September 2008

CANCER RESEARCH UK

Cancer Research UK response to the Department of Health consultation on the future of tobacco control

General Comments

Cancer Research UK[1] is the world's largest independent organisation dedicated to cancer research, with a research spend of over £315 million in 2006/7. Our vision is that together we will beat cancer. We carry out world-class research to improve our understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease.

We know that smoking causes one in four cancer deaths in the UK and is a major cause of health inequalities.[2] One in two long-term smokers will die from a smoking-related illness.[3] One of our organisational goals is therefore to see the number of smokers fall dramatically, preventing thousands of new cases of cancer every year.

Cancer Research UK believes that there is an urgent need for action to ensure that a new generation of young people do not become smokers. We strongly support any measures to reduce smoking rates and the health inequalities caused by smoking. We welcome this consultation as an excellent opportunity for further major steps forward in reducing the harm and health inequalities caused by smoking. We hope to see many of the measures proposed in this consultation implemented as part of a comprehensive, well-funded and evaluated, cross-departmental tobacco control strategy.

There is much common ground among the tobacco control community and other public health organisations. The calls that we make in response to this consultation are supported by many other organisations. We have worked closely with many organisations, particularly Action on Smoking and Health (ASH) and other members of the Smokefree Action Coalition, and Cancer Research UK's tobacco control researchers to develop this response.

Specific comments on consultation questions

Part A: Reducing smoking rates and health inequalities caused by smoking.

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030 and on what basis do you make these suggestions?
Moreover, what else should the Government and public services do to deliver these rates?

Adult smoking rates

[1] Registered charity no. 1089464

[2] See Cancer Research UK CancerStats website: http://info.cancerresearchuk.org/cancerstats/

[3] Doll R, Peto R, Wheatley K, Gray R, Sutherland I (1994). "Mortality in relation to smoking: 40 years' observations on male British doctors". BMJ 309 (6959): 901–11.

Cancer Research UK would like to see a target set to reduce smoking prevalence rates by 2015 to 11% for the general population in England, and 17% amongst routine and manual workers (compared to 22% and 28% respectively in 2006). We would like progress toward this target to be reviewed in 2012, to determine whether and/or how any strategy should be revised. It is also important that national targets link in to local targets set by primary care trusts and local authorities.

We believe that these targets are achievable. A well-funded, comprehensive tobacco control strategy, including the development of a pure nicotine strategy to help those who cannot quit, has the potential to deliver significant gains. Evidence from countries such as Canada and states such as California, which have had comprehensive tobacco control programmes in place for a number of years, demonstrate that such programmes can support a reduction in smoking rates to around 15%. For example, Canada has pursued a comprehensive approach to tobacco control since the mid-1980s including mass media campaigns, public education, regulation of packaging and labelling, community action, point of sale restrictions and tax increases. In addition, a significant decline in smoking rates in the UK has been seen since the introduction of smokefree workplaces legislation: Professor Robert West's 'Smoking Toolkit' study[4] estimates that this represents a 7% decline over the year since the legislation came in. This means significant progress towards the proposed target has already been made.

We believe that it is too early to set concrete targets for 2020 and 2030, but we encourage the Government to aim for less than 1 in 20 of the general population and less than 1 in 10 of routine and manual workers to be smokers by 2020.

Pregnant women

We know that pregnant women significantly under-report their smoking behaviour[5] and this could increase as further tobacco control measures are introduced. The Government could explore the idea of introducing national unlinked and anonymous cotinine testing for pregnant women. (HIV rates in pregnant women are currently measured using unlinked and anonymous testing). This would function both to identify where secondhand smoke exposure may pose a risk to pregnant women, and as a means of accurately monitoring population-level smoking rates during pregnancy. Once baseline measurements have been set, appropriate national targets can then be developed.

Young people

We would urge the Government to continue to monitor changes in smoking uptake in children (defined as those aged 11-15) using the General Household Survey (GHS). In 2007, 6% were regular smokers and it should be possible to reduce this to 4% by 2015.

Furthermore, in order to monitor the impact of the change in the age of sale of tobacco products from 16 to 18, a target for smoking in 16-17 year olds should also be adopted, commensurate with the 2015 targets set for adults.

Other suggested targets

Cancer Research UK also encourages the Government to set ambitious targets to further reduce exposure of children and adults to secondhand smoke.

[4] See http://info.cancerresearchuk.org/news/archive/pressreleases/2008/june/444256 for more information. West R. The Smoking Toolkit Study: http://www.smokinginengland.info/ Cancer Research UK Health Behaviour Research Centre, University College London.

[5] Windsor RA, Woodby L, Thomas M, et al. Effectiveness of AHCPR guideline-patient education methods for pregnant smokers in Medicaid maternity care. Am J Obstet Gynecol 2000;182:68-75.

These targets should help monitor progress in developing initiatives to increase the proportion of smokefree homes and cars [see question 12]. However, if smoking around children and other non-smokers becomes less commonplace, mis-reporting of smoking behaviour may increase. Therefore, continuing to monitor cotinine levels in children via the Health Survey for England will become an increasingly important objective measure of exposure in order to help validate these data.

Current data needs

Many of the above national targets should be measured by reference to the GHS to ensure consistency in monitoring. However, GHS figures are often two years out of date by the time they are released, and self-reported smoking prevalence is usually under-reported by around 2-3%. It is important that more timely prevalence figures are gathered and made available in order to assess trends and the impact of tobacco control measures, and that there is a system in place for updating any overall national strategy in light of any patterns that emerge. Studies such as the Smoking Toolkit study,[6] alongside Omnibus survey figures and HSE cotinine level figures could be used to give more timely data and to estimate the possible degree of adjustment needed in relation to GHS data. In addition, in order to monitor progress towards some of the targets noted above (e.g. rates in 16-17 yr olds), greater investment will be needed to, for example, increase sample sizes for statistical significance.

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

Smoking is the leading cause of preventable ill-health and death in the UK that is most closely linked to health inequalities. Smoking prevalence is higher in places with greater deprivation, amongst the lowest income smokers, and amongst routine and manual workers (compared with those in intermediate or professional roles). Such inequalities could be exacerbated if future declines in smoking occur mainly in higher income groups.

High tobacco prices

High tobacco prices due to taxation are the single most effective intervention to prevent smoking.[7] This is especially so for young people and low-income groups. Cheap smuggled tobacco undermines high prices,[8] and exacerbates health inequalities as its use is concentrated among poorer smokers, as well as young people. Tobacco tax increases should continue to be introduced in every budget, to result in price increases in excess of inflation, and tougher action is needed to stop smuggling. [See questions 4 & 5]

Hand-rolled tobacco (HRT)

Particular efforts need to be made to consistently reduce the affordability of hand-rolled tobacco through price increases and tackling smuggling. Fifty-six percent of HRT is illicit, and a much greater number of low-income smokers smoke HRT. Tobacco industry documents demonstrate that a widening price gap between cigarettes and roll-

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[6] See www.smokinginengland.info

[7] Jha P, Chaloupka FJ. Curbing the Epidemic: Governments and the Economics of Tobacco Control. Washington DC: World Bank, 1999

[8] Approximately 21% of tobacco smoked in the UK is still smuggled. Most of this is non-duty paid, either in the form of legally manufactured but non-duty paid products, counterfeit cigarettes (illegally manufactured and non-duty paid) or hand-rolled tobacco. This represents revenue losses to government of more than £2bn per year. West R, Townsend J, Joossens L. 2007. The need to bear down harder on tobacco smuggling. Manuscript in preparation.

your-own brands are seen as an opportunity to 'grow the sector'.[9] Price increases, alongside an extension of the ban on promotion and advertising to cover smoking accessories would help to stop this undesirable growth in the prevalence of HRT smoking.

Quitting support

Poorer, more disadvantaged smokers tend to be more heavily addicted[10] and need greater support to quit successfully. Cancer Research UK would support action to maximise the use and uptake of the most effective stop smoking methods,[11] alongside more research into new stop smoking products, methods and services for key groups, particularly routine and manual workers, pregnant women and young people. [See questions 13-16]

Support for those who cannot yet quit

Cancer Research UK, along with many of our partners in the public health community, believes that a strategy is needed to help smokers who cannot yet quit (often the more disadvantaged smokers) to switch to much less harmful, pure nicotine products.[12] [See question 17]

Social marketing campaigns

Cancer Research UK calls for a large increase in investment in sustained social marketing campaigns on how and why to quit.[13] Campaigns should be targeted more effectively at key groups. Increased collaboration with different independent agencies and organisations would aid the development of innovative campaigns targeted towards key groups, including low income smokers and parents and carers. In order to realise their full potential, tobacco control media campaigns need adequate exposure levels, and must be sustained over relatively frequent intervals, as shown by a recent Australian study.[14]

Research

Cancer Research UK would like to see further research to support targeted initiatives to reduce the health inequalities caused by smoking. [See question 13]

Monitoring the impact of policies and initiatives

The impact of national policy measures and initiatives to increase awareness, prevent uptake and promote quit attempts, such as those mentioned in this response, must be properly monitored and evaluated at regular intervals. Monitoring the impact of any strategy on health inequalities is particularly important, in order to target initiatives more successfully to high-risk groups. This includes monitoring the impact of stop smoking services and other effective quitting methods.

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[9] Good, G. Presentation at UBS Tobacco conference. 1 December 2006: http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

[10] Jarvis M, Wardle J. Social patterning of health behaviours: the case of cigarette smoking. In: Marmot M, Wilkinson R. (eds) Social Determinants of Health (2nd ed). Oxford, OUP, 2005.

[11] NHS stop smoking services and medication; medication on prescription or bought over the counter; telephone support and medication; internet support and medication.

[12] A switch of 1% per year would save an estimated 60,000 lives in ten years. Lewis S, Arnott D, Godfrey C, Britton J. Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? Tobacco Control 2005;14:251-254

[13] As recommended in the ASH Budget Submission 2007: http://old.ash.org.uk/html/smuggling/pdfs/budget07.pdf

14 Wakefield M. et al. (2008) Impact of Tobacco Control Policies and Mass Media Campaigns on Monthly Adult Smoking Prevalence, American Journal of Public Health.

Although in the short term, as smoking prevalence rates are reduced, inequalities may increase, the key is that all policies have some impact on high risk groups, and that the general downward trend of smoking rates in all groups is maintained and increased.

Question 3: Do you think the six strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

Evidence and experience shows that the six strand strategy for tobacco control [paragraph 2.23 of the consultation document] has been effective in reducing smoking rates and secondhand smoke exposure. Key measures include the 2002 ban on tobacco advertising and promotion, the 2007 smokefree workplaces legislation, and the establishment of the national stop-smoking services.

However, it is important that the UK Government builds upon this success by expanding the six strand strategy into a comprehensive, well-funded, cross-departmental tobacco control strategy which focuses on key current issues. It should:

a) be driven by new and ambitious targets to further reduce uptake, increase quit rates and reduce secondhand smoke exposure; [see question 1]
b) aim in particular to reduce health inequalities;
c) include ways to monitor and evaluate policies and interventions and their effect on attitudes or behaviour;
d) reflect those measures that require action at an EU and international level;
e) be linked to regional and local delivery mechanisms, including parts of the NHS, local authorities, public health and medical organisations and enforcement organisations.[15]

In addition to the current six strand strategy, the Government should also commit to the development of a strategy to help smokers who cannot quit to switch to much less harmful pure nicotine products. [See question 17]

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of illicit tobacco, which undermines other tobacco control measures. Cancer Research UK welcomed the announcement in the 2008 Budget of the forthcoming UK Borders Agency anti-smuggling strategy,[16] which will contain measures to improve both detection and deterrence. How well this is implemented and resourced will be crucial to its success. We hope that it will also include targets for reducing the smuggling, or increasing the seizures, of both cigarettes and hand-rolled tobacco.

We strongly agree with paragraph 2.38 of the consultation document that multi-agency partnership working is needed. A successful strategy to tackle illicit tobacco will require collaborative working between a full range of tobacco control stakeholders. Her Majesty's Revenue and Customs must work with other agencies at national, regional

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[15] In accordance with Article 5 of the FCTC

[16] See HM Treasury Budget 2008:
http://www.hm-treasury.gov.uk/budget/budget_08/bud_bud08_index.cfm

and local levels, including: local authorities; the police; Trading Standards; Crime and Disorder Reduction Partnerships; the NHS; local tobacco alliances; local businesses and community leaders. Some work is underway in the north of England to develop working partnerships and collect case studies of good practice, and Cancer Research UK hopes to see such work supported and expanded in the future.[17] More could also be done to learn from other agencies that have successfully tackled drug use/ abuse and selling.

International collaboration, as outlined in the WHO Framework Convention on Tobacco Control (FCTC), is also needed. We hope that the UK will sign up to the existing EU anti-smuggling agreements and any subsequent agreements with tobacco companies,[18] and should help develop (and ratify by 2010) a strong FCTC illicit trade protocol.[19]

Reducing smuggling must, however, be just one part of a strategy to ensure that the real price of tobacco remains high. High tobacco prices due to high taxation are the single most effective intervention to prevent smoking.[7] This is especially so for young people and low income groups. A strong anti-smuggling strategy must therefore go hand in hand with increases in the tax on tobacco in every budget, to result in price increases in excess of inflation. [20] Furthermore, the introduction of a national scheme of licensing would support the enforcement of any anti-smuggling strategy, as any sales of tobacco outside licensed premises would automatically be illegal.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

More could be done to increase awareness of the scale of the problem, the links between illicit tobacco and organised crime and the greater availability to children of illicit tobacco. Although this would be useful to encourage the public to report illegal tobacco sales, it is unclear what else a greater level of public understanding about the risks of smuggled tobacco products could achieve.

There is a role however for further research into: a) why and how people buy illicit products; b) the attitudes, behaviour and legal sensitivities regarding the passing on of information by members of the public and consumers of illicit tobacco; c) which messages work best with different target groups, such as occasional buyers of illicit tobacco.

It is important to stress that smoking illicit (including counterfeit) tobacco is no more or less harmful than smoking duty-paid, ‘genuine’ tobacco. It is imperative that the message that all cigarettes are harmful to health is prominently communicated: any

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[17] See North of England Cheap and Illicit Tobacco draft Health Action Plan http://www.freshne.com/content/pdf/North%20of%20England%20Cheap%20and%20Illicit%20Tobacco%20Draft%20Health%20Action%20Plan.pdf

[18] Under agreements reached with Philip Morris International (PMI) and Japan Tobacco International (JTI), both companies agree to pay substantial fines for any assignment of their products found to have been smuggled.

[19] Article 15 of the FCTC requires all parties to implement measures with a view to eliminating illicit trade in tobacco products.

[20] Whilst, at £4.60, the price of cigarettes in the UK is high compared to other European countries, the price has not been increased above inflation level in the last two budgets, so affordability of tobacco products has not decreased.

communication to raise awareness should include this message, and the public should be signposted to available support for stopping smoking.

Part B: Protecting children and young people from smoking.

Cancer Research UK commissioned research from the Centre for Tobacco Control Research (CTCR) to support our consultation submission regarding point of sale (PoS) displays of tobacco and the promotion of tobacco associated products (lighters, matches and Roll Your Own (RYO) papers). The attached report consists of four strands of research:

Section A: An analysis of survey data to assess young people's awareness of tobacco marketing prior to and following the Tobacco Advertising and Promotion Act (TAPA) of 2002

Section B: A literature review based on the 2004 expert witness statement by Professor Hastings in opposition to the UK tobacco industry's challenge against the proposed 2004 PoS regulations, updated to include literature from 2004-2008

Section C: A review of tobacco industry retailer-related arguments against PoS restrictions

Section D: An exploration of the marketing campaigns used to promote tobacco associated products

Question 6: What more do you think the Government could do to:
a. reduce demand for tobacco products among young people?
b. reduce the availability of tobacco products to young people?

A comprehensive tobacco control strategy to reduce smoking prevalence across the whole population is the best way to reduce youth incidence and prevalence.[21]

Specifically:

a. Reducing demand

High tobacco prices through taxation are the single most effective intervention to reduce demand, particularly amongst young people.[7] It is important that tobacco prices continue to rise above the rate of inflation via taxation. Action to further tackle smuggling is also needed to prevent high prices being undermined by cheap illegal tobacco [see questions 4 & 5].

There was strong evidence that exposure to tobacco marketing promotes smoking initiation.[22,23] As part of a comprehensive strategy, further restrictions on tobacco promotion and marketing will therefore be needed to reduce demand among young people. Key measures needed are:

I. Removing tobacco products from sight at the point of sale [see question 8]
II. Mandating plain packaging of tobacco products [see question 10];

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[21] Pierce JP, White MM & Gilpin EA. (2005) Adolescent smoking decline during California's tobacco control programme. Tobacco Control 14: 207-12.

[22] See Appendix Section B

[23] National Cancer Institute (NCI). The Role of the Media in Promoting and Reducing Tobacco Use. Tobacco Control Monograph No. 19. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 07-6242, June 2008.

III. Increased funding for sustained mass media campaigns aimed at making smoking less attractive. Collaboration with different agencies and organisations with a variety of specialisations and audiences should also be maximised to develop innovative campaigns to reach youth audiences (such as Cancer Research UK and Channel 4's 'Breathe' project, funded by the Department of Health [24]);
IV. Reducing the visibility of smoking in the media. Currently, the images within the entertainment media make smoking appear both more common and acceptable than it really is, and reinforce the idea that cigarettes have social and cultural significance. Measures to combat this could include:
    i. Implementing initiatives to inform those involved in the production of entertainment media of the potential damage done by the depiction of smoking and display of tobacco brands in the media[25]
    ii. Requiring all films and television programmes that portray positive images of smoking to be preceded by an anti-smoking advert[4]
    iii. Certifying that those involved in the production of films and TV programmes do not receive payoffs from the tobacco industry for the display of tobacco products.

b. Reducing availability

Further action to curb smuggling, and therefore 'cheap' cigarettes, would reduce availability. Prohibiting the sale of tobacco from vending machines would remove another significant source of tobacco for underage smokers [see question 9].

The Government should maintain its commitment to review the current law prohibiting retailers from selling cigarettes to under 18s in 2010, to ensure that the law is being enforced as it was intended to be. Beginning to monitor prevalence in 16-17 year-olds will help to identify the extent to which the law with its current enforcement provisions has affected under-age purchasing [see Question 1]. If it is found that retail outlets are still a significant source of tobacco to minors, the Government should take further action as necessary, such as introducing a scheme of licensing for the sale of tobacco. This would strengthen the control of underage sales, as licences could be withdrawn from those caught selling tobacco to minors. It would also help legitimate retailers by enabling the easier identification of illicit smuggled tobacco sales.

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

Yes. Promotion of tobacco associated products, such as roll-your-own (RYO) cigarette papers, matches and lighters, increases the use of such products. This leads, indirectly at the very least, to increased consumption of tobacco. Lighters and matches are marketed to retailers as "smokers' requisites".[26] These, like RYO cigarette papers, offer the opportunity to promote tobacco use.

Many tobacco associated brands also have commercial connections to tobacco companies, and thus it is likely that they will seek to promote tobacco products through the associated brands. It is of concern that the proportion of smokers using hand-rolled

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[24] See http://info.cancerresearchuk.org/healthyliving/smokingandtobacco/breathe_competition/?a=5441

[25] Hastings, G. & Angus, K. (2008) Forever cool: the influence of smoking imagery on young people. BMA Board of Science: London.

[26] See Appendix Section E

tobacco rose from 12% in 1996 to 22% in 2006.[27] We also know that a much higher proportion of low-income smokers smoke hand-rolled tobacco.[28] One tobacco industry official has suggested that the industry sees the high prices of cigarettes as an opportunity to grow the roll-your-own sector.[29]

The marketing of tobacco accessories increasingly makes use of promotions targeted, directly or indirectly, at young people. Sponsorship and promotions, such as Rizla's "Invisible Players" promotion and Swan's "Chill out in Ibiza" competition, are targeted at youth and create an image of tobacco products as compatible with music and other social activities. Similarly, the use of sports figures, particularly surfing and car-racing, maintain a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sport. Such marketing promotes RYO brands and consumption of the product (i.e. smoking) as fashionable, exciting and glamorous.

Sponsorship and marketing of tobacco associated products has increased since bans on tobacco advertising in many countries,[30] and it is likely that this could become an increasingly strong tool for the promotion of smoking if no steps are taken to regulate it.

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option? [We are particularly interested in hearing from small retailers and in receiving information on the potential cost impact of further restrictions on display. What impact would further controls on the display of tobacco have on your business, and what might the cost be of implementing such changes?]

Yes, Cancer Research UK supports option 3: require retailers to remove tobacco products from display.

Cancer Research UK is encouraged to see the amount of research gathered by the Department of Health to highlight the rationale for further controls on the display of tobacco products in retail environments. We believe that the large weight of evidence, much of which is well summarized in the consultation document, supports the conclusion that the removal of point of sale displays is a necessary next step to protect young people from tobacco marketing.

Cancer Research UK would like to highlight the following points, drawn from our research and that of our partners in the Smokefree Action Coalition[31] to support this conclusion (please see the submitted research report for further information):

PoS as a form of advertising

Although the 2002 Tobacco Advertising and Promotion Act (TAPA) has been successful in reducing the exposure of young people to tobacco marketing,[32] PoS

[27] Smoking-related Behaviour and Attitudes, 2006. Office for National Statistics, 2007

[28] Young D, Borland R, Hammond D, et al. Prevalence and attributes of roll-your-own smokers in the International Tobacco Control (ITC) Four Country Survey. Tobacco Control 2006; 15 (Suppl 3):iii76-82.

[29] Good, G. Presentation at UBS Tobacco conference. 1 December 2006 http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

[30] For example, it is notable that Imperial Tobacco placed adverts for Rizla cigarette papers at the point of sale following the 2002 tobacco advertising ban, since they did not require health warnings.

[31] www.smokefreeaction.org

[32] See Appendix Section C

marketing remains an important avenue for the marketing and promotion of tobacco. Until this is removed, young people will remain susceptible to tobacco promotions.

PoS displays are now the primary means by which tobacco brands are promoted, through the use of the pack itself. Young people are aware of, appreciate and are influenced by PoS displays, as with advertising in general.[33]

Tobacco industry documents reveal that PoS displays are used to recruit new smokers, retain existing ones and cue impulse purchases.[33] This evidence is supported by the industry's investment in PoS promotion, which has increased following restrictions on other forms of advertising.[34] Analysis of tobacco company documents indicates that as tobacco promotion and marketing restrictions are tightened, companies are increasingly considering 'eye level' visibility at PoS as key to brand success.[33] Furthermore, the tobacco industry continues to develop innovative PoS marketing techniques, often using lighting, brand specific colours on surrounds, and attention-grabbing designs. While these are not prohibited, they go strongly against the spirit of the legislation.

When PoS displays were removed in 2002 in Saskatchewan, Canada, combined with tobacco control measures, smoking prevalence rates amongst 15 to 19 year olds fell from 29% in 2002 to 21% in 2006.[35]

Impulse purchases not brand-switching

As stated in paragraph 3.38 of the consultation document, most adult smokers never make a decision on what brand to purchase using the packs displayed at PoS, contrary to the tobacco industry's arguments. This is supported by a recent study funded by Cancer Research UK, in which only 6.4%[36] responded that they chose their brand based on the shop display.[i] Removing tobacco products from sight does, however, remove the temptation for adults who are trying to quit to make an impulse purchase. An Australian study showed that 31% of smokers thought the removal of cigarette displays would help them to quit.[37]

As stated by analysts Morgan Stanley in 2007: "In our opinion, [after taxation] the other regulatory environment changes that concern the industry the most are homogenous packaging and below-the-counter sales. Both could significantly restrict the industry's ability to promote their products."[38]

Cost for retailers

There has been considerable speculation in the retail trade press about the financial impacts of this measure on retailers.[39] However, evidence from Saskatchewan, Canada shows that any initial financial impact resulting from tobacco display bans was relatively small, even for small stores reliant on tobacco displays. As stated in section 3.48 of the consultation document, the costs of re-fitting in Saskatchewan were largely borne by tobacco wholesalers. Importantly, the tobacco industry also continued to pay

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[33] See Appendix Section B

[34] Ibid. (Feighery et al 2008)

[35] Canadian Tobacco Use Monitory Survey 2000 - 2007

[36] (95%CI: 5.0%, 7.9%)

[37] Wakefield, M. The effect of retail cigarette pack displays on impulse purchase. Addiction, Nov 2007 http://www.addictionjournal.org/viewpressrelease.asp?pr=69

[38] Morgan Stanley. Tobacco. Late to the party. January 30, 2007

[39] See Appendix Section D

retailers for the tobacco storage units.[40] The tobacco industry has the incentive and resources to assist tobacco retailers in managing similar changes in the UK.

As explained in section 3.49 of the consultation document, measures to remove tobacco products from view need not be costly, and there are a range of options that could be employed to conceal products. However, the legislation would have to be carefully drafted to preclude the tobacco industry finding further innovative ways to promote tobacco.

This measure, if introduced, would impact on all stores, regardless of size, and smaller stores would still be able to stock the same range of tobacco. Of course, it is expected that any legislation to prohibit point of sale displays would eventually reduce cigarette sales long-term. However, changes in smoking experimentation, initiation and addiction caused by the legislation would only be evident over several years, during which time all retailers would have ample opportunity to diversify their product range to other products to make up for any loss in tobacco sales.

Crime, theft and smuggling

There is no evidence that display bans increase the risk of crime and theft, make tobacco seem more illicit, or increase smuggling. There have been no thefts reported in the province of Saskatchewan, Canada, in connection with the removal of PoS displays.[41] Indeed, some retailers in Saskatchewan reported that they kept their display bans in place during the 18 months the law was delayed, due to tobacco industry legal challenges, because they believe that having tobacco products visible actually increases theft.[42]

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

Yes, we believe that there should be further controls on the sale of tobacco from vending machines, and our preferred option to restrict access by young people is option 3: a total ban on the sale of tobacco products from vending machines.

As stated in paragraph 3.55 of the consultation document, while vending machines account for only 1% of overall cigarette sales, 17% of young people under the legal minimum age obtain cigarettes from this source.

Removing these machines altogether is the only effective way to prevent underage smokers obtaining cigarettes from these sources. International evidence shows that age verification mechanisms, whether by token, ID card or other means, are inherently insecure. For example, age verification cards can be lent to those underage.[43] Also, it is clear that the existing legal requirements for age verification in the UK have not been consistently complied with and adequately enforced, as 78% of 11 to 15 year old

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[40] Anti-tobacco troopers won't butt in - The Gazette (Montreal), 19 May 2008

[41] Saskatchewan Coalition for Tobacco Reduction. Letter from June Blau and Lynn Greaves to the Ontario Provincial Government Standing Committee on Financial and Economic Affairs. Saskatchewan Coalition for Tobacco Reduction. Regina. 27 April 2005

[42] See Appendix Section B (Canadian Council for Tobacco Control, 2006)

[43] See ASH news 6 June 2008: http://www.ash.org.uk/ash_ck0hpb9x.htm#5813

smokers in England often bought their cigarettes directly from shops in 2007, though the age limit for buying cigarettes was 16.[44]

Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it), including 22 countries in Europe,[45] and a total ban on tobacco sales from vending machines has been recommended by the World Health Organisation. In a poll conducted by ASH in February 2008, 65% of the UK public supported introducing this measure in the UK.[46]

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

Yes.

Cancer Research UK commends the Government for considering the evidence on this initiative. Although no jurisdiction has yet implemented a law requiring plain packaging, there is an increasing body of research to show that this could help to reduce the appeal of smoking.

Evidence shows that on-pack branding, including logos and colour schemes, makes cigarettes more appealing to young people and dilutes the impact of health warnings. Cigarette brand image and familiarity are powerful predictors of adolescents' intention to smoke – a more significant predictor of future smoking intentions than even peer influence.[47] Research shows consistently that pack brand imagery distracts from and undermines health warnings.[48]

Since the 2002 Tobacco Advertising and Promotion Act, tobacco packaging has assumed unprecedented importance as a promotional vehicle for attracting new smokers and marketing tobacco products to existing smokers.[49] Tobacco companies invest a huge and increasing amount of resources in making packaging alluring and eye-catching, and it is clear that the industry acknowledges the power of packaging as a marketing tool.[50] For example, the Marketing Vice-President of Imperial Tobacco has stated "It is very difficult for people to discriminate [between tobacco products] blind-tested. Put it in a package and put a name on it, then it has a lot of product characteristics."[51]

There is evidence to show that plain packaging would remove these attractive 'product characteristics', and that this could result in fewer teenagers starting smoking, as

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[44] Fuller E. (2007). Smoking, Drinking and Drug Use Among Young People in England 2006. NHS Information Centre, Leeds

[45] The European Tobacco Control Report, 2007.

[46] Research commissioned by ASH, February 2008. Figures from a sample of 3,329 people polled across the country.

[47] See Appendix Section B (Grant et al 2007)

[48] Goldberg M., Liefeld J., Madill J. and Vredenburg H. (1999). 'The effect of plain packaging on response to health warnings', American Journal of Public Health, 89(9), pp. 1434–1435.

[49] Wakefield, M. The cigarette pack as image: new evidence from tobacco industry documents. Tobacco Control 2002: http://tobaccocontrol.bmj.com/cgi/content/full/11/suppl_1/i73

[50] Good, G. Presentation at UBS Tobacco conference. 1 December 2006 http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

[51] Pollay, R. (2000) How Cigarette Advertising Works: Rich Imagery and Poor Information. http://www.smoke-free.ca/defacto/D057-Pollay-HowCigaretteAdvertisingWorks.pdf

smoking would lose some of its appeal.[52] Studies have shown consistently that compared to branded packs, plain packs are perceived as 'dull and boring', cheap looking and reduce the 'flair and appeal' associated with smoking.[53] Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales.[54]

Tobacco branding is also used to communicate misleading messages: it is now illegal for manufacturers to claim products are 'low tar', 'light' or less harmful yet all these are still implied through clever packaging, such as the use of silver packaging, pastel colours and terms such as 'smooth'. Plain packaging would close the loophole which allows tobacco manufacturers to subvert the bans on light and mild descriptors in this way. Any revision of product packaging should also incorporate the removal of misleading tar and nicotine yields (currently measured by machines that do not accurately represent smokers' exposure), and their replacement with accurate, relevant descriptive information.

Should price decreases accompany the introduction of universal plain packaging, it is suggested that a concurrent tax increase could counter the effect to prevent tobacco products becoming more affordable.[55] The tobacco industry has claimed that plain packaging would violate their rights under international and EU trademark and trade laws. However, international case-law indicates that these claims are likely to prove unfounded.[56]

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

Internal tobacco industry documents suggest that packs of ten are mainly bought by young smokers, including 'new entrants', as a cheaper means of acquiring cigarettes.[57] Recent data from England has shown that many underage smokers buy their cigarettes in packs of ten: over half (55%) of underage smokers' most recent tobacco purchase was a ten-pack.[58] Furthermore, Article 16.3 of the FCTC requires each party to endeavour to prohibit the sale of cigarettes individually or in small packets which increase the affordability of such products to minors.

However, there is also the possibility that packs of ten cigarettes are used by smokers trying to cut down or quit. It is therefore currently unclear whether this measure would have a significant impact on smoking uptake by young people, and whether there would be any unintended consequences, particularly for those who are trying to quit. Cancer Research UK calls for more research to ascertain who buys ten-packs, and what the consequences of removing them from sale might be. The Government could

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[52] Cunnigham R & Kyle K (1995). The case for plain packaging. Tobacco Control; 4: 80-86

[53] Goldberg ME, Pa St U, Kindra G, Univ Of O, Lefebvre J, Tribu L, et al. When Packages Can't Speak: Possible Impacts of Plain and Generic Packaging of Tobacco Products. Mar 1995: http://legacy.library.ucsf.edu/tid/rce50d00

[54] Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008

[55] See Appendix Section D

[56] Freeman B, Chapman S, & Rimmer M (2007). The case for the plain packaging of tobacco products. Tobacco Control. http://repositories.cdlib.org/tc/reports/generic/

[57] British Medical Association (BMA) Board of Science, Breaking the cycle of children's exposure to tobacco smoke, April 2007, p. 38

[58] National Statistics and NHS Information Centre (2006) Smoking, drinking and drug use among young people in England in 2004. London: The Stationery Office.

consider taking reserve powers to bring in a minimum pack size of twenty cigarettes at some stage in future, if the weight of further evidence proves this to be a necessary step.

Question 12: Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

Yes. The Government should commit to the development of ambitious targets to reduce the level of exposure of children to secondhand smoke, and outline a strategy to deliver on these targets within a year.

An estimated 40% of children still live in households where at least one person smokes; this represents more than 5 million children in the UK.[56] Not only does secondhand smoke cause a number of different diseases in children, but children whose parents smoke are also two to three times more likely to become adult smokers, greatly increasing their risk of cancer in later life.[59]

We would support the following steps as part of a government strategy:

a) Research to ascertain children's and young people's views and experiences of secondhand smoke exposure (including from parents, grandparents and other carers) to help inform well funded health promotion initiatives.[60]

b) The development and evaluation of initiatives at national and local level to increase the numbers of smoke-free homes and cars, particularly where children are at risk. There are many good international case studies which could be drawn from.[56] Initiatives should be supported by sustained mass media interventions and social marketing.

c) An appraisal of current international evidence on banning smoking in cars carrying children. Such legislation has been introduced in a number of regions, including Puerto Rico and parts of the USA, Canada and Australia. 76% of the UK public support a ban on smoking in cars that are carrying children under the age of 18.[42] Thirty percent of smokers in England smoke in their cars[61] and over half of all journeys made by children aged under 16 are by car.[62] If the Government did feel that the evidence pointed to significant health risks, further research could be conducted to ascertain whether this measure is likely to be well received and compliance would be high.

d) Continuing to monitor trends in children's levels and sources of exposure to secondhand smoke in national surveys.

[59] Farkas AJ, et al. Association between household and workplace smoking restrictions and adolescent smoking. Journal of the American Medical Association 284: 717-22. 2000.

[60] BMA 'Breaking the Cycle' (FN 56), p.43

[61] Fong GT, Hyland A & Borland R et al (2006) Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK Survey. Tobacco Control 15 (suppl 3): iii51-58

[62] Department for Transport (2006) National transport survey 2005. London: The Stationery Office

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

There are several areas where more research is needed to support a comprehensive tobacco control strategy. Initiatives such as the UK Centre for Tobacco Control Studies (funded by the UKCRC) are helping to consolidate and advance research knowledge on smoking and tobacco. Cancer Research UK hopes to see further collaboration and alliances between the Government, non-governmental organisations and academic institutions aimed at increasing knowledge and skills in tobacco control.

Primarily, it is important that any comprehensive tobacco control strategy is continually monitored and evaluated to assess the impact of national policy measures and initiatives on smoking/tobacco uptake and quit attempts, and particularly their effects on health inequalities. This will help to ensure that ambitious targets are met. Monitoring and evaluation will need adequate funding. [See question 1]

Some key areas for further research are highlighted below. We have taken the opportunity to summarize and highlight the research needs that we have identified throughout this response, beyond just the topic of supporting smokers to quit.

Quitting

- Research to develop new, more effective and cost-effective cessation aids, and to improve current aids, to make them more appealing and available. Particular emphasis should be placed on developing those that will aid quitting and prevent relapse in key groups, including routine and manual workers, pregnant women, young people, ethnic minorities and other groups with particularly high smoking rates [See questions 14 – 16]
- Research to further understand and overcome potential users' barriers to using smoking cessation aids including the NHS Stop Smoking Services, telephone helplines and medicinal nicotine or other pharmacotherapies
- Investigate the factors determining the decision to quit and explore methods of supporting those attempts by developing and piloting alternative stop-smoking services, particularly to support key groups
- Conduct studies into the factors involved in smoking relapse after pregnancy in order to design interventions to prevent relapse
- Review the evidence that smoking cessation influences the prognosis of patients with smoking-related cancers, and develop and pilot interventions to assist smokers with cancer to quit.

Protecting young people

- Research to understand the factors that drive smoking uptake in young people, and how to prevent them:
    - Research to understand the development of nicotine addiction among young people
    - Research to examine the effect of various interventions and prevention approaches including mass media campaigns.
- Research into the issues arising from the sale of cigarettes in packs of less than twenty [See question 11]

- Continued studies to monitor tobacco industry promotion methods and to investigate their effect on smoking perception, behaviours and uptake, particularly by young people.[23]

Secondhand smoke
- Studies to ascertain children's and young people's views and experiences of secondhand smoke exposure to help inform health promotion campaigns [See question 12]

'Harm reduction' strategy
- Research into the effect of long-term pure nicotine use on health and on quitting rates [See questions 14 – 16]

Smuggling and illicit tobacco
- Research into attitudes and behaviours regarding consumption of illicit tobacco.

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:
• smokers who try to quit but do not access NHS support?
• routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?

Stop smoking services are very cost- effective. Smokers who use stop-smoking services and quitting aids (such as Nicotine Replacement Therapy), are four times more likely to quit than using willpower alone. However, just 3% to 6% of smokers make use of the services each year. There is great scope for improving the services and making them more attractive to people seeking help in stopping smoking in order to maximise take-up of the most effective stop-smoking methods. A realistic goal for smokers attending NHS stop smoking services could be 10% of all smokers, and we would like to see a target of 40% of all smokers using NRT to help them to quit (with the proviso that they use it effectively).

Key steps that Cancer Research UK recommends include:

a) Funding for the stop smoking services must be maintained and increased over time to allow the development of more appropriate, attractive and well publicised services. A proportion of the revenues raised from tobacco tax should be ring-fenced for use in providing cessation services, particularly in areas of deprivation.[63]

b) Primary health care providers, other health professionals and community workers should be encouraged and supported to deliver interventions and signpost to stop-smoking services, in line with NICE guidance.[64]

c) Smoking cessation services should be properly integrated into secondary care[65]: Hospitals should be required to monitor smoking rates of patients and to

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[63] In their response to the European Commission consultation on tobacco taxation, the BMA recommended that two per cent of the revenues raised from tobacco tax should be ring-fenced for use in providing cessation services, especially in areas of deprivation.

[64] All health professionals and community workers should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services), and all GPs and nurses should take the opportunity to advise all patients who smoke to quit. NICE (March 2006), Brief interventions and referral for smoking cessation in primary care and other settings, Recommendation 3.

give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services.

d) Further research is needed to ascertain how to improve cessation products, methods and services, particularly those that will support routine and manual workers, pregnant women and young people in stopping smoking, and prevent relapse:

   I. Stop smoking products (including pure nicotine products and others) need to be more available, attractive and affordable.[66] Although the Medicines and Healthcare Regulatory Authority (MHRA) has taken some steps to increase the accessibility of NRT, much more needs to be done. For example, dentists are currently unable to prescribe NRT, despite being ideally placed to play an active role. In addition, stop smoking products should be available wherever tobacco is sold, and pricing should favour them over tobacco.

   II. Stop smoking services also need to be more available, attractive and better promoted. They may be successful in places where people are likely to see them, such as in workplaces, shopping centres and schools.[67] Better use could also be made of existing social networks, such as faith and community groups.

e) Pregnancy is a key potential trigger for stopping smoking, and smoking also seriously harms the foetus.[68] Pregnant women who smoke are not currently guaranteed access to specialist stop smoking services and therapies. Further research is needed to develop evidence-based guidelines on smoking cessation in pregnancy.[69] Midwives should also be trained to provide stop-smoking advice and to refer pregnant smokers to specialist support.

f) Well-funded social marketing campaigns are needed to offer advice and encourage people to quit. These must be sustained over relatively frequent intervals,[70] and better targeted at key groups.

g) The selection, training, assessment and supervision of stop smoking specialists could be improved. The implementation of treatment protocols could be more adequately monitored and enforced. There is also a need for high quality administrative support for services, and ensuring that available resources are appropriate to the requirements of the services.

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[65] See recommendations in BMA 'Breaking the Cycle' (Fn 53). NICE guidelines on Smoking Cessation (see fn53 above) apply to primary and secondary care.

[66] See RCP, Harm reduction in nicotine addiction. Helping people who can't quit, London: October 2007

[67] A recent study by the US NCI (Fn 23) found that mass media campaigns have a greater effect on curbing initiation combined with school- and/or community-based programming.

[68] See BMA 'Breaking the Cycle' (Fn 53), p. 9-12

[69] A Cochrane review of smoking cessation interventions for pregnant women shows that they can make a difference. However, the BMA recommended that more research to identify appropriate interventions is required. BMA 'Breaking the Cycle' (Fn 53), p. 34

[70] A recent study in Australia (see Fn 14) has linked reduced adult population smoking prevalence with increased exposure to ongoing televised tobacco control campaign activity. The effects of TC advertising on smoking prevalence occurred relatively quickly, but the acceleration in prevalence decline also dissipated rapidly in the absence of continued high levels of televised anti-smoking advertisements.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

The NHS smoking helpline number should appear on all tobacco packaging. Mass media health campaigns should be complemented by further community-based initiatives to promote local services.

Cancer Research UK is not involved in the local provision of support for quitting, so has grouped all further recommendations in the answer to Question 14 above.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?
See Question 14

Part D: Helping those who cannot quit.

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

It must be stressed that the term 'those who cannot quit' should be used with caution. Although we recognise that there are some who find it extremely difficult to quit and experience repeated failures, quitting completely must always be the ultimate aim. For this reason, Cancer Research UK prefers to use the term: 'those who cannot *yet* quit'. Nevertheless, Cancer Research UK welcomes the Government's readiness to consider a strategy to support those who find it very difficult to quit.

However, this is a broad question for a highly complex topic. 'Harm reduction', can be used to mean many different things. It is important that it is not used as a general term which is open to misunderstanding but is defined depending on its use:

a) Helping smokers who cannot yet quit:

More attractive and efficient pure nicotine products[71] (like the current medicinal products on the market such as nicotine replacement therapy) which contain only nicotine and no other tobacco constituents, are needed for long-term use by heavily addicted smokers. Such products could play a role as an alternative way to satisfy nicotine cravings without the harmful effects of smoking. Alongside this, research is also needed to monitor the effect of long term pure nicotine use on health, smoking behaviour and quitting rates, and its effect on smoking prevalence in different socio-economic groups. Quitting should still be encouraged as the gold standard, and a harm reduction strategy must complement a strengthened system of quitting support.

Cancer Research UK would strongly support the development of a strategy to help smokers who cannot yet quit to switch to much less harmful pure nicotine products[72] This strategy should:

I. review current legislative and regulatory barriers and encourage the development of pure nicotine products designed for longer term use.

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[71] Such as nicotine replacement therapies (e.g. gum and patches) and possibly other new products that efficiently deliver nicotine but no other harmful chemicals.

[72] A switch of 1% per year would save an estimated 60,000 lives in ten years. Lewis S, Arnott D, Godfrey C, Britton J (2005). Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? Tobacco Control; 14: 251-254

Obtaining a product license for medicinal nicotine requires expensive clinical testing. Historically, the MHRA has not licensed more efficient products which also have more addictive potential, and long-term use of medicinal nicotine as an alternative to smoking is not yet sanctioned by the MHRA. Although steps have been taken recently to facilitate the licensing of new pure nicotine products, much more needs to be done.

II. make pure nicotine products (both for quitting and for long term use) much more attractive, affordable and available sources of nicotine than tobacco-based products. This will also require a sustained communications strategy to counter public misunderstanding of the health impacts of nicotine, as a significant proportion of smokers and health professionals believe incorrectly that nicotine can cause smoking-related diseases such as cancer. [73]

III. research the long term impacts of nicotine and use findings accordingly.

b) Tobacco content testing and appropriate disclosure and public communication:

Cancer Research UK strongly supports the development of guidelines on the FCTC's Articles 9-11 . These will set down standards for a) regulation and accurate measurement of tobacco constituents, b) disclosure of contents to the public, and c) the packaging and labelling of tobacco products.[74] Cancer Research UK urges the Government to work to ensure that these guidelines are as strong and comprehensive as possible.

c) Regulation of all tobacco and nicotine products based on the harm that they cause:

Cancer Research UK encourages the Government to consider the development of a structure or an authority which would take control of the regulation of all nicotine products, including new, supposedly less harmful, cigarettes produced by the tobacco industry ('PREPs'[75]) and non-smoked tobacco products (e.g. snus[76]). This might stem from one agency (such as a Tobacco and Nicotine Regulatory Authority, as recommended by the Royal College of Physicians[77]) or several existing agencies[78] and would need to be entirely independent of either tobacco manufacturers or the pharmaceutical industry.[79]

Cancer Research UK has strong reservations about the role that the tobacco industry might play in the development of new 'less harmful' products, given its past behaviour and the fact that it will continue to make most of its profits from the sale of cigarettes. We do not support the promotion of PREPs, since a) while some toxic

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[73] Siahpush M, McNeill A, Hammond D, and Fong GT (2006). Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. Tobacco Control; 15: iii65-70.

[74] Framework Convention Alliance Factsheet No 4, www.fctc.org

[75] Potentially Reduced Exposure Products

[76] A form of moist, sucked tobacco used extensively in Sweden

[77] Royal College of Physicians (RCP), Protecting Smokers, Saving Lives. The case for a tobacco and nicotine regulatory authority, London 2002. The call for a dedicated regulatory body was reiterated in RCP (2007) (see Fn 65), p. 227.

[78] For more information on the regulatory options, please see forthcoming report by ASH/CR-UK/BHF, Beyond Smoking Kills

[79] In accordance with Article 5.3 of the FCTC, which states that states that when Parties are setting and implementing public health policies related to tobacco control, they shall 'act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.'

constituents may be reduced, others remain or may even be increased ("risk swapping"); b) smokers may be discouraged from quitting; and c) while exposure to particular harmful constituents may be reduced in some countries, companies might offload products that fail to meet regulatory standards to other, probably, low income countries ("risk shifting").

In line with the considered view of the public health community, Cancer Research UK does not at this time support removing the EU ban on snus. However, given its low level of risk relative to smoked tobacco, and its reported effectiveness in helping Swedish men to stop smoking, it should be investigated as a potential aid to quitting. Therefore, following further research, and under very tight regulatory control (for example, for use on prescription only) the potential role of snus for cessation could be explored. But the ideal scenario still strongly remains one where tobacco use in all its forms is reduced.

d) Reduced ignition propensity (i.e. fire-safe) cigarettes: These are well recognised to prevent home fires and therefore Cancer Research UK supports the enforcement of EU standards for Reduced Ignition Propensity (RIP) cigarettes (fire-safe cigarettes) by 2009, a measure already introduced in 22 states in the U.S.A.

We would be happy to provide any further information or detail as required. Please contact the Cancer Research UK Head of Tobacco Control, Elspeth Lee, at elspeth.lee@cancer.org.uk , or on 020 7061 8152.

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[i] **BMRB omnibus survey of those aged 16 and over: results**

- 1,220 people screened to be smokers aged 16 years and over were surveyed in face-to-face interviews across England over a three-week period from 07/08/2008-27/08/2008.
- The analyses are based on 1150, once weighting had been applied to allow for the survey design.
- All analyses are presented on the weighted samples, with a design effect taken to be 1.

Question: Which of these best describes how you decide what cigarette brand to buy? (weighted baseline = 1,150)	Number of respondents	% of smokers	95% confidence interval	
			Lower	Upper
I always buy the same brand	985	85.7%	83.6%	87.7%
I decide what brand to buy based on the shop display	74	6.4%	5.0%	7.9%
Other answers	92	8.0%	6.4%	9.6%

- Only 6.4% (95%CI: 5.0%, 7.9%) responded that they chose their brand based on the shop display
- 85.7% (83.6%, 87.7%) always buy the same brand