This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

Action on Smoking and Health (ASH)

Introduction

ASH is a health campaigning charity working to eliminate the harm caused by smoking, which was set up by the Royal College of Physicians in 1971.

ASH's response to the Nuffield Council's consultation on public health focuses primarily on smoking. In addition to replying to the questions set out in the consultation document we have included a section on harm reduction as this is an issue that will become increasingly relevant to tobacco control in the future.

Q1. Definition of Public Health

ASH broadly agrees with the proposed definition of public health, that is: "What we, as a society, collectively do to assure the conditions for people to be healthy." What is particularly significant about this definition is that it extends the responsibility for public health to everyone, rather than something imposed on a given population by those in positions of authority.

Q.2 Factors that influence public health

We accept that the main influences affecting public health are: the environment, social and economic factors, lifestyle, genetic background, preventative and curative health services. Although it is difficult to put these into order of importance, we would argue that in most cases social and economic factors are likely to be more important than genetics or the environment.

Other factors: Politics can play an important role. For example conservative administrations are generally less likely to favour Government-led interventions on public health and be more in favour of a market-led approach. There is good evidence, both from this country and from other countries such as the United States[i] and Australia, that government intervention can be effective in promoting public health when it comes to smoking.

Q.6 Smoking

(1) *The effects of smoking on health have been known for a very long time. Comprehensive measures by Governments to prevent harm to the population are relatively recent. In your view, what are the reasons for this delayed response? Are there any lessons that can be learned from other countries, or from strategies pursued in other areas of public health?*

ASH response:

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

The delayed response by Governments in relation to smoking is in part due to the well-funded lobbying activities of the tobacco industry which continues to this day. One example is that of tobacco advertising. In response to threats by the UK Government to ban tobacco advertising in the 1960s, the industry responded by persuading the Government to accept a voluntary agreement which allowed the industry to continue marketing its products, albeit in a progressively more restricted way, for a further 30 years. Recent examples of industry attempts to overturn tobacco control policy include the legal challenge to the European Union directive on tobacco advertising and the challenge to the tobacco point of sale regulations.

Key lessons to be learned from this experience are that the Government must not bow to pressure from commercial interests that undermine public health goals. Most countries with strong tobacco control policies have had to defend their actions, sometimes in courts of law, against intense tobacco industry lobbying.

Even where the tobacco industry is not directly involved in a public policy issue, or where their lobbying is not particularly effective, Governments may still be nervous of the political impact of public health reforms. In the UK, the Labour Government made persistent efforts to find a "compromise" solution to the issue of smoking in enclosed public places, which required a determined campaign by civil society to overcome. This related to nervousness about the Government being perceived as supporting a "nanny state", to possible alienation of Labour-supporting smokers, and was also a response to commercial interests not directly related to the tobacco industry but affected by any legislation, particularly pubs and licensed clubs.

It may be, however, that as the proportion of smokers declines in the general population it will become easier for Governments to take more radical policy initiatives. The hope is that this may create positive feedback – fewer smokers leading to less perceived opposition to further reforms, leading to fewer smokers. The objective must be gradually to reach an end point where smoking is no longer seen as a socially acceptable activity for adults.

(2). *What are the responsibilities of companies that make or sell products containing hazardous substances, such as nicotine, that can be addictive? Should they be prosecuted for damaging public health or required to contribute to costs for treatments?*

ASH response:

Tobacco smoking causes the deaths of some 5 million people worldwide[ii] and around 114,000 in the UK every year.[iii]. Any other industry producing a product that killed half of all its life-long customers would be fined, ordered to stop producing the product and put of out business. That tobacco companies have escaped such a fate is largely due to historical accident, i.e. the fact that cigarette smoking had become so widespread before the dangers of smoking were fully understood. In addition, from the mid 1950s onwards, the industry employed skilled PR and legal staff to defend its essentially indefensible position as the producer of a deadly consumer product.

Furthermore it took many years to discover that the tobacco companies knew of the health risks, but deliberately chose to hide the fact and continued to produce cigarettes in the full knowledge that they were hazardous to health. Ethically there is a case for arguing that the tobacco companies should be punished for knowingly producing and promoting a product that kills so many of its customers. This policy has been pursued in the USA with mixed results. Litigation has some merit, if only to act as a "truth machine" to reveal the extent of the misbehaviour through the disclosure of internal industry documents. However, it is costly and depending on the legal system, may not be a realistic way of changing corporate behaviour.

Requiring tobacco companies to pay for the cost of treating people with smoking-induced diseases has also been pursued through the US courts where some individuals have been successfully awarded damages against tobacco companies. The attraction of this policy is that it gives the semblance of justice being seen to be done. However, unlike the USA (where the legal system facilitates the pursuit of punitive damages) in other jurisdictions it is much more difficult to successfully sue tobacco companies.

There may be other means of extracting payments from the industry, e.g. through hypothecated taxes which could be diverted to a specific health fund for the treatment of smoking-induced disease. However, this would be hard to achieve in practice, given that HM Treasury is not in favour of hypothecation in principle, and experience from the US suggests that it may not have the desired outcome. Nonetheless, it is absolutely proper – and necessary – that a high and rising level of taxation be imposed on tobacco products, since this is known to be an effective means of encouraging people to quit.

A more realistic option than hypothecated taxes is to press for greater regulation of the industry in order to set minimum standards for all tobacco products and to work towards reducing the harm caused by tobacco. See section below on harm reduction.

(3) *Should smokers be entitled to higher than average resources from the public healthcare system, or should they be asked for increased contributions? Would similar charges be justified for other groups of people who deliberately or negligently increase their chances of requiring public health resources, such as people engaging in adventure sports?*

ASH response:

It is already the case that smokers are getting higher than average resources from the public healthcare system because smoking is a key factor in the onset of so many diseases. [iv] Smokers are victims of an aggressive marketing policy by a callous industry. Very few people take up smoking as adults: more than 80% of people start to smoke before the age of 18, largely due to external pressures. By the time people who smoke are in a position to make a reasoned judgment about their habit, they are addicted to nicotine and their capacity for rationale judgment is compromised. Therefore it is unfair to argue that smokers are acting negligently or that they should be penalised for their addiction. To charge smokers more because of their higher than average use of the public health care system would be unjust. If such a policy were to be adopted it would be hard not to argue for a similar policy to be adopted for other substance abuse such as illegal drugs or alcohol. The National Health Service is a universal health care system open to all, whatever lifestyles people adopt, and should remain so.

Notwithstanding the basic principle of free-access to the public healthcare system, because smoking is a contributory factor in more than fifty diseases or disorders, smokers seeking treatment are likely to be advised to stop smoking as a condition of undergoing surgery and to assist in post-operative healing. In such cases, people who smoke have an obligation to try to quit smoking. This is because there are inevitable costs, and cost-effectiveness issues to be taken into account. In some cases it may actually be ineffective to treat smokers while they carry on smoking. Therefore, in individual cases, rather than as a matter of policy, clinicians may be entirely justified in withholding treatment from a smoker if their smoking is likely to reduce the chances of successful treatment.

(4) *Smokers argue that they choose to smoke. What rights does the state have to impose sanctions to prevent them from smoking? Does the state have the right to prevent the sale of tobacco, which is known to be addictive and highly dangerous? How vigorously is it reasonable for the state to act to prevent children and teenagers from smoking?*

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

ASH response:

Although many smokers argue that they 'choose' to smoke in practice most are addicted to nicotine and therefore their real choice is compromised. The state has a duty to educate people about the dangers of smoking; to help people who wish to stop smoking; and to take the necessary steps to deter children from starting to smoke. Measures such as the forthcoming ban on smoking in public places will undoubtedly reduce the incidence of smoking as people will be prevented from lighting up in enclosed public places. However, the basic right for adults to smoke (in a private place or where the smoke is not going to affect other people) still remains.

There is little doubt that, if cigarettes were invented today, they would never be permitted for sale. Tobacco certainly does more damage to health than recreational drugs that are currently illegal. Theoretically, it could be argued that the state would be acting in the interests of public health by legislating to end all sales of such a noxious substance. However, the reality is that in the UK alone some 12 million people are regular users of tobacco.[v] Therefore it is not feasible to ban the sale of tobacco and lessons can be learned from the failure of the prohibition of alcohol in the USA in the 1920s. It can in fact be argued that tobacco control measures through tax and regulation are only possible because tobacco is a legal product. In the UK, smoking rates have fallen gradually over fifty years – there is no evidence that consumption of illegal drugs (which can only be regulated through attempts to enforce bans on production, sale and consumption) has fallen over the same period, if anything the evidence suggests the reverse.

Although adults should be allowed to continue to use tobacco, there is a moral case for having measures in place to discourage use amongst children. In fact the best way to deter use is to implement tobacco control measures that apply to the whole population such as the ban on smoking in public places and the ban on tobacco advertising. Enforcement of the law to stop the sale of tobacco to minors is also justified but the wider population-based measures are more likely to help reduce youth smoking than child-orientated policies.

Essentially, tobacco control policy must be applied in the context of tobacco being a legal product, which adults have the freedom to consume. This is qualified to some degree because smoking is a fostered addiction – large companies deliberately attempt to addict consumers and make it as difficult as possible for them to quit their habit. This justifies measures such as advertising bans and high taxation which in the case of other products might be held to offend liberal principles. Also, any right of people to smoke can only properly be exercised where it does not harm the health of others, which justifies legal interventions such as ending smoking in enclosed public places.

Harm Reduction

The concept of harm reduction has been well established for many years in the area of illegal drugs but is still the matter of some debate within the field of tobacco control.

Currently tobacco smoking kills around 114,000 people a year in the UK and half of all lifelong smokers die from diseases caused by their smoking.[vi] For every death from smoking another 20 smokers are suffering from smoking-related diseases.[vii] There is a common misconception that nicotine is harmful but it is the tobacco smoke that kills people not the nicotine. However, it is nicotine that causes addiction. Therefore if less hazardous means of delivering nicotine could be developed to satisfy smokers' cravings for nicotine without the attendant health risks caused by smoking, the public health benefits would be considerable.

Indeed, the public health goal is to reduce death and disease, not to reduce smoking prevalence as an end in itself. A harm reduction strategy is required which would give

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.
smokers access to less harmful forms of nicotine in a form and at a price that is attractive as an alternative to smoking. A switch of only 1% of the population a year from smoking to less harmful nicotine sources, a conservative target, would save around 60,000 lives[viii] in only 10 years.

For example, smokeless tobacco is from around 10 to 1,000 times less hazardous than smoking, depending on the product[ix] [x]. However, currently one of the safest forms of smokeless tobacco, snus[xi] [xii] [xiii], (a specific type of oral snuff), is banned in the EU except for a derogation for Sweden. There is convincing evidence that the use of snus in Sweden can reduce the risk of people starting smoking [xiv] [xv] [xvi]. There is also growing evidence that the use of snus in Sweden can help smokers to give up smoking .

To implement an effective harm reduction strategy would require revision of the current regulatory system in the UK and Europe. The current system of regulation in the EU is illogical: tobacco is banned if it is designed to be sucked (as in the case of Swedish snus) but not if it is intended to be smoked or chewed.[xvii] There is no precedent for banning the less hazardous variant of a product and keeping the most dangerous on the market.

What are needed are consistent single market rules that would regulate product standards and marketing for all non-smoked tobacco products, not simply legalise Swedish snus. The EU ban on snus is under review. [xviii] Until now the UK has supported the ban, the time has come for this support to be reassessed.

In contrast, medicinal nicotine is only licensed for smoking cessation, not for longer-term maintenance use. It is regulated in the UK by the Medicines and Healthcare Regulatory Authority (MHRA). The Secretary of State for Health and Chief Medical Officer should collaborate with the MHRA to produce an integrated approach to regulation of all low harm nicotine products.

A revised regulatory system would encourage the development and sale of new, low harm nicotine products and ensure that all such products were subject to a common regulatory regime. This would give people the choice, not now available to them, to use products many hundreds, if not thousands, of times less hazardous than cigarettes, so saving lives and significantly reducing the costs of the health service.

This would lead to reductions in morbidity as well as mortality, leading to significant immediate as well as longer-term savings to the health service. This would include, for example, reductions in time spent in hospital following operations[xix], fewer premature and low birth weight babies, and fewer heart attacks, strokes[xx] , cases of respiratory disease and cancer.

This is also a key issue of social justice, as there is a strong relationship between smoking prevalence and social class. In social class 1 around 15% of men and 14% of women smoke cigarettes[xxi]. In social class 5 smoking prevalence reaches 45% for men and 33% for women. Amongst men smoking accounts for over half the difference in risk of premature death between the social classes. For certain subsections of the population smoking rates are even higher, Studies of smoking rates among lone parents in receipt of social security benefits have found smoking levels in excess of 75%[xxii]. Smoking rates amongst Big Issue vendors have been found to be over 90%[xxiii] and smoking prevalence among prisoners is estimated to be over 80%.[xxiv] Studies have shown smoking rates to be as high as 80% amongst people with a diagnosis of schizophrenia and people with depression are more likely to smoke and have difficulty giving up.[xxv]

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

References

[i] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999.

[ii] The World Health Report 2003. World Health Organization, 2003.

[iii] Peto, R. et al Mortality from smoking in developed countries 1950-2000 (2nd edition) Oxford University Press, Oxford.

[iv] http://www.ash.org.uk/html/factsheets/html/fact02.html

[v] General Household Survey 2003; mid-2003 population estimates: Great Britain, ONS, 2004

[vi] Peto R. Mortality in relation to smoking: 40 years' observations on male British doctors. BMJ 1994; 309: 901-911

[vii] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5425a1.htm
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5235a4.htm

[viii] Lewis S, Arnott D, Godfrey C, Britton J. Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? Tobacco Control 2005;14:251-254

[ix] Protecting smokers, saving lives: The case for a tobacco and nicotine regulatory authority Prepared by the Tobacco Advisory Group of the Royal College of Physicians, December 2002

[x] Cogliano et al . Smokeless tobacco and tobacco-related nitrosamines. Lancet Oncology 2004; 5; 708

[xi] Asplund, K. Smokeless Tobacco and cardiovascular disease. Prog. Cardiovasc. Dis. 2003 45:383-394.

[xii] Levy, DT, Mumford EA, Cummings KM, Gilpin, EA, Giovino, G, Hyland, A, Sweanor, D, Warner, KE. The relative risks of a low-nitrosamine smokeless tobacco product compared with smoking cigarettes: Estimates of a panel of experts. Addictive Behaviour 2005.

[xiii] National Board of Health and Social Welfare. Folkshalsorapport 2005 (Public Health Report 2005).

[xiv] Furberg H, Bulik C, Lerman C, et al. Is Swedish snus associated with smoking initiation or smoking cessation? *Tob Control*.2005; 14:422-424.

[xv] Rodu B, Nasic S, Cole P. Tobacco use among Swedish schoolchildren. *Tob Control* 2005; **14**:405-408.

[xvi] Ramstrom L, Foulds J. (in press). The role of snus in initiation and cessation of tobacco smoking in Sweden. Tobacco Control.

[xvii] The ban was introduced in Council Directive 92/41/EEC (ban on oral tobacco) and is implemented in England by UK Statutory Instrument 1992 No 3134 as The Tobacco for Oral Use (Safety) Regulations 1992 to prevent the American product Skoal Bandits from entering the market prior to the advertising ban as there was concern it would be marketed to children. However, the advertising ban ensures marketing to underage and new users can be severely limited.

[xviii] This is reviewed every two years under Article 11 of Directive 2001/37/EC.

[xix] Choosing Health: Making Healthy choices easier. Public Health White Paper. 16th November, 2004. Cm 6374.

[xx] Modelling the short term consequences of smoking cessation in England on the hospitalisation rates for acute myocardial infarction and stroke. Naidoo B, Stevens W and McPherson K. Tobacco Control 2000; 9; 397-400 doi:10.1136/tc.9.4.397

[xxi] The data in this section is taken from Smoking and Health Inequalities, a joint publication by ASH and the Health Development Agency, 2001.

[xxii] Marsh A and McKay S (1994) Poor Smokers. London: Policy Studies Institute

[xxiii] Big Issue (2002). Coming up from the Streets: What Big Issue Vendors Need to Escape Homelessness. Vendor Survey October 2002. Cardiff: The Big Issue Cymru

[xxiv] Department of Health (2004) Choosing Health: Making Healthy Choices Easier. London: Department of Health

[xxv] McNeill A (2001) Smoking and Mental Health: a Review of the Literature. London: Smokefree London