MITCHELL | HAMLINE School of Law

William Mitchell Law Review

Volume 34 | Issue 4 Article 13

2008

A Canadian's Perspective: Limits of Tobacco Regulation

David Sweanor

A CANADIAN'S PERSPECTIVE: LIMITS OF TOBACCO REGULATION

David Sweanor J.D.[†]

I. INTRODUCTION 1595
II. "CHECKED ALL THE BOXES" 1598
III. OBSTACLES TO TRADITIONAL REGULATION 1598
A. Diminishing Returns 1599
B. Self-Imposed Limits 1600
C. Existing Regulations Seen as an End Instead of a Means .. 1601
IV. WHICH WAY FORWARD? 1604

I. INTRODUCTION

Canada is widely seen as an example of what can be accomplished by effective tobacco control efforts.[1] The country's numerous policy precedents have been replicated in many countries and have shaped international efforts on tobacco regulation, such as the World Health Organization's Framework Convention on Tobacco Control.[2] The result of Canada's policy interventions is a decline in cigarette smoking over the past quarter century that few countries have been able to match.[3]

[†] Adjunct Professor of Law, University of Ottawa; Special Lecturer, Division of Epidemiology and Public Health, University of Nottingham.

1. David Sweanor & Ken Kyle, *Legislation and Applied Economics in the Pursuit of Public Health: Canada*, *in* TOBACCO CONTROL POLICY: STRATEGIES, SUCCESSES AND SETBACKS 71 (Joy de Beyer & Linda Waverly Brigden eds., 2003).

2. *See* World Health Org. (WHO), *Framework Convention on Tobacco Control*, *at* http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf (last visited Apr. 8, 2008).

3. *See* Donald W. Gardner & Richard J. Whitney, *Protecting Children from Joe Camel and His Friends: A New First Amendment and Federal Preemption Analysis of Tobacco Billboard Regulation*, 46 EMORY L.J. 479, 523–24 (1997); Jennifer Lesny, *Tobacco Proves Addictive: The European Community's Stalled Proposal to Ban Tobacco Advertising*, 26 VAND. J. TRANSNAT'L L. 149, 165 n.143 (1993); *see also* Health Canada, *The National Strategy: Moving Forward—The 2006 Progress Report on Tobacco Control*, Jan. 15. 2007, http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/prtc-relct-

The accomplishment is based, in part, on the fact that Canada started with such a horrendous problem. In the early 1980s, when I first started working full time on tobacco control efforts, Canada had one of the most serious smoking problems in the world. Per capita cigarette consumption was among the highest in the world, with over 40% of fifteen to nineteen-year olds reported to be daily smokers.[4] There were no legislated restrictions on tobacco advertising, no legislated package warnings, and negligible protection from environmental tobacco smoke.[5] Cigarette taxes were not only low, but had fallen in real terms for decades.[6] This situation can be attributed in part to the fact that the tobacco manufacturers were powerful and extremely well connected politically.[7] Also, Canada was a large producer of tobacco with a crop size that, on a per capita basis, was considerably larger than that of the United States at the time.[8]

Currently, Canada has tobacco taxes that are not only among the highest in the world,[9] but are also expressly linked to the goal of reducing smoking.[10] Tobacco advertising and promotion are essentially banned,[11] retail displays are disappearing,[12] graphic health warnings cover half the cigarette package,[13] and additional health information is required as package inserts.[14] Federal law mandates extensive constituent testing and requires disclosure of the results to the federal health department.[15] All cigarettes must meet reduced ignition propensity standards.[16] In addition, smoke-free spaces for public (and many private) areas are mandated by law,[17] and there are legislated—and enforced—restrictions regarding where and to whom cigarettes can be sold.[18]

2006/part2_e.html#1b (showing a greater than 60% decline in per capita consumption from the early 1980s to 2005).

4. Sweanor & Kyle, *supra* note 1, at 73 (citing Health Canada, *Canadians Smoking: An Update*, Cat. No. H39-214/1991E (1991)).

5. *Id.*

6. *Id.* at 74.

7. *Id.* at 73.

8. *Id.*

9. *Id.* at 87–90.

10. *Id.*

11. *See* Tobacco Act, R.S.C., ch. 13, pt. IV(22) (1997).

12. *Id.* at pt. IV(29)–(30).

13. *Id.* at pt. III(15)(1); Sweanor & Kyle, *supra* note 1, at 84.

14. Tobacco Act, R.S.C., ch. 13, pt. III(15)(2).

15. *Id.* at pt. I(7).

16. *Id.*

17. *See* Non-Smokers' Health Act, R.S.C., ch. 15, pt.(3) (1985) (stating that

As a direct result of these policy interventions, per capita cigarette consumption in Canada is down by roughly 60% in the past quarter century.[19] Canada entered the 1980s with a reported smoking prevalence of over 40%.[20] By 2006, only 18% of Canadians fifteen years and older reported being smokers and only 14% reported being daily smokers.[21] Perhaps even more impressive, reported daily smoking among fifteen to nineteen-year olds decreased from 42% at the beginning of the 1980s to only 9% in 2006.[22]

In examining the way policy changes have so dramatically reduced cigarette consumption in Canada, there can be a tendency to think that Canada is somehow different from other countries and that tobacco control policies were somehow easier to achieve. But public policy is like a game of football. Political changes do not happen spontaneously any more than a football moves up or down a field on its own. Policy issues, like footballs, move based on the forces brought into play. In Canada, the health side of policy was not actively engaged in the politics of tobacco until the early 1980s.[23] Once health policy became an issue, the country was radically transformed through a long series of campaigns, and virtually everything found on most standard lists of tobacco control strategies has now been implemented.[24]

This raises some interesting questions, not the least of which is why a lawyer who was a key player in so many of these regulatory battles, who built a career around fighting for such measures and convincing others that policy interventions were the most important measures available to counter the health toll of smoking, would now be asked to talk about "the limits to regulation." To be honest to our long term health objectives, however, it is extremely important to critically examine what has been accomplished

nothing in the act requiring smoke-free environments affects any rights to protection from tobacco smoke under any Act of Parliament or provincial legislation).

18. *See, e.g.*, Tobacco Act, R.S.C., ch. 13 (1997) (limiting how, where, and to whom cigarettes may be sold); Smoke-Free Ontario Act, R.S.O., ch. 10 (1994) ("No person shall sell or supply tobacco to a person who is less than 19 years old.").

19. *See* Health Canada, *supra* note 3.

20. *Id.*

21. *Id.*

22. *Id.*

23. *See* Sweanor & Kyle, *supra* note 1, at 74–81.

24. *Id.* at 74–95.

through policy interventions, to be open to the thought that some of our interventions have not achieved all of our goals, and to think about where tobacco control policy needs to head in the future.

II. "CHECKED ALL THE BOXES"

Canadian tobacco control advocates are perhaps in an ideal position to consider the limits of regulation because Canada is one of a growing number of countries that have implemented virtually all of the components of traditional comprehensive strategies to reduce smoking.[25] The country has "checked all the boxes." Despite all of the policy successes and the dramatic reductions in cigarette smoking over the past quarter century, however, there are still over 4.5 million Canadians who smoke,[26] and smoking is still the country's leading cause of preventable death.[27] Further, many policies have reached either a limit on what can be done, or at least a state of greatly diminishing marginal returns.

Tobacco control is not unlike efforts to contain other causes of disease where measures have been used that reduce the severity of a problem but still leave a large number of people who appear unresponsive to standard treatments. The medical profession deals with such issues on an ongoing basis, and the role of skilled physicians is to consider the limits of standard treatments, prevent iatrogenic conditions, and look to new interventions that can lessen the remaining risks. Public policy advocates dealing with tobacco-caused disease should be just as vigilant.

III. OBSTACLES TO TRADITIONAL REGULATION

Simply doing "more of the same" is a seemingly attractive option when actions to date have worked remarkably well. But, as with doctors who might be tempted to treat an antibiotic-resistant disease with more of the same antibiotics—after all, the treatment worked successfully with plenty of other people presenting with similar symptoms—it is important to consider the limits, as well as the successes of our interventions.

25. *Id.*

26. *See* Health Canada, *Canadian Tobacco Use Monitoring Survey*, Dec. 12, 2007, http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/_ctumsesutc_2006/wave-phase-1_summary-sommaire_e.html.

27. Health Canada, *Smoking and Your Body*, Jan. 24, 2008, http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/body-corps/index_e.html.

A. Diminishing Returns

The first broad category of limits to regulation in Canada is the decreasing marginal benefits of simply continuing to apply traditional tobacco control interventions. An example of this can be seen in relation to tax policy. Canada was able to dramatically increase the price of cigarettes, in part because the price had been so low.[28] Tripling real prices has a tremendous dampening effect on consumption,[29] but tripling prices again is nearly impossible. Among other issues facing Canada, there is now a significant contraband market.[30] Although hard to estimate, it appears that cigarettes manufactured on, or shipped through, Indian Reserves could account for as much as 20% of current cigarette consumption in Canada's two most populous provinces.[31] The presence of these alternative, untaxed sources of supply clearly limit the pursuit of policies that are aimed at making tobacco products less available to smokers through further tax increases. At the same time, measures aimed at requiring cigarettes to be made less palatable to smokers or otherwise trying to force smokers to quit via regulation[32] become less viable in the face of this illicit supply. In effect, tobacco control policy aimed at forcing

28. *See* Sweanor & Kyle, *supra* note 1, at 91 (figure showing that the retail price for 200 cigarettes in Canada was less than twenty Canadian dollars into the early 1980s).

29. *See* WORLD HEALTH ORG., WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2008: THE MPOWER PACKAGE 39 (2008), http://www.who.int/tobacco/mpower/mpower_report_full_2008.pdf [hereinafter WHO REPORT] ("A 70% increase in the price of tobacco could prevent up to a quarter of all smoking-related deaths worldwide.").

30. GFK RESEARCH DYNAMICS, ILLICIT USAGE OF CIGARETTES—NATIONAL STUDY FOR THE C.T.M.C.—CANADIAN TOBACCO MANUFACTURERS COUNCIL 8 (2007) (showing that 22% of purchased cigarettes in 2007 in Canada were contraband, an increase from 16.5% in 2006).

31. In Ontario, 31.6% of cigarettes purchased were contraband. *Id.* at 11. 40.7% of contraband cigarettes were bought on Indian Reserves. *Id.* at 26. As a result, approximately 12.9% of all cigarettes purchased in Ontario were contraband bought on Indian Reserves. In Quebec, 30.5% of purchased cigarettes were contraband. *Id.* at 11. 20.6% of contraband cigarettes came from Indian Reserves. *Id.* at 26. Thus, about 6.3% of all cigarettes purchased in Quebec were contraband bought on Indian Reserves.

32. *See, e.g.*, PHYSICIANS FOR A SMOKE-FREE CANADA, TOBACCO-FREE PHARMACIES (2006), http://www.smoke-free.ca/pdf_1/pharmacy-backgrounder.pdf (advocating banning sales of tobacco in pharmacies).

abstinence is running into some of the same constraints as past and present prohibitionist approaches to alcohol and other drugs.[33]

Further examples of diminishing returns from our policy interventions can be found in the realm of smoke-free policies. Making all workplaces and public areas smoke-free is expected to have a significant impact on both the number of smokers and the amount of cigarettes that are consumed.[34] A tremendous number of smokers are impacted when workplaces and public areas go smoke-free, but once we move into the realm of "tidying up the leftovers"—such as trying to extend smoke-free policies into areas like shared residential buildings—we can expect less overall impact, simply because we are dealing with far smaller numbers of affected people. There are certainly gains that can still be made through the application of more traditional approaches to tobacco control, but such gains pale in comparison to both the accomplishments of the past (the low hanging fruit is gone) and to the magnitude of the projected future health toll from smoking.

B. Self-Imposed Limits

The second broad category of limits on regulation is, paradoxically, effectively self-imposed by the culture of the tobacco control movement. Canada has done much to reduce smoking onset, encourage cessation, and protect non-smokers. Now, the country is running up against the limits of tobacco regulation caused by the attitude of the now-entrenched anti-tobacco community to regulation.[35] Tobacco control advocates have, like other social groups, developed their own paradigms through which they see the world and possibilities for further interventions.[36] As Thomas Kuhn's work demonstrates so well, such paradigms dictate

33. *See generally* CRAIG HERON, BOOZE: A DISTILLED HISTORY 235–66 (2003) (discussing Canada's experience with Prohibition in the 1920s).

34. *See* WHO REPORT, *supra* note 29, at 26 ("Smoke-free laws in workplaces can cut absolute smoking prevalence by 4%. Smoke-free policies in workplaces in several industrialized nations have reduced total tobacco consumption among workers by an average of 29%.").

35. *See, e.g.*, Physicians for a Smoke-Free Canada, About Us, http://www.smoke-free.ca/eng_home/pschome_about.htm (last visited Apr. 12, 2008). The organization has "one goal," which is "the reduction of tobacco-caused illness through reduced smoking and exposure to second-hand smoke." *Id.*

36. *See* THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 24 (2d ed. 1970) ("[T]he paradigm forces scientists to investigate some part of nature in a detail and depth that would otherwise be unimaginable.").

what is acceptable and can blind people to effective alternative courses of action.[37] The result is that a critical limitation on further regulation is actually self-imposed by the views of tobacco control advocates. This can either cause the pursuit of less effective health interventions or prevent the pursuit of strategies likely to yield greater gains.[38]

Further regulatory progress is, for example, constrained by lobbying for impractical goals based on an ideological view of appropriate interventions rather than a pragmatic public health orientation. A group sharing an ideology often sees such schemes as deeply desirable, but these schemes stymie progress on policy interventions by redirecting energy and resources from practical goals to unattainable, ineffective, or even counter-productive strategies. Examples of this, in the case of Canada, include pursuing the nationalization of the tobacco industry[39] and pursuing restrictions on tobacco use that cannot be justified on the basis of protecting others, such as promoting prohibition of the use of *any* tobacco product *anywhere* on the grounds of hospital campuses.[40]

C. Existing Regulations Seen as an End Instead of a Means

A further limitation on regulatory strategies is that, in some cases, existing regulatory measures, such as blanket advertising bans, graphic package warnings, or industry de-normalization, have come to be seen as an end in themselves rather than as a means of achieving improved public health.[41] As such, efforts to re-think such measures are often rejected out-of-hand by anti-tobacco forces

37. *See id.* at 64 ("In the development of any science, the first received paradigm is usually felt to account quite successfully for most of the observations and experiments easily accessible to that science's practitioners.").

38. *See id.* ("[P]rofessionalization leads, on the one hand, to an immense restriction of the scientist's vision and to a considerable resistance to paradigm change.").

39. *See* CYNTHIA CALLARD ET AL., CURING THE ADDICTION TO PROFITS: A SUPPLY-SIDE APPROACH TO PHASING OUT TOBACCO 14–15 (2005), http://www.policyalternatives.ca/documents/National_Office_Pubs/2005/curing_the_addiction_summary.pdf.

40. Ottawa Hospital instituted a campus-wide smoke-free policy in June 2006. Ottawa Hospital, Designated Smoking Areas, http://www.ottawahospital.on.ca/media/extras/smoke-zones-e.asp (last visited Apr. 12, 2008). However, the hospital changed the policy in November 2007 and now allows smoking in three designated outdoor areas. *Id.* Unintended consequences of the policy included effects on patient and employee safety, as well as on neighboring businesses. *Id.*

41. *See, e.g.*, WHO REPORT, *supra* note 29, at 36–38 (advocating "complete" and "comprehensive marketing bans" on tobacco companies).

as being "a step backwards." Yet, this is inconsistent with the pragmatic approaches and recognition of the differences between means and ends advocated by such social reformers as Saul Alinsky,[42] and it can stymie further progress at attaining health goals. For instance, a regulatory strategy could include advertising less toxic tobacco products to current smokers as an alternative to cigarettes, mandating smoker-friendly package messaging aimed directly at facilitating cessation, or differentiating between the culpability of different tobacco companies as a way of changing the behavior of the tobacco companies that are benefiting most from a status quo centered on cigarettes. In the absence of a willingness to re-examine previously passed regulatory strategies, however, progress in such areas is impossible.

This self-imposed constraint on acceptable action by some of those promoting a tobacco control agenda is perhaps most notable—and most damagingly counter-productive—when one examines the issue of harm reduction for nicotine users. There is no scientific doubt that there is a vast continuum of risk depending upon how someone obtains nicotine.[43] If all smokers obtained their nicotine from medicinal or low-toxicity non-combustion products, the health concerns about the drug would approach those associated with the contemporary use of caffeine.[44] Yet many tobacco control advocates generally dismiss the idea of harm reduction in favor of an abstinence-only (or "quit-or-die") orientation.[45] The result is that these tobacco control advocates

42. *See generally* SAUL ALINSKY, RULES FOR RADICALS (Vintage Books ed. 1989) (1972).

43. *See, e.g.*, Neal Benowitz, *The Safety and Toxicity of Nicotine*; TOBACCO ADVISORY GROUP, ROYAL COLL. OF PHYSICIANS, HARM REDUCTION IN NICOTINE ADDICTION: HELPING PEOPLE WHO CAN'T QUIT 88–103, 119–29 (2007), *available at* http://www.rcplondon.ac.uk/pubs/Listing.aspx (follow "Harm reduction in nicotine addiction" hyperlink) (discussing the variety of sources of nicotine and the use of nicotine replacement therapy); Kenneth E. Warner et al., *The Emerging Market for Long-Tern Nicotine Maintenance*, 278 J. AM. MED. ASS'N 1087 (1997) (discussing alternative nicotine-delivery products and a variety of regulatory approaches).

44. *See* BENNETT ALAN WEINBERG & BONNIE K. BEALER, THE WORLD OF CAFFEINE, 303–15 (2001) (discussing how caffeine does cause physical dependence, and toxicity in high doses, but that caffeine use has been normalized). Although physical dependence results, it has not been classified as a clinical dependence syndrome. *Id.* at 303, 306–08.

45. *See* WHO REPORT, *supra* note 29, at 7 ("We must act now to reverse the global tobacco epidemic and save millions of lives."). The WHO estimates one billion deaths from the "tobacco epidemic" in the twenty-first century "unless urgent action is taken." *Id.* at 6.

often sound more like moralists seeking to save souls rather than health campaigners seeking to save lives.[46] This is consistent with what has been experienced in numerous other public health campaigns throughout history[47] and a critical question for future policy directions is just how quickly tobacco control efforts can evolve to become more pragmatic rather than dogmatic.

Abstinence-only orientation, among other things, has greatly limited the ability to implement product standards that can reduce risks for continuing users of nicotine, thereby fulfilling the "fourth leg of public health interventions."[48] This orientation is also strongly at odds with past successful efforts to regulate goods and services which have been principally based on the recognition of differential risks and the resulting ability of regulation to reduce death, injury, and disease.[49] The failure to accept harm reduction strategies as part of its regulatory armamentarium has also sacrificed the moral high ground on the issue of the human rights of smokers. It has gone so far as to include gross

46. *Id.* "The cure for this devastating epidemic is dependent not on medicines or vaccines, but on the concerted actions of government and civil society." *Id.* at 7.

47. *See, e.g.*, ALLAN M. BRANDT, NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880 (1st ed. 1985) (discussing efforts to curb venereal diseases in the United States since 1880); ESTHER KAPLAN, WITH GOD ON THEIR SIDE: HOW CHRISTIAN FUNDAMENTALISTS TRAMPLED SCIENCE, POLICY, AND DEMOCRACY IN GEORGE W. BUSH'S WHITE HOUSE 194–218 (2004) (discussing the Bush administration's effort to combat teen pregnancy and STDs through an abstinence-only message); JAMES HARVEY YOUNG, PURE FOOD: SECURING THE FEDERAL FOOD AND DRUGS ACT OF 1906 (1989) (discussing the campaign to pass the Federal Food and Drugs Act of 1906); David Sweanor et al., *Tobacco Harm Reduction: How Rational Public Policy Could Transform a Pandemic*, 18 INT'L J. DRUG POL'Y 70 (2007) (discussing alternative systems of nicotine delivery and a harm-reduction approach, as opposed to an abstinence-only approach).

48. *See* Sweanor et al., *supra* note 47, at 70 (delineating four broad categories of intervention aimed at "reducing the risk of death, injury or disease from any behaviour" as "efforts to prevent the behaviour ever taking place, efforts aimed at ending the behaviour, efforts aimed at preventing the activity from harming third parties, and efforts aimed at reducing the risks of those who engage in the behaviour"); *see also* David Sweanor, *Legal Strategies to Reduce Tobacco-Caused Disease*, 8 RESPIROLOGY 413, 417 (2003) (discussing both legislative and litigation efforts to address tobacco use).

49. *See e.g.*, SANDRA HEMPEL, THE STRANGE CASE OF THE BROAD STREET PUMP: JOHN SNOW AND THE MYSTERY OF CHOLERA (Univ. of Cal. Press 2007) (2006) (discussing John Snow's effort to discover the cause behind an 1854 London cholera epidemic); YOUNG, *supra* note 47 (discussing the pre-cursors to the eventual regulation of food quality).

misrepresentations of relative risk in an apparent effort to adhere to an abstinence-only agenda.[50]

IV. WHICH WAY FORWARD?

Canada stands as a good example of the limits of standard tobacco regulatory measures and, simultaneously, the limits imposed by the tobacco control community itself on what may be seen as acceptable regulatory measures. Seeking a way forward via the next generation of tobacco control is of huge importance if Canada is to successfully reduce the projected toll of a million smoking-caused deaths in the country over the next quarter century.[51] Canada is also at the leading edge of global tobacco control policy.[52] The path Canada takes will be of enormous importance to the rest of the world because it is projected that a billion smoking-caused deaths will occur globally this century.[53]

50. *See, e.g.*, *Can Tobacco Cure Smoking? A Review of Tobacco Harm Reduction: Hearing Before the Subcomm. on Commerce, Trade, and Consumer Protection of the H. Comm. on Energy and Commerce*, 108th Cong. 40 (2003) (statement of Richard Carmona, U.S. Surgeon General) ("Smokeless tobacco is not a safe alternative to cigarettes."); Carl V. Philips et al., *You Might as Well Smoke*, BMC PUB. HEALTH 4, Apr. 5, 2005, http://www.biomedcentral.com/content/pdf/1471-2458-5-31.pdf (identifying 108 websites claiming "risks from [smokeless tobacco] are as bad or worse than those from smoking"). "[U]se of Western smokeless tobacco (ST) is substantially less harmful than smoking cigarettes." *Id.* at 1. *See also* PHYSICIANS FOR A SMOKE-FREE CANADA, REFLECTIONS ON THE 'SWEDISH EXPERIENCE': IS SNUS UP TO SNUFF? (2003), http://www.smoke-free.ca/pdf_1/snus.pdf (discussing health effects of a Swedish smokeless tobacco product).

51. *See* PARVIS GHADIRIAN, SLEEPING WITH A KILLER: THE EFFECTS OF SMOKING ON HUMAN HEALTH 6–7 (2008), *available at* http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/swk-dat/swk-dat_e.pdf. About one in six smokers are projected to die by the 2020s–2030s, and there were 5.4 million Canadian smokers in 2001. *Id.*

52. *See* Sweanor & Kyle, *supra* note 1, at 71 (stating that the number of Canadian smokers declined from 1965–2001 from 50% of the population to 22%).

53. WHO REPORT, *supra* note 29, at 6.