HOUSE OF COMMONS

# Health and Social Care Committee

## Oral evidence: Prevention in health and social care, HC 141

Tuesday 6 February 2024

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 335 - 412

### Witnesses

I: Andy Tighe, Director of Strategy and Policy, British Beer and Pub Association; Karen Tyrell, Chief Executive, Drinkaware; Sandra Ionno Butcher, Chief Executive, National Organisation for FASD; and Matt Lambert, Chief Executive, Portman Group.

II: Hazel Cheeseman, Deputy Chief Executive, Action on Smoking and Health (ASH); Professor Asma Khalil, Vice President for Academia and Strategy, Royal College of Obstetricians and Gynaecologists; and Professor Peter Hajek, Wolfson Institute of Population Health, Barts, and London School of Medicine and Dentistry Queen Mary University of London.

Written evidence from witnesses:

- [Add names of witnesses and hyperlink to submissions]

# Examination of witnesses

Witnesses: Andy Tighe, Karen Tyrell, Sandra Ionno Butcher and Matt Lambert.

Q335 **Chair:** Good morning. This is the Health and Social Care Select Committee—for the second time in two days. We just cannot get enough. This is our latest public evidence session in our major prevention inquiry, on prevention of ill health. There is a lot of talk at the moment about waiting lists. There is a lot of talk about demand. There is also a lot of talk about supply. We are interested in prevention and trying to stem some of that demand upstream, which is why we are doing this major inquiry.

There are 10 different workstreams as part of that. One of them was on vaccination. We published that report last year. Very recently we published our second report of the inquiry, around healthy places: where we live, where we work and its impact as a determinant of poor health. We are now cracking on with our third workstream, which is alcohol, drugs, gambling and smoking.

In the second panel today, we will talk some more about smoking. Yesterday we heard from Professor Javed Khan, who did the very high-profile Khan review for Government a couple of years ago. We did that on its own because he could not make it today. This is the second evidence session of the prevention inquiry workstream looking at alcohol, drugs, gambling and smoking. Today it is just alcohol and smoking.

On the first panel, we have Andy Tighe, who is director of strategy and policy at the British Beer and Pub Association; Karen Tyrell, who is the chief executive at Drinkaware; Matt Lambert, who is the chief executive at the Portman Group; and Sandra Ionno Butcher, who is the chief executive at the National Organisation for FASD.

As I said, today's session is going to kick off with a panel focused on ill health caused by alcohol use, which includes representatives from the industry and the industry regulator, from Drinkaware and from the National Organisation for Foetal Alcohol Spectrum Disorder—FASD. The evidence being taken is to enable discussion of some specific issues against the backdrop of many—and I mean many—written submissions that we have had from a wide range of contributors, including organisations and experts in the field. As we always do in a Select Committee of the House, we will then consider what further evidence we need to gather, including via oral evidence hearings. Of course, people are still welcome to submit evidence to us, if they wish. At the end of that, we will come to our effective conclusions and recommendations, as we have done throughout this Parliament. This is the start, not the end. I don't believe I have ever said anything else—just as long as that's clear.

Let's start off. I will then bring in my colleagues. This is a cross-party Committee, as you know. In its written submission, Drinkaware states that alcohol misuse is the biggest risk factor for death, ill health and disability among 15 to 49-year-olds and points out that "the harm caused

by alcohol is highly preventable". You are talking our language, if you are interested in prevention.

There are some stats that have been kicking around. There has been an increase in the number of pupils—young people—responding to the NHS "Smoking, Drinking and Drug Use among Young People in England" survey who state that they do not drink, either because they have stopped or because they have never had a drink. There is also a YouGov poll commissioned by the Portman Group that suggests that the younger generation are now the most sober age group overall, with 39%—39%—of 18 to 24-year-olds not drinking alcohol at all. Anecdotally, that very much bears out what I hear as a constituency MP.

I will start with Karen Tyrell from Drinkaware. Drinking is still the biggest risk factor for death, ill health and disability among young people, but the trend seems to be that young people are drinking less and some are not drinking at all. How do you explain the difference between those two pieces of information?

***Karen Tyrell:*** Thank you very much for inviting Drinkaware along to this session today. Drinkaware is the UK's leading alcohol charity. I have quite a lot of experience in this area, having previously worked in alcohol and drug treatment services for about 20 years.

You are absolutely right. Alcohol harm is highly preventable. It is a major cause of ill health and death across the UK. Our figures show that around 8 million people are drinking above the chief medical officer's low-risk drinking guidelines. That is a huge number of people we would like to be able to reach more actively and talk to about their relationship with alcohol. We believe that we need more active engagement from Government on this matter, and we would like to see an alcohol strategy.

Q336 **Chair:** We had one, but it is timed out, isn't it?

***Karen Tyrell:*** Yes. It is out of date. The last strategy was from 2012, which is quite a while ago.

Our view is that we should all feel more comfortable as a society with talking about alcohol, the place that it has and our relationship with it. Some of the shifts that we have seen around how we talk about mental health as a society are things that we think could be happening more usefully around alcohol and the harms that alcohol can cause. It feels like we are ripe for an opportunity to move that dialogue into the mainstream.

One way we could do that is by communicating more actively with those 8 million people and encouraging people to check their drinking from time to time to understand the low-risk drinking guidelines. Recognising and understanding 14 units a week, having several drink-free days in the week, not binge-drinking and, as I am sure Sandra would agree, not drinking when you are thinking about becoming pregnant or are pregnant

are important messages that are not necessarily getting to as many people as they possibly can.

The second part of your question was about the trends that are changing over time. There is a series of different trends happening. You are right. Some of the trends are going in the right direction. There is good news. Our monitor, which is an annual survey that we complete, shows that about 80% of people are drinking within the chief medical officer's guidelines, according to their self-reported measures. That has improved from about 77% about five years ago, so there are some good trends. More people are drinking below the chief medical officer's guidelines of 14 units, which is great. There have also been some reductions in binge-drinking. Some of the more unusual behaviour that happened during the pandemic has eased back as well.

That is going in the right direction. Sadly, some things are not going so well. Alcohol harm is not evenly distributed across our society. There is quite a significant range of health inequalities that mean that in some populations and some parts of our society alcohol-related deaths are much higher than in others. Sadly, alcohol-related deaths are at an all-time high of about 9,500 per year. There is a large number of alcohol-related hospital admissions each year. Some of that prevention activity could make a big shift in those numbers as well.

Finally, the other trend that has shifted over time is that over the last 10 to 15 years there has been quite a move towards people drinking at home rather than in public spaces. What we have seen in our survey results is that when people drink at home they are perhaps drinking for less positive reasons, perhaps because they are trying to cope with some of the strains of life.

Q337 **Chair:** The inequalities point is interesting to us. It is a thread that runs through all of the suggested workstreams that we are doing in this inquiry.

Mr Tighe, when it comes to the people who are responding to the NHS "Smoking, Drinking and Drug Use among Young People in England" survey, it is probably not the playground talk, is it? They may be missing some of the people who are struggling with the greatest inequalities and, therefore, are at greatest risk from alcohol. What is your comment on the seemingly downward trend in alcohol use by young people in particular?

***Andy Tighe:*** As Karen said, it is really encouraging, if you are a parent, that young people are drinking a lot less. Access to alcohol among young people has been addressed over the last 20 years. Through the successful Challenge 21 and Challenge 25 campaigns that the industry runs, it is much more difficult to get hold of alcohol now as a young person, which is positive. There has been some great work in Scotland on proxy purchasing campaigns as well, making it very clear to people over 18 that if you buy for someone who is under 18 you are committing a criminal offence and there is a risk of prison and a big fine.

Those sorts of campaigns are really helping. In the latest NHS survey, just 2% of schoolchildren said that they had accessed alcohol from a pub. The vast majority of them are getting it from parents, elder siblings or other family members. There is still that challenge around young people drinking, but it is decreasing and, overall as a population, we are drinking less. Binge-drinking is coming down. Alcohol-related crime has halved since 2010. Those are all positive trends that, hopefully, will result in fewer alcohol-related deaths and fewer admissions as we go forward.

Q338 **Chair:** Some people listening to you would say that that is a very curious thing for you to say. Why do you want people to drink less?

***Andy Tighe:*** We want people to drink responsibly. We want people to drink at less harmful levels.

Q339 **Chair:** That was a politician's answer, if you don't mind my saying so.

***Andy Tighe:*** As a brewer, you want people drinking beer. Of course you do, and our members are brewers. One of the things that brewers have done to address the change in societal habits that we are seeing is the development of no and low-alcohol alternatives. There is huge growth in no and low-alcohol beer, so you can still enjoy a great beer without having any alcohol at all. Some of the major brands have invested a lot in that space. We are seeing that really take off now.

Encouragingly, that is not necessarily among new people coming into the category. It is existing beer and alcohol drinkers when, on particular occasions—they want to drive, want to prolong their evening or have to get up for work in the morning—having a low or no-alcohol beer is definitely an increasing option. We certainly saw that during dry January. Over a quarter of the people who did dry January chose no and low-alcohol beers as part of that. Most of those—about 70%, I think—said that they will continue to drink those products through the year. There is a way of drinking as much beer and still reducing consumption.

The final point I'll make on that is about the recent changes to the alcohol duty regime, which were really encouraging and were focused on encouraging consumers to choose lower-strength products. A new threshold for products at 3.4% meant a lot of reformulation of brands below 3.4%. People can drink the same amount of product but drink less alcohol.

Q340 **Chair:** I can see why your members would support that, but it is fair to say that those recent changes to the alcohol duty are more welcomed by the beer side of the industry than by the wine side of the industry. You can tweak the medicine to change the percentage, whereas that is much more difficult for a wine producer, of course.

***Andy Tighe:*** It is more difficult, but it is not impossible. The alcohol duty system addresses anomalies where, previously, cider and wine were taxed at a flat-banded rate. Whether it was a 14% ABV wine or a 9% wine, you paid the same rate, and likewise with cider. One of the

challenges that supermarkets have had put to them is around selling cheaply. What the alcohol duty review does is close any ability to sell very strong alcohol very cheaply.

Q341 **Chair:** Yes. Mr Lambert, did I see rightly that Guinness 0.0 was sponsoring the Six Nations games on the weekend? Did I not see that plastered across?

***Matt Lambert:*** Yes, I believe it is.

Q342 **Chair:** Is this a good thing? What do you think about the headline trend I was just talking to Karen and Andy about? Do you recognise it? Do you welcome it?

***Matt Lambert:*** First, we are the self-regulatory body that regulates naming, packaging and labelling—essentially, marketing—as well as sponsorship, to your point about Guinness 0.0 and the Six Nations, for example.

I will try not to repeat what Karen and Andy said, because I broadly endorse most of it, particularly around the general evidence of the stats. The facts are that something like 79% of UK adults are drinking within the chief medical officer's guidelines of 14 units or not drinking at all. That is very good news. As others have said, those trends have continued in all areas, with youth drinking and all ages.

The area of concern is twofold. It varies between the different countries of the United Kingdom, but a group of somewhere between 16% and 18% are drinking above the CMO's guidelines, and somewhere between 3% and 4% are drinking to harmful levels. For women, that is 35 units and above. For men, it is 55 units and above.

There are two things, I would suggest, for your thinking around prevention. First, what more can be done to encourage moderate, responsible consumption or not drinking at all? You have already heard about low and no-alcohol alternatives. We produce an annual survey with YouGov that tracks the progress of that market in terms of consumption and why people are consuming it. It is quite interesting. If you would be interested, I can send you the most recent data. It came out in January, and has come out in every January for the preceding four years.

The interesting thing that we are seeing with youth drinking is that 85% of the 16 to 24-year-old cohort are not drinking alcohol. I fully endorse what has already been said about the chief medical officer's wish or aim that children should enjoy a drink-free childhood. That is all part of that. Low and no-alcohol alternatives also drive that trend because they are hugely popular; something approaching 50% of young drinkers—drinkers above 18 who can legally drink—are drinking those products regularly; two thirds of the drinking population of this country have tried them, and a third are drinking them regularly. We know from our survey that what is driving that is that they want a healthier lifestyle. They want to be able to socialise with friends in pubs or at parties, but they do not want to

drink excessive amounts of alcohol. Quite often, as you can readily guess, it is so that somebody can drive home safely and legally.

Finally, to come back to the point about those who are drinking to excess and what can be done about them, first of all, it is about encouraging those who are drinking above the 14 units to moderate their drinking and come back down. There are a number of industry schemes to encourage that. A very large part of that is in Karen's work. I am sure that she will tell you more about the current drive around the drink checkout, which enables you to look at your drinking, assess whether you are drinking above the guidelines and do something about it. You can get advice if you are drinking above it. Equally, if you think that a friend or a loved one—someone you know—is headed down that path, you can get advice from Drinkaware. I am sure that Karen will tell you much more about that.

The last part of that—the 3% or 4% who are drinking to harmful levels—is an area of deep concern. We commissioned some useful research, which I would happily forward to the Committee, from CFE, who are respected independent researchers. It is not our research, but we commissioned it. It looked at the barriers to getting help among the group who are drinking to the highest levels and what things clearly work well in that area. There are a number of barriers. I can talk more about that, if you are interested.

The interesting thing there—it is sort of after the fact, but it is also preventive in terms of the situation deteriorating further—is that one of the things that clearly works is a more active, assertive outreach, directly working with those who present at A&E and are drinking to high harm levels on a regular basis. It involves co-ordination between all of the social services, the health services and, sometimes, the police, encouraging families to get involved and getting active treatment. A number of studies, particularly by King's College but also by the Universities of Glasgow, Stirling and Dundee, have shown that if you get that sort of direct personal help—sometimes personal trained nurses, psychologists and others—you can bring people back from that path of, essentially, destruction.

Q343 **Chair:** We will come back to that. I think Mr Morris wants to talk in more detail about local areas and public health budgets, which came out yesterday, and which touch on that.

Sandra, your perspective is that of alcohol use in pregnancy. I remember that it was a big issue when I was in the Department and Jeremy Hunt was Secretary of State. He did some important work on that with his then shadow, Mr Ashworth. You will remember that. How big is the problem of alcohol use in pregnancy in England in 2024?

***Sandra Ionno Butcher:*** Thank you for having us here at the table. The first FASD diagnosis was 50 years ago. To the best of my knowledge, this is the first time that we are in this room speaking with you all about foetal alcohol spectrum disorder and the risks of alcohol in pregnancy.

When you think about trends, it is as important to listen to what is not being said as to what is being said. Traditionally, when you talk about alcohol in pregnancy, it is wrapped up in the chief medical officer's guidelines and is a subset of the discussion, but when it comes to talking about alcohol use in pregnancy, there is no safe time, no safe amount and no safe type of alcohol, so the kinds of trends that are being discussed right now do not apply to alcohol in pregnancy. We simply don't have the numbers right now. It should be tracked better. There should be better data collection on it.

The 2010 infant feeding survey got to some of it. It showed that 40% of women drank alcohol in pregnancy. It was higher among more educated, professional white women. The UK has the fourth highest rate of drinking alcohol in pregnancy in the world. That is ahead of Russia, for example. We know that those figures are probably just the tip of the iceberg because of the way the questions are asked. We are looking at a society where about 77% of women are drinking alcohol and about 50% of pregnancies are unplanned, and in more than 40% of those pregnancies alcohol is being used.

We did a survey over the weekend—we have been doing this periodically—in which we tested the general public to see whether they recognise the chief medical officer's guidance on alcohol use in pregnancy. It came back that 20% of the population still do not know about it. It is not necessarily being taught in PSHE in schools. We have yet to see public campaigns from industry and Government. Maggie Throup, the then Parliamentary Under-Secretary, said that there had not been any public health messaging on FASD. There is a great way still to go.

That is just the prevention of harm from alcohol-exposed pregnancy. I am also here to talk about the prevention of further harm from undiagnosed and unrecognised foetal alcohol spectrum disorder. I assume that we will come back to that.

Q344 **Chair:** Yes. We will develop that more. The point that you make, which, clearly, your colleagues on the panel cannot make—

***Sandra Ionno Butcher:*** We should all be tracking it.

Q345 **Chair:** They can't make it because the Prime Minister's argument around smoking is that there is no safe level of smoking, whereas for some people there is a safe level of drinking. For the percentages Mr Lambert was talking about, for instance, there is no safe level of drinking either, but there is no safe level of drinking for pregnant women, which is the point that you make, and make well.

***Sandra Ionno Butcher:*** Exactly.

**Chair:** Let's bring in colleagues. They all have different things they want to ask you about.

Q346 **James Morris:** Approaches to alcohol harm reduction over the last 20 years have focused precisely on that; the strategy has been about harm reduction, rather than population-level intervention. I think that is broadly true. Karen Tyrell, on the basis of what you said, has that approach worked?

***Karen Tyrell:*** There are a number of things that have worked. We have seen some of the trends going in a good direction, but there are certainly a number of trends that have not worked as well.

For us, having more open conversations about alcohol and the part that we do or do not want it to play in our society is a really important step in the right direction. We know that stigma and shame around alcohol consumption are a huge issue. Often people do not want to talk about it in the same way as they would if, for example, they went to the GP and had their blood pressure taken, and the rating was a bit higher than they might have hoped. You would not then immediately be worried about whether you were going to lose your job and your children were going to be taken into care, but if you are thinking about your alcohol consumption, those are genuinely the thoughts that go through people's minds. As a society, we need to do a better job of talking about alcohol. We need to understand more about our own drinking, but we need to ask the Government to take a bit more ownership and responsibility in this area as well.

Q347 **James Morris:** You have described some slightly contradictory trends. When there has been positive development, is that because we have already had a better conversation about this over the last two decades?

***Karen Tyrell:*** Again, I would say that, in some areas, we have. If you look at drinking and driving, for example, a range of stakeholders have come together and worked in collaboration to tackle that. It has broadly gone in the right direction. It might have a stalled a bit recently, but over a longer period of time it has gone in the right direction. Equally, there are other areas where it has not.

Our view at Drinkaware is that bringing all of the different stakeholders together to tackle the issue and to have more adult conversations about alcohol feels like the right approach. We want the public to be confident in their relationship with alcohol. We want people to understand what is going on for them, but we also need to think a bit more actively about how we target help and support. As I mentioned earlier, health inequalities are a huge issue. We know that in areas of deprivation alcohol-related deaths can be around four times higher than they are in wealthier parts of the country.

Q348 **James Morris:** Mr Tighe, I do not want to go back into history, but when the licensing laws were deregulated to allow pubs and other outlets to open 24 hours, or whatever, the vision that was presented by the alcohol industry was that the UK would develop into a kind of Mediterranean country where people would enjoy alcohol differently from the traditional

way they did in certain areas of the UK, with lots of vertical drinking and packed pubs. Do you think that that has happened?

***Andy Tighe:*** We are seeing changes in how people consume alcohol, how people socialise on nights out, how people go out and drink alcohol and how town and city centres are managed during the weekend. You talked about a population-based approach. The Licensing Act is precisely that. There are very strict conditions around having an alcohol licence. If you sell alcohol to young people, you can very quickly lose your licence.

Q349 **James Morris:** We still have a lot of alcohol-related violence in city centres, don't we?

***Andy Tighe:*** We do, but it has come down by 50% since 2010. There have been some big changes. Of course, there is always more to do, but the industry has collaborated with Government, local charities and local partnerships to make city and town centres places where people can come and enjoy a night out safely. Very recently, there have been some campaigns. Ask for Angela, which you may have heard about, is about ensuring that young women are safe on a night out. Ask for Clive is a similar initiative for the LGBTQ community. Lots of positive work is being done to move the culture to one where everybody enjoys alcohol sensibly and responsibly and feels safe on a night out.

The other thing from a population perspective is that we have an alcohol duty system that applies to everybody. We have marketing and promotional codes, which flow through the ASA or the Portman Group. Matt can talk a bit about that. When you talk to colleagues across the world, that is held up as a gold standard for self-regulation and producers taking responsibility. It has teeth. If people are putting products on the market that appeal to young people, they get taken off the shelves in supermarkets pretty quickly. A lot has been done at national level, but it is absolutely right that we also focus on those drinking at harmful levels.

Q350 **James Morris:** Mr Lambert, I go back to the argument about harm reduction versus population-level intervention. I am not saying that there has not been any population-level intervention, but the focus has been very much: "We can have a society where people drink responsibly, but there is a percentage who are drinking harmfully. We need to target our interventions on them." Targeting our interventions on them is quite an expensive thing. This is a generalisation, but I think it is true. There is perhaps an overlap between people who drink harmfully and areas of deprivation and socioeconomic factors, so why don't we just raise the price, rather than spending our time and a lot of money on public health intervention? A lot of the evidence suggests that, if you just raise the price, consumption in that group will come down.

***Matt Lambert:*** I am not the expert on that area, even on this panel. Portman Group is a marketing regulator. We don't really get involved in duty issues.

Q351 **James Morris:** You were talking about some initiatives with the group

that is drinking hard.

***Matt Lambert:*** I will happily comment on that. On your direct question about price, the only thing I would say is this. Of course, you are aware that countries in the United Kingdom—prominently, Scotland—have already tried this with minimum unit pricing. Even the Scottish Government's own evaluation has shown that there is inconclusive evidence on whether that discourages drinking at the highest level—the harmful drinkers. That is the area of deepest concern. As I have already said, the vast majority—four out of five people who drink alcohol—are drinking within the chief medical officer's guidelines, which is where we want people to be. We want them to be drinking that much or not at all, or low and no-alcohol alternatives.

With regard to the harmful group, in terms of the cost and the investment, I would argue a couple of things. While all the other trends that you have heard have been headed in the right direction for 10 or 15 years—binge-drinking, drink-driving, overall consumption—alcohol-related deaths driven by drinking to the most harmful levels spiked during the pandemic, from 2019. Some more figures for England came out literally minutes before we sat down. I think it is a 34% spike overall for England since 2019.

The academic evidence is not conclusive on that so far, as with so much that came out of covid and the pandemic, but there is a clear link that we could all reasonably make between what happened to us in those two years in terms of lack of support from friends and family, and lack of access to health services and advice and so forth. It was everything that was going on—the stress and fear that we all went through from 2020 to 2022. Such a massive spike has to be explained by something. We all very much hope that all of the schemes that you have heard about, and the good work, will bring that down.

Can I address your last point about cost?

**James Morris:** Yes.

***Matt Lambert:*** Academic studies—I think this was the King's Fund—have shown that for every £1 that you put into assertive outreach programmes addressing those who need treatment and support at the highest level, there is a £3.41 return on investment in terms of saved bed days, pressure on the NHS and other types of costs. I believe that that is a clear sign that if Governments were to invest more in treatment services, we would actually save money for the NHS. That is my answer to your question this morning.

Q352 **James Morris:** Sandra, in your opening remarks you seemed to suggest that there was a lack of clarity in the area you are working in about public health messaging and so on. We are into practical recommendation territory. What would be the one recommendation that you would want from Government in order to address foetal alcohol syndrome?

***Sandra Ionno Butcher:*** I would say, don't ask me the question: go back and look at the hundreds and hundreds of hours that have already been done by people in the Department of Health, in NICE, in SIGN and in Public Health England, now OHID. You are sitting here for the first time with every major public health body now saying that there needs to be improvement and more attention paid to this. What I would suggest needs to be done is a Green Paper, on how the implementation of the Department of Health FASD health needs assessment is going, that would lead to an FASD prevention and response Act. There needs to be an FASD prevention and response fund that should equal at least 0.1%, if not 0.2%, of the alcohol duty.

Let's be real about it. I am here as a mum, too. It is hard when you are in this kind of place to portray the reality of lives of people all across the country. We are in a hearing talking about prevention of harm from alcohol. If the people whose lives and futures are affected by alcohol before they take their first breath or see this world are not top of the agenda for every single person in this room, I don't know what we are doing here.

As I said, for now there is a way forward. There have been hundreds and hundreds of hours of investment, so I would say that that is the most important thing. When it comes to the messaging around the use of alcohol in pregnancy, we need to separate it from alcohol harm. That was the problem with it that when the chief medical officers changed their guidance after all those years to say there is no safe time, no safe amount and it is safest to avoid alcohol in pregnancy, it was buried in the other guidelines. That led to confusion, and to it not being considered as important, including by the industry, other alcohol harm groups and policymakers.

You are talking about something that is a teratogen. It is a poison. It does what thalidomide did. It does what some other things do. We have come out more strongly on other kinds of teratogens, but we have not done it for alcohol. Now, it is time. We focus on trying to get the data, and rightly so. Even in the NICE quality standard, it says, when you are coming in for your first maternity check, that you are asked about it. You are asked about it throughout pregnancy, but what about before people get pregnant? What about getting it out there so that young people understand, before they are thinking of pregnancy, that it is not safe to have alcohol?

In Ontario there is something called Sandy's Law. I didn't name it, but I like the name. They have posters up at the point of sale. Industry has done a good job in getting the little thing, the x-ed out woman, on the label. That has been voluntary. It is working, but it is not enough. Other countries have stronger labelling, where they put in words in and use colours. There is a way to not x-out the woman—as a woman, I really dislike that. There is a way to do an empowering image.

There are ways for the industry to make it a priority and to be promoting truly zero-alcohol mocktails. They have the PR machines. There is a lot that can be done. Primarily, and most importantly, it is about separating this out and making it an issue, and I thank you for having me here today. If you, as a Committee, are looking for a place, when you are looking at prevention, where you can have the most profound impact on the future health of this society, there are more people with FASD than autism right now. That is a fact, but what are we doing about it?

**James Morris:** Thank you; we are grateful.

Q353 **Chair:** That is a very interesting fact. It is Sandy's Law in Ontario, Canada.

***Sandra Ionno Butcher:*** Yes. I'm happy to send information on that.

Q354 **Chair:** Mr Lambert, what did you think about the point made to your right? Labelling? Marketing? Do you know about Sandy's Law?

***Matt Lambert:*** I do. Sandra and I have spoken about it, even recently. The facts that Sandra tells us are absolutely shocking. We are absolutely clear that alcohol and pregnancy do not mix. People have to be careful if they are pregnant.

Q355 **Chair:** Is there more you could do to help with what Sandra just said?

***Matt Lambert:*** I appreciate what she said about—

Q356 **Chair:** If you could make recommendations to us—

***Matt Lambert:*** Yes, I appreciate what she said—

Q357 **Chair:** She is sitting next to you; it was amazing.

***Matt Lambert:*** Yes. I feel it, as anybody would, and as a parent. First of all, I appreciate what she said about the labelling, with 99%—effectively, 100%—of products carrying that. I am perfectly willing to look at what the label says and looks like, in terms of what Sandra said about that. As regards Sandy's Law, I need to look at it more closely. I think, in principle, that I would support it. Again, this is for the outlets. Andy can tell you more about that. In principle, I would be supportive of more information at point of sale, point of purchase, so that people are aware of the issues. It is a terrible thing, and it needs to be prevented.

Q358 **Chair:** I like this. This is like a direct recommendation. We are not going via the Minister or the Select Committee. We are just on the panel.

***Matt Lambert:*** I don't have any power over pubs, bars and restaurants, by the way. I can only encourage.

Q359 **Chair:** Sandra is perfectly placed between Andy and Matt.

***Sandra Ionno Butcher:*** It is also important for you, as a Committee, to invite the Secretary of State in and ask what is being done to follow up on the FASD health needs assessment. There has been a lot of people

power out there throughout the systems. What we need is for the Department of Health FASD health needs assessment and the NICE quality standard to be operationalised.

Q360 **Chair:** It is funny you should say that, Sandra. Just before you came in, we were discussing the Secretary of State. I assure you, that is not a point missed on us.

***Sandra Ionno Butcher:*** Please be sure and ask that question.

**Chair:** She will be coming back.

***Sandra Ionno Butcher:*** Thank you.

Q361 **Rachael Maskell:** I have heard a lot about targeting harmful use of alcohol, but people do not normally have a harmful use of alcohol if they have not first had a moderate use of alcohol, and that is where I want to focus my questions.

Matt Lambert, we have seen in the Government's focus around smoking a very targeted approach to remove advertising, reduce the point of sale, restrict access and address issues of affordability. What more can be driven across our country to have such effective measures to reduce and, for some, end the use of alcohol?

***Matt Lambert:*** I would argue that the area for focus there would be encouraging awareness of the chief medical officer's guidelines.

Q362 **Rachael Maskell:** But that's not working, is it, in the sense that—

***Matt Lambert:*** No, it clearly is working.

Q363 **Rachael Maskell:** —we are talking about 8 million people drinking above those guidelines.

***Matt Lambert:*** I am sorry, it clearly is working. The stats are very clear. Consumption is down. The vast majority of people are drinking well within the chief medical officer's guidelines. The average consumption of alcohol is 11.6 units, which is well below 14 units and lower than many comparable countries, such as Ireland, Spain and France. The answer is that, over the last 10 or 15 years, that has clearly worked, yes.

Q364 **Rachael Maskell:** How is it going to work for the 8 million people who are drinking above the Department of Health guidelines?

***Matt Lambert:*** That is what I am saying. I think we should be doing more to encourage people to stay within or below the 14 units, or not to drink at all. There is the innovation and growth of low and no, and alcohol alternatives, and the industry is doing a lot to promote those. We have recently issued guidelines on how those products should be marketed to make sure that that is done in a responsible manner. We are encouraging people to think about their drinking, and encouraging moderation. We are working through Drinkaware, which is the industry's largest investment in

this area, to encourage people to get good advice and information. I believe that Governments could do more.

Q365 **Rachael Maskell:** But 8 million is not a small populace. Therefore, when you say we need to think about it and do more, precisely what does that look like?

***Matt Lambert:*** My strong view is that, where there is drinking at the highest levels, it is around treatment and effective treatment. There is clear evidence about better ways to do that, trying to prevent people going further down a road that leads them to very serious consequences.

Q366 **Rachael Maskell:** Has the horse not already bolted at that point? Should we not be looking more at prevention than at cure?

***Matt Lambert:*** It is twofold. It is encouraging people to drink responsibly, but as you have already said, and I agree, some people drink to high harm levels. They have to start with alcohol. We take a view in this country that adults are entitled to purchase alcohol, but we also encourage them through Government activity, industry activity and co-operation right across pubs, producers and retailers to think about their drinking and to drink responsibly and within safe levels as advised by the Government.

Q367 **Rachael Maskell:** Do you think that maintaining regulation within the industry and the oversight you have is the most effective place, or do you think that that should now be pulled into Government to lead a more national strategy?

***Matt Lambert:*** The evidence is that it has been very effective. The Portman Group has been running for slightly over 30 years. I was not personally involved all the way through that time, but 30 years ago I was helping to think about the origins of the Portman Group and the terms and conditions.

Imagine going back, sitting in that room and saying that, 30 years later, some of these stats would be looking so positive in the right way, in terms of the work that the Portman Group has done and the effectiveness of discouraging irresponsible marketing and protecting minors. All of that work has been primarily driven by two things. One is industry co-operation and adherence to our best practice guidelines, which were drawn up on advice from the Government. We have worked closely with Governments of all colours over the 30 years to encourage good practice by the industry and responsible behaviour. Secondly, the independent complaints panel actively deals with irresponsible marketing. The independent complaints panel is completely independent from me, and certainly from the industry. We have no influence on those decisions whatsoever. We, in my team, are merely the secretariat for the panel. We take their decisions and enact them.

The other part of our work is the huge amount of advice that is given every day by members of my team to the industry on how to stay within

the codes of practice and how to be responsible. That advice is freely available to everybody in the industry, and is widely taken up and used on a daily basis. Marketing departments, producers and so forth call my team and get advice—"Is the product or campaign we are planning acceptable or not?" Secondly, there is low-cost training for the industry, which is increasingly being taken up. A huge amount is done to head off or prevent irresponsible marketing, before it gets into the area where there are complaints, which are dealt with by an independent complaints panel.

To your point, first of all, I think it has worked very effectively. Secondly, it has been at no cost to the taxpayer for 30 years or more. Lastly, it is a very flexible system. We have had six revisions of the code in that time. Most recently, there was the introduction of a new rule in the code around causing widespread offence. It is receptive, flexible and aware of changes in society and attitudes to alcohol. That can happen very quickly, whereas if it was a statutory body with regulation, it would have to go through parliamentary processes, and I don't think it would be as flexible or necessarily have the voluntary support or other co-operation that we get from the industry to ensure good practice in this area.

Q368 **Rachael Maskell:** Clearly, there is a significant cost to the taxpayer because we are talking about deaths, hospital admissions and so much more. We will leave it there.

I now turn to the British Beer and Pub Association. Is regulation, in your book, in the right place, or does more need to be achieved to have better regulation?

***Andy Tighe:*** I think we have a good balance in this country between regulation and self-regulation. I always think there is more that can be done to build on all the positive work that we have talked about over the last 20 years.

One point to make is about the role of the pub, and looking at broader mental health, wellbeing and community wellbeing, particularly in areas of social deprivation; 68% of people say that their local pub helps tackle loneliness and social isolation in their area, and 80% say it is important in bringing people together. There needs to be a proportionate approach because moderate alcohol consumption in a social setting or in a managed environment like a pub is enjoyed by millions of people every week. They do little, if any, harm to themselves or others, and get positive benefits. We need to have a proportionate approach.

The balance we have in this country—with the licensing regime and the tax system that we have now, and the self-regulation on marketing, sponsorship and advertising—provides that. All the great work that Drinkaware is doing in getting people to talk more about alcohol, getting them to monitor carefully what they are drinking, and awareness campaigns when it comes to foetal alcohol syndrome, is really important stuff.

Q369 **Rachael Maskell:** Do you think that communities could benefit from tighter licensing with regard to the number of establishments? In York, it is very much targeted around the night-time economy, and we see a proliferation of vertical drinking establishments. They are not really community pubs. Do you think more can be done in that area?

***Andy Tighe:*** There is a balance. Of course, local authorities have to look at particular areas, and the mix of premises, outlets, retail, hospitality and leisure that they have there. Unfortunately, another 500 pubs closed last year. I don't think we have a net gain in premises selling alcohol for consumption on-trade, certainly from a pub perspective.

Q370 **Rachael Maskell:** I want to briefly turn to Drinkaware. If you were to make recommendations to Government about what they could do, would you keep regulation where it is, with the industry, or would you pull it more into a Government responsibility or a separate body? Secondly, are there other additional things that you want to see to prevent alcohol harm?

***Karen Tyrell:*** From our point of view, what I would be asking for from Government is an alcohol harm prevention strategy. The 8 million people we are talking about need more attention from all of us as part of our society. A broader approach feels important to us. That involves talking to all of the stakeholders across the system and bringing everybody together to help us think about the role that alcohol plays in our society. It feels important as part of that. Making sure that any strategy is based on the evidence but involves as many stakeholders as possible feels right as well.

In terms of things that we can do and would want to see in a strategy, we would certainly be asking for it to be targeted at people who are drinking above the chief medical officer's guidelines of 14 units a week and to be tackling those people specifically. That could be around trying to shift our conversations as a society about alcohol, as I referred to earlier. It would also include expanding access to IBAs, which are things like our drinking check, so that people become more aware of their own drinking patterns and behaviours. Ideally, also, they would be talking to their friends and families about their relationship with alcohol. We know that at the moment about six out of 10 people who drink at increasing risk levels have never had an assessment. There is an enormous amount we could do in that space.

It would be important in any approach for us to make sure that the strategy really recognises the issues around health inequalities and deprivation, recognising that alcohol harm is not evenly distributed. There are quite big extremes between people who choose not to drink at all and who potentially have quite a different relationship with alcohol and those who experience quite a lot of harm.

Finally, we would want any strategy to redouble our approach to alcohol dependency into making sure that we expand access to things like alcohol

care teams in hospitals and provision for alcohol treatment services for those who need that end of the system to be working effectively for them.

**Chair:** We will try to change over to the second panel in 10 minutes or so. We will see how we go.

Q371 **Paul Blomfield:** I want to pursue this a little bit and explore the contradictions between what we are hearing from the industry and the objective drivers behind the alcohol industry. Andy, you started off by celebrating the fact that young people were drinking less. That was your opening remark. If that trend continues, it's not in your interest, is it?

***Andy Tighe:*** It is when they are under 18.

Q372 **Paul Blomfield:** You are only defining young people as those who are under 18.

***Andy Tighe:*** Yes.

Q373 **Paul Blomfield:** Some of the evidence is that 18 to 21-year-olds or 18 to 24-year-olds are drinking less. You don't celebrate that.

***Andy Tighe:*** We celebrate that no under-18 should be drinking alcohol. We are very supportive of that. For 18-year-olds and above, as we have talked about, if people drink within the CMO guidelines, if people drink responsibly and if people drink moderately, with lower-strength products like beer, and go to the pub, of course we celebrate that.

Q374 **Paul Blomfield:** I go to the pub, and I recognise the description you gave of it earlier. You think that people should drink within the CMO guidelines.

***Andy Tighe:*** Absolutely.

Q375 **Paul Blomfield:** According to the Social Market Foundation, 68% of industry revenue comes from people drinking above the CMO guidelines. It is a big blow for your members if people comply with your advice, isn't it?

***Andy Tighe:*** That is why we talk about low and no-alcohol alternatives. That is why we talk about reformulating products. We can still sell great beer, but it may not have any alcohol in it. The industry can still maintain revenues, earn a profit and do what they do. As a society and as an industry, we have to be responsible. We want to see people drinking within the guidelines.

Q376 **Paul Blomfield:** What are your organisation and your members doing to actively promote to the people who drink in bars and pubs that they should be drinking within CMO guidelines?

***Andy Tighe:*** The majority have the CMO guidelines on the labels of their products, so everyone can see those. They have a link to Drinkaware or a responsibility message where people can get all the information about

drinking within the guidelines and doing the audit tool. They follow the Portman Group code on marketing responsibly and making sure that any marketing or promotion of products is done on the basis of moderation. Of course, there are laws. Pubs should not serve to people who are already drunk. People should not buy alcohol for people who are already drunk. There is a regulatory framework, as well as all the good practice work that industry does to champion it. As I say, the big growth in low and no-alcohol products is a huge opportunity.

Q377 **Paul Blomfield:** But if 68% of industry revenue is coming from people drinking above the guidelines, you are not doing very well, are you?

***Andy Tighe:*** There is always more to do, but the statistics and the data all show that things are moving in the right direction.

Q378 **Paul Blomfield:** I think the recent data shows that alcohol-related deaths are growing. I am sure there is lots of discussion we could have around the data.

Perhaps I could pursue the same theme with you, Mr Lambert. There was an Alcohol Health Alliance report on labelling back in August 2020—you are nodding, so you are obviously familiar with it. It said that 70% of labels, in general did not include the official up-to-date low-risk guidelines, three years after they had been updated. That is across the sector. The same report said that among Portman Group members—you set yourselves up as the socially responsible industry leader in good practice—98% did not comply. How did you react to that report?

***Matt Lambert:*** It's wrong. It is completely wrong. We do a market survey on a regular basis. You specifically mentioned the stat on the chief medical officer's guidelines. The last time we checked, that was standing at 79%. We are going to do the survey again this year. I am confident that it will be much closer to 90%, so that stat is wrong. In terms of adherence of Portman Group members, funders, it is 100%. Absolutely 100%, so that stat is completely wrong.

Q379 **Paul Blomfield:** So in 2020, the Alcohol Health Alliance was completely wrong when it said that 98% of your members' labels, at that point, did not include the official up-to-date low-risk guidelines.

***Matt Lambert:*** That is wrong. We don't recognise those figures, and they are wrong.

Q380 **Paul Blomfield:** I am sure that we can follow that up with the Alcohol Health Alliance.

***Matt Lambert:*** Yes, you can. I will happily share with you our market research. Our best practice guidelines advise the whole industry to have a pregnancy warning and unit advice, with the Drinkaware logo and the chief medical officer's guidelines.

Q381 **Paul Blomfield:** Let me follow up specifically on pregnancy. You were endorsing Sandra's comments earlier about the importance of guidelines.

I am referring to the same report, which you are obviously contesting. That said that, while 97% of labels displayed the pregnancy warning logo, only 15% set out information on risks. Do you recognise that imbalance?

***Matt Lambert:*** Risk in relation to pregnancy or generally?

**Paul Blomfield:** During pregnancy. I think it is pretty clear.

***Matt Lambert:*** The piece of advice that we give is to carry the pregnancy warning.

**Paul Blomfield:** The logo?

***Matt Lambert:*** The logo, yes.

Q382 **Paul Blomfield:** At that point, 15% of labels, and credit to those who do it, had information on the risks during pregnancy.

***Matt Lambert:*** I think it is a good idea, but I don't know what the stats for it are. I have difficulty with that survey because I don't recognise the other stats that you mentioned.

Q383 **Paul Blomfield:** You recognise that there is an imbalance between just carrying the logo and setting out the risks, and you would think it—

***Matt Lambert:*** Well, I think it—

**Paul Blomfield:** Hang on. You would think it would be good practice if the other 85%, or whatever it is, were setting out the risks of drinking during pregnancy, so that there was 100% compliance.

***Matt Lambert:*** That is a matter of choice for companies.

**Paul Blomfield:** It is a matter of choice and not good practice. Okay.

Q384 **Chair:** Just to be clear, you are going to write to us in follow-up to that exchange with Mr Blomfield.

***Matt Lambert:*** I would be happy to share with you our own most recent marketing survey.

Q385 **Paul Blomfield:** And where you think the Alcohol Health Alliance report was wrong.

***Matt Lambert:*** I can point out, or you can see, where it diverges.

**Paul Blomfield:** I am familiar with the report.

Q386 **Mrs Hamilton:** Good morning, all. Karen, my question is specifically targeted at you. As the new executive of Drinkaware, do you have any concerns re the emergence of bottomless brunches, and so on, since lockdown?

***Karen Tyrell:*** Bottomless brunches are a new trend. It is something where we are curious to find out more about what is happening. There is a potential perception issue around them encouraging binge-drinking. It is important for this panel to recognise that the ONS definition of binge-

drinking is six units for a woman and eight units for a man. Six units for a woman, for example, would be two large glasses of wine. That is not an enormous amount in your bottomless brunch.

It is an interesting trend. There are, of course, the messages that local pubs, restaurants and others are sharing with the public at that time as well. The regulatory environment that Andy referred to is in place, but, that said, it is certainly an area of interest as a new trend.

Q387 **Mrs Hamilton:** Thank you. Leading on from that, Matt, everybody keeps telling me, and I am sure the figures are right, that young people are drinking less. I have a real issue. I have tried the bottomless brunch—I'll own it. It is a pleasant afternoon. I can only have two, but the young people go crazy. Lots of young people pre-load, especially university students. They drink before they get there. Do you think there is more that could be done at a population level to prevent binge-drinking and other harmful behaviours relating to alcohol?

***Matt Lambert:*** The question there is about the attitude of the alcohol sector. My job is to encourage responsibility by that sector. I talk to CEOs and leaders of the sector very regularly right across every type of beer, wine, spirits, cider and ready-to-drink. Mr Blomfield made a point about what their motivation is and who they want to drink more. I don't detect that they want to see people binge-drinking their products. The trend in the industry, and where they want to make more money, is around premiumisation, which is drinking better but less. There is a very clear trend in that area. To be clear, that is among people who drink alcohol.

The other trend, which you have referenced, is around alcohol alternatives. The thing that has encouraged people to drink more of those, as far as I understand it and from our survey, is quality, innovation and improvement. We can all think back 10 or 15 years ago, wanting to drink an alcohol-free beer in a restaurant or something, and finding that it was not particularly nice. That is not the case at the moment. I drink those products and the quality has vastly improved, particularly in beer but in other categories as well. There are spirit alternatives, and progress is even being made in wine alternatives, although it is a trickier proposition for innovation, as I understand it. I am not an expert in that, but I hear it from experts.

An interesting area is that, as I mentioned, 85% of young drinkers up to the age of 24 are not drinking alcohol at all. Other things are going on there. There are other trends. Again, I am not really expert on what is driving that. Clearly, we see that young people, generally, are more health conscious. They are more concerned about their behaviour and what is visible in their profile on social media and so on, and the potential consequences of getting into difficulty on job prospects. There are a lot of things driving better behaviour, and they are all to be encouraged.

The last thing I would say is that there are huge numbers of really good industry schemes. There is National Pubwatch and there are community

alcohol partnerships, discouraging young people from drinking and giving them alternatives to trying to get access to alcohol. You have heard about the campaigns to discourage parents from buying. A lot of the purchases for people under the age of 18 come from families, unfortunately. There has been big progress in campaigns to make people aware that that is not appropriate and to discourage proxy purchasing, for example. Generally, there is better behaviour in the night-time economy and discouragement of crime, binge-drinking, drink-driving and all of those things. The stats show encouraging progress in that area.

Q388 **Mrs Hamilton:** On my last point, I am not sure who to ask. I have quite a poor constituency, but I have seen a massive increase in 24-hour drinking, with local shops. Large numbers of public health directors are really concerned about that growth and the lack of joined-up thinking between what is going on in the drinking industry and what is going on with local authorities, which someone highlighted earlier.

I'm really not sure who to ask, so whoever jumps in gets the honour, but if you had a recommendation in this area, how could you help us stem some of what is going on, which increases women drinking privately because they can drive out at night, or increases young people—perhaps a group of four of them eating a pizza—going to the shop if they are going to have a drink? What recommendation would you give us, to help us out there in the workplace, in our constituencies, to stop this absolute increase in the 24-hour opening of establishments to buy alcohol?

***Andy Tighe:*** Maybe I could make a point on that, Paulette. Certainly, there are very few pubs with 24-hour licences.

Q389 **Mrs Hamilton:** It is not pubs. These are off-licences that apply for 24 hours, so you can buy drink until very late at night, and sometimes around the clock.

***Andy Tighe:*** Because licensing hours are devolved, and because licensing departments and licensing officers are in local authorities, they would be the ones that are issuing those licences and enforcing against those licences. That would be the place to start in terms of managing their environment and the licences that they provide.

**Mrs Hamilton:** We will leave it there. Chair, I know we are behind.

Q390 **Chair:** Yes, but thank you so much for those really interesting exchanges. Thank you for your time. We really appreciate it.

***Sandra Ionno Butcher:*** Chair, would it be appropriate to say something? I have listened to my colleagues for more than half an hour without saying anything. I would like to say one thing to you. You once famously said that you did not have an ounce of complacency about pre-natal alcohol exposure and FASD.

**Chair:** I did.

***Sandra Ionno Butcher:*** You are sitting here as the Health and Social Care Committee. You have a remit broader than just dealing with this in terms of alcohol use. I encourage you, please, to open up some time to hear from people with FASD and their families. I would like the opportunity to submit some additional information because there are lots of things that can be done to take care of this.

Again, sitting here listening to what is not being said in this room, we are not prioritising or protecting those developing brains and bodies before they take their first breath. We absolutely have to raise the priority. We depend on you and your colleagues to do that. Thank you for having me here.

**Chair:** That is why you were invited. You, and anybody else, is welcome to contact us at any time. As I said at the start, the alcohol issue is massive in the prevention agenda. This is the start, not—underlined, bold, italicised—the end of this part of our inquiry. But it is the end of this session. We will take a quick break while we change the seating to talk about smoking. Thank you very much.

## Examination of witnesses

Witnesses: Hazel Cheeseman, Professor Khalil and Professor Hajek.

Q391 **Chair:** We are continuing our evidence session in our prevention of ill health inquiry. We have been talking about alcohol. We were talking about smoking yesterday, which I guess our panellists were aware of, or maybe even saw a bit of. We had Professor Khan in yesterday to talk about the Khan review.

We now have three more guests, which is excellent. Hazel Cheeseman is deputy chief executive of ASH, which is Action on Smoking and Health. Professor Asma Khalil is vice president for academia and strategy at the Royal College of Obstetricians and Gynaecologists. Professor Peter Hajek is from the Wolfson Institute of Population Health at Barts and the London School of Medicine and Dentistry at Queen Mary University London.

Thank you very much for coming. Let's start with you, Hazel. You and your colleagues at ASH must be very pleased with how things are progressing in terms of all the campaigning over many years, with the Government taking forward some really tough action on smoking, hence the title of your organisation. I will ask the same question as I did of Professor Khan yesterday at the start. Why is there the year-on-year approach, which is obviously going to come forward in a smoking and vaping Bill? Why is it raising the age year on year and not going to 21 now? You will remember that 21 Now was a campaign that ASH promoted quite heavily. I remember you talking to me about it in the past. Obviously, it has been superseded by events, but why not 21 Now first instead of this year-on-year promote?

***Hazel Cheeseman:*** The Government have set a clear ambition as part of their policy on taking forward raising the age of sale; there is now a vision where, as Professor Khan set out in his independent review, we want to make smoking obsolete as a country. We want to be a country where no one smokes. Having a vision that is followed through by the policy, where we raise the age of sale and gradually phase out tobacco, is clearly part of that strategy. I am sure we are going to talk today about how that policy on its own will be insufficient to get us there.

The vision is to make smoking obsolete, so that is a really important part of the jigsaw. From the Government's own modelling, we expect to see smoking in the under-30s phased out over the next few years, so that by 2050 we will not have smoking in the next generation. For those who are growing up now, smoking will be a kind of footnote of history. That is why Action on Smoking and Health and the Smokefree Action Coalition are supportive of the Prime Minister's commitment to bring forward the policy of raising the age of sale one year every year.

Q392 **Chair:** The second part of that is, what is your response to the nanny state argument? There are events happening in Westminster this morning, where I have a funny feeling that this policy will be mentioned. What is your argument in response to the nanny state argument? The second part of that are the practical considerations of the year-on-year policy, whereby a 45-year-old will be able to legally buy tobacco but a 44-year-old won't. Those sorts of arguments will be used to undermine the legislation and almost to ridicule it: nanny state and practical considerations of the policy.

***Hazel Cheeseman:*** The nanny state is often wheeled out in order to counter a regulation about protecting the public's health. We are not talking about a product that is a normal consumer product. This is a uniquely lethal product, which is addictive. From Professor Hajek's research, we can see that when people have their first cigarette, they are very likely to go on to become regular smokers. The free choice is, in effect, that first cigarette. There isn't a free adult choice to smoke or not to smoke if you have become addicted.

The impact on society is profound, as I am sure the Committee knows. Over the last 50 years, the UK has lost something like 8 million lives to tobacco smoking. I am sure that many of us in this room would count loved ones among those 8 million people. This is a unique consumer product, and it requires a unique regulatory response and a future that is smoke-free.

On the practical considerations of how you make it work, there have always been criticisms of bringing forward big public health measures. There were criticisms that smoke-free legislation would not be workable. Of course, the smoke-free legislation was a massive success from day one. One of the reasons it was so successful was that there was good investment in enforcement and communication around that policy. We will absolutely need that for the roll-out of this policy. Enforcement will

need sufficient powers, and capacity to enforce the law and communicate with and inform retailers. The public will need to be informed as well. Those things need to come together.

We would like to see mandatory age verification as part of the regulations that are brought forward, as a way of ensuring that the regulation can be properly implemented. On whether we end up in a position in 20 years' time where you have the 44-year-old and the 45-year-old, the goal is clearly not to end up in that position. The goal is clearly to create a future in which neither the 44-year-old nor the 45-year-old is a smoker. This is part of the package of measures that we need to get us there.

Q393 **Chair:** Professor Hajek, you have been involved in this world for a long time. The NHS stop smoking service was one of yours. How were we doing before we decided to put rocket boosters under the smoke-free ambition that I set when I was doing the public health job? We have come a long way from then in being able to actually make it happen now. The Government seem to be prepared to stand up for what they believe in. How were we doing up until this point?

***Professor Hajek:*** Smoking prevalence is declining faster here than in some other jurisdictions, but it could be going much faster still. Part of the discussions will be about the alternatives to smoking, which pose the promise of getting rid of smoking faster than if we did not have them.

One issue about where the prevalence is going is to look at the product interaction between vaping and smoking. Do you want me to say something about that? I don't want to run off on a tangent on something that you did not really ask, but if you will allow me to, there is a very important question. What is the relationship between the two? It could be that vaping is a gateway into smoking, if young people get the taste of nicotine and progress to smoking. It could be a gateway out, if it helps lots of smokers to switch. It could have no effect if the two trends balance each other out. We now have some evidence, which is quite reassuring, that there is no sign at all of a gateway in. We did a large project that was quite ambitious, funded by NIHR, with international committees of pro-vapers and anti-vapers looking at the trends in smoking over time and the use of alternative products in a number of countries. In no jurisdiction or comparison was there any sign of a gateway in. There were some signs of a gateway out.

One of the comparisons that could be of interest here was when we wanted to see the effects of regulations. We were comparing a trend over years in cigarette smoking and in cigarette sales, which are better figures than prevalence figures, between Australia, where vaping is banned, and the UK and the USA, where it is allowed. These countries had similar types of historical trajectory, tobacco control measures and so on. Since e-cigarettes became popular, the decline in smoking was significantly faster here and in America than in Australia. It is important that that was particularly visible in young people. The prevalence of smoking among young people is declining pretty fast in this country, which is good news.

Surprisingly, sales of cigarettes are dropping much faster in Australia. I say surprisingly because in Australia in 2019—we monitored up to that point—a pack of cigarettes was over £20, and here it was under £9. There was very aggressive pricing out of smokers, and we had a faster decline in cigarette sales.

There is some other evidence outside that one study. For instance, in Sweden snus virtually replaced smoking, with 6% daily smoking prevalence. In Norway, where these alternative snus—oral tobacco pouches—became popular much later, they had 7% prevalence in 2022. In young groups, who are of particular interest because that is the future of smoking, in the age category 16 to 24, they have 0% smoking among women and 4% among men. If, in future, they have 2% smoking prevalence, even if those people continue to smoke, which is quite unlikely, they virtually solve the issue. These alternative drugs have substantial potential to solve the problem for us and to put an end to smoking-related heart disease.

Q394 **Chair:** Thank you. Professor Khalil, it would be interesting to talk to you across both panels this morning. I know that you were very kindly here. Thank you for waiting. You would have been very interested in the foetal alcohol discussion that we were having. Obviously, smoking in pregnancy is a regional challenge. It is a bigger challenge in parts of England than it is in, say, the part of England that I represent, in Hampshire. What are your reflections on what you heard this morning in the alcohol discussion we were having and on the importance of the smoking and vaping legislation that we are bringing forward?

***Professor Khalil:*** Smoking is the single biggest notifiable risk factor for miscarriage, stillbirth, premature birth, birth defects and low birth weight. Looking at the effect of smoking in pregnancy, we can probably group it into three categories: effect on the pregnancy outcomes, effect on the pregnant woman, effect on the child after birth.

In the first group, for example, smoking increases the risk of miscarriage. The relative risk of miscarriage increases by 1% for every cigarette consumed every day. There is a relative risk. Even if you have second-hand exposure to smoking, you increase the risk of miscarriage by 11%. On the stillbirth figures, if you smoke more than 10 cigarettes per day, you increase the risk of stillbirth by 50%. If you smoke between one to nine cigarettes per day, you increase the risk by 10%.

The figures are striking. About one third of deaths that occur during pregnancy or shortly afterwards are likely to be secondary to smoking. You increase the risk of premature birth, birth defect and low birth weight. You could argue, how come smoking increases the risk of low birth weight? Because it restricts the delivery of oxygen and nutrients across the placenta to the foetus.

The effect on the pregnant woman is, of course, the long-term cardiovascular risk or different types of cancer. Even the risk of abruption

is twice as high in women who smoke compared to women who do not smoke. Abruption is when the placenta separates from the uterus. That could be life-threatening to the mother because of the risk of bleeding.

There is then the effect on the child after the baby is born. We know that smoking increases the risk of sudden infant death. It increases the risk of asthma, pneumonia and infections like ear infections and lung infections. It increases the risk of behavioural problems like ADHD or poor performance in school. We also know that children who are born to parents who smoke are themselves more likely to smoke. We have clear evidence that smoking is harmful, both to the mother and to the baby.

To the specific question about alcohol and smoking, there is a strong correlation between the use of alcohol and smoking. The problem with alcohol in pregnancy is that we do not have very reliable or accurate figures as to the scale of the problem. I think it is likely to be underestimated. There are lessons to learn from the work that has been done on addressing smoking in pregnancy, which can be replicated in addressing alcohol in pregnancy. From raising awareness to educating healthcare professionals, how do you create a safe space to be able to have this conversation and help women? Pregnancy is a golden opportunity. It is a teachable moment. Women are more likely to quit smoking during pregnancy than at any point in their life. We therefore need to capitalise on that opportunity.

Q395 **Chair:** Is that primarily due to points of contact? We talk about making every contact count in healthcare. Is it due to that, or are there other factors?

***Professor Khalil:*** There are two points. I think you are right that this is a time when women are more likely to come across healthcare professionals, but there is a strong incentive for women to improve their health because of the baby. That is a really strong motive that we can capitalise on to help these women.

The other huge issue is inequalities, which apply to both smoking and alcohol. Again, the figures are striking. Maternal mortality and stillbirth is twice as high in women from the most deprived areas compared to the least deprived. Also, both smoking and alcohol are likely to have inequalities. Again, the figures are striking. When it comes to smoking, about one in five women in the most deprived areas is more likely to smoke compared to one in 20 in the least deprived. At conception and early pregnancy, about 30% of women in the most deprived areas smoke compared to fewer than 10% in the least deprived areas.

Q396 **Chair:** It is interesting. The evidence base from all three of you is compelling, yet the arguments against action persist. One thing I heard from Professor Khan yesterday is that it might not be elegant to get to where we want to get, but it is the right thing to do, and we have to bite the bullet and get there.

Hazel, what would your reflections be on us getting there? In 20 years' time people will look back and say, "It was obvious." It seems obvious now to ban smoking in public places, but there was a big movement at the time. The Public Health Minister at the time, Caroline Flint, had lots of challenges from working men's clubs and so on who did not want that to happen. My Labour colleagues remember that well. It was a factor. In 20 years' time, we will look back and think it was the right thing to do. Is that what you are saying?

***Hazel Cheeseman:*** Yes. These things are always impossible until they are not. That was absolutely the story with smoke-free legislation. There were powerful vested interests in opposition to that legislation, but their arguments did not win out. We really saw a flip in public opinion and the way that the public have approached the issue of smoking over time. We have been surveying the public for some time. Our surveys go back to 2007. Obviously, there are other sources of public opinion data too.

We have gone from a position back in 2007 when something like a third of the public felt that the Government were not doing enough to address smoking at that time. Now, when we ask the question, two thirds of the public think that the Government are not doing enough to address smoking. We have gone through a period when we have had quite a lot of regulation, kicking off with the smoke-free regulations. The story there is that, as the Government regulate and are successful at regulating and bringing down rates of smoking, the public have a greater appetite for it. They want further regulation. From our own survey work, the public are very on board with the vision of a smoke-free future.

I think those are lessons for other public health issues that this inquiry will be dealing with, particularly alcohol. The support for regulation where Government take leadership is absolutely there among the public. We also know it is the thing that is going to be effective. If we look back at the story of tobacco control in the 1980s and 1990s, particularly among teenagers, smoking rates were flat. They did not really change, despite that being a period when we did lots and lots of educating teenagers and telling them that smoking was very bad for them. Smoking rates were unchanged in that population. It was only when we were bringing in regulations that limited advertising and raised the age of sale that you started to see teen smoking fall.

The 1980s and 1990s were an era of industry self-regulation and voluntary codes. The industry were saying that they could be part of the solution, but they absolutely were not part of the solution. It has only been by keeping the industry at arm's length from the policymaking process that we have seen an acceleration of progress. Those lessons can, and should, be learned for alcohol. It is good to hear that you will be hearing from other health professionals, as well as the alcohol industry, who were here earlier.

I mention alcohol because the session earlier is relevant to tobacco control. We know that the consumption of alcohol is an inhibitor for

people stopping smoking; you alluded to the relationship between alcohol and tobacco. There is some new research coming out showing that it is a common phenomenon that we see heavy drinking and smoking together. It is about 2 million people in the population. It is not trivial. If we can reduce the consumption of alcohol, we will also speed our progress on tobacco.

Colleagues at the University of Sheffield have, for example, been looking at whether, if you align what you are doing on duty and raise the price of alcohol and tobacco, you can have a multiplying effect. If you increase the price of alcohol and increase the price of tobacco, you reduce the consumption of smoking more quickly than by just raising the price of tobacco on its own. Those are the sorts of things that we should be looking at. It is a more coherent approach to prevention. We would welcome the Committee looking at that further. We can share some information on that.

**Chair:** That is why this workstream is considering smoking, alcohol and the addictions together. We recognise that there is a connection. Let's bring in Paul Blomfield, who I know has to go shortly.

Q397 **Paul Blomfield:** Thanks, Chair. Hazel, you make an important point about the place of industry in relation to policymaking, which probably also applies to gambling, and which is another strand of this inquiry.

I want to follow up a little further with Professor Khalil. You graphically described the impact on children of mothers smoking during pregnancy. You described some of the things that encourage mothers to stop. What more could be done to get that message home to pregnant women effectively?

***Professor Khalil:*** That is a really good question. We have a number of interventions, backed up by evidence, that demonstrate that they could help reduce smoking in pregnancy. Ideally, you want women to stop smoking. There is counselling and behaviour therapy. There is some evidence on digital innovation and text messages. We also have, as part of the Saving Babies' Lives Care Bundle, help on how to stop or reduce smoking in pregnancy, focused on mothers' opt-out carbon monoxide testing. That happens at the booking or early stage in pregnancy and is repeated at the end of the pregnancy. If the test is above a certain level, it automatically triggers an opt-out referral to tobacco-dependence treatment services. They have a special adviser. They work with the pregnant woman to tailor a care plan on how to provide ongoing support to the woman throughout the pregnancy.

What else could be done? We have evidence supported by the Cochrane reviews and the NICE guidelines about the financial incentive scheme, which is vouchers to the value of £400. That has been shown to help pregnant women to stop smoking during pregnancy and even afterwards. There are other things such as nicotine replacement therapy, with patches and vaping in pregnancy. There are a number of interventions

where we have evidence to support them. We would really like the Government to ensure that there is ongoing support, not just now but in the future.

Q398 **Paul Blomfield:** The figures show that although, overall, women are tending to have their children later, the interventions to discourage smoking have been less effective among younger mothers. Is there anything you think we should particularly focus on in that context?

***Professor Khalil:*** Obviously, increasing the age of sale is potentially likely to have an impact, particularly on the younger age group. Women aged 20 years or younger are twice as likely to smoke compared with older women. If you look at women who are aged 19 years or younger, about 30% of them smoke before or early in pregnancy. That is a group that has a higher risk of infant mortality, so we would definitely support the proposal of increasing the age of sale, because it is likely to have a bigger impact, particularly on the young age. About 7,000 women in that age group currently smoke at the beginning of, or during, pregnancy.

The figures suggest that, if we implement it, by 2028 we will have 2,300 fewer women who smoke during pregnancy. Modelling from the Department of Health and Social Care suggests that, within three to 10 years of implementation, it is likely that you would halve the number of smokers between the ages of 14 and 30. Again, that is the younger age, who are more likely to be pregnant. It is likely to be close to zero by 2040.

Q399 **Paul Blomfield:** I have one final question, which is on the alcohol issue. You will have heard the exchange about the information on product labels. I think Sandra Butcher was nodding at the suggestion that there should be not simply logos but details of health risk on product labels. The Portman Group representative was ambiguous on the issue. What is your view?

***Professor Khalil:*** My personal view is that, yes, I do not think it is enough. I think you need to have an increasing awareness of the specific risks related to pregnancy, the pregnant woman, the unborn baby and the long-term health of the child. As I mentioned earlier, I think that the scale of the problem of alcohol in pregnancy is greater than the figures show. I think there is under-reporting of alcohol consumption in pregnancy.

**Paul Blomfield:** Thank you very much.

Q400 **Mrs Hamilton:** Good morning, all. Hazel, earlier you talked about the fact that the smoking lobby is very strong, as I have learned to my cost, but you can get there. You also talked about the public having an appetite for change. I absolutely agree with you on both counts.

My question is about the north-south divide. There is so much work going on. It is documented that, in terms of the north-east and Yorkshire, as compared to London, there is a divide. Up north, some of the good work

that is happening it is not cutting through. Could you explain a little bit why that is happening, Hazel?

Dr Asma, why is it that, within health inequalities up north, where the inequalities are far greater, the work just isn't cutting through with pregnant mums the way it is down south? I think what I have asked is quite clear.

***Hazel Cheeseman:*** Historically, we have higher rates of smoking in our more deprived populations. That is true whether you are in the north or the south, but the north has historically had more deprivation and has higher rates of smoking. If we go back a decade, we had a much greater spread across our regions in smoking rates. Rates were much higher in the north-east, Yorkshire and the north-west compared to the midlands, the south and London.

What we have seen over the last decade is that the difference between the regions has narrowed quite substantially. Given that some started at a higher level, it is really instructive to look at what has happened. In the north-east, in particular, they implemented a comprehensive prevalence reduction programme. This programme is called Fresh in the north-east. There has been similar regional co-ordination in Yorkshire, in Greater Manchester and in parts of the north-east. The fact that they have, to some extent, managed to buck national trends and close some of the gaps is really worthy of this Committee's attention. I am sure that people in those areas would be very happy to provide further information.

It would be welcome to see that kind of regional, joined-up approach replicated in other parts of the country. There is a risk that, for example, the midlands is going to potentially get left behind. There has been some plateauing in smoking rates in parts of the midlands and the south. Transferring the lessons of how they have managed to achieve strong progress in those parts of the country would be welcome across the parts of the country which have been a little bit complacent that they have historically had lower than average smoking rates.

Q401 **Mrs Hamilton:** I am glad you mentioned the midlands. I wasn't going to talk about the midlands specifically. I find that it is an area where both sides have dug in. It is the last bastion. They do not want to lose the midlands. The lobbying that goes on in the midlands is ridiculous. Do you agree or disagree?

***Hazel Cheeseman:*** Lobbying from the tobacco industry?

**Mrs Hamilton:** Yes.

***Hazel Cheeseman:*** The lobbying from the tobacco industry is fairly ubiquitous. They have very deep pockets and an awful lot to lose. These are companies that are making £900 million in profits each year just in the UK. We see very strong efforts from the tobacco industry across the country, and I am sure in the midlands as well.

The arguments and the platforms on which the tobacco industry is attempting to communicate to politicians tend to be on things like illicit tobacco, which is always the argument against regulation from the tobacco industry: "Whatever we do will cause an increase in illicit tobacco." But, of course, the data says otherwise. The data shows that when we implemented our comprehensive approach to reducing illicit tobacco, we saw reductions in the illicit market.

The Government have recently renewed that strategy, which is really welcome. We obviously need to keep those efforts up; any size of illicit market is not to be welcomed, because it undermines price as a mechanism for reducing smoking. People selling illicit tobacco don't mind who they sell to, so they are pretty happy to sell to under-18s. We obviously need to keep up our efforts in that area, but I warn politicians to guard against the argument from the tobacco industry that any regulation on tobacco will somehow cause an explosion in the illicit market. It has not been true so far, and there is no reason to think it would be true in the future.

**Mrs Hamilton:** Thank you for that.

***Professor Khalil:*** To address your point about the variation in the figures across the country, particularly between the north and the south, I really don't think it is because of a failure of the services up north. It is probably more likely to reflect the difference in the demographics between the population living in different areas. For example, if you look at age, younger women are more likely to smoke as compared to older women. I mentioned earlier that 30% of women aged 19 years or younger are more likely to smoke prior to or early in pregnancy. That would reflect the demographics between the north and the south.

There is also deprivation. Women are likely to smoke more in deprived areas compared to less deprived areas. There is ethnicity. White women are more likely to smoke, at 15%, compared to 1% in south Asian women and 3% in black women. Certainly, with smoking, there is variation across the demographics and with inequalities.

That brings us to something very important when it comes to pregnancy. We have inequalities. Maternal mortality is twice as high in deprived women compared to less deprived women. Stillbirth is twice as common. Therefore, I think we need to stop admiring the problem and focus on finding the solutions. Finding the solutions is not something that only doctors can fix. We need a multidisciplinary approach. We need the Government and the policymakers to ensure that we can address things that are modifiable risk factors. At the top of the list is smoking and, of course, alcohol.

**Mrs Hamilton:** I am going to leave it there because time is short. Thank you.

Q402 **Rachael Maskell:** Professor Hajek, I am going to focus my questions on

you, if I may. We know that, on average, smoking will cost somebody around £3,500 a year, which is quite a substantial amount of somebody's budgeting, particularly as we know that there is higher prevalence among people who live in deprivation. I was very interested to hear about the data around social housing. We also know about people with mental health challenges. How are we particularly targeting people who live in an area of high deprivation, and people who are in that stubborn group, in being able to move from smoking? Are we doing enough to target those individuals? What additional interventions do you think would be effective on that population?

***Professor Hajek:*** Thank you for that question. The evidence that one can offer on this, or what the research results would say, is that smoking, like other drugs, is more attractive and more rewarding to people with miserable lives. If you live in poverty or you are bored all day long and you don't have much control, you reinforce nice things, and drugs, nicotine and smoking become more attractive for you.

The promise of the alternatives—in this country, primarily vaping; in other countries, heated tobacco or snus—is probably substantial in this area as well. The adoption of vaping could be much faster if there was less misinformation. ASH has data suggesting that a majority of people in this country believe that vaping is as dangerous or more dangerous than smoking. Horrific misinformation is going on, and it may prevent people from making that move.

A few years ago in Japan, when IQOS, a heated tobacco product, was launched, I remember that they were allowed to advertise it by showing risk difference. In Tokyo there were huge, big posters showing the risk of smoking and, at one tenth of it, in a histogram, was the risk of IQOS. Within about five years—it has never happened before and is a fantastic achievement for public health without any involvement of Government—sales of cigarettes in Japan dropped by 50%. Communicating the enormous difference in the risks and encouraging people to switch to something safer could make a difference among smokers who are otherwise difficult to reach and where ill health promotion, nicotine replacement and so on will not cut the ice to the same extent.

Q403 **Rachael Maskell:** I have a second question, which goes back to Professor Sir Michael Marmot and his incredible work looking at health inequalities. Recognising the social determinants of ill health is absolutely fundamental. I think you have just touched on that. Should there be a greater intersection of his work and looking at the strategies that are being developed around smoking, alcohol or other areas of addiction to ensure that we really look at the causation as well as the outcome?

***Professor Hajek:*** Yes, of course. If we had a magic wand and could remove human misery—

**Rachael Maskell:** I'm going to give you one, for now.

***Professor Hajek:*** —we would remove most of the reasons why people are taking drugs. Another thing to note is that it is only a small subsection of the population with the right, or rather the wrong, combination of genes and circumstances who are then vulnerable to becoming hooked on all sorts of drugs, including nicotine. Those people are out there. They see the substance, and they use it and find it rewarding. We need to enable them to do that without killing themselves, and without costing the national health service money because they are getting heart disease, lung disease and cancer. There could be a much bigger emphasis on that.

I notice with some alarm the consideration of banning flavours in vapes, for instance. They seem to be essential for smokers. They are partly responsible for vaping being so much more effective than nicotine replacement treatment. Banning them would be a bad move. It would be protecting cigarette sales, death and disease. Again, it is not in the interest of public health. This is an opportunity to mention that.

Q404 **Chair:** Hazel, what do you think about that? You and ASH have talked to us before in this Committee about the importance of disposable vapes and flavours being part of the mix. Professor Khan talked to us yesterday about prescription of vaping for those where we need to complete the job and get to a smoke-free generation. The Government have gone for what seems to be a complete, outright, ban. We have not seen the detail of the Bill yet, but from the regs that were announced yesterday at the end of the consultation, it seems that they are going for a ban on disposables and all but menthol in flavours.

***Hazel Cheeseman:*** First of all, it would be really welcome to have the Committee look at it in more detail when the Bill is published and when there are more details about how a disposable vape ban might be progressed. You very helpfully had a session on youth vaping, which we addressed, and I think it would be useful for the Committee to revisit that.

We absolutely support the principle that the Government are bringing forward around interventions to reduce youth vaping; we have been saying for some time that further regulation of the market is needed to reduce youth uptake, particularly the popularity of disposable vapes. The devil will be in the detail of how this is executed and done in the way that is most effective. There are risks in progressing, for example, a ban on disposable vapes without ensuring that both import and sales are prohibited, without making sure that we have sufficient enforcement powers, penalties and capacity or without making sure that the definition we put around disposable vapes is adequate. There are lots of questions that this Committee could usefully scrutinise.

On the question of further powers that the Government will be taking to regulate, for example, branding, point of sale and flavours, it would be really valuable to revisit the evidence and bring in the new evidence that

is being developed all the time, in this country and abroad, on the role of flavours and the role of marketing.

Q405 **Chair:** What is your view on the role of flavours?

***Hazel Cheeseman:*** Our view is that the popularity of disposable vapes has been driven by their appeal, their accessibility and their affordability. Those are the priorities that the Government should be addressing. The powers that they are taking around marketing, properly executed, should help to address the appeal question. Potentially, a well-executed ban on disposable vapes might contribute to that. It would be welcome to see the Government take some action around affordability. In our recent submission to the Treasury, we put forward a minimum unit price approach to e-cigarettes, but there are perhaps other ways of looking at that around taxation.

On the question around flavours and what role flavours are playing, it is clear from the research that Peter and others have done that flavours are an important part of why e-cigarettes are acceptable and useful for adults to quit smoking. We have had a very wide range of flavours on the market for a long time. It is not clear that the flavours, in and of themselves, are what drive youth use, but the marketing of those flavours is certainly easier to address and seems more likely to be what is driving youth. You do not need to have them called "Gummy Bear" flavour. Banning some of the quite offensive descriptions would be helpful.

Q406 **Chair:** Call them "Blueberry".

***Hazel Cheeseman:*** Exactly.

Q407 **James Morris:** We have talked about the interrelationship between alcohol and tobacco. We have not really talked about drugs. The traditional approach has been to have an alcohol strategy, a tobacco control plan and a drug harm reduction strategy. Do you think there is mileage in saying that, actually, the Government should have an addiction strategy, if that is the right way of describing it, which is more cross-cutting and with different elements? Do you think that would be workable?

***Hazel Cheeseman:*** I think the Government should have strategies on all those things. Whether you put them into a single strategy or you have individual strategies, I am not sure. Perhaps there is value in linking them and having a single strategy. The problem that we have at the moment is that there isn't an alcohol strategy. Although the Government are bringing forward quite a lot of initiatives on tobacco, which are tremendously welcome, as is the new investment, the lack of a coherent strategy creates risks of fragmentation of the money that is allocated to local government or to the NHS. It would perhaps be useful to talk about the investment in the NHS as well. There is a risk that that is not deployed in the most effective way because we have not had a replacement to the strategy that was published.

Q408 **James Morris:** Why do you think the Government have a reluctance to do that?

***Hazel Cheeseman:*** I don't know why there is a reluctance to do it, but it would be very helpful to have one.

Q409 **James Morris:** Professor Khalil, what do you think?

***Professor Khalil:*** I would welcome the suggestion. If you look at the effects of smoking and alcohol, there are many similarities. I mentioned earlier that smoking increased the risk of miscarriage, stillbirth and premature birth, but alcohol also increases the risk of miscarriage, stillbirth, premature birth, low birth weight and foetal and birth defects. There are the same adverse outcomes.

There is a similar pattern. It is almost a dose-response relationship: the more you smoke, the higher the risk; the more you drink, the higher the risk. There might also be lessons to learn from what we have achieved in reducing the number of people smoking during pregnancy and applying that to alcohol in pregnancy: the behaviour effects; how to create a safe space; how we train healthcare professionals; how to have that conversation with women; how to identify women at risk; and raising awareness among the public. You need not just to target pregnant women. It is probably too late to wait until they are pregnant to target them. You almost need to target them before they get pregnant. The inequalities apply to both.

Q410 **James Morris:** What about the cross-cutting strategy, Professor Hajek?

***Professor Hajek:*** I am not sure that I have anything sensible to contribute.

**James Morris:** I'm sure that isn't true.

**Chair:** It hasn't stopped witnesses in the past.

Q411 **James Morris:** I have a supplementary question for you. You made some comments about human beings and their propensity to get addicted to substances. Is that just a part of the human condition that we have to accept, or can you imagine a future in which the driver towards addiction is removed?

***Professor Hajek:*** I suppose there are activities that humans find pleasurable, and for some people they become too pleasurable, or some other mechanism takes over and people have more limited control over it.

Let me use the sometimes mentioned addictiveness of vaping. It is actually much less addictive than smoking. Nicotine, on its own, has limited addictive potential, which you may find surprising. You cannot get a user to self-administer nicotine. They would self-administer other addictive drugs, but not nicotine on its own. Generally, vaping would have a much lower addictive potential than smoking.

There is some data on never-smokers who take up vaping and become daily vapers. The figures are fairly low. I have a note here of the ONS data, which states that among non-smokers 6% become daily vapers. Martin Jarvis from UCL analysed some of those results and said that only 0.2% show any signs of dependence on e-cigarettes. With smokers, over 50% become daily smokers if they try one cigarette, but with vaping it is much less. Vaping would be more addictive than nicotine replacement treatments, which are not addictive at all, but would be much less addictive than smoking. It is not often appreciated that there is that difference.

**James Morris:** Thank you, Chair.

Q412 **Chair:** I might just conclude on that. We have talked in this Committee before about how I worry. You know how I worry, Hazel. What I worry about is that we can take away the packaging and the flavours called Gummy Bear, but what I hear as a constituency MP, and when I am contacted by people as Chair of this Committee, is that so many young people are completely addicted to vapes. I have heard of some pretty disturbing behaviour going on as to what young people will do to get them. It worries me that, with all the work that we are going to do, there is an addiction because the nicotine is hooking them, as it did with cigarettes. That is what the companies wanted. They wanted to create Marlboro Man and to hook people into their product. It is happening again.

I worry that, with all the work that we are going to do, the addiction is still there, so we have to break the addiction. I wonder if there is any work that ASH has done on that, particularly with young people. They shouldn't be buying them, parents shouldn't be giving them and they shouldn't be getting them online. I get it—I get all that—but the fact is that they are hooked on them.

***Hazel Cheeseman:*** We wanted regulations more than two years ago because we could see that there was an increasing trend among young people. We are going to get some regulations now. That will reduce youth uptake but, as Peter said, there will be individuals in the population who are at risk of becoming addicted to nicotine through vaping. We need to make sure that those people are supported.

There is a big risk in the level of misunderstanding in the population around the relative harms of vaping for that population of young people. I have had data shared with me from focus groups with young people who do not understand that vaping is much less harmful than smoking. As a consequence, the risk of them moving between the behaviour of vaping and the much more harmful behaviour of smoking is quite high.

We have done research from our own large population surveys showing that 18 to 24-year-old smokers are much less likely to identify a range of illnesses as being smoking-related than older smokers in the population. Something is going wrong in how we are communicating the differences

between these products to people, as well as the inherent harms from tobacco. It is great that the Government are going to invest in mass media campaigns. We have not really been on TV for a very long time. There will be £15 million spent on mass media. That is great. Hopefully, there will be hard-hitting health messages. We also need to do pack inserts. The Government consulted on that, but they do not seem to be bringing forward anything around pack inserts to encourage quitting. We need information on dissuasive cigarettes, like Canada.

I absolutely hear what you are saying in relation to youth vaping—perhaps Peter would want to add to it—but we cannot lose sight of the very profound harms of tobacco smoke and the risk that, as we are regulating, as we absolutely should be, to reduce youth consumption of vaping, we do not risk them transitioning into tobacco smoking.

**Chair:** I am going to leave it there because we need to go downstairs, but we are very appreciative of you coming in. The Committee are very grateful for your time. This is the start of a very interesting workstream that has created a lot of interest, as indeed it should. Hazel Cheeseman, Professor Khalil and Professor Hajek, thank you so much for your time.