Health claims and public health ads for e-cigarettes:

CAP and BCAP's evaluation of responses

1. Introduction

Following consultation, the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) are changing rule 22.5 (CAP) and rule 33.5 (BCAP) of their Codes to remove the prohibition on health claims being made for e-cigarettes in lawful ads. This document provides a summary of significant comments received and CAP and BCAP's evaluation of these comments: it should be read alongside the consultation document. A regulatory statement setting out the reasons for the change has been published separately.

The following points about the evaluation should also be noted:

- Question 4 was strictly concerned with the wording of text which CAP has subsequently decided not to include in its Code and has therefore not been evaluated.

- Question 5 invited additional information about CAP and BCAP's consideration of health claims. CAP and BCAP received a range of general information in response to this question, much of which covered similar issues discussed in the main consultation questions and separate evaluation was therefore unnecessary. The responses to those questions can be seen in the raw consultation responses, published separately.

1.1 WHO Framework Convention on Tobacco Control

Consistent with the guidance given in the World Health Organisation (WHO) Framework Convention on Tobacco Control, which requires that interactions with the tobacco industry are transparent[1], those respondents who CAP and BCAP understand are either tobacco companies, their partners, subsidiaries or representatives are indicated in bold and underlined text in the below table.

[1] http://www.who.int/fctc/treaty_instruments/Guidelines_Article_5_3_English.pdf

2. List of respondents and their abbreviations used in this document

	Respondent	Abbreviation
1	Action on Smoking and Health	ASH
2	ASH Scotland	ASH Scot
3	ASH Wales	ASH Wales
4	Bluespur Limited	Bluespur
5	Boots UK Ltd	Boots
6	**British American Tobacco Ltd**	**BAT**
7	British Medical Association	BMA
8	Cancer Research UK	CRUK
9	Cuts Ice Ltd	Cuts Ice
10	East Renfrewshire Council	ERC
11	E-cigarette Direct	ECD
12	Faculty of Public Health	FPH
13	**Fontem Ventures**	**Fontem**
14	Fresh (North East of England tobacco control)	Fresh
15	GlaxoSmithKline	GSK
16	Independent British Vape Trade Association	IBVTA
17	Inter Regulatory	IR
18	Johnson & Johnson Consumer Services EAME Ltd	J&J
19	JAC Vapour	JAC
20	**Japan Tobacco International**	**JTI**
21	Liberro	Liberro
22	Liberty Flights	LF
23	London School of Hygiene and Tropical Medicines	LSHTM
24	New Nicotine Alliance	NNA
25	Proprietary Association of Great Britain	PAGB

	Respondent	Abbreviation
26	**Philip Morris Ltd**	**PML**
27	Public Health England	PHE
28	Royal College of Physicians	RCP
29	Royal College of Physicians of Edinburgh	RCP Ed.
30	Royal Environmental Health Institute of Scotland	REHIS
31	Society of Chief Officers of Trading Standards in Scotland	SCOTSS
32	The Freedom Association	TFA
33	Trading Standards Institute	TSI
34	UK Centre for Tobacco and Alcohol Studies	UKCTAS
35	UK Vaping Industry Association	UKVIA
36	University of Edinburgh's Group for Research on Inequalities and Tobacco (GRIT)	GRIT
37	University of Glasgow	UOG
38	University of Stirling	UOS
39	Welsh Government	Welsh Gov.
40	Mr A. (A private individual)	Ms A.
41	Mr B. (A private individual)	Ms B.
42	Ms C. (A private individual)	Ms C.
43	Ms D. (A private individual)	Ms D.
44	Mr E. (A private individual)	Mr E.
45	Mr F. (A private individual)	Mr F.
46	Mr G. (A private individual)	Mr G.
47	Ms H. (A private individual)	Ms H.
48	Mr I. (A private individual)	Mr I.
49	A doctor responding in a personal capacity	Dr. J

1. Do you agree with CAP and BCAP's proposal to remove the prohibition on health claims from unlicensed, nicotine-containing e-cigarettes? If not, please explain why. Please also provide any relevant evidence not taken into account by CAP and BCAP in making this proposal.			
1.1	**ASH, CRUK, ERC, Fresh, NNA, PHE, RCP, TFA, UKCTAS,** **BAT, Bluespur, Boots, Cuts Ice, ECD, Fontem, IBVTA, IR, JAC, JTI, Liberro, LF, PML, UKVIA** **Mr B, Ms C.,Ms D., Mr E., Mr F., Mr G., Mr I.**	**The respondents listed on the left supported the proposal. Significant points made by one or more respondents are set out below:** 1. At the time of the last consultation, both Public Health England and the Royal College of Physicians had concluded that e-cigarettes were significantly less harmful than smoking. Indeed, the PHE review in 2015 concluded that most toxins responsible for health damage from smoking are absent in e-cigarette aerosol and that those that are present are there at much lower levels than in conventional cigarettes. Since the last consultation, additional studies in support of this position have been published. The Tobacco Control Plan for England promotes the role of e-cigarettes as an alternative to tobacco. 2. The scientific evidence is sufficiently strong to permit generic health claims to be made by advertisers that e-cigarettes are significantly less harmful than smoked tobacco and that vaping is therefore significantly less harmful than smoking. 3. The evidence does not support absolute claims for health benefits from vaping, only claims of relative health benefit compared to continuing to smoke. Nor does it suggest a significant health benefit from "dual use" (smoking at the same time as vaping); health claims need to make that clear. 4. There is a well-evidenced misperception amongst the public and smokers about the relative risks of smoking and vaping with fewer adults now able to correctly identify that e-cigarettes are a lot less harmful that smoking and a growing number incorrectly thinking that they are more harmful. These misperceptions potentially discourage smokers who might otherwise switch to vaping from doing so, or where they have switched make it more likely that they continue dual use; and may make it more likely that vapers who have quit using electronic cigarettes revert back to smoking. The current rules prevent this misperception being corrected. 5. The regulatory framework for consumer e-cigarettes under the EU Tobacco Products Directive is now in effect. It has significantly reduced the variation in quality, safety and efficacy of products on the market. By the end of September 2017, over 32,000 e-cigarette and refill container products had been notified to MHRA by over 400 companies. The notifying manufacturer or importer bears full responsibility for the quality and safety of the product. A body of product / emissions data is being collected and notified to the MHRA.	**CAP and BCAP's evaluation** CAP and BCAP agree, in general terms, with the points made in support of the proposal. However, they acknowledge the concerns expressed particularly about the absence of evidence for absolute claims and for the benefits of dual use. CAP and BCAP do not propose to prohibit claims of this nature absolutely but have examined these concerns in their regulatory statement to make clear the difficulties advertisers are likely to have in substantiating such claims. **Responses on more detailed points follow below.** Response to point (7): Broadcast ads which refer to e-cigarettes are subject to pre-clearance by Clearcast and RadioCentre. CAP provides free pre-publication advice on how non-broadcast ads can comply but seeking such advice is voluntary. CAP does, however, reserve mandatory pre-clearance as a sanction for advertisers who commit serious or repeated breaches of the Code. In response to point (10): CAP and BCAP consider it highly unlikely that the ASA will consider evidence for claims for products which have not met legislative requirements.

		6. Product-specific claims will need to be substantiated by product-specific evidence in line with the Advertising Guidance on Substantiation. Further guidance on the application of this to the e-cigarette sector would be welcome. 7. Consider that all ads making health claims should be pre-vetted prior to publication by the ASA, until best practice is established and well understood by the manufacturers and importers. 8. NICE is currently consulting on its revised guidance on smoking cessation interventions and services (PH1 and PH10), which includes a recommendation that healthcare professionals should offer advice to smokers on their use of e-cigarettes. 9. One of the arguments against permitting relative health claims to be made for e-cigarettes is that medicinal licensing provides the appropriate channel for those who wish to make health claims. To date, there is no licensed e-cigarette commercially available in the U.K. There are significant boundaries to licensing e-cigarettes through the MHRA and respondents not aware of any intent to remove these boundaries. Therefore, requiring a medical licence for a product to communicate the relative harms of e-cigarettes and tobacco is not a realistic avenue. 10. The MHRA periodically publishes a list of notified e-cigarette products with corresponding European Community Identification Number numbers on its website which have undertaken the rigorous testing. Strongly consider that only products which have been published on the MHRA website which have undergone the rigorous testing should be allowed to make any health claims. Companies which have chosen to ignore legislation and not take their products through the TRPR notification process cannot prove the safety of their ingredients, and therefore should remain unable to claim any health benefits more broadly associated with the regulated side of the e-cigarette market. 11. The prohibition should be removed to allow increased freedom in advertising. The current restrictions imposed by the European Tobacco Products Directive hinder manufacturers' ability to communicate even the most basic factual and scientific information about their products to smokers, or indeed the differences between products and devices.	
1.2	**ASH Scot, BMA, FPH, GRIT, LSHTM, RCP Ed., REHIS, SCOTTS, TSI, UoG, UoS,**	**The respondents listed on the left opposed the removal of the prohibition on health claims. Key points made in support of this argument by one or more respondents:** 1. Current evidence suggests e-cigarettes are less harmful than tobacco cigarettes but there is not undisputed evidence that they are completely harm-free. They have not been in use for long enough to understand whether there are any long-term health	CAP and BCAP note and take seriously the objections to the proposal put forward by respondents. However, they do not consider that these concerns can justify a continued absolute prohibition on health claims, particularly

	PAGB, GSK **Mr A., Dr J,**	implications of repeated or prolonged use. They have no intrinsic health benefits and there are real concerns that they will be proposed as a "healthy" option when in fact they are a "less harmful" option. 2. Removing this prohibition would permit an unacceptable degree of latitude for commercial entities, including the tobacco industry. Commercial advertisers are not best placed to carry health messages to the public. 3. Dual use of e-cigarettes and smoked tobacco presents much of the same risk as continuing to smoke, and has not been decisively demonstrated to lead to quitting tobacco in the longer term. Advertising which could have the effect of causing smokers only to reduce their smoking or supplement it with e-cigarette use, rather than quit entirely, is unlikely to result in a net benefit for public health. 4. Medicinal licensing via the MHRA provides the appropriate route for marketers to make health claims. The question arises as to whether evidence for specific products even exists outside that context. 5. Companies can already refer to evidence that using e-cigarettes without tobacco is less harmful than using conventional cigarettes, as highlighted in the recently published Scottish Consensus Statement on e-cigarettes. 6. NICE's smoking Harm Reduction guideline (PH45) states that only licensed nicotine-containing products are explicitly considered to be safe on a long-term basis. The WHO recommended, that if electronic nicotine-delivery systems are not deemed safe by a competent national body, consumers should strongly be advised not to use these products, including electronic cigarettes. 7. General health claims about the relative risk compared to tobacco, for example the claim that they are 95% safer than tobacco, may appeal to non-users of nicotine and could encourage non-nicotine users and children to try these products. It must always be made clear that e-cigarettes are a stop smoking aid or an aid to reduce smoking, therefore a health claim about the relative risk compared to tobacco should not be made without making clear that it is part of an anti-smoking message. 8. Public Health England (PHE) and the Royal College of Physicians have publicly stated that e-cigarettes are approximately 95% less harmful than smoking. However, this figure is flawed and the study itself acknowledges numerous weaknesses in its own methodology. This study also made clear that e-cigarettes are far from harm-free and have numerous negative health effects. 9. PHE and RCP authors still predict that e-cigarettes will likely cause serious adverse effects when used long term, including, for example, incurable lung disease (COPD),	in the context of improved product standards and the positive view taken by many in public health of their benefits as a stop smoking aid. Where marketers make claims for products they will have to meet strict standards of substantiation and ensure their claims are not misleading. Response to point (4): CAP and BCAP are not aware of the availability of any medicinally licensed e-cigarettes. Nor do they consider that the availability of licensing justifies prohibiting claims made for consumer products which can be legitimately sold and marketed outside of that licensing regime. Response to point (5): Companies are currently prohibited from making such references by the prohibition on health claims. CAP and BCAP's removal of the prohibition will allow them to do so. Response to point (6): CAP and BCAP understand that NICE is consulting on changes to this guidance but, notwithstanding that, other public health bodies (e.g. PHE) have already promoted e-cigarettes as a smoking cessation aid. The current PH45 guidance also suggests that stop smoking services may advise that non-licensed nicotine-containing products are likely to be less harmful than cigarettes. In CAP and BCAP's view, this division of opinion does not support the maintenance of an absolute prohibition of substantiated claims in advertising. Response to point (7):

		and often incurable lung disease (lung cancer). It is not currently possible to advise users and potential users as to what the relative risks involved actually are. The public are, therefore, currently unable to make an informed choice regarding the devices, which necessitates the retention of the current prohibition on making health claims in E-cigarette adverts. The commonly cited "estimate" of 95% safer is, firstly, not scientifically substantiated, and, secondly, misleading, as it does not specifically, and explicitly, explain to the public what the RCP and PHE really believe the likely results of long-term e-cigarette use are: these opinions are clearly significant to making an informed choice. 10. Any specific health claim currently regarding the safety of e-cigarettes relative to conventional cigarettes cannot be scientifically substantiated, due to lack of relevant data, and, therefore, lack of an appropriate and essential risk assessment. Utilising a single figure to represent this differential, as PHE has done, is not scientifically credible. It would be misleading to advertise E-Cigarettes without warning users, firstly, of the likely serious health effects of long term use, as discussed above, and secondly, that the evidence to substantiate the effectiveness of E-Cigarettes as an effective aid to smoking cessation is currently absent: restricting adult consumers from receiving this information is not justified. 11. As indicated, health claims are not permitted on product labelling under the Tobacco Products Directive. The Tobacco and Related Products Regulations 2016 state that nothing on the label must suggest that a: "particular electronic cigarette or refill container— (I) is less harmful than other electronic cigarettes or refill containers, (ii) has vitalising, energising, healing, rejuvenating, natural or organic properties, or (iii) has other health or lifestyle benefits" 12. Respondents also question whether the permission of health claims would contradict 22.8 of the code ' Marketing communications must not encourage non-smokers or non-nicotine-users to use e-cigarettes'. 13. Health claims of any kind are not allowed on any form of alcohol and are tightly controlled in relation to food. 14. What is included in the liquid used in e-cigarettes varies considerably. Ads are generally generic in their claims of health giving properties and seldom directly related back to a given liquid mix.	CAP and BCAP consider that their strict rules which require ads not to appeal particularly to those under 18, not to feature those under 25 in a prominent role and not to be placed in children's media apply adequate protection. These rules will apply equally to those ads which make health claims. Response to point (10): CAP and BCAP do not take a view on the methodology of the study conducted by PHE. The question at issue is whether the evidence of harm remains sufficient to justify an outright ban. Response to point (11): CAP and BCAP agree that the TPD and TRPR prohibit health claims on product packaging; however, this does not apply to advertising. The Department of Health has minimally transposed the TPD. CAP and BCAP are not aware of evidence that they need to reflect this prohibition for advertising. Response to point (12): CAP and BCAP do not consider that the presence of a health claim is likely in and of itself to encourage non-smokers or non-nicotine users to use e-cigarettes. Ads are currently, and will be continue to be, prohibited from addressing those groups explicitly by the rules mentioned. Response to point (13): Such claims are controlled by the European Regulation for Nutrition and Health Claims made on Food. That legislation has no relevance to e-cigarettes. Neither the European nor the UK parliament has seen fit to control the claims made for e-cigarettes in a similar

			way. CAP and BCAP's decision is based on the evidence base for the health impacts of e-cigarettes and the existence of legislation controlling other product categories is not relevant to this decision. Point (14): Where marketers make health claims, they will need to ensure that those claims can be substantiated for their specific product.
1.3	J&J	1. Do not object to the proposal in principle but concerned that the much-quoted "95% safer than cigarettes" claim for e-cigarettes in general, while very impactful, is not based on data from controlled clinical studies. 2. The new rules relating to quality and safety of e-cigarette products and their notification have yet been shown to be effective; and overall, there is still divided opinion in the medical and scientific community regarding the risk reduction associated with electronic cigarettes. 3. Allowing health claims could change the status of smoking cessation medicines in the eyes of the general public and specifically the quitting consumer. Concerned that a consequence of this, over time, could be to reduce confidence in medicines. 4. Believes there should be safeguards to ensure that relaxation of this rule does not lead to unintended consequences, e.g. inappropriately unrestricted advertising by e-cigarette manufacturers, which could in turn lead to adverse public health consequences.	Response to points (1) and (2): CAP and BCAP do not take a view on the methodology of the study conducted by PHE, nor the efficacy of the wider regulatory regime. The question at issue is whether the evidence of harm remains sufficient to justify an outright ban. In CAP and BCAP's view, it does not. Response to point (3): Smoking cessation claims will be governed by the medicines licensing regime. Response to point (4): CAP and BCAP have clarified in their regulatory statement the types of claims that are likely to be acceptable.
1.4	FPH	Concerned that the proposal to amend the wording of these regulations originated as a request from the tobacco industry. Also very concerned that amending the regulations in response to a tobacco industry request breaches Article 5.3 of the World Health Organisation Framework Convention on Tobacco Control (WHO FCTC), which the UK government has both signed and ratified. Parties to the WHO FCTC have pledged to resist tobacco industry interference.	The tobacco industry has provided legitimate responses to this, and the previous, consultation. Those responses have been considered, evaluated and published in the same way as all others, in line with CAP and BCAP's standard consultation processes.
1.5	Welsh Gov	Concerned that allowing claims about the health benefits of unlicensed nicotine-containing e-cigarettes relative to tobacco in promotional material has the potential to attract experimentation among children and non-smokers.	CAP and BCAP consider that their strict rules which require ads not to appeal particularly to those under 18, not to feature those under 25 in a prominent

			role and not to be placed in children's media apply adequate protection. These rules will apply equally to those ads which make health claims.
1.6	Ms H.	Supports the proposal specifically only if ads are required to supplement comparisons with cigarettes with information about the benefits of not using e-cigarettes or tobacco at all.	CAP and BCAP do not intend to limit the types of claims which marketers can make; however, marketers will have to hold substantiation for the claims which they make.

***

2.	Do you agree with CAP and BCAP's proposed changes to the wording of the rules, as set out above? If not please explain why.		
2.1	ASH, CRUK, ERC, PHE, RCP, UKCTAS BAT, Bluespur, Boots, Cuts Ice, ECD, Fontem, IBVTA, IR, JAC, JTI, LF, Liberro, PAGB, PML, SCOTTS, UKVIA Dr J., Mr B., Ms C., Mr E., Mr I., NNA, TFA,	**The respondents listed on the left supported the proposed wording.** **The following responded made specific points:** 1. BAT considered that the reference to "medicinal claims" required clarification within the rule. 2. ECD requested clarification as to whether advertisements could refer to claims made by PHE and the RCP about, for example, e-cigarettes being 95% safer than tobacco. 3. Many respondents requested further guidance on how the revised rule should be complied with.	1. CAP and BCAP do not consider that the definition of medicinal claim requires repetition in the rule. The definition is provided in the relevant sections of the Codes which address the advertising of medicines. 2. Where advertisers repeat claims made by third parties about the benefits of e-cigarettes generally, including the 95% claim made by PHE, it is very likely that the ASA will consider this to be an implied claim for the advertised product and require the advertiser to hold evidence to substantiate it. 3. The revised rule only removes a prohibition. Marketers will be subject to the same evidential standards as other categories of product / service making health claims. CAP and BCAP already provide Advertising Guidance on how marketers should substantiate such claims.
2.2	ASH Scot, ASH Wales, FPH, Grit, Mr G., RCP Ed., TSI, REHIS,	**The respondents listed on the left opposed the proposed change to the wording of the rule, many citing their reasons given in response to Question 1. Many of these respondents considered that ads should be able to carry a comparative claim about risk compared to tobacco.**	Please see CAP and BCAP's evaluation of question 1.

	UOG, UOS		
2.3	GSK	Considers that claims should only be made as part of a clear quit-smoking message.	Please see CAP and BCAP's evaluation of question 1.
2.4	J&J	Rules should be amended to make clear that only substantiated health claims are permitted.	CAP and BCAP consider that the rules in the sections of their Codes which deal with Misleading Advertising and medicinal and health claims already achieve this.

3. Do you agree with CAP's proposal to add qualifying text to the introductory text of the e-cigarette section of its Code as set out above? If not please explain why.			
3.1	ASH, ASH Scot, ASH Wales, BMA. CRUK, Fresh, GRIT, GSK, J&J, Mr A., PAGB, RCP Ed., UOG, UoS	**The respondents listed on the left objected to the proposal. Significant points made:** 1. Do not believe that commercial organisations should run public health campaigns on smoking cessation and prevention. Particularly concerned about such campaigns run by tobacco companies or tobacco industry linked or funded organisations, for example trade bodies or other third parties. The tobacco industry has a track record of running public education campaigns, for example on youth smoking prevention, which have been ineffective in reducing smoking prevalence and the industry and its front groups should not be trusted to run such campaigns. 2. No public health campaigns or information on smoking cessation should be used to support a specific brand or product. 3. Organisations with a commercial and vested interest should be able to promote public health messaging about quitting smoking but only by linking to campaigns from independent and reputable health bodies, for example the Stoptober campaign run by Public Health England, not by running such campaigns themselves. 4. Branding of any such public health campaigns should not appear in association with that for a specific brand or product. Where the logo of a campaign on electronic media, for example on a web site landing page or app is included, it should link to material exclusively to that campaign and not to promotions of any product or brand. 5. Section 22 of the CAP code should apply to public health advertisements with the exception only of 22.6 (prohibiting use of health professionals) and 22.12 (limiting type of media which can be used), specifically with respect to public health campaigns run by reputable public health bodies,. 6. Involving the tobacco industry in public health messaging, even incidentally, could be viewed as a breach of the UK's responsibilities under Article 5.3 of the Framework Convention on Tobacco Control (FCTC). **[Cancer Research provided a legal opinion**	In this consultation question CAP asked whether the content rules which govern e-cigarette ads should always apply to public health messages which refer to e-cigarettes but which do not refer to a particular product or brand. Responses however generally focussed on whether public health campaigns should be permitted at all, particularly if they were originated by a commercial entity. CAP has explored these concerns and their ramifications in its regulatory statement, published separately. Readers should refer to the evaluation of Question 1 above in relation to these points. In relation to point (6): CAP notes the legal opinion provided. While not relevant to the specific consultation question at issue it poses broader questions about CAP and BCAP's regulation of public health advertisements.

		about the effect of the FCTC] 7. Question whether organisations that are not recognised public health institutions necessarily have the expertise to provide unbiased, evidence-led and non-misleading health messages to the public. 8. The evidence so far shows e-cigarettes are far safer than smoking and can help smokers to stop. However, they are not completely safe in their own right and should not be promoted to people, particularly youth, who do not smoke. Public health campaigns should not be used to market e-cigarettes as 'cool', 'desirable', or 'an aspirational part of your life'. They should be treated as a smoking cessation tool only. Consider that public health campaigns should be pre-vetted by CAP/BCAP before they can be published. 9. Consider that the inclusion of e-cigarettes in public education campaigns, such as Stoptober, could confer a "halo effect" on these products, suggesting they have equivalent evidence of effectiveness as licensed smoking cessation medicines. As outlined earlier in this response, the impact of long-term use of e-cigarettes is not known, and although there is evidence to suggest they are safer than tobacco cigarettes, there is not evidence to suggest they are without harm entirely. 10. Tobacco companies and e-cigarette companies are heavily interrelated, and any opportunities for them to run advertising and marketing campaigns and messaging about public health therefore should be avoided as likely to be counter-productive to the aims of public health. Article 5.3 of the Framework Convention on Tobacco Control has been an important landmark in protecting public health and this proposed change could breach its effectiveness. This should be avoided. 11. The proposal would allow medicinal (quitting support) claims across the whole category of e-cigarette products, despite not one of those products on the market having reached the standards required for being licensed for smoking cessation by the MHRA. Should this proposal be accepted, public health advertisements could make category-wide claims on the health benefits of e-cigarette use, for which individually no company has sufficient substantiation. This may include their medicinal use to quit - as is currently the case for the 2017 Stoptober promotion. We can see no justification for having differing requirements for levels of evidence for different stakeholders. 12. Acknowledge that there are now greater product and safety controls due to TPD requirements but do not consider that these measures have yet been shown to be effective. 13. This could open to door for tobacco firms or groups of firms to promote e-cigarettes generally for health reasons. We do not think this is at all desirable or in the public	

		interest, and we believe that the removal of these restrictions should be limited to public health campaigns undertaken by public health stakeholders who have no direct commercial interest in the e-cigarette category and not those who are acting on behalf of or funded by commercially interested parties. 14. NICE in its present draft guidance states regarding e-cigarettes, "there is currently little evidence on the long-term benefits or harms of these products". Should there be long-term issues that come to light it would be important to understand where the liabilities might sit for those who may have delivered public health programmes using health/medicinal claims, but are not the manufacturers. We would encourage consideration of where liabilities will lie, i.e. those delivering a public health campaign versus those who manufacture or market the products.	
3.2	BAT, Bluespur, Boots, Cuts Ice, Dr J., ECD, ERC, Fontem, IR, JAC, JTI, Liberro, LF, LSHTM, REHIS, Mr I., NNA, PML, PHE, RCP, SCOTTS, TFA, TSI, UKCTAS, UKVIA, Welsh Gov Mr B., Ms C., Ms D., Mr E., Mr F., Mr G.	**The respondents listed on the left supported the proposed additional text. Significant points made by one or more respondents are as follows:** 1. It would be incongruous if government, state agencies, charities and other not-for-profit groups could not undertake public health campaigns in support of e-cigarettes. Indeed, as both the UK Government has endorsed the use of e-cigarettes as part of their tobacco control strategy, and recently NHS Scotland has stated its support of e-cigarettes as an alternative to smoking there is a need for these organisations to share these views widely among adult consumers. 2. It is important that appropriate provisions are put in place to ensure there is a clear delineation between public health campaigns and brand marketing campaigns. On that basis we would add a provision that confirms that brand/marketing campaigns are subject to existing ASA rules. 3. Agree. Consider that CAP and BCAP are right to make clear their intention not to prohibit brand and product-neutral public health campaigns from including e-cigarettes as an option for existing smokers. 4. E-cigarettes have a significant role to play in encouraging smokers to give up smoking and it is crucial that public health authorities, charities, the industry and non-governmental organisations are able to advertise vaping as a less harmful alternative to cigarettes. 5. According to the latest figures provided by the anti-smoking charity ASH, there are at least 2.9 million vapers in the UK, of whom 1.5 million have stopped smoking completely. There are however, still roughly nine million smokers in the UK. In IBVTA's view, smoking is a personal choice and no one should be forced to stop. At the same time, smokers should be given access to accurate information about significantly less harmful alternative products.	Please see evaluation provided at point 3.1, above.

		6. At present this information is not getting through to smokers. The latest ASH/YouGov survey, this year found that the proportion of smokers who thought vaping was just as, or more harmful than, smoking increased from nine per cent to 22 per cent. 7. It is the opinion of IBVTA that as a direct result of misinformation about vaping, including sensational and inaccurate reporting or over interpreted studies, the public's perception of the risks posed by vaping is being warped, deterring smokers from switching. This is not good news, and something that should be of concern to all those with a genuine interest in public health and choice. 8. In order to challenge misinformation and to promote the health benefits and reduced harm messages relating to vaping, public health organisations, the government, and related bodies such as PHE need to be free to speak and campaign openly. The benefits of this are clear in that it will provide smokers and existing vapers with confidence when it comes to vaping and will lead to more smokers making the choice to switch to vaping.	

A detailed evaluation of questions 4 and 5 has not been included, although the responses to these questions can be seen in respondents' original submissions, published separately. Question 4 was strictly concerned with the wording of text which CAP has subsequently decided not to include in its Code and has therefore not been evaluated. Question 5 invited additional information about CAP and BCAP's consideration of health claims. CAP and BCAP received a range of general information in response to this question, much of which covered similar issues discussed in the main consultation questions and separate evaluation was therefore unnecessary.