ETHICS, PUBLIC HEALTH, AND TOBACCO

Chapter for OUP Handbook on Public Health Ethics, November 2016

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Abstract: This chapter considers normative issues that tobacco raises at the population level, particularly with respect to the anti-smoking strategies policy-makers might pursue and the reasons and justifications underlying these strategies. After setting out several background factors that shape the debate about these questions, the chapter discusses different grounds on which state and public health actors might seek to restrict tobacco use, considering in turn those justifications that focus on protecting smokers and those that seek to protect third parties. The chapter then considers normative problems arising in relation to specific anti-smoking strategies, such as restrictions on the sale, use and marketing of cigarettes, taxation, incentives for cessation and denormalisation strategies.

Keywords: tobacco; smoking; equality; global health; autonomy; paternalism; denormalisation; stigma

Acknowledgements: I would like to thank Joanna Cohen, Nancy Kass and Brendan Saloner for their helpful comments on earlier versions of this chapter.

1 INTRODUCTION

Tobacco control raises many challenging normative questions. This chapter focuses on normative issues that arise at the population level, particularly with respect to the anti-smoking strategies policy-makers might pursue and the reasons and justifications underlying them. Section 2 sets out several background factors that shape the debate about these questions. Section 3 discusses different grounds on which state and public health actors might seek to restrict tobacco consumption. Section 4 considers normative issues arising in relation to specific anti-smoking strategies.

2 BACKGROUND

2.1 Tobacco and its health effects

Tobacco has been identified as the most significant health risk factor in high-income countries and the second leading health risk factor globally, causing an estimated 6.3% of the world's disease burden (Vos et al., 2012). Globally, it causes about five to six million deaths annually (Jha, 2011). For the 21st century, a total of one billion deaths are predicted, with about half of them occurring below the age of 70 (Jha, 2011; Jha and Peto, 2014).

Long-time smokers face significantly increased risks for conditions such as lung and other cancers and heart disease. Significant differences in mortality rates between smokers and never-smokers become apparent from middle age onwards, and the lifespan of long-term smokers is estimated to be 10 to 11 years shorter than that of never-smokers (Doll et al., 2004; Pirie et al., 2013). Smoking has also been linked to a variety of non-fatal conditions,

such as asthma and tuberculosis (ASH, 2015). For heavy, life-long smokers, studies estimate the risk of developing lung cancer over the course of one's life to be up to 25%, compared to 0.2-1% for never-smokers (Brennan et al., 2006). Cessation can mitigate some of these effects: those who quit smoking before the age of 30 have a life expectancy that is almost the same as that of never-smokers (Pirie et al., 2013; Jha et al., 2013).

Tobacco smoke contains a wide range of chemicals, many of which have been identified as posing health risks. Nicotine, because of its addictiveness, is crucial in maintaining smoking behaviours over time (Jarvis, 2004; Benowitz, 2010). As discussed below, questions about the addictiveness of nicotine and its influence on individual autonomy have played an important role in the normative debate. The direct health risks posed by nicotine are less clear, however. While nicotine is toxic, the doses contained in cigarettes traditionally have not been considered problematic in themselves. However, the increasing use of electronic cigarettes has been accompanied by greater attention on nicotine as potentially having problematic health consequences when used long-term (Grana, Benowitz, and Glantz, 2014; for discussion about how nicotine has been viewed within the public health community, especially within the context of electronic cigarettes, see Bell and Keane, 2012).

2.2 Tobacco as a global issue

Across the World Health Organization (WHO) regions, the highest smoking rates can be found in the European Region (29%) while the lowest is in the African region (8%). These figures obscure significant variations by gender. Among men, smoking prevalence is highest (46%) in the Western Pacific Region (which includes countries such as China, Japan,

Australia and Malaysia); for women, it is highest in the European region (20%) (WHO, 2011).[1] Already most of the deaths that tobacco is estimated to cause in the 21st century are expected to occur in low- and middle-income countries (Jha, 2011). Efforts by the tobacco industry to recruit non-smokers in these countries, especially women and adolescents (Gilmore et al., 2015), and increases in smoking rates in many developing countries (Bilano et al., 2015) heighten these concerns. It is crucial, therefore, to approach tobacco as a global issue.

2.3 Inequality: smoking and disadvantage

An important factor for any normative discussion of tobacco is the close link between tobacco and various kinds of disadvantage. First, smoking is associated with poverty, low education, and other indicators of social class and socioeconomic status. As already mentioned, smoking is increasingly common in low- and middle-income countries. Within industrialised countries, smoking rates tend to be higher in low-income and less educated groups. In the UK, for example, the smoking rate in managerial and professional occupations is 16% but reaches 30% in routine and manual occupations (Lader, 2008). In many low- and middle-income countries similar associations between educational level and smoking have been found (Di Cesare et al., 2013). This makes smoking a major contributor to social inequalities in health outcomes; it is estimated that in the UK, it causes about half of the SES difference in death rates (Hiscock et al., 2012).

Research also points to differences in smoking norms across communities. For example, research from deprived neighbourhoods in Scotland suggests that smoking is 'the norm',

that much socialising happens around smoking and that people in these communities overestimate smoking rates (Wiltshire, 2003; MacAskill, 2002; Stead, 2001). This also gives a very different meaning to cessation, which can be experienced as a break from peer group norms (Chamberlain and O'Neill, 2007; MacAskill et al., 2002). A New Zealand study also raised concern about 'smoking islands': communities in which smoking is regarded as a form of resistance to dominant anti-smoking norms (Thompson, Pearce, and Barnett, 2007). Smoking has been associated with additional forms of disadvantage, other than SES, such as sexual and gender minority status (Antin et al., 2015) and poor mental health (Schroeder and Morris, 2010). Finally, social perceptions of smoking and smokers have become increasingly negative (Stuber, Galea, and Link, 2008; Graham, 2011), exposing smokers to negative attitudes, stigmatisation and differential treatment (e.g. non-smoker hiring policies, which exclude smokers from employment; see Voigt, 2012b; Schmidt, Voigt, and Emanuel, 2013; Asch, Muller, and Volpp, 2013; Houle and Siegel, 2009).

These considerations have led many commentators to urge a social justice perspective in connection with tobacco control (Healton and Nelson, 2004; Voigt, 2010; Breton and Sherlaw, 2011). This includes, in particular, a recognition of how socioeconomic inequalities contribute to unequal smoking rates (Voigt, 2010) and, in turn, a debate about the extent to which inequalities that result from unequal smoking rates should be considered a problem of social justice (Roemer, 1993; Segall, 2010). A social justice perspective may also recommend greater sensitivity to the impact of different anti-smoking strategies on different social groups (Breton and Sherlaw, 2011).

3 NORMATIVE GROUNDS FOR GOVERNMENT ATTEMPTS TO REDUCE TOBACCO CONSUMPTION

On what grounds might it be legitimate, or perhaps even required, for governments and state actors to introduce policies to reduce tobacco consumption? This section focuses on two particularly salient goals: protecting smokers and protecting third parties. Throughout, I will also comment on considerations of equality.

3.1 Protecting smokers

While the protection of smokers is often recognised as an important goal in arguments around tobacco control, interference with individuals' choices for their own good is often considered disrespectful of individuals and unduly limiting their freedom. The question of what degree of paternalism might be acceptable in public health is, of course, central to public health ethics. Importantly, paternalistic motivation does not *necessarily* make a policy problematic and further analysis will be required to determine whether or not such a policy is justified, all things considered (Wilson, 2011). Moreover, as proponents of strategies that seek to protect smokers from harm have argued, there may be reason to think that smoking choices are less than fully autonomous, making interference less paternalistic than it might be in the case of other choices. For example, Robert Goodin's argument focuses on the addictiveness of smoking, combined with the often very young age at which smokers become addicted to tobacco, which means that smokers did not make an informed choice about becoming smokers. This, he argues, makes interference with such choices less problematic than other kinds of paternalistic interventions (Goodin, 1989). He also argues that smoking choices often lack endorsement by smokers themselves: while

they, at one level, 'prefer' to smoke, they typically would prefer not to have that preference. Interfering with unendorsed preferences, he argues, and making people act in accordance with those preferences that they themselves endorse (even if they do not currently act on them), is a justified instance of paternalism (Goodin, 1991). More recently, Sarah Conly has argued that the susceptibility of individuals' decision-making to cognitive biases gives us reason to interfere with smoking choices, possibly to the point of a complete ban of cigarettes (Conly, 2012).

These arguments seek, in different ways, to make the paternalism implicit in interfering with smokers' choices more acceptable. Of course, such arguments are going to hold little sway for those who consider it a fundamental right to act in ways that might harm oneself (so long as third parties remain unaffected), even where various factors will detract from fully autonomous decision-making. This raises broader concerns about the legitimacy of government interference with risky choices and behaviours and about the degree of paternalism that might be acceptable in tobacco control (as in other public health contexts) (Flanigan, 2016). Some commentators have sought to establish that smoking choices are more autonomous than is often assumed in the philosophical literature (Shapiro, 1994). A somewhat different approach is to emphasise that even where anti-smoking policies interfere with autonomous choices, the costs of such interference are likely to be outweighed by the health and wellbeing losses that restrictive tobacco policies could avert (Grill and Voigt, 2016). The association of smoking with various forms of disadvantage also suggests that paternalist policies can lead to more egalitarian outcomes: in a context where

individuals are not equally positioned to abstain from smoking, paternalistic policies can help prevent smoking-related inequalities (Voigt, 2015b; Grill and Voigt, 2016).

3.2 Protecting third parties

Many prominent arguments in the tobacco control debate have focused not on the harm to smokers but, instead, on the harms of smoking to third parties. This has especially been the case with respect to arguments for restrictions on where people can smoke, many of which rely on concerns about the risks associated with exposure to environmental tobacco smoke (Colgrove, Bayer, and Bachynski, 2011).

While such arguments can appeal to widely accepted ideas such as the harm principle (roughly, that individuals have the right to harm themselves but not to harm others), they are not straightforward. While many arguments emphasise that there is no risk-free exposure to second-hand smoke (e.g. U.S. Department of Health and Human Services, 2006), this does not by itself establish the case for restrictions. Many activities, such as driving a car, involve risks to others but we generally do not think that any amount of such risks can *by itself* justify restrictive policies; any such justification would involve an assessment of the severity of the risks involved and the benefits derived from the activity. Building the case for smoking bans on the basis of the harms of second-hand smoke must involve an assessment of the harms involved in different contexts (e.g. smoking in cars vs. smoking outdoors), the implications of a ban on smokers and an argument that the harms are sufficiently great to justify restrictions on smokers. Relatedly, it is important to recognise the limitations these arguments face. Not all anti-smoking policies can be justified on the

basis of third-party harms; for example, it has been argued that such arguments are insufficient to establish the case for outdoor smoking bans (Bayer and Bachynski, 2013).

4 ETHICAL ISSUES ARISING IN RELATION TO SPECIFIC STRATEGIES FOR PREVENTING TOBACCO-RELATED HARMS

The preceding sections describe the background against which the debate about normative issues around smoking revolves and also consider some relevant fundamental philosophical questions. This section takes on issues that arise in relation to specific strategies to reduce tobacco consumption (either by encouraging current smokers to smoke less or quit, or by preventing the uptake of smoking by current non-smokers) and/or to protect third parties from the effects of smoking.

4.1 Restrictions on use

Perhaps the most common policy strategy has been to restrict where people are allowed to smoke. While such policies can be driven by concern for third parties who, in the absence of protections, would be exposed to environmental tobacco smoke, they can also pursue the goal of reducing smokers' own risks, as smoking bans can increase smokers' incentives to quit or smoke less. While smoking bans in enclosed public spaces have become the standard in many countries, a recent debate has focused on whether such bans should be extended to open spaces, such as parks and beaches (Colgrove, Bayer, and Bachynski, 2011; Chapman, 2000; Chapman, 2015; Bayer and Bachynski, 2013).

Given the associations between smoking and various form of disadvantage, there have been concerns about how smoking bans might affect particularly vulnerable populations, for

example when smoking is banned in prisons (Butler, 2007) or mental health facilities (Jochelson, 2006). At the same time, this may present an important opportunity to ensure cessation among vulnerable populations, especially when concerns about enforced cessation can be alleviated through cessation aids (Williams, 2008).

4.2 Restrictions on sale

A different set of policies restrict the sale of cigarettes, for example by implementing restrictions on sale to children or sale of individual cigarettes. These policies, which primarily seek to protect children from harms that they may not yet be in a position to fully understand, are generally considered appropriate and ethically uncontroversial. There have also been proposals to make cigarettes available only for those who have previously purchased a smoking licence (Halliday, 2016; Chapman, 2012). Such proposals arguably strike a balanced compromise: On the one hand, they are not overly restrictive and respect people's right to take certain health risks. On the other hand, they help to address concerns that smokers are acting on preferences that are driven by an irrational amount of time discounting (giving too little weight to their future wellbeing relative to immediate pleasures or benefits) and the concern that smoking choices are not endorsed by many smokers themselves. Imposing significant costs before cigarettes can be purchased can make smoking choices more sensitive to the long-term risks of smoking and/or an individual's endorsed preferences about smoking. Licenses do involve a restriction on individuals' liberties but proponents argue that these restrictions are not necessarily greater than they are for other types of interventions, such as taxes (Halliday, 2016).

Perhaps the most radical restriction on sale is to prohibit cigarette sales entirely. While such restrictions were attempted in the US between 1890 and 1927 (Proctor, 2013), the only country to currently ban cigarette sales altogether is Bhutan (Ugen, 2003). In the tobacco control community, the idea of slowly phasing in a complete ban on cigarettes is gaining traction, for example in the form of a 'tobacco-free generation' proposal, where cigarettes will be available only to people born before a certain date, leading, over time, to a situation where no one will be able to legally purchase cigarettes (Berrick, 2013; Walters and Barnsley, 2015; Proctor, 2013; Daynard, 2009; Malone, McDaniel, and Smith, 2014); in 2014, the Tasmanian Parliament debated the introduction of such legislation (Walters and Barnsley, 2015; Berrick, 2013). By allowing current smokers to continue to smoke while at the same time preventing young people from becoming smokers in the first place, such proposals are thought to be less susceptible to illicit markets than a complete ban on tobacco (Walter and Barnsley, 2015). Philosophers, too, have considered such proposals. While for those who insist on the impermissibility of infringing on people's right to smoke, tobacco bans may be overly restrictive, arguments for such bans have been made – on the grounds that smokers' choices are irrational (Conly, 2012), not endorsed by smokers themselves (Goodin, 1991) or because of the wellbeing losses such a ban could avert (Grill and Voigt, 2016).

An important concern is the protection of future generations, for whom an effective tobacco ban would remove the possibility of becoming smokers in the first place. For current generations, however, and in particular current smokers, the impact of these kinds of

proposals on different smokers, both in terms of health and in terms of wellbeing more broadly understood, is an open question. While such a ban could lead to particularly significant gains for the disadvantaged, who, as discussed in section 2.3 above, have significantly higher smoking rates, there is also the concern that the disadvantaged may find cessation particularly difficult and burdensome and that additional strategies must be employed to reduce such burdens (Gostin, 2014; Grill and Voigt, 2016).

4.3 Marketing restrictions

Marketing restrictions focus on how and where tobacco can be marketed. This can include requirements to include health warnings on tobacco packaging and advertisements. Some countries also require so-called graphic warning labels that not only describe particular health risks but provide photographs depicting conditions associated with smoking.[2] Graphic warning labels have been criticised for their potential to contribute to negative and stigmatising perceptions of smokers (Haines-Saah, Bell, and Dennis, 2015).

Other types of marketing restrictions include bans on advertisements on print media, TV and billboards, bans on tobacco companies sponsoring sports teams and 'plain packaging' legislation, which requires all cigarettes to be sold in white packaging, without company logos or brand design. Such restrictions are often seen as crucial in preventing the tobacco industry from glamorising cigarettes and as an extension of more traditional marketing restrictions. The extent to which such restrictions are implemented varies across the world (Eriksen et al., 2015).

Restrictions on marketing are sometimes challenged as a violation of free speech, especially in the US, where commercial speech is given a relatively high level of legal protection (Bayer and Kelly, 2010). How much protection commercial speech should be granted in principle, how concerns for free commercial speech should be weighed against public health concerns and how such questions might be resolved in relation to tobacco marketing in particular, raises complex questions about freedom of expression and the grounds on which this freedom might be restricted. Freedom of expression is generally not considered an absolute right and the case for its protection must be weighed against the costs of such protection. Moreover, commercial speech seems less closely connected to the basic interests that freedom of expression seeks to protect than is the case for many other forms of speech, such as political expression, making restrictions easier to justify (Cohen, 1993). While 'more speech' (e.g. educational messages or social marketing) may seem like an appealing alternative to restrictions, governments cannot match the amount of resources tobacco companies invest into marketing.

Equality considerations can provide another reason for marketing restrictions. Such restrictions can prevent industry activities that target disadvantaged groups, e.g. industry efforts in low-income countries where restrictions on tobacco are low (Brandt, 2007; Gilmore et al., 2015), placing advertising disproportionately in low-income and ethnic minority neighbourhoods (Barbeau et al., 2005; Yerger, Przewoznik, and Malone, 2007) and devising marketing strategies with particular appeal to those on low incomes, the homeless

and those with mental health problems (Apollonio and Malone, 2005; Healton and Nelson, 2004; MacAskill, 2002).

4.4 Price policies and taxation

Tobacco taxation is another way in which governments have sought to reduce tobacco consumption. Taxation has the advantage of providing a disincentive to smoke without being overly restrictive. It has also been recommended as the most cost-effective tobacco control intervention (Shibuya et al., 2003). Taxation, however, raises egalitarian concerns. Proponents argue that taxation is very effective, including – unlike many other interventions – among disadvantaged groups; some studies suggest that it is one of the few interventions that can in fact reduce inequalities in smoking rates (Hill et al., 2014). Thus, while tobacco taxation is a regressive tax, it has also been referred to as 'progressive' public health policy to indicate that it will benefit lower-income groups more than higher-income groups to the extent the former are more sensitive to price changes (Warner, 2000). Such arguments, however, rely on aggregate outcomes and obscure the concern that many people will not be able to quit in response to price increases. These smokers will not see any health benefits from taxation but will end up paying a higher proportion of their income on tobacco (Voigt, 2010).

4.5 Incentives

There has been an increasing interest in incentives as a means to effect changes in health behaviours, including smoking. While some commentators are sceptical of incentives that seek to change more complex behaviours such as smoking (Jochelson, 2007), there has been some evidence to suggest that financial incentives could increase cessation rates

(Volpp et al., 2009). Particular attention has been paid to whether incentives could be effective among disadvantaged groups. Some incentive schemes have targeted disadvantaged populations; for example, a recent scheme offered pregnant women in deprived communities supermarket vouchers for not smoking (Radley et al., 2013). Such schemes also have the advantage of not restricting individuals' options. However, incentive schemes raise problems. Particularly relevant here is the concern that incentives are more accessible for those with better opportunities for quitting, thus creating unfair inequalities (Voigt, 2012a), and that incentive schemes could propagate stigmatising messages about disadvantaged groups (Voigt, 2017; Popay, 2008), for example by reinforcing perceptions that the poor are irresponsible or too weak-willed to quit on their own.

4.6 Cessation aids

Providing assistance for cessation has also been a central tenet of tobacco control. This includes counselling for patients during medical appointments, 'quit lines' and cessation aids such as nicotine patches and gums and other medications. There is also an ongoing and highly polarised debate about electronic cigarettes, which deliver nicotine in the form of a vapour and is seen by some experts as a possible cessation device (though the evidence on this is as yet uncertain) (for discussion of some of the normative issues around electronic cigarettes, see van der Eikjk, 2016; Voigt, 2015a).

Cessation aids could be particularly important also because of unequal cessation rates across different social groups: even though the desire to quit and the number of cessation attempts is similar across different social groups, people from lower income groups are less

likely to succeed (Kotz and West, 2009). One normative question here is whether cessation aids should be provided for free or at highly reduced cost – perhaps only to disadvantaged smokers (Healton and Nelson, 2004), or for all smokers as is the case in the UK – so as to address financial barriers to their use.

4.7 Education and cessation advice

Education campaigns seek to underscore the risks of smoking and provide information and advice on cessation. Such campaigns may seem innocuous because they do not involve restrictions on individuals' liberties. Moreover, there are concerns that lower-income and less educated groups may not be as well informed about the risks as higher-income groups, both in industrialised (Stein et al., 2007; Rutten et al., 2008) and developing countries (Abdullah and Husten, 2004; Jha and Chaloupka, 1999). Education campaigns could help close these knowledge gaps. At the same time, however, not all education campaigns are equally well placed to benefit smokers from low SES backgrounds and may, therefore, contribute to unequal quit rates among different social groups (Niederdeppe et al., 2008).

4.8 Denormalisation and stigma

Many campaigns go beyond the provision of information and aim to 'denormalise' smoking, that is, they seek to shape social norms around smoking and/or perceptions of smokers, particularly in relation to perceptions about how common and how desirable smoking is (Lavack, 2001). Different kinds of interventions may (advertently or inadvertently) further denormalisation, including several of those already discussed here, such as marketing restrictions, public health messages that depict smoking as disgusting or irresponsible, and smoking bans that make smoking less visible and communicate to smokers that their

smoking is socially unacceptable (Voigt, 2013). The rationale of denormalisation strategies is primarily to motivate smokers to quit by making its social perception increasingly negative (Kim and Shanahan, 2003).

Denormalisation is considered by many a crucial factor in the significant reductions in smoking rates seen over the past few decades and, therefore, a central component of comprehensive tobacco control strategies. While there have been attempts to support claims about the effectiveness of denormalisation in bringing down smoking rates (Hammond et al., 2006; Kim and Shanahan, 2003; Alamar and Glantz, 2006), the complexity of the mechanisms involved makes this hypothesis difficult to test empirically.

At the same time, many commentators have worried that denormalisation strategies stigmatise smokers (Kim and Shanahan, 2003; Bell et al., 2010a; Bell et al., 2010b). Such stigmatisation may violate principles of equal and respectful treatment and thus be problematic in itself (Voigt, 2015a). It may also have negative effects on those stigmatised, for example by making them more secretive about their smoking, thus losing out on cessation advice and support (Stuber and Galea, 2009). These concerns are compounded by the fact that smoking is increasingly associated with other kinds of stigmatised characteristics, such as poverty and poor mental health. While for some commentators, these implications mean that stigmatising forms of denormalisation are wholly unacceptable, it has also been argued that, at least in principle, the negative effects of stigmatisation could be outweighed by the health gains to which it could lead (Bayer, 2008).

A related denormalisation approach targets the tobacco industry (Lavack, 2001; Thrasher et al., 2006). Tobacco industry denormalisation approaches have been employed, for example, in the 'Truth' campaign, which sought to highlight the tobacco industry's reliance on deception regarding the health risks associated with smoking (Healton, 2001). Such campaigns avoid some of the problematic aspects of denormalisation campaigns by shifting the focus away from smokers towards corporate actors (Voigt, 2013).

5 CONCLUSION

This chapter began by highlighting several features of tobacco that should inform the discussion of tobacco as a public health issue. It then discussed some of the normative grounds on which state actors might seek to reduce smoking rates and normative concerns about particular anti-smoking strategies.

To what extent can a discussion of the normative issues around tobacco control be instructive for other areas of public health? Because tobacco has been recognised as a health problem for longer than other health risk factors, such as poor nutrition and lack of physical exercise, and because of the success of policy interventions in achieving substantial reductions in smoking rates, there are attempts to apply insights from tobacco to other public health concerns. By the same token, arguments in support of restrictive policy approaches to tobacco are often seen as the beginning of a slippery slope that ends with bans on other potentially harmful substances, such as sugar or fatty foods. However, it is

important to resist the urge to apply normative arguments made in the context of tobacco to other health problems without considering the combination of features that distinguish tobacco from other substances – in particular the addictiveness of nicotine, the very significant risks for long-term users and the disproportionately high smoking rates among the disadvantaged. While many normative problems surrounding tobacco are also highly relevant to other health risk factors, it is crucial that the arguments be made on their own terms and in light of the specific characteristics of the risk factor in question. While the normative debate about tobacco can be instructive in many ways, it does not permit straightforward conclusions about other public health issues and the strategies it is permissible or desirable to use to address them.

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[1] A map indicating which countries belong to particular WHO regions can be found at http://www.who.int/about/regions/en/index.html.

[2] See, for example, the photographs used in Canada: http://www.smoke-free.ca/warnings/canada-warnings.htm