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EQUITABLE CONSEQUENCES?

Issues of Evidence, Equity and Ethics Arising from Outdoor Smoke-free Policies

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Introduction

Kass argues that an ethical approach in public health is one that places the fewest burdens on individuals' health without significantly reducing the potential benefits of intervening.[1] Yet many population health regulations are highly intrusive, compromising individual liberty and imposing penalties for non-compliance. Moreover, the benefits of these regulations and the burdens they impose may not be shared equally. When developing interventions, the state has, therefore, an obligation to consider the benefits and burdens, particularly on those vulnerable to health inequities and other disparities.[2]

The prevalence of smoking in the general population of Canada is low (18%), but remains elevated in certain sub-populations,[3] raising the possibility that universal tobacco control policies may impose disproportionate burdens on some and exacerbate health inequities.[4] Outdoor smoke-free policies are

being increasingly introduced within Canada even as evidence remains inconclusive about the risks of secondhand smoke exposure in outdoor settings and the efficacy of such bans. To remain consistent with Kass' definition of an ethical approach, the design and implementation of outdoor smoke-free policies should question whether these bans could result in an imbalance of benefits and burdens. Further, whether such bans increase the stigmatization of smokers and, in so doing, violate a core ethical principle and potentially increase health inequities should also be considered.[4,5]

Case

Municipalities are increasingly prohibiting smoking in parks, beaches and other outdoor public spaces. Smoke-free spaces are primarily justified on the basis of three goals: (i) reducing exposure to secondhand smoke; (ii) encouraging people to quit smoking; and (iii) preventing youth smoking initiation.[6]

Does evidence demonstrate that such bans effectively, equitably and ethically accomplish these goals? On balance, smoke-free policies in parks and on beaches may have a small positive population health impact. Such policies may reduce secondhand smoke exposure by eliminating the combination of circumstances that creates sufficient concentration of tobacco smoke to pose serious health risk; such bans may also facilitate smoking cessation or reduction for some people. There is little evidence to date, however, that smoke-free policies in parks and on beaches have an impact on the prevention of smoking initiation among youth. As well, the documented positive benefits may be offset by other, unintended consequences, such as when the stigmatization of smoking makes it harder for some smokers to quit or contributes to stigmatization.[4, 7–9]

While smoking prevalence among the general population in Canada (as in many high-income countries) is relatively low and declining, smoking rates are disproportionately high among youth,[3] low-income adults,[10] people with substance use disorders and/or mental illness[11–13] and Aboriginal people.[14, 15] These uneven rates of smoking both reflect and contribute to social and geographical health inequalities.[4] Universal outdoor smoke-free policies may have different effects on such sub-groups of smokers, including their use of tobacco, exposure to tobacco smoke and responses to smoking restrictions.[16] Paradoxically, by limiting the settings in which smoking is

allowed, smoking restrictions in public spaces may increase the concentration of secondhand smoke in private indoor spaces such as homes and cars and prompt strategies of resistance rather than compliance.[4] This could be particularly problematic for those without access to safe outdoor spaces and, by increasing exposure to tobacco smoke indoors, may undermine potential health benefits. Moreover, smoking restrictions in public spaces are intended to reduce the prevalence of tobacco use, in part by reducing the social acceptability of smoking.[17–19] Such denormalization of tobacco segregates smokers, makes them an identifiable minority, may compound experiences of social isolation and marginalization and may contribute to poorer quality of health among individuals who already face discrimination on multiple levels.[4, 7, 8, 20, 21] Stigmatization may contribute to poorer health outcomes and greater health inequity by generating higher levels of stress and contributing to reluctance to seek care.[22] Moreover, some argue that, by definition, the use of stigma as a public health strategy is inherently unethical because it is dehumanizing through its use of shaming to exert social control.[5]

Could proportionate universalism, wherein actions are tailored to the level of need or disadvantage, complemented by the behavioural justice approach, which places the responsibility on society to provide opportunities for all to make healthier choices, help address the ethical challenges posed by this imbalance in burdens and benefits? Applying these principles might lead to structural interventions designed to address the challenges facing disadvantaged smokers, thereby enhancing the positive aims and outcomes of smoke-free policies for all.

Scenario shift

Smoking in private cars when children are present has recently been identified as an environment for public health intervention to further reduce exposure to secondhand smoke. While policies legislating this behaviour are seen by some as an infringement on individual rights, scientific evidence exists which shows there is the potential for significant harm to those exposed to smoke in this enclosed environment.[23] In a discussion about John Stuart Mill's Harm Principle, Upshur[24] argues that public health interventions are justified when a behaviour or action causes undue harm to others, but should not be implemented merely for the benefit of the person who engages in the

behaviour. Therefore, the ethical issues raised by outdoor smoking bans are altered when considering the banning of smoking in spaces such as private vehicles because there is evidence that such behaviour is potentially harmful to both smokers and non-smokers.

Questions for discussion

1 Some have argued that it is never acceptable for the state to use shaming as a mechanism of social control. The stated goal of tobacco "denormalization" policies in Canada and elsewhere is to stigmatize smoking without stigmatizing the person who smokes. Is this possible?

2 A number of jurisdictions have introduced outdoor bans by designating specific spaces for smoking. Does this approach address the equity and ethical issues identified here? Or are we establishing "smoking islands" which cast smokers as outsiders and poor citizens for not taking responsibility for their health?

3 Some might argue that it is ethical to do anything that reduces the prevalence of smoking among vulnerable groups because the benefits associated outweigh the costs. Is such paternalism justified in public and population health practice?

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REFERENCES

1 Kass, N. E. (2001). *An ethics framework for public health*. Am J Public Health. 2001;91(11):1776–1782.

2. Childress, J. F., Faden, R. R., Gaare, R. D., et al. (2002). *Public health ethics: Mapping the terrain*. J Law Med Ethics. 2002;30(2):170–178.

3 CTUMS. (2010). *Canadian Tobacco Use Monitoring Survey* (CTUMS) 2010. Retrieved from: http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2010-eng.php
4 Thompson, L., Pearce, J. & Barnett, J. R. (2007). *Moralising geographies: Stigma, smoking islands and responsible subjects*. Area. 2007;39(4):508–517.
5 Burris, S. (2008). *Stigma, ethics and policy: A commentary on Bayer's "Stigma and the ethics of public health: Not can we but should we"*. Social Science & Medicine. 2008; 67:473–475.
6 Thomson, G., Wilson, N. & Edwards, R. (2009). *At the frontier of tobacco control: A brief review of public attitudes toward smoke-free outdoor places*. Nicotine Tob Res. Jun 2009; 11(6):584–590.
7 Burgess, D. J., Fu, S. S. & van Ryn, M. (2009). *Potential unintended consequences of tobacco-control policies on mothers who smoke: A review of the literature*. Am J Prev Med. 2009;37(2, Supplement 1):S151–S158.
8 Bell, K., McCullough, L., Salmon, A. & Bell, J. (2010). *'Every space is claimed': Smokers' experiences of tobacco denormalisation*. Sociology of Health and Illness. 2010;32(6):914–929.
9 Lawn, S. J., Pols, R. G. & Barber, J. G. (2002). *Smoking and quitting: A qualitative study with community-living psychiatric clients*. Soc Sci Med. 2002;54(1):93–104.
10 Dube, S., Asman, K., Malarcher, A. & Carabollo, R. (2009). *Cigarette smoking among adults and trends in smoking cessation — United States, 2008.* Morbidity and Mortality Weekly Report. 2009;58(44):1227–1232.
11 Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D. & Bor, D. H. (2000). *Smoking and mental illness*. JAMA-J Am Med Assoc. 2000;284(20):2606–2610.
12 Degenhardt, L. and Hall, W. (2001). *The relationship between tobacco use, substance-use disorders and mental health: Results from the National Survey of Mental Health and Well-being.* Nicotine Tob Res. 2001;3(3):225–234.
13 Grant, B. F., Hasin, D. S., Chou, S. P., Stinson, F. S. & Dawson, D. A. (2004). *Nicotine dependence and psychiatric disorders in the United States*: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2004;61(11):1107–1115.
14 Health Canada. (2007). *First Nations, Inuit and Aboriginal Health: Tobacco*. Retrieved from: http://www.hc-sc.gc.ca/fniah-spnia/substan/tobac-taba/index-eng.php
15 Assembly of First Nations RHS National Team. (2007). *RHS Our Voice, Our Survey, Our Reality: Selected Results from RHS Phase 1 (2002/03)*. Ottawa, ON: Assembly of First Nations.
16 Greaves, L. and Jategaonkar, N. (2006). *Tobacco policies and vulnerable girls and women: Toward a framework for gender sensitive policy development*. J Epidemiol Commun H. 2006;60:ii57–65.
17 Bayer, R. and Colgrove, J. (2002). *Science, politics, and ideology in the campaign against environmental tobacco smoke.* Am J Public Health. 2002;92(6):949–954.

18 Chapman, S. and Freeman, B. (2008). *Markers of the denormalisation of smoking and the tobacco industry*. Tob Control. 2008;17:25–31.
19 Zhang, X., Cowling, D. W. & Tang, H. (2010). *The impact of social norm change strategies on smokers' quitting behaviours*. Tob Control. 2010;19(Suppl 1):i51–i55.
20 Stuber, J., Galea, S. & Link, B. G. (2008). *Smoking and the emergence of a stigmatized social status.* Social Science & Medicine. 2008;67(3):420–430.
21 Ritchie, D., Amos, A. & Martin, C. (2010). *"But it just has that sort of feel about it, a leper" — Stigma, smoke-free legislation and public health*. Nicotine Tob Res. 2010;12(6):622–629.
22 Bell, K., Salmon, A., Bowers, M., Bell, J. & McCullough, L. (2010). *Smoking, stigma and tobacco 'denormalization': Further reflections no the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue* (67:3). Social Science & Medicine. 2010;70:795–799.
23 Rees, V. and Connolly, G. (2006). *Measuring air quality to protect children from secondhand smoke in cars*. Am J Prev Med. 2006;31(5):363–368.
24 Upshur, R. E. G. (2002). *Principles for the justification of public health intervention.* Can J Public Health 2002;93(2):101–103.