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Differential access to health care and support? A qualitative analysis of how Australian smokers conceptualise and respond to stigma

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Abstract
Scholarship on stigma, originally theorised as a 'mark' of social disgrace or difference, has since moved away from individual-level analyses to consider the socio-cultural context in the 'marking' of groups of people. In response to this theoretical shift, scholars have demonstrated how extensive tobacco denormalisation policies have contributed to the stigmatisation of smokers, documenting smokers' experiences of stigma across a number of developed countries. We extend this analysis to the Australian context, examining smokers' constructions of stigma and their reactions to policies that would give smokers differential access to healthcare. Based on 29 interviews with Australian smokers, we focus on what constitutes evidence of stigma and how participants' use social comparisons to respond to stigma. We then explore an assumption underpinning participants' accounts of stigma: that only smokers committed to cessation are 'deserving' of treatment. We close by discussing theoretical perspectives and opportunities in stigma research and the need to extend a stigma lens to study emerging public health issues, such as electronic cigarettes.
Keywords: stigma, smoking, tobacco denormalisation, qualitative research, Australia,

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Internationally, the tobacco control movement accelerated in the 1960s and 1970s after the release of two major health reports documenting the harms of smoking. The US Surgeon General's report in 1964 represented the first major health warning about the significant health effects of smoking (US Surgeon General, 1964). The US Surgeon General's report in 1972 was the first to warn of the significant harm of second-hand smoke to non-smokers, including children and babies (US Department of Health, 1972).

The tobacco control movement aims to reduce smoking rates and prevent uptake by denormalising tobacco use. In broad terms, denormalisation has been defined as "all programs and actions undertaken to reinforce the fact that tobacco use is not a mainstream or normal activity in our society" (Lavack, 1999, p. 82). In their analysis of government documents, public polls and marketing reports, Markle and Troyer (1979) tracked the changing positioning of smoking in its re-marketing by tobacco control advocates as a deviant behaviour. They stated that "attacks on smoking and tobacco have continued, but with different emphasis, during the mid and late 1970s. [...] New regulations, which treat the smoker more as enemy than friend, focus on the protection of minors, air and food pollution and fire prevention" (p. 612).

Tobacco denormalisation policies, including legislation to ban smoking in public places, have subsequently shaped social norms surrounding smoking (Poland, 2000) to the extent that scholars have argued that denormalisation has also contributed to the active stigmatisation of smoking and smokers (Poland, 1998; Voigt, 2013).

Smoking-related stigma

Stigma, according to Goffman (1963), arises when an individual bears an attribute or 'mark' of social disgrace or difference. In response to the extensive uptake of the concept of stigma in the social sciences, Link and Phelan (2001) proposed a return to studying stigma from a

distinctly sociological perspective. Specifically, they argued that five components need to co-occur in order for stigma to occur: distinguishing and labelling differences; associating differences with negative attributes; separating ‘us’ from ‘them’; status loss and discrimination; and the dependence of stigma on power differentials.

Bell, McCullough, Salmon, and Bell (2010) were the first to apply Link and Phelan’s (2001) stigma framework to smoking. Bell and colleagues conducted an analysis of interviews with 25 Canadian current and ex-smokers to examine how participants interpreted and responded to tobacco denormalisation policies. The authors identified the stigmatised identity of a smoker, an identity to which participants oriented in their interviews, as they described their experiences of being stereotyped and labelled. According to Bell and colleagues, participants’ experiences, along with their perceived loss of social status, fit within Link and Phelan’s framework of stigma. In relation to power, the authors argued that “given the class composition of smoking and the growing concentration of smoking amongst the poor and disenfranchised, stigma is clearly dependent upon social, cultural, economic and political power differences between smokers and non-smokers” (p. 922). They suggested that smokers are susceptible to dual forms of stigmatisation, in that smoking stigma becomes connected with the stigma associated with material deprivation to the extent that smoking becomes concentrated among the socio-economically disadvantaged.

In light of the increasing socio-economic inequalities in smoking (Graham, 2012; Thompson, Pearce, & Barnett, 2007), there has been significant debate about the ethics of deliberately stigmatising smoking and smokers through public health policy (Bayer, 2008; Guttman & Salmon, 2004; Stuber, Galea, & Link, 2009). Although tobacco use is legal, it has been argued that stigma is being used as a tool to replace the prohibition of tobacco use (Bell, Salmon, Bowers, Bell, & McCullough, 2010). That is, stigma is being used as a form of social control, coercing people to adopt ‘healthier’ behaviours (Burris, 2008) and instilling

middle-class values as the yardstick of ‘acceptable’ behaviour (Poland, 1998). Also considered problematic is the inclusion of moral overtones in anti-smoking campaigns, which have been said to elicit feelings of guilt, shame and blame (Brown-Johnson & Prochaska, 2015; Guttman & Salmon, 2004; Voigt, 2013).

However, there have been questions about the relationship between the tobacco denormalisation movement and stigmatisation (Burris, 2008). The purpose of tobacco denormalisation has been summarised as “depicting smoking as a negative behaviour” and this is claimed to be distinct from stigmatisation (Burgess, Fu, & van Ryn, 2009, p. 155), which has been described as “an arbitrary and cruel form of social control” characterised by shaming, blaming and discrediting smokers and smoking (Burris, 2008, p. 475). Some have argued that stigma is an unintended negative consequence of tobacco denormalisation policies (Burgess et al., 2009; Stuber et al., 2009), while others believe denormalisation policies lead directly to stigmatisation, particularly smoke-free legislation (Poland, 1998; Voigt, 2013). We take the view that stigmatisation, whether deliberate or not, has consequences for individuals and requires careful and continuing examination in light of significant smoking inequalities.

There is substantial evidence documenting smokers’ experiences of stigmatisation in light of tobacco denormalisation policies (Bell, McCullough, et al., 2010; Burgess et al., 2009; Greaves, Oliffe, Ponic, Kelly, & Bottorff, 2010; Kim & Shanahan, 2003; Phillips, Amos, Ritchie, Cunningham-Burley, & Martin, 2007; Ritchie, Amos, & Martin, 2010; Thompson et al., 2007; Wigginton & Lee, 2013). For example, the authors of an analysis of interviews with 40 Scottish smokers argued that since the introduction of smoke-free legislation, smokers had experienced a loss of social status in public spaces. They noted instances where smokers self-stigmatised their own smoking behaviour, coped with stigma by smoking in less visible places, and smoked less when out socialising (Ritchie et al., 2010).

However, this literature (except: Bell et al. 2010) does not return to Link and Phelan's (2001) framework of stigma in documenting and continuing to theorise experiences of stigma.

Additionally, there is little data examining Australian smokers' perceptions and experiences of stigma (except: Wigginton & Lee, 2012) despite shaming tactics used in Australian anti-smoking campaigns (e.g. Amonini, Pettigrew, & Clayforth, 2015). In addition, we know little about whether, and how, Australian policy level changes, which are among the most comprehensive globally (Scollo & Winstanley, 2015), contribute to smokers' perceptions of, and responses to, stigma. Potential differential treatment of smokers resulting from various policies requires consideration. Indeed, these questions are important in understanding the ethical and practical implications of future denormalisation policies.

For instance, a number of US and international organisations (including the World Health Organisation) have implemented policies that restrict smokers to apply for employment within their organisation (Voigt, 2012). Voigt argues that these policies are positioned under the guise of health promotion and serve to discriminate against people on the basis of their tobacco use, not on their ability to perform the job. Similarly, university and educational institutions in the US and in Australia are increasingly implementing smoke-free policies that extend to the whole campus (Lee et al., 2010). These policies arguably go beyond second-hand smoke protection to justify maximum smoke-free space and potentially implicate smokers' access to higher education facilities (Chapman, 2008).

We join Burris (2008) in his suggestion that we should document "how stigma works, and follow scholars like Link and Phelan in trying to understand stigma as a harmful phenomenon experienced by vulnerable groups" (p. 475). These questions are increasingly relevant in the context of current debate and public consultations in Australia (Department of Health, 2015) asking consumers to share their views about potential changes to private health insurance based on, for instance, health factors and lifestyle. In this article, we ask how do

Australian smokers conceptualise, and respond to, stigma in light of potential policies that could lead to the differential treatment of smokers.

Method

Sample

Semi-structured interviews were conducted with 30 daily smokers aged 18 years or over from a large metropolitan Australian city. Participant demographics are included in Table 1. One interview (S112) was excluded from analysis because the participant disclosed during the interview that they had stopped smoking. The recruitment strategy was periodically adjusted to obtain maximum diversity in relation to age, gender, education, and socioeconomic status. Advertising took place via community centres and noticeboards, a university mailing list, a senior's database, and an online classified site. Participants were provided with a gift voucher in appreciation for their time.

Table 1. Demographic characteristics of sample

Participant ID	Age	Gender	Highest level of education	Cigarettes per day
S101	24	Woman	University	1-10
S102	19	Man	Technical	1-10
S103	32	Woman	University	1-10
S104	43	Woman	University	11-20
S105	32	Man	Less than high school	11-20
S106	18	Man	University	1-10
S107	24	Man	University	1-10
S108	24	Man	University	11-20
S109	23	Woman	Less than high school	11-20
S110	20	Woman	Technical	1-10
S111	30	Man	University	1-10
S113	28	Man	Technical	11-20
S114	35	Man	High school	11-20
S115	34	Woman	Technical	1-10

S116	21	Woman	University	1-10
S117	32	Woman	High school	31 or more
S118	26	Man	Less than high school	11-20
S119	22	Woman	High school	11-20
S120	58	Woman	University	11-20
S121	63	Man	High school	21-30
S122	31	Man	University	11-20
S123	56	Woman	Technical	21-30
S124	48	Man	Technical	31 or more
S125	56	Woman	Technical	21-30
S126	40	Woman	Less than high school	31 or more
S127	42	Man	Technical	31 or more
S128	38	Man	Technical	1-10
S129	57	Woman	University	11-20
S130	48	Man	Technical	(missing)

Interviews

Ethics clearance was received from the Behavioural & Social Sciences Ethical Review Committee of the University of Queensland. All recruiting and interviewing was conducted by the second author between October 2012 and July 2013. All participants provided informed consent. Interviews were recorded and transcribed verbatim, and ranged in length from 25 to 80 minutes. To ensure anonymity, all identifiable information was removed during transcription. Prior to the interview commencing, a short survey with questions about demographics and smoking history was completed by participants. The interview schedule focused on the following themes: thoughts about their own smoking; addiction; treatment and prevention; and neurobiological understandings of addiction, the results of which have been reported elsewhere (Morphett et al, 2016; Morphett et al, 2015).

Analysis

The first and second author conducted several readings of the interview transcripts, along with notetaking of interesting features, to gain familiarity with the content. Questions from the interview schedule that prompted talk relating to stigma, judgement, discrimination, and unfair treatment were analysed (listed in Table 2). Responses to these questions were copied into Microsoft Word. Following this, the first author went through (line by line) and descriptively coded responses to summarise the content of participants' talk (Braun & Clarke, 2006). This process led to a list of various codes and broader concepts that were identified in participants' accounts. The first and second author consulted the list of codes derived from initial coding and together decided to focus on perceptions of, and responses to, stigma. Relevant codes were then subject to further analysis, during which the first author checked for consistency within and across codes, and identified any exceptions (or negative cases) within the data. The analysis then focussed on how participants understood stigma, what 'evidence' they drew on to describe experiences of stigma, and how they responded to hypothetical[1] healthcare policies that treat smokers' differently from non-smokers.

Table 2. Responses to the following questions were subject to analysis

a.	Do you feel that smokers are stigmatised? What makes you feel this way? Can you give any examples?
b.	What sort of things should be done to prevent cigarette smoking by young people?
c.	What do you think the government should do about smoking?
d.	Should the government pay for stop smoking medications? Why/why not?
e.	Should the government provide free medical treatment to smokers for smoking related health problems? Why/why not?
f.	Do you think smokers should pay more than non-smokers for health insurance?
g.	Do you think a smoker should have an equal opportunity for a lung cancer transplant as a non-smoker? Why/Why not?

Results: Conceptualising stigma

Participants overwhelming agreed that smokers are stigmatised. When asked to elaborate on why or how, participants' responses oriented to comprehensive denormalisation policies and the resultant changes in the (un)acceptability of smoking. In particular, smoke-free legislation and smoking bans in various outdoor spaces characterised participants' understandings of *how* smokers are stigmatised. For instance, when asked if she thinks smokers are stigmatised S110 responded:

S110: Yeah definitely, a lot of people, especially in Australia.
Facilitator: *Where are you from?*
S110: France. So, yeah, back home it's pretty random to smoke, like a lot of people do it, we still do it in coffee shops like this and stuff, so it's less stigmatised than it is here and I think it's because of all the campaigns doing with smoking, really definitely I think it is.

Looking across participants' accounts, stigma was seen to encapsulate a range of 'things' imposed by the government. These 'things' included anti-smoking campaigns, public bans and restrictions on smoking, and together were seen to result in a lack of spaces to

smoke without facing verbal or non-verbal disapproval. For instance, when asked whether participants thought smokers are stigmatised, respondents generally agreed:

> Definitely. A lot of people look down on you. Even if you're standing four metres away from a door at a shopping centre and you're standing in a designated area, some people will put their hands over their noses or - do you know what I mean? (S126)

> Yeah, we're feeling rejected, yeah. Especially with - I only just came up here in the February - I was born here but you can't even smoke in the Queen Street Mall anymore. That's ridiculous. That's segregating us, you know what I mean? (S127)

Participants' referenced certain public places that disallow or restrict smoking in explaining how smokers are stigmatised. These restrictions were seen to create segregation between smokers and non-smokers. Similar to S126's extract, several others described instances in which they were 'following the rules' of smoking in public and still faced disapproval from strangers.

Similarly, S116 explained "so when I'm standing outside the bar yeah, that's stigmatising because you just think you're the only one standing out there, and you have to stand outside the restaurants. Then the odd person that walks by and coughs because you're getting cigarette in *their* air" (our emphasis). The language S116 used orients to the notion that non-smokers have the right to claim public space and smokers are infringing on the 'clean' air of others (i.e. non-smokers). This relates to Link and Phelan's (2001) framework in which status loss and a separation of 'us' and 'them' are central to stigmatisation. The exclusionary nature of smoke-free legislation, according to participants, was seen to contribute to a sense of 'othering' smokers. It was others' reinforcement of this legislation, and the moral judgements attached to this, that was also evidence of stigma:

> I mean everybody thinks that we are smoking because we neglect our bodies, we do not care about people, we do not care about family, we do not care about even strangers that are walking by us while we smoke. But I do feel that that's a really wrong stereotype (S108).

The perception that non-smokers think that smokers "do not care" was shared by others who described the ways in which their smoking status implicated stereotypes about

smokers. Bell, McCullough, et al. (2010) argued that it was not merely smoking as a behaviour that was subject to judgement but that the 'smoker' label was associated with an undesirable identity, which one participant in their study described "sometimes, you know, you really are labelled as a bad person if you smoke" (participant: Bill, p. 921). A similar sentiment was shared by S120 who stated that "before the interview I used that expression 'bogan' as in there's this association of people who smoke as being stupid, dirty, ill-educated. So it's very prejudiced attitude towards smokers". As suggested in this quote, in Australia the term "bogan" has classist undertones. The association of smoking with class is recognised by participants, who orient to the stigmatisation that smokers face as a result of occupying a socially and economically disadvantaged position within society as "poor smokers" (Thompson et al., 2007, p. 508) and show how stigma is reliant upon (economic) power (as per Link & Phelan, 2001).

Participants also spoke of various assumptions circulating about smokers in response to the question of whether they think smokers are stigmatised:

> Oh absolutely. We're dirty. We're stinky. We're killing ourselves. We're harming other people. We waste our money that could be better spent on other things, completely ignoring that we're getting taxed ridiculously (S122).

S122's extract orients to an assumption about smokers as people who neglect their bodies and health, harm others in the process, and ultimately waste their money. Particularly within the Australian context, where taxation on tobacco has been increasing (Scollo & Winstanley, 2015), participants described paying a high price for an undeniably harmful product as used to imply they have a level of ignorance or carelessness about their smoking. This is reflected in the participants' accounts in which they were rehearsing cultural rhetoric about smokers as careless, stinky people who are knowingly (or stupidly) killing themselves.

Indeed, taxation for tobacco was often raised in participants' accounts. Several participants raised the topic of taxation to justify smokers' entitlement to health care and

medication. For instance, in responding to a question about whether the government should pay for stop-smoking medication for people that want to quit, one participant described:

S121:	Definitely.
Facilitator:	*Yep, why do you think so?*
S121:	They're the ones collecting the taxes. They're the ones, I don't know how much they get, but it's obviously a lot of money. So why can't they subsidise it? I mean, they're trying to help us with these ad campaigns that are not worth crap. Why don't they give out free patches? Because if they do that, people will start giving up smoking. Where's our tax going to now? We get nothing back. So it's a catch 22. I'd love to see them pay it, subsidise it through Medicare or something like that.

Responding to the prospect of differential treatment of smokers

Part of the interview explored participants' responses to questions about whether the government should fund support for cessation and the health costs of smoking-related illnesses, and whether smokers should pay more for private health insurance than non-smokers (see Table 2). It was in these responses that participants questioned whether the differential treatment towards smokers is justified or fair. We identified a common rhetorical strategy participants utilised in their responses to these questions. Specifically, participants used social comparisons to respond to various government policies that treat smokers differently from non-smokers or other citizens.

In particular, participants compared smoking to a range of risky behaviours (e.g. extreme sports, drink driving, dangerous jobs), lifestyle 'choices' (e.g. obesity, birth control), and other addictions (e.g. illicit drugs, alcohol). In some cases, participants compared *smokers* to other 'at risk' populations, including alcoholics, methamphetamine users, minority groups, and 'morbidly obese' people. We will show how comparisons served as a flexible rhetorical tool allowing participants to normalise or challenge policies that treat smokers differently.

Several participants compared smoking to other risky behaviours to normalise differential treatment. This was particularly prevalent in responding to the question about whether smokers should pay more for private health insurance. In these instances, other risky behaviours were mobilised to suggest that smoking is simply a matter of risk and should be treated accordingly. For instance, S101, along with others, agreed that smokers should pay more for health insurance than non-smokers on the basis of how insurance companies deal with other risky behaviours:

> Because there's so many proven, like, health risks. Like, you are, you're putting yourself at risk. I do, I do think it makes a difference. Then that's the same way as somebody who does extreme sports. They have got more of a chance of injuring themselves and needing – so, but, I do think – but, I mean, you can't argue with statistics and smoking and that.

Insurance premiums were often viewed as 'objective' and 'neutral' reflections of reality ("you can't argue with statistics"). Despite Australian law prohibiting differential premiums based on health behaviours[1], many participants agreed that it is fair for smokers to pay more for health insurance on the basis of how other risky behaviours are also treated by insurance companies. However, in relation to government funded healthcare for smokers, a risk-based argument was used to challenge differential treatment. When asked about whether the government should provide free medical treatment to smokers, S104 described:

> Well, no, any more than people who get injured bungy jumping should be. I think with any activity that carries risk there is a certain personal amount of risk…. For some the risk pays off, for some it doesn't. So I don't think there should be any difference at all between charging or opting not to treat because people smoke.

The comparison between smoking and bungy jumping allowed this participant to suggest that smoking is simply another risky behaviour and should *not* be treated any differently on the basis of risk – similar to the insurance example. Indeed, the use of a risk-based argument in the context of smoking is not new. Several analyses have illustrated the ways in which smokers mobilise risk language to downplay the health risks of smoking (Gough, Fry, Grogan, & Conner, 2009; Heikkinen, Patja, & Jallinoja, 2010; Wigginton &

Lafrance, 2014). For instance, Gough et al. (2009) showed how participants positioned smoking on a continuum of risk in which other behaviours (alcohol, diet, obesity) were claimed to be more risky, allowing participants to speak to the unfair and over-targeted treatment of smoking and smokers.

When responding to the question about whether the government should provide free medical treatment for smoking-related disease, a similar approach was taken by our participants, in that eating McDonalds (S116) or not exercising (S119) were equated with smoking to suggest it is another unhealthy 'lifestyle choice'. Several participants framed smoking as a matter of personal choice to argue that the government should *not* pay for this medical treatment. Positioning smoking as a matter of choice also allowed participants to suggest that if smokers wanted to receive medical treatment (e.g. a lung transplant) they should simply choose to stop smoking. However, one participant (S103) mentioned that, by paying high tax, smokers are essentially already investing in their future publicly-subsidised medical care.

In particular, participants suggested that the government should not be taking responsibility for people's 'lifestyle choices' and therefore should not pay for stop smoking medications or offer free treatment for smoking-related issues. Several argued that the harmful effects of smoking are well publicised and therefore smokers must take responsibility for their own behaviour. This, largely accepted, view in our data is consistent with neoliberal policies that allocate responsibility to individuals, thereby obscuring the influence of structural and contextual factors on individual health (Ayo, 2012; Fullagar, 2002; Lindsay, 2010). A choice-based argument has been identified previously in an analysis of smokers' interviews (Heikkinen et al., 2010), in which smokers viewed smoking (including the exposure to the risks associated with smoking) as a private choice and participants positioned themselves as rational actors who were choosing to continue to smoke in light of known

health risks. In addition, Heikkinen and colleagues found that participants compared smoking to other lifestyle choices (e.g. obesity) in debating whether smoking is the lesser evil.

We identified similar arguments centring on the notion of personal choice and responsibility when participants compared smoking to other addictions. For instance, when asked whether the government should pay for stop smoking medications, S106 responded:

> No, no, because it's the person's responsibility. It's not the government's responsibility. I'm not sure about this, but does the government pay for rehabilitation of methamphetamine users? […] like [famous Australian rugby player], he was a cocaine addict. He went to a private rehab and he got himself fixed up. I think it's your responsibility.

Despite cultural understandings of addiction as removing a person's agency and control over their behaviour (White, Oliffe, & Bottorff, 2013), participants suggested that addictions should be the responsibility of the individual, not the government. Similar to the pattern we identified in the risky behaviour comparisons, participants used these same comparisons to make conflicting arguments. For instance, another participant used examples of other addictions to challenge differential treatment towards smokers:

> Do they want to withdraw treatment from a heroin addict? Do they want to withdraw people from meth? No, they don't withdraw treatment from them, and especially a coke addict who's snorted away the whole inside of their nose. They don't withdraw treatment from them. (S123)

Prior to offering this comparison, S123 explained how her doctor is reluctant to give her surgery for claudication in her legs because it was caused by smoking. By comparing smoking to other drug addictions, such as heroin and methamphetamine, S123 is able to challenge the refusal of medical treatment for smokers (including herself) with the implication that nicotine addiction is no different to other drug addictions. Chapple, Ziebland, and McPherson (2004), in their interviews with patients with lung cancer, similarly found participants described fears about limited access to medical care because of their smoking. For instance, one participant in their study described how his diagnosis was potentially delayed because his "smoker's cough" was not treated seriously enough, while people who

“fall off a cliff through rock climbing are not stigmatised in the same way that smokers are” (p. 3).

Differential treatment was also challenged by emphasising the legal status of tobacco and comparing it to other legal (and harmful) products. S124 drew on a legal argument to challenge discrimination against smokers and smoking. For instance, in response to the question about whether the government should provide free medical treatment for people with smoking-related problems, S124 responded:

> I do. I do because it's not illegal to smoke. You know what I mean? They treat drug addicts. I'm doing something that's legal. I'm smoking. So why refuse to treat me if I smoke? I'm an alcoholic. They sell alcohol to alcoholics. Why refuse to treat him if he's an alcoholic? Make it illegal. Don't treat him. I'm not breaking the law by smoking so why refuse to give me medical treatment.

A legal argument was often raised by participants in our study to draw attention to the hypocrisy of governmental decisions and whether the government genuinely wanted people to stop smoking. In fact, some questioned whether tobacco should be made illegal. Indeed, the legal status of tobacco has been discussed in debates that consider the ethics of restricting the sale of other less harmful nicotine products (e-cigarettes) (Hall, Gartner, & Forlini, 2015a). Another participant mobilised a legal argument using alcohol as a point of comparison to argue the unfair targeting of tobacco:

> I think the government has stuck its foot in it enough already to be honest. From a rights point of view I actually personally think that it's not fair, all this plain packaging type of stuff being that it is a legal product. That a company is not even allowed to brand its own products with its own logos, I find that very strange that they can sort of do that and at the same time alcohol - which causes many, many, many deaths and goes along with all the same sorts of things is advertised freely. You'll see please drink responsibly in tiny letters at the bottom, but there just seems to be a lot of hypocrisy there. (S117)

Access to donated lungs for smokers committed to stopping

The final aspect of this analysis is dedicated to an assumption underpinning participants’ responses to questions about smokers receiving lung transplants. This is the assumption that

only smokers committed to stopping smoking ‘deserve’ support from society and the government to treat a smoking-related illness. In some instances, it was smokers’ willingness to show commitment to cessation that was used to decide the extent of support for this medical treatment. For instance, when asked whether a smoker should have an equal opportunity to a lung transplant as non-smokers, one participant responded:

S123: That's a really good one. If they're going to keep smoking, no. If they give up and it's going to be forward without, yes I do.
Facilitator: *Why do you think so?*
S123: Well why put a good set of lungs to someone who's going to wreck them again.

This view seemed to arise in conjunction with the notion of smoking as a choice and cessation as the responsibility of the individual, who by not stopping is inviting ill-health.

> I reckon a non-smoker should get priority because if a smoker wants a new lung just to keep on smoking then what’s the point, you know? Just die, who cares? Why are you going to keep doing what you’re doing if you don’t want to change? Unless he’s 100 committed, then no. (S118)

Similar to S118, several other participants suggested that there is “no point” in providing a smoker with new lungs if they are going to continue to smoke. A smoker with new lungs was seen to be wasting “a good set” of organs. This was seen to be a particular ‘waste’, when compared to people who need organ transplant for problems unrelated to ‘lifestyle choices’ (e.g. Cystic Fibrosis: S117). This may also reflect a pragmatic response to the distribution of a very scarce resource (donated lungs) and a desire to see maximum benefit obtained by prioritising those who are most likely to take care of the donated organ the most by not smoking. Along these lines, the view that smokers who are committed to stopping smoking should have the same access to a lung transplant as non-smokers indicates participants thought such medical decisions should be based on whether the recipients would take care of the donated organ, rather than based on past behaviour. Despite this strong view, participants acknowledged that it would be difficult to determine a smoker’s commitment to stopping smoking, with some suggesting that promising to quit is not enough.

Some participants also expressed the view that those who continued to smoke after receiving a lung transplant were ‘ungrateful’. Problematically, this assumption overlooks the difficulty of stopping smoking, implying that continuing to smoke is a lifestyle ‘choice’. This finding is also concerning in light of the fact that it is smokers themselves who express these views, despite embodying the challenges of quitting smoking. Interestingly, only one participant applied the lung transplant question to herself:

> Well, I think they should probably agree to quit smoking with their new lungs, and I'm saying that as a smoker. If you were going to give me brand new lungs the least I could do is quit smoking. I do think that, but then I don't know how many other smokers would agree with that. I'm sure if I needed a set of lungs right now I'd be willing to quit, but do I need to be held hostage though, if I don't quit I don't get the lungs. It's a bit rude. I don't know. (S113)

However, it is worth noting briefly that some participants’ expressed a view directly opposing this assumption: that, in the case of life and death (e.g. a lung transplant to live), all lives are precious and equal regardless of previous health behaviour or decisions.

Discussion

The aim of this article was to examine smokers’ conceptualisations of, and responses to, stigma and policies that treat smokers differently to non-smokers using interviews from 29 smokers from a large metropolitan city in Australia. We drew on broader literature and Link and Phelan’s (2001) stigma framework to contextualise participants’ accounts of smoking stigma. Link and Phelan’s (2001) framework was intended to move the study of stigma away from the individual and their cognitions to highlight the broader social processes that perpetuate the production of stigma. With this in mind, we focussed on participants’ conceptualisations and evidence of stigma.

Participants viewed smoke-free laws as stigmatising and argued that these laws marginalised smokers for engaging in a harmful practice. Indeed, government interventions were seen to segregate smokers from the rest of society, and to promote negative views about

smokers and their moral character. According to participants, ‘evidence’ of stigma centred on physical separation and surveillance from society (resulting mostly from smoke-free legislation), verbal and non-verbal disapproval from others, and negative attitudes towards smoking and smokers. Together this had the effect of marginalising, denigrating and stereotyping smokers – in line with Link and Phelan’s (2001) framework.

We found that participants often used broad sweeping terms such as “the government” as the source or perpetrator of stigma. While this language is likely to have been co-constructed, in that these terms were part of the interview questions, it is interesting to note that when asked for examples of when they have experienced stigmatisation many participants described one-on-one interactions with others (often non-smokers). This focus on interactions, as examples of stigma, is consistent with Goffman’s (1963) theorising, in which stigma is produced through social interactions (for instance, with the non-stigmatised). Participants emphasised how this judgement was often unjustified because they were smoking in areas where smoking was permitted.

Participants’ conceptualisations of stigma are consistent with a photo-narrative analysis about smoking and quitting (Haines-Saah, Oliffe, White, & Bottorff, 2013). In their analysis, smokers produced images of smoking restriction signs to point to their discomfort experienced when smoking in public and their social position as outsiders. In addition, smokers’ interviews highlighted the extent to which denormalisation policies contributed to the perspective that they are “trapped out of everyday society into your smoking corner” (p. 23, p. 11). The use of the term “smoking corner” depicts the physical separation and marginalisation of smokers in the public sphere. A participant in our study also used this term to describe stigma: “Well they're starting to make you feel like ‘oh, er, they're smoking’, like they're putting you in your little corner and they're over there you know” (S118).

The second part of our analysis demonstrated the prevalence of social comparisons in participants' responses to specific policy possibilities where smokers are treated differently from non-smokers. We showed how social comparisons are rhetorically flexible, in that this tool allows speakers to effectively compare smoking to other risky behaviours, lifestyle 'choices' and addictions to debate about the differential treatment towards smokers. However, we showed the precarious ground of social comparisons, in that they can be reconstructed to accept or challenge differential treatment.

The final aspect of our analysis dealt with an assumption underpinning participants' accounts, that is, only smokers committed to stopping smoking 'deserve' a lung transplant. This in itself is a form of discrimination suggesting that there are 'deserving' and 'undeserving' smokers and that this may be an acceptable approach to determining access to treatment. This assumption is guided by the view of smoking (and cessation) as a choice and overlooks any physiological, contextual and economic constraints. However, it should be noted that we focussed on access to lung transplants within the interviews. Lung transplants were chosen due to the clear relationship between smoking and lung-related diseases (lung cancer, chronic obstructive pulmonary disease). Some of the views expressed may have incorporated a recognition of the scarcity of donated lungs and recognition that pragmatic choices often need to be made concerning who will receive a donated lung when one becomes available. Future research may consider smokers' access to a wider range of medical treatments, including those which are more widely available.

More broadly, our analysis builds on existing work to show how denormalisation policies have not only stigmatised the practice of smoking, but have also called smokers' identities (their moral and social worth) into question (Bell, McCullough, et al., 2010; Greaves et al., 2010; Holdsworth & Robinson, 2008; Thompson et al., 2007; Wigginton & Lafrance, 2015). This raises questions about the extent to which stigmatisation serves to

construct certain ‘profiles’ of moral and healthy citizens – thus moving beyond a targeting of behaviour to a targeting of groups of people. This is especially relevant in the context of public health policy, where there have been concerns that stigma-induced policy is used to instil middle-class values as the ‘yardstick’ of acceptable behaviour (Poland, 1998).

The role of public health policy

In understanding the ways in which public health policy constructs a cultural context in which individuals participate in the stigmatisation of smoking and smokers, we advocate a postmodern perspective to studying stigma. This perspective allows an acknowledgement of the broader socio-cultural, political and economic forces that structure stigmatisation (Parker & Aggleton, 2003) – consistent with Link and Phelan’s (2001) sociological framework. In particular, this perspective avoids positivist assumptions that stigma exists universally (devoid of cultural context) and instead attends to the ways in which stigma is intimately tied to larger systems that produce structural inequalities (Kumar, Hessini, & Mitchell, 2009), which is particularly relevant given smoking-related inequalities (Siahpush, 2004) and increasing denormalisation of tobacco use via policy. In addition, such a view of stigmatisation importantly attends to the inherently political context of stigma (Graham, 2012), in which self-governance, personal responsibility and risk-management are socially valued practices of the autonomous and health conscious citizen (Bell, Salmon, & McNaughton, 2011; Petersen & Lupton, 1996).

For instance, Hannem and Bruckert (2012) proposed the concept of “structural stigma” (p. 5) to describe a situation in which stigmatic assumptions have become embedded into social policies and practices. They argued that, in contemporary society, this often occurs under the guise of ‘risk management’, in that risk language is used both to stigmatise a group of people and to frame them as ‘dangerous’ or ‘risky’ and hence requiring increased

surveillance and intervention to manage them. This perspective on stigma usefully seeks to explore the knowledge systems through which stigma is reproduced and social control is exercised, and has strong resemblances to our analysis. Future attention to how public health policies contribute to a cultural context that stigmatises risky and unhealthy lifestyle 'choices' is important in working towards theorising the political processes of stigma.

In terms of policy implications, our analysis suggests that smokers' perceive tobacco denormalisation legislation, particularly smoke-free legislation, to have a profound impact on their experiences of stigma. It is important that policymakers, researchers and practitioners consider the implications of an increasingly anti-smoking climate and how denormalisation policies contribute to smokers' feelings of being unfairly targeted when they view their smoking as one of many possible 'risky lifestyle choices'. For example, debates surrounding smoke-free legislation in the home offer an opportunity for reflection on the ethical issues attached to the "protection of vulnerable children discourse" (p. 8) – a discourse often deployed in the justification of such policies – including questions around whose interests are being served, who would be disproportionately affected by such policies, and whether the home is of public concern (Rouch et al. 2010). While differential access of smokers to highly finite medical treatments, such as lung transplants, may present an example of pragmatic, rather than moralistic, decision making, there is an increasing number of examples of opportunities that smokers may be denied, such as housing (New South Wales Government 2016), employment (HC Online, 2012) or emergency financial assistance (Kelly, 2013). The potential impacts of these policies on smokers who are increasingly from highly disadvantaged populations requires careful thought (Brown-Johnson and Prochaska, 2015).

We also see discussions of stigma-induced policy as relevant to emergent public health challenges, such as electronic cigarettes (e-cigarettes). E-cigarettes hold a precarious position as a harm reduction device because they threaten to re-normalise non-therapeutic

nicotine use (Bell & Keane, 2012). With emerging discussions about the ethics of regulating these products (e.g. Hall et al., 2015a; Hall, Gartner, & Forlini, 2015b), it also begs the question of extending these debates to the ethics of stigmatising e-cigarettes and their users through policy and public health campaigns. For instance Williamson, Thom, Stimson, and Uhl (2014) argued that stigma-induced approaches and policy adopted to address tobacco use should not automatically be extended to e-cigarettes given that these two products have vastly different risks and benefits to the user. However, this raises questions of whether (and how) e-cigarette users experience stigmatisation and whether less restrictive policies on vaping reduces stigmatisation and encourages switching from smoking to vaping – a question for future research.

Footnote: [1]In Australia, it is illegal to charge any group more than another for private health insurance.

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