

Meeting suspended.

11:32

On resuming—

Subordinate Legislation

Alcohol (Minimum Price per Unit) (Scotland) Order 2018 [Draft]

The Convener: Item 2 is consideration of an affirmative instrument. As is usual with such instruments, we will have an evidence session with the cabinet secretary and her officials. Once we have asked our questions about the instrument, we will move to the formal debate and the motion.

The instrument in question is the draft Alcohol (Minimum Price per Unit) (Scotland) Order 2018. I welcome the Cabinet Secretary for Health and Sport, Shona Robison, accompanied by Daniel Kleinberg, the head of health improvement, Louise Feenie, alcohol policy team leader, Marjorie Marshall, economic adviser, and Lindsay Anderson, solicitor, also from the Scottish Government. I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you, convener. I am delighted to join the committee this morning to consider Scotland's first minimum unit price for alcohol.

Last November the UK Supreme Court concluded that minimum unit pricing was targeted, proportionate and lawful. That unanimous judgment fully endorsed Scotland's alcohol pricing policy. My statement to Parliament then set out our plans for consultation and engagement. As you know, I proposed a minimum unit price of 50p per unit of alcohol from 1 May 2018 and we ran a public consultation on 50p throughout December and January. We received 130 consultation responses. Of those who commented on the 50p proposal, 74 per cent supported it.

The consultation process did not bring to light any new relevant evidence. Taking account of a number of factors, we concluded that a minimum price of 50p per unit strikes a balance between public health and social benefits and intervention in the market. We have engaged extensively with the alcohol industry since November and our approach has been welcomed by trade bodies and businesses alike. We have produced comprehensive Government guidance for industry and funded two bespoke products, the Scottish Grocers Federation booklet for smaller retailers, and the Scottish Wholesale Association guidance for wholesalers. We have been working with licensing standards officers and have provided a range of communications materials for retailers and alcohol and drug partnerships.

Scottish ministers' decision to propose a minimum unit price of 50p per unit is supported by an updated business and regulatory impact assessment, the BRIA, which I have laid before Parliament. Members will see from the BRIA that 51 per cent of all off-trade sales in 2016 were below a minimum price of 50p. This indicates that a sizeable portion of the alcohol market will be impacted at the level of 50p. The BRIA also details outputs from the University of Sheffield modelling. In 2016, Sheffield estimated that 50p per unit would lead to 58 fewer alcohol-related deaths in the first year, with a cumulative total of 392 fewer alcohol-related deaths within five years. The reduction in alcohol-related hospital admissions would be similarly substantial.

While I remain open-minded about future consideration of the rate, our collective priority must be to implement the policy without further delay. I need not detail the extensive cost of alcohol to our health, our economy and our society. However, I remind the committee that, as a nation, we drink 40 per cent more than the low-risk drinking guidelines of 14 units per week for men and women.

Minimum pricing has been a long time coming but it is not a panacea. It sits within a framework of more than 40 measures and a policy that we are refreshing to ensure that it keeps pace with Scotland's relationship with alcohol. Alcohol policy is backed by significant public funding. Since 2008 we have invested more than £746 million to tackle problem alcohol and drug use. We have also committed an additional £20 million per year to frontline alcohol and drug services.

Members will know that Parliament legislated for a sunset clause on minimum pricing. Scottish ministers will therefore bring to Parliament a report on the impact of the policy five years on. Parliament will then vote on the policy's continuation before the sixth year of operation. NHS Health Scotland is conducting an independent evaluation and the industry is involved in studies to look at the policy's economic impact. I am sure that the committee will take a keen interest in the evaluation and keep track of emerging findings in the coming months and years.

With Parliament's support, I look forward to implementing the 50p rate on 1 May and I hope that it will be endorsed across Parliament.

The Convener: We now move to questions from members.

Alex Cole-Hamilton: It is six years since the Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed and its implementation was stalled,

for reasons we are all very well aware of. The minimum unit price of 50p was agreed six years ago and it has been somewhat overtaken by the rise in inflation and other factors and pressures, to the point at which it is fair to say that its impact will be diminished, and I think that will be echoed by third sector organisations and campaigning groups. I understand that you want to implement the policy without any further delay but what consideration has the Government given since the Supreme Court judgment to that price of 50p and would you consider lifting it to 60p, which is what a number of groups, and certainly my party, now advocate?

Shona Robison: First, you will be aware that all the University of Sheffield modelling was based on the 50p per unit price—that is important.

Changing the price is not as simple as just replacing one price with another. A load of issues would flow from that that could cause a considerable delay in the implementation of minimum unit pricing.

The court case and the evidence that was led in court were based on the modelling done by University of Sheffield on 50p. It is the affordability of alcohol that matters, not just the price, and that will depend on other factors such as income growth and how the market reacts to minimum unit pricing as well as inflation. We have to look at the evidence and monitor and evaluate Scotland's alcohol strategy because that will give us a fuller picture.

We want to keep the price issue under review as we proceed, but given the journey that we are on, which Alex Cole-Hamilton outlined in his question, I am keen that there is no further delay.

I will give one example of what such a change would cause. In 2012, we had to notify the European Commission of the proposed 50p minimum unit price. If that was to change, we would have to go back to the EC with the new price. That is a lengthy process and it could leave us open to further legal challenge, based on whether there was a challenge about a different price being proportionate.

We won the case because 50p is a proportionate price and it balances public health with business interests. It is not as simple as taking one number off and putting another on. A lot of complex issues and further delay would certainly flow from that. We have had enough delay; we want to get on with the implementation.

Alex Cole-Hamilton: I understand that and I share the willingness to press on and see this implemented. However, you said in your opening remarks that the price will be kept under review, so although changing it is complex, it is not impossible. What are the staging posts for the review and when will we come back to the issue?

Shona Robison: We have five years before the sunset clause kicks in and it will depend on the evidence that emerges. That is not going to happen in six months. Evidence about the full impact on the market, for example, will take some time to emerge. I do not therefore want to set a moment in time, because it might not be the right moment in time, depending on the evaluation. We should keep these matters under review.

There is obviously the formal pause in five years when we can look at whether the policy will continue, given the sunset clause, but I would be reluctant to set a point in time at this moment. I am sure though that the committee will want to look at the evidence as we go forward and I would be happy to engage with the committee on the evidence as it emerges and not just wait for the five-year point.

Sandra White: I fully support the minimum unit price. We need minimum unit pricing, particularly because of the substantial number of hospital admissions that you mentioned. I have visited the royal infirmary and was quite appalled at the amount of people who were lying on trolleys having had accidents because of alcohol.

That brings me on to the social responsibility levy. I know that there were plans for that but nothing in the draft order would introduce the social responsibility levy, which would be of substantial help to the health service and local authorities, as it was planned in the 2012 act. Are there any plans to introduce the social responsibility levy when you are looking at the five-year plan? Will the social responsibility levy be introduced?

Shona Robison: Whether it is a public health supplement or social responsibility levy, the Government will keep it under review. Remember that the social responsibility levy was geared towards recouping local costs, such as additional policing costs, that could be associated with alcohol. It was more about covering local costs than being applied in relation to minimum unit pricing.

The additional revenue highlighted is a high estimate so we need to see what the evidence shows. If behaviours change and people consume less, we need to see that evidence. These are estimates and they are based on what we think might happen but we will not know until we see the market operation.

The estimates are also of revenue and not profit and, again, we will need to see the evidence of where that revenue goes. We do not know whether it would be to the retailers, the wholesalers, the producers or a combination of

them, so whom should we put the levy on? We need to understand all that, but we should keep it under review. When we have the evidence, we would be in a better position to look at all that in more detail.

We also have to take current economic circumstances into account when introducing a levy or a supplement. Although we have no plans to introduce the levy now, we will keep it under review. We will look at the evaluation and the evidence as it emerges and that will help us to better understand whether there are additional revenues from this policy and where they fall, and then we will be able to make a more informed decision.

11:45

Sandra White: That was one of the points I wanted to raise. If there was additional revenue, would it be the licensee who would benefit from it? That was supposed to be part of the social responsibility levy.

If you look at the effect that the policy has had in five or six years and you decide to change the minimum unit price, would it be for this committee or Parliament or the minister to do that? If you produce the evidence, could the committee ask or could it be asked in Parliament if you are going to introduce a social responsibility levy as we go along through that five to six years?

Shona Robison: We will reflect on all those matters in the light of the evidence that will emerge over the next five years. We will reflect on the impact of the policy per se and we will look at whether additional revenues have been raised—that is yet to be tested—and where they fall. The Government will have the opportunity to consider all the issues in the round and come to an informed conclusion about that.

What is important at the moment is getting this up and running and getting on with it at the beginning of May. That will allow us to look at the evidence as it emerges rather than making estimates based on what we think might happen. We need to see what personal behavioural changes there are and what happens in the market. Again, we are happy and keen to work with the committee as that evidence emerges over time.

David Stewart: I go back to Alex Cole-Hamilton's point to look at how MUP will be uprated. You have talked about the review and I understand that, but during the passage of the bill, cabinet secretary, you said that there could be an inflation-linked mechanism such as the retail price index. Nothing I can see in the order adjusts for inflation. For example, if we have 3 per cent inflation for the next five years, that will badly erode the current figure. Are you considering an inflation index, and if you are, will you consider one that is obviously in the current thinking, such as the consumer price index or CPIX? As you know, the Bank of England does not recommend RPI any more.

Shona Robison: As I said earlier, it is the affordability of alcohol that matters, not just the price. That will depend on factors such as income growth, how the market reacts in reality, as well as inflation. It is not just about inflation; there are also all these other factors to consider. I do not think it would be prudent to commit to reviewing the minimum unit price in line with a single economic measure. As I have said, we will keep the rate under review, along with the emerging evidence from the extensive evaluation programme. That will help us to decide what the next step will be, rather than just fixing on one economic measure.

David Stewart: Is there any mechanism within the instrument to allow any change to the figure before a five-year review?

Daniel Kleinberg (Scottish Government): You would have to lodge a further instrument setting a different price. There is no mechanism for change in the instrument, but that change would be available as the evidence develops, if it were to take you to a different place.

David Stewart: That is useful, because the other way of doing it—I know it is not just about inflation, cabinet secretary, but just for argument's sake—you could have had an inflation indicator within the instrument that would allow an annual uprating.

Shona Robison: I take your point. As evidence emerges and the policy develops, we will be able to see whether we need to revisit that issue. At the moment, we really need to see how the policy works in the market, what it tells us about any future price and how we would come to an informed decision on that.

David Stewart: If any change was required while we are still subject to EU regulations, would we require EC permission for that?

Shona Robison: Louise Feenie might want to say a little bit more about that, but the answer is yes, because we notified the commission about the price way back in 2012, believe it or not—it was quite a while ago. If there was a change in the price, the commission would require to be notified again and that is quite a lengthy process.

That is one aspect, which is why it is important that the evidence of the impact of the policy rules out a further challenge based on what interests might perceive as being a disproportionate response. We won the case based on our response being proportionate. If there was a price

change in future, we would have to be mindful about making sure that that test was still met, otherwise I think we could open ourselves up to a different line of challenge.

Brian Whittle: A point was recently raised with me at an addiction treatment centre about those for whom behavioural change is more of a challenge and the impact that minimum unit pricing could have on them and their families. With that in mind, what consideration has the Scottish Government given to supporting those who have that additional challenge, and to supporting addiction treatment centres? Is that part of the strategy?

Shona Robison: Yes, and maybe Daniel Kleinberg will say a little bit about this.

The aim is to make sure that people are given the opportunity. Given all the publicity around the issue, we also have opportunity to have that discussion with people who are using alcohol at harmful levels or indeed have an addiction. This is a good opportunity for them to seek and receive services and support. The policy has always been to target hazardous and harmful drinkers. We know that those who drink most heavily and live in deprived areas experience the greatest levels of harm and we have always argued that they will benefit most from the policy. We know that rates of alcohol-related deaths in deprived areas are six times those in least deprived areas. We have this opportunity to have a big impact on health inequality, and the policy has always focused on those with an addiction. We have been talking to alcohol and drug partnerships about the support that can be given.

Daniel Kleinberg: That is exactly the point I was going to make. We have spoken to ADPs to prepare them and make them aware that minimum unit pricing is an innovative measure, so things may land differently as it comes in.

Shona Robison: We are really talking about dependent drinkers.

Daniel Kleinberg: Yes, and we are talking about investment in services to support people who, by the time they are drinking the cheapest alcohol, are probably already drinking at levels that require attention.

Shona Robison: We are providing materials to ADPs to distribute locally and signposting to local services that can help people whose drinking is problematic. A bit of thought has been put into this, and we have an opportunity to signpost people to services.

Brian Whittle: Are we also looking at supporting those third sector organisations that are involved in the treatment of addiction? I imagine that some of the burden will fall on them.

Shona Robison: Yes. A lot of the support to third sector organisations that provide support on the frontline is done through the ADP structures so that support will come through the usual mechanisms and resources that are around those systems at the moment. There is also an additional £20 million, and I am sure that a lot of third sector organisations will benefit from that.

Miles Briggs: Cabinet secretary, in your statement you mentioned work with the Federation of Small Businesses Scotland and the Scottish Wholesale Association. The timescale for implementing the policy is now quite tight, so what consultation and work is the Government undertaking with those organisations?

Shona Robison: Extensive work has been done to make sure that, for example, we support them with materials that explain clearly to them and their members about minimum unit pricing and how it works, how they can communicate with the public about how it works, and that it is a Government policy and they can signpost anyone who wants to make further inquiries to the Government. A lot of work has been done on the development of those materials so that when the policy is implemented, it hits the ground running because that awareness has been raised.

Louise Feenie (Scottish Government): We have engaged extensively with individual businesses and their trade bodies since the Supreme Court judgment in November. As the cabinet secretary says, we have made available a lot of physical materials as well as guidance and support on a one-to-one basis. Our sense is that has been welcomed and that the vast majority of businesses are ready for implementation on 1 May. More importantly, they have resources within their toolkit that they can use to deal with customers who have questions or concerns about how the policy will impact on them.

Alex Cole-Hamilton: I have also been in discussion with the Scottish Wholesale Association about the policy, and there is a small technical wrinkle. I understand that some members, such as wholesaler organisations or companies, also have or are operating with a premises licence. It creates a bit of a loophole or a problem for them, in that they might need to use dual pricing or have separate aspects to their building. Is the Government offering a workaround for that?

Shona Robison: We are certainly working on that. Daniel Kleinberg, do you want to comment?

Daniel Kleinberg: It is a very technical issue to do with, I think, the operation of a 2005 act. We are aware that there are different interpretations. We are clear there is nothing about MUP in itself that needs to apply to trade-only sales, but the

way in which companies hold their licence could have a read-across. We are talking to them at the moment. We are happy to consider further where that leaves them, whether or not they need to adjust their business, and what steps we can take to help resolve any uncertainty.

The Convener: There being no further questions from members, we now move to item 3, which is the formal debate on the affirmative instrument on which we have just taken evidence. Members will recall that there are no longer opportunities either to ask questions of the minister or to ask questions of officials, but we do start with the cabinet secretary, and I invite her to move motion S5M-11141.

Motion moved,

That the Health and Sport Committee recommends that the Alcohol (Minimum Price per Unit) (Scotland) Order 2018 [draft] be approved.—[*Shona Robison*]

Motion agreed to.

The Convener: Thank you very much, and thank you to the cabinet secretary and her officials. We now move into private session.

11:57

Meeting continued in private until 12:32.

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