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Tobacco Denormalization, Anti-Healthism, and Health Justice

TOBACCO DENORMALIZATION, ANTI-HEALTHISM, AND HEALTH JUSTICE

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I. INTRODUCTION

In 1965, one year after Surgeon General Luther Terry released a landmark report on the health hazards of smoking,[1] more than 42% of American adults were current smokers.[2] In 2015, after a half-century of efforts to reduce tobacco use, that number was down to just over 15%.[3] Tobacco control is considered to be among the greatest public health successes of the twentieth century[4] but there is still much work to be done. Tobacco control advocates warn that "[e]ach day, about 2,500 kids in the United States try their first cigarette; and another 400 additional kids under 18 years of age become new regular, daily smokers."[5] The effects of nicotine addiction set in very quickly, with symptoms "often occur[ing] only weeks or even just days after youth 'experimentation' with smoking first begins."[6] The majority of tobacco users say they want to quit, but in addition to addiction, many face barriers such as lack of social support and inadequate access to cessation aids and counseling.[7]

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1. U.S. Dep't of Health, Educ. & Welfare, *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*, PUB. HEALTH SERV. PUB. NO. 1103, at 7-8 (1964), https://profiles.nlm.nih.gov/ps/access/nnbbmq.pdf [https://perma.cc/PCH3-UMEH].

2. U.S. Dep't of Health & Hum. Servs., *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* 720 (2014), https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf [https://perma.cc/RF2Z-T5KD].

3. Ctr. for Disease Control & Prevention, *Current Cigarette Smoking Among Adults—United States, 2005–2016*, 65 MORTALITY & MORBIDITY WKLY. REP. 1205 (Nov. 11, 2016).

4. *See, e.g.*, Ctr. for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Tobacco Use—United States, 1990-1999*, 48 MORBIDITY & MORTALITY WKLY. REP. 986, 986-88 (Nov. 5, 1999).

5. Laura Bach, *Smoking and Kids,* CAMPAIGN FOR TOBACCO-FREE KIDS, (Jan. 12, 2017), (citing Substance Abuse and Mental Health Servs. Admin., *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables* Table 4.14A (Sept. 8, 2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf [https://perma.cc/YYC5-CXJ8].

6. Bach, *supra* note 5, at 1 (citing Joseph R. DiFranza et al., *Initial Symptoms of Nicotine Dependence in Adolescents*, TOBACCO CONTROL (Apr. 14, 2000), http://tobaccocontrol.bmj.com/content/tobaccocontrol/9/3/313.full.pdf [https://perma.cc/8XF7-G7GX]).

7. Ctr. for Disease Control & Prevention, *Quitting Smoking Among Adults—United States, 2001-2010*, 60 MORBIDITY & MORTALITY WKLY. REP. 1513, 1513, 1515-16,1518 (Nov. 11, 2011); U.S. Dep't of Health & Hum. Servs., *Treating Tobacco Use and Dependence: 2008 Update* 2-3 (2008) (concluding that cessation services and aids increase the odds of successful cessation), https://www.ncbi.nlm.nih.gov/books/NBK63952/; [https://perma.cc/8EDU-X2AF]; *cf.* D. Kotz et al., *Explaining the Social Gradient in Smoking Cessation: It's Not in the Trying, But in the Succeeding,*

The success of tobacco control is widely attributed to a strategy referred to as *denormalization*.[8] The strategic association of negative social norms with tobacco companies, products, use, and users is readily apparent in counter-marketing campaigns that depict the industry as predatory and manipulative, tobacco products as monstrously toxic, and tobacco use as cosmetically and socially risky.[9] Warnings about stained teeth, wrinkled skin, bad breath, impotence, and loss of control are highly visible,[10] but law also plays an important role in denormalization. Laws regulating tobacco products and advertising constrain industry efforts to make them appear appealing, appropriate, and desirable, especially for young teens.[11] Laws prohibiting smoking in bars, restaurants, workplaces, and other public spaces serve multiple goals. They protect bystanders from exposure to secondhand smoke, make smoking less convenient for smokers, and make nonsmokers and those who are trying to quit less likely to view smoking as a

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TOBACCO CONTROL 43, 46 (Oct. 20, 2008), http://tobaccocontrol.bmj.com/content/18/1/43.full [https://perma.cc/2Y6A-3MGA] (discussing socio-economic disparities in cessation success in England); Diana Williams Stewart, *Predictors of Social Support Provided to Smokers* 3, 4 (2008) (unpublished M.A. thesis, Louisiana State University), http://digitalcommons.lsu.edu/cgi/viewcontent.cgi?article=1547&context=gradschool_theses [https://perma.cc/57VN-MD5B].

8. *See, e.g.*, Cal. Dep't of Health Servs., *A Model for Change: The California Experience in Tobacco Control* 3 (1998) ("The California Tobacco Control Program has sought to . . . denormalize smoking and other tobacco use . . . Evaluation results indicate that this approach is working in California: people are smoking less and more people are protected from exposure to second-hand smoke."), http://www.cdph.ca.gov/programs/tobacco/Docments/CDPH%20CTCP%20Refresh/Policy/Social%20Norm%20Change/CTCPmodelforchange1998.pdf [https://perma.cc/Y843-5NH3]; Sei-Hill Kim & James Shanahan, *Stigmatizing Smokers: Public Sentiment Toward Cigarette Smoking and its Relationship to Smoking Behaviors*, 8 J. HEALTH COMM. 343, 360 (2003) (finding "that smoking rates are lower in the states where the public" sentiment toward smoking is more negative and "that smokers who have experienced unfavorable public sentiment are more willing to quit smoking than those who have not"); David Hammond et al., *Tobacco Denormalization and Industry Beliefs Among Smokers from Four Countries*, 31 AM. J. PREV. MED. 225, 229 (2006) (finding that people who perceive high levels of social denormalization of tobacco use are more likely to quit smoking); Benjamin Alamar & Stanton A. Glantz, *Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption*, 96 AM. J. PUB. HEALTH 1359, 1362 (2006) (finding that states where smoking is socially unacceptable have lower rates of smoking and concluding that "[t]obacco control programs should . . . reinforce the nonsmoking norm").

9. *See infra* Part II.B.

10. *Id.*

11. *See infra* Part II.A-B.

normal part of adult life.[12] Lawmakers sometimes argue that allowing or encouraging employers, insurers, and landlords to discriminate against tobacco users will prompt users to quit and discourage others from starting.[13]

Tobacco denormalization has generated significant litigation over the scope of government authority to regulate tobacco manufacturers, sellers, users, and other parties (e.g., employers, health insurers, and landlords).[14] Existing constitutional precedents and statutory protections do little to constrain tobacco denormalization. Constitutional freedom of speech protections for tobacco companies, which impose the only firm limit on tobacco control in the United States, create perverse incentives for regulators.[15] Statutory protections for tobacco users vary from state to state and are inadequate to address social exclusion, bias, and many forms of overt discrimination.[16] Open questions remain, however, that will shape tobacco denormalization efforts in the future.[17]

Tobacco denormalization also raises ethical and political questions that scholars, policymakers, and consumer advocates have debated for more than a decade.[18] Is it legitimate for the state to promote abstinence from tobacco use as part of a particular conception of the good life? Even if discouraging tobacco use is an acceptable goal, is it acceptable for government to encourage social exclusion and discrimination against tobacco users? Even if denormalization was appropriate at a time when a large proportion of the population used tobacco, should it be reevaluated in light of the potential effect of anti-tobacco bias on the socially disadvantaged groups who are more likely to be current smokers? Are the negative effects of denormalization on tobacco users who are unable or unwilling to quit (e.g., loss of

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12. *See infra* Part II.E.

13. *See infra* Part II.F.

14. *See infra* Part III.A.

15. *Id.*

16. *Id.*

17. *Id.*

18. Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J. L. MED. & ETHICS 179, 187 (2002) [hereinafter Burris (2002)]; Scott Burris, *Stigma and the Law*, 367 THE LANCET 529, 529-30 (2006) [hereinafter Burris (2006)]; Scott Burris, *Stigma, Ethics and Policy: A Commentary on Bayer's "Stigma and the Ethics of Public Health: Not Can We but Should We?*, 67 J. SOC. SCI. & MED. 473, 475 (2008) [hereinafter Burris (2008)]; Kim & Shanahan, *supra* note 8, at 343; Tamar M.J. Antin et al., *Tobacco Denormalization as a Public Health Strategy: Implications for Sexual and Gender Minorities*, 105 AM. J. PUB. HEALTH 2426, 2426 (2015).

social status, employment, insurance, or housing) outweighed by the positive effects for former users (who are encouraged to quit) and non-users (who are protected from secondhand smoke and influenced by social norms that make it less likely they will take up tobacco use themselves)? Extralegal frameworks based on liberal, libertarian, utilitarian, egalitarian, and communitarian notions of justice provide varying answers to these questions. In turn, these answers may inform lawmakers as they consider reform proposals and judges and regulators as they consider questions of constitutional and statutory interpretation raised by tobacco denormalization.

Critics sometimes use a harsher term, *stigmatization*, to describe the intentional use of social disapproval to influence tobacco use.[19] Choice of this term conveys skepticism about the acceptability of tobacco denormalization. Indeed, public health ethicists and legal scholars debate whether the bias, social exclusion, and discrimination experienced by tobacco users amounts to true stigma. In the view of some critics, a "stigma's decentralized and visceral mode of social control" renders its intentional use as a public health tool flatly unethical.[20] True stigmatization of a health condition (e.g., HIV), health-related behavior (e.g., injection drug use), or status (e.g., men who have sex with men) is a detriment to health at the individual and population level.[21] It calls for a very different public health strategy, *destigmatization*, which aims to protect individuals from

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19. *See, e.g.*, Kirsten Bell et al., *Smoking, Stigma and Tobacco 'Denormalization': Further Reflections on 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)*, 70 SOC. SCI. & MED. 795, 795-96 (2010); Kirsten Bell et al., *'Every Space is Claimed': Smokers' Experiences of Tobacco Denormalisation*, 32 SOC. HEALTH & ILLNESS 914, 922 (2010), http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2010.01251.x/pdf [https://perma.cc/ZYC2-S6XJ].

20. Burris (2008), *supra* note 18.

21. *See, e.g.,* World Summit of Ministers of Health, *London Declaration on AIDS Preventions*, WORLD HEALTH ORG. 2 (Jan. 28, 1988), http://apps.who.int/iris/bitstream/10665/60718/1/WHO_GPA_INF_88.6.pdf [https://perma.cc/Y7XD-8JL4] ("Discrimination against, and stigmatization of, HIV-infected people and people with AIDS and population groups undermine public health and must be avoided."); Ronald Bayer & Jennifer Stuber, *Tobacco Control, Stigma and Public Health: Rethinking the Relations*, 96 AM. J. PUB. HEALTH 47, 48 (2006) (noting that in a 1987 address to the United Nations General Assembly, Jonathan Mann, director of the World Health Organization's Global Program on AIDS, "underscored the significance of stigmatization and the social and political unwillingness to face the epidemic as being 'as central to the global AIDS challenge as the disease itself'"); (citing Richard Parker & Peter Aggleton, *HIV and AIDS-Related stigma and discrimination; a conceptual framework and implications for action*, 57 SOC. SCI. & MED. 13, 13 (2003)).

stigma through privacy and antidiscrimination protections.[22]

In their groundbreaking work on healthism, Jessica Roberts and Elizabeth Weeks Leonard have waded into this debate.[23] Although their focus is on health-status discrimination more broadly, they frequently discuss tobacco control strategies as examples. They point to employer "bans on hiring nicotine users" (as distinguished from bans on smoking in the workplace) as "paradigmatic healthist conduct."[24] On the other hand, they argue, "participation-based, employee smoking-cessation programs" are "an easy case of a non-healthist policy that discriminates based on health status.[25] Their framework for distinguishing between the two (and between other forms of "'good' and 'bad' health-status differentiations"[26]) relies on several factors, including whether the differentiation "[i]s driven by animus," and whether it "[s]tigmatizes individuals unfairly, [p]unishes people for their private conduct, [i]mpedes access to health care, [c]uts off resources or otherwise limits the ability to adopt healthy life choices, [p]roduces worse health outcomes, or [m]aintains or increases existing disparities."[27]

In this commentary, I demarcate the value added by the Roberts and Leonard anti-healthism framework by comparing it to alternative frameworks for assessing the legal, ethical, and political issues raised by tobacco denormalization. In Part II, I describe current and potential tobacco denormalization strategies. In Part III, I introduce four frameworks for assessing tobacco denormalization strategies: (1) constitutional doctrines and statutes that secure the liberty of tobacco manufacturers,

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22. *See* Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 ALB. L. REV. 831, 835-36 (1998) (describing the destigmatization strategy for HIV as entailing the adoption of new legal frameworks "to protect people with HIV from discrimination in employment, housing, and public accommodations; . . . to protect HIV-related medical information; and . . . [to] protect medical privacy and limit HIV testing in the absence of informed consent" and "opposition to . . . coercive legal measures, such as mandatory testing and a whole range of criminal laws directed at conduct that was thought to contribute to the spread of the disease").

23. *See* Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159 (2012) [hereinafter Roberts (2012)]; Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571 (2014) [hereinafter Roberts (2014)]; Jessica L. Roberts & Elizabeth Weeks Leonard, *What is (and isn't) Healthism?*, 50 GA. L. REV. 833 (2016) [hereinafter Roberts & Leonard (2016)].

24. Roberts & Leonard (2016), *supra* note 23, at 846, 896.

25. *Id.* at 900.

26. *Id.* at 896.

27. *Id.* at 895.

retailers, and users and protect them from discrimination; (2) the *health justice* framework I have developed to assess the use of law as a tool for reducing health disparities; (3) a critique advanced by Petr Skrabanek[28] and others, which I will call *libertarian anti-healthism*; and (4) the alternative vision of anti-healthism developed by Roberts and Leonard, which I will call *egalitarian anti-healthism*. In Part IV, I compare the four frameworks described in Part III by applying them to each of the denormalization strategies described in Part II. In Part V, I offer concluding reflections on the value added by the Roberts and Leonard framework and some suggestions for their ongoing development of anti-healthism as a principle for assessing health care and public health policy.

II. STRATEGIES FOR TOBACCO DENORMALIZATION

Before assessing the legal, ethical, and political issues raised by various tobacco denormalization strategies, it is important to develop a common understanding about what denormalization is and a taxonomy of the various forms it may take. The traditional epidemiological model of agent, host, vector, and environment[29] offers a useful starting point. According to this model, patterns of tobacco-related disease are produced by the interaction of a *host* (a consumer of tobacco products, potential consumer, or bystander) with the *agent* of disease (tobacco products and smoke) within an environment (which is shaped by social, cultural, economic, and legal factors).[30] In this model, tobacco companies and their business practices act as the *vectors* of disease, spreading propaganda and misinformation in an effort to hook new consumers.[31] Young teenagers are the target demographic—for industry and public health officials alike. Virtually all tobacco users initiate their tobacco use and become regular users in their teen years.[32] Accordingly, a person who does not start tobacco use

28. *See* PETR SKRABANEK, THE DEATH OF HUMANE MEDICINE AND THE RISE OF COERCIVE HEALTHISM (1994) [hereinafter Skrabanek (1994)].

29. LEON GORDIS, EPIDEMIOLOGY 19 (5th ed. 2014).

30. C. TRACY ORLEANS & JOHN SLADE, NICOTINE ADDICTION: PRINCIPLES AND MANAGEMENT ix (1993).

31. Dirk Hanson, *The Tobacco Industry as Disease Vector*, ADDICTION INBOX 2 (May 26, 2012), http://addiction-dirkh.blogspot.com/2012/05/tobacco-industry-as-disease-vector.html [https://perma.cc/K95B-YE76].

32. U.S. Dep't of Health & Human Serv.'s, Substance Abuse & Mental Health Administration, *National Survey on Drug Use & Health 2014* (2014), http://www.icpsr.umich.edu/icpsrweb/NAHDAP/studies/36361/version/1

prior to adulthood is unlikely to ever take it up.[33]

Denormalization alters the social environment in which consumers and potential consumers make choices about tobacco use. Here, I will focus on seven types of tobacco control interventions that influence social norms: (1) taxes that increase the cost of tobacco products; (2) regulations that targets tobacco products as the agent of disease; (3) marketing restrictions that target tobacco companies as vectors; (4) counter-marketing campaigns sponsored by government and nongovernmental organizations; (5) laws requiring tobacco companies and retailers to display warnings on product packaging, advertisements, or at the point of sale; (6) smoke-free laws prohibiting users from smoking in particular locations; and (7) laws permitting, encouraging, or requiring discrimination against tobacco users. It is important to emphasize that policymakers and public health officials have adopted many of these interventions without explicitly intending to denormalize tobacco.[34] Indeed, each of the interventions discussed here serves other purposes beyond denormalizing tobacco companies, use, and users. For some of them, the effect on social norms is incidental to other effects, such as increasing the economic cost of tobacco.

A. Tobacco Taxes

Federal, state, and local taxes on tobacco products reduce consumption significantly, especially among teenagers and young adults.[35] In 2009, for example, when Congress raised the federal tax on cigarettes after a long period of stagnation, researchers documented an immediate impact on teen smoking. One month after the tax went into effect, "the percentage of middle and high

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[https://perma.cc/H9SW-3WLW]; *See* U.S. Dep't of Health & Hum. Servs., *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General* 101 (2012), https://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/full-report.pdf [https://perma.cc/QG69-E9EE].

33. Dennis Thompson, Jr., *Teens and Smoking*, EVERYDAY HEALTH (July 13, 2011), http://www.everydayhealth.com/smoking-cessation/understanding/smoking-and-teens.aspx [https://perma.cc/X8SD-PSGC].

34. As Ronald Bayer has described, "those who smoked [became] targets of public health policies that *at first inadvertently but then explicitly* sought to utilize the power of denormalization and marginalization to reduce tobacco consumption." Ronald Bayer, *Stigma and the Ethics of Public Health: Not Can We But Should We*, 67 SOC. SCI. & MED. 463, 466 (2008) (emphasis added).

35. *See, e.g.*, Frank J. Chaloupka, *Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products*, 1 NICOTINE & TOBACCO RES. S105, S105-07 (1999).

school students who reported smoking in the [previous] thirty days [had] dropped by 10 percent, . . . resulting in a quarter of a million fewer . . . smokers[.]"[36] The current federal tax on cigarettes is $1.01 per pack.[37] State taxes vary considerably depending on political preferences about taxation and the influence of the tobacco industry, ranging from $4.35 per pack in New York to $0.30 per pack in Virginia.[38] "[M]ore than 600 local jurisdictions" also tax cigarettes.[39] These taxes are cumulative. For example, the combined federal, state, county, and city taxes amount to $7.17 per pack in Chicago.[40]

So called "sin taxes" increase the financial cost of targeted goods and services, while also signaling social disapproval.[41] Other excise taxes may have a more direct effect on social norms. Taxes on disposable shopping bags, for example, are applied at check-out in a way that is highly visible to the consumer and others who might be watching.[42] Still, even tobacco taxes applied in more subtle ways send a social signal.[43] Bruce Carruthers has argued that taxation of "[l]egal but morally problematic" goods and services and earmarking of funds for "'motherhood and apple pie'" projects like tobacco education can project "negative social meanings" associated with disfavored market activity.[44]

B. Product Regulation

Surprisingly few measures target tobacco products as agents of disease. Flavor bans, such as the 2009 Tobacco Control Act's

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36. LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 278 (3d ed. 2015) (citing Jidong Huang & Frank J. Chaloupka, *The Impact of the 2009 Federal Tobacco Excise Tax Increase on Youth Tobacco Use,* NAT'L BUREAU OF ECON. RES. (Working Paper No. 18026, 2012), http://www.nber.org/papers/w18026.pdf [https://perma.cc/Q9WT-ZCEX]).

37. Ann Boonn, *Top Combined State-Local Cigarette Tax Rates*, CAMPAIGN FOR TOBACCO-FREE KIDS (Nov. 17, 2016), http://www.tobaccofreekids.org/research/factsheets/pdf/0267.pdf [https://perma.cc/UTH3-UYQR].

38. Ann Boonn, *State Cigarette Excise Tax Rates & Rankings*, CAMPAIGN FOR TOBACCO-FREE KIDS (Jan. 3, 2017), https://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf [https://perma.cc/4KZT-ANQH].

39. Boonn, *supra* note 38.

40. *Id.*

41. Bruce G. Carruthers, *The Semantics of Sin Tax: Politics, Morality, and Fiscal Imposition*, 84 FORDHAM L. REV. 2565-66 (2016) (arguing that "negative social meanings can be projected through public revenue systems").

42. GOSTIN & WILEY, *supra* note 36, at 277 (discussing potential lessons of the social impact of bag taxes for public health taxes).

43. Carruthers, *supra* note 41, at 2565-66.

44. *Id.*

prohibition on flavored cigarettes,[45] and state and local laws that prohibit additional flavors and products,[46] are a notable exception. Flavor bans are not aimed at rendering the agent less toxic. Indeed, menthol, the one flavoring that research suggests may render tobacco products more lethal[47] and addictive[48] is currently exempted from the federal ban.[49] Prohibiting fruit and

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45. 21 U.S.C. § 387g(a)(1)(A) (2012) ("[A] cigarette or any of its component parts (including the tobacco, filter, or paper) shall not contain, as a constituent (including a smoke constituent) or additive, an artificial or natural flavor (other than tobacco or menthol) or an herb or spice, including strawberry, grape, orange, clove, cinnamon, pineapple, vanilla, coconut, licorice, cocoa, chocolate, cherry, or coffee, that is a characterizing flavor of the tobacco product or tobacco smoke. Nothing in this subparagraph shall be construed to limit the Secretary's authority to take action under this section or other sections of this chapter applicable to menthol or any artificial or natural flavor, herb, or spice not specified in this subparagraph."); At least some flavored tobacco products were previously prohibited under the Master Settlement Agreement, in which tobacco companies agreed that they would not market their products to youth, and under state and local laws in a few jurisdictions. *See* Mitchell Hamline School of Law, Public Health Law Center, *Flavored Products*, PUB. HEALTH L. CTR. 1-2, http://publichealthlawcenter.org/topics/tobacco-control/sales-restrictions/flavored-products [https://perma.cc/UTD7-EMPU].

46. Mitchell Hamline School of Law, Public Health Law Center, *Regulating Flavored Tobacco Products*, PUB. HEALTH L. CTR. 1-2, (describing state and local restrictions on flavored tobacco products). http://publichealthlawcenter.org/sites/default/files/resources/tclc-guide-regflavoredtobaccoprods-2014.pdf [https://perma.cc/C9R7-ESRP]

47. *See* U.S. Food & Drug Admin., Tobacco Prod. Sci. Advisory Committee, *Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations* 191, 206, 210, 217-18, (2011) (reviewing scientific evidence regarding disease risks associated with menthol versus non-menthol cigarettes and finding the evidence inconclusive), http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/TobaccoProductsScientificAdvisoryCommittee/ UCM269697.pdf [https://perma.cc/P7CL-GVJ2].

48. *Id.* at 225-26 (reviewing scientific evidence regarding the physiological effects of menthol cigarettes and finding sufficient evidence "to conclude that menthol has cooling and anesthetic effects that reduce the harshness of cigarette smoke" and "that it is biologically plausible that menthol makes cigarette smoking more addictive").

49. *Flavored Products, supra* note 45, at 1. In 2011, a report by FDA's Tobacco Products Scientific Advisory Committee (TPSAC) found that while menthol cigarettes are no more toxic than unflavored cigarettes the anesthetic properties of menthol "could increase prevalence [of smoking] by increasing the rate of initiation and subsequent addiction and by more strongly maintaining addiction and reducing successful cessation." U.S. Food & Drug Admin., *supra* note 47, at 3, 25. In 2013, FDA issued an advanced notice of proposed rulemaking to solicit input on regulating menthol cigarettes. U.S. Food & Drug Admin., *FDA Invites Public Input on Menthol in Cigarettes* 1, (July 23, 2013) http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm361966.htm [https://perma.cc/84EG-GC7T]. FDA regulation was delayed, however, by litigation initiated by tobacco companies alleging that the TPSAC report was invalid due to conflicts of interest. In 2016, the D.C. Court of Appeals held that the FDA was permitted to rely on the TPSAC report. R.J. Reynolds Tobacco Co. v. U.S. Food & Drug Admin., No. 1:11-cv-00440 (D.C. Cir. 2016). As of this writing,

candy flavorings does, however, render tobacco products less attractive to children and other potential new users.[50]

The link between flavor bans and social norms is perhaps somewhat attenuated, but in addition to making tobacco products less *appealing* to children, flavor bans limit industry efforts to configure tobacco products in ways that suggest they are *appropriate* for children. Tobacco companies intentionally design flavored products to be "obviously youth oriented" in the words of an internal RJ Reynolds memo from 1974.[51] "'This could involve cigarette name, blend, flavor and marketing technique . . . . For example, a flavor which would be candy-like but give the satisfaction of a cigarette.'"[52] As intended, the idea that flavored products are socially appropriate for kids and teens has caught on among tobacco users. For example, "[a] Lorillard report summarizing the test results from new cigarette flavors, included smokers' description of 'Tutti Frutti' flavored cigarettes as 'for younger people, beginner cigarette smokers, teenagers . . . when you feel like a light smoke, want to be reminded of bubblegum.'"[53]

Bans on non-menthol flavorings for cigarettes are an important starting point for reducing youth smoking initiation.[54] However, they leave many candy-flavored tobacco products on the market, in addition to menthol cigarettes (an issue I'll return to

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the FDA has not issued a proposed rule banning menthol. In 2013, Chicago became the first jurisdiction to ban the sale of all flavors, including menthol. The ban survived constitutional

challenges by tobacco retailers; Menthol in Cigarettes, Tobacco Products; Request for Comments, 78 Fed. Reg. 44484 (proposed July 24, 2013) (to be codified at 21 C.F.R. pt. 1140); Pub. Health L. Ctr., *Chicago's Regulation of Menthol Flavored Tobacco Products: A Case Study*, TOBACCO CONTROL LEGAL CONSORTIUM, http://www.publichealthlaw-center.org/sites/default/files/resources/tclc-casestudy-chicago-menthol-2015_0.pdf [https://perma.cc/AZF2-45JS]. (last visited Mar. 31, 2017); 76 Enter., Inc. v. City of Chicago, No. 1:14-cv-08306, at 2-4 (N.D. Ill. 2014); Indep. Gas & Serv. Stations Ass'ns., Inc. v. City of Chicago, 112 F. Supp. 3d 749, 751-52, 754, 756-58 (N.D. Ill. 2015); *see* Michael Freiberg, *The Minty Taste of Death: State and Local Options to Regulate Menthol in Tobacco Products*, 64 CATH. U. L. REV. 949, 973-74 (2015).

50. *See, e.g.*, G. Ferris Wayne & G. N. Connolly, *How Cigarette Design Can Affect Youth Initiation into Smoking: Camel Cigarettes 1983–93*, 11 TOBACCO CONTROL i32 i35, i37-i38 (2002), http://tobaccocontrol.bmj.com/content/11/suppl_1/i32.long [https://perma.cc/753C-9LXH].

51. Laura Bach, *Flavored Tobacco Products Attract Kids*, CAMPAIGN FOR TOBACCO-FREE KIDS 5 (Sept. 14, 2016), https://www.tobaccofreekids.org/research/fact-sheets/pdf/0383.pdf [https://perma.cc/284Y-9VBV].

52. *Id.*

53. *Id.* (quoting R.M. Manko Associates, *Summary Report: New Flavors Focus Group Sessions* (1978), https://www.industrydocumentslibrary.ucsf.edu/pdf [https://perma.cc/4C66-DJ8F]).

54. *See, e.g.*, Wayne & Connolly, *supra* note 50, at i33, i35, i37-i38.

in Part III.A). The Food and Drug Administration (FDA) has, thus far, declined to prohibit candy-flavored smokeless tobacco (e.g., chewing tobacco and snus) or liquids for use in electronic cigarettes, (also known as e-cigarettes) and water pipes (also known as hookas). Research suggests that the ubiquity of flavors designed to appeal to youth is contributing to the dramatic increase in e-cigarette and hooka use among children, teens, and young adults.[55]

C. Advertising Restrictions

Drawing on "'vector analysis' which first emphasized tobacco industry activities, rather than smokers' individual behaviors, as critical for tobacco control,"[56] denormalization emerged in direct response to industry marketing strategies that promote tobacco products as part of a socially desirable lifestyle.[57] For more than a century, tobacco companies have used colorful package inserts and advertisements to associate their products with sports stars and other celebrities.[58] Tobacco companies sponsor sports and entertainment events to "reinforce the imagery of the brand."[59] Marketing campaigns target particular demographic groups—especially teens and young adults—by portraying tobacco use as a way to convey the user's social status, lifestyle choices, political preferences, and more.[60] Key advertising themes include that

55. M.B. Harrell et al., *Flavored E-Cigarette Use: Characterizing Youth, Young Adult, and Adult Users*, 5 PREVENTATIVE MED. REP. 33-34, 39 (2017) (noting that "flavors play a particularly prominent role" in e-cigarette initiation among youth and young adults, compared to adult users who initiate e-cigarette use to stop using conventional cigarettes). Note, however, that e-cigarettes do not pose the same risks as conventional tobacco products. *See* Wendy E. Parmet, *Paternalism, Self-governance, and Public Health: The Case of E-Cigarettes*, 70 U. MIAMI L. REV. 879, 924, 952 (2016).

56. Ruth E. Malone et al., *Tobacco Industry Denormalisation as a Tobacco Control Intervention: A Review*, 21 TOBACCO CONTROL 162, 162 (2012) (quoting Von Eric LeGresley, *A "Vector Analysis" of the Tobacco Epidemic*, MEDICUS MUNDI SCHWEIZ 1, 3 (1999), http://www.medicusmundi.ch/de/bulletin/mms-bulletin/kampf-dem-tabakkonsum/grundlagentexte-zur-tabakepidemie/a-vector-analysis-of-the-to-bacco-epidemic [https://perma.cc/F6V4-WU5T]).

57. David Hammond et al., *Tobacco Denormalization and Industry Beliefs Among Smokers From Four Countries*, 31 AM. J. PREV. MED. 225, 225 (2006).

58. GERARD S. PETRONE, TOBACCO ADVERTISING: THE GREAT SEDUCTION 154-55 (1996).

59. Speech by unknown author, RJ Reynolds Records (May 1989), *available at* https://industrydocuments.library.ucsf.edu/tobacco/docs/jrkm0084. [https://perma.cc/Y63V-63GN].

60. *See*, *e.g.*, BARBARA S. LYNCH & RICHARD J. BONNIE, GROWING UP TOBACCO FREE: PREVENTING NICOTINE ADDICTION IN CHILDREN AND YOUTHS 105-06, 116, 120,

tobacco use is "an expression of independence, individualism, and social sophistication,"[61] that "'[t]obacco use is a rite of passage to adulthood[,]'" that "'[s]uccessful, popular people use tobacco[,]'" and that "'[t]obacco use is relaxing in social situations.'"[62] Finally, "[b]y associating tobacco use with commonplace activities, events, social spaces, or mind-sets, advertising reassures users that smoking and chewing are normal, pervasive, and socially acceptable."[63]

Advertising restrictions are intended to reduce demand in part by constraining companies' ability to market their products as a normal, socially desirable part of adult life. The Public Health Cigarette Smoking Act of 1969 banned television and radio ads for cigarettes and little cigars.[64] The Family Smoking Prevention and Tobacco Control Act of 2009 bans outdoor advertising within 1,000 feet of schools and playgrounds and prohibits sponsorship of sports and entertainment events, among other restrictions.[65] The 2009 law also gave state and local governments more flexibility to enact time, place and manner restrictions on cigarette advertising.[66] Many state and local governments have focused on imposing additional restrictions on outdoor and point-of-sale advertising.[67]

Advertising restrictions reduce consumers' and potential consumers' exposure to tobacco marketing, which impacts a person's attitudes about tobacco, likelihood of initiating tobacco use, number of quit attempts, and prevalence of use.[68] For

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123 (1994).

61. *Id.* at 118.

62. *Id.* at 120 (emphasis omitted).

63. *Id.* at 121.

64. 15 U.S.C. § 1335 (2012).

65. 21 U.S.C. § 387a-1(2) (2012); Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents, 61 Fed. Reg. 44396 (proposed Aug. 28, 1996) (to be codified at 21 C.F.R. Pt. 801, 803, 804, 807, 820, 897).

66. 15 U.S.C. § 1334(c) (2012) ("[A] State or locality may enact statutes and promulgate regulations, based on smoking and health . . . imposing specific bans or restrictions on the time, place, and manner, but not content, of the advertising or promotion of any cigarettes."); *see also* Nat'l Ass'n of Tobacco Outlets, Inc, v. City of Providence, 731 F.3d 71, 76-81, 85 (1st Cir. 2013) (discussing the legislative purpose of § 1334(c), which was intended to provide greater authority to state and local governments than had previously been granted by the Supreme Court).

67. *See, e.g.*, Paul A. Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 WASH. U. L. REV. 1219, 1226-27, 1233 (2014) (reviewing state and local restrictions on outdoor advertising).

68. *See, e.g.*, Lisa Henriksen, *Comprehensive Tobacco Marketing Restrictions: Promotion, Packaging, Price and Place*, 21 TOBACCO CONTROL 147, 149 (2012).

example, longitudinal studies indicate that "within months after the [United Kingdom] banned [tobacco] advertising, . . . Fewer adolescents (ages 13-15) overestimated smoking prevalence among peers[,]" an important measure of tobacco denormalization.[69] It is difficult to isolate the impact of advertising restrictions from other tobacco control measures, such as tax increases or minimum price laws, which are often implemented at the same time as advertising restrictions. The few studies that have attempted to so isolate tobacco control measures suggest that only price increases are more effective than advertising restrictions in reducing the prevalence of tobacco use.[70]

D. Counter-Marketing

Marketing campaigns sponsored by government and nongovernmental organizations can be used to counter industry advertising by portraying tobacco products as unethical or unclean, tobacco companies as manipulative, and tobacco users as socially ostracized.[71] Although health communications campaigns have long used mass media to convey messages about the health risks of tobacco use, more recent efforts against tobacco use prompt people "not only to avoid hazardous health consequences or legal sanctions (such as cigarette taxes), but also to escape from such psychological punishments as social isolation or embarrassment."[72] Campaigns highlighting the effects of tobacco use on appearance (wrinkled skin, yellow teeth) and sexual desirability (bad breath, impotence) are characteristic of the denormalization strategy. For example, a campaign launched by the FDA in 2014 focused on cosmetic effects as well as other social costs like being pulled away from the school dance by the need to go outside to smoke, and the loss of control that

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69. *Id.*

70. *See, e.g.*, M. M. Schaap et al., *Effect of Nationwide Tobacco Control Policies on Smoking Cessation in High and Low Educated Groups in 18 European Countries*, 17 TOBACCO CONTROL 248, 254 (2008); D. T. Levey et al., *The Role of Tobacco Control Policies in Reducing Smoking and Deaths in a Middle Income Nation: Results from the Thailand SimSmoke Simulation Model*, 17 TOBACCO CONTROL 53, 57 (2008).

71. U.S. Dep't of Health & Hum. Servs., *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*, 635, 643, 669, 672 (2012), https://www.ncbi.nlm.nih.gov/books/NBK99237/pdf/Bookshelf_NBK99237.pdf [https://perma.cc/7EP4-GGJK].

72. Kim & Shanahan, *supra* note 8, at 349.

accompanies addiction.[73] Messages aiming to denormalize tobacco use "do not try to persuade young adults they risk serious health problems in later life, but instead undermine the immediate social and psychological benefits they hope to access by smoking."[74] Evidence suggests that this approach is more effective than campaigns focusing solely on straightforward descriptions of health risks.[75]

Some campaigns specifically target the tobacco industry and its practices. For example, the "Truth Campaign" highlights internal industry documents describing deceptive marketing practices or denigrating consumers.[76] In the words of the advertising executive who steered the campaign's development,

> While rather counterintuitive, what made tobacco so alluring to youth was its deadly qualities . . . . Generations of well[-]intentioned social marketers had pounded the airwaves doing everything they could to explain that tobacco kills. What they did not understand (and the tobacco industry did) was that they risked actually making tobacco that much more appealing to youth . . . . [W]e surmised that we could not take away [teens'] tool of rebellion without giving them an alternative. Attacking the duplicity and manipulation of the tobacco industry became "truth's" rebellion.[77]

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73. U.S. Food & Drug Admin., *The Real Cost: Campaign Overview,* THE CTR. FOR TOBACCO PRODS. (last updated March 2017), https://www.fda.gov/downloads/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/AbouttheCenterforTobaccoProducts/PublicEducationCampaigns/TheRealCostCampaign/UCM384307.pdf; [https://perma.cc/9W6Q-KZSB]; Li-Ling Huang et al., *Impact of* The Real Cost *Campaign on Adolescents' Recall, Attitudes, and Risk Perceptions About Tobacco Use: A National Study*, 14 INT'L. J. ENVTL. RES. & PUB. HEALTH 42, 42-43 (2017); Brice, *R.J. Cyler in* "The Real Cost" *Commercial*, NO PINK SPANDEX (July 29, 2016), http://awwman.com/ nps/main/2016/07/r-j-cyler-in-the-real-cost-commercial/ [https://perma.cc/VA7R-JUUK].

74. Janet Hoek et al., *A Qualitative Exploration of Young Adult Smokers' Responses to Novel Tobacco Warnings*, 13 BMC PUB. HEALTH 609, 610 (2013).

75. *See, e.g.*, Huang et al., *supra* note 73, at 43; John Taylor et al., *A Qualitative Evaluation of Novel Intervention Using Insight into Tobacco Industry Tactics to Prevent the Uptake of Smoking in School-aged Children*, 16 BMC PUB. HEALTH 539, 540 (2016).

76. Matthew C. Farrelly et al., *The Influence of the National Truth Campaign® on Smoking Initiation*, 36 AM. J. PREV. MED. 379 (2009); Amanda Kalaydjian Richardson et al., *Evidence for Truth®: The Young Adult Response to a Youth-Focused Anti-Smoking Campaign*, 39 AM. J. PREV. MED. 500, 500 (2010).

77. Jeffrey J. Hicks, *The Strategy Behind Florida's "Truth" Campaign*, 10

These efforts, sometimes referred to as tobacco *industry* denormalization, are "associated with a decreased risk of smoking initiation," reduced smoking prevalence, and increased quit attempts and intentions to quit.[78] They may also contribute to political support for more stringent regulation of the tobacco industry.[79]

E. Warning Mandates

In 1965, shortly after the first Surgeon General's report on smoking and health, the Federal Trade Commission (FTC) promulgated a rule requiring that all tobacco advertisements include a warning about health hazards. A few years later, Congress preempted the FTC rule by enacting a warning mandate that applied to product packaging, but did not apply to advertisements. Once a pioneer of tobacco control efforts, the U.S. has now fallen behind other countries, many of which have adopted large, graphic warning labels depicting the health and social consequences of tobacco use and urging tobacco users to quit.[80] The black and white, text-only warnings that are used in the U.S. to convey the Surgeon General's advice about smoking and health have not been updated in decades. The 2009 Tobacco Control Act directed the FDA to develop graphic warnings that would occupy 50% of cigarette packs.[81] As discussed below, the FDA withdrew its proposed warnings in 2013 after a circuit split emerged regarding their constitutionality under the Supreme Court's evolving commercial speech jurisprudence.

The graphic warnings proposed by the FDA focused on health effects, rather than social consequences, but the images were arresting enough to prompt one commentator to argue that they impose a "psychic tax" on tobacco users:

TOBACCO CONTROL 3, 4 (2001).

78. Farrelly et al., *supra* note 76, at 381-82; Malone et al., *supra* note 56, at 162, 168; *see, e.g.*, Debra H. Bernat et al., *Adolescent Smoking Trajectories: Results from a Population-Based Cohort Study*, 43 J. ADOLESCENT HEALTH 334, 337-40 (2008).

79. Malone, *supra* note 56, at 162, 169.

80. Gostin & Wiley, *supra* note 36, at 447-48.

81. 15 U.S.C. § 1333(a)(1-2) (2012).

> [B]y making risks vivid and easy to imagine, graphic warnings may trigger an emotional response that textual warnings do not . . . . Marketing experts have long relied on classical conditioning to associate their products with positive emotions. Graphic warnings may have the opposite effect. In other words, they may condition people to experience negative emotions when presented with a particular product . . . . [B]y manipulating feelings of guilt, graphic warnings may channel consumption choices in the direction that the government deems appropriate.[82]

Graphic warning labels used in other countries are more clearly linked to denormalization, focusing on impotence as a health risk associated with smoking,[83] warning that "smoking causes foul and offensive breath,"[84] and depicting addiction with an image of a man behind bars made of cigarettes.[85] Warning mandates place denormalization messages where government-sponsored campaigns cannot reach: on product packaging. Research suggests that warning labels focusing on short-term social consequences are more effective in dissuading teens from smoking than warnings focused on health effects.[86]

F. Smoke-Free Laws

Smoke-free laws target individual smokers and potential smokers as the hosts of disease and as vectors for delivery of secondhand smoke to nonsmokers. State and local jurisdictions regulate smokers directly by making smoking a civil offense. For

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82. Gary M. Lucas, *Paternalism and Psychic Taxes: The Government's Use of Negative Emotions to Save Us from Ourselves*, 22 S. CAL. INTERDISC. L. J. 227, 254-55 (2013).

83. P. Vateesatokit et al., *Thailand: Wining Battles, But the War's Far From Over*, 9 TOBACCO CONTROL 122, 123-24 (2000), http://tobaccocontrol.bmj.com/content/tobaccocontrol/9/2/122.full.pdf; [https://perma.cc/Q33S-VQFE]; D. Hammond et al., *Impact of the Graphic Canadian Warning Labels on Adult Smoking Behaviour*, 12 TOBACCO CONTROL 391, 393 (2003).

84. *New Zealand: Tobacco Labelling Regulations*, TOBACCO LABELING RESOURCE CTR., http://www. tobaccolabels.ca/countries/new-zealand/ [https://perma.cc/4VWP-EHNY] (last visited Apr. 17, 2017).

85. *European Union: Tobacco Labelling Regulations*, TOBACCO LABELING RESOURCE CTR., http://www.tobaccolabels.ca/countries/european-union/ [https://perma.cc/BCV2-75BE] (last visited Apr. 17, 2017).

86. Hoek et al., *supra* note 74, at 610.

example, an Illinois statute prohibiting smoking in public places, places of employment, and government-owned vehicles imposes a fine of "$100 for a first offense and $250 for each subsequent offense" on individuals who smoke in prohibited areas.[87] Smoke-free laws may also regulate third parties by mandating that they adopt policies prohibiting smoking. For example, the same Illinois statute obligates individuals and corporations that own, operate, or otherwise control a public place or place of employment to post no smoking signs, remove ashtrays,[88] and "reasonably assure that smoking is prohibited,"[89] subject to a fine of "$250 for the first violation, . . . $500 for the second violation within one year . . . , and $2,500 for each additional violation within one year . . . ."[90]

Within the last several years, a few local governments have pioneered the adoption of ordinances prohibiting smoking in multi-unit housing facilities.[91] Many ordinances apply only to publicly subsidized housing, while others apply to non-subsidized units as well.[92] Smoke-free housing laws reduce the exposure of nonsmokers to secondhand smoke in their homes because it is not possible to block smoke from traveling through ventilation systems and other conduits.[93] Tobacco residue can be found on the floors and surfaces of nonsmokers' homes due to smoking in neighboring units, posing a hazard to young children.[94]

Like recent efforts to prohibit smoking in multi-unit housing facilities, early prohibitions on smoking in enclosed spaces such as restaurants, bars, and workplaces were justified primarily in terms of harm to others from secondhand smoke. It soon became clear, however, that these laws "reduce smoking because [they] undercut the social support network for smoking by implicitly

87. 410 ILL. COMP. STAT. 82/45(b) (2016).

88. 410 ILL. COMP. STAT. 82/15; 410 ILL. COMP. STAT. 82/45(b).

89. 410 ILL. COMP. STAT. 82/20(b-c).

90. 410 ILL. COMP. STAT. 82/45(b).

91. Diller, *supra* note 67, at 1230.

92. Mireya Navarro, *U.S. Will Ban Smoking in Public Housing Nationwide*, N.Y. TIMES (Nov. 30, 2016), https://www.nytimes.com/2016/11/30/nyregion/us-will-ban-smoking-in-public-housing-nationwide.html?_r=0 https://perma.cc/M6NA-9YSF].

93. Nat'l Ctr. for Healthy Housing, *Reasons to Explore Smoke-Free Housing*, http://www.nchh.org/portals/0/contents/nchh_green_factsheet_smokefree.pdf [https://perma.cc/G8HN-JE73] (last visited April 17, 2017); Karen M. Wilson et al., *Tobacco-Smoke Exposure in Children Who Live in Multiunit Housing*, 127 PEDIATRICS 85, i, viii-ix, 86 (2011).

94. *See* U.S. Dep't of Housing & Urban Dev., Regulatory Impact Analysis, *Instituting Smoke-Free Public Housing* 7-8 (Dec. 5, 2016).

defining smoking as an antisocial act."[95] The denormalization purpose of smoke-free laws has become increasingly explicit as several jurisdictions have extended smoke-free rules to outdoor areas where secondhand smoke poses little risk.[96] "[E]fforts to extend smoking bans to beaches and parks [appear to be] policy initiatives designed to denormalize smoking[,] having as their ultimate goal a profound transformation in public norms and behavior."[97] Some jurisdictions have expanded their smoke-free laws to include e-cigarettes because of concerns that the rapid increase in e-cigarette use could renormalize smoking behavior.[98]

Smoke-free laws are aimed at altering the behavior of current smokers while also altering the social environment in which consumers make choices about whether to initiate or continue tobacco use.[99] Bans on smoking in workplaces, restaurants, bars, and other spaces make it less convenient to smoke, while also "reducing smoking visibility in these settings and encouraging societal disapproval of smoking."[100] Smoke-free housing laws, particularly if they are applied to subsidized low-income housing, leave residents with few alternatives to quitting. They may also create a more supportive environment for those who are trying to quit.[101] "More than most other tobacco control measures, smoke-free legislation can denormalize tobacco use by transforming smoking norms and accelerating approval of a nonsmoking

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95. RONALD BAYER & ERIC FELDMAN, UNFILTERED: CONFLICTS OVER TOBACCO POLICY AND PUBLIC HEALTH 24 (2004) (quoting Samuel Glantz); *see also* Burris (2002), *supra* note 18, at 187 ("From being a glamorous activity, smoking has been transformed into antisocial self-destruction. Law, it is said, has played a role in this by, for example, forcing smokers who wish to light up in public to congregate in special and often undesirable areas, such as outside the doors of smoke-free facilities or in sepulchral basement smoking rooms.").

96. Ronald Bayer & Kathleen E. Bachynski, *Banning Smoking in Parks and on Beaches: Science, Policy, and the Politics of Denormalization*, 32 HEALTH AFFAIRS 1291 (2013).

97. *Id.* at 1291.

98. *See* Parmet, *supra* note 55.

99. Tan CE et al., *Association Between Smoke-free Legislation and Hospitalizations for Cardiac, Cerebrovascular, and Respiratory Diseases: A Meta-Analysis*, 126 CIRCULATION 2177 (Oct. 30, 2012); Cheng KW et al., *Association Between Smokefree Laws and Voluntary Smokefree-Home Rules*, 41 AM. J. PREV. MED. 566 (2011).

100. Abraham Brown et al., *A Longitudinal Study of Policy Effect (Smoke-free Legislation) on Smoking Norms: ITC Scotland/United Kingdom*, 11 NICOTINE & TOBACCO RES. 924, 925 (2009).

101. Maya Vijayaraghavan, *The Effectiveness of Cigarette Price and Smoke-Free Homes on Low-Income Smokers in the United States*, 103 AM. J. PUB. HEALTH 2276 (2013); A. Hyland et al., *Smoke-Free Homes and Smoking Cessation and Relapse in a Longitudinal Population of Adults*, 11 NICOTINE & TOBACCO RES. 614 (2009).

environment as the prevailing norm."[102]

G. Discrimination Against Tobacco Users

Some interventions target tobacco users indirectly by permitting or even encouraging private parties to discriminate against tobacco users. Employers, health insurers, landlords, and condominium associations all have economic incentives to discriminate against tobacco users. Insurers pay for much of the health care tobacco users need. Market forces and regulations limit their ability to pass those costs along to users. In addition to bearing significant health care costs, employers may also be affected by lost productivity due to tobacco users who experience more frequent illness. Landlords have legitimate concerns about property damage to units occupied by smokers. In each of these cases, private parties may be seeking to deter tobacco users from applying for jobs, insurance, or housing, to encourage current employees, insureds, or residents to quit, or a combination of the two. Considering that the vast majority of the population does not smoke, landlords, condominium associations, and employers may try to attract nonsmokers by barring smokers.[103] Some employers announce their intention to discriminate against tobacco users quite publicly,[104] suggesting that a stance against tobacco use is part of the image they wish to present to the public.[105]

Even employers who are willing to hire tobacco users routinely discriminate against them with respect to the terms of health insurance coverage. The Affordable Care Act's (ACA) restrictions on discrimination based on health status-related

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102. Brown, *supra* note 100, at 923.

103. Bayer & Stuber, *supra* note 21, at 47 ("Firms boldly announce that they will not employ and may even fire smokers, because of the additional cost of their medical care, or because smoking does not project the 'image' they want to project to the public.").

104. Christopher Valleau, *If You're Smoking You're Fired: How Tobacco Could Be Dangerous to More Than Just Your Health*, 10 DEPAUL J. HEALTH CARE L. 457, 462 (2007) (describing high profile announcements by employers).

105. Bayer & Stuber, *supra* note 21. *See also* Elizabeth Rader et al., *No Smokers Allowed*, 30 ACC DOCKET 80 (April 10, 2012) (quoting an announcement by the Cleveland Clinic that it will not hire smokers: *"As a true 'health care' provider, we must create a culture of wellness that permeates the entire institution, from the care we provide, to our physical environment, to the food we offer, and yes, even to our employees. If we are to be advocates of healthy living and disease prevention, we need to be role models for our patients, our communities and each other. In other words, if we are to 'talk the talk' we need to 'walk the walk.'").*

factors, which inspired Roberts's first foray into healthism,[106] explicitly permit discrimination based on tobacco use.[107] In the employer-based insurance market, insurers have long been required to set premiums at the population level rather than discriminating based on an individual employee's (and dependents') risk profile.[108] Insurers are permitted, however, to impose penalties on individual employees for tobacco use through a wellness program, an exception that is codified within the ACA.[109]

Health insurers operating independently of employers also discriminate against tobacco users. The ACA permits insurers in the small-group and non-group markets to vary premiums for individual versus family coverage and based on geographic area, age, and tobacco use—while prohibiting rate setting based on any other consideration.[110] Through either mechanism—the premium surcharge in the direct-purchase market or wellness program penalties in the group market—insurers may charge tobacco users up to 50% more than nonusers.[111]

III. FRAMEWORKS FOR ASSESSING TOBACCO DENORMALIZATION

In applying their anti-healthism principle to policies that discriminate on the basis of tobacco use, Roberts and Leonard enter an ongoing debate over the legal and ethical permissibility of tobacco control. In this part, I introduce four alternative frameworks for assessing tobacco denormalization. I begin by describing the legal protections that apply to tobacco control generally and denormalization in particular. Then I describe

106. Roberts (2012), *supra* note 23.

107. 42 U.S.C. § 300gg (2012).

108. Roberts (2012), *supra* note 23, at 1178-82 (discussing limits discrimination imposed on group health plans by the Health Insurance Portability and Accountability Act).

109. *See* Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An Assessment of the Affordable Care Act's Personal Responsibility for Wellness Provisions*, 11 IND. HEALTH L. REV. 642 (2014) (discussing the history of wellness program regulation under HIPAA and the ACA) [hereinafter Wiley *Access to Health Care*].

110. 42 U.S.C. § 300gg(a) (2012).

111. 42 U.S.C. § 300gg(a)(1)(A)(iv) (2012) (providing that rates may not vary based on tobacco use by more than a ratio of 1.5 to 1); Wiley *Access to Health Care*, *supra* note 109, at 680 n.146 (discussing the HHS Secretary's decision to raise the threshold for wellness program rewards to 50% for tobacco cessation, but not for other programs).

health justice, the libertarian principle of anti-healthism, and Roberts and Leonard's alternative anti-healthism principle.

A. Legal Protections

The Supreme Court's interpretation of constitutional protections for liberty and autonomy allow the government wide latitude to discourage tobacco consumption. Of course, "[t]he Constitution does not explicitly mention smoking" or tobacco.[112] "Therefore, if there were a constitutional right to smoke" or use or sell tobacco products, "it would have to fall under the umbrella of one of the recognized constitutional rights."[113] One argument is that the liberty to sell and use tobacco products is protected by the Due Process Clause of the Fifth and Fourteenth Amendments.[114] Another argument is that the Equal Protection Clause of the Fourteenth Amendment (applied to the federal government via incorporation into the Fifth) protects tobacco users and sellers from unjustified discrimination.[115] Finally, the First Amendment's guarantee of free expression has implications for communication about tobacco use, including government-sponsored countermarketing, advertising restrictions, and warning mandates.[116] Essentially, while the government's legitimate interest in protecting the health and safety of the people (even from their own choices and actions) is well established,[117] in cases where a fundamental right or suspect classification is implicated, a purely paternalistic government interest may not be sufficiently compelling to justify infringement.[118]

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112. Samantha K. Graff, *There is No Constitutional Right to Smoke*, TOBACCO CONTROL LEGAL CONSORTIUM 2 (2008), http://www.smokefreehousingny.org/wp-content/uploads/No-constitutional-right.pdf [https://perma.cc/8HTL-TEVG].

113. *Id.*

114. *Id.*

115. *Id.*

116. GOSTIN & WILEY, *supra* note 36, at 449-57.

117. *See, e.g.*, Atwater v. City of Lago Vista, 532 U.S. 318, 323 (2001) (upholding the constitutionality of an arrest and the jailing of a woman for failure to wear a seatbelt); Simon v. Sargent, 346 F. Supp. 277, 278-79 (D. Mass. 1972) (per curiam) (holding that a statute requiring motorcyclists to wear protective headgear does not violate due process, notwithstanding the claim that "police power does not extend to overcoming the right of an individual to incur risks that involve only himself"), *aff'd without opinion*, 409 U.S. 1020 (1972).

118. *See, e.g.*, 44 Liquormart, Inc. v. Rhode Island, 517 U.S. 484, 507 n.12 (1996) (striking down a regulation prohibiting advertisement of alcohol prices on First Amendment grounds, in part because "[i]t is perfectly obvious that alternative forms of regulation that would not involve any restriction on speech would be more likely to

Tobacco users and sellers have found little success under the Fourteenth and Fifth Amendments. Although the Due Process Clause has been interpreted as protecting a fundamental right to privacy, including decisional privacy,[119] the Supreme Court has not extended constitutional privacy doctrine to encompass a right to buy, sell, or use any particular product or service in any particular configuration.[120] Longstanding Supreme Court precedents interpreting the Equal Protection Clause apply minimal judicial scrutiny to government actions that draw classifications that are not constitutionally suspect.[121] Actions that distinguish between tobacco users and nonusers, between tobacco products and other products, between tobacco manufacturers and other manufacturers, or between tobacco retailers and other retailers satisfy the Constitution's guarantee

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achieve the State's goal of promoting temperance" including taxation, direct regulation establishing minimum prices or maximum per capita purchases, or education); Va. State Bd. of Pharm. v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 770 (1976) (striking down a "highly paternalistic" regulation prohibiting pharmacists from advertising the prices of prescription drugs, but noting that the state "is free to require whatever professional standards it wishes of its pharmacists"); Frontiero v. Richardson, 411 U.S. 477, 484 (1973) (rejecting sex discrimination "rationalized by an attitude of 'romantic paternalism' which, in practical effect, put women, not on a pedestal, but in a cage").

119. GOSTIN & WILEY, *supra* note 36, at 135-36.

120. *See, e.g.*, Abigail Alliance for Better Access to Dev. Drugs v. Von Eschenbach, 495 F.3d 695, 697, 703-07 (D.C. Cir. 2007), *cert. denied*, 552 U.S. 1159 (2008) (holding that terminally ill adult patients do not have a fundamental right of access to investigational drugs, after surveying the long history of drug regulation); Lange-Kessler v. Dep't of Educ. of N.Y., 109 F.3d 137, 139 (2d Cir. 1997) (holding that the right to privacy does not encompass a woman's right to choose a direct-entry midwife to assist during childbirth); *see also* Samuel R. Wiseman, *Liberty of Palate*, 65 ME. L. REV. 737, 744 (2013) (concluding that there is no constitutionally protected right to consume the foods of one's choosing, based on "the long history of curtailment of food choice, and the lack of any constitutional protection or tradition of broadly protecting food rights"). "[T]he Court declared decades ago its 'abandonment of the use of the 'vague contours' of the Due Process Clause to nullify laws which a majority of the Court believed to be economically unwise.'" In re Late Fee and Over-Limit Fee Litig. v. Bank of America, 741 F.3d 1022, 1029 (9th Cir. 2014) (Reinhardt, J., concurring) (quoting Ferguson v. Skrupa, 372 U.S. 726, 731 (1963) and citing Lochner v. New York, 198 U.S. 45 (1905) (Holmes, J., dissenting); *see also* JOHN HART ELY, DEMOCRACY AND OF JUDICIAL REVIEW DISTRUST: A THEORY 14 (1980) (*Lochner* and similar cases are "now universally acknowledged to have been constitutionally improper"); *see* Michael J. Phillips, *Another Look at Economic Substantive Due Process*, 1987 WIS. L. REV. 265 (reviewing the historical development and demise of enhanced constitutional protection of economic liberties under the substantive due process doctrine, assessing proposals to revive it, and ultimately concluding that such a revival would be inadvisable).

121. Suspect classifications include race, color, national origin, and religion. GOSTIN & WILEY, *supra* note 36, at 137-38.

of equal protection unless they lack a rational relationship to a legitimate state purpose—a very low bar. Discouraging tobacco use is widely accepted as a legitimate government purpose.[122] Under the rational basis test applicable to most tobacco control measures, judges are generally reluctant to second-guess lawmakers' judgment regarding the best means for serving that purpose.[123]

The First Amendment provides the only significant constitutional limit on governmental tobacco control. Beginning in the 1960s, the Supreme Court extended limited First Amendment protection to commercial advertisers.[124] Under an intermediate review standard articulated by the Court in 1980, the government bears the burden of showing that restrictions on commercial speech directly advance a substantial government interest and are no more extensive than necessary to serve that interest.[125] Reducing tobacco use is widely viewed as a substantial interest,[126] but courts have invalidated some restrictions on tobacco advertising based on a judicial determination that lawmakers' chosen means do not directly advance that interest or are more extensive than necessary.[127] Tobacco companies and others continue to litigate the open question of whether the same standard applies to compelled speech, including mandated warnings. The Supreme Court has differentiated between mandates that "prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein" and those that "prescribe what shall be orthodox in

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122. *See* GOSTIN & WILEY, *supra* note 36, at 456.

123. *Id.* at 147-48.

124. Va. State Bd. of Pharm. v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 773 (1976).

125. Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y., 477 U.S. 557, 566 (1980).

126. *But see* R.J. Reynolds Tobacco Co. v. U.S. Food & Drug Admin., 696 F.3d 1205, 1218 (D.C. Cir. 2012) (assuming that the FDA has a substantial interest in reducing smoking rates, while cautioning in a footnote that "we are skeptical that the government can assert a substantial interest in discouraging consumers from purchasing a lawful product, even one that has been conclusively linked to adverse health consequences. Nonetheless, the Supreme Court has at least implied that the government could have a substantial interest in reducing smoking rates because smoking poses 'perhaps the single most significant threat to public health in the United States.'" (quoting U.S. Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 161 (2000)), *rev'd on other grounds*, Am. Meat Inst. v. U.S. Dep't. of Agric., 760 F.3d 18 (D.C. Cir. 2014)).

127. GOSTIN & WILEY, *supra* note 36, at 455 (discussing Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001)).

commercial advertising."[128] The Court has applied the more lenient rational basis test to evaluate mandates to disclose "purely factual and uncontroversial information" about a product or service,[129] but the scope of this carve-out is unclear.[130]

Although these cases concern the liberty enjoyed by tobacco sellers rather than consumers, decisions striking down advertising restrictions often rely on a pro-consumer rationale.[131] The Supreme Court has repeatedly noted that protecting commercial enterprises' freedom of expression serves the public's interest in receiving information about lawful consumer products.[132] But the notion that constitutional protection for commercial speech is justified by consumer freedom only goes so far. Ironically, courts have struck down advertising regulations precisely because the government has the option of reducing tobacco use through other means (e.g., banning tobacco products or mandating a minimum price) that are less restrictive of sellers' speech, even though many would view them as far more restrictive of consumers' freedom.[133]

Moving from constitutional to statutory limits on tobacco control, state and local governments have broad police power to adopt antidiscrimination protections that extend beyond the Supreme Court's Equal Protection Doctrine. As discussed in more detail below, about half of states prohibit employment discrimination based on off-the-job tobacco use[134] and several

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128. Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio, 471 U.S. 626, 651 (1985) (internal quotation marks omitted) (quoting W. Va. State Bd. of Educ. v. Barnette, 319 U.S. 624, 642 (1943)).

129. *Id.*

130. *See infra* Part III.D.

131. GOSTIN & WILEY, *supra* note 36, at 143 (discussing Bigelow v. Virginia, 421 U.S. 809 (1975) and Va. State Bd. of Pharm. v. Va. Citizens Consumer Council, Inc., 435 U.S. 748 (1976)); Alan B. Morrison, *How We Got the Commercial Speech Doctrine: An Originalist's Recollections*, 54 CASE WESTERN RESERVE L. REV. 1189 (2004).

132. GOSTIN & WILEY, *supra* note 36, at 456.

133. *Id.* (discussing 44 Liquormart, Inc. v. Rhode Island, 517 U.S. 476 (1995).

134. *See, e.g.*, WYO. STAT. ANN. § 27-9-195(a)(4) (West 1957) (providing that it is a discriminatory or unfair employment practice "[f]or an employer to require as a condition of employment that any employee or prospective employee use or refrain from using tobacco products outside the course of his employment, or otherwise to discriminate against any person in matters of compensation or the terms, conditions or privileges of employment on the basis of use or nonuse of tobacco products outside the course of his employment unless it is a bona fide occupational qualification that a person not use tobacco products outside the workplace. Nothing within this paragraph shall prohibit an employer from offering, imposing or having in effect a health, disability or life insurance policy distinguishing between employees for type or price of coverage based upon the use or nonuse of tobacco products if: (A) Differential rates

states have broader statutes barring employment discrimination based on any lawful, off-the-job activity or consumption of lawful products.[135] The tobacco industry has joined civil liberties advocates to promote protections for smokers.[136] These laws are in tension with federal rules that permit employers to penalize tobacco users by imposing higher health insurance premiums or less favorable cost-sharing terms on them via an employee health plan. Congress has expressly saved state and local antidiscrimination laws from preemption, however, noting that wellness programs must comply with applicable federal and state antidiscrimination laws.

The federal government has also used its power to regulate interstate commerce to restrict disability discrimination by employers, public programs, and public accommodations. Courts have held that the Americans with Disabilities Act (ADA) does not afford protection to nicotine addicts.[137] These precedents predate 2008 amendments to the ADA that significantly broadened its definition of disability, however, and the current status of nicotine addiction as a protected disability is unclear.[138] As noted above, the Affordable Care Act explicitly permitted discrimination against tobacco users, even as it restricted discrimination based on other health status-related factors.

Public health law scholar Scott Burris (whose work on the ethics of shame-based public health interventions is discussed in Part II.C below) has argued that public health advocates should be mindful of the *limitations* of law as a tool for protecting people from health-based stigma: "Much, perhaps most, enacted stigma

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assessed employees reflect an actual differential cost to the employer; and (B) Employers provide written notice to employees setting forth the differential rates imposed by insurance carriers.").

135. *See* Stephen D. Sugarman, *"Lifestyle" Discrimination in Employment*, 24 BERKELEY J. EMP. & LAB. L. 377, 418 (2003) ("'Smokers' rights' laws swept through more than two dozen legislatures in the early 1990s as a result of the combined lobbying of the American Civil Liberties Union (ACLU) and the tobacco industry. These laws were provoked primarily by reports that a significant number of firms already refused to hire smokers and a fear that the trend was growing. At the urging of the ACLU and others, once smokers' rights proposals got into the legislative process, they were broadened in some jurisdictions . . . to cover alcohol, to cover all legal products, to cover other specific behavior, as in New York, and to cover all off-work behavior, as in North Dakota and Colorado.").

136. *Id*.

137. *See e.g.,* Brashear v. Simms, 138 F. Supp. 2d 693, 695 (D. Md. 2001).

138. Matthew M. Allen, *Everybody's Vaping for the Weekend: Nicotine Addiction as a Workplace Disability*, 83 U. CIN. L. REV. 1393, 1395 (2016) (arguing that the 2008 amendments and recent case law "can be interpreted to protect nicotine addicts who consume electronic cigarettes during smoking cessation attempts").

will not take the form of the sort of overt and demonstrably intentional discrimination prohibited by law."[139] For this reason, Burris and others turn to extralegal frameworks to assess potential interventions, rather than ending their inquiry by determining that discriminatory or shame-based interventions are legally permissible. In turn, these extralegal frameworks may guide lawmakers as they assess potential reforms and judges and regulatory agencies as they interpret existing laws.

B. Libertarian Anti-Healthism

Notwithstanding the lack of constitutional protections for tobacco users' and sellers' liberty interests, critics of tobacco control have long argued as a political and ethical matter that anti-tobacco regulations go too far in hampering autonomy. Some libertarian critics, most famously Robert Crawford[140] and Petr Skrabanek, have used the term *healthism* to describe "the ideology of the 'health of the nation,'" which they warn poses a danger "to our right to do as we like with our lives, to our autonomy to pursue our kind of happiness, to the liberty of the Savage in the Brave New World."[141] Skrabanek, himself a smoker,[142] traced the rise of healthism as a "state ideology" to

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139. Burris (2002), *supra* note 18, at 182.

140. Robert Crawford, *Healthism and the Medicalization of Everyday Life*, 10 INT'L J. HEALTH SERVICES 365, 368 (1980) (defining healthism "as the preoccupation with personal health as a primary—often *the* primary—focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help."); Robert Crawford, *Health as a Meaningful Social Practice*, 10 HEALTH 401 (2006); *see also* SHARI L. DWORKIN & LINDA FAYE WATTS, BODY PANIC: GENDER, HEALTH, AND THE SELLING OF FITNESS 11-12 (2009) (crediting Crawford with coining the term *healthism*).

141. Skrabanek (1994), *supra* note 28, at 11; *see also* DANIEL CALLAHAN, PROMOTING HEALTHY BEHAVIOR: HOW MUCH FREEDOM? HOW MUCH RESPONSIBILITY? 141-142 (2000) (discussing the tyranny of "healthism"); Stacy Carter et al., *Shared Health Governance: The Potential Danger of Oppressive "Healthism"*, 11 AM. J. BIOETHICS 57, 68 (2011) (characterizing "oppressive healthism" as "impairing people's opportunities to be who they want to be by enforcing health practices that may not be valued by all—or even by most."); Andrea Freeman, *The Unbearable Whiteness of Milk: Food Oppression and the USDA*, 3 UC IRVINE L. REV. 1251, 1270 (2013) ("Healthism promotes the ideals of thinness and fitness and perceives individuals who fail to adhere to or achieve these ideals to be imposing unfair costs on others."); *See e.g.* KATE FITZPATRICK & RICHARD TINNING, EDS., HEALTH EDUCATION: CRITICAL PERSPECTIVES (2014) (collecting several essays reflecting on Crawford's concept of healthism).

142. Skrabanek (1994), *supra* note 28, at 9. After his death at age 53 from prostate cancer, Skrabanek was accused of accepting support from the tobacco industry. *See* Clare Dyer, *Tobacco Company Set Up Network of Sympathetic Scientists*,

efforts in the United States in the 1970s to attack the "moralists' trinity of evils—drink, tobacco, and sex."[143] It was then, he argued, that the government first adopted a strategy that "goes beyond education and information on matters of health and uses propaganda and various forms of coercion to establish norms of a 'healthy lifestyle' for all."[144]

Skrabanek was not a legal scholar, but his position would support a broader reading of the Due Process Clause to protect the liberty to buy and use products and services despite the government's determination that they are harmful. His position might also support broader First Amendment constraints on mandated commercial speech by rejecting the Supreme Court's current distinction between government efforts to prescribe orthodox ideology (which are strictly scrutinized by judges) and those that aim merely to prescribe what is orthodox in matters of commercial advertising.

Skrabanek frequently articulated his position in terms of debates over the legitimate scope of medical practice and public health. He criticized the rise of what he called "anticipatory medicine," which, he explained, "is not the same as traditional preventive medicine which was limited mainly to vaccination against specific diseases, and the reduction of the spread of infection by maintaining a clean water supply, abattoir inspection, control of the food chain, etc." He connected this phenomenon to the rise of a new model of public health:

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316 BMJ 1553 (1998). The *Lancet*, also implicated in the scandal, clarified that the accusations were unsubstantiated and that there was no evidence that Skrabanek's writings published in the Lancet were influenced by any relationship he may have had with the tobacco industry. James McCormich & Robin Fox, *Death of Petr Skrabanek*, 344 LANCET 52 (1994). In response to the scandal, the *Lancet* Ombudsman recommended that, going forward, the journal should require all authors to declare financial relationships with industry. *See* Thomas Sherwood, *Ombudsman's Second Report, and Tobacco*, 352 LANCET 7 (1998). Richard Epstein, a legal scholar who has articulated libertarian views in his work on tobacco control, has disclosed ties to the tobacco industry. *See* Richard A. Epstein, *Subrogation, and Insurance, with Special Reference to the Tobacco Litigation*, 41 N.Y.L. SCH. L. REV. 493, 493 (1997) ("[F]irst a disclaimer. I have worked with Philip Morris on a variety of tobacco cases for a long period of time.") [hereinafter Epstein (1997)].

143. Skrabanek (1994), *supra* note 28, at 11-12; *see also* Crawford *Healthism and the Medicalization of Everyday Life*, *supra* note 140 (linking healthism to "social effort[s] to gain control over that part of the human experience captured by the concept of health . . . made in the late 1970s in the United States.").

144. Skrabanek (1994), *supra* note 28, at 15.

> While the old public health was based on discoveries made by natural sciences and on technology and engineering, the new public health, while retaining the title, has little to do with science. . . . It accepts evidence not according to its quality but according to its conformity with a foregone conclusion. Nearly all its evidence is based on convoluted statistical arguments.[145]

In his characteristically stark, memorable prose, Skrabanek cautioned: "The roads to unfreedom are many. Signposts on one of them bear the inscription HEALTH FOR ALL."[146]

Legal scholars have also sought to defend the old public health against the new.[147] Richard Epstein,[148] Mark Hall,[149] and Mark Rothstein[150] have expressed concerns about the expansion of public health law to encompass noncommunicable disease, injury prevention, and the social determinants of health.[151] Epstein in particular has argued vehemently against categorizing

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145. Skrabanak (1994), *supra* note 28, at 28. *See also* P. Skrabanek, *Smoking and Statistical Overkill*, 340 THE LANCET 1208 (1992) [hereinafter Skrabanek (1992)] ("In clinical medicine, strict standards apply for evaluation of therapies, and anything short of randomized double blind trials is frowned upon as unreliable evidence. By contrast, risk-factor epidemiology relies on case-control or cohort studies, without rigorous standards of design, execution, and interpretation, even though such studies are susceptible to at least fifty-six different biases . . . . In politically sensitive areas—for example, the alleged harm of passive smoking—poor data are manipulated to reach a foregone conclusion.").

146. Skrabanak (1994), *supra* note 28, at 11.

147. *See generally* Lindsay F. Wiley, *Rethinking the New Public Health*, 69 WASH. & LEE L. REV. 207 (2012) (characterizing and responding to critics of an expanded scope of public health law) [hereinafter Wiley *New Public Health*].

148. Richard A. Epstein, *Let the Shoemaker Stick to His Last: In Defense of the "Old" Public Health*, 46 PERSP. IN BIOLOGY & MED. S138 (2003) (hereinafter Epstein (2003)]; Richard A. Epstein, *In Defense of the "Old" Public Health*, 69 BROOK. L. REV. 1421 (2004) [hereinafter Epstein (2004)]; Richard A. Epstein, *What (Not) to Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L. J. 1361 (2005) [hereinafter Epstein (2005)].

149. Mark A. Hall, *The Scope and Limits of Public Health Law,* 64 PERSP. IN BIOLOGY & MED. S199, S199, S207 (2003).

150. Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J. L. MED. & ETHICS 144 (2002); Mark A. Rothstein, *The Limits of Public Health: A Response*, 2 PUB. HEALTH ETHICS 84 (2009).

151. *See, e.g.,* LISA F. BERKMAN & ICHIRO KAWACHI, SOCIAL EPIDEMIOLOGY 352-54 (2000); JULIE G. CWIKEL, SOCIAL EPIDEMIOLOGY: STRATEGIES FOR PUBLIC HEALTH ACTIVISM 371 (2006). For a critical discussion of the emergence of social epidemiology as a distinct field, see Gerhard A. Zielhuis & Lambertus A.L.M. Kiemeney, *Social Epidemiology? No Way*, 30 INT'L J. EPIDEMIOLOGY 43 (2001).

so-called lifestyle diseases related to diet, physical inactivity, and tobacco use as "public health" problems because "the case for government intervention . . . gets that extra boost of legitimacy" when framed as a public health issue.[152]

Epstein and like-minded legal scholars base their libertarian critique largely on economic theory." These scholars view people as rational actors who carefully weigh costs and benefits and make choices that maximize their own utility (or well-being). If this view is correct, paternalism in general, and psychic taxes in particular, should play no role in government policy."[153] Some, such as Epstein, attack the very premise that tobacco use and other risk factors for noncommunicable disease are legitimate public problems, as opposed to personal ones:[154]

> [S]ome measure of blame for poor health and wealth outcomes should fall on the individuals, and their parents, who have failed to make any . . . efforts at self-improvement and self-preservation. Most modern public health issues have nothing to do with communicable diseases. The current killers are drug abuse, obesity, diabetes, heart disease, high blood pressure, tobacco and alcohol, all of which are best controlled by individual decisions that don't depend on state intervention to control or cure. . . . [The egalitarian] literature seems to suffer from an undercurrent of making excuses for bad conduct, which only aggravates the basic problem. Of course, no one should treat all these harms as though they were self-inflicted. But we should expect some serious examination of the tough trade-off between extra assistance after the fact and the increased risk of poor behaviors before the fact.[155]

Others, such as Gary Lucas, point out that even if public health advocates are content to have the government discourage tobacco use, they should nonetheless be concerned about a "slippery slope, leading to the adoption of laws that many people

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152. Epstein (2004), *supra* note 148, at 1424.

153. Lucas, *supra* note 82, at 230.

154. Epstein (2005), *supra* note 149, at 1368-69.

155. Richard A. Epstein, *Decentralized Responses to Good Fortune and Bad Luck*, 9 THEORETICAL INQUIRIES L. 309, 338 (2009).

will find objectionable or even abusive."[156] Lucas points to state laws mandating misleading statements by doctors about purported risks of abortion. "Abortion-rights advocates will likely find it easier to oppose this practice if the public generally views psychic taxes with suspicion than if psychic taxes are an established instrument for manipulating behavior."[157] Lucas's point, perhaps unintentionally, turns the central insight of the denormalization strategy against its proponents: take care lest government denormalization become normalized.

C. Health Justice

The question at the heart of libertarian critiques of new public health's expanded focus on noncommunicable disease and injury—what, if any, actions should the state adopt to encourage healthier lifestyles—also animates the work of many public health ethicists and legal scholars, including myself. Indeed, the recent emergence of public health ethics as a discipline distinct from bioethics and the ongoing public health law renaissance can be traced, in part, to the issues raised by the new public health.[158] Whereas bioethics and health care law are principally concerned with the relationship between the patient and the health care system with an eye toward securing patient autonomy, public health law and ethics focus on the relationship between the individual and the state with an eye toward balancing individual autonomy with the common good. Public health ethicist Dan Beauchamp began his seminal 1985 article with questions much like those that drove Skrabanek's inquiry a decade later: "Can there be good reasons for public health paternalism in a democracy? Are health and safety individual interests, or also common and shared ends?"[159] Needless to say, ethicists and legal scholars who identify themselves as working within the public health tradition—myself included—typically adopt a perspective that is at odds with libertarian antipaternalism. We are deeply

156. Lucas, *supra* note 82, at 231-32.

157. *Id.* at 231-32.

158. Wiley *New Public Health*, *supra* note 148, at 224 (describing the emergence of the behavioral and social-ecological models of public health and associated controversy over the legitimate scope of public health law); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV 833, 864-65 (2016) (describing the emergence of public health ethics as distinct from bioethics) [hereinafter Wiley *Patient Rights*].

159. Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 THE HASTINGS CTR. REP. 28 (1985).

concerned with individual liberty, but we seek to balance it with collective interests in the context of a broader focus on social justice. Nancy Kass describes public health ethics as aiming to "advance traditional public health goals [of improving the health of populations rather than of individuals] while maximizing individual liberties and furthering social justice."[160] Public health ethicists propose, for example, that data must substantiate that a [public health intervention] will reduce morbidity or mortality; burdens of the program must be identified and minimized; the program must be implemented fairly and must, at times, minimize preexisting social injustices; and fair procedures must be used to determine which burdens are acceptable to a community.[161]

Similarly, Lawrence Gostin and I have advocated for a systematic evaluation of public health regulation that draws on public health science and ethics to assess (1) regulatory justifications, (2) risks to health and safety, (3) the effectiveness of interventions, (4) economic costs, (5) personal burdens, (6) distribution of benefits and burdens, and (7) the transparency and legitimacy of the regulatory process.[162]

Gostin and I expressly advocate for *health justice*.[163] Most relevant for the purposes of this article, the health justice model emphasizes the need for more probing inquiry into the effects of class, racial, and other forms of social and cultural bias on the design and implementation of measures to reduce health disparities.[164] It also counsels prioritization of facilitating social-ecological interventions (e.g., ensuring sufficient access to health

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160. Nancy E. Kass, *An Ethics Framework for Public Health*, 91 AM. J. PUBLIC HEALTH 1776, 1776 (2001). To be fair, Skrabanek raised concerns about social justice as well as autonomy. "Extreme versions of healthism," he noted, "provide a justification for racism, segregation, and eugenic control." He believed, however, that this extreme situation was not found in "Western democracies" where a weaker version of healthism prevails. Skrabanek (1994), *supra* note 28, at 15.

161. Kass, *supra* note 160, at 1776.

162. GOSTIN & WILEY, *supra* note 36, at 40. The framework we describe, which first appeared in previous editions of the text authored by Gostin alone, owes much to the Human Rights Impact Assessment developed by Gostin and Jonathan Mann. *See* Lawrence Gostin et al., *Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 HEALTH & HUM. RTS. 58, 59 (1994).

163. Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 83 (2014) [Hereinafter Wiley *Social Justice*]; Wiley *Patient Rights*, *supra* note 158, at 888; GOSTIN & WILEY, *supra* note 36, at 531–50; Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-managed Social Phenomenon*, 16 HOUSTON J. HEALTH L. & POL'Y 101, 129 (2016).

164. Wiley *Social Justice*, *supra* note 163, at 95-101.

care and public health services and other forms of social support) over individually-targeted, victim-blaming behavioral interventions (e.g., punishments and rewards that put the onus on individuals to make healthier choices without necessarily making it easier for them to do so).[165]

To sum up the public health framework as I have described it thus far: first, public health ethics requires an assessment of the benefits and burdens of tobacco denormalization as a public health intervention. Second, health justice requires attention to the effects of bias on the design and implementation of tobacco denormalization. Third, health justice also demands prioritization of facilitating social-ecological interventions over individually-targeted behavioral interventions.

The growing literature on stigma and health provides insights useful for applying many of the public health ethics and health justice principles summarized above. Public health ethicists and legal scholars have questioned "the general propriety of governmental attempts to direct social values and lifestyles" even when these attempts are limited to government sponsored communications.[166] They express alarm at government interventions that exploit "unfavorable public sentiment toward smoking . . . as an informal social control device that enforces behavioral conformity among smokers."[167] In part, these concerns arise out of the apparent tension between tobacco denormalization and the widely held view that stigmatization of those who are already vulnerable provides the context within which disease spreads, exacerbating morbidity and mortality by erecting barriers between caregivers and those who are sick, and by constraining those who would intervene to contain the spread of illness. In this view, it is the responsibility of public health officials to counteract stigmatization if they are to fulfill the mission to protect the communal health.[168]

Ethicists and legal scholars, including Scott Burris,[169] Jennifer Stuber,[170] and Ronald Bayer,[171] have built on the general

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165. Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. DAVIS L. REV. 121, 184 (2013) [hereinafter Wiley *Obesity*].

166. Ruth R. Faden, *Ethical Issues in Government Sponsored Public Health Campaigns*, 14 HEALTH EDUC. Q. 27 (1987).

167. Kim & Shanahan, *supra* note 8, at 349.

168. Bayer & Stuber, *supra* note 21, at 47.

169. Burris (2002), *supra* note 18, at 179; Burris (2006), *supra* note 18, at 529; Burris (2008), *supra* note 18.

170. Bayer & Stuber, *supra* note 21, at 47.

171. *Id.*; Bayer (2008) *supra* note 34, at 466.

principles of public health ethics and sociological analyses of stigma and health to assess whether tobacco denormalization is consistent with the destigmatization strategy adopted by many public health advocates with respect to HIV prevention. Elsewhere, I have articulated these factors as follows: shame-based public health intervention is inappropriate where there is (1) a power differential between the stigmatized and the "normal" that makes possible (2) labeling, stereotyping, and categorization of the stigmatized as separate from the normal; and (3) the experience of status loss and discrimination by the stigmatized group that is enduring and engulfs the entire identity.[172] Finally, after the first three factors have been considered, a balancing of the negative impact of the purported stigmatization against the potential utility of shame-based sanctions, in terms of public health costs and benefits, may be appropriate.[173]

Considering these factors, Stuber, Bayer, and Burris conclude that at least some forms of tobacco denormalization are acceptable, but their conclusions are contingent on social factors that are inherently dynamic. Indeed, some tobacco control advocates have called for reevaluating denormalization in light of widening socioeconomic disparities between smokers and non-smokers. For example, in 2010, Kristen Bell et al., argued that "[s]tigmatizing smoking will not ultimately help to reduce smoking prevalence amongst disadvantaged smokers—who now represent the majority of tobacco users. Rather, it is likely to exacerbate health-related inequalities by limiting smokers' access to healthcare and inhibiting smoking cessation efforts in primary care settings."[174] It may also be the case that social disparities help explain why shame-based interventions are politically feasible. Indeed, Bayer and Stuber have noted that states with aggressive antismoking campaigns began to "embrace [ ] a strategy of denormalization" only after "the social class composition of smokers underwent a dramatic shift downward."[175]

D. Egalitarian Anti-Healthism

In her scholarship on the Affordable Care Act's restrictions on health insurance underwriting and employment

172. Wiley *Obesity*, *supra* note 165, at 139.

173. *Id.*

174. Bell, *supra* note 19, at 795.

175. Bayer & Stuber, *supra* note 21, at 49.

discrimination, Roberts expressly repurposed the term *healthism* to describe "discrimination on the basis of health status."[176] Working together, Roberts and Leonard add nuance, defining healthism as "systematic differential treatment of *unhealthy* individuals—individuals who have a sufficiently severe condition that they or society deem undesirable—in a way that inflicts a normative wrong."[177] The healthism decried by Crawford, Skrabanek, and others was an "ism" in the sense of communism or capitalism. In contrast, Roberts and Leonard seek to establish healthism among "other familiar 'isms,' such as racism, sexism, ageism, and ableism."[178]

Roberts and Leonard articulate "a theoretical framework for understanding when differentiating on the basis of health is acceptable and when such differentiation should constitute legally restricted discrimination."[179] They articulate several factors in their efforts to "grapple with the normative-wrong and trait-versus-conduct elements of [their] healthism definition."[180] Their framework is intended to provide a foundation for "extending the [anti-healthism] project [from Roberts's initial focus on health insurance and employment] into a variety of other spheres, including health-care access, public health, reproductive technology, the marketplace, and the judicial system."[181] Ultimately, their purpose is to "define a roadmap for policymaking that promotes health without unfairly discriminating."[182]

Even as they seek to extend their critique of healthism beyond employment discrimination and risk-based insurance underwriting, Roberts and Leonard continue to place theories of discrimination at the center of their framework. They openly struggle, however, with the traditional focus of antidiscrimination

176. Roberts (2012), *supra* note 23, at 1171. Roberts described previous uses of the term as referring to "the shift in responsibility for health problems from the individual to the state" involving "the government's promotion of coercive health norms, and its attempts to impose lifestyle choices deemed 'healthy' on its citizens." *Id.* This formulation does not quite capture Crawford's core concern that health promotion activities in the 1970s reinforced a harmful notion of personal responsibility that blamed individuals for their own health problems. It is more accurate as a reading of Skrabanek's work, though I would describe his work as critiquing the shift in *authority* over health-related behaviors from the individual to the state.

177. Roberts & Leonard, *supra* note 23, at 856.

178. *Id.* at 838.

179. *Id.* at 835.

180. *Id.* at 856.

181. *Id.* at 837.

182. *Id.* at 862.

law on "distinctions between 'mutable' and 'immutable' traits" based on "[t]he rationale . . . that individuals should not be disadvantaged on the basis of traits that they did not choose, did not cause, and cannot change."[183] They note that "antidiscrimination law has moved beyond immutability" with respect to characteristics like religion and sexual orientation on the grounds that "such characteristics are very difficult, as a practical matter, to change, or . . . are so fundamental to personhood that 'it would be abhorrent for government to penalize a person for refusing to change them.'"[184] Ultimately, they rely on expansion of antidiscrimination law beyond protection of immutable traits to "carve out a set of health-related statuses, traits, conditions, [and] conduct that should be protected from disadvantage, regardless of voluntariness."[185] They note that this is "a very difficult line to draw."[186] The challenge for Roberts and Leonard is that this "difficult line" is central to their project. On one hand, their anti-healthism project depends on an antidiscrimination norm that condemns at least some forms of differentiation based on conduct and mutable traits. On the other hand, the notion that "the law can appropriately incentivize individuals to alter their 'bad' conduct or choices and gain the privileges enjoyed by others who make 'good' choices"[187] is the touchstone of their effort to save other forms of differentiation.

Roberts and Leonard offer two rubrics for distinguishing between "'good' and 'bad' health-status differentiations."[188] Unacceptable differentiation "[i]s driven by animus," "[s]tigmatizes individuals unfairly, [p]unishes people for their private conduct, [ ] impedes access to health care, [c]uts off resources or otherwise limits the ability to adopt healthy life choices, [p]roduces worse health outcomes, or [m]aintains or increases existing disparities."[189] In a rough mirror image of the first rubric, acceptable differentiation is characterized by its tendency to "[p]romote healthy decisionmaking, [f]acilitate individual choices regarding health, [l]ower health risks, [l]ower health-care costs, and/or [f]acilitate better health care and better

183. Roberts & Leonard, *supra* note 23, at 843.

184. *Id.* at 844 (quoting Watkins v. U.S. Army, 875 F.2d 699, 726 (9th Cir. 1989) (Norris, J. concurring)).

185. *Id.* at 843.

186. *Id.*

187. *Id.* at 843.

188. *Id.* at 896.

189. Roberts & Leonard, *supra* note 23, at 895.

health-care access."[190] Together, the two rubrics emphasize the importance of discriminatory intent and impact, as well as consideration of health-related costs and benefits.

IV. ASSESSING TOBACCO DENORMALIZATION

The various tobacco denormalization interventions described in Part II offer fertile ground for examining the nuanced (and not-so-nuanced) differences among the four frameworks introduced in Part III. For each intervention, I will briefly discuss legal considerations before comparing and contrasting how the intervention might be viewed from the perspective of libertarian anti-healthism, health justice, and the Roberts and Leonard egalitarian anti-healthism principle. All forms of tobacco denormalization are problematic from Skrabanek's and Epstein's libertarian anti-healthism perspective,[191] but parsing what is most objectionable about any given strategy from this perspective is a worthwhile pursuit. Health justice and the Roberts and Leonard anti-healthism principle provide more nuanced critiques of tobacco denormalization, which deem some strategies problematic and others acceptable.

A. Tobacco Taxes

New taxes may face political challenges, but so long as they are adopted by the proper government body using prescribed procedures, they are largely invulnerable to legal challenge.[192] Courts give broad deference to the political branches with respect to taxation, even in cases where the tax has an obvious regulatory purpose.[193]

Tobacco taxes can be justified in economic terms. If calculated correctly, taxes can force tobacco users to internalize costs that would otherwise be imposed on others.[194] But

190. *Id.* at 895-96.

191. I will focus on Skrabanek and Epstein in particular because their work shares an emphasis on liberty largely untempered by concerns about equality and social justice. Other scholars (*see, e.g.*, Crawford, *supra* note 140 at 368; Freeman, *supra* note 141; Dworkin & Watts, *supra* note 140) have used the term healthism in the sense that Skrabanek used it, but have cautioned against the neoliberal emphasis on personal responsibility that Epstein and (to a lesser extent) Skrabanek have embraced.

192. GOSTIN & WILEY, *supra* note 36, at 279.

193. *Id.* (citing License Tax Cases, 72 U.S. 462 (1866)).

194. *Id.* at 276-78 (citing Adam J. Hoffer et al., *Sin Taxes: Size, Growth, and*

economically-minded libertarians question whether the externalities associated with tobacco use are overestimated.[195] They also point out that costs used to justify taxation and other tobacco control measures are artificially induced by publicly financed health care programs (for the elderly, disabled, and poor), laws that prohibit private health insurers from charging actuarially fair premiums, and other mechanisms that adopt a needlessly collective approach to health-care financing.[196] In addition to critiquing the economic unfairness of sin taxes, libertarians also critique the signal they send about the government's moralistic disapproval.

Roberts and Leonard do not discuss tobacco taxes directly, but their discussion of the federal tax on artificial tanning services provides a window into how they might view other public health taxes. Their approval of the tanning tax hinges on their assessment that "people who use tanning beds have not been the subject of widespread animus or stigma on par with smokers or overweight people."[197] Presumably, then, tobacco taxes are more concerning from the egalitarian anti-healthist perspective.

From a health justice perspective, the most concerning

Creation of the Sindustry, MERCATUS CTR. (Feb. 5, 2013); *see also* William J. Baumol, *On Taxation and the Control of Externalities*, 62 AM. ECON. REV. 307, 308-09 (1972); James R. Hines, *Taxing Consumption and Other Sins*, 21 J. ECON. PERSP. 49, 64 (2007).

195. Skrabanek (1992), *supra* note 145.

196. Epstein (2004), *supra* note 148, at 1463 ("Indeed today the major argument for extensive regulation of individual health practices comes from the government's role as the insurer of (first and) last resort . . . . [T]he government . . . has no willingness to impose explicit conditions that exclude people for dangerous habits (e.g., skydiving) or charge them differential rates for smoking or obesity . . . . [T]he best course would be to weaken the public safety net that induces harmful individual behaviors in the first event, and to replace it with a system of tailored disincentives that do not encroach on individual liberty."); Richard A. Epstein, *Subrogation, and Insurance, with Special Reference to the Tobacco Litigation*, N.Y.L. SCH. L. REV. , 496-97 ("[G]overnments, both state and federal, have proved utterly incapable of administering and controlling their Medicare and Medicaid budgets. . . . The more inept the management of these programs, the more substantial the recoveries they . . . obtain from the tobacco companies for tobacco-related illnesses . . . . [I]t will . . . be said that Medicare and Medicaid are different because federal obligations mandate that states expend their resources to counteract the harmful effects of smoking. . . . The obligation . . . takes the form of another unfunded mandate. Surely the right answer is for the states and the federal government to work their disagreements out between themselves. It is not to export them onto tort defendants."). *See also* Lindsay F. Wiley, Micah L. Berman & Doug Blanke, *Who's Your Nanny? Choice, Paternalism and Public Health in the Age of Personal Responsibility*, 41 J. L. MED. & ETHICS S88 (2013).

197. Roberts & Leonard, *supra* note 23, at 904.

feature of tobacco taxes is not the government's promotion of a particular notion of the good life. If the choice to disapprove of tobacco use is made through fair and transparent democratic procedures, it represents the prerogative of the community to signal its values and promote its preferred way of life. The impact of taxes on tobacco users as such is also unconcerning. On the other hand, their regressive nature is problematic from a social justice standpoint.[198]

B. Product Regulation

Direct regulation of tobacco products as the agent of disease is constitutionally permissible so long as it is rationally related to the government's legitimate purpose of reducing tobacco consumption.[199] It raises considerable concerns from a libertarian anti-healthism standpoint, but is relatively unproblematic from my health justice perspective or in terms of Roberts and Leonard's anti-healthism principle because it does not affect the social status of tobacco users in any way.

The fact that the most prominent regulation of tobacco products is focused on restricting the use of flavorings that increase the appeal and perceived appropriateness of the products for children raises an interesting issue for libertarian antihealthism. Are government efforts to promote an "ideology" of healthy living more or less objectionable when they target minors? The typical libertarian argument against government paternalism toward children is that it unnecessarily (maybe even harmfully) supplants parental responsibility. That argument has less force with respect to tobacco given that few, if any, parents would express a preference for their children to use tobacco. Perhaps the more attractive argument is that efforts to protect children (who have limited autonomy anyway) also affect adults (whose autonomy should be paramount). While the candy-and dessert-flavored tobacco products permitted under current law are not favored by the majority of adults, some adults do choose to use them.[200] Thus, there is reason to believe that adult tobacco

198. GOSTIN & WILEY, *supra* note 36, at 278-79.

199. Because distinctions between tobacco products and other products are not constitutionally suspect, the Constitution's guarantee of equal protection and due process require only that the regulation of tobacco products be rationally related to a legitimate government purpose and reducing tobacco use is widely recognized as legitimate. *See supra* Part III.A.

200. *See* Wayne & Connolly, *supra* note 50, at i34-i35 (Table 2) (highlighting the "significant appeal" of flavored products for 18-24-year-old smokers).

users are harmed by the flavor bans that are in effect.

Roberts and Leonard do not address tobacco product regulation, but their discussion of the portion rule for sugary drinks adopted by the New York City Board of Health in 2012 (and invalidated by the state's supreme court on state administrative law grounds shortly thereafter) is instructive. They note that "[w]hile the Big Gulp ban might promote healthy decision-making by creating incentives to reduce consumption of sugary beverages . . . it does not clearly produce positive effects, including positively impacting the range of available choices, lowering health risks or costs, or facilitating better health care."[201] The fact that their analysis is reduced to a calculation of the likely effectiveness of this regulation of products and retailers suggests that their egalitarian anti-healthism principle is not doing much work here that could not be done as well or better by widely accepted public health ethics frameworks or the administrative law requirements that eventually spelled the intervention's demise in the courts.[202]

From a health justice perspective, product regulations are a crucial component of the facilitating social-ecological strategies that should take precedence over individually targeted behavioral strategies. The problem with flavor bans from a health justice standpoint is that they do not go far enough. The fact that menthol-flavored products, which the industry has used to target Black consumers for decades, enjoy protected status under federal law is evidence of exactly the kind of racial and economic bias that health justice demands attention to.

C. Counter-Marketing

Government sponsored speech does not raise constitutional concerns, even when it is funded by taxes paid by the industry it seeks to denigrate.[203] Counter-marketing campaigns that denigrate the tobacco industry may be problematic from the libertarian anti-healthism standpoint, while those that seek to denigrate tobacco users raise concerns under all of the extralegal

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201. Roberts & Leonard, *supra* note 23, at 904.

202. *See* Lindsay F. Wiley, *Sugary Drinks, Happy Meals, Social Norms, and the Law: The Normative Impact of Product Configuration Bans*, 46 CONN. L. REV. 1877, 1888 (2014); Lindsay F. Wiley, *Deregulation, Distrust, and Democracy: State and Local Action to Ensure Equitable Access to Healthy, Sustainably-produced Food*, 41 AM. J. L. MED. 284 (2015).

203. GOSTIN & WILEY, *supra* note 36, at 142 (citing R.J. Reynolds Tobacco Co. v. Shewry, 423 F.3d 906 (9th Cir. 2005)).

frameworks discussed above.

From the libertarian anti-healthism perspective, counter-marketing campaigns that focus on tobacco users would seem to be a prime example of government endorsement of a tobacco-free lifestyle as socially desirable. Skrabanek and Crawford repeatedly expressed concerns that healthism was inappropriately tinged by the supposed moral superiority of individuals who adopt healthy behaviors. Even campaigns that focus solely on demonizing the tobacco industry are probably objectionable to libertarians, though some ultimately defer to government's freedom to express its own point of view in the marketplace of ideas as a less restrictive alternative to advertising and product regulations, which they find far more abhorrent.

Counter-marketing campaigns that target the tobacco industry and tobacco products are generally consistent with the health justice perspective, especially those that focus on revealing and remedying industry practices that target racial, ethnic, and sexual minorities. Counter-marketing campaigns that associate tobacco use with negative cosmetic and social consequences should be carefully assessed, but are largely acceptable. The bias that they generate against smokers does not amount to true stigma. As Burris notes:

> One could argue that smokers are not really relegated to a "them" status, that smoking does not supplant all other traits and is not automatically or durably associated with a range of negative stereotypes. Or one could argue that it satisfies all the criteria of stigma in a formal way, but that in none of the domains is the effect serious enough to rise to the level of stigma.[204]

More systematically, Bayer has argued that tobacco denormalization involves "marginalization that can be shed," that "permits, even [ ] as its goal, the reintegration of those who have been shamed."[205] Thus, it may be appropriate if its public health benefits outweigh its costs.[206]

Roberts and Leonard do not address counter-marketing

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204. *Id.* at 187.

205. Bayer (2008), *supra* note 34, at 470.

206. *Id.*

campaigns, but they might view campaigns focusing on undesirable social and cosmetic consequences of tobacco use with suspicion. Does the fact that such campaigns are less common with respect to other risky activities (such as adventure sports or alcohol use) indicate that they are prompted, at least in part, by animus against tobacco users? I think not, but I also disagree with Roberts and Leonard's similar assertion about the role of animus against smokers as a motivation for employment discrimination. I agree that such campaigns deploy social shaming, but unlike Roberts and Leonard, I feel it is important to distinguish between acceptable uses of shame and those that exacerbate *true* stigma.

D. Advertising Restrictions

The Supreme Court's evolving jurisprudence regarding First Amendment protection for commercial speech has put advertising restrictions at risk in recent years.[207] Thus far, federal restrictions on tobacco advertising have largely been upheld.[208] But some state and local restrictions have been invalidated by the courts on the grounds that they impermissibly infringe upon the First Amendment rights of tobacco companies and sellers.[209] Evidence regarding the efficacy of advertising restrictions is crucial to litigation over their constitutionality. Under the heightened standard of review the courts now apply to restrictions on commercial advertising,[210] regulators must establish that each restriction directly advances an important government interest. Few judges question the importance of reducing tobacco consumption,[211] but many are skeptical about the incremental, population-level effects of restrictions.[212]

Interestingly, while advertising restrictions are the most problematic denormalization strategy from a constitutional standpoint, they are in many ways less concerning than other strategies from the standpoint of the extralegal frameworks presented in this article. Perhaps surprisingly, Epstein has noted exactly this contradiction, in the context of a case upholding state

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207. GOSTIN & WILEY, *supra* note 36, at 453-57.

208. *Id.*

209. *Id.* at 455 (discussing Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001)).

210. *Id.*

211. *Id.* at 456 (discussing Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001) (Thomas, J., concurring)).

212. *Id.* at 454-56.

restrictions on gambling advertising:

> It is better that people not gamble, not only for their own personal character, but also for the corrosive effect gambling has on family and business obligations. Nonetheless, it is just too costly to try to control gambling by criminal sanctions. Better therefore to legalize the "disfavored" activity, which can then be taxed to keep participation within reason. Disfavored activities, moreover, need not be treated like all other business activities. Advertisement stimulates business, so it might be proper for a state to decide that, while it should not ban gambling, it should nonetheless moderate its growth by banning advertising. Surely if the issue were the legalization of marijuana and other drugs, a respectable argument could be made to allow their sale, subject to a general tax and to prohibitions or restrictions on advertising, which, because of advertising's public visibility, should be reasonably easy to enforce. In effect we have adopted such a strategy with respect to cigarettes, which are sold, heavily taxed, and subject to advertisement restrictions, at least on television and radio.[213]

Roberts and Leonard do not take a particular position on advertising restrictions, but applying the factors they articulate, one could easily defend such restrictions as "[p]romot[ing] healthy decisionmaking, . . . [l]ower[ing] health risks, [and] [l]ower[ing] health-care costs."[214] Advertising restrictions do not draw any obvious distinction based on health behavior, nor does this appear to be an intervention that is "driven by animus, [s]tigmatizes individuals unfairly, [p]unishes people for their private conduct, [i]mpedes access to health care, [c]uts off resources or otherwise limits the ability to adopt healthy life choices, [p]roduces worse health outcomes, or [m]aintains or increases existing disparities."[215] Advertising restrictions are also appropriate from a health justice perspective. They alter the social and cultural

213. Richard A. Epstein, *Unconstitutional Conditions, State Power, and the Limits of Consent*, 102 HARV. L. REV. 4, 65-66 (1988).

214. *Id.* at 895-96.

215. *Id.* at 895.

environment in which choices about tobacco use are made, rather than targeting individuals directly.

E. Warning Mandates

All four frameworks can be used to draw a rough distinction between mandates to provide straightforward information about product ingredients and the health risks associated with tobacco use and those that associate tobacco use with negative cosmetic and social consequences. The Supreme Court's *Zauderer* precedent carves out an exception to heightened review for mandates to disclose "purely factual and uncontroversial information."[216] How far this exception extends is a matter of ongoing disagreement among the lower courts.[217] Roberts and Leonard characterize public health interventions that "educate or . . . better inform the public of the risks"[218] as socially beneficial and therefore acceptable. They do not address graphic warnings that (like counter-marketing campaigns) associate tobacco use with socially and cosmetically undesirable consequences, but (as with counter-marketing) one could imagine that labels emphasizing bad breath or impotence would meet their working definition of stigmatizing. They could also be concerned about the possible role of animus in prompting these kinds of government-mandated messages. From a health justice standpoint, warning mandates of all types are acceptable to the extent that tobacco use is not truly the object of stigma. If, however, warning labels were adopted that sought to associate tobacco use with other stigmatized traits, such as gender nonconformance, that could be problematic.

F. Smoke-Free Laws

Bayer and Burris both focus considerable attention on smoke-free laws. Consistent with the notion that denormalization of tobacco use is not identity spoiling and encourages reintegration, rather than permanent marginalization, Bayer concludes that laws prohibiting smoking in public places involve "segregation that is demeaning but not degrading," and

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216. Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio, 471 U.S. 626, 651 (1985).

217. GOSTIN & WILEY, *supra* note 36, at 449-52.

218. Roberts & Leonard, *supra* note 23, at 893 (critiquing excise taxes on sugary drinks and artificial tanning services for failing to educate or better inform the public of health risks).

separation that is "temporary rather than enduring,"[219]

The impact of smoke-free housing laws, particularly as applied to publicly assisted housing, on those who are unable to quit smoking is concerning from the health justice perspective even if (as Burris argues) tobacco use is not the object of *true* stigma. Such laws adopt a behavioral approach—punishing individual smokers without necessarily making it easier to quit—toward current smokers. Roberts and Leonard express similar concerns, noting that "for any paternalistic policy designed to encourage healthy decision-making to be fair and effective, individuals must have the ability to actually make better decisions [and t]here are good reasons to doubt that that is always the case."[220]

On the other hand, unlike either version of anti-healthism, health justice demands attention to the needs of nonsmokers, as well as smokers, particularly with respect to low-income housing.[221] Smoke-free laws represent a social-ecological strategy with respect to those who are trying to quit or have not yet started smoking. They alter the social environment in a housing development, reducing exposure to smoking as a normal activity and reinforcing nonsmoking as the dominant social norm. A commitment to health justice—which emphasizes the priority of facilitating social-ecological interventions over individually-

219. Bayer, *supra* note 34, at 470.

220. Roberts & Leonard, *supra* note 23, at 893.

221. ChangeLab Solutions, *Smokefree Housing Ordinance: A Model California Ordinance Regulating Smoking in Multi-Unit Residences* (June 2015), http://www.changelabsolutions.org/publications/model-ord-smokefree-housing [https://perma.cc/VS47-92RS] ("By adopting laws eliminating exposure to secondhand smoke in people's homes, communities can ensure that smoke free living is not a luxury but instead made available to all residents, regardless of their economic means, race, or ethnicity."); Amy K. Olfene, *Of Asthma and Ashtrays: Examining the Rights of and Exploring Ways to Protect Maine Tenants Living in Multi-Unit Rental Housing Who are Involuntarily Exposed to Secondhand Tobacco Smoke in Their Homes*, 66 MAINE L. REV. 292, 294 (2013) (noting that "72% of Maine adults choose to ban smoking in their own homes, but only 47% of Maine tenants report living in a rental building that prohibits smoking. Thus, not surprisingly, although the majority of Maine households have adopted voluntary smoke-free policies, low-income individuals continue to be exposed at much higher rates than the general population."); Non-Smokers' Rights Association, Smoking & Health Action Foundation, *Smoke-Free Affordable Housing: Picking on Poor People or a Case for Social Justice?* (2010), http://www.smokefreehousingny.org/wp-content/uploads/Case-for-Social-Justice.pdf [https://perma.cc/R93N-P8EA] ("there remains an acute shortage of multi-unit buildings for people who need or want to live smoke-free. This is the case for Canadians seeking market rate rental housing, and especially so for those who cannot afford market rate and must rely upon affordable housing.").

targeted behavioral interventions[222]—would suggest that prohibitions on smoking in public housing facilities may be acceptable if they are preceded by supportive interventions to ensure adequate access to cessation services and social support. Roberts and Leonard's focus on protecting "meaningful choices"[223] raises intriguing possibilities in this regard, but it is not yet sufficiently fleshed out to provide a useful framework for supporting a smoke-free ban if adequate supports for smokers are in place while rejecting it if they are not.

G. Discrimination against Tobacco Users

Permitting or encouraging private discrimination against tobacco users—whether in employment, insurance, or housing—would seem to be the most problematic form of tobacco denormalization from the standpoint of all four of the frameworks presented here. But the devil is in the details.

From a legal standpoint, firing, or refusing to hire an employee based on off-the-job tobacco use is prohibited in about half of states.[224] These antidiscrimination laws are justified in terms of egalitarian and libertarian concerns. On the other hand, employer-sponsored wellness programs, which may create a hostile work environment for employees whose behavior or status designates them as unhealthy, are not only permitted, but encouraged by federal regulatory exemptions and grant programs.[225]

Roberts and Leonard argue that refusing to hire or firing an employee for tobacco use is unacceptably healthist because it "classif[ies] and subordinate[s] . . . employees based on legal conduct that tends to correlate with poor health."[226] Pointing to the "rarity of similar lifestyle discrimination policies targeting alcohol consumption or high-risk recreational activities (e.g., mountain climbing, racecar driving, scuba-diving, spelunking), which may present similar or greater threats to health and productivity," they suggest that these laws may be based on animus (in addition to rational considerations regarding increased health care and productivity costs borne by

222. *See* Wiley *Obesity*, *supra* note 165, at 131.
223. Roberts & Leonard, *supra* note 23, at 894.
224. Wiley *Obesity*, *supra* note 165, at 181.
225. Wiley *Access to Health Care*, *supra* note 109, at 664.
226. Roberts & Leonard, *supra* note 23.

employers).[227] They also suggest that "hiring bans . . . stigmatize nicotine users . . . by reducing them to [a] single characteristic [ ]—. . . nicotine use . . . —without regard for their other attributes that could make them good employees."[228] They note that bans on off-the-job smoking "denies . . . wages to pay for health care out-of-pocket, as well as the benefits of employer-provided wellness programs, which—perhaps ironically—frequently include tobacco-cessation" and thus, "cut off resources and limit a person's ability to adopt healthier life choices."[229] Finally, they note that

> Shutting nicotine users . . . out of employment may paradoxically produce a healthier workforce but a less healthy overall population. In addition, because people of color, people with disabilities, and lower-income individuals are more likely to use nicotine . . . nicotine-use . . . bans disproportionately affect these groups'[,] potentially perpetuating existing health disparities.[230]

Roberts and Leonard also express discomfort with insurance premium surcharges for tobacco users, noting that lawmakers might allow the surcharges "as an incentive for tobacco users to quit," but "instead smokers faced with medium or high penalties chose to forgo coverage altogether to avoid elevated premiums."[231]

On the other hand, Roberts and Leonard hold up employer-sponsored wellness programs that offer rewards for participating in a smoking cessation program as "an easy case of a non-healthist policy that discriminates based on health status."[232] Their approval turns on the notion that workplace wellness programs "typically offer a range of supportive services, funded fully or partially by the employer, including individual coaching, support groups, web-based tracking and support, and smoking cessation drugs."[233] They caution that such programs "should be carefully designed to avoid stigmatizing participants,"[234] but the strategies

227. *Id.* at 896.
228. *Id* at 897.
229. *Id*.
230. *Id*.
231. *Id.* at 894.
232. Roberts & Leonard, *supra* note 23, at 900.
233. *Id.*at 900-01.
234. *Id.* at 901.

they suggest for avoiding stigma—"requir[ing] employers to permit workers time away from work duties to participate or publically recognized quitting milestones to the employee community"[235]—bear little relationship to health-related stigma, as sociologists have described it. Elsewhere, they note that "it remains to be seen whether [workplace wellness programs that rely on biometric screenings to assess weight, blood pressure, cholesterol, etc.] actually lower costs, reduce risks, or produce better health outcomes," cautioning that "perhaps the law should be agnostic with respect to such initiatives, at least until empirical evidence is clearer."[236] While supportive, participation-based smoking cessation programs get their seal of approval, other workplace wellness programs run afoul of their egalitarian anti-healthist principle.

The health justice approach, informed by the work of Burris and Bayer on health-related stigma would question, in the first instance, whether tobacco use is the object of true stigma (as discussed above). Where true stigma *is* at issue—as I have argued is the case for wellness policies that target individuals based on body mass index—the strategies suggested by Roberts and Leonard do not respond to health justice concerns. Time away from work to change the targeted behavior (e.g., to attend weight loss or smoking cessation seminars) would do little to combat stigma. Public recognition of those who have disavowed the targeted status or behavior and may actually exacerbate the stigma surrounding it.[237]

Assessing workplace wellness programs from the libertarian anti-healthist perspective is more difficult. Roberts describes employer-sponsored wellness programs as healthist in the "traditional" (what I refer to as libertarian) sense.[238] However, Epstein (whom I classify as a libertarian anti-healthist) has written favorably of "differential premiums for smokers and non-smokers" which "would create incentives to reduce the level of smoking, and . . . reduce any implicit subsidy that nonsmokers are forced to pay for the benefit of smokers."[239] More generally, he has argued that if "more health costs [are] privately borne, most individuals will take more care to avoid illness and injury than

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235. *Id.*

236. *Id.* at 903.

237. Wiley *Obesity*, *supra* note 165; *see also* Wiley *Access to Health Care*, *supra* note 109, at 640.

238. Roberts (2012), *supra* note 23, at 1171.

239. Epstein (1997), *supra* note 142, at 498.

before."[240] Skrabanek, who died in 1994, did not have occasion to comment on such programs, but could conceivably have taken issue with corporate nannies just as he did with government nannies.

V. CONCLUDING REFLECTIONS

At its core, the egalitarian anti-healthism principle put forward by Roberts and Leonard is an antidiscrimination principle. The various factors they use to distinguish good health-related discrimination from bad health-status discrimination boil down to consideration of whether there is discriminatory (or animus-based) intent and whether there is a discriminatory (or disparate) impact, mixed with a little cost-benefit analysis.[241] Their groundbreaking work evaluating the discriminatory intent and impact of interventions purportedly aimed at improving health provides fertile ground or further exploration. It offers an egalitarian counterweight to the libertarian critiques that have dominated discussions of public health policy.

On the other hand, the egalitarian anti-healthism principle is insufficient, by itself, to inform a thorough evaluation of some kinds of public health intervention. The limitations of the anti-discrimination principle are the subject of voluminous literature. Barring animus as a motivation for state action has not been a terribly successful strategy for policing the boundaries of government authority. Animus is notoriously difficult for challengers to prove. Disparate impact may be susceptible to objective proof, but many judges and lawmakers have deemed its use as a legal standard over-inclusive.[242] Cost-benefit analysis is well established as a tool for assessing the acceptability of regulatory interventions. Public health ethics and statutory regulatory impact analysis requirements already provide ample support for assessing the likely impact of a public health intervention on health outcomes, health care access, and costs.

The antidiscrimination principle put forward by Roberts works well when it is applied to employers' decisions about whom to hire and fire and insurer's decisions about whom to insure and at what rate. It accurately describes the ACA's efforts to

240. Richard A. Epstein, *Living Dangerously: In Defense of Mortal Peril*, 1998 U. ILL. L. REV. 909, 918 (1998).

241. Weeks & Leonard, *supra* note 23, at 862.

242. *Id.* at 857.

constrain risk-based underwriting. In turn, the ACA's constraints on risk-based underwriting increase the motivation for employers to engage in health-status discrimination—in their hiring and disciplinary practices, and by using workplace wellness programs to create a workplace environment that is hostile to unhealthy employees. Roberts's proposal that existing prohibitions on discrimination by employers and insurers should be broadened and new prohibitions should be adopted to protect individuals from discrimination on the basis of health status adds considerable value to ongoing debates about why certain health conditions should trigger a mutual aid response and how far that mutual aid response should extend.

But anti-healthism as antidiscrimination may be too simplistic a principle to provide useful insights regarding more complex matters such as taxes, advertising restrictions, and counter-marketing campaigns targeting products and services that have deleterious health effects, and prohibition of smoking (which is harms the health of bystanders as well as users) in designated places. These policies may contribute to social exclusion of people whose conduct is perceived as unhealthy[243] but it is difficult to prove that they are motivated by *animus* toward particular health-related behaviors. The impact of these policies on health can be assessed individually (e.g. a smoker who spends significant income on cigarettes because he cannot or will not quit has less income to spend on other goods and services that could be beneficial for his health). But as a policy matter, surely their effects should be assessed in the aggregate, at the population level (e.g., the deleterious impact of cigarette taxes on a tobacco user who cannot or will not quit is outweighed by the positive health impact of reducing the prevalence of smoking). These interventions may have a disparate impact on people of color, people who live in low-income households, and people with low formal educational attainment.[244] But, as Roberts and Leonard point out, those effects are addressed through principles that reject bias based on race, ethnicity, income, and education.[245]

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243. Notably, Roberts repeatedly distinguished between discrimination (a term she used to describe healthism) and social exclusion (a term she used to describe ableism) in her initial work applying her anti-healthism principle in the context of employment and health insurance determinations. *See* Roberts (2012), *supra* note 23, at 1171, 1174.

244. Roberts & Leonard, *supra* note 23, at 852.

245. *Id.* at 856 ("Concluding that lifestyle discrimination, at least with respect to nicotine use and obesity, is normatively wrong primarily because it has a disparate impact on historically disadvantaged populations does not require . . . a new protected

Other frameworks, built on the general principles of public health ethics, are better suited to assessing the role that bias plays in the development and implementation of public health interventions and the distribution of benefits and burdens (including social exclusion) associated with those interventions.

The Roberts and Leonard anti-healthism framework neglects analysis of the nature of the health-related conduct, trait, or status at issue and its relationship to individual identity. Unlike frameworks developed by Bayer, Stuber, Burris, and others, the Roberts and Leonard framework does not assess whether smoking, consumption of sugary drinks, rejection of vaccines, obesity, HIV-status, and other health-related behaviors and traits are—like religion and sexual orientation—"characteristics [that] are very difficult, as a practical matter, to change, or . . . are so fundamental to personhood that it would be abhorrent for government to penalize a person for refusing to change them."[246]

category for the unhealthy. From this perspective, healthism is simply a new form of discrimination against already protected (to varying degrees of scrutiny) groups."). Ultimately, however, they conclude that protections against people who are unhealthy, while more difficult to justify, are necessary to fully address their concerns.

246. *Id.* at 844 (quoting Watkins v. U.S. Army, 875 F.2d 699, 726 (9th Cir. 1989) (Norris, J. concurring)).