The Tobacco Advertising Bill [Bill 12 of 1993/94]

Research Paper 94/22

7 February 1994

A Private Members' Bill to ban tobacco advertising was presented by Mr Kevin Barron on 16 December 1993 and is due to have its Second Reading on 11 February 1994. This paper discusses the health aspects of tobacco, considers the potential effects of an advertising ban and examines the Bill's provisions.

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PART I Tobacco and health

The message on cigarette packets that "smoking seriously damages health" is widely accepted as a truism. This knowledge follows from years of careful epidemiological and medical research. Accordingly it should come as no surprise that reductions in the numbers of people who smoke are a significant part of health strategies throughout the UK.[1,2,3,4]

A. The Health of the Nation

The Government's health strategy for England is set out in the White Paper *The Health of the Nation.*[1] The targets for smoking, which are representative of targets in other parts of the UK, are:

> "To reduce the prevalence of cigarette smoking in men and women aged 16 and over to no more than 20% by the year 2000 (a reduction of at least 35% in men and 29% in women, from a prevalence in 1990 of 31% and 28% respectively).
>
> In addition to the overall reduction in prevalence, at least a third of women smokers to stop smoking at the start of their pregnancy by the year 2000.
>
> To reduce the consumption of cigarettes by at least 40% by the year 2000 (from 98 billion manufactured cigarettes per year in 1990 to 59 bn.).
>
> To reduce smoking prevalence among 11-15 year olds by at least 33% by 1994 (from about 8% in 1988 to less than 6%)."

As far as the last target is concerned, initial progress has been disappointing with the figure for children's smoking actually rising to 10% in the year 1990.[5]

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[1] *The Health of the Nation* 1992 Cm 1986

[2] *Scotland's Health: a challenge to us all* HMSO 1992

[3] *Health for all in Wales: plans for action 3* Health Promotion Authority for Wales 1992

[4] HC Deb 11 March 1991 c.392W

[5] HC Deb 13 July 1993 c.409W

Commenting on the original consultative document,[6] an article in the *British Medical Journal* has added:[7]

> "Any government that is seriously committed to improving the health of its population must have a strategy for controlling the use of tobacco and reducing the number of people who smoke. It is therefore encouraging that *The Health of the Nation* recognises smoking as a key area for action and suggests a fairly ambitious target that by the year 2000 around four out of five people should be non-smokers ...
>
> ... *The Health of the Nation* describes smoking as "the largest single preventable cause of mortality" and adds "that it accounts for more than a third of all deaths in middle age." Current estimates suggest that about 115000 deaths, and roughly 106000 admissions to hospital in Britain every year are attributable to smoking. Passive smoking increases the risk of lung cancer by 10-30% and causes respiratory complaints in children.
>
> Smoking costs the NHS at least £500 million annually, but the costs of ill health to society are considerably more, with an estimated 50 million working days being lost through sickness absence."

Estimates of hospital costs alone were estimated in 1992 as being £437 million annually. This figure does not include the costs of the care given by GPs or at health clinics or other care in the community.[8]

B. Smoking and disease

According to the Health Education Authority's report, *The Smoking Epidemic*,[9] smoking is a known cause of coronary heart disease, lung cancer, chronic obstructive pulmonary disease (chronic bronchitis and emphysema), cerebrovascular disease (stroke), atherosclerotic peripheral vascular disease (resulting in a narrowing of the arteries), and cancers of the oral cavity, larynx (voice box), and oesophagus. In terms of the number of deaths attributable to smoking, the most important diseases are lung cancer, coronary heart disease and chronic obstructive pulmonary disease. These are discussed in more detail in the sections below.

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[6] *The Health of the Nation* 1991 Cm 1523

[7] "The Health of the Nation: responses" *British Medical Journal* 19 October 1991 pp973-7

[8] HC Deb 19 October 1992 c.85W

[9] *The Smoking Epidemic* Health Education Authority 1992

1. Lung cancer

The link between lung cancer and smoking was first established using the statistical methods of epidemiology. In 1951, Sir Richard Doll, the late Austin Bradford Hill and others began a study of the smoking habits of almost 40,000 doctors.[10] It soon became apparent that smoking was overwhelmingly implicated with the disease. Sir Richard last year commented in an interview:[11]

> "We found that 0.5 per cent of the patients with lung cancer were non-smokers and 5 per cent of the general population were. You had a 10-fold difference. That was the key figure. You rarely got the disease unless you had been smoking."

The direct link between lung cancer and smoking has been further demonstrated by over 30 studies in 10 countries.[12] According to *The Smoking Epidemic*, 81 per cent of all lung cancer deaths in the UK can be attributed to smoking. *The British Medical Association Complete Family Health Encyclopedia* (1990) adds the following qualifications:

> "Because pipe and cigar smokers tend not to inhale tobacco smoke, they have a slightly lower risk of lung cancer, although the risk is still significantly greater than for nonsmokers. The risk of developing lung cancer begins to diminish as soon as smoking is stopped."

Although the detailed mechanisms whereby smoking causes lung cancer have still to be ascertained, the tar in tobacco smoke seems to be the major cause. Exposure to tobacco smoke stimulates the cells making up the bronchi (major airways) of the lungs. As a result the cells can begin to divide at a faster rate than they otherwise would. This increases the risk of cancerous cells being produced, some of which can be carried to other parts of the body - forming secondary cancers - by the vessels of the body's lymphatic system.[13]

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10 "Cancer prevention tomorrow" *The Lancet* 20 February 1993 p.486

11 "A life against tobacco" *The Independent on Sunday* 10 January 1993 p.23

12 *The British Medical Association Complete Family Health Encyclopedia* 1990

13 Roberts J, *Mastering Human Biology* 1991

2. Coronary heart disease

According to the UK figures in *The Smoking Epidemic* over 32,000 deaths from coronary heart disease are annually attributable to smoking. This is about the same number as for lung cancer. The risk of coronary heart disease in a young man who smokes 20 cigarettes a day is about three times higher than for a nonsmoker; and the risk increases further with the number of cigarettes smoked.[14]

The main substances responsible are nicotine and carbon monoxide. The former stimulates the release of adrenaline into the bloodstream which acts to encourage the formation of atheroma. These are fatty deposits which can build up in the inner lining of the coronary arteries. They can then cause a blockage thus restricting the supply of blood to the heart. Carbon monoxide in tobacco smoke compounds the problem by reducing the efficiency with which the blood can transport oxygen to the heart muscle. The results can be angina pectoris (chest pain) or acute myocardial infarction (heart attack). Although there is clear evidence that the tar in cigarettes is carcinogenic (cancer causing), it does not appear to be a significant risk factor for heart attacks. Switching to low-tar cigarettes is probably ineffective in this particular context.[15]

3. Chronic obstructive pulmonary disease

The breathlessness which characterises chronic bronchitis and emphysema is the result of damage to the lungs' airways, respectively the bronchi and alveoli (the tiny air sacs of the lungs). Irritant substances in tobacco smoke reduce the efficiency with which the lungs can absorb oxygen in two ways. Firstly, mucus production increases and this collects in the airways. The action of the cilia (tiny hairs) in the airways would ordinarily transport mucus and harmful substances to the throat and nose; but this is also compromised by smoke. As a result, not only tobacco smoke, but also microbes and dirt, enter the alveoli causing further damage. About three-quarters of deaths from chronic obstructive pulmonary disease have been attributed to smoking.

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14 *The British Medical Association Complete Family Health Encyclopedia* 1990

15 "Tar yield of cigarettes and risk of acute myocardial infarction" *BMJ* 12 June 1993 pp1567-70

4. Deaths attributable to smoking

The Smoking Epidemic: A manifesto for action in England [16] contains estimates of the actual numbers of deaths caused by smoking in the UK, for the year 1988. In that (typical) year 110,692 deaths were caused by smoking, amounting to 17% of all deaths of people aged 35 and over. The precise figure quoted should not be taken to imply an ability to ascribe deaths to smoking in individual cases; people die of heart attacks, for example, for other reasons.[17] A proportion of the deaths arising from smoking can be obtained by taking into account the smoking habits of the British population, and using a knowledge of risk factors obtained from epidemiological surveys.

The final column of the table below gives the number of deaths, in the UK in 1988, due to the main smoking-related diseases. The third column demonstrates how large a role smoking plays in the deaths from each disease; for example, 40% of deaths due to cancer of the bladder are attributable to smoking.

Table A1.1. Estimates of percentages and numbers of deaths attributable to smoking, UK 1988

	Attributable percentage			Attributable deaths		
	Men	Women	All	Men	Women	All
Coronary heart disease	24	11	18	23573	8536	32109
Cerebrovascular disease (stroke)	19	7	12	5507	3492	8999
Aortic aneurism and atherosclerotic peripheral vascular disease	44	15	29	2433	472	2905
Chronic obstructive pulmonary disease	80	69	76	15525	6463	21988
Cancer of the lung	86	69	81	23908	8437	32345
Cancer of the buccal cavity, oesophagus, larynx	84	48	71	4468	1478	5946
Cancer of the bladder	45	29	40	1651	491	2142
Cancer of the kidney	49	7	32	774	71	845
Cancer of the pancreas	22	30	26	716	1065	1781
Cancer of the cervix	—	29	29	—	588	588
Ulcer of stomach & duodenum	24	20	22	517	527	1044
Total				**79072**	**31620**	**110692**

The Smoking Epidemic also provides information in terms of life expectancy. A 35-year-old woman who smokes can expect to live five years fewer than a non-smoker. For a 35 year-old-man the figure is seven years; or, to put it another way, these smokers lose on average more than one day of life every week.

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[16] *The Smoking Epidemic: A manifesto for action in England* Health Education Authority 1992

[17] "Smoking accepted on death certificates" *BMJ* 3 October 1992 pp829-30

5. Could smoking have any beneficial effects?

In the context of general public health, the answer to the question "Could smoking have any beneficial effects?" must be an emphatic "no". It has been estimated that one fifth of all people now in developed countries will be killed by smoking.[18] Although the details of the calculation will undoubtedly be subject to continuing scrutiny,[19] few doubt that "smoking is a major preventable cause of death and disease throughout the world."[20] The rising consumption of tobacco in developing countries is rightly viewed with alarm.[21]

Despite the evidence described above, there exist popular misconceptions largely based on a disregard for statistics. It is always gratifying to learn of ninety year old grandmothers, heavy smokers since the age of twelve, who still enjoy rude health. The irrelevance of such occurrences, from a public health standpoint, is illustrated by a report in *New Scientist*:[22]

> "The man who smoked 60 a day and lived to be 95 does exist said [Sir Richard] Doll, but he is rare: 3 out of 200 heavy smokers might expect to reach age 90 compared with 9 light smokers and 30 nonsmokers."

As summarised in an article in the *British Medical Journal*, a range of arguments in favour of smoking can nevertheless be deployed:[23]

> "Efforts to reduce smoking are almost always met with fierce opposition and powerful counter lobbying, most of which originates from the tobacco industry. Attempts to encourage people not to smoke lead to accusations of interference with personal liberties, "nannying," or "victim blaming." Loss of £6 billion revenue from tobacco taxation, increased unemployment, and rising costs to the NHS because of increasing numbers of people surviving beyond the age of 65 years are all arguments which are put forward.

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18 "1 in 2 smokers may die early, says mass study" *The Guardian* 22 May 1992

19 "Deaths from tobacco" *The Lancet* 11 July 1992 p.121

20 "Tobacco-associated deaths" *The Lancet* 12 September 1992 pp666-8

21 "Tobacco endangers millions of lives" *The Independent* 7 July 1993 p.10

22 "Smoking study strengthens cancer link" *New Scientist* 20 February 1993 p.5

23 "The Health of the Nation: responses" *BMJ* 19 October 1991 pp973-7

> A stronger case is the evidence that smoking provides an essential coping strategy for people whose lives might otherwise be intolerable because of the material and cultural deprivation they experience. Strategies to reduce smoking among these groups would need to tackle the origins and effects of poverty, so why not address these issues first?"

There is suggestive evidence that smoking may protect against some diseases, including the possibility that nicotine could contribute to the prevention of Alzheimer's disease. Although there are conflicts in the epidemiological evidence, research into the brain's nerve cells suggests that nicotine may provide some protection.[24] Given the large number of substances contained in tobacco smoke, it would perhaps not be surprising if some components might impart benefits. This is one illustration of the importance of continued research.

C. Passive smoking

Exposure to other people's tobacco smoke is also deleterious to health, to an extent that goes well beyond the familiar complaints of itchy eyes, runny nose and headache. It is the involuntary nature of passive smoking that excites particular controversy. According to *The Smoking Epidemic* there is "incontrovertible evidence" that maternal smoking adversely affects foetal growth and pregnancy outcome. The implications of maternal smoking are an increased likelihood of low birth weight, spontaneous abortion, preterm delivery, still birth or early neonatal death. Exposure of the mother to household smoke from cohabitants is an additional risk.

A summary of work into the effects of passive smoking has been given in a written answer (HC Deb 15 July 1993 cc 623-4W):

> "**Ms Primarolo:** To ask the Secretary of State for Health what estimates have been made of the annual number of people dying from causes related to passive smoking; what plans there are to ban smoking in public places to which children have access; and if she will list the diseases in children which can be caused by passive smoking.
>
> **Mr. Sackville:** In its fourth report, published in 1988, the Independent Scientific Committee on Smoking and Health estimated the numbers of lung cancer deaths in non-smokers exposed to environmental tobacco smoke over most of their lives as "several hundred deaths per year" [in the UK]. A copy of the report is available in the Library.

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[24] "Peering through the smoke screen" *New Scientist* 9 October 1993 pp14-5

> The "Health of the Nation" White Paper sets a target of 80 percent. of public places being covered by effective smoking policies by 1994. The White Paper states that the Government would consider legislation on smoking in public places if voluntary progress is not maintained.
>
> International scientific studies suggest that exposure of children to environmental tobacco smoke from parental smoking is causally associated with:
>
> > increased prevalence of respiratory symptoms of irritation,
> >
> > increased prevalence of middle ear effusion ("glue ear"),
> >
> > increased risk of lower respiratory tract infections (pneumonia, bronchitis and bronchiolitis) in infants and young children,
> >
> > additional episodes and increase of severity of asthma in children who already have the disease."

The detection in the urine of non-smokers of raised levels of tobacco-derived carcinogens provides experimental support for a link between passive smoking and lung cancer.[25] There is also some evidence that passive smoking is implicated in coronary heart disease, though further research is necessary to establish this beyond reasonable doubt.[26]

The U.S. Environmental Protection Agency has produced a report on the *Respiratory Health Effects of Passive Smoking*.[27] This report was based on over 30 epidemiological studies as well as biological measurements of human uptake of tobacco smoke components. The EPA also took animal data into consideration. Estimating that 3,000 tobacco-related lung cancer deaths in passive smokers occur annually in the USA, the EPA concluded that "the widespread exposure to environmental tobacco smoke in the U.S. presents a serious and substantial public health risk." This work underlines the summary of the effects on children itemised in the above written answer (HC Deb 15 July 1993 cc 623-4W). Representatives of the U.S. tobacco industry described the EPA study as shoddy and misleading, characterised by a "preference for political correctness over sound science."[28]

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25 "Urine tests confirm fears about passive smoking" *New Scientist* 29 January 1994 p.16

26 "Does passive smoking cause heart disease?" *BMJ* 15 December 1990 pp1343-4

27 *Respiratory Health Effects of Passive Smoking* Environmental Protection Agency, January 1993 (Deposited Paper 10152)

28 "Tobacco industry fumes over passive smoking" *New Scientist* 17 July 1993 p.5

The growing recognition of the risks from passive smoking has led to calls on employers to protect their workforce.[29] Section 2 of the *Health and Safety at Work etc. Act 1974* (cap 37) imposes a general duty on "every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees". More specifically, regulation 25(3) of the *Workplace (Health, Safety and Welfare) Regulations* SI 1992/3004 requires that "Rest rooms and rest areas shall include suitable arrangements to protect non-smokers from discomfort caused by tobacco smoke"; this is now in force for new workplaces and will come into force on 1 January 1996 for existing workplaces. The first successful claim for compensation for passive smoking in the UK resulted in Stockport Metropolitan Borough Council paying the plaintiff £15,000 in an out of court settlement.[30]

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[29] *Passive Smoking: A Health Hazard* Imperial Cancer Research Fund and Cancer Research Campaign 1991

[30] "UK woman wins first settlement for passive smoking" *BMJ* 6 February 1993 p.351

Part II Views on the effect of an advertising ban

The proposal to ban tobacco advertising has aroused a considerable degree of interest. In July 1992, the Health Select Committee decided to hold an enquiry into the issue, in connection with the proposed EC Directive banning both direct and indirect advertising of tobacco except inside retail outlets.[31] The EC Directive was remitted for future consideration on 13 December 1993 and is unlikely to progress further in the near future. However, the evidence collected by the Select Committee in their enquiry provides a useful summary of the divergent views held by different organisations.

A. Arguments in favour of a ban

The primary argument advanced in favour of a ban on tobacco advertising is two-fold:

- that smoking is damaging to health and
- that advertising forms an encouragement to take up or continue smoking.

This argument is set out clearly by Action on Smoking and Health [ASH] in the introduction to their brief "Tobacco advertising: the case for a ban":

> "Advertising is a potent force in maintaining smoking as an apparently normal, socially acceptable habit: it swamps the health education message, reinforces the habit for those already hooked - and recruits new smokers, the overwhelming majority of whom start as children. ... An advertising ban will save many children from being misled into thinking smoking is a desirable habit - smart, "cool", sophisticated, adult or whatever. It will help adult smokers to quit. And it will mark society's rejection of the morally indefensible promotion of addiction to what has been recognised for at least 30 years as a most dangerous drug."[32]

Similar arguments are advanced by organisations such as the British Medical Association, the Health Education Authority, the Maternity Alliance and the Public Health Alliance in evidence and memoranda to the Health Select Committee enquiry.

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[31] Select Committee on Health, *"The European Commission's proposed directive on the advertising of tobacco products"*, 14 December 1992, HC 221 1992/93

[32] ASH, "*Tobacco Advertising - the case for a ban*", January 1993, pp 1-2

The health effects of tobacco have already been discussed in Part I of this paper. The assertion that advertising encourages people to take up smoking is not undisputed. The tobacco companies have argued strongly that the function of tobacco advertising is not to recruit new smokers, but to encourage those who already smoke to switch brands. In oral evidence to the Health Select Committee, the Tobacco Advisory Council stated:

> "If there is only one thing that we hope we can get across today, Madam Chairman, it is our absolute conviction that a ban on advertising would not reduce the level of smoking, and that is a conviction based on the facts."[33]

B. Arguments against a ban

Organisations who oppose the principle of a ban do so on several grounds including the following claims:

- a ban would not be effective
- advertising encourages the use of "safer" forms of tobacco
- it would be a restriction on the right to free speech
- it would be damaging to UK industry.

1. A ban would not be effective

The question of the effectiveness of a ban in reducing smoking is the cause of much dispute. ASH claim that similar bans in other countries have led to significant drops in tobacco consumption: 12% in Norway after the introduction of a ban in 1975; 7.6% (1989) and 6.7% (1990) in Canada after the introduction of a ban in January 1989, compared with earlier annual decreases of an average 3.6%; and by 7.6% (first quarter of 1991) and 9.6% (second quarter, compared with corresponding quarters) in supermarket sales in New Zealand since a ban was imposed in December 1990, double the drops in sales in the previous year.[34]

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[33] Select Committee on Health, op cit, Q1

[34] ASH, op cit, pp 21-26

These figures, however, are dismissed by the Tobacco Advisory Council [TAC] and the Freedom Organisation for the Right to Enjoy Smoking Tobacco [FOREST]. TAC argue that the Norwegian data are inconclusive because of the way consumers switch between manufactured cigarettes and hand-rolled tobacco as their relative prices vary. TAC also ascribe the drop in consumption in Canada to increased taxes, levied both by the federal and provincial governments.[35] ASH, on the other hand, point out that even higher price increases in 1985 and 1986 led to far smaller drops in consumption and that therefore price alone cannot be assumed to be responsible for the decline.[36] FOREST argue that the decrease in New Zealand can be ascribed to "massive regular excise tax increases" initiated shortly before the ban took effect in December 1990; moreover, they assert that "tobacco consumption had already, since 1975, fallen faster in New Zealand before it instituted the ban than in any country that already had bans".[37] ASH, on the other hand, claim that no additional increase in taxation took place during the period from which ASH's figures were drawn.[38]

In 1992, the Department of Health's Economics and Operational Research Division published a discussion document "Effect of tobacco advertising on tobacco consumption" (the Smee report). Clive Smee, the report's author, agrees that the attempt to assess the effect of advertising bans in other countries is complicated by other measures introduced at the same time, such as stronger health warnings and additional health education. Nonetheless, he concludes:

> "Though there are qualifications (for example the bans in Canada and New Zealand are relatively recent and so may not yet have had their full impact), the current evidence available on these four countries [Norway, Finland, Canada and New Zealand] indicates a significant effect. In each case, the banning of advertising was followed by a fall in smoking on a scale which cannot reasonably be attributed to other factors."[39]

The validity of the Smee report's findings was severely questioned by the Tobacco Advisory Council who felt that it was "confused, selective in its review of the available data and deeply flawed."[40]

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35 Select Committee on Health, op cit, p13-14

36 ASH, op cit, p.23

37 FOREST, "*Up in smoke: the economics, ethics and politics of tobacco advertising bans*", 1991, p.9

38 ASH, op cit, p.21

39 Dept of Health, "*Effect of tobacco advertising on tobacco consumption: a discussion document reviewing the evidence*", 1992, p.22

40 TAC, "*Hear the other side*", issue no. 6, December 1992

2. Advertising encourages the use of safer forms of tobacco

The argument that advertising helps to promote the use of safer tobacco products was made by TAC in their memorandum to the Health Select Committee:

> "A ban on advertising would seriously reduce the ability of manufacturers to introduce new tobacco products or brands to the market. The introduction of filter and lower tar cigarettes in to the UK market was aided by advertising."[41]

This assertion, however, was treated with caution by the Health Select Committee, on the basis that the figures supporting the argument were very out of date, and that if the tobacco industry were genuinely committed to encouraging the use of low tar and filter cigarettes, they could do so through their pricing and marketing structures.[42]

3. A ban would restrict the right to free speech

A number of organisations, including the Advertising Association, the Newspaper Publishers Association Ltd and the Institute of Practitioners in Advertising, have expressed the view that a ban on the advertising of a legal product would constitute an infringement of the right to freedom of expression. In their memorandum to the Health Select Committee, the Advertising Association state:

> "Free commercial speech, with certain necessary and mutually agreed controls, is synonymous with freedom of expression. The right to freedom of expression is recognised by the individual Member States as well as the European Convention on Human Rights. As part of free speech a manufacturer should have the right to promote products if those products are legal in the Community. "[43]

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41 Select Committee on Health, op cit, p.3

42 Select Committee on Health, op cit, p.xiii

43 Select Committee on Health, op cit, p.59

Other organisations, however, argue that tobacco is an exceptional case in that it is potentially lethal even when used as intended. In a memorandum to the Health Select Committee, the Health Education Authority state:

> "Tobacco is unique in being the only consumer product which kills at least one in four of its regular users when used exactly as intended by the manufacturer."[44]

A further argument relates to children's vulnerability to advertising. The British Medical Association argue:

> "The freedom argument is often used against the introduction of an advertising ban. But it is important to reflect on the section of the population who start smoking and those who are most susceptible to the power of advertising. Five out of six smokers have started smoking by the age of fifteen. Adults are free to choose whether they want to start smoking, children are more vulnerable and should, therefore be protected."[45]

4. A ban would be damaging to UK industry

The Tobacco Advisory Council have argued that a ban on advertising would be damaging to UK industry, in that companies would be unable to defend their market share and would therefore lose out to foreign competitors.[46] The Advertising Association also advanced the argument that a ban would be harmful to UK companies, but from the opposite point of view: that a ban on advertising is fundamentally a protectionist measure and would hinder the attempts of UK companies to export new products.[47] The Coronary Protection Group, on the other hand, dispute the assumption that imports are necessarily cheaper, claiming that the UK industry has responded to the demand for cheaper cigarettes through the sale of cut-price, "own-label" supermarket brands. They also raise the question "should a lethal habit be promoted just to support the British tobacco industry?"[48]

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44 Select Committee on Health, op cit, p.46

45 Select Committee on Health, op cit, p.19

46 Select Committee on Health, op cit, Q1

47 Select Committee on Health, op cit, p.59

48 Coronary Prevention Group, "*The case against tobacco advertising*", 1991, p.12

C. Conclusions reached by the Health Select Committee

After taking evidence from a wide variety of organisations, the Health Select Committee concluded that a ban on tobacco advertising was justified. To quote from their report:

> "In the debate about a tobacco advertising ban, there are undoubtedly inconsistencies on both sides of the argument. We believe this stems from the curious position of tobacco in our society, which is largely an accident of history. Over the last century, governments of all persuasions have been quick to propose the most draconian controls over dangerous drugs which are abused by a tiny minority of the population. Few would argue that they were wrong to do so. However, by the time the dangers of tobacco were established, it had become a widespread and socially acceptable habit indulged in by the majority of the male population. It would be manifestly impossible at present to make the consumption of tobacco illegal. It is argued therefore that because tobacco is legal to sell it should be legal to advertise. To accept this argument is to accept that we are caught in a Catch 22: that we can only outlaw tobacco advertising if we outlaw its sale and consumption, and that because it would be impossible to do the latter it must be impossible to do the former. No doubt some of those who deploy the argument for free expression in defence of tobacco advertising are less than committed to the goal of eliminating this potentially lethal habit. We are quite sure that the present Secretary of State is not one of those and that, as she puts it herself, she holds no candle for tobacco advertising. However, there seems to be some danger that the Government is allowing itself to be caught on the horns of a largely imaginary dilemma.
>
> The Government cannot continue to procrastinate on the issue of an advertising ban on the grounds that it is awaiting a level of proof about its effectiveness which is in the nature of things unobtainable. If Ministers wish to nail their colours to the mast of "free expression" they should do so explicitly, and not continue to dally over the health issues. In order for it to achieve the very demanding targets set out in *The Health of the Nation* it is our belief that the Government cannot afford to ignore the potential of a statutory ban as one amongst a group of measures which will ensure that those targets are met. **We therefore recommend that the Government adopt as its policy the total elimination of tobacco advertising other than at point of sale.**"[49]

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[49] Select Committee on Health, op cit, pp xvii-xviii

D. The Government's position and the voluntary code

Throughout the debate, the Government has maintained its stance that voluntary agreements with the tobacco industry are the best way of controlling tobacco advertising. In its response to the Health Select Committee's report, the Government reiterated its position:

> "The Government believes that the voluntary agreements with the tobacco industry have proved an effective way of controlling tobacco advertising and promotion. The agreements have proved sufficiently flexible to respond to particular concerns, and to allow for further development where necessary ... The Government believes that the imposition of a statutory ban on the advertising of a product which is legal to sell would be a major change of principle which would need to be justified in terms of the likely size of any effect. As indicated above, the Government remain to be convinced that sufficient evidence is presently available to provide such justification, though it will give very careful consideration to the responses to the Department of Health's recent report."[50]

It has been reported recently that the Department of Health will soon announce that this code is to be tightened, so as to head off the possibility of a total ban being implemented under Mr Barron's private members' bill. Apparently, these measures are suspected to include a ban on poster advertising, tight controls on advertising in women's magazines, an end to shopfront advertising and bigger health warnings on cigarette packets.[51]

Restrictions on tobacco advertising were first imposed in 1964, following the publication two years earlier of "Smoking and Health" by the Royal College of Physicians on the health hazards of smoking. As a result, manufacturers stopped advertising on television before 9 p.m., and a year later a total ban on television advertising was adopted (the ban was extended to include cigarillos after 1975). In addition, the tobacco industry set up a voluntary code of advertising, supposedly to prevent cigarettes being over-glamorised, though it was not until 1975 that control of this code was transferred to an indepedent body, namely the Advertising Standards Authority. Radio advertising was also banned, following the development of commercial radio in the early 1970s. Health warnings on cigarette packets were introduced in 1971, and included information about the tar content of the particular brand after 1974. The scope and extent of tobacco advertising continued to be gradually restricted under this voluntary system for the next decade.

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50 "*The European Commission's proposed directive on the advertising of tobacco products*", Cm 2163, p.5

51 "Tobacco advert curbs to be unveiled", *Financial Times", 26 January 1994*

The current Voluntary Agreement on Tobacco Products' Advertising and Promotion and Health Warnings was made on 1 April 1986, between the Government, and the tobacco industry (as represented by the Tobacco Advisory Council and the Imported Tobacco Products Advisory Council). The agreement included a series of provisions covering matters such as ending advertising in cinemas, the wording and size of health warnings on cigarette packets and promotional material, preventing the display of tobacco advertising close to schools, and restricting advertisements in women's magazines. The agreement was to be monitored by a new body, the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship (COMATAS), under an independent chairman. In announcing the creation of the new code, the then Secretary of State for Social Services (Norman Fowler) described how the committee would operate:

> "The committee's task will be to ensure that the terms of the voluntary agreement are properly adhered to, to receive details of complaints about compliance, and to undertake surveys from time to time on the industry's observance of particular aspects of the agreement ... The establishment of this new monitoring machinery should go a long way towards ensuring public confidence in the system of controlling tobacco advertising and promotion by means of voluntary agreements."
>
> [HC Deb 24 March 1986 cc370-2W]

The chairman of COMATAS is required to publish an Annual Report on the committee's work, which will include its conclusions on the industry's practices. However, the research surveys that the Committee carries out are confidential. When this policy was questioned, representatives from the industry argued that such material was not originally intended for publication, and its dissemination would be commercially damaging. The committee agreed that if one party insisted on this data remaining private, then it should be.[52]

Initially, there appears to have been some disagreement about the purpose of the code. The then chairman (Sir Peter Lazarus) wrote in the first COMATAS annual report[53] that, "I do not think that, on some important issues, the present agreements are adequate," though he felt that there were only a few cases where "companies might have tried a bit harder to avoid breaches." In passing, he noted that "this report will not satisfy those critics who want to see all tobacco advertising and sponsorship banned."

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52 HC Deb 27 October 89 c.631W

53 Dept of Health, "*First Report of the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship*", 1988

The agreement was reviewed in 1991, and a revised version came into effect from 1 January 1992. The most significant changes in the code were that all permanent shopfront advertising was to be cut by 50 per cent by 1997, and that the language used in health warnings printed on advertisments and packaging was made "tougher." Introducing the new code, the then Secretary of State for Health (William Waldegrave) stated, "the conclusion of this new agreement once again underlines out desire to control tobacco advertising and promotion in an effective and responsible way".[54] Perhaps the major criticism made of the voluntary code was made at the time by the Coronary Prevention Group, which termed the agreement as "collusion."

The main provisions of the code are published in the latest COMATAS Annual Report.[55] In 1992-93, the Committee received reports of 32 supposed breaches of the code, of which it found that 4 actually broke it (3 of these were seen as inadvertent). This compares with 462 reports of the code being breached listed in the Committee's First Report (of which, 41 wereheldto be breaches, with 8 cases of the code being broken inadvertently).

The use of voluntary codes in other EU Member States, as well as legal restrictions, was summarised in a recent article in the Financial Times[56] (see table below), which reported on the arguments continuing at Council level as to whether a Europe-wide ban on advertising should be implemented:

Tobacco advertising in the EU: being stubbed out

(TV advertising is banned throughout EU)		Cigarettes per capita per annum (1991)
France	Banned	1,714
Portugal	Banned	1,503
Italy	Banned - widely circumvented by indirect advertising	1,691
Belgium	Severe restrictions; total ban in the pipeline	1,681*
Denmark	Local radio ban; other controls through voluntary agreement	1,556
Germany	Banned on radio. Other legal controls and voluntary agreements	1,821
Greece	Banned on radio. Other controls	3,012
Ireland	Detailed regulations	1,714
Luxembourg	Major legal restrictions	1,681*
Netherlands	Banned on radio; press and posters voluntary agreements	1,222
Spain	Radio and poster banned; additional voluntary restrictions	2,140
UK	Voluntary agreements	1,641

Source: Action on Smoking and Health and Euromonitor

* For Belgium and Luxembourg combined

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54 "New tobacco advertising agreement under attack", *The Independent*, 10 September 1991

55 Dept of Health, *"Sixth Report of the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship*", July 1993, pp 16-18 (Deposited Paper No.9564)

56 "Smoke gets into Europe's eyes", *Financial Times*, 13 December 1993

Part III The Bill's provisions

Clause 1(1) makes it a criminal offence to publish an advertisement for a tobacco product, or cause such an advertisement to be published. Subclauses 2-8 then list the circumstances in which this provision would not apply.

Clause 1(2) allows certain point of sale advertisements. Advertisements in premises used mainly for the purpose of selling tobacco products are permitted as long as they cannot be seen or heard from outside the premises. Advertisements which only contain information about price, the health aspects of smoking and any other information prescribed by the Secretary of State are also permitted, again as long as they cannot be seen or heard from outside the premises.

Clause 1(3) sets out a number of defences in proceedings resulting from the publication of an advertisement for a tobacco product. It is a defence to demonstrate that the advertisement was non-commercial (ie no money or other form of payment changed hands) and that the person responsible for the advertisement was not involved in the tobacco industry. It is also a defence to show that the person responsible for the advertisement was not involved in the tobacco industry and had no intention of promoting a specific tobacco product. Other defences are that the advertisement was directed only at persons in the tobacco industry, or that the alleged advertisement was used on business stationery, not for advertising purposes. Exceptions are also made for publications not aimed primarily at the UK market: it is a defence to prove that the advertisement appeared in a publication produced outside the UK and only 5% of the circulation (or 1000 copies if this is fewer) had been imported into the UK. Likewise, it is a defence to prove that the person publishing the advertisement reasonably believed that only 5% of the circulation (or 1000 copies) would remain or be imported into the UK.

Clause 1(4) permits advertisements for non-tobacco products or services which have the same name or a similar name to a tobacco product as long as a number of conditions are fulfilled: the tobacco product must have been available for sale on 11 February 1994; the brand name in question must have been associated for longer with the non-tobacco product or service than with the tobacco product; and the value of sales from the non-tobacco products or services must have been substantially more than the value of sales from the tobacco product for a continuous period of at least twelve months in the two years before the advertisement was published.

Clause 1(5) allows for certain existing advertisments: advertisements published within a year of the Act coming into force and which form part of a permanent structure set up before 11 February 1994 are exempted, as are advertisements in publications which existed before the

Act came into force and whose main purpose was not to advertise tobacco.

Clause 1(6) clarifies the term "advertisement for a tobacco product": it covers any form of communication which directly or indirectly promotes the use of tobacco products, with the exception of normal retail packaging.

Clause 1(7) gives guidance on what might constitute direct or indirect promotion of tobacco products, mentioning in particular the use of a name, pictures, symbols or colours associated with a tobacco product. This includes situation where they are ostensibly being used to promote another product, service or event.

Clause 1(8) clarifies the provisions of clause 1(3) in cases where the advertisement in question is ostensibly promoting a non-tobacco product, service or event. Where the defence includes the claim that the person responsible for the publication is not involved in the tobacco industry, they must also not be involved in any way with the non-tobacco product, service or event in question.

Clause 2 makes it an offence for anyone in the tobacco industry to distribute tobacco products either free of charge or at a price substantially below the usual rate, after taking any reasonable trade discount into account. It is also an offence to offer gifts (including the right to enter a game or other such event), cash rebates or similar benefits as an inducement to buy tobacco products. However, if the gift or special offer is only incidentally connected with buying tobacco products and a similar offer is available by buying other products or services, the offer will not constitute an offence.

Clause 3 allows the Secretary of State to make regulations which will further restrict or prohibit the promotion of smoking or tobacco products.

Clause 4 sets out the penalty for offences under this Act: on summary conviction, a fine not exceeding level 5 on the standard scale (currently £5,000) or imprisonment for up to six months: on conviction on indictment either a fine or imprisonment for up to two years, or both.

Clause 5 defines a tobacco product as a product made wholly or partly of tobacco for the purpose of being smoked, sniffed, sucked, chewed or otherwise used orally or nasally.

Clause 6 allows regulations under this Act to be exercised by negative statutory instrument.

Clause 7 gives the short title, commencement and extent of the Act.