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Imperial Tobacco Group

Imperial Tobacco makes the following invited submission to the Nuffield Council on Bioethics consultation on *"Public Health: Ethical Issues"*. The submission is in two parts; firstly, a discussion of the principles involved from our perspective and secondly, responses to the individual questions raised in the consultation document. We request that both are considered together.

1. Discussion of Principles

> *"…the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty or action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him or visiting him with any evil in case he do otherwise."*
>
> John Stuart Mill, "On Liberty", 1859

1.1 Adult choice

Imperial Tobacco agrees with the principle that adults are free to make their own choices subject to minimal and justifiable constraints. The onus should be firmly on those who seek to limit adult freedom of choice to justify their attempts beyond a simple *ipse dixit,* an unproven assertion or a populist exercise of power.

Adults choose to smoke because smoking provides a pleasurable and frequently socially enjoyable experience. It is neither legally nor ethically sufficient to prevent smokers from exercising this fundamental freedom of choice because others either may not choose to smoke or may not like smoking. Nor is it sufficient on those grounds to impose an adverse penalty on those adult smokers who choose to smoke.

There are two common objections to the principle of adults exercising choice in smoking: the first relates to children; the second to addiction of smokers.

1.1.1 Children and Smoking

Imperial Tobacco believes that the decision to smoke is a choice for adults. We do not want children to smoke.

Underage smoking is an issue for society as a whole to work together to resolve, recognising that different societies or sections within society may have different cultural approaches to the matter. We play our part by not directing the marketing of our products to anyone under the age of 18. We adhere strictly to relevant national regulations, we operate a stringent voluntary marketing code across our business (appendix A), and we support governments and the retail trade with a range of programmes designed to discourage the sale of tobacco products to children.

We believe that smokers should show courtesy to other adults when smoking, and that this courtesy should be extended to children who are often unable to exercise choice in their environment and surroundings in the way that adults can.

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1.1.2 Addiction

Imperial Tobacco agrees that smoking can be characterised as addictive as the term is commonly used today. Some people may find it difficult to stop smoking, but we believe it is important for them to understand that they are able to do so. Millions of people have stopped smoking; the majority without assistance.

In examining the expert evidence on addiction in the case in the Scottish High Court of McTear v Imperial Tobacco, the Rt Hon Lord Nimmo Smith made judgement in May 2005 as follows:

> *"I am prepared to accept that Mr McTear found it difficult to wean himself off his habit once he had started smoking and in that sense could be described as addicted. I do not accept that he was for this reason unable to stop smoking[1].*
>
> *"The fact that smokers such as Mr McTear may find it difficult to give up does not appear to me to deprive them of the element of free will which is fundamental to the individualist philosophy of the common law"[2]*

We believe that freedom of adult choice is not diminished by smoking tobacco products.

1.1.3 Risks

The risks associated with smoking are well known. As a result, exercising an adult choice to smoke is making an informed choice. While others may not agree with such a choice, it is our view that this is not sufficient to prevent an informed adult from making this choice.

On 30 January 1964, in a parliamentary reply to a question about smoking and young people, the then UK Prime Minister, Sir Alec Douglas Home, asserted:

> *"I do not think there is any excuse for anyone not to know the connection between smoking and lung cancer"[3]*

In the McTear judgement, Lord Nimmo Smith stated:

> *"I am satisfied that at all material times, and in particular by 1964, the general public in the United Kingdom, including smokers and potential smokers, were well aware of the health risks associated with smoking, and in particular of the view that smoking could cause lung cancer."[4]*
>
> *There is no breach of duty of care on the part of a manufacturer, if a consumer of the manufacturer's product is harmed by the product, but the consumer knew of the product's potential for causing harm prior to consumption of it. The individual is well enough served if he is given such information as a normally intelligent person would include in his assessment of how he wishes to conduct his life, thus putting him in the position of making an informed choice[5]"*

We support sound, reasonable and practicable regulation of tobacco products. We recognise that it is the role of governments to provide the general public with clear and consistent messages about the health risks to smokers that are associated with their smoking. We do not challenge those messages.

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[1] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 9.3
[2] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 6.207
[3] Hansard, 1963-64, Vol. 683, col. 528
[4] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 9.4
[5] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 9.11

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However, more recent regulatory proposals are not designed to add to consumer knowledge but to coerce or to prevent adult consumers from exercising their informed choice. For example, we do not believe that the use of graphic pictorial heath warnings is necessary. We disagree with their use, particularly as they make no overall contribution to the public awareness of the risks associated with smoking, which we believe are already well known. It is our view that such warnings are designed to shock and to stigmatise smokers, who exercise their freedom to choose to smoke.

1.2 Constraints on adult choice

In his 2004 final report *"Securing Good Health for the Whole Population"*, Dereck Wanless (the former Group Chief Executive of NatWest) asserted:

> "Individuals are, and must remain, primarily responsible for decisions about their and their children's personal health and lifestyle. Individuals must be free to make their own choices about their own lifestyles. They are generally the best judges of their own health and happiness; people differ significantly in their preferences and their situations in life. But this does not remove the duties on government and many organisations in society, including businesses, to help individuals make better decisions about their health and welfare. Significant failures in how decisions are made can lead to individuals inadvertently making choices that are bad both for themselves and society. Therefore, to promote improved health outcomes and to reduce health inequalities, the government and other bodies need to act to reduce these failures and assist individuals to make better decisions.[6]
>
> "…for good decisions to be made both for the individual and society as a whole, it is important that:
> - The individual is fully informed about all possible options, and their consequences;
> - The individual is forced to take all the consequences of a decision (including those that affect others) into account;
> - The social context within which individuals make decisions is conducive to making good choices; and
> - Opportunities exist for individuals to engage fully in the management of their health and general welfare; regardless of their background and circumstances."[7]

We agree that in general matters of public health, some individuals may require support in their decision making, but this should be achieved in ways which are educative and enabling, rather than disproportionate, coercive or discriminatory. In the case of smoking, we believe that the risks are already well-known, and have been so for more than a generation.

One main barrier to be overcome is the generally poor understanding of the concept of risk in society. This opens the way for sensationalism or coercive publicity and leads to disproportionate responses. For example, the media may report a doubling of risk as a shocking story when the risks involved may be mathematically minute and unlikely to affect an individual who sees the story.

1.2.1 Hazard, Risk and Dread

The science of toxicology has developed standard ways of defining potential hazards to heath and assessing the risk to health that these present. Mathematical risk assessments are conducted routinely on many types of product, from food to floor cleaning materials. These risk assessments follow the form that RISK = HAZARD x EXPOSURE, where the hazard is determined generally by the lowest No Observed Adverse Effect Level (NOAEL) in a series of biological tests conducted to maximise the potential for adverse effects. A Margin of Safety (commonly 10 or 100 fold) is usually

[6] Wanless D (2004) Securing Good Health for the Whole Population HMSO section 7.3
[7] Wanless D (2004) Securing Good Health for the Whole Population HMSO section 7.5

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incorporated to reflect the nature of the toxicity endpoints observed and the applicability of the hazard data to humans.

Controlling exposure to low quantities of any material is a simple way to reduce the risk to humans presented by that material. Therefore a concern about the effects on human health of the potent carcinogen aflatoxin might lead to eating fewer peanuts, a common source of aflatoxin.

Such considerations are used in the regulation of many consumer products and the health warnings they display.

The recent House of Lords' Select Committee on Economic Affairs report on *"Government Policy on the Management of Risk"* (published 7th June 2006) pointed out :

> *"Most of the things we do have uncertain outcomes and risk is necessarily an inherent feature of life…Perceptions of risk by the public clearly have a potentially important impact in a policy environment that rightly aims to be responsive to public concerns over safety…In this context, it is worth noting that excessive risk aversion in the formulation of policy, which, if it exists, has been attributed to the pressure arising from public perceptions or the media, may also stem from single interest lobbying groups or indeed from government itself…"*[8]

Sir Kenneth Calman, a former UK Chief Medical Officer, has pointed out :

> *"In understanding issues surrounding risk assessment, perception is a key aspect of understanding patient and public choice…"*
>
> *"This leads to one of the major issues facing those who make decisions about public health: the relation between the science base, the knowledge available, the evidence accumulated, and the public policy which derives from them. This can be extraordinarily difficult, and the costs of taking action based on minimal evidence or simply on the basis of a proposed hypothesis can be very considerable indeed…"*
>
> *"The public should have a right to as much information as is available, but people also have to recognise that this information may not be complete and that it may not be possible to provide further information on a particular issue without more work, resources and, in particular, time. Nevertheless, individuals need to make choices, and the individual perception of risk is important"* [9].

In a later paper[10] Sir Kenneth went on to propose a scale for assessing relative risks by their relationship with those encountered in everyday life. The approach did not clearly differentiate between acute and chronic risk: for example, how does the risk of death from overdose of paracetamol relate to the risk of its daily use in low dose as a pain killer, and how should that be reflected in the way the product is regulated? In the example of smoking, the practice is sometimes treated as if it were at risk of the acute poisoning type, when, in fact, the risks are associated with chronic exposure over a number of years.

There is a significant emotional overlay placed on the dispassionate scientific calculation by consumers when certain disease end-points are potentially involved. Cancer is a case in point. Mathematical Risk is effectively replaced by emotional Dread and real but distorted perceptions result.

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[8] House of Lords' Select Committee on Economic Affairs 5th Report of Session 2005-06 p6 sections 4, 6,8
[9] Calman K C (1996) British Medical Journal 313: 799-802
[10] Calman K C (1997) British Medical Journal 315:939-942

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Such considerations lead to political or overcautious judgements and to measures beyond the proportionate response that the data warrants. These in turn lead to undue or disproportionate constraints on an adult's freedom to choose.

Such emotional judgements may also lead to coercive approaches to their enforcement. The example of the UK government's approach to Environmental Tobacco Smoke (ETS) and the resultant UK regulation of smoking in public places follows.

1.2.2 Science and proportionality – ETS

Imperial Tobacco recognises that other people's tobacco smoke can be unpleasant or annoying, and can raise concerns leading to calls to ban smoking. However, it is our view that the scientific evidence taken as a whole, is insufficient to establish that other people's tobacco smoke is a cause of any disease.

We have reached this conclusion based on a proper assessment of the opinions of experts and made this information available to the UK House of Lords' Select Committee on Economic Affairs, which considered the issue (which they termed "passive smoking") in their enquiry into *Government Policy on the Management of Risk*.

Our summary evidence (appendix A) concluded:

> *"It is Imperial Tobacco's view that regulation should be a proportionate response to risk. Properly analysed and understood, the scientific and statistical evidence on ETS leads to the conclusion that a ban on smoking in public places cannot be justified on health grounds."*[11]

In his evidence to the Committee, Sir Richard Peto, an expert on statistical epidemiology, independently commented on the size of the risk posed by environmental tobacco smoke:

> *"…the point is that these risks are small and difficult to measure directly…The exposure that one would get when breathing other people's smoke obviously depends on the circumstances, but even heavy exposure would be something like one per cent of what a smoker gets, maybe in other circumstances 0.1 per cent, so you would expect that if there was proportionality to get something up to about 20 per cent excess [risk]. This is what you see in the average of all studies, and people have pointed to the uncertainties in this evidence…"*[12]

The Committee called on the UK Government to pay more attention to the risks to personal liberty posed by new legislation on smoking in public places and argued:

> *"Given the evidence about the impact of passive smoking, we are concerned that the decision to ban smoking in public places may represent a disproportionate response to a relatively minor health concern."*[13]

The Committee went on to conclude:

> *"In particular, the purpose of legislation should have been defined more clearly and greater attention should have been given to available scientific evidence, the relative merits of alternative policy options and the impact of legislation on personal freedom and choice. Failure to consider these matters properly has resulted in the introduction of a policy that appears to demonstrate a disproportionate response to the problem.*[14]*"*

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[11] Imperial Tobacco submission to House of Lords Economic Affairs Committee – Appendix A p6
[12] House of Lords' Select Committee on Economic Affairs 5th Report of Session 2005-06 p143
[13] House of Lords' Select Committee on Economic Affairs 5th Report of Session 2005-06 section 78
[14] House of Lords' Select Committee on Economic Affairs 5th Report of Session 2005-06 Section 84

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We believe that concerns about smoking in public places can be resolved through common sense and courtesy, and by introducing practical solutions such as well ventilated smoking and no-smoking areas into workplaces, restaurants and other public places.

The case to limit an adult's opportunity to exercise freedom of choice in this regard has not been proved.

1.2.3 Precautionary Principle

There are occasions when little is known about the possible effects on human health of a material and some prudence is called for before such information is available. These considerations gave rise to the "precautionary principle"[15].

This is not a legal principle. It is a principle applied increasingly widely by public health bodies and regulators, including the European Commission. Put simply, the principle as it has come to be understood suggests that where there is doubt about the safety of a product or an ingredient or component food stuff, consumer product, environmental emission etc then it should not be used or should be removed. It is an approach to avoid public health risks by erring on the side of caution.

However, the European Commission[16] states that measures based on the precautionary principle should be;

1. proportionate to the chosen level of protection;
2. non-discriminatory in their application;
3. consistent with similar measures already taken;
4. based on an examination of the potential benefits and costs of action or lack of action;
5. subject to review, in the light of new scientific data; and
6. capable of assigning responsibility for producing the scientific evidence necessary for a more comprehensive risk assessment.

The principle appears to be being used with alarming regularity to bolster general risk-aversion.

> *"The precautionary principle undermines legal certainty by providing bureaucrats with an excuse to change the rules of the game in an essentially arbitrary manner…Attempts to redefine the precautionary principle have done little more than restate the views of interest groups and regulators whose antipathy towards the development of new technologies was already well known."*[17]

Imperial Tobacco shares the concerns of the House of Lords Economic Affairs Committee, which stated:

> *"We are concerned that regulatory requirements concerning risk appear to rely heavily on a range of concepts – such as As Low As Reasonably Practicable (ALARP), Gross Disproportion, Societal Concerns and the Precautionary Principle – which may not be sufficiently well-defined to enable the framing of useful operational guidelines. The danger inherent in the use of such ambiguous concepts is that they may encourage excessively risk-averse responses from policy-makers."*[18]

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[15] See Morris J Ed. (2000) "*Rethinking Risk and the Precautonary Principle"*Butterwoth-Heinemann, Oxford
[16] Communication from the Commission on the Precautionary Principle (2nd February 2000) COM(2000)1
[17] Morris J Ed. (2000) "*Rethinking Risk and the Precautonary Principle"*Butterwoth-Heinemann, Oxford p19
[18] House of Lords Select Committee on Economic Affairs 5th Report. Section 60

1.2.4 Truth telling

In a recent anthology on bioethics, Kuhse and Singer[18] drew attention to constraints on freedom of choice commonly placed by physicians.

> *"In the Hippocratic tradition of medicine, it has long been assumed that the first and foremost responsibility of doctors is towards the health and well-being of each individual patient, rather than to patients as a whole, or to society at large. Another traditional assumption among physicians is that they are entitled to be paternalistic towards their patients. This means that doctors may sometimes – in seeking to protect the physical health and well-being of patients – ignore the wishes of their patients, and deceive them about the state of their health. Today, however, it is widely assumed that respect for patient autonomy, rather than medical paternalism, ought to be a cornerstone of the doctor/patient relationship."*[19]

It is a significant issue for public health campaigning, for anti-smoking pressure groups and tobacco companies alike that coercion of an individual's exercise of freedom of choice should not dominate the transmission of factual information about the product and its potential health consequences.

Unfortunately, the techniques of persuasion adopted in some public health campaigns and the frank admissions of some eminent bodies and single issue pressure groups indicate a seemingly deliberate coercive approach. For example,

> *"By reducing the number of people who smoke and reducing the number of people who ever commence, we will begin to make a difference. Eventually smoking cigarettes will become less socially acceptable...If smoking tobacco is seen as a behaviour arising from overwhelming social influences, then it can no longer be considered or debated as an individual 'choice'."*[20]

A non-coercive approach is consistent with the reported views of the UK Prime Minister, Tony Blair, who (in a speech on public health and personal responsibility) re-affirmed the dominant role of the individual in such decision making:

> *"And above all a state that sees its role as empowering the individual, not trying to make their choices for them, can only work on the basis of a different relationship between citizen and state.. Government can't be the only one with the responsibility; it's not the only one with the power. The responsibility must be shared and the individual helped but with an obligation to help themselves."*[21]

Ultimately, the factual basis on which companies act and - we would hope - all parties to the development of public policy and regulation also act, must be capable of being tested in a Court of Law to the required standards of evidence and proof. UK law has explicit and rigorous requirements of the expert evidence on which judgements may be made. We would argue that this should be the standard to which all in the debate concerning tobacco are required to adhere. In his judgement in McTear *vs* Imperial Tobacco, Lord Nimmo Smith summarised these requirements and concluded as follows:

> *"…I conclude that it is necessary to consider with care, in respect of each of the expert witnesses, to what extent he was aware of and observed his function. I must decide what did or did not lie within his field of expertise, and not have regard to any expression of opinion on a matter which lay outside that field…I must decide in relation to each of the expert witnesses whether, and if so to what extent, he may have been acting as an advocate rather than providing independent assistance to the court…expert witnesses are usually professional people who would normally be*

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[19] Kuhse H & Singer P (2006) Bioethics, an anthology 2nd Edition, Blackwell. p591

[20] Royal Australasian College of Physicians and Royal Australian and New Zealand College of Psychiatrists (2005) 'Tobacco Policy: using evidence for better outcomes'. RACP, Sydney

[21] Blair A 26 July 2006 http://www.number-10.gov.uk/output/Page9921.asp

> *expected to seek appropriate remuneration for research, preparation of reports and attendance at court… Everything depends on the independence of the researcher and the quality of the research; and it may well be that ample funding leads to sound research.*[22]*"*
>
> *"From what I have seen of the scientific literature, it appears possible to divide it into three categories, which I shall call the primary, the secondary and the tertiary literature. The primary literature contains…the "archival data"…There is, as I understand it, an expectation of transparency in the primary literature, so that the author's work can be subject to the scrutiny of their peers…What I call the secondary literature takes the form of review articles, where data from more than one publication in the primary literature are drawn together and re-evaluated. This process may serve to produce more reliable results, as being derived from a larger dataset which is the aggregate of the data in the other studies and may also serve to demonstrate errors or anomalies in previous studies. What I call the tertiary literature is different from the secondary literature because it involves the examination of both the primary and secondary literature without performing the kind of exercise which is done in the case of a review article…*
>
> *"From what I have seen of them, documents such as USSG [United States Surgeon General's report] 1964 and IARC [International Agency for Research on Cancer] 1986 fall into this [third] category: the authors conducted no original research, nor did they subject the data to the kind of processes that would be useful in a review article. Instead, they act as compendia for summaries of numerous publications (as can be seen from the extensive lists of references), and the conclusions are therefore derived from a comprehensive though not necessarily exhaustive examination of all of the relevant literature.* [23]
>
> *"…there is good reason from these and other examples to think that the tertiary literature cannot necessarily be relied upon. If the conclusions of papers such as these in the primary literature may on critical examination be found to be unsound, then there may be more: and in that event, if the primary literature has been accepted without criticism by authors of the tertiary literature, the latter may not be as reliable as one would expect"*[24]

The primary literature and a rigorous examination of that literature in the secondary literature should be the bases on which judgements of fact and of public policy and formed.

These standards have not often been adhered to in the debate on smoking. In our view, this lack of adherence has allowed the debate to be dominated by the repetition of ill-founded science, its political manipulation or the overt coercion of adults who are exercising their rightful freedom to choose.

1.3 Legal considerations

Imperial Tobacco recognises that, in most countries, individuals are free to act as they please, subject to legal prohibitions and restrictions placed on specific lifestyle activities. We believe that regulators should neither remove nor undermine the ability of adults to exercise choice over such activities simply because other adults may disapprove of those activities.

It is our view that the risks associated with smoking are well known, and we believe that adults should be allowed to choose whether or not to smoke. Adults who choose to smoke should also be free, within reason, to choose where to smoke. We do not want children to smoke and we do not direct the marketing of our products to anyone under the age of 18.

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[22] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 5.17, 5.18
[23] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 6.160
[24] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 6.161

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Whilst we recognise that we operate in an industry that is controversial to some people, the fact remains that tobacco products are legally manufactured, promoted, sold and smoked in every country in which we operate, bringing pleasure to those adults who choose to smoke and significant revenue to governments. It is worth remembering that close to 78p of every £1 (77.7% – October 2002 data) spent on cigarettes goes to government in UK – and the percentage is similar in many countries of the EU. Tobacco products have been legal for several hundred years, and a realistic world view suggests that they will continue to be so in the future.

A similarly realistic world view would suggest that tobacco products will continue to be amongst the most heavily regulated of consumer products. The UK government has, since 1956, believed that smoking can be a cause of certain diseases and, together with public health authorities, has warned the British public of this view. Within the same time-frame, the UK government has introduced progressively more restrictive regulation to the manufacture, promotion, sale and smoking of tobacco products.

For more than 40 years, Imperial Tobacco worked alongside the UK government to address smoking and health issues. The positive and constructive dialogue between the UK government and Imperial Tobacco (and other UK tobacco companies) developed into a regime of voluntary agreements regulating the sale of tobacco products. This co-operative approach was applauded by successive governments and resulted in what the Secretary of State for Health described in 1993 as

> *"… one of the most advanced, comprehensive and effective systems of voluntary control in Europe"*[25]

Alongside manufacturers of other types of goods in the UK, Imperial Tobacco operates and always has operated under the common law duties of care owed by manufacturers to consumers. In his judgment in the case of McTear v Imperial Tobacco, Lord Nimmo Smith found that Imperial Tobacco had not breached any of its obligations.

Imperial Tobacco is, in addition, subject to statutory duties imposed on UK manufacturers. These non-tobacco specific duties include obligations on manufacturers imposed by the General Product Safety Directive and the Product Liability Directive, with which Imperial Tobacco has complied.

Given this history of legal compliance, what legal considerations are relevant to the issue of whether it is acceptable or reasonable to limit adult freedom of choice to smoke? In our view, the answer lies in the areas of human rights and discrimination.

1.3.1 Human Rights

There is nothing in formal expressions of human rights, such as the European Convention on Human Rights (ECHR), which prevents individuals from choosing lifestyle activities that may be considered an annoyance or nuisance to other people. There is no human rights law, therefore, which prevents smokers from exercising their right to choose to smoke.

There is a human rights law, however, that protects the rights of every person to respect for one's private and family life and one's home (ECHR, Article 8) and the right to the peaceful enjoyment of one's possessions (ECHR Protocol 1, Article 1).

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[25] Virginia Bottomley, Department of Health Press Release, 4 March 1993

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The smoking bans introduced in Scotland in 2006, and that are about to be introduced in the rest of the UK are, in our opinion, incompatible with an individual's ECHR rights. In particular, they are:

(1) incompatible with an individual's right to respect for his private and family life and his home (Article 8); and

(2) incompatible with his entitlement to the peaceful enjoyment of his possessions (Protocol 1, Article 1).

1.3.2 Discrimination

In recent years, the rights of non-smokers have been greatly advanced at the expense of the rights of smokers. This phenomenon has become so advanced and aggressive that it has recently[26] given rise to allegations that it amounts to discrimination.

To discriminate socially is to make a distinction between people on the basis of class or category without regard to individual merit. Established examples of such discrimination include racial, religious, gender, sexual orientation, disability, ethnic, height-related and age-related discrimination. Many governments, including the UK government, have attempted to reduce racial discrimination through civil rights legislation and equal opportunities law. Article 14 of the ECHR, for example, defines the right of individuals to be free from discrimination.

Increasingly, smoking bans are infringing on the lives and lifestyles of those individuals who choose to smoke. Smokers are, or will shortly be, prevented from smoking in many places they wish to frequent and in which they want to smoke, including workplaces, pubs, restaurants and even, in the case of publicans who live "over the pub", their homes. Some employers are now stipulating that candidates for new jobs must be non-smokers. Such discrimination against what is a lifestyle choice is, in our opinion, unreasonable, unjustified, undemocratic and, arguably, unlawful.

1.3.3 Right to Health

It may be argued, wrongly in our view, on so-called "right to health" grounds, that non-smokers rights must be protected above those of smokers, or that public health authorities have grounds to coerce the freedom of smokers to make adult choices.

The right to health in international law (and the formulation of the right most commonly invoked) is contained in Article 12 of the International Convention on Economic, Social and Cultural Rights 1966. It is worth setting it out in full:

> *"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
>
> *"2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
>
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>
> *(b) The improvement of all aspects of environmental and industrial hygiene;*

[26] Scotland on Sunday 6th August 2006 "Anti-smoking ad flack" Sam Marsden

> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness* "…

By its own admission, the UN states that the Right to Health is not to be understood as a right to be healthy; rather the right to health contains both freedoms and entitlements.[27] Such freedoms include the right to control one's health and body which is encompassed by the right to be free from interference. Therefore an initial conclusion could be that the right for an individual to smoke is a right enshrined in the Covenant itself, as the UN states that each individual has the right to control their own health.

Furthermore, the case that smoking in public places affects the rights of non-smokers falls on the basis of the insignificant nature of any incremental risk to health, as detailed above.

1.4 Ethical Considerations

A dispassionate consideration of the ethical issues surrounding smoking should examine the issues from the viewpoints of different ethical systems.

1.4.1 Deontological ethics

In referring to a deontological approach to ethical evaluation, we mean to broaden from a purely faith-based (God-given) analysis to timeless truths, rights and duties that are commonly accepted. For example, Kant held that particular kinds of acts are ethically wrong because they are inconsistent with the status of a person as a free and rational being, and so should not be carried out under any circumstances. Conversely, acts that further the status of people as free and rational beings should always be carried out.

In the Jewish and Christian traditions, no formal prohibition of smoking is applied to adherents.

The general principle of care or expressing love for one's neighbour might characterise the Christian approach to ethics, alongside a bias towards the disadvantaged in society. Such an approach is principled but not self-evidently proscriptive. It has shaped, and may be most clearly and practically enunciated in the English common law duties of a manufacturer described above.

In terms of personal freedom, this is seen as a fundamental attribute of being human.

> *"From the beginning of creation, humanity is called in freedom to be members of God's family. For Christians the justification for respect for human rights and freedom is extremely personal. Our common sharing in the image of God requires that our relationships with one another be based on mutual respect, dignity, freedom and ethical responsibility. Every person's humanity, integrity and rights are to be respected…"*[28]
>
> *"…we believe that humanity is created in the image of God and that personal autonomy and freedom are gifts from God to be cherished and advanced.*[29]*"*

In one sense, limiting freedom to choose is de-humanising.

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[27] UN Economic and Social Council General Comment No.14 (2000) at paragraph 8.
[28] Report of the Lambeth Conference 1998 Section 1 Called to Full Humanity p15 Morehouse Publishing
[29] Ibid p45

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In a broader consideration, there has been no serious attempt to condemn smoking or smokers on the basis of generally accepted, timeless truths which transcend cultural considerations.

1.4.2 Consequential / Utilitarian ethics

Inevitably there is a tension between what is appropriate for an individual and what is appropriate for a population.

A consequential approach to ethics seeks to ensure that the responsibility for an individual's actions informs those actions and their consequences. As such, the approach reinforces the responsibility of an individual to make choices which benefit society as a whole.

A Utilitarian approach seeks to weigh 'good' and 'bad' consequences of an action to create benefit for the greatest number. In commenting on the problems associated with using this system to make judgements, Rafik Beekun writing on Islamic Business Ethics comments:

> *"Problems associated with this [Utilitarian] ethical system are many. First, who determines what 'good' is for the maximum number of people? Is it wealth, pleasure or health? Second, what happens to the minority? If the majority in the US should decide that the doctrine of free love will rule the land, who will protect the interests of the minority who believes in matrimony and monogamous relationships as prescribed by God? Third, how are costs and benefits to be assessed when non-quantifiable issues such as health are to be dealt with? Fourth, individual rights and responsibilities are ignored in favour of the collective rights and responsibilities.*[30]"

There are examples of the superficial use or misuse of such an approach in the debate about smoking.

The first example is the use of attributable fractions in public health epidemiology.

In his evidence in the case of McTear vs Imperial Tobacco, Professor Michael Lewis addressed the issues concerning the extrapolation from an odds ratio, derived from epidemiological studies, to estimates of numbers affected in the general population

> *"An underlying premise of public health epidemiology is that disease incidences can be reduced by the removal or reduction of risk factors in the population (Hennekens et al., 1987; Friedman, 1994). In order to estimate the quantity of disease removed from the population by the elimination of a risk factor, the concept of attributable fractions was developed.*
>
> *"Whereas the relative risk (or odds ratio) compares disease occurrence within two groups (e.g. exposed and unexposed), the attributable fraction (AF), which is mathematically derived from the relative risk, calculates the fraction of cases in the population which is attributed to the exposure (Northridge, 1995) …*
>
> *"The problems associated with attributable fractions include technical, computational, statistical, and interpretational issues. The technical issues concern problems of study conduct, as well as different possible definitions of exposures and outcomes … Computational and statistical problems relate to the way attributable fractions are calculated, and to issues of confounding, bias and study variability … Finally, interpretational issues relate to what conclusions, if any, can be drawn from the use of attributable fractions …"*[31].

Having discussed each of the sources of error in turn, some of which are appreciable mathematically, he then points out that

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[30] Rafik Issa Beekun (1997) in Islamic Business Ethics, International Institute of Islamic Thought, USA. p10
[31] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 5.780

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> *"… individuals can belong to a large number of groups (Robins et al., 1989). The identification of an individual by age, sex, and exposure does not capture all attributes which may determine risk. People are black, white, rich, and poor, employed or unemployed, have unique genetic profiles, and engage in various health and lifestyle habits. Each one of these groups constitutes a different risk set and would have a different attributable fraction. Each individual, who may have different characteristics such as being white, poor, and unemployed, thus belongs to multiple risk sets, and has multiple attributable fractions that may be applicable to him. Further, for any given disease, the sum of all attributable fractions for all factors will exceed 100%. … The concept of probability of causation or "assigned shares" ignores the existence of diversity and individual differences."*[32]

The concept of attributable fractions is, therefore, prone to several sources of error and, because individuals are members of several risk groups simultaneously, leads to serious over-estimates of deaths from any one risk. More deaths are predicted from the summation of attributable fraction calculations than in fact occur.

Such errors must be borne in mind when taking a mathematical, utilitarian approach to public health decision-making. They also may mislead when used in the media to assert that a given number of deaths arise each year from a particular source, for example obesity, which for any individual may be only one of a number of lifestyle risk factors.

The second example is the cost of smoking to the NHS.

It has been claimed that smokers represent a net cost to the NHS. Counter-claims have been made that smokers subsidise the costs to the NHS of treating *non*-smokers as taxation on tobacco products generates more revenue for government than is spent in treating smokers.

The formal economic analysis provided to the Chief Medical Officer, Sir Liam Donaldson, in 2003 made reference to the net impact of smoking on health care expenditure

> *"There is controversy as to the net impact of smoking on health care expenditure. An estimate which applies the disease by disease population attributable fraction to NHS costs indicates excess costs of about £1.5 billion a year, about £150 per smoker. However, estimates which take account of increased life expectancy in non-smokers and ex-smokers do not indicate a net cost burden. On the other hand, these estimates in turn do not appear to distinguish the age related costs due properly to high mortality rather than age itself. No estimate of the impact on NHS costs is attempted here."* [33]

Such examples illustrate that very careful examination of the mathematics associated with the generalisations used in utilitarian ethics is essential for reaching a defensible conclusion.

In general, the application of these utilitarian or consequential forms of ethical consideration can set up tensions between the choices of minorities and their effects on the majority. The balance of judgement, however quantified, becomes one between the freedoms of the individual and the benefit and coercive power of the majority.

Such coercion becomes overt discrimination if exerted on the basis of class or category without regard to individual merit.

Great care must be taken in applying a utilitarian or consequential approach, for example, to rationing access to health care treatments in case they are discriminatory. One sees

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[32] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 5.800

[33] 'Smoke free workplaces and public places: economic analysis' http://www.dh.gov.uk/Publications And Statistics/Publications/PublicationsPolicyAndGuidance/fs/en#5011235

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reported in the media cases of purported restrictions on treatment access for particular groups of people, obese persons, consumers of alcohol, smokers etc. This gives rise to concerns that they may be discriminatory under UK law.

1.4.3 Post-modern ethics

This ethical system makes relative all perspectives and rules. It validates the experience and perspective of individuals without judging between them. There can be no meta-ethical position applying to all; no rules applying to all; no dominance of a majority view; no "objective truth".

Under this ethical approach the choices exercised by smokers and non-smokers are valid for each. There can be no value judgement between these choices. Applied to public health, each has valid claims as individuals and no judgements, discrimination or preferential treatment can be exercised between them.

1.4.4 Virtue / Value ethics

The current emphasis on business Values driving behaviour and performance stems from the revival of Virtue ethics, whereby particular characteristics (Virtues or Values) are used to govern behaviour or to judge worth. Modern concepts of honesty and integrity have replaced more ancient virtues of beauty or war-like ferociousness.

While a Virtues approach is valuable in an individual choosing to regulate their own behaviour, the application of such virtues to others can be fundamentally coercive. The code says this; conform or be ostracised. Circumstances are very rare when such coercion can be justified; in fact, many legal systems are set up precisely to prevent such coercion. For example, to dismiss an employee because they did not agree with the company value of thrift, or to restrict health care because an individual once served a gaol sentence for theft, seem bizarre, but they could be consequences of such a coercive ethical approach.

There are also problems concerning the choice of Virtues. Even the choice by governments of such values can be seen as flawed (twentieth century examples include Nazism and Soviet collectivism).

There is no agreed set of values which might be applied throughout a free, multi-cultural, multi-faith society. While in many ways appropriate for a framework for an individual's ethical choices, the evidence of history is that such an approach is flawed as a basis for social ethical judgements.

Rawls[34] has suggested that it is enough to develop for the purposes of subsequent action an *overlapping consensus* of the principal substantive ethical or political doctrines in a community (somewhat akin to values). In the absence of such consensus, it would not be possible to regulate interactions between or distribute resources to members of that community. Such a "least common denominator" model is pragmatic, but the implementation of decisions based on the model inevitably has the problems of coercion of minorities and of discrimination against their rights.

Care should be exercised by public bodies seeking to act from a Virtue ethics approach. While such an approach may provide a degree of personal satisfaction to that body, the

[34] Rawls J *Political Liberalism* (New York: Columbia University Press, 1993) and *A Theory of Justice* (Cambridge, Harvard University Press, 1971)

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adoption of a particular set of Virtues may have no defensible – or even legal – mandate and the outcome of 'virtuous' decisions may be discriminatory, particularly to minorities.

1.5 In conclusion

We believe that the proper and legitimate function of government is to safeguard the sovereignty of the individual and their ability to be self determining. Key to this is the ability to make informed decisions (regardless of the popularity of those decisions). We believe that individuals are the best judges of their own interests. It is the role of the state to protect such freedoms not to remove them or to make such decisions on an individual's behalf. Such freedoms should be protected by the state and should, in particular, be protected from simple majority rule.

We believe that an individual's personal authority over their own life is both natural and fundamental. The state exists for the sake of the individual;not the individual for the sake of the state.

The harm principle is, of course, the most complex element of this point of view. However, our view is that it is relatively uncontroversial to say that any restriction to this personal authority (which is justified on the basis that the restriction is to prevent harm to others) must be based on solid, factual evidence (rather than emotive speculations) and should be treated consistently with other potential risks which are accepted (or legislated against) by the law maker.

We believe that when removing any such freedom, a burden of the highest order is placed on the law maker to examine such risks from a factual point of view and to satisfy itself that the risk is; a) real; b) of a quality which has led to similar restrictions for other risks; c) incapable of being managed in another way which does not restrict personal authority (convenience or ease of application or enforcement is not enough to justify any restriction where other options are possible). This must be a minimum expectation for any state which attaches value to the sovereignty of the individual.

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2. SPECIFIC QUESTIONS

FACTORS THAT INFLUENCE PUBLIC HEALTH

- ***Do you agree that interactions between the following five factors are the main influences affecting public health: the environment, social and economic factors, lifestyle, genetic background, preventative and curative health services? If so, do you think some are more important than others? Are there are other factors we should include? If so, what are they?***

We do not agree that these factors are necessarily and exclusively the main factors affecting public health.

Of the factors named in the question, we would argue that the primary determinants of the public health are genetic background and the lifestyle choices people make. It is these factors which primarily determine the demand placed upon heath care. Modulating that demand are environmental, social and economic factors. Preventative and curative health services are there simply to meet that demand, but are themselves also modulated by environmental, social and economic factors.

Of the three modulating factors, the economic factors are strongest influencers. Governments make social and political decisions to constrain the resources available to preventative and curative health care services. Economic factors are also the primary determinant of whether a patient chooses to place a demand on public heath services. It can be argued that governments are also largely instrumental in shaping this choice through their wealth creation and personal taxation policies.

Critical to the generation of successful outcomes from its public health care policies are the policies governments pursue in terms of national wealth creation and taxation. On the generation of public wealth hangs the success of public health.

In this regard, it is interesting to note that a recent survey by the UK Department of Trade and Industry named Imperial Tobacco the second largest wealth generator in the UK, generating £3.61 of national income for every £1 it spent.

A further two factors should be considered alongside the factors mentioned above.

Firstly, the problems of an ageing population and the nature of the quality *versus* quantity of life which have become significant public health issues in their own right, in our view.

Dr Nuala Kenny writes:

> *"The aging of Canadian society raises a number of crucial public policy issues relating to the meaning of ageing, to the fair and equitable allocation of resources between and among the generations, and even to social cohesion. How can Canada meet the goal of becoming a society of justice and fairness for all ages? Or, to frame the question more broadly, how does an aging society make ethical public policy choices now and for the future?"*[35]

[35] "What's fair? Ethical decision-making in an aging society" Nuala Kenny.(2004) Canadian Policy Networks and The Change Foundation pg v

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Secondly, there has been a crucial and political change of policy which affects the entire analysis, namely, that public health policy is based on health inequalities not public health excellence *per se.*

The opening paragraphs of Sir Donald Acheson's report on Health Inequalities in 1998 assert:

> *"Since 1980, although health and expectations of life have generally improved, the social gradients of many indicators of health have deteriorated or at best remained unchanged. Although this period was also marked by substantial economic growth, income differentials widened to a degree not seen since the Second World War"*[36]

Clearly, as health and expectations of life diverge from their social gradients, it is important to understand which are being targeted by any potential public health measure before a decision to implement is made.

The Wanless report goes further in asserting his (arguable) belief that:

> *"As our society places significant value on social solidarity and supports actions to reduce inequity, interventions to encourage greater equity in society also need to be considered. Effectively, society has decided that it is willing to sacrifice some of its total welfare to improve the distribution of this welfare amongst its individuals."*[37]

The relativistic approach adopted has meant that any factors which are associated with social inequalities have become potential targets for public health intervention. Thus, poverty, income tax, benefits, education, employment, housing and the environment, crime, violence, mobility, transport, pollution, walking, use of motor vehicles, the Common Agricultural Policy, smoking, alcohol, and ethnicity were discussed in the Acheson report in relation to their health outcomes.

The difficulty of this approach is the diluting effect of chasing correlations and associations, rather than targeting specific, conventional causes of ill heath.

SMOKING

- ***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 others areas of public health?***

In 1956, the UK Minister of Health, Mr R.H. Turton, announced that there was an incontrovertible association between smoking and the incidence of lung cancer[38]. Over the last 50 years, successive UK governments have created a comprehensive framework of regulation over every aspect of the manufacture, advertising, sale and smoking of tobacco products, often in consultation and with the explicit and voluntary agreement of UK tobacco companies including Imperial Tobacco[39]. In 1993, the UK Secretary of State for Health called the regulatory regime

[36] Acheson D (1998) Independent Enquiry into Inequalities in Health Report p32 The Stationary Office
[37] Wanless D (2004) Securing Good Health for the Whole Population HMSO section 1.41
[38] Hansard, 552, Col. 803, 1956
[39] Memorandum from Imperial Tobacco Group PLC to the Health Committee of the House of Commons , October 1999.

> *"one of the most advanced, comprehensive and effective systems of voluntary control in Europe"*[40].

In our view, therefore, it is a fallacy to assert in this question that *"comprehensive measures by governments to prevent harm to the population are relatively recent".* In our view, there has been no delayed response. The "response" began 50 years ago. Historically, the UK government has rightly taken a lead role in ensuring proper public education on all material health risks. Since the 1950's, the UK government has taken a lead role in ensuring proper – and, indeed, successful - public education on the health risks of smoking. As long ago as January 1964, the UK Prime Minister asserted

> *"I do not think there is any excuse for anyone not to know the connection between smoking and lung cancer"* [41].

The UK has been at the vanguard of tobacco control for nearly 50 years. In our view, no lessons are to be learned from other countries other than to deplore the increasingly extremist drive towards the denormalisation of a lifestyle activity that continues to bring pleasure to adults exercising their right to choose to smoke, which at the same time generates massive revenues to government.

- ***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?***

The legal duties and responsibilities of companies that operate in the UK, whatever product they may make or sell, are established by both common law and statute. Tobacco manufacturers are no different in this respect than companies operating in any other industry sector.

Failure by a company to comply with its common law duties of care may result in a legal claim against it for damages in negligence. In order for such a claim to succeed, it must be proved that a duty of care was owed by the company, that the duty was breached, and that the breach caused or materially contributed to the alleged injury. Such a claim was brought against Imperial Tobacco in the case of McTear v Imperial Tobacco. The judgement handed down by Lord Nimmo Smith, included the following:

> *"In any event there was no lack of reasonable care on the part of ITL at any point at which Mr McTear consumed their products, and the pursuer's negligence case fails. There is no breach of a duty of care on the part of a manufacturer, if a consumer of the manufacturer's product is harmed by the product, but the consumer knew of the product's potential for causing harm prior to consumption of it. The individual is well enough served if he is given such information as a normally intelligent person would include in his assessment of how he wishes to conduct his life, thus putting him in the position of making an informed choice"*[5].

With respect to nicotine, Imperial Tobacco has complied with all relevant regulation and, to the extent that Imperial Tobacco has any specific responsibilities arising from the unalterable fact that natural tobacco contains nicotine, these responsibilities have been met. As early as 21 April 1976, Dr R B Hunter (later Lord Hunter of Newington), Chairman of the Independent Scientific Committee on Smoking and Health, stated that

> *"In justice it has to be recognised that over the last decade there has been substantial voluntary reductions by the industry of the tar and nicotine levels – the introduction of filters and ventilated*

[40] Department of Health Press Release, 4 March 1993.
[41] Hansard 1963-64, 683, col. 528

> *paper. It may be that it was commercial competition and the desire to improve the safety image which produced this – but it was not legislation. It was a voluntary effort*" [42].

Turning to the issue of addiction, Imperial Tobacco agrees that smoking can be characterised as addictive as the term is commonly used today. Some people may find it difficult to stop smoking, but we believe it is important for them to understand that they are able to stop. Millions of people have stopped; the majority without assistance.

In examining the expert evidence on addiction in the case of McTear v Imperial Tobacco, the Rt. Hon. Lord Nimmo Smith made judgement in May 2005 as follows:

> *"I am prepared to accept that Mr McTear found it difficult to wean himself off his habit once he had started smoking and in that sense could be described as addicted. I do not accept that he was for this reason unable to stop smoking[43].*
>
> *"The fact that smokers such as Mr McTear may find it difficult to give up does not appear to me to deprive them of the element of free will which is fundamental to the individualist philosophy of the common law"[44]*

We believe that freedom of adult choice is not diminished by smoking tobacco products.

UK Claims for Health Care Costs against Tobacco Companies

This issue was raised in the UK in the mid 1990s following similar claims in the United States.

UK Action on Smoking and Health (ASH) obtained a legal opinion from Mr Justice Melville Williams as to the potential success of actions by UK Health Care Trusts. The opinion suggested that actions on the basis of negligence or liability arising from defective products were unlikely to succeed. The only action envisaged that might succeed would rely on the demonstration that tobacco companies had conspired jointly

> *"to promote tobacco sales and to defend themselves against claims that smoking injures health. That for the latter purpose they presented evidence about the risks and causation of the smoking related diseases which they know to be false and misleading and that they did so to the public, in the form of advertising and various public statements, to the Government for instance in negotiations about restrictions on advertising and perhaps to their shareholders."[45]*

The British Medical Association took up the cause through the press. Claims were made that the then Minister for Health did not support legal action.

In 1998, the NHS confederation surveyed its members on the issue in relation to the Government's White Paper on Tobacco Control.

Meanwhile, Government's opinion was that such an action would not be allowed under section 1(2) of the NHS Act 1977 unless new legislation was passed; something that the Government did not intend to do.

In 1997 ASH proposed four significant changes in the British legal system to allow such an action to proceed – no win no fee; punitive damages; plaintiffs not liable for costs if they lose; trials before juries not judges. These elements in the American legal system

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[42] Memorandum from Imperial Tobacco Group PLC to the Health Committee of the House of Commons, October 1999 page 18.
[43] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 9.3
[44] McTear vs Imperial Tobacco (2005) Court of Session, Edinburgh. Section 6.207
[45] Smoking Related Disease possible Claim for Health Care Costs; Opinion J Melville Williams QC 15 October 1996

were at the time leading to successful claims. Subsequently all but four such claims have been overturned in superior courts in the USA on appeal.

In 1999, Michael Fabricant MP proposed to amend UK law to allow claims to proceed. This was not approved by the Government. *"To institute such proceedings would be very complicated legally and, in our judgement, neither the Secretary of State nor NHS bodies would be able to recover damages from tobacco companies".* The amendment was withdrawn[46].

Cigarette taxation

Finally, there is a common belief that it is the tobacco companies and their shareholders who benefit most from the sale of cigarettes. This is incorrect in many countries of the world, where governments are by far the major beneficiaries of revenue from cigarette sales.

In the UK, the total taxation levied as a percentage of the retail price was 77.7% (October 2002 data), in other words close to 78p of every £1 spent on cigarettes goes to government. In Ireland the figure is 78.4%, France 80.4% and Germany 74.5%. Very different market conditions apply in the USA, where the figure is 30.6%.

- ***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 adventurous sports?***

It has been claimed that smokers represent a net cost to the NHS. Counter-claims have been made that smokers subsidise the costs to the NHS of treating *non*-smokers as taxation on tobacco products generates more revenue for government than is spent in treating smokers.

The formal economic analysis provided to the then Chief Medical Officer, Sir Liam Donaldson, in 2003 made reference to the net impact of smoking on health care expenditure[47]

> *"There is controversy as to the net impact of smoking on health care expenditure. An estimate which applies the disease by disease population attributable fraction to NHS costs indicates excess costs of about £1.5 billion a year, about £150 per smoker. However, estimates which take account of increased life expectancy in non-smokers and ex-smokers do not indicate a net cost burden. On the other hand, these estimates in turn do not appear to distinguish the age related costs due properly to high mortality rather than age itself. No estimate of the impact on NHS costs is attempted here."*

It should also be noted in this context that the income to the government from tobacco taxation in 2005 was £11bn, almost ten times the health care costs quoted above. It could therefore be argued that the purported imbalance was simply a question of assignment of taxation revenues by the government.

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[46] Health Bill (Lords) Standing Committee (11 May 1999) House of Commons Standing Committeee A (pt9) Mr Denham (Minister of State, Department of Health).

[47] 'Smoke free workplaces and public places: economic analysis' http://www.dh.gov.uk/Publications And Statistics/Publications/PublicationsPolicyAndGuidance/fs/en#5011235

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Any analysis of proportionality in the use of health care should take this into account. Entitlement should be a matter of the clinical needs of the individual.

If changes to the traditional practice of equality of access to health care are contemplated, then great care should be exercised in distinguishing between groups based on lifestyle activities or on risk tolerance.

It is possible to differentiate between the effects of illegal and legal activities. Ought this to become a primary differentiator of service provision, addressing first the effects of illegal activities such as drug taking, personal violence, driving without seat belts or under the influence of alcohol or without insurance?

There is no logical place to draw the line between legal lifestyle choices such as diet, alcohol consumption, smoking, sporting choices or even unprotected sexual activity or sexually transmitted diseases.

- ***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 prevent children and teenagers from smoking?***

The state already imposes sanctions that prevent smokers from smoking. Laws implementing bans on smoking have been introduced by many countries in various forms over the years, including the UK. In Scotland, for example, the Smoking, Health and Social Care (Scotland) 2005 Act took effect on 26 March 2006 prohibiting smoking in all enclosed public places, including bars, restaurants, shopping centres, theatres and offices. Similar legislation will come into force in England and Wales during 2007. State sanctions that prevent smokers from smoking are commonplace.

To consider extending these restrictions with the objective of preventing the sale of tobacco altogether raises numerous questions concerning the role of the state and the rights of individual citizenship within that state. Prohibition of alcohol in the US in the early 20th Century is universally considered to have been a failure, resulting in organized crime taking over the manufacture and distribution of contraband alcohol, and as a result of widespread non-compliance of prohibition by otherwise law-abiding citizens, an increasing erosion of respect for authority. Reputable manufacturers were put out of business but, because demand remained, alcohol production fell to criminals and unregulated clandestine home manufacturers that fell outside the regulatory regime of the day. Prohibition of tobacco would almost certainly have similar consequences: millions of smokers would be criminalized at a stroke and opportunities would be created for unregulated and indeed untaxed manufacturers and distributors acting outside of the law to profit.

With respect to children, Imperial Tobacco believes that the decision to smoke is a choice for adults. We do not want children to smoke. Underage smoking is an issue for society as a whole to work together to resolve, recognising that different societies or sections within society will have different cultural approaches to the matter. We play our part by not directing the marketing of our products to anyone under the age of 18, including through the operation of a stringent marketing code across our business, and by supporting governments and the retail trade with a range of programmes designed to discourage the sale of tobacco products to children.

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ETHICAL ISSUES

- ***In your view, is there one of the following principles that is generally more important that the others: autonomy, solidarity, fair reciprocity, harm principle, consent, trust (see section 5 in Part B)? If so, which one and why? Are there any other important principles that need to be considered?***

In a recent paper on the ethics related to age and public health care, Nuala Kenny[48] asserts that

> *"If public policy making is a moral endeavour, how do we clarify its moral and ethical dimensions and implications? Ethical frameworks and sets of guiding principles have become tools for this process of clarification in public policy. While principles are normative generalisations that guide and direct choices and actions, frameworks are intended to help us see an issue from varying perspectives and identifying consequences of different policy options from points of view of 'affected others'. Both are tools to stimulate our moral imagination and help make transparent the values at stake in policy options."*

Dr Kenny goes on to advocate for practical decision-making an "ethic of care" combined with principles of respect for all ages, meaningful autonomy, solidarity, protection of the vulnerable, responsible citizenship, accountability and sustainability. All or some of these principles may be applied to specific issues.

> *"These principles are only a starting point for thinking about the ethic of care as an ethical framework for decision-making in an aging society"*

In so far as the principles mentioned in this question are vehicles for elucidating the issues at stake in public health decision-making, then they could be of use. However, they have no legitimacy as evaluative criteria against which a policy option may effectively be scored.

For the clear reasons documented earlier, the foundation for such policy option considerations must be the freedom of the individual to choose – a principle well established in legal and ethical terms. If that is what the authors mean by *autonomy*, then that would be the overriding principle in our view.

The list of principles is neither exhaustive nor timeless. Twenty years ago, the list would have been different: in twenty years time the list will be different again. To that extent it is artificial and may well serve to over-simplify what are complex and fundamental issues concerning the freedom of individuals and the legitimate rights of public bodies.

- ***Can these principles be ordered in a hierarchy of importance? If so, how would such an order relate to the five case studies (infectious diseases, obesity, smoking, alcohol, and the supplementation of food and water)? Would the order have to be redefined for each new case study? Are there particular principles that are of special importance in some case studies?***

We do not believe that this particular set of principles, nor any other set, can be ordered into a strict hierarchy.

We do not agree with Rawl's approach[31] of creating an overlapping consensus from diverse views, in this case within the UK or internationally, and then using this consensus

[48] What is fair? Ethical decision-making in an aging society, (2004) Canadian Policy Research Networks Inc.

to drive policy making. Such an approach places the importance of the community above that of the individual and tends to violate or coerce the freedoms and right of individuals in a civilised society.

We would counsel caution in applying this approach selectively to the evaluation of the case studies listed.

Misuse of drugs, various surgical procedures, mobile telephones or electric power lines, living in proximity to nuclear power plants, exposure to diesel exhaust fumes, sexually-transmitted diseases: what was the motivation for excluding these as case studies?

- ***In cases such as vaccinations or fluoridation parents decide on behalf of their children. Which ideas or principles should guide parents in their decisions?***

Imperial Tobacco believes that the decision to smoke is a choice for adults. We do not want children to smoke. Parents should be free to decide how they discharge their duties of care towards those minors for whom they are responsible. Public health authorities should not seek to act *in loco parentis.*

Underage smoking is an issue for society as a whole to work together to resolve, recognising that different societies or sections within society will have different cultural approaches to the matter. We play our part by not directing the marketing of our products to anyone under the age of 18, including through the operation of a stringent marketing code across our business (appendix B), and by supporting governments and the retail trade with a range of programmes designed to discourage the sale of tobacco products to children.

We believe that, in the same way that smokers should show courtesy to others adults when smoking, this should be extended to children, who are often unable to exercise choice in their environment and surroundings in the same way that adults can.