

Welsh Government Public Health White Paper Consultation

Who we are

Every year around 300,000 people are diagnosed with cancer in the UK and more than 150,000 people die from cancer. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. Together with our partners and supporters, our vision is to bring forward the day when all cancers are cured. We support research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses. In 2012/13 we spent £351 million on research.¹ The charity's pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. We receive no government funding for our research.

Overview

We welcome the Welsh Public Health White Paper as part of a comprehensive response to improve public health in Wales. Cancer is the single biggest cause of premature mortality in the UK with over 60,000 premature deaths from cancer in 2010.² Given that four in ten cancers are preventable, we welcome an opportunity to contribute to suggestion to reduce cancer incidence. We believe that a comprehensive approach should reduce smoking and drinking and encourage a healthy diet. In our response we have focused on the questions most relevant to cancer prevention and make the following key points:

- A tobacco retailers' register can reduce illegal tobacco sales to minors.
- A tobacco retailers' register would assist with the display ban.
- E-cigarettes are almost certainly far less harmful than conventional tobacco cigarettes.
- E-cigarettes use in enclosed public spaces does not require legislation as there is insufficient evidence they normalise smoking or undermine the smokefree legislation.
- A voluntary approach to smoke free open spaces is sufficient.
- There is insufficient evidence to suggest whether or not minor's access to tobacco over the internet is a significant problem.
- A minimum unit price of 50p and a mechanism to increase the price over time should be introduced.
- Minimum unit pricing is an evidence based measure for reducing alcohol harm.
- Nutritional food standards should be introduced for pre-schools and care homes.

Tobacco and electronic cigarettes

Tobacco Retailers' Register

Question 1. Do you agree with the proposal to create a tobacco retailers' register for Wales under the terms outlined above?

Yes ☒

No ☐

Cancer Research UK supports the introduction of a tobacco retailer's register in Wales, in consideration of the following points, which are developed in this response:

- A tobacco retailers' register can reduce illegal tobacco sales to minors – through enabling easier detection and enforcement by Trading Standards Officers. The Chartered Institute of Environmental Health recognises that a positive licensing system (as proposed in this consultation) provides an effective deterrent to retailers considering selling tobacco to underage customers.^{3,4}

- In enabling easier identification of retailers who sell tobacco, a retail register would also enable analysis of tobacco retailer outlet density – which evidence shows has contributed to the underage purchase in ‘high-risk’ areas such as near schools, and which may inform further policy.^{5,6,7}

Legislation introducing a form of a tobacco retail registers’ has already been introduced in Scotland⁸, Northern Ireland⁹ and The Republic of Ireland¹⁰. In Scotland, the first country to introduce such a measure, the *Tobacco Strategy for Scotland* notes the register has allowed enforcement agencies to target their activity.¹¹

Evidence also suggests that simply providing information about the law is not effective, but sustained compliance is reliant on regular enforcement (or warning thereof)¹², underlining the importance that the measure is backed by a commitment to support compliance (for more information, see response to Question 4).

Question 2. Do you consider that the creation of such a register will (i) assist in attempts to reduce under age sales of tobacco products, and (ii) assist in the enforcement of the display ban?

Yes X No ☐

As identified in the consultation document, Trading Standards Officers have commented that a tobacco retailers’ register would help them to identify retailers who sell tobacco once the display ban¹³ is operational in small shops in April 2015. Furthermore, as noted in the response to question one, the *Tobacco Strategy for Scotland* notes their register has allowed enforcement agencies to target their activity.¹⁴

Based on this information, we believe a central register of tobacco sellers, maintained by a nominated local authority, would assist in the enforcement of the display ban – providing the scheme is adequately funded and staffed, and coordinated between the nominated local authority and Trading Standards officers.

Question 3. Do you consider the proposed fee structure to be reasonable? Please suggest an alternative if not.

Yes X No ☐

While we understand the fee will be used to fund the central collection and maintenance of the register – we would be keen to know more information about expected revenues from the retailer licence – and whether any excess revenues (after the cost of the maintaining the register had been deducted) would allow for fund, for example, cessation services and/or funding for enforcement officials to help combat the illicit tobacco trade.

There is evidence from Australia¹⁵ showing that a significant (15 fold) increase in the cost of a retail licence resulted in a large reduction in the number of tobacco licences purchased. The Republic of Ireland have reportedly considered increasing the retail license fee from 50 Euros to 500 Euros¹⁶.

There is evidence from the US demonstrating that tobacco retail outlets were disproportionately located in areas with higher levels of socio-economic disadvantage.¹⁷ Furthermore a study from Victoria, Australia which looked at tobacco retail outlets near schools found a positive association between tobacco retail outlet density and cigarette consumption among adolescent smokers.¹⁸ In 2012, 44% of pupils in England who smoked cigarettes said they had bought them from a shop.¹⁹ A

study from Ontario, Canada, reported that 42.1% of underage smokers were never asked for their age when trying to buy their own cigarettes. It concluded the more tobacco retailers that were surrounding a school, the more likely smokers were to buy their own cigarettes.²⁰

This evidence suggests that the adjustment of the retail fee – where a licensing scheme is in place – could be a policy lever used to discourage retailers from selling tobacco products, resulting in the reduction of exposure o tobacco products to young people.

Question 4. Do you consider the proposed enforcement and penalty arrangements for the tobacco retailers’ register to be appropriate? If not, could you please provide us with your suggestions?

The consultation states that “Legislation would also introduce new offences or penalties associated with failure to register to sell tobacco in order to ensure that businesses that sell tobacco products comply with the duty to register”. We would need to see the details of those offenses or penalties before we could fully comment on their appropriateness.

Though sanctions are available to Trading Standards for retailers found to be selling tobacco to underage customers, the Tobacco action plan for Wales²¹ notes that the use of maximum sanctions has been “limited” and that engagement with magistrates is required to ensure that awareness and severity of tobacco control offences is recognised.

We would support the view of the Chartered Institute of Environmental Health, who have stated that proposed positive licensing schemes could also be strengthened by the ability to issue on the spot fines to retailers.²²

Question 5. Are there any other features of a tobacco retailers’ register that we should consider?

Yes ☐

No ☒

E-cigarettes

Question 6. Do you consider that the use of e-cigarettes in enclosed and substantially enclosed public places (including work places) undermines and makes more difficult the enforcement of the current ban on smoking in such places?

Yes ☐

No ☒

Electronic cigarettes (e-cigarettes) are almost certainly much safer than tobacco cigarettes and may help smokers to cut down or quit smoking. Cancer Research UK support the use of high quality e-cigarettes because we believe that they have significant potential to help smokers who aren’t otherwise ready or able to quit smoking by providing them with much safer alternatives to smoked tobacco.

We believe that any expansion of the smokefree legislation should be based on peer reviewed evidence. Currently there is insufficient evidence to introduce a ban on the use of e-cigarettes in enclosed public spaces or workspaces. We recognise that the growth of e-cigarette use may present some challenges for individual businesses and organisations. However, so far there remains very little evidence of systematic problems around the enforcement of the current ban which has high

compliance rates. A more effective solution would be the provision of further information and guidance to local authorities and businesses to help them make sure that the enforcement of the current ban on tobacco use continues. Such guidance should be developed with expert organisations.

Question 7. Do you consider that the widespread use of e-cigarettes in enclosed and substantially enclosed public places (including work places) normalises the act of smoking and acts as a gateway to the use of conventional tobacco products?

Yes ☐

No ☒

One of the consequences of the smokefree legislation was to ‘denormalise’ smoking which helped to facilitate quit attempts.²³ The introduction of new behaviours that imitate smoking may undermine the denormalisation of smoking and may affect the number of people who quit. However, prohibiting e-cigarette use in areas covered by smokefree legislation may have unintended consequences which may affect genuine quit attempts. Currently there is insufficient evidence to show which scenario is more likely.

A recent study has shown that passive exposure to e-cigarette use does increase the urge to smoke among young adult daily smokers.²⁴ However, it is unclear to what extent e-cigarette use will increase urges to smoke in a real world context. Further research is needed to understand how passive exposure to e-cigarettes affects attitudes towards smoking conventional tobacco cigarettes amongst smokers and non-smokers.

In the UK only 1.1% of never smokers have ever tried electronic cigarettes and virtually none continue to use them. Furthermore, there is little evidence that children are using e-cigarettes regularly.²⁵ Only 1% of children who have never smoked have used an e-cigarette once or twice.²⁶ There is no evidence of regular electronic cigarette use among children who have never smoked or who have only tried smoking once. There is also no evidence to show that regular use of e-cigarettes leads to use of tobacco products among children or to show whether e-cigarettes as a whole have any impact on smoking prevalence among children and young people.

A study in the US has shown that use of e-cigarettes has increased in students of middle and high school.²⁷ However the study was unable to show the frequency of their e-cigarette use. The study also showed that use of e-cigarettes was associated with higher odds of ever or current cigarette smoking, higher odds of established smoking, higher odds of planning to quit smoking among current smokers. However, as a cross-sectional study, it is unable to show whether youth initiation began with conventional tobacco cigarettes or e-cigarettes. It is therefore unable to show whether a gateway effect exists with e-cigarettes. It is also unclear to what extent e-cigarette use helps or hinders youth quitting of tobacco. Further longitudinal studies are needed to show whether e-cigarette use by never smokers leads to use of tobacco in youth populations.

Question 8. Do you have any evidence or practical experiences to support your views in relation to questions 6 and 7? If so we would be grateful to receive such evidence or receive details of such experiences.

Yes ☒

No ☐

We have detailed the relevant evidence above but cannot offer any relevant practical experience. While practical experience is useful to inform guidance, we believe that any regulation of e-cigarettes should be based on peer-reviewed evidence.

Question 9. Do you consider legislation would assist in the enforcement of the existing Smoke-Free requirements and reinforce the message that smoking is no longer the norm? Please provide evidence to support your answer, if available.

Yes ☐

No ☒

As detailed above we consider there to be insufficient evidence to suggest that further legislation would assist the enforcement of the existing Smoke-Free requirements. There is no evidence that the use of e-cigarettes in the majority of smokefree premises undermines the enforcement of the smokefree legislation. We believe that rather than introducing new legislation, further guidance should be produced with expert organisations to help inform local authorities and businesses on the best way to respond to the rise in the use of e-cigarettes in enclosed public spaces and work places. With such guidance businesses can make informed decisions about whether a ban on the use of e-cigarettes in their premises is appropriate.

We also do not believe that there is sufficient evidence to legislate to prevent e-cigarettes renormalizing smoking. We are concerned that a legislative restriction to prohibit the use of e-cigarettes in enclosed public spaces could have unintended consequences that undermines those making genuine quit attempts.

The main reason for the introduction of the smokefree legislation was to protect people from the harms of second hand smoke. Second hand smoke is more harmful than second hand vapour from e-cigarettes. E-cigarette vapour does contain toxicants however this is usually at levels which are far lower than those found in tobacco cigarettes.²⁸ E-cigarette vapour has also been shown to include 'particulate matter'.²⁹ This is a 'catch-all' term for small particles of a variety of substances and has been linked to a range of health harms as part of other complex mixtures like air pollution and cigarette smoke.³⁰ More studies are needed to understand the impact of exposure of e-cigarette vapour particularly in the long term.

E-cigarettes are predominantly used by current or ex-smokers and it is estimated that in the UK 18% of smokers were using e-cigarettes in 2013 – approximately 2.1 million people although another study suggested it was 16%.^{31 32} The survey also found that only 1.1 per cent of never smokers have ever tried electronic cigarettes and virtually none continue to use them. E-cigarette users suggest that they use e-cigarettes to help them quit tobacco and to help former smokers who had quit stay off tobacco. There remains some uncertainty about the efficacy of e-cigarettes in helping people to quit. But e-cigarettes have been shown to be as effective as nicotine replacement therapy among smokers who have attempted to stop without professional support³³, although it is not been shown to be more effective than behavioural support and pharmacotherapy.³⁴ Further research is needed to understand the efficacy of e-cigarettes in supporting cessation and how best to use e-cigarettes to support a quit attempt. However, prohibiting the use of e-cigarettes in enclosed public spaces and workspaces would be a disproportionate response in light of the current evidence. A ban may move e-cigarette users from a smokefree environment within an enclosed space to an environment with smokers such as a smoking area just outside premises. However we believe that careful monitoring

is needed to see the impact of e-cigarettes on the enforcement of the current smokefree law and on renormalizing smoking.

10. In considering such a proposal, should the ban on the use of e-cigarettes in enclosed and substantially enclosed public and work places be subject to the same exemptions and penalties as conventional tobacco products?

Yes ☐

No ☒

As previously stated we do not believe that it would be a proportionate response to ban the use of e-cigarettes in enclosed spaces and work places. We believe that should the Welsh Government wish to pursue a ban, greater consideration should be given to how best it can be done to minimise unintended consequences. Given the differences between e-cigarettes and traditional tobacco cigarettes, they would need to undertake a detailed assessment to determine which enclosed public places and work places any potential ban would apply to.

Given the reduced harm of second hand vapour compared to second hand smoke, it would not be reasonable to apply the same penalties for use of e-cigarette as for use of tobacco cigarettes in smokefree places.

11. What other measures, if any, should the Welsh Government be considering in relation to e-cigarettes?

We encourage the Welsh Government to work with Public Health Wales and its equivalent bodies across the UK to ensure that a clear message is provided to health professional on e-cigarettes. The Welsh Government should also be mindful of the EU Tobacco Products Directive and the twin track approach to the regulation of e-cigarettes.

We would also recommend that clear guidance is given to NHS bodies and local authorities to ensure that the UK's commitments under the Framework Convention on Tobacco Control are adhered to. This would mean that all Government bodies in Wales should protect public health policy from the tobacco industry and its interests. These interests include e-cigarettes companies owned by subsidiaries fully or partially owned by the tobacco industry.

Smokefree Open Spaces

12. Do you consider that voluntary smoking bans in hospital grounds, school grounds and children's playgrounds are sufficient, or are these areas where Welsh Ministers should consider legislating? Can you provide any evidence for your view?

Yes, voluntary bans are sufficient ☒

No, Welsh ministers should consider legislating ☐

NICE guidance is clear that non-smoking should be the norm in all NHS premises and grounds.³⁵ The guidance states that hospitals should ensure that there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services. The Welsh Government may wish to adopt a similar approach.

It may be appropriate, as has been the case with a number of local authorities in England and Wales, to introduce voluntary bans in areas such as children's playgrounds, parks and school grounds. The

World Health Organisation highlights that compliance with smokefree legislation requires three components, they are: (1) good legislation (2) a good enforcement strategy and (3) a good communications and outreach strategy.³⁶ In the case of a voluntary ban, this structure could not be applied, therefore, it should not be expected that voluntary bans can deliver the same impact as statutory provisions. For example the smokefree England compliance data showed 97% compliance 2-week after implementation and 98.7% at the end of the measurement period in 2009³⁷.

Internet Sales of Tobacco

13. Do you consider there is a problem with persons aged under 18 receiving delivery of tobacco products which have been ordered online by an adult? Please provide evidence to support your response, if available.

Yes ☒

No ☐

There is insufficient evidence to suggest whether or not young people accessing tobacco products over the internet is a significant problem.

However, the EU Tobacco Products Directive (TPD) (2014/40/EU) recognises the potential for tobacco control legislation to be undermined by cross-border distance sales, and gives a proviso for member states to prohibit cross-border distance sales of tobacco and related products³⁸.

We believe that more research is needed to give a clearer picture, but welcome the enabling instrument which the TPD has put in place in enabling member states to act if they choose to do so. Therefore, if research demonstrated there to be a problem, implementation of UK-wide action would be optimal.

14. Is this an area where the National Assembly for Wales should consider strengthening the existing legislative framework to make it an offence to deliver tobacco products to a person who is under the legal age of sale for tobacco products (which is currently 18)?

Yes ☐

No ☒

We do not believe that at the moment this is an area that requires further legislation given the current evidence. (See response to Q13)

Alcohol

Minimum Unit Pricing

15. Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

Yes ☒

No ☐

Cancer Research UK supports the introduction of a minimum unit price (MUP) for alcohol as evidence based measure to reduce alcohol consumption, particularly amongst hazardous and harmful drinkers.

Alcohol is one of the most important modifiable risks for cancer after smoking and obesity. The International Agency for Research on Cancer classified alcohol as a group 1 substance, meaning that it is known to cause cancer in humans.³⁹ Alcohol can cause seven cancers - mouth, pharyngeal, laryngeal, oesophageal, breast, bowel and liver. In 2010, 12,500 cases of cancer in the UK (4%) were attributable to alcohol.⁴⁰ Although, another study suggested that the number could be even higher.⁴¹

Cancer risk is associated with total alcohol consumed over time. Current evidence shows that the less alcohol people drink, the lower the risk of cancer.⁴² However, no level of drinking has been found to be free of cancer risk.⁴³ Therefore measures to improve health should tackle the amount of alcohol consumed by individuals over time. In Wales, 42% of adults in 2012 said that they had drunk more than the recommended guidelines on at least one day in the past week.⁴⁴ The true figures are likely to be even higher, as the remaining 58% who drank within the guidelines included all abstinent adults; removal of the 13% of teetotallers would reveal a higher percentage of overconsumption amongst drinkers. In this context MUP would be an appropriate and proportionate response.

The evidence suggests that a minimum unit price would reduce drinking at the population level.⁴⁵ The case for a MUP is also justified by real world experience. The impact of a marginal increase in minimum price is demonstrated by its use in Canada. Research shows that a 10% increase in the minimum price in Saskatchewan, Canada led to an 8.43% reduction in alcohol consumption.⁴⁶ Therefore, with an effective mechanism to increase the price, minimum pricing should lead to sustained reductions in alcohol consumption and thus should reduce the long term health harms associated with drinking.

16. Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

Yes ☒

No ☐

We support a MUP of 50p per unit as an appropriate level to reduce alcohol harm without any disproportionate effects. Modelling by Sheffield University demonstrates that a MUP of 50p could lead to a 6.7% reduction in drinking and could avoid 3,000 premature deaths after 10 years in England. By comparison they estimate a MUP of 45p will lead to a 4.3% reduction and avoid 2,000 premature deaths after 10 years.⁴⁷

MUP would also not have a disproportionate impact on moderate drinkers. A minimum price of 50p would mean an estimated increase in spending on alcohol of less than 23p a week per moderate drinker, whereas harmful drinkers would pay an extra £3.13 per week.⁴⁸

17. Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

Yes ☒

No ☐

A properly enforced minimum unit price would lead to reduced alcohol harm. As previously stated the modelling evidence shows that a minimum unit price of 50p would reduce consumption and prevent premature deaths and reduce hospital admissions.⁴⁹ A further study of British Columbia, Canada showed that minimum unit prices were associated with reduced acute alcohol related hospital admissions after 1 year and with reduced alcohol related hospital admissions for chronic diseases such as cancer and liver disease after 2-3 years.⁵⁰ The measure has also been shown to be progressive and could lower health inequalities without penalising moderate drinkers.⁵¹

18. Do you think any level of Minimum Unit Pricing set by the Welsh Government should be reviewed and adjusted over time? Please provide evidence to support your answer, if available.

Yes X

No ☐

In the long term, it is not the price but the affordability of alcohol that shapes consumer behaviour. Whilst overall alcohol consumption has declined in the last few years, in the UK consumption is still over 40% more litres per head of population than we were in 1970, despite a rise in non-drinkers.⁵² Alcohol is currently 61% more affordable than it was in 1980, largely because duty rates and therefore retail prices have not risen in line with disposable income. This increased affordability is reflected by increased levels of consumption and alcohol related harms. Therefore without a method to increase the price level, the impact of minimum unit pricing will diminish over time.

A minimum unit price should be reviewed regularly. Such a review would take into account rises in incomes, inflation and examine other factors affecting alcohol consumption. This process should be systematic, transparent and undertaken independently of Government and the alcohol industry.

19. As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?

We are unable to advise on the best method to pursue a MUP within the legislative framework of the Welsh Assembly.

20. Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?

Yes X

No ☐

We believe that there is a need for a comprehensive alcohol strategy in Wales to help reduce excessive consumption. We recommend that such a strategy promotes evidence based measures on price, promotion and health information as set out in *Health First*, part-funded by Cancer Research UK and produced by the University of Stirling.⁵³ In particular, we encourage the Welsh Government to explore the feasibility of restricting alcohol promotions and sponsorship. Alcohol advertising increases the likelihood that young people will start to drink alcohol and will drink more if they already do so.^{54 55} We therefore believe that comprehensive restrictions, similar to those in the French marketing law *Loi Evan* are necessary to restrict the media and content of alcohol promotions. We also support evidence based mass media campaigns to reduce alcohol consumption. Such campaigns should emphasise the long term harms of alcohol consumption including the risk of cancer. The Welsh Government should also explore what further local authorities can do to tackle alcohol harm in their areas.

Obesity

Nutritional Standards

21. Do you agree that nutritional standards should be introduced in the settings we are proposing, that is, pre school settings and care homes?

Although the evidence for effectiveness is limited, we believe that expanding the application of nutritional standards is something worth exploring. However, given the limited amount of evidence, we are unable to say whether expanding it to pre-school or care homes is beneficial. Unhealthy diets have been linked to cancers of the bowel, stomach, mouth and oesophagus. It is estimated that 9.2% of cancer cases in the UK in 2010, or around 29,000 cases of cancer were due to poor diets.^{56 57 58 59} Expanding nutritional standards to other environments may help to improve people's diet and in particular applying it to pre-school may entrench health eating habits in children. Further work is required to understand the full impact of expanding the use of nutritional standards to these settings.

22. Do you think there are any other public sector settings that should be considered in relation to mandatory nutritional standards?

As above, we recognise that there are likely to be merits to expanding the use of nutritional standards. However, given the current evidence we are unable to say in what settings such standards would be most useful.

Do you think there are other practical steps we could take to contribute to this issue?

Yes ☒

No ☐

We believe that a comprehensive approach is needed to make sustained reductions in those who are overweight and obese. We welcome the Welsh Government's support for the ban on advertisements for foods high in sugar salt and fat before the watershed. Current restrictions on advertising of foods high in sugar, salt, and fat have been shown to have had no effect on children's exposure.⁶⁰ In addition, these rules do not address the rapid growth of online marketing of unhealthy foods.⁶¹ Extending the ban to the watershed could help reduce children's exposure to foods high in sugar salt and fat which can affect their consumption.⁶²

We also believe that the Welsh Government should explore how to support local authorities who may want to reduce the availability of unhealthy alternatives such as hot takeaways particularly around schools. Reducing the availability of unhealthy food and increase the attractiveness of school meals may help ensure that more children get a healthier diet.

Next Steps

47. Do you have any other comments or useful information in relation to any of the proposals in this White Paper?

As detailed in the World Health Organisation Framework Convention on Tobacco Control⁶³ there is no doubt as to the efficacy of a comprehensive tobacco control policy in reducing tobacco use. A pointed example is Russia, where a raft of measures have been rapidly introduced from February 2013 – including smoke-free laws, bans on advertising and promotion, and restrictions on sales – resulting in cigarette consumption falling by 12 per cent in the first quarter of 2014 (compared to the same period in 2013)⁶⁴.

In countries where many of these strides forward in tobacco control policy have already been made, it is vital that the momentum of progress is not lost, and that any evidence-based measure, which can result in more comprehensive and robust tobacco control policy – such as a retailer licensing scheme – is supported. We also believe measures such as the introduction of standardised packaging of tobacco products - which has been publicly backed by Health Minister Mark

Drakeford⁶⁵ and Public Health Wales⁶⁶ – are vital to the continued progress in tackling the greatest public health challenge the UK faces: more than 100,000 people die from tobacco-use every year⁶⁷ 5,450 of which are in Wales⁶⁸

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¹ Includes £13 million for the transfer of our Cambridge Research Institute to the University of Cambridge

² England under-75 mortality rates for 2010 from Office of National Statistics

(www.statistics.gov.uk/statbase/Product.asp?vlnk=6725). Comparisons with the EU-15 countries, as well as Norway and Switzerland, are generally for 2010 and from the WHO Health For All database (www.euro.who.int/hfad) and Detailed Mortality Database (data.euro.who.int/dmdb/). Data is from 2009 for France, Greece, Italy and Luxembourg, and from 2006 for Belgium and Denmark.

³ The Tobacco Advertising and Promotion (Display) (Wales) Regulations 2012 ban the display of tobacco products. These Regulations came into force in December 2012 for large shops and will come into force for small shops in April 2015.

⁴ Chartered Institute of Environmental Health (2008). CIEH response to the Department of Health consultation on the future of tobacco control.

⁵ Novak, S P et al (2006). Retail tobacco outlet density and youth cigarette smoking: a propensity-modeling approach. *Am J Public Health*. 2006 April; 96(4): 670–676

⁶ Scully M et al (2013). Density of tobacco retail outlets near schools and smoking behaviour among secondary school students. *Aust N Z J Public Health*. 2013 Dec;37(6):574-8.

⁷ Leatherdale ST and Strath JM (2007). Tobacco retailer density surrounding schools and cigarette access behaviours among underage smoking students. *Ann Behav Med*. 2007 Feb;33(1):105-11

⁸ See Tobacco and Primary Medical Services (Scotland) Act 2010

⁹ See Tobacco Retailers Act (Northern Ireland) 2014

¹⁰ See (The Public Health (Tobacco) Act, 2002 (as amended 2009) <http://www.tobaccoregister.ie/about-the-register/about-the-register.aspx>

¹¹ Scottish Government (2013). Creating a tobacco-free generation: A tobacco control strategy for Scotland.

¹² Stead LF and Lancaster T (2008). Interventions for preventing tobacco sales to minors (Review). The Cochrane Collaboration.

¹³ The Tobacco Advertising and Promotion (Display) (Wales) Regulations 2012 ban the display of tobacco products. These Regulations came into force in December 2012 for large shops and will come into force for small shops in April 2015.

¹⁴ Scottish Government (2013). Creating a tobacco-free generation: A tobacco control strategy for Scotland.

¹⁵ Bowden J A et al (2013). What happens when the price of a tobacco retailer licence increases? *Tobacco Control* (Online).

¹⁶ <http://www.irishexaminer.com/ireland/tobacco-fee-for-retailers-to-cost-10-times-more-246311.html>

¹⁷ Novak, S P et al (2006). Retail tobacco outlet density and youth cigarette smoking: a propensity-modeling approach. *Am J Public Health*. 2006 April; 96(4): 670–676

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²¹ Welsh Government (2012). Tobacco control action plan for Wales. P.16

²² Chartered Institute of Environmental Health (2008). CIEH response to the Department of Health consultation on the future of tobacco control.

²³ Hammond et al, (2006) Tobacco Denormalization and Industry Beliefs Among Smokers from Four Countries. *American Journal of Preventative Medicine* 2006;31(3):225–232

²⁴ King, A et al. (2014) Passive exposure to electronic cigarette (e-cigarette) use increases desire for combustible and e-cigarettes in young adult smokers. *Tobacco Control* doi:10.1136/tobaccocontrol-2014-051563

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²⁶ ASH (2013) Use of e-cigarettes in Great Britain among adults and young people (2013)

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