OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 30 September 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 30 September 2021

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COVID-19 RECOVERY COMMITTEE
6th Meeting 2021, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alex Cole-Hamilton (Edinburgh Western) (LD)
Professor John Drury (University of Sussex)
Professor Christopher Dye (University of Oxford)
Professor Stephen Reicher (University of St Andrews)
Elizabeth Sadler (Scottish Government)
Graham Simpson (Central Scotland) (Con)
Dr Gregor Smith (Scottish Government)
John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 30 September 2021

[The Convener opened the meeting at 08:30]

Decision on Taking Business in Private

The Convener (Siobhian Brown): Good morning, and welcome to the sixth meeting in 2021 of the COVID-19 Recovery Committee. We are joined by Alex Cole-Hamilton, who is not a committee member but is attending due to his interest in proceedings. I welcome Alex to the meeting and invite him to declare any interests that are relevant to the committee.

Alex Cole-Hamilton (Edinburgh Western) (LD): Thank you, convener. I have no relevant interests.

The Convener: Murdo Fraser and Alex Rowley are running slightly late and will join us shortly.

The first agenda item is a decision on taking in private item 4, which is consideration of the evidence that we have heard. Do members agree to take item 4 in private?

Members *indicated agreement.*

Vaccination Certification

08:31

The Convener: Under item 2, we will take evidence from stakeholders on vaccination certification. I welcome to the meeting Professor Christopher Dye FRS, professor of epidemiology at the University of Oxford; Professor Stephen Reicher, Bishop Wardlaw professor of social psychology at the University of St Andrews; and Professor John Drury, professor of social psychology at the University of Sussex.

It might be helpful to start by giving a brief recap on the vaccination certification scheme. The Scottish Government announced on 1 September its intention to introduce a vaccination certification scheme, to be in place by tomorrow. The committee intends to listen to the witnesses' views and to feed them back directly to the Scottish ministers in our regular evidence sessions with them. Any issues that you raise will also inform our scrutiny of any relevant legislation that is introduced to give effect to the scheme. As such, your input is valuable to the committee and we are very pleased to hear from you and to have received your written evidence.

What are the key priorities that should be embedded in the proposed scheme to make it work?

Professor Christopher Dye (University of Oxford): Good morning, everybody. I hope that you can hear and see me.

I think that I am attending this session because of the work that the Royal Society did some months ago, the purpose of which was to lay out what we felt and, through consultation, what others felt were the main criteria for using vaccination passports. In advance of the meeting, I circulated the report that we produced. We came up with 12 detailed criteria, but they fall into three main categories. The first relates to whether vaccines are technically good enough—in other words, whether they are protective enough and do what we want them to do in medical and clinical terms—to warrant certification. It is clear that the answer to that question is yes.

The second relates to whether it is possible practically, through software and hardware, to set up a system that will guard people's privacy, for example, which is an issue that has concerned many people. There are many debates on that subject—perhaps we will have some of them during this session—but my broad answer to that question is that it is possible to do that.

The third area is perhaps still the most contentious and relates to whether Covid passes

or vaccination certificates can be set up fairly. A certification scheme is intrinsically discriminatory and exclusive—that is the very nature of it. Can we set up a system that is broadly regarded as being fair? In other words, does the system do what we want it to do? Does it give peace of mind to individuals who attend collective events—restaurants, bars, nightclubs, sports events or whatever it might be—as well as to those who organise such events and to the overall community?

We laid out the criteria. We were not expressing an opinion about whether the passports should or should not be used; our goal was to lay out the criteria under those three broad headings, with the 12 points of detail, as you can see in our report.

My view of the situation, some months on, is that vaccination certification is a feasible and helpful process, by and large. We have not ironed out all the difficulties, but it is a feasible and successful approach that adds force to our central approach to controlling Covid nowadays, which is vaccination. In that regard, I read with interest the evidence paper that was circulated to us yesterday evening. With one or two comments and queries, I must say that it is a good report and I broadly agree with its basic recommendations, which are that vaccination certification is a useful approach to supporting the vaccination programme in Scotland.

I have a couple of queries, however. Why has the system in Scotland decided to focus on vaccination certification only and not on the other two things—negative testing and a confirmed prior episode of Covid-19—that I have seen used elsewhere? I am speaking to you from France, where I live mostly, especially during pandemics. That is one question, and I do not quite know what the answer is, although I can perhaps guess. The other thing that, to my eyes, is missing from the report is a discussion about approaches to care homes, clinical settings and hospital settings. Those are two smaller points.

That is my broad overview of where we now stand on certification.

The Convener: Thank you, Professor Dye.

Professor Reicher, what do you think are the key priorities that should be embedded with the proposed scheme?

Professor Stephen Reicher (University of St Andrews): My sense of the vaccination certification scheme and of vaccination certificates more broadly is that they are a double-edged sword. How they work is a function of social trust. In areas of high social trust, where people believe that the vaccination certification schemes are there to help them and are a public health intervention, by and large, they give the vaccine indifferent—those people who are not anti-vaccine but who have not got around to it—a good reason to get vaccinated. When you introduce such schemes, there is quite often a surge of people getting vaccinated, and that is certainly true in France.

However, in countries and communities in which there is low social trust, such schemes can have a different impact because they lead to a sense of compulsion and a sense that the vaccine is mandatory, in effect. When you try to impose things on people, you get psychological reactance and people reassert their autonomy, and it also undermines their relationship with authority. Indeed, we have data to show that, in individuals and communities with a high level of trust, the prospect of vaccination passports increases the intention to get vaccinated, whereas in those communities with a low level of trust, such as the black community, it not only can have no effect but can increase opposition.

The evidence paper that we have been given slightly understates the problem. It says that a scheme might not have much effect among those who have a low level of trust, but it could actually lead to greater opposition. The issue of social trust is therefore a major problem.

The second issue is what it does to other behaviours. Early on in the pandemic, when vaccines were first introduced, there was some data to suggest that those who were vaccinated were given an illusion of immunity and invulnerability, and they increased their risky behaviours. What you get on one hand, from vaccination, you lose on the other, through an increase in risky behaviours, so messaging is important.

That has a number of practical implications. First, the broader context in which you introduce vaccination passports is critical. They work only when you are doing other things to increase social trust, especially around vaccination. It is important not to see vaccination passports as your sole strategy for increasing vaccination. They must be seen in the context of increasing the ease of getting vaccinated, including by ensuring that there are vaccination stations in schools, colleges, universities, workplaces and communities. Secondly, you must engage with people—listen to their concerns, take those concerns seriously and address them.

There are other things that you must do to increase trust, one of which, for instance, is to have a clear set of criteria for the end of the scheme, otherwise you will feed into those narratives that say that it is about controlling us and that it is the thin end of the wedge of identity cards. You need a clear set of criteria for when the scheme will be taken away, to show that it is

temporary. It would also help to have an option for a conscientious objection, if you like—a procedure by which people do not have to get a vaccination passport if they do not want to. Not many people would be likely to take advantage of that, so I do not think that it would be a major problem in terms of numbers, but it would show that the passport was not going to be imposed on people—that they would not have to sign up to it. Those issues are critical in how you introduce such a scheme.

The other point is that messaging is absolutely critical. It is really important to say to people that vaccinations do not make them invulnerable—vaccinations make you safer; they do not make you safe. As I say, if behaviours change following vaccination, the advantage of vaccination will be undermined.

Finally, although the evidence document is very impressive, as I have indicated, it understates the risks and the importance of messaging. It also understates the alternative. One of the points that the document makes—it is not made prominently, but it is a really important point—is that vaccines are crucial for making us safer but they are not enough on their own. We need other measures, such as improved ventilation and improved hygiene. Indeed, the research on even larger events in indoor spaces shows that, if there is proper ventilation and hygiene, levels of transmission are very low.

Therefore, vaccination passports are a double-edged sword, because they create problems and alienate people from authority. There needs to be much more emphasis on making venues safe—necessarily safe—and having clear criteria for their opening. I do not think that vaccination passports should be an alternative to closure—it should be vaccination passports or safe venues. Indeed, perhaps we should have vaccination passports and safe venues. There is not enough emphasis on that aspect in the document or in the discussion more generally.

The Convener: Thank you, Professor Reicher. May I ask the same question of Professor Drury, please?

Professor John Drury (University of Sussex): Yes. I think that I am here because I conducted the only systematic review, so far, of possible behavioural consequences and social impacts of vaccination passports and other forms of Covid certification. My priorities relate to psychology, behaviour and social impacts, and they divide into three areas. The first, which has already been mentioned, is the possibility of social exclusions. As has been mentioned, by definition, vaccination passports exclude some people, but the question is whom they exclude. The criterion is vaccination, and we need only look at the vaccination data to see that there is a consistent pattern in that the groups who are behind others in getting vaccinated tend to be those who are more deprived and those who are black. They will be the ones who are disproportionately excluded by such a scheme. Therefore, recognising that or trying to mitigate it must be a consideration.

08:45

My second concern is about take-up and backfire effects. One of the arguments for vaccination passports is that they might incentivise people to get vaccinated, although there is mixed evidence for that. There is anecdotal evidence that, in the countries that have implemented such schemes, there have been surges in take-up, but we have to take into account the fact that there are different cultures. Denmark is a good example of somewhere that has been successful. Denmark has high levels of public engagement with testing and vaccination, but it also has much higher levels of trust in its authorities than we have in this country.

There is some evidence that a scheme such as the one that is proposed would lead to an increase in vaccination take-up. I note that there is some evidence in the Government's paper that the prospect of the scheme led to a surge in take-up in Scotland. However, there are also possible backfire effects. When we did our systematic review last year, we started to think about that and began to notice the circumstantial evidence. Most of the studies were carried out before vaccination passports were introduced. They were survey-type studies and experiments, and they were a bit hypothetical. However, there was a suggestion—a hypothesis, if you like—that vaccination passports could be introduced.

Since the review was published, there have been two studies that I know of that show backfire effects. One of them is cited in the paper, but I am not sure about the other one. We have much firmer evidence of what can happen with such effects. Some groups, instead of being motivated to get vaccinated, harden in their anti-vaccine view because they construe and understand the scheme as a form of control. Those tend to be the same groups—or people in the same groups—as those who are not getting vaccinated. Therefore, social exclusion and backfire effects interact.

There is a related point to that. It might benefit our response to Covid to introduce such a scheme and make many more venues and activities available, but, if the backfire effect occurred to any degree, I would be concerned about the impact on the long-term relations that those groups would have with authority. My research background is partly in public behaviour in emergencies and how the public interpret and respond to different interventions by the professional emergency

services and the authorities. When there is a poor relationship, that relationship can be damaged by interventions, and the consequences of that could be long term. I am saying that there could be consequences for future engagement with the authorities. For example, one of the studies in our review found that, if vaccination was made mandatory, people would be less likely to be motivated to take a subsequent vaccine. There are such knock-on effects.

My third concern, which is probably less important than the other two, is that there is evidence that vaccination and vaccination passports can provide false reassurance. One of the mechanisms by which they would achieve that in the case of Covid would be the dichotomisation of risk. A sophisticated understanding of vaccination is that it reduces your risk; it does not eliminate it. However, with vaccination passports, there is suddenly a dichotomy of people who are able to engage in certain activities and people who are not. That creates and supports the impression that there are fully safe venues and other venues that are unsafe. We know about risk compensation, whereby people change their risk-related behaviours—their precautionary behaviours—after some vaccinations. That is a third possibility.

The Convener: We have been joined by Graham Simpson MSP, who is not a member of the committee but is attending due to an interest in our proceedings. I welcome him to the meeting and invite him to declare any interests.

Graham Simpson (Central Scotland) (Con): I have no relevant interests to declare, convener.

The Convener: Thank you. I call Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Thank you, convener, and apologies for my late arrival, which was due to a train being cancelled.

Picking up on Professor Drury's interesting comments about backfire effects, I think that one would have expected the introduction of vaccination passports to encourage take-up of vaccinations, but your argument is that, according to some evidence, it might be having the opposite effect on some groups. That seems counterintuitive, and it would be worth exploring that further with Professor Drury and the other panellists.

I have two questions that might help to form the discussion. First, would it assist with the groups that you mentioned if the vaccination passport had an end date? Would that make any difference? Secondly, as an alternative exclusively to vaccination passports, would it make a difference if, as has happened in other countries, there were an alternative to testing at venues? For example, people could either be double vaccinated or produce negative test results.

Perhaps we could start with Professor Drury.

Professor Drury: As I have said, there are a couple of studies that show these backfire effects and, as Professor Reicher has pointed out, they are associated with existing levels of trust in those groups. It is all about what the scheme means, which I guess we can manage to some extent; however, sometimes those meanings escape our control. If the authorities that are trying to reconstrue the meaning of a scheme by presenting it as something democratic are themselves not trusted, that presents some limitations.

The end date issue is important, because if you set such a date, you work against the possible narrative that these things are about control. I understand that, in some of the existing schemes, no end dates have been set, which I think is problematic. If you want to increase trust, you will want to have an end date.

Testing is, as I have said in my submission, certainly one of the alternatives, but there are practical problems with it. For example, if people self-test, you have the issue of self-reporting and people's honesty, and if testing is required to get into a venue, the fact is that not everybody can be tested.

On the one hand, people's engagement with testing is subject to the same demographic variability as vaccination. Indeed, as evidence from last year's mass testing programme in Liverpool has shown, it is deprived groups and ethnic minorities that are not coming forward. On the other hand, though, testing is far less controversial than vaccination, and it does not have the same connotations for those who mistrust authority. You can imagine a one-off testing scheme being more acceptable to people.

I agree with Professor Dye. I am slightly surprised that testing was not included, given that it is perhaps the more acceptable alternative to purely being reliant on vaccination passports.

Professor Dye: Before I answer the question directly, I would point out that we have already heard this morning about the pros and cons of certification, and what we are ultimately dealing with is the balance of the two. Adverse effects have been documented, and Stephen Reicher and John Drury have outlined many of them, but the important question is whether they are dominant enough in any situation to outweigh the advantages of certification and, where they are important, how we can directly compensate for them. Stephen Reicher said as much, and I completely agree with him.

On the end date part of your question, in the United Kingdom—I am not there at the moment; I am in France—there has been a slogan: “data not dates”. There is some merit in that. My preference would be not so much for an end date, which might have to be rescinded, but for end criteria, so that, once we have reached them, we would remove the passport. That would give assurance that it is not a permanent method of control and that the intention is to release it. That would be a better criterion for doing so.

On the alternatives to vaccination certification, which John Drury has just covered nicely, I was surprised when I read in the documents for this meeting that the Scottish intent is to use vaccination only and not the other two back-up methods that are used most widely in Covid passes around Europe—namely, a negative test of some kind or evidence of a previous episode of Covid, implying that the subject is immune in some regard. The advantage of a tripartite system such as that is that it provides a back-up for those people who really do not want to be vaccinated or who cannot be vaccinated for medical reasons. It factors in the third aspect—fairness—which I spoke about in my introductory comments.

I do not know what the reason is for excluding those other two options in Scotland, but I can think of a couple of possibilities. One is that it increases the incentive for getting vaccinated, which is what we would like from a public health perspective. There might be cost aspects, particularly for a Government that is providing a free testing service with rapid antigen test or polymerase chain reaction tests. That is a cost that the Government might not wish to bear, so it might be another factor. However, I do not know the reason.

Across Europe in general, the tripartite system has been broadly agreed on and is what has been adopted by the European Union. As a consequence, the Scottish system would not be interchangeable with a European Covid pass and, with regard to travel and movement, that would be a considerable disadvantage.

Professor Reicher: To understand the backfire effects, it is important to place what is going on in a broader context to see the influences on people’s behaviour. People are not only subject to information from the Government telling them to get vaccinated. There are other voices—anti-vaxxer voices—telling them not to get vaccinated and that vaccines are a problem and a form of control. That is part of the broad populist politics that says that the system is trying to control you. People are positioned between the different voices. What does one do to ensure that the voice of the Government—the pro-vaccination voice—gets traction and the anti-vax voice does not get traction? One wants to avoid doing anything that will give traction to anti-vaxxer voices. We have to look at these things in that context and be aware of the fact that those voices are out there.

One problem is that vaccination passports potentially give traction to the argument that vaccination is about control, in particular among groups that, historically, have concerns along those lines. The reason why there is more vaccination hesitancy among the black population is not because they are stupid or backward in any way but because they have historical experience of the control element being a reality. A couple of years ago, there was a report by the House of Commons and House of Lords that showed that 70 or 80 per cent of the black population felt that the health system did not take their interests into account. Historical beliefs exist and the danger is that, if you feed into them—a vaccination passport is easily interpreted as being about control—that leads to more resistance.

Therefore, we have to ask ourselves how we undermine the sense that the passport scheme is about control and what levers we have in order to do that. I agree that we need end criteria rather than end dates. “Data not dates” is a slogan in the UK that has sometimes been observed in the breach, especially in England. Nonetheless, it is a key slogan here, and it has to be about criteria, because we have seen how dates can backfire.

09:00

As I said, there are other things that we can do. First, we need to look again at the broader context of building trust. Building trust is essential in so many ways in the pandemic, so we need to engage with communities. We should not treat people who have doubts and questions about vaccines as if they are foolish, ignorant or selfish but, instead, take them seriously. It is absolutely central to any scheme that it is done in the context of building trust more generally. If we just have vaccination passports and use them as an alternative to community engagement, that will increase the backfiring effects. As I said, secondly, a conscientious objection process would also be helpful. It would not be something that people could do by just ticking a box—there has to be a process so that if it is a matter of convenience, it is easier to get vaccinated than to opt out—but it would show that people can opt out if they want to. As I said, in the way that we use messaging to introduce the passport scheme and provide alternatives, it is absolutely critical to build trust and undermine the narrative that the scheme is about control.

The final thing about testing—and here I agree with the others—is that, in one sense, it is very simple. People, especially if they are self-testing, will not test positive if they cannot afford to and,

right at the beginning, we saw that with the mass testing schemes in Liverpool. There was much less take-up among the poorest sections of the community, who could not afford to find that they were positive, because they could not afford to self-isolate. The evidence from the events research programme was very clear about that, when the Euros led to a large spike in infections. One reason is that people might not go to the lengths of making sure that they self-test well if it makes it more likely that they test positive and therefore cannot go and see the game. The problem with testing is that self-testing is not very reliable if the effect of a positive is to stop someone from doing the thing that they want to do, and it is practically inconvenient to be tested by others.

There are difficulties, but I still accept the argument that those options are part and parcel of undermining the narrative that the scheme is about control. If the Government is going to introduce vaccination passports, it should include all the various options, even if that is less about practicality than about messaging very clearly that vaccines are for people and for their health—they are not imposed on them and they are not about controlling them.

Murdo Fraser: Thank you. In view of the time, I will leave it at that.

The Convener: We move to questions from Alex Rowley. We have about 10 minutes each.

Alex Rowley (Mid Scotland and Fife) (Lab): I have noticed that, in the past few weeks, the messaging from NHS Fife has been saying to people that, if they have any questions or are uncertain, there are people who they can discuss it with, so I will pick up on that point with Professor Reicher. Have you come across concrete evidence from places where such schemes have been introduced—for example, Israel, across Europe and in some states in America—that shows that they have led to an uptake in vaccination? The UK seems to have good uptake, and the Government in Scotland seems to be aiming its messaging particularly at young people. Is there best practice out there that we can build on, with regard to encouraging those who have not yet taken the vaccine to take it? That question goes to all of the witnesses, but perhaps Professor Reicher will want to answer first.

Professor Reicher: Those are very good questions; they are also very challenging. Early on, one of the first examples of a vaccination passport scheme was the green pass scheme in Israel, which got lots of positive publicity. However, some of the literature coming out of Israel suggested that take-up was not simply to do with the green pass—indeed, the green pass was often not being scrutinised or as effective as it might have been. There were very impressive community engagement schemes. In many ways, the Israeli Government pioneered the philosophy of it going to the people rather than getting them to come to it. For example, there were vaccination stations outside the bars in Dizengoff in the middle of Tel Aviv for young people to go to. People were given something to eat and drink—it was not alcoholic—to make it attractive for them to do that. In many ways, the uptake in Israel was as much to do with those forms of engagement as it was to do with other measures.

Back in January, one of the first things that the WHO said was that community engagement must be at the centre of any vaccination roll-out. Indeed, historically, there is plenty of evidence that supports that. We wrote a piece in *The Lancet* showing how effective community engagement schemes are among the black community.

There are many such schemes. As you said, there is a large amount of very good work going on in that regard. If you go to the website of the Royal College of General Practitioners, you will find hundreds and thousands of such schemes up and down the country, which have been very effective.

It would be better if community engagement was the focus of a nationally co-ordinated campaign. I would echo the WHO's position at the start: community engagement must be at the centre of any vaccine roll-out programme.

Professor Dye: I live in France, so I will speak about the French experience. I also operate in Switzerland, which has a similar approach to that of France.

A number of people, particularly a vocal minority, have expressed reservations about vaccination and continue to do so. However, we know that that is not the majority sentiment. When President Macron announced in July that vaccination certification—the pass sanitaire, as it is called in France, which is a three-part Covid pass—would be mandatory for access to many venues, a million people signed up to get vaccinated within a few weeks. Most of those were people whom Professor Reicher referred to as not anti-vaxxers but those who did not initially feel the need to get vaccinated; they then did feel that need. Consequently, large numbers of people signed up and the scheme has been very effective in boosting vaccination coverage.

In France, the system has worked—from my perspective, it has worked pretty well. There are few complaints about the Covid pass and how it is used. It has quickly become a routine fact of everyday life, along with mask wearing. It is obligatory, so people just do it and they do not

complain about it. The scheme has been a success.

That leads me on to Mr Rowley's remark about the good uptake of vaccines. The question is: what level of uptake is good enough? During the most recent months of the pandemic, with the emergence of new variants, one thing that we have discovered is that we will need very high vaccination coverage to keep Covid at very low levels. The initial assessment that 70 per cent coverage might lead us to cross the herd immunity threshold is now generally viewed as being too low, so we will need higher vaccination rates. Vaccination rates are good but we need them to be as high as possible. Vaccination certification will be a way to help with that.

I will make a final remark on Alex Rowley's first point about the need to support those people who might be excluded for one reason or another and what kind of support that should be, which follows on from what Stephen Reicher said. It is not good enough for it to be passive support—in other words, putting out an announcement saying, "Please contact us if you have problems," because the people who have problems are not the people who will contact you. We need a much more proactive approach to those people who feel that they are excluded. We also need to work out the reasons why they are excluded and ways of compensating for that.

Professor Drury: I will add a few points to what has been said. The Israeli situation is regarded as an example of success. As Stephen Reicher said, there is a confound there with the community engagement programme, which included things such as working with trusted leaders. Trust was important.

In my initial remarks I mentioned Denmark, which is also a success story. As far as I understand it, it has now abolished its passport scheme, because it has had so much success. As I said, there are very high levels of trust in that country and there were already very good levels of engagement with the vaccination scheme and testing before it introduced the passport scheme. I also read that it was reported in Italy that vaccinations increased by 15 per cent after it introduced its scheme and made it compulsory, as well as similar reports from the Netherlands. However, a lot of that is anecdotal and I have not seen any peer-reviewed evidence from those countries.

Professor Dye's point about attitudes in France is interesting. We are all aware of the very visible opposition that there was before its scheme came in and at the beginning of it. I acknowledge that there are various dimensions of variability for attitudes to vaccination passports, which came through in the systematic review that we carried out last year. We have already talked about population demographic variability—that is, different groups having different attitudes to vaccination passports. There is also lots of evidence that the purpose to which the vaccination passport is put is another variable. Public support for vaccination passport schemes tends to be much stronger in relation to international travel and much weaker in relation to activities such as going to work. Other activities, including leisure activities, lie in the middle.

The other dimension along which attitudes vary is time. When we looked at the many attitude surveys that have been carried out on vaccination passports last year and this year, one thing that was clear was that attitudes change—they become more positive and they become more negative. One factor that makes attitudes more positive is implementation and roll-out, which tend to be associated with greater public acceptance. However, that is not to say that there will not still be a rump of people who oppose the scheme. The question of whether it is worth it boils down to knowing how big that rump of people is, and the consequences of that opposition for later public health engagement and interventions.

John Mason (Glasgow Shettleston) (SNP): There is a lot in there. My first question is for Professor Dye. You mentioned people who could not be vaccinated. It has been suggested to us that that is fewer than one in 1,000 people. Is that about right?

Professor Dye: I cannot give the committee a precise figure, but it is a very small minority from a medical perspective. However, I echo what others have said in that regard, which is that, just because those people who cannot be vaccinated are in a small minority, they should not be ignored. Nonetheless, in terms of balance, it is a very small number of people.

John Mason: Professor Reicher mentioned conscientious objection. I am interested in how that might work. Can somebody simply say that they object to vaccination passports and therefore will not get one? If so, should they still be excluded from going to a big football match or a nightclub or that kind of thing, or should they be counted as exempt, just like somebody who is medically exempt?

09:15

Professor Reicher: Let me go back to the logic for that. In relation to the impact of vaccination passports, we have to distinguish between the effect in the short and the longer term. The short-term effect is genuinely positive, because it leads those who I call the vaccine indifferent to think, "Well, I might as well get a vaccine, because it is

more of a hassle not to". Those are people who simply have not got around to it, which is why we then see the surge in uptake.

However, the danger is that, although that approach wins over the vaccine indifferent, in the longer term, it consolidates the opposition of those who are already doubtful. That is important not only in relation to social exclusion—as John Drury pointed out, those people tend to be in rather marginalised groups in our society—but because it has, in a sense, a biological implication.

One of the problems when we talk about herd immunity is that we do so as if the population is homogenous and as though, if 90 per cent of people are vaccinated, it is evenly spread. However, if take-up is unevenly spread and there are some communities in which there are much lower levels of vaccination, it means that we have pockets in our society where the virus can continue to spread and where new variants can still come about, which poses a major problem. Even if there are only some communities in which there are lower levels of vaccination, it is still very much a problem.

The great advantage of enabling conscientious objection in relation to the vaccine indifferent is that it will not undermine the take-up of the vaccine by the vaccine indifferent, as long as the procedures make it easier to get vaccinated than not to get vaccinated. At the same time, for those who are doubtful and who think that it is a form of control, that approach says to them that there is a way out if they want it. It could therefore have the advantage that we would still win over the people we can win over but would not alienate the ones we do not want to alienate. In order to achieve that effect, people who choose to go through the process and be conscientious objectors should still be able to go to venues and so on. In other words, it would be a device to undermine the narrative of control and to have the benefits of the vaccination passport system as a whole, without the problems.

John Mason: Other members might have follow-on questions on that point.

France, which has been mentioned a few times as a comparator, seems to have a much wider scheme in the sense that people need to have a certificate for many more services. Does that make a difference? Can we be more relaxed because we are saying that our scheme is for only a very small number of high-risk, luxury items? Is the advantage of France's wider scheme that it has become more widely accepted? I will put that question to Professor Dye, because he is in France.

Professor Dye: The reason the French scheme is more comprehensive is that it was introduced at a time when a new resurgence of Covid was beginning during the summer. The Government decided that it wanted to use all means at its disposal to control that new resurgence. It decided, in effect, to take few risks by being more comprehensive about the way in which the vaccination programme was done, backed by the Covid pass system. Subsequently, for that and other reasons, case incidence has come down to relatively low levels.

That reminds me of what has been absent from this conversation so far. We have talked about balancing risks, but of course whether and how certification is used depends on the epidemiological circumstances of each country. Where there is no Covid, there is no longer any need for any certification process. That was the point that Israel almost reached earlier this year.

We have to translate what is happening in France, Denmark, Switzerland and other comparator countries into the current Scottish epidemiological situation, which is less favourable. I see from the data that the number of cases is now coming down, but Covid is still at pretty high levels in the UK, which means that there are stronger arguments for reinforcing the vaccination programme and strengthening methods to improve coverage. Certification is one part of that.

The difficulty that I see with conscientious objection—I offer this just for discussion—is that whether someone is permitted to object depends on the circumstances under which they are operating. Let me take an uncontroversial example in medicine. Doctors who do surgery have to be vaccinated against hepatitis. If you are in medical service, you cannot be a conscientious objector and refuse to have that vaccine, because the risk is simply too high for everybody concerned.

The same will be true under Covid certification. There will be circumstances in which people can simply opt out and be objectors. People do not have to go to nightclubs, for example. However, in medical and clinical settings, such as care homes, the community at large might take a different view on that. That is a difficulty with the idea of conscientious objection.

John Mason: That leads me to my final question, which I will put to Professor Drury. Although the intention of the Government and the Parliament is that certification would be needed only for nightclubs, big crowds and so on, I presume that employers and other venues could use the system as part of their entry requirements. Would that be a good thing or a bad thing? Are there risks in that?

Professor Drury: My first point is that a group that we have not talked about yet is people who work at such venues. One of the arguments in favour of a vaccination passport scheme is that it

could make front-line workers safer. People who work in bars, for example, are exposed a lot.

It is interesting that you have brought up the question of employment. Earlier, I said that we can compare public attitudes on vaccination passports across the different activities that they allow or disallow. The activity for which there is most support for vaccination passports is international travel, and there is least support for their use in allowing people to go to work. Israel's scheme included certification for people going to their workplace, and there is some evidence that that led to conflicts when some people were not able to get into their workplaces.

I would like to broaden the discussion and address the question of scope, which we have touched on. It is quite interesting to compare the scope of the Scottish proposals with the scope in other places. On the one hand, we could say, as Professor Dye did, that the activities and venues that are included under the scheme are ones in which people have a relatively high level of choice. Therefore, we could say that the possible exclusions for certain groups would be less severe, because those included are not necessarily everyday activities such as going to the pub or the shops. On the other hand, I was interested to see that, as well as nightclubs, which are indoors, outdoor events are included. That is perhaps slightly paradoxical, because, as we are all now aware, there is fresh air at outdoor events so people are much less likely to be infected.

Earlier, we talked briefly about the events research programme. It is useful to consider the evidence from that programme and other evidence that has been brought to bear on people's attitudes on and engagement with vaccination passports for live events.

A survey that was carried out earlier this year by an agency in the live events industry found a very high level of support for such measures among people who go to events. However, the question was framed with a reference to "all biometric testing", so that included not only vaccination passports but testing for immunity—the broad range of tests. There is broad support for that.

The events research programme has found considerable variability in outcomes, which is consistent with Stephen Reicher's point that it seems that it is possible to operate outdoor live events and minimise the risk of infection without a vaccination passport scheme but with other things instead. The research picked up relatively low levels of infection at Wimbledon and relatively high levels of infection at other events, such as the Euros. There are two key variables that seem to matter. One is how an event is managed and the other is the behaviour of participants—the culture, the levels of intimacy and physical proximity, and whether people are shouting. The key point is that both those things can be modified. That is the logic and rationale behind a scheme that certifies venues and events as an alternative or complement to a vaccination passport scheme.

Brian Whittle (South Scotland) (Con): I am trying to establish where the evidence base is for not just the introduction of vaccination passports but the way in which the Scottish Government has introduced them. I am concerned that we seem to be comparing Scotland with what is happening in other countries and trying to take lessons from them when, of course, there is a huge variation in vaccine uptake across other countries, so there is variation in the need to encourage uptake. Is comparing the Scottish vaccination passport scheme with schemes in other countries an accurate way to assess whether we should adopt vaccination passports in Scotland?

Professor Reicher: Comparison with other countries is both the best of worlds and the worst of worlds. It is the best of worlds in that we can learn much from what has happened elsewhere, but it is the worst of worlds if the comparisons are made mechanically and ignore the key parameters that differentiate between countries. It seems to me that the key parameters are biological-medical and social. As Professor Dye has pointed out, incidence rates are a major factor. There is a need for schemes only if there are high rates in the community. At a social level, I come back to the absolutely critical role of trust—social trust is a key parameter. Such schemes are understood in different ways and have different implications in different countries. Professor Drury made the point that Denmark, where schemes have worked well, is a high-trust country. The Scandinavian countries have the highest rates in the world of trust in Government and of people's trust in one another. The world trust surveys that are carried out every year find that to be the case systematically.

Any comparison must take those two factors into account. Whatever we do around the pandemic, the central issue for me as a psychologist and social scientist is about the building of trust. We can give people all the information that we like but, if they do not trust the source, they will not listen to us. I go back to the fact that we are involved in a battle with the anti-vaxxers over information. We will win that battle to the extent that there is more trust in us than there is in them. However, anything that atrophies or undermines trust is corrosive not only in terms of vaccination but in terms of any measure that we need to deal with the pandemic.

To go back to the question, let us take international comparison very seriously, but only in the context of an awareness of the key parameters

that differentiate between countries. For me as a social scientist, that key parameter is trust.

09:30

Brian Whittle: Do either of the other two witnesses want to add anything before I move on?

Professor Dye: I agree with Stephen Reicher that international comparisons are important but limited. The difficulty is that we do not know how much of what goes on in France, Denmark, Switzerland or indeed any other country applies directly to Scotland. In other words, the decision that is being made now on certification will be made in the presence of uncertainty. That is a key point: we are never going to have all the information that is needed.

The question, therefore, is what decision should be made in light of a certain amount of evidence and plenty of uncertainty. Is the political decision to err on the side of caution and strengthen the vaccination programme through certification or is it to err on the side of less caution and more risk—one might say—and not introduce certification? It seems to me that the decision has already been made, given that, as we heard at the start of the meeting, the intention is to introduce the scheme tomorrow. What follows from that uncertainty is the need to follow things up with data collection and information in order to understand how successful the introduction of certification has been, with regard to not only the practicalities of what is and is not acceptable—which we have already spent a lot of time on—but the epidemiological impact. There is a really important need to continue collecting data and information to see how well the scheme is working.

Brian Whittle: The Scottish Government has said that the main driver for introducing the vaccination passport scheme is to encourage those who have not been vaccinated to get vaccinated. As we heard in last week's evidence and as Professor Reicher's evidence has highlighted, one of the key issues is the reluctance of certain groups to get the vaccine. In that regard, a big driver is ethnicity—I am thinking especially of our Polish and African communities—and another is living in areas of deprivation. If we are saying that people need to be vaccinated to get into nightclubs or football matches, I would suggest that the people in those groups are unlikely to be participants in those activities. Will the way in which the vaccination passport is being introduced help those groups do what the Scottish Government wants them to do, which is to get vaccinated? I will ask Professor Drury to respond first, given that he has not spoken to me yet.

Professor Drury: First, I want to make a broader point about that particular evidence, because it frames everything that we say. How can we be confident in the arguments that we are making? We have four different types of evidence for the backfire effects in vaccination take-up and so on: international comparison is one such set, and we also have survey and self-report evidence and evidence from experiments. Of course, experiments and surveys themselves might be based on self-reporting and are rather artificial, but they provide relatively consistent patterns of the types that we have been talking about. There are also the vaccination rates and the demographic differences that I have talked about.

That is all we have. It might look like a lot, but we do not have, for example, the randomised control trials that are the gold standard. However, we still need to make decisions, and we are doing so.

I am afraid that I do not have any specific evidence with regard to the two groups that you mentioned, and I guess that, to answer your question, what we need to do is understand their existing attitudes.

Professor Reicher: My dad came from Poland during the war to join the Polish air force in the UK, and you should have seen him when the football was on. The Poles are quite interested in football, as is the black community.

We have some unpublished data from a study that I did with one of my masters students that showed reasonably clearly that, for black participants, the introduction of vaccination certification for large events such as concerts and football led to a greater sense that vaccination is about control—that it is done to us rather than for us—and led to lower intentions to get vaccinated. I absolutely accept all the provisos to which John Drury has just pointed—it is experimental data, self-reporting and so on—but I also echo what he said about it being consistent. The point is that, especially among the black community, there is traction for a narrative that people in the community are not well treated by authority and are controlled by it. Therefore, anything that feeds into that is more likely to be read in those terms and to lead to more resistance.

It is also consistent with the evidence on vaccine hesitancy. Overall, there is little vaccine hesitancy in the UK. Only 4 per cent of people are vaccine hesitant but, when we look at the smaller communities we see much higher levels of hesitancy: among the unemployed and the Muslim community, it is 14 per cent and, among the black community, it is 21 per cent. For me, that is not only a social problem—although it is a major social problem—but, potentially, an epidemiological problem because we have potential reservoirs of infection in the UK and will never get herd immunity while those reservoirs exist.

Brian Whittle: Professor Dye, would you like to add anything to that?

Professor Dye: I will add a comment about the purpose of certification. You mentioned that the main purpose is to increase incentives for vaccination. The evidence paper says that as well. In fact, it is equally to protect health and stop transmission because it is a way of controlling—I use that word advisedly and, I hope, carefully—the transmission of infection at the events and mass gatherings about which we are talking. It is about incentivising vaccination but it is also about protecting personal and public health.

Brian Whittle: Given that, as has been highlighted, there are specific pockets of our population that are less likely to be vaccinated, what should we do to encourage vaccination uptake?

Professor Dye: That is a difficult question to answer specifically. I can only reinforce everything that has been said.

Perhaps I am stating the obvious, but it starts with not dismissing people who do not want to be vaccinated as fools—stronger language has been used in many circumstances. My knowledge of the behavioural literature on the matter is somewhat limited. However, the studies that I know of that have investigated the reasons why people do not wish to be vaccinated discovered that it is not a single reason but that there are four, five or six different groups of reasons in different communities. We have to start with that understanding of why people do not want to be vaccinated. We might say that it is irrational but, from their perspective, it could be fully rational and very reasoned. Unless we understand those reasons by working with those communities, we will not be able to persuade them.

That goes to the point about messaging as well. We need not just messaging per se but effective communication with the people who are on the receiving end of those messages.

In short, we must understand why people do not want to be vaccinated. When we do that, we will be in a better place to increase vaccination rates.

Professor Reicher: There is a very long answer to that and a very short answer, and the short answer is community engagement. It is about going to people, listening to them, respecting them and allowing them to have doubts and to go away and come back to you. It is very much about treating those who are vaccine hesitant as perfectly reasonable people who have real doubts.

It is also important to distinguish between different populations. The first thing is that the number of people who are not vaccinated is far higher than the number of people who are vaccine hesitant, because most people who are not vaccinated are vaccine indifferent—they have not got around to it—and they are the ones who can catch up more easily. The difficult ones are those who are vaccine hesitant—they have questions—but they are fundamentally different to anti-vaxxers. Anti-vaxxers do not have questions; they think that they have the answers—they know that the vaccine is wrong. If you treat the vaccine hesitant as though they are like anti-vaxxers and lump them all together, the danger is that they will become all lumped together. You want people to see you as being on their side and to trust you, but you have got to respect them, if you want them to respect you. Therefore, engagement is the first thing.

Secondly—again, it is a simple philosophy—do not wait for them to come to you; go to them. Make it so much easier to get vaccinated: set up vaccination centres in communities, give people paid time off to get vaccinated, use community champions and so on. I would put all those things at the start of my debate about how to increase vaccination rates—I would not have it as an add-on after vaccination certification.

With regard to my final point, I agree absolutely with what John Drury said—in many ways, it is the most important thing that has been said today. Certification for individuals creates all the problems that we have been talking about, because you then need forms of scrutiny and surveillance to ensure that people have vaccination passports and you introduce all the problems of what happens when you have to stop people and ask them to show passports and all the problems of alienation that we have talked about. It seems to me that we ought to be placing equal, if not greater, emphasis on certification for venues.

If venues are well ventilated and have high hygiene standards, they are relatively safe. Not only is there evidence about large events outdoors, but there was a recent large study in *Nature* that showed that even indoor large events are relatively safe if they are well ventilated and have high hygiene standards. Therefore, if you had certification for venues, so that they had to meet particular standards before they could welcome individuals, you would have many of the advantages without so many of the disadvantages.

It is not a case of either/or—you can have both—but if you are going to have certification, you should do it in the context where you put much more work into community engagement and certifying venues. In that context, where you show that you are acting to protect people, again, you are likely to get far more trust in and traction for the narrative that vaccination passports are about

protecting people rather than taking away their freedom.

Professor Drury: As Christopher Dye said, incentivisation is not usually the main rationale for such schemes. I know that that has been mentioned by many policy makers, but, from a public health perspective, such schemes are usually about making spaces safer.

To echo what Stephen Reicher said, hesitancy is only one reason why people are not getting vaccinated. Successful public health campaigns around the world have all been based on community engagement. There are accounts of inspiring campaigns on AIDS and Ebola in some countries.

On top of community engagement and building trust, there is the practical side of facilitation. For example, sometimes people are reluctant to get vaccinated because they expect to be sick for two days afterwards, so we should give them paid time off work. Sometimes people are reluctant to be vaccinated, because the vaccination centre is out of town, so we should bring the vaccination programme to people—that is what was done in Israel and in some local authorities here.

The final point is about the different groups of people who are not coming forward to be vaccinated. Different groups have particular concerns. For example, yesterday, I was at a seminar where new evidence was presented that reluctance among young women often relates to concerns around pregnancy. That is a specific concern that needs to be addressed in a community engagement programme.

09:45

The Convener: Thank you. I am conscious of time, and I remind the committee that we have only 15 minutes before one of our witnesses has to leave.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I welcome the witnesses. First, I would like to know how to pronounce Stephen Reicher's last name, because we have heard it pronounced in different ways.

I have listened carefully to what has been said today and I have read the committee papers. I have to say that this is a hugely confusing and conflicting conversation, but I have drawn some conclusions, which I will quickly run through. We know that the virus is endemic in the population and we know that it kills people; the target scheme is working, which we know because we are getting an uptick in the number of people who are getting vaccinated at the moment; the vaccine reduces infection by up to 50 per cent, as we heard in a previous meeting; the virulence of the delta variant is much higher, as we have also heard previously; the post-vaccination passport messaging requires a strong focus on continuing with hand washing and mask wearing, because of the false sense of reassurance that you have spoken about today; and, largely, the Scottish Government is trusted on what it has done so far, which is helped by the fact that the scheme that we are discussing is subject to a sunset clause—I know that there is a debate in relation to time and data.

To me, events and venues do not transmit the virus—people do. By and large, the nightclub industry has worked incredibly hard to make the venues as safe as possible. I take the point that you are making about venues and events, but I would argue that it is the people who transfer the virus, not the events, so I have a couple of questions.

Conscientious objectors have a choice: you are right to say that they absolutely can choose not to take the vaccine. The scheme is a targeted one. People do not have to go to the events that they will be excluded from if they do not have the vaccine. However, following on from what Professor Reicher has said, by allowing conscientious objectors access to events, are we taking away the rights of the people who are in the venue and also discriminating against the business owners, because having those conscientious objectors in the venue could put other people at risk and cause the business owners a problem?

My second question is one that I have asked on numerous occasions. Care home workers in my constituency have been sacked by a care home owner because they will not take a double vaccine. The owners have taken the view that, on balance, the rights of the residents are more important than the rights of the workers. We have discussed that at length and it is something that we need to delve into. The question is, whose rights are more important: the conscientious objectors or the people on the other side who want to see a vaccinated population?

I want to make a point about the backfire effect, which I will leave open for further discussion. If the backfire effect occurs, events cannot open and businesses cannot trade. If there are people who simply refuse to get vaccinated and continue to spread the virus and put pressure on our NHS by blocking beds and preventing other people getting various treatments—all the stuff that we know is already happening—how does the rest of the community react to that demographic, whether the reason for their not getting the vaccine involves a hesitancy or a failure to believe that it will work? How does that affect the majority of the community who are saying that those people are stopping everyone else from getting on with their lives? I

know that is controversial, but I would like to discuss it.

Professor Reicher: There is no time left. [*Laughter*.]

There are lots of questions there. First, Christopher Dye pronounced my name correctly: it is Reicher with a "sh" sound. However, that is not quite correct, because the actual pronunciation is a guttural Polish sound that I cannot do. My father always used the "sh" sound.

I would not be able to answer every question even if we had three days to do it, but I will make two broad points.

First, in many ways, my arguments are pragmatic. They are about what will get people to be vaccinated. I absolutely agree that we want more people to be vaccinated. Vaccinations save lives. It has been estimated that they save more than 100,000 lives. What is more—this, too, is a really important message—is that if people are not vaccinated and, indeed, if they act in risky ways by not wearing masks or not socially distancing, they create an exclusive society. It means that people who are vulnerable do not feel confident and able to go out in society and that, as we reopen our society, we reopen it to some but imprison others more.

One thing that worked about the messaging early on in the pandemic was that it focused on the communal rather than the individual—it was about "we" rather than about "I"—and many people went along with restrictions that were quite onerous and quite difficult for the community. A lot of evidence in a number of studies showed that the key factor in adherence was about wanting the community to come out of things well. It was not about personal risk but about communal risk.

You talked about messaging. We need to get across that message and build norms in particular groups and communities that we are behaving in this way so that we as a community can reopen, so that even vulnerable people can go out to the cinema and nightclubs. That communal framing is an absolutely central point. We have forgotten it a little bit and the messaging needs to concentrate very much on it.

That is one general point. On the various issues about the impact of vaccination certification, my arguments are that if you introduce such interventions and moderate the scheme in such a way that people do not feel that it is a form of control, they are more likely to go along with it and get vaccinated in such a way that it becomes safer for everyone, the vulnerable can go out and the venues can stay open.

I absolutely agree that most places are good and have put huge efforts into making their venues safe. Why not then make that formal and show it? Just as when you go into a restaurant, you see hygiene certificates that tell you that you will not be infected by bugs from the cooking, if people see that the venue is safe, it will give them more confidence to go out and use the economy, which would be good not only for public health but for the economy. It is a matter of not only making us safe but making us know that spaces are safe so that we can use them. A certification scheme for venues would be good all round. It would be good for public health and for the employers and owners who have put huge efforts into making their venues safe.

Professor Dye: As you said, Mr Fairlie, safe people are not an alternative to safe venues. We should have both because both together will have the best effect.

Your point about care homes and whose rights are important raises a question of general importance. The science that lies behind that, which is why we are here, can take us only so far. From the perspective of epidemiology, we can speak about risks to individuals and groups of people in different settings such as care homes. However, the assessment of rights and values is a subjective judgement that needs to be made by all those who are involved—not just by one group of people, such as the people who run care homes, but by the community of all the people who are involved in what care homes do. In the UK especially, we hear a lot about following the science, but it takes us only so far. When it comes to the assessment of value, that is a community-based decision, and it might be a different decision when made in different circumstances.

Professor Drury: I have my own views on rights, but the points that I have been making are based not on rights but on public health outcomes. Care home workers are a case in point. The difficulties with retention in that respect are a real practical problem, so the argument that might be made against mandatory vaccination for those workers is, for me, not one of rights but all about having a viable care home.

The point about the rights of others is similar to that about those shielding; in fact, it was made in the UK—or, I should say, English—context around 19 July, when many people who were shielding felt that they were being systematically disadvantaged and losing their freedom and rights at a time when everyone else had been given the right not to wear a mask or distance. However, that was an argument in favour not of vaccination passports but of other public health measures such as distancing, mask wearing, hygiene and so on. It is important that we remind ourselves that most public health experts say that we will still

need other public health measures and that vaccination cannot do all the work.

Finally, on your divide-and-rule point, division is a real worry for me as something that might come out of vaccination passports, with people feeling excluded and different groups feeling resentful towards others. However, my understanding is that the affected venues are already open. Unless I have misunderstood it, the scheme is not for reopening venues but for use by venues that are already open. I am not sure that that would be a basis for resentment.

The Convener: I am sorry, Mr Fairlie, but we have to move to Alex Cole-Hamilton.

Alex Cole-Hamilton: Good morning, panel. I have just one question that I hope will be pretty straightforward.

Section 5.1 of the Government's evidence paper, which was produced last night, states that the scheme first and foremost

"aims to ... Reduce the risk of transmission".

Driving vaccine uptake is in fact ancillary to that, as it is the fourth bullet point. That chimes, I think, with the theme that the Government is trying to set out in its case, which is that Covid ID cards and vaccination certification are in and of themselves tools of infection control. When I asked the First Minister to respond to the fact that 5,000 cases occurred at an event that had required vaccination passports, she stated as indisputable fact that, without those passports, transmission would have been worse. As Professor Stephen Reicher is leaving, I will start with him. Do you think that that is fact? Would the situation at that event have been worse had there been no vaccination certification?

Professor Reicher: It is terribly difficult to deal with such counterfactuals. The simple answer is that I do not know, but I can point to the issues that are important.

On the balance of risks, when it comes to the issue of vaccination take-up, which we have been discussing at great length, you have an advantage with the indifferent but a disadvantage with those who lack trust. That is the balance to be struck.

With regard to transmission, it is indisputable that those who are vaccinated are less likely to be infected and less likely to transmit the virus, although we do not know exactly by how much. What we do not know is whether people's potential sense of invulnerability leads to riskier behaviours.

10:00

There is some evidence that, when people were first vaccinated, they began to act in riskier ways. There was evidence from Israel that that was happening, and there was evidence of it in the UK—the over-80s were going out and socialising more. Although that is a rather nice image, it led to the potential for more transmission, because the simple fact is that the more contacts we have, the more transmission there will be.

We cannot say absolutely what effect vaccination passports will have on behaviour because, in large part, that is also a matter of communication, which is why the issue of communication and messaging is so important. John Drury's point is an absolutely essential one. We misunderstand the pandemic and it is not helpful if we see things in binary terms, such as vaccination either works or does not work, or vaccination either breaks the link to hospitalisation or does not. Vaccination does not make us safe—it makes us safer. It is really important to message in such a way as to ensure that if people get vaccinated, they do not then behave more riskily. Let us say that, biologically, the vaccine makes us half as likely to get infected. If we then go out and see twice as many people, we will, in the end, have lost the advantage of vaccination. Therefore, behaviour and the messaging are critical.

Where the First Minister is indisputably right is that, at a biological level, getting the vaccine makes us safer. When it comes to the way in which vaccination is introduced, we must send the messages that make sure that that is not undermined by behaviours that are riskier.

Alex Cole-Hamilton: I put the same question to Professor Dye.

Professor Dye: I broadly agree with all of that, of course. It is never possible to say what would otherwise have happened in one particular instance or at one particular event, but it is clear where the balance of probabilities lies. It is clear that vaccination certification is a way of increasing the safety of such events—in other words, there would probably be less transmission under circumstances of vaccination certification.

On risk compensation, I take the point that that could happen in society at large, but one would have to imagine how risk compensation among people who are vaccinated doing riskier things would take place in a particular nightclub, bar or whatever. It seems to me that it might not be so important under such circumstances, because people do what they do in nightclubs. By and large, I think that the First Minister is right when it comes to the balance of probabilities, but it is impossible to speak about what might have happened at any single event.

Alex Cole-Hamilton: I want to bring in Professor Drury, who has spoken extensively about behavioural science in this area. Given the significant coverage that vaccination already

enjoys across the UK, is there a tipping point—I am thinking of an event such as the Boardmasters event in Cornwall, where there were 5,000 infections—at which the benefits of people evidencing their vaccinated status versus the risks of them dispensing with some of the precautions and indulging in riskier behaviour because of that means that it is more of a liability than an asset to ask for Covid certification?

Professor Drury: On the specific question of the venue, I am not an epidemiologist, so I cannot comment on that. I understand that all the published studies on the reduction in transmissibility that is provided by the vaccine are pre-delta. Given that we are talking about delta, there is even more uncertainty.

On the balance of risks, again, it is not easy to give an answer to that, because it relates to what Stephen Reicher said about the consequences and how much risky behaviour follows from people's understanding of what it means to be vaccinated. Therefore, I cannot really give an answer to that.

The Convener: I thank the witnesses for their evidence and for giving us their time this morning. If you would like to offer any further evidence to the committee, you can do so in writing. The clerks will be happy to liaise with you about how to do that.

I suspend the meeting to allow for a changeover of witnesses and a short comfort break.

10:04

Meeting suspended.

10:11

On resuming—

Ministerial Statement

The Convener: Item 3 is evidence on the latest ministerial statement on Covid-19. I welcome John Swinney, Deputy First Minister and Cabinet Secretary for Covid Recovery; Dr Gregor Smith, chief medical officer; and Elizabeth Sadler, deputy director, Covid ready society, Scottish Government. Thank you for your attendance this morning.

Deputy First Minister, would you like to make any remarks before we move to questions?

The Deputy First Minister and Cabinet Secretary for Covid Recovery (John Swinney): Yes, I would, thank you, convener.

I am grateful to the committee for the opportunity to appear before you once again. On Tuesday, the First Minister set out a number of Covid-related updates on the rules on international travel, and on promoting better ventilation, including the immediate step to make up to £25 million of additional funding available to support business to enhance ventilation.

The focus of the First Minister's comments on Tuesday was the Covid certification scheme. The Scottish Government takes the position that the implementation of a mandatory domestic certification scheme is proportionate and appropriate at this point in the pandemic.

Recent data has been a stark reminder of the challenges that we continue to face as a nation. Getting vaccinated remains the single most important thing that any of us can do to help cases to remain under control.

We have seen considerable efforts from businesses and individuals to step up compliance with the mitigation measures that remain in place. That remains crucial to how we emerge from the pandemic.

In line with our strategic intent

"to suppress the virus to a level consistent with alleviating its harms while we recover and rebuild for a better future",

the Covid-19 vaccination certification scheme will allow us to meet the following aims: to reduce the risks of transmission; to reduce the risks of serious illness and death, and, in doing so, alleviate pressure on the healthcare system; to allow high-risk settings to continue to operate as an alternative to closure or more restrictive measures; and to increase vaccine uptake.

Last week, we set out details on how a domestic certification scheme would operate, and, on Tuesday, we published detailed guidance on how

we expect that to be implemented in the small range of sectors that are within the scheme's scope.

We have listened to a range of stakeholders and very much appreciate the challenges that the implementation of the scheme presents. That is why we are ensuring that the enforcement measures will not take effect until 18 October.

To be absolutely clear, the expectation is that businesses adopt the scheme from 1 October, so we will be monitoring that closely to ensure that the requirements are being met.

The interim period will allow businesses to familiarise themselves with the guidance, to develop measures for enforcing Covid certification and to test those in collaboration with local authority representatives and, indeed, with Government ministers.

The Government's view is that certification can play a useful role in helping to keep case numbers low as we move into winter. We have come a long way in recent months, our economy is open and we are seeing a relative return to normality. Partnership has been key to that, and I ask that businesses and individuals continue with that endeavour in the coming weeks, to ensure that we are all doing all that we can to recover collectively from the ill effects of the pandemic.

This afternoon, the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/349) will be laid and will come into force from 5 o'clock tomorrow morning. I understand that, in line with the usual agreed procedure for made affirmative Covid Scottish statutory instruments, my officials shared draft regulations with committee clerks yesterday.

The regulations that are amended by the instrument require Scottish ministers to review the requirements at least once every 21 days and revoke any requirement as soon as it is no longer necessary.

I look forward to responding to your questions.

10:15

The Convener: Thank you, Deputy First Minister. I will ask the first question.

Could you comment on the indicators that the Scottish Government intends to use to monitor the implementation of the vaccination certification scheme?

John Swinney: We intend to monitor the pattern of the pandemic, as we have done on a consistent basis up until now. The key indicators that we examine relate to the daily cases, the age breakdown within those, the levels of hospitalisation and the demand on intensive care units, and we apply that information to the wider modelling of the pandemic to determine the effect that all the measures are having within the handling of the pandemic and the scale of the challenge that we face.

That enables the Government to formulate a view about what measures remain proportionate, as that is the key test that the Government must continue to fulfil to ensure that there is legal foundation to the approach and, fundamentally, to enable us to make a judgment about the course of the pandemic and the measures that are required for us to take the necessary intervention.

The Convener: What key indicators will you be looking at to determine whether the scheme is working as intended? How will businesses, organisations and the public be able to provide feedback on the implementation of the scheme? Will you publish that information as part of the three-week review process?

John Swinney: I am happy to consider what material we can helpfully publish to demonstrate the response and the reaction to the measures. We publish a huge amount of data on a regular basis but, if the committee wishes to specify and stipulate areas where it believes that the publication of data would be of assistance, I will be happy to consider what could be published in that context.

The Convener: Thank you.

The committee has received correspondence from a member of the public who was a volunteer participant in the stage 3 Novavax trial in Aberdeen that took place in December last year. He claims that NHS England has registered all 13,000 volunteers but that no participants have been registered in Scotland. First, do you recognise those figures? Secondly, what contact has the Scottish Government had with the vaccine trial participants to hear and address their concerns?

John Swinney: I will invite Dr Smith, the chief medical officer, to comment on that. First, I would be happy to consider the letter that has come from the member of the public and to try and address the issues that have been raised. It is important that individual cases are looked at properly.

Secondly, we have written to those who have been involved in vaccine trials to provide them with assurance that they will be exempt from the Covid certification arrangements. If a particular issue has arisen as part of that process that we have not taken account of, I would be very happy to do that.

Perhaps Dr Smith can give more detail.

Dr Gregor Smith (Scottish Government): First, I give a big thank you to everyone who has participated in the trials. They have been enormously important in giving us the knowledge and the confidence to move forward with the incredibly successful vaccine programme. We are eternally grateful to everyone who has participated.

There are some specific trials that are still on-going. Within those trials, there are trial protocols that mean that people are blinded, so they perhaps do not know whether they have had a particular type of vaccine or a placebo.

What we have committed to—and what we have done to this stage—is that, for those people who are participating in trials in Scotland, the principal investigators for those trials have written to each of the participants with a letter that they can use in the same circumstances as those in which certification is currently employed. That is like a letter of comfort showing that those people have been involved in trials and should be treated as though they are vaccinated.

When it comes to how those certification letters are recognised internationally and received by other countries, it becomes a bit more challenging, and there are international discussions in that regard. The issue is not unique to the UK—every country is currently working through some of the challenges, and we continue to liaise with our colleagues in the UK Government as to how we might achieve a solution.

Murdo Fraser: Good morning. I have a large number of questions that I would like to ask, but time constraints will allow me to ask only a fraction of them. However, we will see how we get on. My questions relate to the draft regulations and evidence paper that we got yesterday afternoon.

On the issue of allowing negative polymerase chain reaction tests as an alternative to proof of double vaccination, at paragraph 5.1 of your evidence paper, you say:

> "Scotland will be the only European country that will adopt a vaccine only certification scheme with no option to provide a negative PCR or antigen test result or proof of recovery from a previous COVID-19 infection within a predetermined time period."

In evidence this morning, we heard from experts, including Professor Drury, who talked about the backfire effects of requiring vaccination certification, and how it might depress vaccine take-up among those who are already vaccine hesitant. On that basis, and given that every other European country allows testing as an alternative, why was that not considered by the Scottish Government?

John Swinney: It has been considered by the Scottish Government, and we came to the judgment that the core purpose of the scheme was to encourage improvements in the take-up of the vaccine. I accept that with almost all the questions that we wrestle with in relation to Covid there is a balance to be struck, because there is never a crystal-clear position to be adopted. Therefore, we felt that, on balance, the benefits of concentrating the scheme on the purpose of increasing vaccine take-up rates would be potentially undermined by having an alternative route of demonstrating evidence of testing. That was the judgment that we arrived at on that question.

We have said that we will continue to consider whether a testing approach can be added to the arrangements that we are putting in place. We have not ruled it out for all time, but we have taken a view that, as we introduce the scheme with the express purpose of boosting vaccination rates, we should not adopt the approach that Mr Fraser has put to me.

Murdo Fraser: Thank you for that.

In evidence this morning, we heard from Professor Dye and others that the backfire effects might be minimised if the vaccination certification provisions were time limited. If people could see an end point, that could remove the potential distrust among vaccine-hesitant groups. Is that something that the Scottish Government has considered?

John Swinney: There are two aspects to that issue. I accept the point that time-limited restrictions and constraints are beneficial, because everybody wants to feel as though we will not be in the current situation for ever, and that there will be an end point. I completely accept that point. That is why we have end points for a number of the statutory arrangements for Covid restrictions, when regulations will naturally fall.

The second point is that there is a three-weekly review of whether the measure should carry on. That three-weekly review will have to be tested against the judgment of whether the intervention remains proportionate. Every three weeks, the Government will have to demonstrate why the measure remains a proportionate one to be in place. I hope that that perhaps addresses some of the legitimate points that the committee has heard this morning. I think that the public need to hear a message that the measure has been introduced only for a certain set of circumstances and for a certain purpose, and that it will not last for ever. I hope that that addresses some of those points.

Murdo Fraser: Do I have time for one more question, convener?

The Convener: You can have one more.

Murdo Fraser: Thank you.

Yesterday, in the Court of Session, James Mure appeared for the Scottish Government. According to reporting by the BBC's Philip Sim, who is an excellent court reporter, Mr Mure told the court:

> "there is ample time for the government's evidence paper ... to be considered by all parties before the vaccine passport scheme is actually 'enforced', on 18 October, rather than when the regulations come into force on Friday",

which is tomorrow. I do not understand what that comment is supposed to mean, because the regulations have been made and come into force tomorrow. Did he intend to mean that the Scottish Government might review the matter before 18 October or withdraw the regulations? What did he mean?

John Swinney: I think that Mr Mure means what he says, which is my experience of Mr Mure on all occasions. He means that the regulations come into force tomorrow morning at 5 o'clock, but they will not be enforced until 18 October. I think that Mr Mure was simply trying to make a helpful point to the court, which was that the evidence paper is available and can be considered by any interested party.

There has been quite a lot of discussion on the publication of an evidence paper. It is important to remember that the Government regularly publishes a report on the state of the pandemic. No studious observer of those reports could come to any conclusion other than that we face a very challenging and acute on-going situation in relation to the handling of the pandemic. My contention is that the evidence is marshalled on a regular basis—I think that the state of the pandemic report is issued weekly.

Dr Smith: It is.

John Swinney: Therefore, on a weekly basis, we publicly express what we think to be the scale of the challenge and provide the evidence base for why we need to take action. We are taking other actions. We maintain a position that face coverings have to be worn in indoor settings in public places, such as on public transport, in shops and all the rest of it. We encourage physical distancing. We are taking a variety of interventions based on the evidence that we have marshalled and communicated publicly.

Murdo Fraser: I have a lot more questions that I would like to ask, but I am afraid that we do not have time.

Alex Rowley: I have a quick question on vaccination passports before we move on. The evidence that we received earlier from the expert witnesses was, by and large, that the paper that was published yesterday is fairly good. However, they said that setting a date for when the measures could perhaps end might backfire. They suggested setting an end criterion. Would the Government be interested in considering that?

John Swinney: I contend that that is exactly what the Government has done by recognising that, as I confirmed again to the committee this morning, the Government can sustain the regulations only if there is a proportionate justification for doing so. That is, in essence, the answer to the question that the witnesses expressed to the committee and the point that Mr Rowley fairly puts to me in his question. I cannot sit here and say that the regulations will be in place until a given date, because the state of the pandemic could improve to an extent to which I do not have the justification for that. I cannot say to Mr Rowley that the regulations will be here until X date, because that would in essence be to prejudge the three-weekly review that we have to undertake.

We expect cases to be high and hospitalisation to remain high, and that will put great pressure on the system. That is why we need to take steps to suppress the prevalence of the virus, and the best way to do that is to increase vaccination uptake.

I hope that that helps to address Mr Rowley's question.

10:30

Alex Rowley: I think so. I took from what was said that there would be criteria in which you would set out that hospital admissions because of Covid were down to zero or whatever. You would therefore have criteria to work towards rather than a specific date. It probably makes more sense to take that approach.

John Swinney: I do not want to sound as if I am disagreeing with Mr Rowley in any way, because that is the approach that we are taking, but we express it slightly differently in the legal test of proportionality. If we find ourselves in a situation in which there is not a sustainable legal case to be made for the proportionality of the regulations, the Government will have to deal with that.

Alex Rowley: I want to move on to a much more pressing issue for the public. The more I speak to people who work in our national health service and our health and community services, the more concerned I become about our ability to cope this winter. The pressure on staff and services is immense.

Last Tuesday, I raised with the First Minister the issue of home care and community care services. From what I can see, waiting times are growing for people who live in the community who need home care support and for people who have been assessed as needing care. Their numbers are going up. That will have a very clear impact on

accident and emergency departments, because many of those people find A and E to be the only route forward. More widely, care services that support older people in the community are under pressure.

I want to ask you the question that I asked the First Minister. Last week, I met NHS Fife, which was keen to stress to me that the problem is not just a Fife problem but one that exists throughout the country. However, it is not clear to me where the solutions lie. Do we need a task force that can look at the extent of the problems that exist in community care and consider what we can do to address them in the here and now, given that, if we do not address them, they will become significantly greater as we get into the winter, and there will be massive pressure on our hospitals?

John Swinney: There was a lot in that question; Mr Rowley has acutely summarised the dangers and challenges.

As of yesterday, there were 1,581 delayed discharge patients in our hospitals. I know that it is a very controversial issue, but sustained efforts were made to ensure that patients who did not require to be in hospital in spring 2020 were discharged to other settings. If my memory serves me right—Dr Smith might help me out—that number went down to about 700, at its lowest.

Dr Smith: I would need to check, Deputy First Minister.

John Swinney: Forgive me: I do not have the number in front of me, but my recollection is that delayed discharges came down to about 700, compared with 1,581 yesterday. That created space in our hospitals to deal with the upsurge in Covid patients.

I accept that our hospitals are congested just now; there are 1,581 delayed discharge patients within that congestion. A proportion of them could go to home settings, if the appropriate care packages were available to them. I am of the view—I am pretty satisfied that this is the case—that the problem in availability of care home packages is not availability of money to provide for the packages but availability of personnel to deliver them. That is to do with the shortage of people in our country who can be employed in care. We have lost from the workforce people who, because of Brexit, returned to their countries. As a consequence, we have fewer people available. I also point out that unemployment is sitting at 4 per cent. Furlough ends today; we will see the effect of that on unemployment, but we do not expect its impact to be significant.

What that means is that we have to do one or both of the following. First, we should maximise the number of people who can be activated to enter the labour market and deliver the care services that Mr Rowley highlighted. Secondly, we could take a different position on free movement of individuals; abolition of free movement has, as was predicted, been a disaster for Scotland's labour market.

Those are not new issues. When he was First Minister in the early part of this century, Lord McConnell highlighted—rightly, in my view—the dangers of Scotland's population falling below 5 million and the population profile being weighted more towards the older population and economically inactive people. In 2004, those issues in the labour market in Scotland were addressed by free movement; now that has been taken away, which is creating real difficulty. The matters that Mr Rowley has highlighted represent a significant threat to our ability to manage our way through the winter. Because there are not enough people, the care packages that could get people out of hospital and into their homes cannot be supported.

Forgive me for giving such a long answer, but Mr Rowley raised some big questions. He also asked whether a task force is necessary. We are probably straying into the portfolios of my colleagues Mr Yousaf and Ms Robison, but I can say that we are focusing on the issues every day in our dialogue with local government and health boards. I assure Mr Rowley that the issues are being addressed. I can make no criticism of the level of engagement of public bodies in the process, but if we need to think about using some other means, channel, mechanism or device such as a task force, I am very open to considering that.

Alex Rowley: For me, the issue is not just bed blocking and people being able to get home care packages in order to get out of hospital. It is also about the number of older people who are living in the community and have been assessed as needing support to do so, but have been put on waiting lists that are growing and growing.

Yesterday, I visited Kinross-shire day centre, which, supported by Perth and Kinross Council, does a brilliant job of supporting older people in the community by bringing them in for lunch, getting lunch to them and so on. If that level of support is not available in the community, older people will end up at the doors of accident and emergency departments. That is my key point. The issue goes much wider than bed blocking; what we need to focus on is the fact that the whole social and community care system is falling apart at the seams.

John Swinney: The points that I have just made are designed to address exactly the situation that Mr Rowley outlined. This is not just about some compartmentalised A and E problem, if I can express it that way; it is a whole-system challenge. Mr Rowley has legitimately highlighted

that people would be much better supported if they were able to get to a day centre and had a wee bit of care in their homes. Their entire quality of life would be better than it would be in a setting that was not appropriate or suitable. Such provision is not being delivered because the availability of people to deliver such services has been severely constrained. I assure members that the Government is preoccupied with trying to address that situation.

Jim Fairlie: The initial concerns that I had about the passport scheme when it was first announced have, by and large, been allayed. I am comfortable with where we are, and even more so after this morning because all the witnesses today have given a good account of the evidence paper that was released yesterday.

However, what still concerns me—it has come up this morning—is messaging to deal with vaccination hesitancy among certain demographics and how we get to those people. I am comfortable with us having the vaccination passport, but I am concerned that some of our communities are not engaging with the process. By not doing so, they are putting themselves and wider society at risk.

What is the Government doing in respect of messaging to get to the communities in which people are genuinely concerned about vaccination? I accept that we cannot treat people as "other" because they have a problem with getting a vaccine. How are we getting to those people to make them trust the system in the first place?

John Swinney: It is important to look at the matter in two ways. There is the Covid vaccination certification scheme; one of its purposes is to increase take-up of the vaccine. It is, however, not the only tool in the box. Among the other tools in the box we must have very tailored communication and dialogue with the particular sectors of our society in which there is a challenge in relation to vaccine take-up. That is about, for example, trying to ensure that respected figures or voices in a particular community make the case for vaccination. Many people in specific communities have been encouraged to do that and are doing it.

It is also about vaccine availability and making sure that getting the vaccine is practical and conceivable for communities. It is unlikely that somebody who is living in poverty and for whom the vaccine is an expensive public transport journey away will get it, so we have to take the vaccine to those individuals. A lot of work is being done on vaccine buses and other approaches to enable the vaccination programme to be taken right into communities.

I do not want the committee to take the view that the Government views the vaccination certification scheme as the only means of encouraging take-up. There are a variety of other interventions to enable that to do with messaging, practical measures and wider targeting of communications.

John Mason: One of the experts in today's previous panel said that, at one point, we thought that a 70 per cent vaccination rate would be enough to give herd immunity to our whole society. We have now realised that that figure was too low. Are there are target figures, both for the whole population and for the minorities who, as Mr Fairlie said, have not got the vaccine yet?

John Swinney: I invite the chief medical officer to respond to that question.

Dr Smith: The concept of population immunity means that you and I being vaccinated protects other people as well, because the likelihood of our being able to pass on infection diminishes as a consequence. Some early calculations that were based on the early virus type suggested that 70 per cent to 75 per cent might have been enough to begin to develop population immunity, if we added in natural exposure in the country.

The unfortunate truth is that that was blown out of the water with the arrival of the delta variant. The original wild-type virus that came from Wuhan probably had a reproduction number of about 2.5 to 4, whereas delta is estimated to have a raw R number that is probably closer to 6. Achievement of population immunity in that context is much more difficult, because delta is so much more transmissible. The virus is also showing some signs of escape properties that allow it go beyond vaccination protection, although that is marginal.

At the moment, achieving population level immunity is very difficult even to estimate, because we do not have the full estimate of the unadulterated raw R numbers for the delta variant. However, we can say with confidence that they are likely to be much higher than those for the original virus, or alpha variant, so it is likely that the vaccination rate would have to be 85 per cent or 90 per cent or more, for immunity on a whole-population basis to be achievable.

10:45

John Mason: Thank you; that was helpful. If we did not have vaccination certificates, what would we need to do? For example, if we were not to have certificates, would we just close all nightclubs at midnight? If the attendance limit for events was 10,000, would we put a limit of 10,000 on all crowds?

John Swinney: Obviously, over the course of the past 18 months, we have had to demonstrate,

reluctantly, the types of restrictions that can be put in place on the liberties and activities of our fellow citizens, so members of the public clearly understand the range of interventions that are available. It comes down to restrictions on sectors and opening hours and all the other measures with which colleagues are familiar. We are trying to take an approach that enables sectors to remain open, but case numbers and hospitalisation levels are a very serious threat.

I have rehearsed with Mr Rowley this morning the challenges that our healthcare system faces because of levels of hospitalisation. Yesterday, more than 1,000 people were still in hospital with Covid. We cannot just wish that away, because that hard reality is causing the challenges in the healthcare system. Although, thankfully, they are lower today than they were a couple of weeks ago, the number of cases is much higher than it has been at other stages during the pandemic, when communities were locked down.

Mr Mason represents Glasgow; we locked down Glasgow when it had a rate of 300 cases per 100,000 people, but its case rate per 100,000 will be in excess of that today. Obviously, the vaccine now provides us with a certain amount of protection, but it cannot provide us with total protection, which is why we need tempering measures to moderate the effects of the virus. One of the motivations for the Covid vaccination certification scheme is that we want to keep open sectors that would likely, in any other circumstances, have to close because of prevalence of the virus.

John Mason: I will leave it at that, just now.

Brian Whittle: This morning, we have heard that one of the key successes of vaccination passports will be community engagement, but we heard from the Deputy First Minister three weeks ago that there was no public or business consultation prior to declaring the intention to implement the vaccination passport, because you did not want it to become public knowledge that you were considering it. How did the Scottish Government gather the evidence on the potential effectiveness of the vaccination passport?

John Swinney: We gathered that evidence by looking at international experience. We have seen examples in other jurisdictions in which application of a Covid vaccination certification scheme has significantly increased vaccination take-up. Evidence for that has been demonstrated in other jurisdictions. One of the very strong examples is France, but there are other places where that has been the case.

We also looked at the experience that emerged from the studies that Public Health England undertook when the United Kingdom Government was exploring questions around access to events earlier this year. A lot of that research material is charted in the evidence paper that was published yesterday.

Brian Whittle: This morning, we heard that France, for example, does not just use vaccination passports; evidence of previous infection is also taken. It was suggested that, when making comparisons with schemes in other countries, we have to be careful how we utilise the data because it will be specific to the country. Even the Government's evidence paper says that the impact in Israel is unclear.

The committee has heard evidence, which was alluded to by Jim Fairlie, that one of the main barriers to increasing vaccine uptake, which is what vaccination passports are being introduced to do, relates to ethnic minorities, especially our Polish and African communities, and areas of deprivation. Where is the evidence that suggests that the introduction of vaccination passports will have a positive impact on those communities, which are the hardest to reach?

John Swinney: I covered a lot of that in my response to Mr Fairlie. I see Covid certification as one part of a two-part strategy. I cannot give Mr Whittle a tangible number of members of the Polish and black and minority ethnic communities who will get vaccinated as a consequence of Covid certification. However, I am confident that, if we have that scheme plus measures to reach those communities in a direct, focused and targeted way, with messaging from within the community and access to vaccination services, we can increase vaccination levels in those communities and in others. In particular, we want to ensure that take-up is maximised among younger people and those who use higher-risk settings.

Brian Whittle: The point that I am trying to make is that the Government uses the percentage of the population that is vaccinated. However, when we drill down into the figures, we find that there are high levels of vaccination among the indigenous population of Scotland—perhaps higher than we would have expected at the start—but that there are pockets in our communities in which vaccination levels are not high. My problem is that I am not convinced that you have the evidence to suggest that using vaccination passports for nightclubs or football matches will impact the people who require our attention the most. I agree that community engagement is really important, but vaccination passports will not impact those communities to the extent that you want.

John Swinney: I fear that we are not going to have a meeting of minds on that issue. Let me make a sweeping generalisation and say that

people below the age of 39 are more likely to be in nightclubs than people of my vintage—I am sorry to break the solemn news to Mr Whittle that he will not bump into me in a nightclub. Vaccination levels for people below the age of 39 are lower than they are for people above that age. Part of the approach to Covid certification is to further incentivise those people to get vaccinated so that they can participate in those activities.

Obviously, a large number of people of different ages go to some of the other settings; I accept that there is a much broader age demographic at football matches, for example. However, I encourage colleagues to think of Covid certification as one part of a two-part strategy.

I do not dispute Mr Whittle's point about making sure that we have targeted and focused interventions for people living in deprivation, the black and minority ethnic community and other social groups that have low take-up. We accept that we need to concentrate our efforts on that. I pay tribute to the vaccinators for their efforts in that regard. In that way, we will reach the point, as Mr Mason said, of having such high vaccination levels that they provide the population with as much protection as possible.

Brian Whittle: To be fair, cabinet secretary, you probably will not find over-70s from the African community in nightclubs, either, but their vaccination rate is 20 per cent lower than the average. We are not going to have a meeting of minds. I do not believe that you had the evidence that you suggested you had three weeks ago. You are backfilling that evidence now to establish the need for vaccination passports. That is the point that I am making.

John Swinney: If Mr Whittle were to look back at the weekly state-of-the-pandemic evidence papers from the past six, 10, 12 or 20 weeks, he would see the same evidence base emerging of the challenges that we face. The question that flows from that evidence is what we do, in a changing pandemic, to address those circumstances and, ideally, avoid the scenarios that Mr Mason put to me, in which wider restrictions might have to be applied to the operation of particular sectors.

Brian Whittle: I would love to take this to appeal but, unfortunately, we do not have time, so I will step back.

Graham Simpson: What level of vaccination do we need to get to in order for the Government to drop the scheme?

John Swinney: That is a difficult question for me to answer, because we have to weigh up a range of factors in the discussion of the scheme's proportionality. Mr Simpson will be familiar with the fact that we have tended not to have one particular indicator for performance at any given time. We have to look at the basket of information. I have cited the fact that we have to look principally at case numbers, levels of hospitalisation and levels of vaccination. Those three factors provide us with a reasonable assessment of where we are and how we are performing. Within the condition of those three indicators, we have to make a judgment, principally about the proportionality of any intervention that we make.

It is not just about vaccination certification. I will give another example. When the schools returned in August, we said that, regrettably, we required pupils in the secondary sector to continue to wear face coverings for an initial period of six weeks. Given the prevalence of cases, particularly among the younger school-age population, we had to say that, regrettably, that period was going to be extended. However, we judged that to be a proportionate act based on information on the segmentation of case numbers.

Graham Simpson: You will not say—or you cannot say—what level of vaccination you wish to get to. Will you be in a position at any point to give the public your thinking on the number of cases and on vaccination and hospitalisation rates—the whole suite of measures that you just mentioned—so that we know what we are aiming for?

John Swinney: The best thing that I can say to that is that we know what we are aiming for, which is to suppress the virus to a position whereby we can get on with normal life. If we get good levels of compliance with the baseline measures that we have in place—my sense is that, in recent weeks, there has been a significant upsurge of compliance with baseline measures, which is helping to suppress levels, and I thank members of the public for that—we can come to a judgment about proportionality.

Mr Simpson asks me when we can do that. Every week, the First Minister updates Parliament, Cabinet looks at the issues and we take stock of whether there is an on-going justification for the measures. On Tuesday, the Cabinet took the view that there was an on-going justification but that there was no justification for going beyond the Covid certification scheme. We look at that every week, and the results of the formal three-weekly reviews are reported to Parliament.

11:00

Graham Simpson: I am not asking you to respond to this, but the problem with that is that the rest of us have nothing to judge you against because you will not say what you are aiming for.

Privacy is an issue that really concerns me. If my daughter goes to a nightclub tomorrow—I would be astonished if that ever happens—and

has to show a QR code, her name and date of birth will pop up. Anyone could then find out where she lives and other stuff about her. That is an awful breach of privacy that has the potential to put people at risk.

John Swinney: It might help if I were to provide Mr Simpson and the committee with the opportunity to have a more detailed briefing from the officials and teams who have developed the app. I would be happy to arrange that, if that would help to reassure members about the issues and practicalities.

Graham Simpson: I am not a member of the committee. My point is that information will be given to a complete stranger at a nightclub or a football match. At the moment, a person's name and date of birth are given; later, it will be just their name. Why should a complete stranger know someone's name, see their face and be able to look them up?

John Swinney: In some circumstances, that happens in other environments. If I show my passport at an airport, I am showing it to a complete stranger who will know my name, date of birth and passport number.

The Convener: People have to show identification such as a driving licence when they go to nightclubs. Stewards would usually see that.

John Swinney: I am delighted that the convener's knowledge of nightclubs has come to my assistance. Mr Simpson raises a serious point, and I will reflect on whether there is a way in which members of Parliament can be briefed about the approach in order to provide some reassurance about those issues. I totally understand the sensitivity of the question.

Graham Simpson: It is a data protection issue. That is the question.

John Swinney: I do not for one moment trivialise the significance of the issues raised.

Graham Simpson: I hope that I have time for one more quick question. I have read through the draft regulations. Correct me if I have misread them, but it seems to me that cinemas are exempt.

John Swinney: They are.

Graham Simpson: Theatres are not exempt.

Elizabeth Sadler (Scottish Government): Theatres offer live entertainment, which technically brings them within the scope of the scheme. However, capacity limits are also taken into account. The regulations would affect only theatres with more than 10,000 people so, in practice, theatres do not fall within the scope.

Graham Simpson: It would have to be a big theatre. A small theatre would be exempt.

Elizabeth Sadler: It would not be within the scope. The regulations affect indoor settings of 500 or more people who are mainly standing and live events in indoor settings with more than 10,000 people. I think that that takes out every theatre in Scotland.

Graham Simpson: Right, so all theatres in Scotland are exempt.

Elizabeth Sadler: Unless there is a theatre that has a capacity of more than 10,000.

Graham Simpson: Okay. That is useful.

Alex Cole-Hamilton: Deputy First Minister, Murdo Fraser brought to our attention what I think is the most striking admission in the Government's evidence paper, which was published last night—that Scotland, when it introduces vaccination certification, will be the only country in Europe to bring in such a scheme in isolation, without a requirement for testing. Murdo Fraser asked you about that, and I wrote down part of your answer. You said that the Government did not want to undermine vaccination uptake.

Do you have empirical evidence from other European countries that have brought in certification in tandem with testing requirements that suggests that vaccination uptake has been inhibited by that combination of measures?

John Swinney: I do not have any information on that point, but I make two points to Mr Cole-Hamilton. First, other jurisdictions are bringing in a vaccination-only Covid certification scheme. Secondly, the Government has made a choice about the focus of the scheme, which is primarily to drive an increase in vaccination rates.

Alex Cole-Hamilton: That seems slightly at odds with the messaging in the Government's evidence paper, which was published last night.

In section 5.1, which is about the basis for the introduction of vaccination certification, the very first bullet point is about reducing transmission. Increasing vaccine uptake is ancillary to that—it is the fourth bullet point. I recognise that—

John Swinney: On that point, if we increase uptake of vaccination, we increase the degree of protection in the population, which has the effect of suppressing the circulation of the virus. I suspect that we are about to get into whether the chicken follows the egg or the other way around.

Alex Cole-Hamilton: I am more than happy to concede on that.

John Swinney: Mr Cole-Hamilton and I know what we are debating here.

Alex Cole-Hamilton: Of course. I am happy to concede that point. My anxiety is that, as we have heard from eminent academics this morning,

vaccination certification could drive down uptake in hesitant—or, rather, vaccine-sceptical—groups. If they feel browbeaten, they might not take up vaccination.

John Swinney: I want to reflect on that point, in the light of the evidence that the committee has heard this morning. The witnesses added another important element, which was to do with the question whether vaccination certification is being introduced in an environment of trust in society. I think that the evidence generally suggests that there is a high level of trust in Scotland on the way in which Covid-related issues have been handled. It is important that we acknowledge that that backdrop enables such a scheme to be applied in the fashion that I have suggested to the committee.

Alex Cole-Hamilton: Thank you for that. My final area of questioning is about proportionality.

Last week, we heard from the Scottish Human Rights Commission that there is anxiety that the scheme will roll back our application of human rights, including statutory ones. Judith Robertson, the chair, made it clear that it is acceptable for states to do that in times of pressing need—obviously, coronavirus is a pressing need—but only if the scheme that is being introduced and the rollback of rights that goes with it can demonstrably impact on pushing down against that need. She also talked about proportionality, as did you.

My question is on the evidence of proportionality. Meeting the test that was set to us by the Scottish Human Rights Commission requires the Government to evidence that it has considered alternatives to the scheme. Are you satisfied that you have considered the use of testing as an alternative to vaccination certification to an extent that would satisfy the Scottish Human Rights Commission?

John Swinney: Obviously, I cannot speak for the Scottish Human Rights Commission, but I absolutely accept the tests that it would place upon us. Such tests matter to the Government.

Mr Cole-Hamilton will be familiar with the Government's position on the significance of human rights in all our activities. He knows about the legislation that the Government has taken through Parliament—for example, on the incorporation of the United Nations Convention on the Rights of the Child. That is an illustration of the Government's commitment to a human rights-based approach. The Covid recovery strategy that the Government is working on focuses on a human rights-based approach, and it will be material to the public inquiry that takes place on Covid issues. I do not in any way dispute the importance and significance of human rights questions.

I agree with Judith Robertson that those questions fundamentally hinge on the question of proportionality. The Government must be able to satisfy itself on the question of proportionality in relation to any measures that it takes forward. As Mr Cole-Hamilton will well know, we also have to satisfy ourselves that we could withstand legal challenge on any of those questions. The Government considers that issue very carefully on all occasions.

In answer to the question about alternatives, the Government considers a range of possible approaches that we might take. Mr Mason invited me to speculate on some of those as alternative measures on the restriction side. There are other arguments in relation to testing approaches, which, I would contend, the Government is using to the best of our ability in order to ensure that those devices are being used. We judge that a Covid certification scheme is a proportionate measure, in addition to the range of other interventions that we are taking to suppress the virus, increase vaccination uptake and protect the public.

The Convener: Murdo Fraser has a brief question.

Murdo Fraser: I will try to be brief. I have some specific questions about the terms of the regulations. I will ask one and see how we get on.

There is a new power of entry contained in regulation 16A of the draft instrument that we saw yesterday afternoon, which gives power to enter a property without warrant where permission to enter is refused, to ensure that an offence is not committed under the regulations. That power can be exercised by a police officer or a local authority officer. How does the Scottish Government foresee those regulations being enforced? For example, do you see there being a role for the police in that regard?

John Swinney: No, I do not. I am happy to put on the parliamentary record that we will take the habitual approach that is taken in all such settings. I had a helpful discussion with local authorities on the issue the other day. Our approach will involve engaging, explaining and encouraging before we get to enforcing. The four Es approach, with which many institutions will be familiar in relation to the work of local authority regulators, will be the one that is taken.

We want to work with businesses to make sure that they understand the obligations on them, and to support them in putting in place the practical measures that they can take. That will be the cultural approach that is taken. Local authorities are keen to make sure that that approach, which is

commonplace in local authorities in Scotland, is maintained.

Murdo Fraser: Do I have time for one more quick question, convener?

The Convener: You have one minute.

Murdo Fraser: I have one more question about the draft regulations. There is a provision in new regulation 7E that sets out the list of exempt events. Subparagraph (c) of regulation 7E exempts

"an event designated by the Scottish Ministers as a flagship event according to criteria, and in a list, published by the Scottish Ministers".

That gives a very wide power to the Scottish ministers. We have no definition of what "a flagship event" is. Will you explain what is envisaged there? What would fall under that list?

John Swinney: The provision seeks to provide the appropriate opportunity for us to designate individual events that might be of a particularly noteworthy nature. For example, Her Majesty the Queen is coming to the Parliament on Saturday and I would describe that as a flagship event. There is no necessity for us to consider the issues in question, because the numbers of people involved will not be appropriate, but I can envisage flagship events to which we might all wish to give appropriate recognition. I invite Ms Sadler to come in.

11:15

Elizabeth Sadler: The committee may recall that, during the summer, a number of events were allowed to progress that were outwith the scope of the regulations that were in place at the time. Those included events such as the Edinburgh international festival and some of the larger golf events; on the basis of public health advice, those events were considered to be so significant in terms of their impact on Scotland as an internationally recognised place where people want to do business that they were allowed to progress. There are no events in that programme extant at the moment, but the purpose of the provision in regulation 7E is to enable such events to be exempted from certification, if required. We do not have any such events planned at the moment.

Murdo Fraser: There is much more that I could ask, but I think that we are out of time.

The Convener: I go back to Graham Simpson's point and ask the Deputy First Minister, with the agreement of the committee, whether it would be possible for all members, not just those on the committee, to receive a briefing on the new app.

John Swinney: There is a fair point to be addressed there, so I will take the issue away and put that into motion.

The Convener: Thank you.

That concludes our consideration of that agenda item. I thank the Deputy First Minister and his officials for their evidence. The committee's next meeting will be on 7 October, when we will take evidence from the Cabinet Secretary for Health and Social Care on the vaccination programme and pandemic preparedness.

That concludes the public part of the meeting.

11:17

Meeting continued in private until 11:30.

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