Tyranny of the majority – each country should decide whether it wants to ban oral tobacco

written by Clive Bates | 1 March 2013



A response to the UK *Balance of Competences Review…*

Should the EU impose a blanket ban on oral tobacco (other than in Sweden, which is allowed an exception)? Why not allow each member state to decide? If a member state wants to take a robust evidence-based approach to tobacco harm eduction by allowing low risk alternatives to cigarettes, why should other member states prevent it?

As it happens, the generalised version of this very question is under consideration by the UK Government – through its Balance of Competences Review. This is part of the British effort to 'redefine the UK relationship with Europe' prior to a referendum on the UK membership of the EU by 2017. This posting includes my response to the Department of Health component of that review.

In his major speech on Europe in January, UK Prime Minister David Cameron said:

> *In Britain we have already launched our balance of competences review – to give us an informed and objective analysis of where the EU helps and where it hampers. Let us not be misled by the fallacy that a deep and workable single market requires everything to be harmonised, to hanker after some unattainable and infinitely level playing field. Countries are different. They make different choices. We cannot harmonise everything.*

In this context, I have made the following submission to the Department of Health review:

Balance of competences review – oral tobacco

*1. **Summary**. In summary, this submission proposes that competence to ban or to allow oral tobacco ('snus') to be placed on the market should rest with member states, not the EU. However, where member states do allow it, the concepts of the single market should apply and product quality regulation should be harmonised to secure a high level of health protection.*

*2. **Subject for realignment of competence: oral tobacco**. I would like to draw your attention to one area of policy that causes harm to health by virtue of European Union level competence. That is the policy regarding 'oral tobacco' (tobacco for oral use that is not inhaled or chewed), often known as snus. Oral tobacco is banned throughout the EU, with the exception of Sweden, under Article 8 of Directive 2001/37/EC and would remained banned under the Commission's proposed revision to the Directive COM(2012) 788 final – Article 15.*

*3. **Evidence**. There is no justification for this ban on scientific, ethical or legal grounds (see my review Death by regulation: the EU ban on low-risk oral tobacco). Sweden has the lowest smoking prevalence by far in the EU (13% vs 28% average – Eurobarometer 2012 survey), and has the lowest rates of smoking related disease as a result. The risk reduction associated with snus is use exceeds 90% and it is likely that the low-nitrosamine version of this product carry minimal cancer, cardiovascular and lung risk – certainly far lower than cigarette smoking. It is clear beyond doubt that in Sweden, oral tobacco displaces cigarettes use and facilitates smoking cessation. There are no signs of significant 'gateway effects'. The effect of snus in Sweden, and in Norway, is unambiguously positive for health. Yet through EU decision-making, this product remains subject to an unjustifiable ban. I attach letters from scientists making the case for lifting the ban and replacing this with a regulated market.*

*4. **Reason for the ban**. The reason for the ban is essentially political – all other*

attempts at justification have been quite convincingly dismissed. For countries where there is no history of this product, where it is hard to envisage its beneficial effect, or where decision-makers simply don't want to take on the reputational risk, lifting a ban on a tobacco product comes with political cost and no obvious political gain. The real-world effect of this is to give greater weight to looking tough on tobacco than to real health outcomes and to the rights of consumers to have access to safer alternatives to cigarettes where such alternatives exist. Whilst that is an explanation, it is not a justification. The current balance of competencies allocates competence to the European Union – but the effect of that is to lock in a ban and prevent any country that does see the advantage of a harm reduction strategy based on oral tobacco outvoted by those that do not.

5. ***Opportunity to do better by realigning the balance of competencies****. However, it is not impossible or implausible that a 'harm reduction' market in oral tobacco could develop in some Scandinavian, North European or Baltic states, where the product is more familiar and where decision makers are closer to the experience of Sweden and Norway and have a better instinctive grasp of the benefits. Why should they be prevented from doing this, because the idea does not find favour in Spain, Italy or Germany? We should also consider the possibility that the UK will adopt a more robust evidence-based approach to tobacco harm reduction at some point in the evolution of its tobacco policy – perhaps recognising that certain groups have particular needs for alternatives to cigarettes (ageing low income smokers, people with psychiatric conditions etc). It should not require the re-opening of an EU directive and securing a qualified majority for UK ministers to decide that this product should be available in some form in the UK – no other member state would be harmed or affected at all if they were to do this, yet there could be significant health benefits in the UK.*

6. ***Proposed realignment of competencies.*** *A split competence is proposed for oral tobacco:*

> *(1) allow members states to take the decision on whether to ban or allow oral tobacco – this would determine the geographical extent of the single market in oral tobacco and would in effect allow members states to opt-in to the exemption that Sweden already has, though via a different mechanism. As with Sweden, members states where the product was permitted would*

still have the obligation to prevent sales in members states where it is not. It does not, therefore, create significant new points of principle or practice.

(2) Once the geographical extent of the market is established by member states, then the European Union should impose a harmonised regulatory standard for those countries where the members states have opted in to allowing sales of oral tobacco. The standard could be that proposed by the WHO's TobReg Committee, a variant on the voluntary 'Gothiatek' standard, an existing member state standard such as that used in Germany or a newly defined EU standard drawing on these.

This would support the development of the internal market with a high level of health protection, but only in those countries where member states wished to have a market like this. It would not permit, but not require, the UK to allow sales of oral tobacco, and so return powers to UK ministers. It would also provide a basis for other member states to consider whether to lift the ban and increase experience in the introduction of low risk alternatives to cigarettes.

I attach three files to support this case:

1. Letter from 15 international experts to Commissioner Dalli in 2011, calling for lifting of the ban on oral tobacco
2. Letter from six experts to Sweden's health minister in February 2013, calling for her to champion lifting the ban through allowing member states discretion, as envisaged above.
3. Supporting data on the health benefits of oral tobacco in Sweden

Yours sincerely

Clive Bates
Former Director, Action on Smoking and Health (1997-2003)
***Disclosure**: no competing interests. I have been pressing for better tobacco harm reduction strategies since 1999.*