Nuffield Council on Bioethics

4 September 2008

Tobacco Consultation
Department of Health
Room 712, Wellington House
133–155 Waterloo Road
London SE1 8UG

Dear Sir/Madam

Consultation on the future of tobacco control

I am pleased to attach a response from the Nuffield Council on Bioethics to the above consultation.

In November 2007 the Council published a report, *Public health: the ethical issues*, which included a case study on tobacco use. This response is drawn primarily from the conclusions and recommendations made in that report, insofar as they relate to the questions posed in the consultation. A copy of the report is included with this letter.

Paragraph numbers have been provided at the end of each paragraph, in order to indicate from where in the report the recommendations are derived.

I hope that this contribution is useful, and thank you for providing us with the opportunity to comment on this subject. Please do not hesitate to contact us if you require further information or clarification.

Yours faithfully

Hugh Whittall
Director

NUFFIELD COUNCIL ON BIOETHICS

Department of Health consultation on the future of tobacco control

Introduction

1   In its report *Public health: the ethical issues*, the Council considers the responsibilities of governments, individuals and others in promoting the health of the population. It concluded that the state has a duty to help everyone lead a healthy life and reduce inequalities in health. Our 'stewardship model' sets out guiding principles for making decisions about public health policies:

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;

- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;

- pay special attention to the health of children and other vulnerable people;

- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;

- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;

- ensure that people have appropriate access to medical services; and

- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;

- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and

- seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values [para 2.44].

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

2   People in socio-economic groups with fewer resources are disproportionately affected by the harms caused by tobacco. Therefore, under the stewardship model, public health

policies in this area should aim to reduce these health inequalities [para 6.37].

3   Public education and information have a key role, since they are non-coercive ways of bringing about improvements in health. Their success is dependent upon the ability to motivate people to change their attitude, and ultimately their behaviour, by information that they find persuasive. However, sustainable behaviour change is a major challenge even for those who have changed their attitude, and would like to act differently. When such an approach fails, a more interventionist public policy may be needed, especially if it is to significantly reduce health inequalities [para 2.33].

4   The Council has proposed an 'intervention ladder' as a method of thinking about the acceptability and justification of different public health policies. In general, the higher the rung on the ladder at which the policy maker intervenes, the stronger the justification has to be. A more intrusive policy initiative is likely to be publicly acceptable only if it is the least intrusive intervention available; that there is clear evidence that it will produce the desired effect; and that this can be weighed favourably against any loss of liberty that may result [para 3.37].

The intervention ladder

Eliminate choice. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.

Restrict choice. Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.

Guide choice through disincentives. Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.

Guide choices through incentives. Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.

Guide choices through changing the default policy. For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).

Enable choice. Enable individuals to change their behaviours, for example by offering participation in a NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools.

Provide information. Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.

Do nothing or simply monitor the current situation.

Question 6: What do you think the Government could do to:
   a. **reduce demand for tobacco products among young people**
   b. **reduce the availability of tobacco products to young people**

5   Producers, advertisers and vendors of alcohol and tobacco need to recognise more fully the vulnerability of children and young people, and take clearer responsibility for preventing harms to health. This would include refraining from understating risks, and from exploiting the apparent desirability of drinking alcohol and smoking, particularly in ways that appeal to children and young people. Where commercial agents fail to act on these responsibilities, the state would be justified in considering more coercive measures. Furthermore, it would appear that whatever the legal position, these products are currently widely available to underage children, and existing law and policy need to be implemented more stringently. We welcome the raising of the minimum age for the purchase of tobacco from 16 to 18 years that has taken place throughout the UK as part of a strategy to protect vulnerable people. Although thought needs to be given to the way in which this measure can be implemented most effectively, it is an appropriate initiative in the context of the stewardship model, as the market has largely failed to self regulate in this area [para 6.33].

Question 12: Do you believe that more should be done by the government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

6   Even before the smoking ban in public places was introduced in England in 2007, most secondhand smoke exposure occurred within the home.[1] This raises the question as to whether the smoking legislation should be widened to extend to the home to protect the most vulnerable, not only in public places, but also in private spheres. For example, children exposed to smoke at home have a higher risk of a range of health problems and exacerbation of other illness [para 6.14].

7   In principle, therefore, the general ethical and scientific arguments that apply to banning smoking in enclosed public spaces also apply to banning smoking in homes (and other places) where children are exposed to environmental tobacco smoke. However, this would be extremely difficult to enforce without significantly compromising privacy, and a ban on smoking in the home would therefore be disproportionate and ineffective. We recommend that the Department for Children, Schools and Families should communicate to local authority children's services that there may be exceptional cases where children, for example, those with a serious respiratory condition, would be at risk of such a substantial level of harm from passive smoking that intervention to prevent such harm

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[1] Royal College of Physicians (2005) *Going Smoke-free: The medical case for clean air in the home, at work and in public places*, available at: http://www.rcplondon.ac.uk/pubs/contents/fe4ab715-2689-4a4a-b8c7-53e80386c893.pdf

may be ethically acceptable. Clearly, this would be an exceptional situation which might, ultimately, need to be decided in the courts [para 6.15].

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:
- **Smokers who try to quit but do not access NHS support?**
- **Routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?**

8   One method of providing a more effective NHS Stop Smoking Service for manual and routine workers would be for the UK health departments to further liaise with employers about how best to offer assistance with behaviour change programmes, such as smoking cessation, which could benefit the employer as well as employees [para 6.17].

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

9   Large and profitable companies are involved in the alcohol and tobacco industries, and almost all of these have established 'corporate social responsibility' policies, which often include so-called 'harm-reduction strategies'. In the case of the tobacco industries, a stringent harm-reduction strategy is difficult to imagine as this would ultimately require them simply not to sell their products [para 6.23].

10   A recent initiative of the tobacco industry to reduce harms has been to develop a form of smokeless tobacco known as snus. Snus, which is placed underneath the lip, has been used legally in Sweden and some other countries for many years although it is banned in all other Member States of the European Union. It is addictive to the consumer but eliminates the risk of harm to third parties [para 6.24].

11   Based on our considerations of the stewardship model of the role of the state in relation to public health, the Working Party is not persuaded that snus should be permitted. Although there may be evidence of lower overall health risks compared with cigarette smoking, there is still evidence of harm and addiction. In view of the health risks and the possibility that consumers may be led to believe they are using a relatively harmless product, we are not persuaded that permitting snus or conducting further research on the health risks is a helpful approach. Allowing snus might also carry the risk of increasing health inequalities in the UK as members of certain ethnic groups who already have a culture of chewing stimulants, such as betel nut, might more easily take up snus [para 6.25].

12   Although the report *Public health: the ethical issues* does not directly refer to the advertising of tobacco *accessories*, the wider approach taken to tobacco advertising in general applies.

13   Policies on selling and advertising tobacco and alcohol that afford the greatest protection to consumers should be adopted. The members of the UK Tobacco Manufacturers' Association and other companies that produce or market tobacco products should implement a voluntary code of practice that universalises best practice in terms of consumer protection [para 6.27].

Further Comments

14   Question seven of the consultation related to the advertising and promotion of tobacco accessories. While the Council report does not specifically address this issue, it is important to note that, in relation to advertising tobacco products generally, it is ethically inconsistent for tobacco and alcohol companies advertising and selling their products in developed countries to claim corporate social responsibility, yet apply different standards for protecting consumers in different countries depending on local laws [para 6.27].

15   Acting ethically exceeds simply complying with relevant laws and regulations. Policies on selling and advertising tobacco and alcohol that afford the greatest protection to consumers should be adopted worldwide. The members of the UK Tobacco Manufacturers' Association and other companies that produce or market tobacco products should implement a voluntary code of practice that universalises best practice in terms of consumer protection. One example would be worldwide adherence to standards in advertising that have been developed and agreed by the industry in the EU, and particularly the UK [para 6.27].