ASH ACTION ON SMOKING & HEALTH

Global action for everyone's health.

May 12, 2016

To the Members of the CalPERS Board of Administration:

We are writing to express our concern that the CalPERS Board is considering re-investing in tobacco. As you may be aware, tobacco products kill more people than alcohol, AIDS, car accidents, illegal drugs, murders and suicides combined worldwide. An average of 40,000 Californians die each year from tobacco related causes. Left unchecked, tobacco use will kill 1 billion people in the 21st century.

CalPERS is one of the largest and most influential pension funds in the U.S. Deciding to reinvest in tobacco would be a risk; both a reputational risk and a financial risk. Reinvestment would also violate several of CalPERS stated investment beliefs, including considering the impact of long-term investments on future generations, taking risks that may not be rewarded and integrity/ethics. By choosing to reinvest, CalPERS has the potential to negatively impact the movement towards socially responsible investing nationwide.

Reputational risk is an important consideration in reinvestment. The reputations of governments and retirement funds are at stake when they invest in and therefore profit from the death and disease caused by tobacco companies. It is also harmful to a reputation to continue to do business with tobacco corporations, which lobby and sue governments in an effort to delay or deter the introduction of stronger tobacco control regulation. There is no evidence that divestment from tobacco causes financial harm to portfolios, so funds that choose to divest are unlikely to lose any profit, and they have the potential to enhance their reputations.

In addition to the moral implications and reputational risk, the tobacco industry is not a good investment. The tobacco market is seeing dramatically increasing regulation as well as escalating litigation. Several countries have vowed to end tobacco use by 2030. In California, the governor just signed a law increasing the minimum legal age to purchase tobacco to 21, which will certainly negatively impact the profits of tobacco corporations. This is a national trend that is gaining momentum, and we will likely see other states doing the same in the next few years.

The new legal age is the latest indication of the strong pro-health stance that the State of California has taken for several decades. Public investment in the tobacco industry creates a government-wide conflict of interest, as well as an obvious argument for the tobacco industry in its efforts to hinder further steps against tobacco use.

Tobacco also costs the citizens and the state of California a significant amount of money. Annual health care costs in California caused directly by smoking are approximately $13.29 billion. The tax burden on residents is about $777 per household per year. Smoking productivity losses in California are over $10 billion.[1] Tobacco is bad for business.

[1] Campaign for Tobacco Free Kids, The Toll of Tobacco in California, available at https://www.tobaccofreekids.org/facts_issues/toll_us/california.

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ASH
ACTION ON SMOKING & HEALTH

Global action for everyone's health.

Opponents may argue that tobacco divestment is a "slippery slope" that will force governments to divest from other industries which may be considered "undesirable;" however, tobacco is a unique product which can be placed in a category all its own:

- Tobacco kills when used exactly as intended. There is no safe level of use.
- The scale of the negative impact of tobacco is profound. Six million people die each year from tobacco related illness. It is estimated that one billion people will die this century from tobacco-related causes, unless there is significant change in tobacco consumption.
- Many financial institutions actively try to engage with companies in which they own stock, in order to create positive change. Positive influence on the tobacco industry via engagement is not possible, as the only acceptable outcome would be for the industry to cease its primary business.

For these reasons, the case for divestment of tobacco stocks is black and white. We encourage the Board to continue to forego investment in tobacco companies, and we would be happy to answer any questions or assist in any way.

With highest regards,

Laurent Huber
Executive Director

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CFA
California Faculty Association

1110 K Street, Sacramento, CA 95814
(916) 441-4848 • www.calfac.org • cfa@calfac.org

Rob Feckner, President, CalPERS Board of Administration
Henry Jones, Chairman, CalPERS Investment Committee
400 Q Street
Sacramento CA 95811

May 13, 2016

Dear President Feckner and Chair Jones:

The Board of Directors of the California Faculty Association is disturbed to learn that in the course of reviewing your policies you are considering reinvestment in tobacco.

Given all that we know about tobacco and its cost to smokers' lives in terms of chronic illness, death, addiction, and financial stability, and the cost to their families and to society, we conclude that it is ethically wrong to promote that addiction through CalPERS investments.

But this action you are taking is doubly disturbing because CalPERS is not only a public institution that provides retirement benefits; it is also a public institution that provides health care benefits for large numbers of Californians, including the California State University faculty that we represent.

Every year, we hear about the difficulties CalPERS encounters negotiating the cost of health insurance for CalPERS members, and even with the advantages CalPERS offers, we see our faculty and their families struggle with the ever-rising cost of insurance.

As has been well-established by medical organizations, the cost of medical care is dramatically inflated due to the use of tobacco—the only legal product we can identify that kills half of its users when used as directed.

Just this week, researchers at UC San Francisco Medical Center (see link below) issued a report on the dramatic reductions in health care expenditures in just one year from a 10 percent reduction in smoking by a population.

Can CalPERS actually afford not to support those kind of savings to keep our public health insurance program afloat?

Furthermore, CalPERS as a pension fund lives in perpetuity, unlike like mere mortals. CalPERS, through its investments, affects future people and shapes society as a whole. Any analysis of the cost or loss of opportunity from not investing in tobacco needs to be offset against long-term future medical care costs of treating future patients, not to mention the effects on pubic health.

From both short- and long-term views, promotion of tobacco is harmful not just to individuals and to society, but to CalPERS itself.

It would be grossly ironic for CalPERS to profit from the promotion of sickness on one hand while CalPERS and our members confront the astronomical costs of that sickness on the other. It is short-sighted and wrong. We cannot address financial concerns that way.

Furthermore, it is cynical enough that the tobacco industry promotes its products overseas in ways that are not allowed here in California, and that it promotes smoking directly to children. Here at home, we see promotion of smoking to the students on the campuses where we teach. The California State University is now in a process of adopting rules that restrict that practice.

We cannot build the stability of our own retirements on profits predicated on the addiction of our students or on other teachers' students in another country.

We realize that no investment is perfect and that investing is fraught with conflicts. But some decisions are easy ones. This is an example.

Decide today. Do not revisit tobacco investments.

Sincerely,

Jennifer L. Eagan

Jennifer Eagan
President, California Faculty Association
on behalf of the CFA Board of Directors

cc: Members, CalPERS Board of Administration
Micheal Bilbray
John Chiang
Richard Costigan
Richard Gillihan
Dana Hollinger
J.J. Jelincic
Ron Lind
Priya Mathur
Bill Slaton
Teresa Taylor
Betty Yee

Reference

Smoking Behavior and Healthcare Expenditure in the United States, 1992–2009: Panel Data Estimates
UCSF study on tobacco use:
http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002020
KQED news report:
http://ww2.kqed.org/stateofhealth/2016/05/11/ucsf-study-smokers-quit-and-health-care-costs-drop-in-next-year/

CalPERS Stakeholder Relations

From: Diana Douglas <Diana.Douglas@lung.org>
Sent: Friday, November 11, 2016 12:48 PM
To: CalPERS Stakeholder Relations
Cc: Vanessa Marvin; Jim Knox; Eric Batch; Josh Brown; Jamie Morgan; Tim Gibbs; Erin Reynoso
Subject: CalPERS divestment comments - ALA, ACSCAN, AHA
Attachments: CalPers Divestment Letter - ALA - ACSCAN - AHA - Nov 2016 .pdf

Please find attached a letter on behalf of the American Lung Association in California, American Cancer Society Cancer Action Network, and American Heart Association urging CalPERS to continue its current policy of tobacco divestment.

Best regards,
Diana Douglas

Diana Douglas | **Tobacco Policy Analyst**

American Lung Association in California
1531 I Street, Suite 201, Sacramento, CA 95814

email: diana.douglas@lung.org | office: 916-585-7673

November 11, 2016

Rob Feckner
Board President
CalPERS Board of Administration
P.O. Box 942701
Sacramento, CA 94229-2701

Dear Mr. Feckner,

Smoking is the single leading cause of preventable death in this nation and in California, killing 40,000 Californians annually. According to the most recent Federal Trade Commission reports on cigarettes and smokeless tobacco marketing, the tobacco industry spends nearly $26 million dollars every day to promote their products.[1, 2] Although this industry claims to have ceased all intentional advertising to kids, evidence shows that stores that have more youth customers have more than three times as many tobacco ads as stores in areas with fewer youth.[3]

As health organizations who have led the way in reducing the death and suffering from tobacco, we are extremely disappointed to learn that the California Public Employees Retirement System (CalPERS) is considering reversing a decision made 16 years ago to divest from tobacco companies. Investing in tobacco would pit CalPERS's portfolio against the financial and physical well-being of its members and the rest of California. We also urge CalPERS to take this opportunity to close the loophole in its policy which currently exempts third-party fund managers from divestment requirements.

The tobacco industry inflicts more than $23 billion of health care and lost productivity costs upon Californians on an annual basis—including $3.5 billion of direct costs to California taxpayers to pay for treating tobacco related disease of Medi-Cal patients.[4] Meanwhile, California continues to invest heavily in its tobacco control program, with appropriations totaling over $70 million in 2016-2017.[5] Investing in the same companies whose products we spend millions to suppress is at odds with the financial interests of Californians, including members of CalPERS.

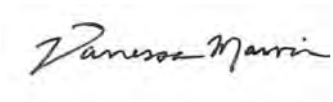
However, it is not just about the money. CalPERS' divestment from tobacco companies represents not only a financial decision, but also an ethical decision made on behalf of all Californians. There is precedent for CalPERS to weigh ethical and public safety concerns alongside fiduciary responsibility to its investors—in 2013, the board voted to eliminate investments in certain manufacturers of assault weapons, citing a commitment to playing a part in reducing acts of gun violence.[6] Given that half of all smokers expect to die from their addiction, we implore CalPERS to give similar consideration to the implications of investing in tobacco companies.

Each year, 16,800 kids in California become new regular, daily smokers. That's 441,000 kids now under 18 and alive in our state that will ultimately die prematurely from smoking.[4]

Every dollar we invest in the tobacco industry helps it addict more of our youth to a product that will ultimately degrade their quality of life, kill thousands, and cost all of us billions of dollars in health care expenses.

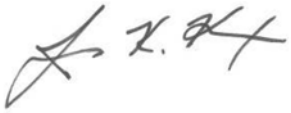
It is simple: investing in Big Tobacco may bring in some additional funds, but at what cost? California will end up paying much more, physically and financially. That is not a wise investment in our future. We respectfully urge you to continue the current divestment policy, extend the policy to CalPERS' third-party fund managers, and send a message that California will not trade the health of its kids for tobacco profits.

Sincerely,



Vanessa Marvin
Vice President,
Public Policy & Advocacy
American Lung Association in California

Eric Batch
Vice President, Advocacy
American Heart Association



Jim Knox
Vice President,
Government Relations, California
American Cancer Society
Cancer Action Network

Cc: Members, CalPERS Board of Administration
The Honorable Rob Bonta, Chair, Assembly Public Employees, Retirement and Social Security Committee
The Honorable Richard Pan, Chair, Senate Public Employment and Retirement Committee

1. U.S. Federal Trade Commission (FTC). Cigarette Report for 2012, 2015 , https://www.ftc.gov/system/files/documents/reports/federal-tradecommission-cigarette-report-2012/150327-2012cigaretterpt.pdf
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5. CTCP Budget http://www.cdph.ca.gov/programs/tobacco/Documents/CDPH%20CTCP%20Refresh/About%20Us/Program%20Budget/CTCPBudget-web.pdf
6. CalPERS to Divest from Manufacturers of Assault Weapons Illegal Under California Law. February 19, 2013. https://www.calpers.ca.gov/page/newsroom/calpers-news/2013/divest-assault-weapons

CalPERS Stakeholder Relations

From: Delos Reyes, Ma Elloi Glenn T. <MGDeLosReyes@mednet.ucla.edu> on behalf of Ong, Michael M.D. <MOng@mednet.ucla.edu>
Sent: Thursday, November 10, 2016 9:46 AM
Subject: CalPERS DIVESTMENT FROM THE TOBACCO INDUSTRY
Attachments: TEROC Public Comments to CalPERS_ Divestment_ Final.pdf

Please read the attached letter RE: CalPERS DIVESTMENT FROM THE TOBACCO INDUSTRY

Sent on behalf of Dr. Michael Ong.

STATE OF CALIFORNIA
TOBACCO EDUCATION AND RESEARCH OVERSIGHT COMMITTEE

November 10, 2016

C/O Office of Stakeholder Relations
CalPERS Board of Administration
400 Q Street
Sacramento, CA 95811

RE: CalPERS DIVESTMENT FROM THE TOBACCO INDUSTRY

To Whom It May Concern:

The Tobacco Education and Research Oversight Committee (TEROC) is a legislatively mandated oversight committee (California Health and Safety Code Section 104365-104370) that monitors the use of Proposition 99 tobacco tax revenues for tobacco control, prevention education, and tobacco-related research in California. TEROC advises the California Department of Public Health, the University of California, and the California Department of Education with respect to policy development, integration, and evaluation of tobacco education programs funded by Proposition 99. TEROC is also responsible for the development of a master plan for the future implementation of tobacco control and tobacco-related research, and making recommendations to the State Legislature for improving tobacco control and tobacco-related research efforts in California. TEROC's 2015-2017 Master Plan, Changing Landscape: Countering New Threats lays out a vision for preventing and reducing tobacco use in California, which includes objectives to prevent youth and young adults from beginning to use tobacco and to minimize tobacco industry influence and activities.

On October 18, 2016, the California Public Employees' Retirement System (CalPERS) hosted a webinar to provide information about its past and future investment strategies. CalPERS encouraged stakeholders to submit public comments regarding the CalPERS future decision to remain divested from the tobacco industry. **TEROC appreciates the opportunity to submit a public comment and strongly urges CalPERS to continue to divest from the tobacco industry. Reinvesting in the tobacco industry conflicts with California tobacco control policies, sends mixed messages about tobacco use, and could potentially link CalPERS to racketeering.**

The public policy of California regarding tobacco use, since the passage of Proposition 99 in 1988, has been to save lives by reducing tobacco use. Under this initiative, smoking prevalence and tobacco consumption have steadily declined. CalPERS' decision to reinvest in the tobacco industry would not only conflict with California's tobacco control efforts, but would send the wrong message to its beneficiaries and other Californians that tobacco use is acceptable.

CalPERS provides retirement and health benefits to more than 1.4 million public employees, retirees, and their families. With your mission being "to advance the financial and health security for all who participate in the System, it is contrary to your mission and service to beneficiaries if CalPERS added tobacco stocks and bonds to its portfolio.[1]

In California, tobacco use is a major contributor to the leading causes of death: heart disease (24.1%) and cancer (23.2%).[2] Moreover, the cost of smoking to California totals $18.1 billion each year, including direct healthcare costs and lost productivity costs from illnesses and premature death.[3] A little more than five percent of CalPERS beneficiaries are smokers and contribute to the cost of smoking in California.[4] It is in CalPERS' best interest to support and reinforce the tobacco control policy efforts to reduce tobacco use, tobacco-related death and disease, and the healthcare costs associated with tobacco use and exposure to secondhand smoke. Furthermore, activities undertaken by the tobacco industry directly conflict with the healthcare services CalPERS provides, and contributes to premature death, disease, and rising healthcare costs.

TEROC recommends that CalPERS retains its position to divest from the tobacco industry, which will continue to 'advance financial health and security of its' beneficiaries, and diminish tobacco industry influences. Reinvesting in the tobacco industry is a threat to population health in California, which must be countered. TEROC's 2015-2017 Master Plan, *Changing Landscape: Countering New Threats* underscores the importance of healthy investments in human capital, and presents seven objectives and a comprehensive approach to improve the health of all Californians through tobacco control research, prevention education, and advancing tobacco use norm change. All of which aligns with the November 2015, CalPERS Investment Belief #4: Long-term value creation requires effective management of three forms of capital - financial, physical and human.[5]

Continued divestment from the tobacco industry directly aligns with TEROC's 2015-2017 Master Plan Objective 5: Prevent Youth and Young Adults from Beginning to Use Tobacco and Objective 7: Minimize Tobacco Industry Influence and Activities. Strategies in support of Objective 5 include building capacity for preventing tobacco use and combating tobacco industry actions. Continued divestment would send a clear message that CalPERS does not support marketing of e-cigarettes, flavored tobacco, or any other tobacco product that either entice or engage youth in tobacco initiation.

Strategies supporting Objective 7 include increased rejection of tobacco industry funding, sponsorship, and partnership. Large investors often use "partnership and/or engagement" with outlier industries as justification for investment, arguing that, as a large shareholder, they can engage with management to obtain business reforms. To

the contrary, the tobacco industry uses involvement and/or inclusion of stakeholders to surreptitiously polish their brand and addict customers to traditional and emerging products. CalPERS reinvestment would only lead to preservation rather than cessation of the tobacco industry business.

TEROC also urges CalPERS to consider the impact of its investment practices on its reputation if it reinvests in racketeering. The United States (U.S.) tobacco industry was found to have violated the federal Racketeer Influenced and Corrupt Organizations Act (RICO) by a federal court in 2006. The court found the tobacco companies fraudulently covered up the health risks associated with smoking and marketing their products to children. "As set forth in these Final Proposed Findings of Fact, substantial evidence establishes that Defendants have engaged in and executed – and continues to engage in and execute – a massive 50-year scheme to defraud the public, including consumers of cigarettes, in violation of RICO." The U.S. Court of Appeals for the District of Columbia Circuit upheld the decision and the U.S. Supreme Court declined to hear the appeal.

Additionally, the long-term prospects for the tobacco industry are not promising. Regulations globally are increasing under the World Health Organization's Framework Convention on Tobacco Control, including smokefree laws, plain packaging and graphic warning labels on packaging. The tobacco industry has fought these global developments vigorously because it knows the measures will adversely affect its business prospects. The U.S. Food and Drug Administration regulations are just beginning, with graphic warning labels and plain packaging on the horizon. Private litigation by smokers suffering from tobacco-related diseases is still thriving in the U.S. and abroad. Canadian provinces are suing to recover healthcare costs. The federal RICO litigation against the industry is ongoing with the Corrective Statements by the industry yet to be finalized; in these Statements, the industry must publicly admit to the world that it engaged in misrepresentation and fraud.

California also is not looking to support the tobacco industry, given the recent vote on Proposition 56. The passage of Proposition 56 will also adversely affect the tobacco industry. According the Centers for Disease Control and Prevention (CDC), a 10 percent price increase results in a 3 to 5 percent decline in tobacco consumption.[6] A study shows that the same 10% price increase also results in up to a 7% drop in youth smoking rates.[7]

In closing, all sectors of California government need to do their part in preventing and reducing tobacco use, the leading preventable cause of death. CalPERS has a long history of recognizing the harms incurred by tobacco and the industry that supports it, and we applaud CalPERS for its prior actions that minimize the effects of tobacco in California. We encourage CalPERS to take further steps and provide the necessary

leadership to ensure that its investment portfolio continues to exclude tobacco stocks and bonds. If TEROC can provide further information that would facilitate your decision-making regarding this matter, please contact me directly at (310) 794-0154 or via e-mail at mong@mednet.ucla.edu.

Most respectfully,

Michael Ong, M.D., Ph.D.
Chairperson

REFERENCES

1. CAlPERS: Public Employees Retirement. CAlPERS: Public Employees Retirement,. http://kern.org/hr/retirement/calpers/pers/. Accessed November 2, 2016.
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7. Chaloupka FJ. Macro-social influences: the effects of prices and tobacco-control policies on the demand for tobacco products. *Nicotine & Tobacco Research.* 1999;1(Suppl 2):S77-S81.

CalPERS Stakeholder Relations

From: Cynthia Hallett <Cynthia.Hallett@no-smoke.org>
Sent: Friday, November 11, 2016 10:27 AM
To: CalPERS Stakeholder Relations
Subject: Comments on Maintaining Tobacco Divestment Policy
Attachments: ANR Comments to CalPERS re Tobacco Divestment.pdf

November 11, 2016

CalPers Stakeholder Relations,

On behalf of Americans for Nonsmokers' Rights, a member-based public health advocacy non-profit organization, we wish to express our concern regarding the CalPERS proposal to reinvest in tobacco. Tobacco is still by far the leading preventable cause of health costs, disease, and death in California, the U.S., and much of the world. We strongly urge you to maintain the current divestment policy. Reinvesting in tobacco is contrary to CalPERS mission of well-being for the long-term.

Tobacco stocks are still risky.

- The U.S. adult smoking rate today is only 15%, a record low. Millennials also have a record low smoking rate. For context on how much tobacco use rates have declined, the national adult smoking rate was 21% in 2005. The recently voter approved Prop 56 in California is expected to dramatically further reduce tobacco use rates in California –possibly down to 5%. It will cost tobacco companies an estimated $250 million in lost sales starting next year and will save billions in health costs.
- Numerous market analysts have recently stated they believe that tobacco stocks are at a peak – the result of mergers and consolidation and product price increases to make up for a quickly declining user base across mature markets. Even in emerging markets such as Indonesia that initially showed increased smoking, smoking rates declined as their market matured and the tobacco industry had to increase prices to make up for the decline in sales.

Tobacco Companies are Racketeers and Face Growing Regulatory Pressure Worldwide

In 2006, tobacco companies were found by a federal district court to have engaged in racketeering acts in violation of the Racketeer Influenced and Corrupt Organizations (RICO) Act. In her ruling, Judge Kessler noted that the industry's illegal behavior was likely to continue. The remedies from the Department of Justice case are still being challenged in court by tobacco companies. However the process is still moving forward. The remedies could still have a major impact on tobacco stocks in the next few years. CalPERS should not be investing in companies whose profits depend on illegal behavior, addiction, and death.

Additionally, FDA now has significant regulatory authority over tobacco, including electronic smoking devices. The potential for regulatory action via the RICO case and FDA mean tobacco stocks remain risky.

Internationally, scores of developing countries are boosting best practice regulatory pressure on tobacco companies and tobacco use rates, steadily closing the gap with developed countries. In the past, tobacco companies were able to grow their international user base in developing nations without much push back from governments but that paradigm has shifted as a result of the Framework Convention on Tobacco Control (FCTC), which provides party countries with a

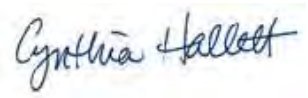
powerful counter balance to tobacco industry interference. For example, plain packaging regulations are expanding in many developing countries along with numerous other "best practice" regulations such as smokefree laws.

Socially Responsible Investing is Profitable

Many institutional investors around the world are adopting screens (divestments) for tobacco in light of both industry behavior and the outlook for long term decline. For example insurance group AXA adopted such a policy earlier this year. Since the CalPERS policy was adopted in 2000, there has been a significant trend toward "Socially Responsible Investing" (SRI) and ESG (Environmental, Social, Governance) factors in investment decisions. There is a growing body of academic research shows a strong link between ESG and financial performance. Several research studies have demonstrated that companies with strong corporate social responsibility policies and practices are sound investments. For example, in 2015 Deutsche Asset & Wealth Management and Hamburg University conducted a meta-analysis of over 2,000 empirical studies, making it the most comprehensive review of academic research on this topic. They found that the majority of studies show a positive correlation between ESG standards and corporate financial performance. **Therefore, we believe that tobacco investments are not required in order for a plan to perform well and strongly urge CalPERS to refrain from reinvesting in tobacco.**

Many thanks for the opportunity to weigh in on this important matter.

Sincerely,



Cynthia Hallett, MPH
President and CEO

(Letter is also attached to this email.)

Cynthia Hallett, MPH
President & CEO
Americans for Nonsmokers' Rights
ANR Foundation
2530 San Pablo Avenue, Suite J
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work (510) 841-3045
mobile (510) 460-0748
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http://www.no-smoke.org

To join or contribute to ANR: https://salsa4.salsalabs.com/o/51299/donate_page/anr-donate?track=CH
To make a donation to the ANR Foundation: https://salsa4.salsalabs.com/o/51299/donate_page/anrf-donate?track=CH

Follow us on Twitter: http://twitter.com/ANR_Smokefree

Please remember the ANR Foundation in your will or trust.

ANR AMERICANS FOR NONSMOKERS' RIGHTS

Defending your right to breathe smokefree air since 1976

November 11, 2016

CalPers Stakeholder Relations,

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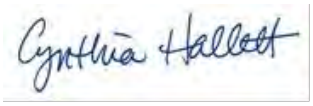
Many thanks for the opportunity to weigh in on this important matter.

Sincerely,



Cynthia Hallett, MPH
President and CEO

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From: CalPERS Stakeholder Relations
To: CalPERS Stakeholder Relations
Subject: RE: Cenkos: Global Tobacco - On Ethics
Date: Friday, November 18, 2016 10:27:06 AM
Attachments: image001.png

From: Rae Maile [mailto:rmaile@cenkos.com]
Sent: Wednesday, October 05, 2016 2:26 AM
To: Newsroom
Subject: FW: Cenkos: Global Tobacco - On Ethics

Further to your decision to review your (lack) of investments in tobacco, your investment committee may find the attached report of some interest.

With best regards

Rae Maile

Rae Maile
Institutional Equities | Cenkos Securities plc
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Please visit our website : www.cenkos.com
Please consider the environment before printing this email

From: Rae Maile [mailto:equityresearch@cenkos.com]
Sent: 26 September 2016 07:18
To: Cenkos London
Subject: Cenkos: Global Tobacco - On Ethics

Download the full report

Tobacco

Global Tobacco

On Ethics

Smoking has been controversial since its first appearance in Europe. The first recorded European smoker, Rodrigo de Jerez who had sailed with Christopher Columbus, was imprisoned by the Spanish Inquisition. This started a long history of tighter regulation, higher taxes and increasing demonisation of smokers. This has been for their own good and for the good of society as smokers face considerable risks to themselves, pose risks to others and are a drain on society. They cannot help themselves as they are addicted to nicotine, and kept that

way by the tobacco industry which has long withheld the truth from them. Smoking, it is said, will be the cause of a billion preventable deaths over the next century. It follows, therefore, that investment in the tobacco industry is “unethical”.

Although this summary may appear a compelling damnation of the tobacco industry it is based on a fundamental assumption regarding the motives of smokers which is barely discussed, namely that smokers simply cannot be making a rational choice in deciding to smoke, cannot ever derive utility from smoking. It is compounded by selective use and manipulation of statistics, science, politics and history by those averse to the freely-made choice of others to use tobacco.

We do not deny that there are risks to health borne by tobacco users from their smoking. We do believe, however, that those risks have been overstated. We dispute that there is a risk to non-smokers from others’ smoking. Giving up smoking may be difficult, but the fact that ex-smokers outnumber current smokers in the UK and the US, for example, shows that it is far from impossible. The idea that smoking imposes a cost to society confuses public costs with private costs. The direct costs to the health service in the UK from smoking are dwarfed by tax revenues from smokers.

We can rightly question and certainly not condone the past behaviour of the tobacco industry, but we should bear in mind that the current generation of tobacco company executives were not born, were children or were very junior within the industry at the time. In terms of current behaviour the leading tobacco companies are proponents of products which may well reduce harm. The introduction of such products is, however, being complicated by some elements of Tobacco Control who seem to believe that the only way for harm to be reduced is for the tobacco industry to be destroyed and for smokers to quit, or die. The ethics of this approach should be questioned, we believe.

We ourselves may not choose to smoke and we may not like the smell of cigarette smoke. But personal prejudice is not the same as an ethical point of view. Indeed, to conflate the two is, perhaps, unethical.

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Global Tobacco

On Ethics

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On Ethics

Introduction

Some disclosures: my youngest son owns 110 shares of British American Tobacco (disclosed in this, and previous reports, as being held by me); I and my wife have investments in collective investment schemes which own various tobacco companies' shares; I have accepted hospitality from tobacco companies in the past, and may do so again in the future if I am invited. Cenkos has no tobacco company as a corporate client. The idea and the decision to research and publish this note were mine.

I do not smoke and never have, as a matter of personal choice; I believe smoking tobacco to be a potential risk to a person's health and that if someone wishes to avoid the health risks of smoking then not smoking is the best policy. I am very strongly of the belief that should someone choose to smoke, and to continue to smoke, then that is a choice that they have made in full understanding of the potential risks, and it is nothing to do with me. I do not believe that someone smoking near me is a risk to my health.

It is also important to understand that the views expressed are my own, and have been reached through considerable research and thought. I have been researching the tobacco sector, initially as a fund manager and subsequently as a stockbroker, for some 25 years. Through essentially all of that time I have held the view that share prices in the sector offered investors a rate of return which was in excess of the risks being run, both in an absolute sense and also relative to broader stock markets. There have been times when that has been wrong but over the long term investors have been handsomely rewarded. I do not need to be positive on the business prospects for the industry, or for any particular company within the industry. There are no stock recommendations in this note, deliberately, but my stock recommendations are a matter of public record.

I set out these statements as the subject of this note will be seen as controversial to many people. I am not an "industry shill" and I am definitely not "in the pay of Big Tobacco". As stated, I do believe that smoking entails risks to the smoker. But I also believe that there is an important debate to be had with respect to the tobacco sector but one which is rarely had. As far as the debate has been staged, it has been one-sided and lazy. Some (and perhaps many) of the "facts" regularly presented against the industry are actually no more than "opinions". An untruth repeated often and loudly does not become the truth.

Although the decision to exclude tobacco investments from a portfolio is often said to have been "on ethical grounds" in our view it is more often a case of personal prejudice. That is absolutely fine as we are all entitled to our own opinions, but to claim that it is more is, perhaps, unethical.

The background to this paper

This year has seen the debate regarding investment in the tobacco sector highlighted in a way that it has not in some considerable years.

In April the California Public Employees Retirement System, CalPERS, announced that it was reviewing its policy of divestment from certain industries, and in particular the decision it took in 2000 to divest from the tobacco industry. It was reported that

CalPERS estimated that its decision to divest had cost it, at that point, some $3bn in missed profits.

It was also reported that Norges, the Norwegian Government Pension Fund, which has excluded most tobacco related investments since the end of 2009, had missed $1.9bn of potential profit and reduced its returns by 0.68% per annum from 2010 to 2015. Although CalPERS was reviewing its policy, Norges was not.

Subsequently, in May AXA announced that it would sell immediately its €200m own-account investments in tobacco company equities and stop all new investments in tobacco industry corporate bonds, running off its €1.6bn of existing holdings as they matured. It was not selling either equity holdings or bonds in funds managed as third party mandates. AXA argued that smoking posed the biggest threat to public health in the world today and that "tobacco will kill one billion people worldwide during the 21st century", citing statements from the World Health Organisation (WHO).

Alongside these debates has been the continuing and active debate regarding the safety or otherwise of e-cigarettes, their role in harm reduction, the regulation of the sector and the role of the tobacco companies in production and promotion of the category. This debate has seen a schism in "Public Health" with those in favour of the products being countered by others who claim "it isn't yet known if they are safe". Media headlines ("Vaping as bad as fags" for example) have played a role in changing public perceptions of the relative risks of e-cigarettes compared with combustible cigarettes, with ASH suggesting that the proportion of survey respondents thinking that e-cigarettes were equally or more harmful that tobacco cigarettes increasing from 12% in 2013 to 23% in 2015. In many cases the tactics and language used by the detractors of e-cigarettes are reminiscent of earlier chapters of tobacco's history and not in a way which is flattering to the current generation.

The regulatory environment with respect to tobacco has been developing over many decades and, as the majority of the population in most countries are not smokers, the impact of that regulation is rarely considered as it does not, *prima facie*, impact upon most of us. Many of us may have welcomed "smoke-free workplaces" although at the time of the introduction of such legislation in the UK most of us were already working in smoke-free workplaces (according to the ONS by 2005 only 8% of adults were working where there were no restrictions on smoking). We may well have welcomed the restriction on smoking in pubs from a personal perspective, although the introduction of such legislation has undoubtedly been bad for the pub trade in the UK (with similar evidence overseas). The banning of point of sale display of tobacco products in the UK and the introduction of plain packaging this year will barely have made a ripple in most of our lives. Given that the majority of us are not tobacco users, and many may not personally approve of tobacco use, each of these further restrictions would have either gone unnoticed or have been welcomed as "a good thing".

That the experience of tobacco control is being widely quoted as a template to be used in other areas "of concern" is probably less well recognised. The idea of a "slippery slope" in regulation of legal products has been vehemently denied by some supporters of tobacco regulation, but not by all as the following entries from the 2015 WHO Tobacco Atlas show quite clearly.

Figure 1: WHO Tobacco Atlas 2015 (p80)

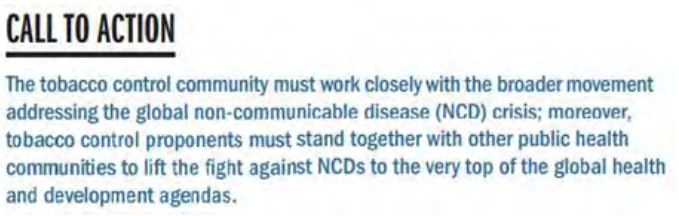
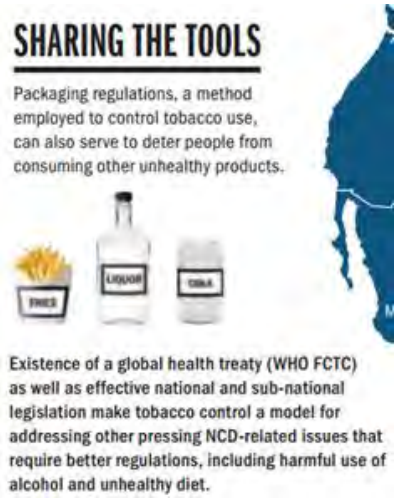


Figure 2: WHO Tobacco Atlas 2015 (p80)



Source: WHO

While restrictions on tobacco impact a minority, and a minority which has become wearily accustomed to being singled out, the fact is that the approach used in tobacco (which itself originally stemmed from the campaign for Prohibition in the US) is now starting to reveal itself in products which might be closer to home for many more of us. The reduction in "safe" drinking levels in the UK is a clear case in point with the UK now having the lowest "safe" levels anywhere in the world and being the only country where the levels are the same for men and women. Moreover "*there is no level of regular drinking that can be considered as completely safe*" (p17) according to the Chief Medical Officer. This is in stark contrast to the weight of evidence on this matter and therefore also completely counter to the introduction of the document which states "*People have a right to accurate information and clear advice about alcohol and its health risks*". It does, however, follow as advice from a committee of experts who are by and large from a temperance background.

Concerns have been raised with respect to obesity levels in society, and this in turn has prompted the proposed introduction of the Soft Drinks Industry Levy in the UK with similar approaches taken in Mexico, France, Finland, Hungary and Philadelphia. The wide availability of low or no-sugar variants of "sugary" drinks does not appear to have influenced the decision to introduce the levy nor indeed the lack of evidence of either sugary drinks in excess calorie consumption or of success elsewhere from taxation. Any of us that prefers "core" styles of fizzy drinks will face either changes to the product and/or higher prices, and yet we would probably not have regarded ourselves as "at risk" and therefore not in need of reformulation or being charged more for a product we freely choose.

In the last 12 months, WHO has deemed Processed Meat to be a "Group 1" carcinogen, ranking it alongside plutonium, alcoholic drinks, coal fires in the home and sunshine, based on "*limited evidence*". The report regarding processed meat caused an immediate reduction in demand from UK consumers for bacon and sausages. WHO has also deemed drinking very hot beverages as a "*probable cause of oesophageal cancer*" although coffee was granted a respite and is no longer considered "possibly carcinogenic to humans (Group 2B)". Many probably looked askance at the idea that bacon was so high risk and have little intention on changing their consumption, and probably never considered that coffee had previously been deemed to be carcinogenic.

The apparently frequent and contradictory messages regarding the ideal diet (is it carbs, sugar, fat or something else that should be avoided this week?) capture headlines but do not inspire confidence in the scientific basis of the claims made. It is, perhaps, no wonder that Britain has "had enough of experts", although it does highlight an understandable personal tendency to believe statements that chime with our own prejudices and behaviours but to discount those that do not.

The argument against tobacco

The case against the tobacco industry includes, according to WHO, that:

- Tobacco use is the leading preventable cause of death and disease globally.
- A billion people will die from smoking over the next century.
- Tobacco kills up to half of its users (sometimes two-thirds of smokers).
- There is no safe level of exposure to second-hand tobacco smoke.
- Smoking imposes a cost on society.

In addition it is widely reported that "many adult cigarette smokers want to quit" although success in quitting is low because cigarettes "contain the addictive drug nicotine". Indeed it has been reported that "nicotine is as addictive as cocaine".

It is further argued that the industry has a long and chequered history and so nothing it says today can be trusted. It has sought to work against regulation of the industry. Tar and nicotine levels have been manipulated. It has long argued that the case against the risks of smoking was overstated.

We can consider this list to cover most, but probably not all, of the usual arguments as to why an investment in the tobacco industry is "unethical".

Challenging the conventional wisdom

Demonic possession

"*… **being a smoker is not a matter of free choice; they're gripped by an addiction fuelled by the tobacco industry and they need support to give up***"

Deborah Arnott, Head of ASH

The first and most important issue to raise is the one which is least often discussed in polite company, namely the fundamental question as to why someone should choose to smoke in the first place, and then continue to smoke, despite the risks of doing so. Maybe, just perhaps, smokers like smoking?

This is fundamental to the question of "tobacco control" as control is only required if consumers are acting in an entirely irrational manner, causing harm to themselves and (in the next logical development of the argument) harm to others. This, it is implicitly argued, is because tobacco is "addictive", and customers are lured into smoking through aggressive marketing by "Big Tobacco" as the comment from Deborah Arnott above suggests.

This has been eloquently described as the "theory of demonic possession" whereby the individual's responsibility for their actions has been subverted by some greater (and inherently, therefore, evil) force. The implication of this theory is that any intervention can be justified in the name of "public health" including punitive taxation; ever increasing regulation of both the product and the ways in which consumers use the product; and outright stigmatisation of the consumer by "denormalisation".

Figure 3: Government-mandated commentary on smokers

Source: NHS

For this characterisation of smokers to be true we would have to believe that there was no personal choice being exercised and that smokers derive absolutely no utility (in an economic sense, ie "pleasure") from smoking at all. The obvious fallacy of the argument is that, despite everything, millions of people around the world continue to smoke **in knowledge and therefore acceptance of the apparent risks**. A rational view must be that smokers have accepted the potential risks of their habit, and borne the obvious financial cost imposed on them for maintaining in their habit, because they "value" smoking – for the taste, the sensation, the stimulation, the relaxation, the conviviality or for whatever other reason or combination of reasons.

On a personal level we may not see that trade off in the same way as we ourselves have either chosen not to smoke or to cease smoking. But then people may well disagree with our personal life choices, each of which themselves may come with their own costs, risks and pay backs.

Figure 4: Risk of a "healthy" commute in London

Source: R. Maile, courtesy of an altercation with a Boris bike which was in the wrong place, Feb 2016

The counter to this is, inevitably, the survey data which suggest that the vast majority of smokers want to give up and/or wish they had never started. But then asked if you think you really should lose some weight, drink less, eat more healthily and give more to charity you would probably agree with all of those sentiments, especially if asked by an interviewer who catches you on the High Street. Each is within your gift if, that is, you want to forego that chocolate cake, not finish that bottle of claret (and open a second), eat more kale (really?) and hand over more cash to every worthy cause that asks. Each of these would, however, require a reduction in utility (pleasure) in the short term which may not be balanced by the promised benefit in terms of increased longevity in the very long term.

We discuss the question of "Addiction" more fully below, but at this point we make a number of points.

- There is no accepted medical or scientific definition of "addiction".
- There are more ex-smokers in the UK and the US as current smokers.
- Until 1988 the Surgeon General did not regard nicotine as "addictive", rather it was an "habituation".
- Even when declaring nicotine to be "addictive" in 1988, the view of the then Surgeon General was that *''For many smokers, a genuine desire to quit and, if necessary, persistent and repeated attempts to quit may be all that is necessary*".

Quitting smoking may well be difficult for many, we do not doubt that, but it is not impossible (as many millions of people have proven) and it is certainly not life-threatening. The "addictive" properties of nicotine (using the word in the sense of common, current parlance) are only one part of the reason for smoking and are, in many ways, no different to the "addictive" qualities of caffeine. And no-one judges you for drinking coffee.

Preventable deaths, premature deaths and "a billion lives"

We can look at these charges as a group as they are interlinked.

It is widely and often claimed that "smoking is the leading cause of preventable death". By implication, presumably, not using tobacco would mean that death could be prevented. That is patently not true of course as even we non-smokers are going to die. Death simply cannot be prevented.

What could be argued is that of all the life style choices that can be made freely by individuals, smoking may result in a reduction in expected longevity, *ceteris paribus*, and, if measured in terms of "years of potential life lost" (YPLL), it may be one of the "most costly". This, however, requires many more assumptions to be made and in particular a definition of how long anyone is **meant** to live which is an entirely subjective construct. YPLLs are often stated with respect to a reference age, for example 75, as though we all live "normalised" lives and should all live the same length of time. Clearly we do not and while smoking is one major point of difference so will be how we eat, drink, work, play and our genetic composition. The debate about what constitutes "a healthy diet" is a case in point, as everyone eats and therefore not eating "properly" will aggregate to a much greater impact on YPLLs than smoking which is undertaken only by a minority.

This concept may sound counterintuitive because "smokers die young". Probably the disease which most would commonly associate with smoking, and where the epidemiology suggests that the risk is most elevated for smokers relative to non-smokers, would be lung cancer. According to Cancer Research UK the average age of diagnosis with lung cancer is over 70. In 2000 there were an estimated 63,000 male "smoking-related" deaths in the UK from a total of 290,000 (22%); 42,000 were in men over the age of 70. Of the estimated 51,000 female smoking-related deaths (16% of the total), 40,000 were over the age of 70. In 2014 the average age of death of men was 75.4 years, while the average age of death from lung cancer was 73.8 years, a difference of 19 months. It is normal to assume that 80% of lung cancer cases are associated with smoking, and there is clearly a reduction in longevity, but perhaps not to the degree which might have been expected.

This raises a number of important points. There are no illnesses which are unique to smoking. Moreover the illnesses which are normally associated with smoking are typically illnesses of old age and not of youth. "The dose makes the poison" and the likelihood of illness from smoking is closely associated with duration and frequency of smoking. While it is stated that "half of all smokers will die from smoking" this is both overstated and is consistent with saying that "half of all smokers will NOT die from smoking". The chances of developing lung cancer as a smoker are put anywhere between eight and 40 times the risks faced by non-smokers. The chance of developing lung cancer as a non-smoker is very low and so even at a high multiple of a very small risk the absolute risk of developing lung cancer as a smoker is around one in ten.

Returning to the point of what constitutes a "premature" death there is, as with addiction, no formal definition. Defining a smoking-related death as a premature death therefore makes the assumption that smoking, and smoking alone, was responsible for death. But it is readily observable that income levels, education and even where you live are also statistically significant variables. If longevity alone is your objective in life then it is best that you are rich, well educated, eat well, drink moderately, exercise and live in a nice part of the country. Even then you may not necessarily live longer, but it may well feel like you have.

Given that the basis for determining what constitutes a "smoking related" death is itself questionable, the idea that smoking will "kill a billion people over the next century" is clearly an extrapolation of poorly based assumptions. According to WHO there are currently over a billion smokers in the world. To argue that smoking will kill a billion over the next century really amounts to saying nothing other than "people alive today are unlikely to be alive 100 years from now". This is simply, therefore, a truism.

A derivation of this argument is that "smoking kills someone every X minutes". Taking the figures quoted above for the UK, in 2000 that would have amounted to "a smoker died every five minutes". And a non-smoker died **every** minute.

It is not about you, it is about me

"The health risks from Second Hand Smoke ("SHS") exposure are now well documented and there is no risk-free level of exposure to SHS"

ASH

With this argument the debate about smoking risks moves beyond the smoker and on to the population in general. No longer is the smoker simply increasing their own risk but they are threatening all those around them.

Prior to the early 1970s smokers, only recently displaced as the majority of the UK or US adult population, were tolerated by non-smokers. The change came from the mid 1970s onwards, in part encouraged by the decision taken at the 1975 Third World Conference on Smoking and Health which called for "Programs aimed at creating a social environment in which smoking is unacceptable". In the words of Sir George Godber: "We must foster an atmosphere where it is **perceived** that active smokers would injure those around them" (our emphasis added).

It certainly seems sensible to assume that non-smokers must be exposed to risk from being near smokers after all we are all aware of the smell. But as we have seen the risks faced by smokers themselves are easily overstated, and so even elevated risk is not the same as material, absolute risk.

The SCOTH report suggested a 24% increase in risk to non-smokers of lung cancer from exposure to SHS. This sounds material but, once again, the absolute risk of lung cancer in non-smokers is negligible and therefore a 24% increase will still render the absolute risk negligible. The suggestion was made that the risk was dose responsive, and therefore those with the greatest exposure over the longest time periods were the most in need of protection. From this comes the requirement to protect, for example, bar workers who worked in smoky venues hence the 2007 introduction of "smoke free workplace legislation" which brought an end to smoking in pubs and increased materially the rate of smoking on the streets.

There are many problems with the theory of SHS and the risk to non-smokers. The most obvious problem is that WHO's own investigation of the risks showed no statistically significant increase in risk from either spousal smoking or smoking in the workplace, and a reduced risk for children. Those studies which purport to show an increased risk tend to be very small sample sizes where statistical significance is rather easier to achieve. But even with these studies, most fail the usually accepted norms of "increased risk". There is, of course, the fact that we, and certainly our parents' generation, would have grown up in a considerably smokier environment than we

have done. The general health and well-being of the population had been improving long before the idea of restricting where people could smoke was introduced.

There is also the fact that smoking restrictions on "public places" are more usually restrictions in private places. Public houses are not "public places", they are private enterprises. No-one is forced to enter any particular pub or restaurant, while the claim made that there would be no impact (and that indeed there would be a benefit) to the hospitality trade from the introduction of restrictions on smokers has been demonstrated to be palpably false.

Again the point is that the claim made against tobacco is not borne out by the evidence. In the end the introduction of restrictions on smoking in public places was not about "health" it was simply the "next logical step" which opponents of tobacco wished to pursue.

The societal cost of smoking

"The government believe it is right that tobacco manufacturers and importers make a greater contribution to the societal costs of smoking"

HM Treasury Tobacco Levy consultation document, December 2014

As well as the health impact on non-smokers of smokers, it is argued that the "true" costs to society (and hence non-smokers) are greater than the income in respect of tax and duty. It is argued that while tax and duty raised from English smokers (78% of the total take from UK smokers) was around £10bn, the "true" cost of smoking in England was £13.9bn. Smoking therefore "imposes a cost to society".

The derivation of annual income is straightforward enough but the "cost" side of the equation is not. To derive the costs to society there is the inclusion of estimated, tangible costs to the Health Service but to this are added various imputed costs including, for example, the cost of "smoking breaks". This conflates two ideas; firstly that smoking breaks are a cost to society as a whole whereas these are quite clearly costs to individual employers; and that non-smokers never deviate from their work. As we all know well we can all find ways to waste time at work and if we were to consider the "cost to society" of social media, internet shopping and the time spent complaining about colleagues who do not share our Stakhanovite work ethic then the costs of smoking breaks taken by a minority of employees quite clearly is shown to be irrelevant.

If we were to be completely cold hearted in this analysis we should compare lifetime income generated from a smoker with the lifetime costs which will include both healthcare costs but also pensions. As we have described already, there is a modest reduction in life expectancy for smokers and hence a "saving" relative to non-smokers from pension payments. In the case of lung cancer we demonstrated that diagnosis tends to come quite late in life, but survival rates are low and this is generally true of "smoking-related" illnesses that expiry tends to follow quickly from diagnosis. This compares with "healthy" non-smokers (especially the skinny ones) where a long period of old age will be associated with material costs of treating the ailments which come with a long life and require significant levels of care.

They cannot be trusted

"The evidence presented also permits the jury to find a tobacco industry conspiracy, vast in its scope, devious in its purpose and devastating in its results."

District Judge Sarokin, the Cipollone Decision, April 21 1988

"… at all material times and in particular by 1964 the general public in the United Kingdom were well aware of the risks to health associated with smoking, above all the view that cigarette smoking could cause lung cancer"

Lord Nimmo Smith, McTear case, 31 May 2005

The release of secret industry documents as part of the litigation wars in the US in the 1990s has fomented the idea of a vast industry conspiracy to hide the truth about the risks of smoking. Moreover the past is regularly raised as a reason not to trust the industry today, as stated explicitly by Article 5.3 of the WHO's Framework Convention on Tobacco Control.

It is certainly the case that the industry challenged the epidemiological evidence linking smoking with illness over very many years, and to suggest that it did not would be simply wrong. It also raised questions regarding addiction, but quite fairly in my opinion. But to suggest that the tobacco industry, and the industry alone, framed the debate about smoking's risks in the period is equally wrong.

Roy Norr, author of "Cancer in a Carton" published by Readers' Digest in 1952 gave a speech in 1953 in which he referred to the warning of Ewing in 1926 that "cancer propaganda should emphasise the danger signs that go with [smoking]" and highlighted similar concerns from Tylecote (1927), Hoffman (1929), McNally (1932), Lickint (1935), Arkin and Wagner (1936), Raffo (1937), Muller (1939), Proetz (1939), Flory (1941), Ochsner (1949), Wynder and Graham (1950) and, of course, Doll and Hill (1952). As those "secret" documents make clear the suggestions of a link between smoking and ill health "have been given extensive publicity in magazines of national circulation". Despite all of these warnings, in 1957 the Surgeon General did not advise smokers to give up and the view that causality did not follow necessarily from correlation was not a view held solely by the industry.

On 13 February 1954 the UK Government declared that the relationship between smoking and lung cancer should be regarded as established. Since that time there has been an ever rising level of regulation of the product and packaging; consistently tightening restrictions on advertising and promotion; and restrictions on where and when smokers can smoke. Health warnings have been introduced, enlarged and made graphic. In addition taxes have risen inexorably. Smoking has not, however, been prohibited (except in Bhutan). To suggest that the tobacco industry has successfully lobbied against any of these developments is to ignore the evidence that every demand made by Tobacco Control to date has been implemented.

While fully recognising the (increasingly distant) past, it is also important, in our view, to consider the present and the future. The fact is that for almost two decades the various tobacco companies have made no secret of the fact that smoking comes with risks. It is also the case that each of the majors now has at least one form of product in the category of "reduced harm" be it in nicotine replacement, snus, heat-not-burn or e-cigarettes. A number of the companies have much longer histories in attempting to develop "less hazardous" products for consumers, based on the knowledge and

understanding of the complex nature of the risk exposure as it was understood at the time.

Until relatively recently reduced harm products have had very limited experience of success with customers. Reasons for this are many including, but not restricted to, the failure of the product to replicate "the theatre of smoking" much less the physical experience of smoking. It is also the case that attempts to introduce potentially safer products have encountered hostility from regulators and/or Public Health bodies where the attitude in the 1960s of "harm reduction" had stiffened into the harder line of "quit or die".

The increasingly hard-line attitudes of some elements of Public Health have been vividly demonstrated by the response to the latest innovation in reduced harm, namely e-cigarettes. The behaviour of some elements of Public Health, in questioning the accumulated and accumulating science in favour of e-cigarettes and in dismissing the views of proponents of e-cigarettes, is reminiscent of the behaviour of the tobacco industry in the 1950s so lambasted by Tobacco Control campaigners. Opponents of e-cigarettes are accused, fairly we believe, of selective use of science, of *ad hominen* attacks on opponents, and of creating increasing uncertainty with respect to the relative safety of e-cigarettes compared with combustible cigarettes.

The science of tobacco smoke is no less complicated today than it was in the 1950s but today it is only the tobacco industry which has the financial resources and more importantly the inclination to pursue the science to seek a reduced harm product which is acceptable to consumers. Of course the tobacco companies have a vested interest in this, but the whole point about e-cigarettes surely is that they have been a free market answer not having been sought, financed or developed by Public Health or by tobacco regulators.

The interesting question is the degree to which the e-cigarette debate being had within Public Health today reveals a new policy or simply one which has highlighted past behaviour by Tobacco Control. In our opinion the traits are not new, and have been justified previously by being part of a noble lie that "smoking is bad". But a lie repeated often does not become the truth, and our reading of the analysis is that the case against tobacco has been wilfully exaggerated by a relatively small number of individuals with a personal dislike of smoking and smokers. We may share that dislike of smoking, but ultimately that is a personal opinion not an ethical stance.

The statistics of smoking

"Epidemiology cannot be used to establish causation in any individual case, and the use of statistics applicable to the general population to determine the likelihood of causation in an individual is fallacious. Given that there are possible causes of lung cancer other than cigarette smoking, and given that lung cancer can occur in a non-smoker, it is not possible to determine in any individual case whether but for an individual's cigarette smoking he probably would not have contracted lung cancer."

Lord Nimmo Smith, 31 May 2005

"Smoking is one of the leading causes of all statistics"

Liza Minnelli

In 1950 Doll and Hill published their Preliminary Report on "Smoking and Carcinoma of the Lung", followed up in 1954 by their second report "The mortality of doctors in respect of their smoking habits". Their original investigation looked into the "phenomenal" increase in deaths attributed to lung cancer between 1922 and 1947, and the question as to whether it may have been due to better diagnosis, environmental factors or something else, in this case smoking. It is regarded as one of the ground-breaking pieces of epidemiology, then a very new branch of medicine. In the early 1950s there had been a number of reports looking at the potential links between smoking and health and by the time of the second report Doll and Hill concluded "All these studies agree in showing that there are more heavy smokers and fewer non-smokers among patients with lung cancer than among patients with other diseases". On 13 February 1954 the UK Government declared that the relationship between smoking and lung cancer should be regarded as established.

Smoking-related illnesses

Since the 1950s smoking has been linked to an ever increasing list of illnesses, with the US National Cancer Institute's website listing cancers of the lung, oesophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon, rectum, acute myeloid leukaemia, heart disease, stroke, aortic aneurysm, chronic obstructive pulmonary disease (COPD) (chronic bronchitis and emphysema), diabetes, osteoporosis, rheumatoid arthritis, age-related macular degeneration, cataracts, pneumonia, tuberculosis, and other airway infections. In addition, "smoking causes inflammation and impairs immune function".

In addition ASH states

- Smoking is the primary cause of preventable illness and death. Every year smoking causes around 96,000 deaths in the UK.
- Smokers under the age of 40 have a five times greater risk of a heart attack than non-smokers.
- Smoking causes around 80% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and about 14% of deaths from heart disease.
- More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, pancreas, stomach, liver and cervix.
- About a half of all life-long smokers will die prematurely.
- On average, cigarette smokers die 10 years younger than non-smokers.

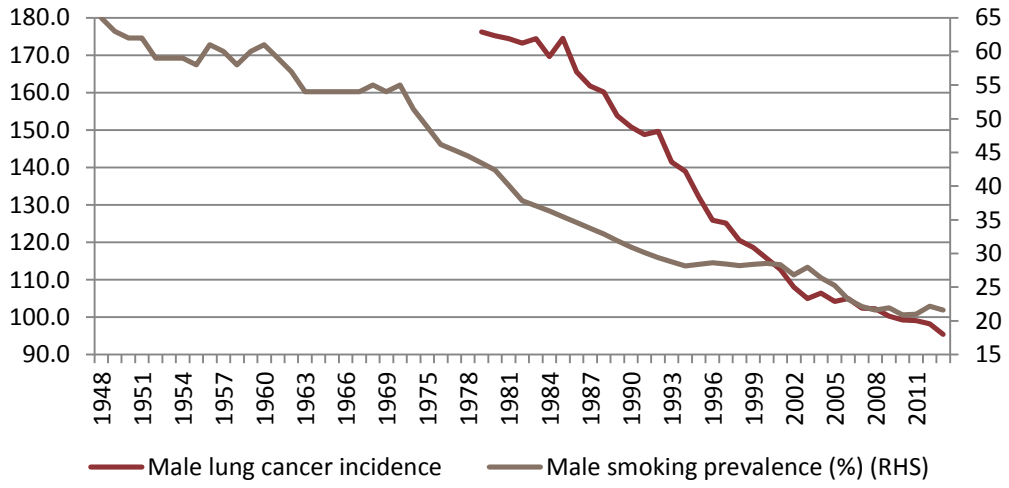
One important thing to note, however, is that there is no disease which is uniquely associated with smoking. While smoking can increase the risk of any particular disease non-smokers can and do succumb to exactly the same diseases.

Smoking and lung cancer

The disease probably most commonly associated with smoking is lung cancer and, as per ASH's statement, it has been suggested that 80% of all lung cancer cases are attributed to smoking. In 2014 in England & Wales, there were 529,655 deaths registered of which 147,757 were cancer-related. Of the cancer-related deaths, 30,520, or one in five, were lung cancer.

Over time the incidence of lung cancer has been in decline in men, as shown in Chart 1 below, which also shows the decline over time in the prevalence of male smoking.

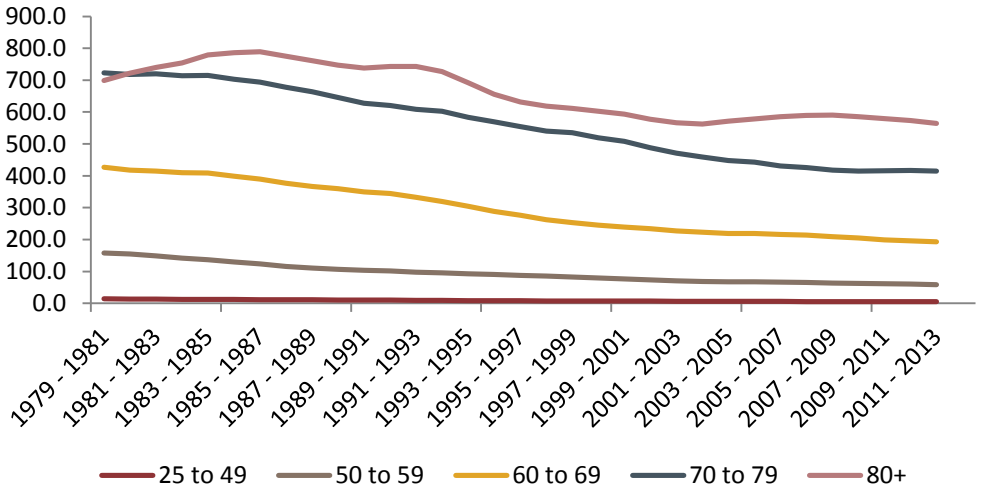
Chart 1: Rates of male lung cancer incidence and smoking prevalence, UK



Source: cruk.org/cancerstats

The lag between the decline in male smoking prevalence and the incidence of lung cancer is normally ascribed to a number of important factors, the most relevant of which is perhaps the age at diagnosis.

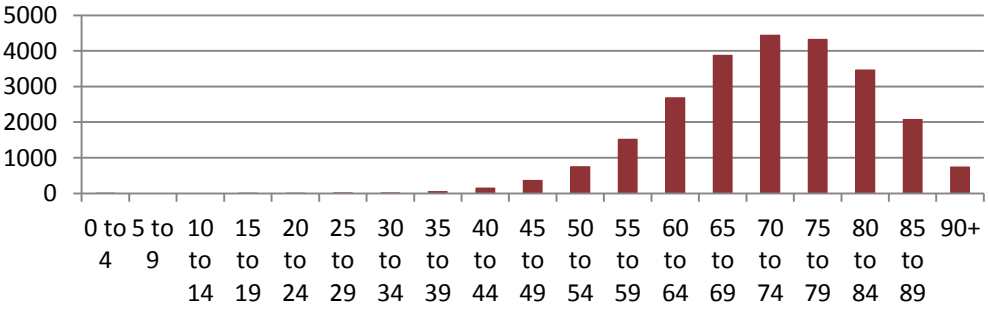
Chart 2: Lung Cancer (C33-C34), European Age-Standardised Incidence Rates, by Age, Males, Great Britain, 1979-2013



Source: cruk.org/cancerstats

As can be seen clearly, lung cancer is typically a disease of old age. Data from 2011-2013 show that of the 24,483 cases of lung cancer diagnosed on average each year in men in the UK, only 2% of cases were in men under 50 and 12% in men under 60. 61% of cases were diagnosed in men over 70 and more than one in four cases were in men over 80. The average age at diagnosis on a weighted basis was 72 and a half.

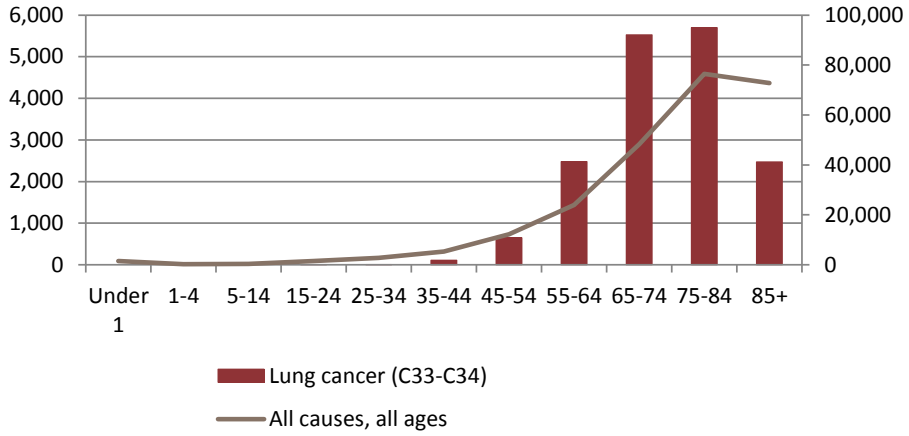
Chart 3: Lung Cancer (C33-C34), Average number of new cases per year, males, UK, 2011-2013



Source: cruk.org/cancerstats

Survival ratios for lung cancer are typically low albeit that they have risen over time. One year male survival rates are ~30%, but five year survival is less than 10% and 10 year survival less than 5%. This is reflected in the following chart which shows age at death for men in England & Wales in 2014.

Chart 4: Mortality from lung cancer (C33-C34) and all deaths, males, England and Wales, 2014



Source: cruk.org/cancerstats

The average age of death from lung cancer from these statistics was 73.8 years which compares with an average age of all deaths of 75.4 years, a difference of 19 months. Lung cancer accounted for 7% of all male deaths, and 7% of all male deaths over 65. Looking at the equivalent data for Scotland, the average age of death from lung cancer was 73 for men, compared with an average age of death of 73 and a half. Lung cancer accounted for 8% of all deaths.

It is interesting, in our view, that the average age of death from lung cancer should be quite so close to the average age of all male deaths, both in England & Wales and Scotland. It is certainly not clear from the data that, as per ASH's much repeated statement, "On average, cigarette smokers die 10 years younger than non-smokers". We will return to this in due course.

Relative risks, absolute risks

In Doll and Hill's original research they concluded that the **relative** risk of lung cancer for smokers over 45, and smoking 25 or more cigarettes a day, was possibly as much as 50 times higher than it was for non-smokers. The Center for Disease Control in the US puts the relative risk at 25x for US males. This is, of course a material increase relative to the chances of contracting lung cancer as a non-smoker but then the chances of contracting lung cancer as a non-smoker are remote. Even a very large multiple of a very small number remains a very small number.

By way of demonstration of this point, we can look at the Statistics on Smoking, England for 2016 as published by the NHS. These data shows that of the 459,087 deaths recorded in England in 2014, 77,800 were ascribed as "attributable to smoking". It is worth noting that this is an estimate and not an actual figure, and is based on estimates for each of the possible illnesses identified as being related to smoking. Of all the deaths recorded, 28,826 were lung cancer deaths and 23,100 were ascribed to smoking. Lung cancer therefore accounted for 30% of all deaths ascribed to smoking, but just 5% of all deaths. Given the earlier discussion of the age at which lung cancer is typically diagnosed (over 70) and the age at which mortality occurs (just short of 74), we need to look back to smoking prevalence some 50 years prior to judge the risks of subsequently developing and dying of lung cancer. According to the Cancer Research data presented earlier, the prevalence of male smoking in the UK in the early 1960s was typically around 54%. *Prima facie* this would suggest that lung cancer has occurred in around one in ten smokers.

A similar outcome was observed by P.D. Finch in his analysis of Australian smokers, where he also argued that "Each year ever-smokers of both sexes and all ages are more likely to die of causes other than smoking than they are to die because of their smoking, and until they reach 40 years of age considerably more likely to do so". In Table 1 below we show Finch's estimates of the annual relative risks by age and sex that an ever smoker has of dying from a tobacco-related condition and from causes other than smoking rather than because of their smoking.

Table 1: Annual relative risks by age and sex, Australia, 1992, that an ever smoker has of dying from a tobacco-related condition and causes other than smoking

	Males		Females	
Age group (yrs)	Tobacco-related	Other than smoking	Tobacco-related	Other than smoking
20-24	2.3	42.2	2.3	16.4
25-29	2.3	35.0	2.1	13.4
30-34	2.3	14.7	2.2	8.8
35-39	2.3	7.3	2.2	6.6
40-44	2.4	3.7	2.4	4.2
45-49	2.5	2.5	2.4	3.5
50-54	2.7	1.8	2.9	2.3
55-59	2.6	1.6	2.7	1.9
60-64	2.6	1.4	2.8	1.5
65-69	1.9	2.1	2.0	2.1
70-74	1.8	2.3	1.9	2.2
75-79	1.7	2.6	1.7	2.4
80 plus	1.5	3.0	1.4	3.5

Source: P.D.Finch

As can be seen, for men the risk of dying from something other than smoking is considerably higher when young, similar by the late 40s, lower until 65 and then higher again in old age. To put these relative risks into some context we also show annual death rates shown as percentages rather than the odds presented in the original work.

Table 2: Annual death rates: In tobacco-related conditions both for causes other than smoking, among smokers and non-smokers alike, and those among ever-smokers because of their smoking, together with those for all conditions, other than smoking, among smokers and non-smokers alike, by age and sex, Australia, 1992

	Males			Females		
	Tobacco-related conditions		All conditions	Tobacco-related conditions		All conditions
Age group (years)	Causes other than smoking among smokers and non-smokers	Caused by smoking among ever smokers	Causes other than smoking among smokers and non-smokers	Causes other than smoking among smokers and non-smokers	Caused by smoking among ever smokers	Causes other than smoking among smokers and non-smokers
20-24	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
25-29	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
30-34	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
35-39	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
40-44	0.0%	0.0%	0.2%	0.0%	0.0%	0.1%
45-49	0.1%	0.1%	0.2%	0.0%	0.0%	0.2%
50-54	0.1%	0.2%	0.4%	0.1%	0.1%	0.3%
55-59	0.2%	0.4%	0.6%	0.1%	0.2%	0.4%
60-64	0.4%	0.7%	1.0%	0.2%	0.4%	0.6%
65-69	1.0%	0.9%	1.9%	0.5%	0.5%	1.1%
70-74	1.7%	1.3%	3.0%	1.0%	0.8%	1.9%
75-79	3.1%	2.0%	5.3%	2.0%	1.4%	3.4%
80 plus	6.7%	3.6%	11.1%	6.7%	2.8%	10.0%

Source: P.D.Finch

Putting the relative risks against the absolute risks it can be seen that even for men of 50-54 when the relative risks of dying of a tobacco-related illness are at their highest (2.7x) the absolute risk of dying of a tobacco-related illness was just 0.2% or, expressed as odds, one in 487.

The important thing to stress is that smoking is risky, without doubt, but the absolute level of that risk is easily overstated by a focus on relative risks. The warning "Smoking Kills" can be true, but in a minority rather than majority of smokers.

The Japanese Paradox

Given the argument that “smoking causes lung cancer” it would be expected to logically follow that the incidence of lung cancer should mirror smoking prevalence. This is not, however, the case and has led to much discussion of "The Japanese Paradox”.

In Table 3 below we show for a selection of countries male smoking prevalence in 1960, 1970 and 1980 and 2008 data for the incidence of lung cancer among the total population, ie allowing a considerable period of time for the "incubation" of smoking-related harm. The contrast in lung cancer incidence in Japan despite much higher prevalence is marked.

Table 3: Male smoking prevalence (%), lung cancer incidence per 100,000

	Male smoking prevalence (%)			Lung cancer
	1960	1970	1980	incidence
USA	61	55	38	42.1
UK	52	44	42	31.3
Japan	81	78	70	24.6

Source: WHO

There have been a number of academic attempts to justify this marked difference, with one study suggesting lower alcohol consumption by Japanese males; lower fat intake by Japanese males; higher efficiency of filters on Japanese cigarettes; lower levels of carcinogenic ingredients in Japanese cigarettes; and lung-cancer-resistant hereditary factors among Japanese males.

Each of these possible explanations may have merit, but it also suggests that there is a question of factors other than smoking which may have an influence on general health as well as incidence of cancers of any type. As the 2010 Marmot Review commented “A wide body of epidemiological and sociological evidence suggests that health inequalities are likely to persist between socioeconomic groups, even if lifestyle factors (such as smoking) are equalised”. Put more brusquely you are likely to live longer if you are well educated, live in a "nicer" area, have a good job, eat well and take exercise, with these latter factors almost inevitably linked to the previous ones. It is also the case, according to Cancer Research UK, that on a diagnosis of cancer those on higher incomes, with better jobs, etc, have a higher survival rate. Smoking is a major influence on health, but as each of these two reviews points out, it is not the only factor by any means.

Premature death

The threat of smoking, as employed by the anti-smoking industry, is that of "premature death". As discussed above, there is evidence that lung cancer sufferers do die modestly sooner than the general population of the UK, but "premature" in this case is measured in months rather than years. We have also pointed out that "smoking-related illnesses" tend to be illnesses of old age.

The question does, therefore, arise of what exactly constitutes a "premature death". And surprisingly, there is no strict definition. "Premature" requires some sense of "appropriate" and that will differ between us all. It also takes no account of "quality" of life, only of "quantum". My maternal grandmother smoked her first cigarette at the age of six (according to family legend) and was chased all around Tooting Broadway by "the policeman" for doing so. She died a week before her 89th birthday smoking to the end albeit that others had to light the cigarettes for her by that point. She may have lived longer had she not smoked, and so her death would be classed as both "smoking-related" and "premature" despite the fact that her life expectancy at birth would have been considerably less than the age she achieved. My father died of stomach cancer at the age of 70. His death felt premature at the time, and still does. He drank rarely after his 21st birthday and certainly never to excess to my knowledge. He never smoked. He did, however, live longer than the life expectancy at birth of man born in 1935.

Do we all want to live longer? Perhaps. Do we all want to live longer but have those sunset years beset by the ailments of old age resulting in years of lost independence? Perhaps not. There is, as we will discuss further, an apparently avid pursuit of longevity in "Public Health" and longevity without consideration of any (subjective) quality measure. The concept of a "premature" death should be seen in this light.

Summary

There can be no debate that smokers face elevated health risks compared with non-smokers in a majority of cases. The relative risks of lung cancer are typically put at over 20x and sometimes as high as 50x those of a non-smoker. The absolute risk of a non-smoker contracting lung cancer is, however, extraordinarily low and so even a very large multiple of a negligible risk remains quite small. In general the chances of contracting lung cancer as a smoker might be as low as one in ten, or alternatively nine out of ten smokers will not contract lung cancer. While mortality rates suggest a higher proportion of smokers will die in late middle age than non-smoking peers, the chances of dying in late middle age are relatively modest. In general, smoking related illnesses are illnesses of old age.

Addiction

"For many smokers, a genuine desire to quit and, if necessary, persistent and repeated attempts to quit may be all that is necessary."

Everett Koop, Surgeon General, May 1998

Nicotine is named after Jean Nicot, the French ambassador to Portugal from 1559 to 1561. He is credited with bringing tobacco plants and seeds back to France, and for introducing snuff to the French royal court. It was extracted from tobacco in the early 1800s, and the chemical formula of the substance ($C_{10}H_{14}N_2$) was determined by the 1840s. It is an alkaloid that is found in the nightshade family of plants, mainly in tobacco. It is also present in low quantities in tomatoes, potatoes, cauliflower, aubergines and green peppers.

Nicotine can be poisonous in its pure form. Reports dating back to the sixteenth century suggest nicotine poisoning from the "therapeutic" use of tobacco-infused enemas. It is not, however, lethal in the doses typically found in cigarettes.

In the first Surgeon General's Report on Smoking and Health in 1964 deemed the tobacco habit to be "an ***habituation*** rather than an ***addiction***, in conformity with accepted World Health Organisation definitions, since once established there is little tendency to increase the dose; psychic but not physical dependence is developed; and the detrimental effects are primarily on the individual rather than society." (p354, emphasis in the original).

It was not until 1988, when Everett Koop was Surgeon General, that nicotine was deemed "addictive" and, moreover, that "the processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine". This has subsequently often been repeated as "nicotine is as addictive as heroin" although that is not what was actually stated.

The World Health Organisation's definition of "addiction" is as follows:

Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. The life of the addict may be dominated by substance use to the virtual exclusion of all other activities and responsibilities. The term addiction also conveys the sense that such substance use has a detrimental effect on society, as well as on the individual; when applied to the use of alcohol, it is equivalent to alcoholism. Addiction is a term of long-standing and variable usage. It is regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug, which is remorselessly progressive. From the 1920s to the 1960s attempts were made to differentiate between addiction; and "habituation", a less severe form of psychological adaptation. In the 1960s the World Health Organization recommended that both terms be abandoned in favour of dependence, which can exist in various degrees of severity. Addiction is not a diagnostic term in ICD-10, but continues to be very widely employed by professionals and the general public alike.

The description of addiction from WHO is interesting in a number of respects: addiction is not a diagnostic term but one of common parlance; addiction conveys the sense of a detrimental effect on society; addicts may be dominated to a point of virtual exclusion of all other activities; there is great difficulty in modifying use; the user is "intoxicated"; tolerance is "prominent" meaning that a higher dosage is required to achieve the same level of response.

Returning to the 1964 Surgeon General's report (p350) there is a useful characterisation of what was meant at the time as the similarities and important differences between addiction and habituation.

Table 4: Drug addiction and drug habituation

Drug Addiction	Drug Habituation
Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:	Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include:
■ An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;	■ A desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders;
■ A tendency to increase the dose;	■ Little or no tendency to increase the dose:
■ A psychic (psychological) and generally a physical dependence on the effects of the drug;	■ Some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome;
■ Detrimental effect on the individual and on society.	■ Detrimental effects, if any, primarily on the individual.

Source: Surgeon General, 1964

Even a non-smoker can readily see that tobacco is unlikely to meet the hurdle for "addiction" as described above. It is readily accepted that quitting smoking can be difficult, but there are as many ex-smokers in the UK and the US as current smokers, suggesting that many have met the challenge. It is not clear that smokers display "tolerance" as average daily consumption has been declining for many decades. "Social smokers" demonstrate that use can be modified according to circumstances, whether that is abstinence in the early part of a week or increased consumption in a social setting. The question of the "societal" cost of smoking is dealt with in more detail below.

The Surgeon General commented in 1964 (p352) "In contrast to drugs of addiction, withdrawal from tobacco never constitutes a threat to life". As the opening quotation from Everett Koop suggests, despite his comparison of nicotine to cocaine, his own view was closer to that of the 1964 report. It appears that "the message" that smokers should quit was more important than the science, once again.

Of course the classification of smokers as "addicts" is important in other ways. By classifying smokers as addicts, it removes from them the liability of personal choice. It is no longer the smoker's fault that they are a smoker it is the fault of the tobacco companies ("Big Tobacco"). It also means that regulation and taxation of their habit can be undertaken "for their own good" because they are clearly in the grip of a force greater than their own free will and cannot be trusted to make their own decisions with regard to their health.

The costs of smoking

"The government believe it is right that tobacco manufacturers and importers make a greater contribution to the societal costs of smoking"

HM Treasury Tobacco Levy consultation document, December 2014

One of the major arguments used against the tobacco industry and smokers is the "true cost" of smoking to society. According to ASH this cost in England is "approximately £13.9bn a year" and comprises:

- The cost to the NHS of treating smoking related illnesses (approximately £2bn).
- Loss in productivity due to premature deaths (£4bn).
- Cost to business of smoking breaks (£5.8bn).
- Smoking-related sick days (£979m).
- Social care costs of older smokers (£1.1bn).
- Costs of fires caused by smokers' materials (£259m).

In 2013-2014 the Treasury received £9.5bn in revenue from tobacco duties and a further £2.8bn in VAT, a total income of £12.3bn. Given that these figures are for the whole of the UK and the £13.9bn was a cost to England alone, the case looks settled.

Looking at the "costs to society" more closely, however, shows that the vast majority of the costs identified are neither real nor "societal" costs at all, but a variety of estimates and extrapolations of imputed "opportunity costs" and, more importantly, private costs.

The cost of lost productivity is moot on a number of bases. Firstly it seems to assume that we are all here to serve society through our productivity and that, in some Orwellian way, it is our duty to do everything to ensure that we maximise our productive years for the benefit of society. It is also the case that, as we have discussed above, the basis of assumption that "smokers die young" is questionable. In fact smoking related illnesses are generally those of old age and hence the "productivity" of a smoker will largely have been delivered to society if that is the belief set that is held.

The cost to business of smoking breaks is quite clearly a made up number, and most definitely not a social cost. Should colleagues of yours or mine be spending excessive time on smoking breaks that is a problem for our employers and for them, and not society, to address. It also assumes that non-smokers do not waste time at work, which is palpably untrue. If the cost of smoking breaks is £5.8bn, I shudder to think of the "social cost" of the sidebar of shame on a well-known, and improbably well frequented, website of a national newspaper. Those without sin are welcome to cast the first rocks.

The cost of smoking-related sick days is another estimate and, again, absenteeism for any reason is a cost to employers not society. It might be fair to impute some element of costs for public sector workers, but that opens a much bigger box of questions on the efficiency or otherwise of the public over the private sector.

The social care cost of older smokers is somewhat ironic given that we are meant to be allowing for the lost productivity of smokers dying younger. It also seems to assume that if these people had not smoked they would not firstly need to be looked after in old age and secondly not need to be looked after for longer than they would as smokers who are, once again, apparently going to die younger.

The rather specific cost of fires caused by smokers' materials (£259m) is not referenced and so its derivation is unclear. As with the other costs, how this is a "societal" rather than private cost is unclear. Provision of the fire service comes from government funds and there is no "call out" charge. Should a house be damaged by fire presumably the cost of repair would be covered by insurance (from premiums paid by the individual) or not, and if there is no insurance the costs will be borne by the householder. Presumably there will be a subset of costs for fires in social housing, but at that point the numbers are presumably rather small.

Given, therefore, that the only identifiable financial costs are those of the NHS, then the £12bn in tax from smokers very easily covers the direct costs of any smoking-related illnesses.

It has been argued in the past, in litigation in the US and in the Czech Republic, that the analysis should be extended to look at the total cost of smokers by also allowing for reduced pension payments. Such an approach can easily be regarded as deeply cynical, and indeed it has been treated exactly that way over the years. But the point remains any cost:benefit analysis must fully account for all genuine costs and all genuine benefits. Either smokers die younger than non-smokers (which statistically they do) in which case there is a genuine reduction in expected future payments, or they do not in which case the suggestion that "smokers die young" is invalidated. It cannot be both.

The crusaders

Have you not reason then to bee ashamed, and to forbeare this filthie noveltie, so basely grounded, so foolishly received and so grossely mistaken in the right use thereof? In your abuse thereof sinning against God, harming your selves both in persons and goods, and raking also thereby the markes and notes of vanitie upon you: by the custome thereof making your selves to be wondered at by all forraine civil Nations, and by all strangers that come among you, to be scorned and contemned. A custome lothsome to the eye, hatefull to the Nose, harmefull to the braine, dangerous to the Lungs, and in the blacke stinking fume thereof, neerest resembling the horrible Stigian smoke of the pit that is bottomelesse.

James I, A counterblaste to Tobacco, 1604

Tobacco control campaigners have seen themselves as crusaders, their triple goal to end the death and disease caused by tobacco, to end nicotine addiction and to destroy the tobacco industry.

Deborah Arnott, 2012

James clearly had a way with words. Interestingly his approach also shows that very little has changed in over 400 years with respect to the arguments against smoking and smokers: you should be ashamed to be a smoker; you are stupid to be a smoker; you should be scorned and held in contempt by others; you are harming yourself; and you smell. The only thing missing from today's repertoire is the alleged risk to others. Of course James I's position was a personal attitude rather than a scientifically arrived at judgement. In this he has gained much support over the years.

Although his "Counterblaste" was delivered in 1604 James was by no means the first to take against tobacco. The first two recorded European smokers were Rodrigo de Jerez and Luis de Torres who sailed with Columbus in 1492. On returning to Spain de Jerez was jailed by the Inquisition for seven years. In 1588 Lima was the location for the first recorded restriction on tobacco usage, when Catholic priests were banned from taking snuff or from smoking before administering mass.

Over time smokers have been taxed (frequently, heavily, everywhere); maimed (Russia); permitted to smoke only once a day (Connecticut); and banned entirely (New Amsterdam in history, Bhutan today). With the exception of Bhutan, no generally recognised government currently prohibits the sale of tobacco products, with government's generally preferring to warn against the use of tobacco (to varying degrees) but to enjoy also the benefits of taxing the consumption of tobacco.

The aims of tobacco control campaigners, who see themselves as "crusaders" are threefold:

- To end the death and disease caused by tobacco.
- To end nicotine addiction.
- To destroy the tobacco industry.

We should highlight immediately that these are not our interpretations of how tobacco control campaigners see themselves and their aims they are the words of the current head of ASH in the UK, Deborah Arnott writing in 2012.

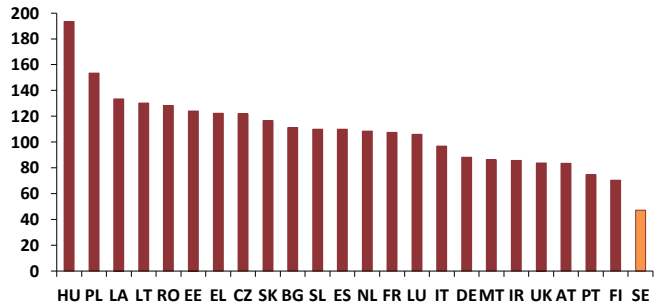
Of these three objectives the last two are immediately questionable. As we have discussed, nicotine *per se* is not harmful and for many brings benefits. Addiction is moot and whether it should matter more broadly that someone seeks to use nicotine is questionable. Remember that ASH promotes the use of nicotine replacement therapy (NRT) and so cannot be "anti-nicotine" but is, quite clearly, anti-smoking and anti-smoker.

Seeking to "destroy" an industry which produces a product which is legal, very heavily regulated and very heavily taxed has to be brought into question by shareholders in any industry where any individual or group may choose to consider the product "controversial". Moreover it seems scandalous that this should be the stated aim of an organisation which is funded in large part by taxpayers.

Returning to the first there is the issue of conflating "tobacco" with "cigarettes", a common "oversight" made by tobacco controllers but rarely corrected. It has long been established that there is a continuum of risk in tobacco, with the highest risks being associated with combustion, ie with cigarettes.

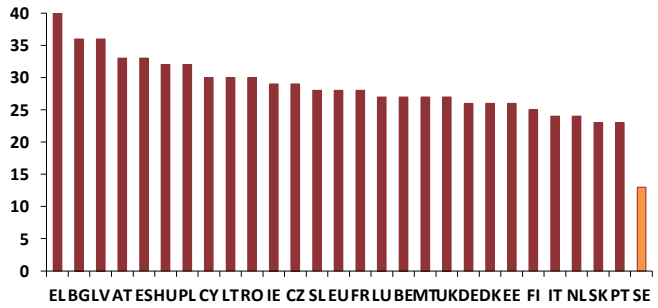
There are other ways of using tobacco without combustion and have been for many centuries. Snuff was the predominant form of usage when tobacco was first introduced into mainland Europe, and snus is the dominant form of tobacco usage in Sweden and Norway. Sweden has the lowest rate of cigarette consumption and the lowest incidence of lung cancer in the EU. There is no evidence of any greater risk of mouth cancers or dental problems. Indeed one commentator has pointed out that, statistically, the risk of dying from smokeless tobacco use is about the same as the risk of dying in a car accident.

Chart 5: Lung cancer mortality, deaths per 100,000, males



Source: IARC

Chart 6: Smoking prevalence (%)



Source: Eurobarometer

Despite this snus remains banned in the EU, except for in Sweden and under the EU Tobacco Products Directive snus in Sweden now needs to carry a health warning that (translated) says "This tobacco product damages your health and is addictive", ie the same warning as on cigarettes. The original ban on snus was orchestrated by ASH in the UK and WHO, who in June 1987 has called for "a pre-emptive ban" on snus and all forms of smokeless tobacco to prevent a new public health epidemic. Concerns were expressed regarding alleged carcinogenic impacts, dual use and the possible "gateway impact on children". Despite the accumulating and very clear evidence of "harm reduction" over the years, the ban on snus in Europe remains firmly in place while the introduction of new warnings in Sweden demonstrates that there is no interest from tobacco control in offering a safer way of using tobacco apart from in the form of NRT supplied by the pharmaceutical industry. It appears that the desire to "destroy the

tobacco industry" is held to be more important that to "end the death and disease from [cigarettes]".

As "crusaders" for a cause, it appears that those seeking to control the use of tobacco by others are not averse to being "economical with the actualite". The American Lung Association, for example, carries a list of "a few of the chemicals in tobacco smoke and other places they are found" including "Tar – material for paving roads". The tar used for paving roads is short for "Tarmacadam". "Tar" as it refers to tobacco is an acronym of "Tobacco Aerosol Residue" and is the weight of particles collected on a filter pad after smoking a defined number of cigarettes under precise puffing and atmospheric conditions and to a certain length, and with the amount of water and nicotine collected on the filter pad away from the weight. It is not used to surface roads, although it appears that this distinction has also been lost on the Center for Disease Control.

Figure 5: Just "no"

Source: CDC twitter feed, 27 July 2016

Perhaps the most alarming recent example of how much the Tobacco Control movement is seen as a crusade we can consider the 1 June 2016 comments of Ms Elizabeth Hoff, a WHO representative. Speaking at a World No Tobacco Day event which "*featured presentation of poems, essays, and cartoon drawing by youths and school children to reflect the harmful effect of tobacco consumption*" she urged "*health authorities at all levels to collaborate with WHO and implement the 'plain packaging approach'*". She "*stressed the urgency for controlling tobacco and shisha consumption among the population – especially among youths, women and teenage school children*". The event was held in Syria.

It's not about you, it's about me

The right of smokers to smoke ends where their behaviour affects the health and well-being of others.

C. Everett Koop, Surgeon General, 1982-1989

The discussion above has looked at the risk of smoking to smokers but arguably the greatest success that the anti-tobacco industry has secured has been in making the risk of smoking at least as important to non-smokers as it is to smokers. The point at which this happened is perhaps easiest to link to the third "World Conference on Tobacco and Health", held in New York in 1975 where among the conclusions of the conference

was one which stated "Passive smokers should be investigated in a large scale study to determine if excess morbidity and/or mortality occur".

The first paper to suggest an increased risk to non-smokers from smokers was published in 1981, Hirayama's "Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan". The research suggested that wives of heavy smokers had a higher risk of developing lung cancer, and that the risk was dose-responsive. The relative risk of lung cancer was 1.61 for wives whose husbands were ex-smokers or smoked less than 20 cigarettes a day and 2.1 where husbands smoked more than 20 a day. Although there was statistical significance to the result, it is also the case that the spouses were self-certified as non-smokers. Given the societal views of female smoking in Japan, this was not necessarily the case.

Further papers followed over the years and by 1986 the Surgeon General's specific report on the risks of passive smoking stated that

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers.
2. The children of parents who smoke compared with the children of non-smoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates in increase in lung function as the lung matures.
3. The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

The risks of second hand smoke increased greatly over the following 20 years as by the 2006 report the Surgeon General included as a major conclusion "There is no risk-free level of exposure to secondhand smoke".

In the intervening period WHO had conducted a study of Environmental Tobacco Smoke and lung cancer in Europe. It was a case control study with a large sample size (650 patients with lung cancer and 1,542 controls) conducted over 12 centres in seven European countries over a period of seven years. The study was one of the largest ever undertaken and, unlike many before and since, well designed. Unfortunately for the anti-smoking campaign it concluded that

- ETS exposure during childhood was not associated with an increased risk of lung cancer (odds ratio for ever exposure 0.78; 95% confidence interval 0.64-0.96).
- The odds ratio for spousal exposure to ETS was 1.16, with a 95% confidence interval of 0.93-1.44. There was no clear dose-response relationship for cumulative exposure.
- The odds ratio for workplace ETS was 1.17, with a 95% confidence interval of 0.94-1.45, with weak evidence of increasing risk for increasing duration of exposure but no detectable risk after cessation of exposure.

Even a basic knowledge of statistics (or vague memories of undergraduate degrees) will allow the reader to understand that a confidence interval which includes 1.0, as the spousal and workplace exposures did, suggests no statistically significant increase in risk. Moreover the generally accepted measure of relative risk being established starts at 2.0x (and often 3.0x). Despite this ASH still cites this study as evidence that passive smoking is a risk to non-smokers. And of course we should stress again that

these are relative risks, i.e. an increase over the very, very small (but not zero) risk that a non-smoker faces of ever developing lung cancer in the first place.

As an aside, on Desert Island Discs in 2001 Richard Doll, otherwise the doyen of the anti-smoking movement, raised the ire of his supporters by stating "The effects of other people smoking in my presence is so small it doesn't worry me". Given he had dedicated much of his research career to the study of risks associated with smoking, that seems a fairly clear message.

The widespread introduction of restrictions on smoking in "public places" has been based on the argument that second-hand smoke was a risk to non-smokers, and in particular to workers in the hospitality industry. ASH has written at length about how it sought to "lever political action by Government" when the Government was committed to an alternative approach. In its own words the review of the levering by ASH highlights:

- That its key message was "everyone has a right to a smokefree workplace".
- It designed its public polling to show public support for the answer it was seeking.
- It sought to circumvent Government opposition to its proposal.
- Once draft legislation was introduced which would have provided an exemption for wet-led pubs and private members' clubs it sought to undermine the Government's proposals and then provided detailed briefing to the media on disagreements between ministers.
- It lauds the fact that the debate was "won" through use of "evidence" which proved that the argument that making pubs and bars smokefree "would damage the hospitality trade economically" was false.
- Its key lesson for others in Tobacco Control is the need "to create the impression of inevitable success".

It is a remarkable document to behold. It has also been proven woeful in its suggestion that there would be no impact on the hospitality industry. Pub closures accelerated sharply post 2007's introduction of smoke-free legislation, before the impact of recession started to be felt. Bingo halls were devastated. The idea that there were hordes of people not using pubs because of smoking who would suddenly start using pubs has been shown to be a straw man.

Of course there is also the issue of what a ban on smoking in "public places" actually means in practice. Pubs, clubs and restaurants are not "public places" they are private enterprises which can (and do) set their own restrictions on entry. They do not employ forced labour, and employees have always had the choice not to work in the hospitality trade. This was, therefore, not about public places but private property.

Once this Rubicon has been crossed, then the next logical step is to seek to control smoking in other private places, for example in cars and then homes. Stated objectives of ASH include a desire to see smoking banned in all cars whether children are present or not; to require any film or programme which includes smoking to be preceded by an anti-smoking film whether in a cinema, on TV or on pay-to-view internet; that theatrical performances should no longer have an exemption for actors smoking in character; and to have your smoking history recorded on your death certificate. ASH explicitly states "the ban on smoking in cars carrying children provides a platform for

considering a wider ban on smoking in all motor vehicles" (p44). This piecemeal approach to ever tightening regulation is invidious while the idea that to watch Casablanca I would need to sit through a state-sponsored anti-smoking message is positively Orwellian.

One final word on the role of second-hand smoke should go to Stanton Glantz, who summed up his view at the 1990 Seventh World Conference on Tobacco and Health: "*the main thing the science has done on the issue of ETS, in addition to help people like me pay mortgages, is it has* ***legitimised the concerns that people have, that they don't like cigarette smoke****. And that needs to be harnessed and used … we are all on a roll and the bastards are on the run and I urge you to keep chasing them*".

The past, the present, the future

"It's the only issue I know of where there aren't two sides – two intelligent sides. I have a comic-book mentality – I grew up with comic books – and I see this as good versus evil."

Joseph Cherner, former bond trader and head of Smoke-free Educational Services, 1993

"… that's the question that I have applied to my research relating to tobacco: If this comes out the way I think, will it make a difference [toward achieving the goal]. And if the answer is yes, then we do it, and if the answer is I don't know, then we don't bother. Okay? And that's the criteria."

Stanton Glantz, Conference transcript, 1992

Introduction

Litigation in the US against the tobacco industry started in the 1950s as the health risks of smoking became higher profile. The industry reacted in various ways to the implications of the growing evidence that smoking was related to various illnesses, and analysis of the multitude of "secret" documents has highlighted a long campaign questioning the veracity of the analysis undertaken. It is clear that the various companies' private views were at odds with public views through until the late 1990s. It is said that the industry maintained its stance towards health risks while "knowing the truth" but denying it in public.

To damn the companies for their behaviour during the period of the 1950s through to the end of the 1990s is easy enough for many and to even debate the issue could be seen as futile. It does, however, require us to consider yesterday's behaviour by the standards of today's knowledge and attitudes. It also assumes that the only information available to consumers was that provided by the tobacco companies and that information from them bore more weight than all other information available. We must also look at the behaviour of those (still) calling the tobacco companies to account, at the time and subsequently.

Who knew?

The science of tobacco, tobacco smoke and the exact process by which something or things in tobacco smoke causes, in some cases, illness remains unresolved even today. Tobacco smoke is an incredibly complicated compound. The number of constituents in tobacco smoke was initially estimated to be around 300 by the Royal College of Physicians in 1962, was put at 5,000 in 2011 and 7,000 according to the American Lung Association now. Obviously scientific methods have developed enormously over the last half century, hence the ability to record more compounds but this highlights that the "newer" compounds discovered must be in very small quantities indeed. As highlighted in 2000 in New Zealand (and based on an estimate of 4,000 chemical constituents) "400 have been measured" and "of the 400, a significant amount of toxicology data exist for less than 100".

How the combinations of factors in smoke interact, over considerable periods of time, remains unproven in science and has proven incredibly difficult to replicate in the laboratory. Originally the aim of scientists, within and out with the tobacco industry,

was to isolate "the element" which was possibly, or probably, carcinogenic to humans and to remove it. Unfortunately it has been unclear how to achieve this and, as one scientist in the sector once put it to me, removing just one element may not change the outcome. He chose as an example the removal of one ball from a snooker table. When the pack is hit without that one ball there will be movement still, just that the impact will be different. As we cannot, still, isolate the crucial element removing one interaction could simply create different ones. As the seminal 1962 Royal College of Physicians report "Smoking and health" stated (para 100) "*It should be realised that since we cannot identify the substances in tobacco smoke that may be injurious to health, no firm claims for the safety of modified cigarette tobaccos or filters can be made. It would, of course, be many years before it would be possible to detect any effector upon death rates resulting from the use of cigarettes with filter tips, or of modified tobaccos*".

The suggestion is normally made that the industry hid its own research but the tobacco companies in the UK worked with the Government and public health groups, setting up a Standing Committee in 1956 with the mission "To assist research into smoking and health questions, to keep in touch with scientists and other working on this subject in the UK and abroad, and to make information available to scientific workers and the public". In 1968 America's National Cancer Institute set up "The Less Hazardous Cigarette Working Group" to investigate the possibility that the health risks of smoking could be reduced. Scientists from the tobacco industry were invited to join, with the only influence exerted by the industry being in the change of name to "The Tobacco Working Group". The aim at the time was very clearly one of harm reduction.

It is fair to say that various tobacco industry executives called into question the veracity of the suggested links between smoking and ill-health. But they were not alone. The statistical approach adopted by Doll and Hill was challenged by R. A. Fisher with some merit, although he believed cigarettes to be harmless which bears little scrutiny with the passing of time. Dr Charles Mayo, the son of the founder of the Mayo Clinic, said "I just don't believe smoking causes lung cancer". In 1957 the Surgeon General of the time, Dr Leroy Burney, was asked "Do you think people should quit smoking?" to which he replied "No, sir, I do not believe they should quit smoking". Perhaps this was related to his answer to a question in a different interview in which he was asked "What do you mean exactly by 'excessive and prolonged'? Do you mean a pack of cigarettes a day, two packs, a period of 20 years, or what do you mean by that?" to which he offered the answer "*We mean at least two packs a day, or more, and over a period of 20 to 30 years. Now that's a long while*".

The advice of the RCP in 1962 was that the harmful effect of smoking might be reduced through "*efficient filters, by using modified tobaccos, by leaving longer cigarette stubs or by changing from cigarette to pipe or cigar smoking*". So the efforts of the industry to seek modified versions of tobacco, to reduce tar and to explore filtration were not necessarily part of a vast conspiracy but rather consistent reactions to the advice of external experts.

The pursuit of a safer cigarette

The "low tar" controversy is another stick used to beat the industry, conflating a number of issues. It is said that tobacco companies wilfully manipulated tar levels to give the impression of safety while knowing that there was no differential risk. It is because of the perception that lower tar equates to lower risk that "descriptors" (eg Light, Mild) have subsequently been banned.

In 1953 a US magazine, Consumer Reports, listed tar yields for the most popular cigarette brands as measured by an independent laboratory. The league table became a biannual feature and in 1955 the FTC issued guidelines to manufacturers about the claims which could be made about tar yields. In 1957 Readers Digest reported that filtration did not necessarily reduce tar yields with unfiltered Camel cigarettes delivering less tar than filtered Winston. In 1958 the FTC held a two day conference aimed at producing a single test for measuring tar, but also requiring a voluntary agreement that forbade the companies from making any health claim related to tar yields.

Although things developed more slowly in the UK, where there was scepticism about the value of tar yields to the health debate, by 1971 the RCP recommended "the tar and nicotine content of all marketed brands of cigarettes should be published and a public statement made on the possible effects of smoking them". In addition the RCP recommended an upper limit on tar and nicotine levels, while those whom continued to smoke should be encouraged to smoke fewer cigarettes; to inhale less; to smoke less of each cigarette; to take the cigarette out of the mouth between puffs; and to **smoke brands with low nicotine and tar content**. The Government not only ultimately adopted the low tar approach, running adverts as late as 1981 recommending smokers move to lower tar product, but through the 1970s entered voluntary agreements aimed at reducing tar levels across the product range. As we know now, smokers compensate for the lower nicotine delivery of "lighter" cigarettes by inhaling more deeply, and therefore there is no differential risk.

Lower tar was not the only approach to modifying risk pursued. Many recognisable brands were initially introduced to "deal with the health issue". Liggett & Myers saw early success with its "Lark" brand because of its cellulose filters while "L&M" was launched with the slogan "THIS IS IT. L&M filters are just what the doctor ordered"; what happened to the "Epic" product which L&M developed using palladium in the filter is unclear; Lorillard's "Kent" brand was launched in the US with a "micronite" filter which unfortunately used asbestos; "Winston" was RJR's first ever filtered cigarette, but to counter concerns that the filter would deaden the taste of the product, the tar and nicotine content was increased; Brown & Williamson introduced "Fact" which had several compounds removed; RJR raised the bar with "Premier", the first heat-not-burn product; B&W countered with "Eclipse" which had "All of the taste … Less of the toxins".

In general the products claiming to be "safer" were commercial failures (Winston being the notable exception, its failure would come subsequently when filtered cigarettes were eclipsed by "lighter" cigarettes). In part this was because of that change in perspective from the "public health" lobby which had decided that there was simply no safe level of smoking. In the US, the journal Cancer Research would not carry an article on L&M's Epic for fear that it would encourage smoking and when RJR was trying to introduce its improved Premier product, Eclipse, in 2000 the American Cancer Society was at the forefront of demands that the product be removed from the market.

From harm reduction to "quit or die"

The hardening in attitude among the anti-smoking lobby away from harm reduction and towards abstinence had been seen as early as the 1970s. Dr Gio Gori was Deputy Director, Division of Cancer Cause and Prevention and Director, Smoking and Health Programme at the National Cancer Institute. He published a paper in The Journal of the

American Medical Association in 1976 discussing the need to protect individuals who continue to smoke despite all warnings. He compared the strength in tar and nicotine yields of cigarettes on the market in the 1970s with their counterparts in the 1960s, and discussed the idea of a "tolerable level" of risk. He went out of his way to say "We don't want to call them safe. We don't think there is such a thing". Despite the very clear warning he made that in his opinion the only safe cigarette was an unlit one, there were immediate calls that Gori should be sacked. He left the NCI in 1980 and subsequently worked for the tobacco industry, mainly it seems because he could not find work in "public health". All of his prior work in harm reduction, of which there was much, has been overshadowed by his subsequent work with the tobacco industry although as his 1976 paper makes clear "*Antismoking education campaigns in our society have met with only partial success*".

It is around this time, in our view, that the lines of what constitutes "the truth" about tobacco become most blurred and as much as the companies continued to withstand admitting the potential risks of smoking, so those risks – to smokers directly and to non-smokers via the stance taken on the risks of second hand smoke – were amplified by the anti-tobacco movement.

We have discussed above the hardening of stance taken at the 1975 World Conference on Smoking and Health and the clear intent to "denormalise" smoking but there was also a more aggressive stance being taken towards those that did not subscribe to the official mantra. As well as the treatment of Gio Gori other examples exist, perhaps most tellingly in the case of Dr Michael Siegel, Professor in the Department of Community Health Sciences, Boston University School of Public Health, who describes his history thus:

> *"If you take part in secondhand smoke policy training in the tobacco control movement, chances are that you will be taught that all opposition to smoking bans is orchestrated by the tobacco industry, that anyone who challenges the science connecting secondhand smoke exposure and severe health effects is a paid lackey of Big Tobacco, and that any group which disseminates information challenging these health effects is a tobacco industry front group. Consequently, the chief strategy of tobacco control is to smear the opposition by accusing them of being tobacco industry moles. And in no situation should one say anything positive about an opponent, even if true.*
>
> *How do I know this?*
>
> *Because for many years, I was one of the main trainers of tobacco control advocates in the United States. And this is what I taught, because this was what I was led to believe. I attended many conferences and trainings and this is precisely what I was taught. I accepted it for the truth, and passed it along to others."*

The e-cigarette debate in an historical context

We tend to become like the worst in those we oppose.

Frank Herbert

As discussed above, the issue with cigarettes turns on combustion not on nicotine. If it were possible, therefore, to deliver nicotine without combustion there should be a benefit to an individual's health and therefore to "public" health. This is genesis of the concept of the electronic cigarette, the first version of which was patented in the 1960s.

The debate about the e-cigarette market has been played out in scientific circles, the media and in the investment industry. There are very many, strongly held views on all sides regarding safety, regulation, usage, targeting, product design, the role of the existing tobacco industry and the potential costs and benefits to users and society more generally.

The UK has been seen as one of the most progressive nations with respect to e-cigarettes with both endorsement from Public Health England and a licencing programme for Nicotine Containing Products as Medicines. By contrast e-cigarettes are banned in Australia, Argentina, Hong Kong, Mexico and Singapore, for example. How can it be that there are such divergent views?

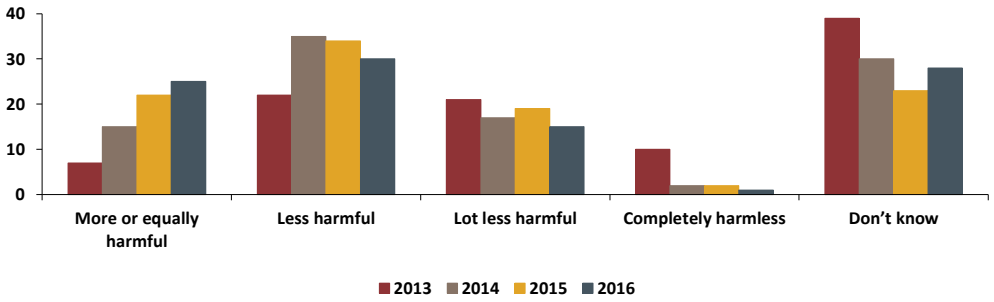
The argument in favour of e-cigarettes is fairly straightforward: e-cigarettes do not contain tobacco and do not involve combustion; there are typically only four components to the aerosol inhaled by consumers namely propylene glycol (glycerine), water, flavourings and usually - but by no means always - nicotine; they do not produce smoke.

There is a weight of scientific evidence that e-cigarettes do not expose users to the risks of combustible cigarettes. The veracity of the claim that e-cigarettes are "95% safer" than cigarettes is a different matter, but to be able to say that for those that wish to continue using nicotine but do not want the risks of smoking that e-cigarettes are "a good thing" seems justifiable, and sensible.

Countering this there are various strands of arguments used against e-cigarettes; that it is too early to tell if harm is genuinely reduced; that there are potential risks from e-cigarettes either from "fine particles" or from certain chemicals contained in vapour; that they "renormalise" smoking; and that they will act as a "gateway" product initiating youth into nicotine addiction which will inevitably lead to cigarette smoking.

The headlines regarding the potential risks of e-cigarettes have received much coverage and have resulted in a situation where survey data suggests that uncertainty regarding the relative safety of e-cigarettes has been increasing rapidly.

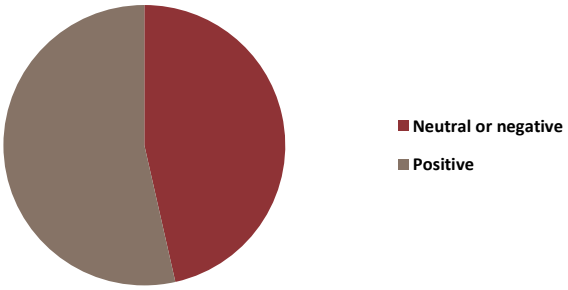
Chart 7: Adult population perception of harm from e-cigarettes relative to smoking (2013-2016)



Source: ASH. Unweighted base: All GB adults who have heard of e-cgarettes. 2013 n=8936; 2014 n=11,307; 2015n = 11340; 2016 n=11489

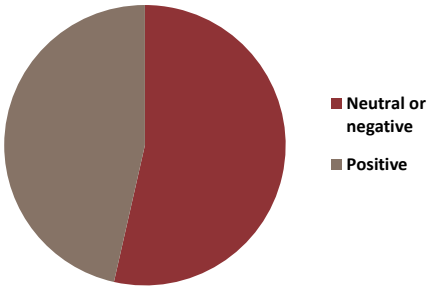
Simplifying the answers into just two views of "Neutral or negative" and "Positive" shows that over the last four years uncertainty has increased to the point where the majority view is now that e-cigarettes are not necessarily safer.

Chart 8: Positive v Neutral or negative, 2013 (%)



Source: ASH

Chart 9: Positive v Neutral or negative, 2016 (%)



Source: ASH

This level of uncertainty is important for a number of reasons. Firstly for smokers considering vaping as an alternative to smoking, if there is uncertainty of any health benefit the decision to cease smoking may not be made which seems entirely counter to the objective of "public health". Secondly the survey is not of e-cigarette users but of the general population. If the general public is not convinced that vaping is safer than smoking then the same approach of regulating vaping in "public places" can be pushed through by playing on the same, engineered, perception of "second hand" risk.

Perhaps one of the major stumbling blocks in the growth of the vaping trend has been that the original claims made by many manufacturers that "you can vape anywhere" have been undone by increasing levels of regulation which precludes vaping in the same places that smoking is already restricted. Vaping bans are already common on airlines, public transport, pubs and at least one major global financial institution which once employed me. In the latter case the arguments against the use of e-cigarettes on company premises included that the FDA had not ruled on them; the American Cancer Society had not ruled on them; they were "a bit smelly"; and that they may present a visual distraction for those trying to quit smoking. On this latter point, those on a diet were not prevented from entering the canteen despite the visual distraction that food might have presented.

In November of 2016 WHO will hold the 7th "Conference of the Parties" to the Framework Convention on Tobacco Control. It has released the documents for the five

day conference, including one on "Electronic Nicotine Delivery Systems and Electronic Non-Nicotine Delivery Systems". The document raises a number of issues pertinent to the debate about e-cigarettes, but also to the debate about tobacco control more generally.

The document is equivocal on the potential health benefits of vaping relative to smoking and quotes the risks a number of claims which have been roundly dismissed elsewhere but does state that "***it is very likely that ENDS/ENNDS are less toxic than cigarette smoke***". It also states that it is "***reasonable to assume that the increased concentration of toxicants from second hand aerosol (SHA) over background levels poses an increased risk for the health of all bystanders***". It argues that "***given the scarcity and low quality of scientific evidence, it cannot be determined whether ENDS may help most smokers to quit or prevent them from doing so***". It is uncertain that ENDS/ENNDS use in youth is a precursor to smoking (ie "the gateway effect") but states that "***ENDS/ENNDS use by minors who have never smoked at least doubles their chance of starting to smoke***". It also finds that "***A growing concern is the extent to which research on the topic has links to commercial and other vested interests of the ENDS/ENNDS industry, including the tobacco industry, and its allies. In a review of 105 studies analysing the composition of liquids and emissions, 30% had authors that had received funding from ENDS/ENNDS interests - including the tobacco industry***".

The paper concludes with four objectives:

- prevent the initiation of ENDS/ENNDS by non-smokers and youth with special attention to vulnerable groups.
- minimize as far as possible potential health risks to ENDS/ENNDS users and protect non-users from exposure to their emissions.
- prevention of unproven health claims being made about ENDS/ENNDS.
- protect tobacco control activities from all commercial and other vested interests related to ENDS/ENNDS, including interests of the tobacco industry.

To achieve these objectives 28 recommendations are made including:

- Banning or restricting advertising, promotion and sponsorship of ENDS/ENNDS.
- Taxing ENDS/ENNDS at a level that makes the devices and e-liquids unaffordable to minors in order to deter its use in this age group.
- combustible tobacco products should be taxed at a higher level than ENDS/ENNDS to deter initiation and reduce regression to smoking.
- Banning or restricting the use of flavours that appeal to minors.
- Regulating places, density and channels of sales.
- Taking measures to combat illicit trade in ENDS/ENNDS.
- Regulating electrical and fire safety standards of ENDS/ENNDS devices.
- Prohibiting by law the use of ENDS/ENNDS in indoor spaces or at least where smoking is not permitted.
- Requiring health warnings about potential health risks deriving from their use.
- Prohibiting implicit or explicit claims about the comparative safety or addictiveness of ENDS/ENNDS with respect to any product unless these have been approved by a specialized governmental agency.

- Rejecting partnerships with the industry.
- Banning activities described as "socially responsible" by the industry, including but not limited to activities described as "corporate social responsibility".

There is a somewhat inevitable collection of ban-tax-regulate in the list of recommendations despite the somewhat limited evidence of success from similar strategies in combustible cigarettes. There is also an interesting juxtaposition of a desire to see higher prices for ENDS/ENNDS and an acknowledgement that higher prices (and other regulation) may well see an increase in illicit trade. The regulation of electrical and fire safety standards is also illuminating given the recent experience of Samsung with another battery-powered, habit-forming product which is definitely aimed at youth.

There is very little in the objectives or recommendations for action which suggests that WHO will be taking an encouraging stance towards e-cigarettes in our view, in marked contrast to the much more liberal view taken in the UK. There is certainly no suggestion that those countries which currently have bans on e-cigarettes should consider revoking them. It appears that WHO is being somewhat selective in its choice of research to consider, and is willing to put more credence to reports which highlight risks than those which suggest lessened or negligible risks. The claim is made in the document that in "one review of 105 studies analysing the composition of liquids and emissions, 30% had authors that had received funding from ENDS/ENNDS interests - including the tobacco industry" (para 27). The report itself has been thoroughly debunked by Clive Bates who points out that "*many researchers in this field have undisclosed conflicts relating to funders, regulators, employers' prior policy positions, and their long-held beliefs*". In this respect while it is usual to flag conflicts that arise from association, even vague, with the tobacco industry it is not usually regarded as a conflict if funding has been provided by the pharmaceutical industry, even when those companies may be directly in competition in the provision of nicotine via Nicotine Replacement Therapies.

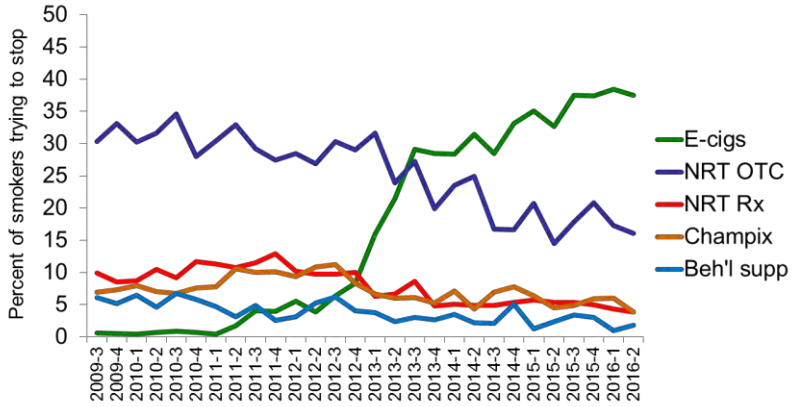
The hostility of certain parts of Public Health looks set to bring about a number of outcomes which are directly opposed to what we would generally assume to be the objectives of Public Health, and certainly counter to the objectives of ASH described above. In particular the introduction of material regulation of product required by the FDA, for example, will involve material barriers to entry for smaller companies. During 2012 there was much focus from investors with regard to the potential of e-cigarettes, and of the anti-tobacco commentary which was demanding increased regulation, was based on the fear of "Big Tobacco" dominating the industry. In actual fact the tobacco companies were somewhat late to the subsector, but as regulation has increased their financial firepower and long history with being regulated actually cement their position at the expense of the innovative smaller companies which originally built the sector.

The fear about "gateway" products based on fruit flavours which "only appeal to youth" ignores the clear testimony of many former smokers who have moved to vaping and then moved quickly away from tobacco-flavoured (and nicotine containing) e-liquids. As data from the UK shows, one third of current vapers use tobacco flavours but half use non-tobacco flavours including fruit (22%), mint (22%), vanilla (3%), chocolate/desserts/sweets (3%), coffee (2%) or alcoholic or energy/soft drink flavours (2%). While WHO decries the lack of scientific evidence in support of reduced-harm claims, there is even less support for the idea of e-cigarettes acting as a gateway to smoking especially given on-going declines in youth smoking rates according to, for

example, US data. Put simply while there appears to be growing use of e-cigarettes among US youth, the rate of decline in smoking has accelerated and that alone seems to call into question any validity to the argument that vaping is a gateway to smoking.

It begs the question as to why should WHO and some elements of Public Health be so against vaping? It appears that as much as e-cigarettes have the potential to be disruptive to the combustible cigarette market, so they have been disruptive to the approach employed for so long by the anti-tobacco movement. The message has therefore morphed from "quitting smoking" to "quitting nicotine" but also beyond that as the WHO's discussion paper makes clear by also now considering not only nicotine-containing electronic products but also those that do not. Mission creep is quite clear. Perhaps this is due to the (anecdotal, it would be said by critics) evidence that quit attempts increasingly use e-cigarettes and not the commonly advised combination of pharmaceutical nicotine products and Government-sponsored professional advice. Of course it is also worth noting that e-cigarettes are a free market solution, not one that has been inspired by or funded by Public Health.

Figure 6: Aids used in most recent quit attempt, UK



Source: www.smokingengland.info/latest-statistics. N=11695 adults who smoke and tried to stop or who stopped in the last year; method is coded as any (not exclusive) use

We started this section with the observation that "We tend to become like the worst in those we oppose". It appears that this is certainly the case with some of the most vocal opponents of e-cigarettes from within Public Health, and the arguments between opponents and proponents becoming particularly vitriolic.

In the Lancet, in an unattributed editorial, the position of Public Health England was dismissed as "*the opinions of a small group of individuals with no prespecified expertise in tobacco control*" which seems a harsh judgement on a group which included:

- the head of the Nicotine Research Group at the Institute of Psychiatry, Psychology & Neuroscience, King's College London,
- two Lecturers and a research assistant in Addictions in the Nicotine Research Group, KCL, and
- the director of Health and Lifestyle Research Unit at Wolfson Institute of Preventive Medicine, Queen Mary University of London.

The Lancet editorial further complained of conflicts of interest of two authors of one of the papers considered in the PHE document. This prompted a response from one of those authors, Riccardo Polosa, in which he covers his "*temporary involvement with a*

small-size e-cigarette company that went out of business" and repeats earlier disclosures of grants from Pfizer and personal fees from Novartis and GlaxkSmithKline.

Interestingly the Lancet editorial has been sourced to one opponent of e-cigarettes who has subsequently written of his views the EU Referendum campaign. While stating that "*It is, of course, important that all sides of an argument are heard. It is also important that the values of those who might be considered an educated elite are challenged*" he goes on to bemoan that "*where those involved had ever received funding … this was qualified by accusing them of being hopelessly tainted by having done so*".

It appears that some in Public Health have adopted an approach which dismisses science which is unhelpful to them and will attack opponents as being paid stooges. It begs the question as to whether this is a new approach, or actually one that is now simply out in the open.

Back to the future in harm reduction

"One of the most important public health debates in recent decades: To redefine the place of nicotine in society and in the law, and make room for recreational nicotine products"

Professor Jean-Francois Etter

There are many strands to the debate about the future of tobacco and we do not think it is as simple as suggesting that the combustible market disappears or that everything moves to electronic delivery, two theories which have received attention over the past few years. Returning to the fundamental fallacy of demonic possession, there are very, very many cigarette smokers who are entirely happy with the choice that they have made and feel no compulsion to change. Because of this we believe that combustible cigarettes will remain an important, and probably the most important, part of the tobacco industry for very many years to come.

In the realms of harm reduction, however, it is now a number of the leading tobacco companies which are making the running on both the scientific front but also in taking that science into products for consumers. The critics of the industry will, no doubt, argue that this is simply the latest part of the "grand conspiracy" but the fact is that as far as the science of tobacco goes it is the tobacco companies which have the funds and the inclination to carry on the scientific research required. As we have discussed above, the science of tobacco smoke has not become any easier over the years while the financial incentive to research it has waned with the "all smoking is simply bad" message. As such a blanket view that any science that emanates from the industry must be "tainted" is churlish, we believe, and ignores the fact that outside of the tobacco industry little new research is being undertaken.

While it is certainly the case that there was a lull in industry efforts to pursue harm reduction, that claim simply holds no water today in our view. Since the late 1990s the tobacco companies, in our view not completely wisely, have made clear statements that smoking entails risk and can cause disease. Each of the tobacco majors has sought to develop products which aim at harm reduction in its various possible forms be it smokeless, heat-not-burn or electronic.

The motives for the industry to embrace harm reduction are, inevitably, questioned. We would perhaps question instead the motive for the industry not embracing harm reduction. According to the tobacco control lobby this is the same industry that lied in the past. Quite clearly it is not as if no tobacco company today suggests that smoking does not carry risk. It is also the case that the current generation of senior management across the industry were born when the controversy regarding the potential health impacts of smoking rose to prominence in the 1950s or after. By the time any of them joined the industry, health warnings were already prevalent, the Readers Digest had long since published "Cancer in a Carton" and the Surgeon General had published 14 reports on the health consequences of smoking.

Table 5: Year of birth and year of joining tobacco industry

Name	Company and position	Year of birth	Year of joining industry
Martin Barrington	Altria, Chairman & CEO	1953	1993
Nicandro Durante	BAT, CEO	1956	1981
Alison Cooper	Imperial Brands, CEO	1966	1999
Mitsuomi Koizumi	Japan Tobacco, CEO	1957	1981
Andre Calantzopoulos	PMI, CEO	1958	1985
Susan Cameron	RAI, CEO	1958	1981

Source: Company data

Perhaps the determination to see no change in the tobacco industry really stems from the need for Tobacco Controllers for consumers to continue to choose to smoke. To finish with a quote from Nietzsche "*Whoever lives for the sake of combating an enemy has an interest in the enemy's staying alive*".

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Definition of research recommendations
Expected absolute returns

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- HOLD is an expected return -10% - +10%; and
- SELL is an expected return less than -10%.

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Recommendation History

Date	Company	Share price	Recommendation
13.07.16	British American Tobacco	4840p	BUY
28.07.16	British American Tobacco	4747p	BUY

Source: Cenkos Securities

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British American Tobacco Plc – 1, 6

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CalPERS Stakeholder Relations

From: Maham Akbar <MAkbar@truthinitiative.org>
Sent: Thursday, November 10, 2016 9:04 AM
To: CalPERS Stakeholder Relations
Cc: David Dobbins
Subject: Letter from Truth Initiative re: Tobacco Divestment Policy
Attachments: Letter from Truth Initiative.pdf

Hello,

Please find the attached comment being submitted by Truth Initiative for the December 19 discussion at the board meeting on reconsidering the tobacco divestment policy. You will also receive a hard copy via FedEx tomorrow. Please feel free to be in touch with me if you have any questions.

Best,
Maham

By speaking, seeking and spreading the truth about tobacco, Truth Initiative has helped bring teen cigarette use to a record low of 7 percent!

Maham Akbar
Manager, Public Policy

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truthinitiative.org
202 454 5555

November 11, 2016

CalPERS
c/o Office of Stakeholder Relations
400 Q Street
Sacramento, CA 95811

To Whom It May Concern:

Truth Initiative welcomes the opportunity to submit stakeholder feedback to CalPERS regarding its review of restrictions on tobacco investment. We strongly urge CalPERS to continue its directive to divest from tobacco-related securities.

Truth Initiative is committed to creating a generation of Americans for whom tobacco use is a thing of the past. We believe each individual has the right to live in a world free from tobacco dependence, tobacco-related death and disease, and the devastating dollar cost to individuals and society. Truth Initiative's proven-effective and nationally recognized public education programs include truth®, the national youth smoking prevention campaign that has been cited as contributing to significant declines in youth smoking; EX®, an innovative smoking cessation program; and research initiatives exploring the causes, consequences and approaches to reducing tobacco use. Truth Initiative also develops programs to address the health effects of tobacco use –with a focus on priority populations disproportionately affected by the toll of tobacco –through alliances, youth activism, training and technical assistance. Located in Washington, D.C., the organization was created as a result of the November 1998 Master Settlement Agreement (MSA) between attorneys general from 46 states, five U.S. territories and the tobacco industry.

While it is estimated that investing in tobacco companies in the past 15 years since CalPERS banned tobacco company investments could have added $2-3 billion in investment returns, California has lost much more money and lives in that time due to tobacco use. In California, the health care costs directly caused by smoking amount to $13.29 billion annually and Medicaid costs caused by smoking amount to $3.58 billion each year. Additionally, California loses $10.35 billion in productivity each

year due to smoking.[1] This amounts to an estimated $200 billion spent in the state on tobacco-related health care and $155 billion in lost productivity that businesses in the state have endured due to smoking in the time since CalPERS banned tobacco company investments. The economics make it clear that tobacco is a bad investment for California.

Again, we strongly urge CalPERS to not reverse its ban on investing in tobacco companies. The best approach for California and its residents, and especially the more than 3,000 employers and 1.8 million members participating in the CalPERS system, is to remain divested from tobacco. If you have questions or need further information, please contact Dave Dobbins, COO at Truth Initiative, at ddobbins@truthinitiative.org, or 202-4455555.

Sincerely,

David Dobbins
Chief Operating Officer

[1] Campaign for Tobacco-Free Kids. The Toll of Tobacco in California. 2016; https://www.tobaccofreekids.org/facts_issues/toll_us/california. Accessed November 8, 2016.

CalPERS Stakeholder Relations

From: Ari Rubenstein <arubenstein@stopcorporateabuse.org>
Sent: Friday, November 11, 2016 1:40 PM
To: CalPERS Stakeholder Relations
Subject: Public comment regarding CalPERS' tobacco investments
Attachments: CalPERSsubmission_CorporateAccountabilityInternational_11.11.16.pdf

Hello,

Please find attached public comment from Corporate Accountability International regarding CalPERS' pending decision on tobacco reinvestment. Thank you for your time and consideration. We look forward to further conversation.

Sincerely,

Ari

--
Ari Rubenstein
Executive Assistant to the Deputy Director, Campaigns & Research
Corporate Accountability International
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Boston, MA 02108
617.695.2525
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November 11, 2016

Office of Stakeholder Relations
California Public Employees' Retirement System
400 Q Street
Sacramento, CA 95811

To the Board of Administration of CalPERS:

I write to you today on behalf of tens of thousands of Corporate Accountability International members and supporters worldwide—including thousands in California—to urge you to remain divested from stocks in tobacco corporations.

Corporate Accountability International is a nonprofit grassroots watchdog organization with a nearly 40-year history of protecting people and the planet from corporate abuse. Our longest-running program is the campaign to Challenge Big Tobacco, launched in 1994. After more than 20 years of researching, monitoring, exposing, and challenging the tobacco industry, we deeply understand that these corporations are driving an epidemic of tobacco-related death and disease globally that kills around 6 million people each year.

Globally, tobacco-related death and disease is on the rise. Following decades of hard-fought victories against industry abuses in the United States and other Global North countries—including through waves of major institutional divestment—the industry is expanding this epidemic in the Global South. This expansion fuels financial performance for tobacco transnationals, making industry stocks an attractive investment based on potential return. A profitable tobacco industry, however, means more deaths, with a disproportionate burden on the Global South, women, and low-income communities.

The tobacco industry achieves this expansion through aggressive, predatory marketing tactics that were common in the U.S. in 1994 but would be unthinkable here today: tactics like youth-oriented pro-smoking campaigns and cigarette giveaways. Moreover, it secures its expansion through well-documented criminal activity: British American Tobacco has engaged in cash bribery of government officials in countries across West Africa, and Philip Morris International has been implicated in illicit trade in Nigeria. Institutional reinvestment in tobacco bolsters this industry's ability to expand—and undermines decades of global progress on tobacco control.

Regardless of the tobacco industry's current financial footing, one need only look to the meetings of the Framework Convention on Tobacco Control (FCTC) currently underway in Delhi, India, to see that the world is united to end tobacco death and disease. At these meetings of the FCTC (also known as the global tobacco treaty), high-level government delegates from nearly every country in the world have advanced international legal mechanisms to challenge the industry's political power and reduce its global death toll. Indeed, just *today*, these officials adopted a liability regime for the tobacco industry—formally enshrining in international law a regime to hold the industry civilly and criminally liable for its abuses. Implementation of these mechanisms over the next decade is sure to save millions of lives—and deal a significant blow to the tobacco industry's profitability.

For all of these reasons, we strongly urge you to maintain your leadership position on this critical issue by upholding your policy of disinvestment in tobacco. We would welcome the opportunity to discuss our unique perspective and experience regarding tobacco industry abuses with you further. Please let us know if we could set up a phone call with your board members to speak directly, or otherwise offer our support in helping you maintain your divestment policy. Feel free to follow up with me via phone at 617.695.2525 or email at jstewart@stopcorporateabuse.org. And thank you for your historic leadership on this issue, and for your consideration and time.

Sincerely,

John Stewart
Deputy Campaigns Director, Challenge Big Tobacco
Corporate Accountability International

STATE CAPITOL
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California State Senate

SENATOR
DR. RICHARD PAN
SIXTH SENATE DISTRICT

CHAIR
PUBLIC EMPLOYMENT & RETIREMENT

COMMITTEES:
AGRICULTURE
BUDGET & FISCAL REVIEW
EDUCATION
HEALTH

SUBCOMMITTEE:
BUDGET SUBCOMMITTEE 4

November 7, 2016

Rob Feckner, President
Board of Administration
CalPERS
Lincoln Plaza
400 Q Street, Sacramento, CA 95811

Re: CalPERS Tobacco Divestment Policy – Comment Letter

Dear President Feckner:

In response to the call for stakeholder comments requested by CalPERS' October 18, 2016, webinar on the issue of CalPERS' tobacco divestment policy, I urge the Board of Administration to reject any change to the current policy. CalPERS should continue its longstanding commitment to protect the public's health and taxpayers' money. Investing in tobacco is a huge step backward in these efforts.

Re-investing in tobacco would pit CalPERS' portfolio against the financial and physical well-being of its members and the State of California. Big Tobacco inflicts more than $23 billion of health care and lost productivity costs on Californians on an annual basis – including $3.5 billion of direct costs to California taxpayers to pay for treating tobacco-related diseases afflicting Medi-Cal patients.

Changing the current policy to permit re-investment in tobacco companies sends a message that California supports an industry that richly profits by selling a product that often results in disease and death when used as directed. Half of smokers can expect to die from their addiction. Smoking is the single leading cause of preventable death in this nation and in this state, robbing 40,000 Californians of their lives annually.

The latest data shows teen e-cigarette users are three times as likely as non-vapers to smoke traditional cigarettes a year after they become accustomed to nicotine via an e-cigarette as all three major tobacco companies are investing in electronic cigarette brands that offer over 7,700 flavors including Captain Crunch, gummy bear, cotton candy, Atomic Fireball and Fruit Loops. With flavors like these, it is clear the target is our youth, and it's no surprise that the teen popularity of these products tripled from 2013 to 2014.

Shortening people's lives for financial gain is not what Californians want. California must align its investments with its values. CalPERS should not send California money to the same tobacco companies that harm Californians, including CalPERS members and their families. This is a detriment to public health; and it is inconsistent with our values as a state.

California ended its romance with tobacco 16 years ago. There is no reason to revisit the issue today.

Sincerely,

Dr. Richard Pan
Chair Senate Public Employment and Retirement Committee

SEIU California

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www.seiuca.org

November 9, 2016

JJ Jelincic
Member, CalPERS Board
P.O. Box 942701
Sacramento, CA 94229-2701

Dear Mr. Jelincic:

SEIU represents over 700,000 California workers and we are stunned that CalPERS is even considering the possibility of reversing its tobacco investment policies. We urge you not to make a short-sighted and narrow-viewed decision that could permanently scar California's health, economy and global leadership position.

The leading cause of preventable death in our state, smoking kills over 40,000 Californians each year. Cancer and other tobacco-related diseases kill more people than car accidents, guns, alcohol, illegal drugs, and AIDS combined.

The wind is against tobacco on so many fronts. California has one of the nation's lowest adult smoking rates. Gov. Jerry Brown signed into law bispartisan-supported tobacco restrictions including raising the age to buy tobacco in California to 21 and extending tobacco laws to e-cigarettes. The FDA also has imposed new regulations on e-cigarettes, which are climbing in popularity among youth.

A historic coalition including dozens of California Chambers of Commerce from every major metropolitan area of California - who have traditionally opposed cigarette taxes - have mounted an unprecedented campaign to reduce smoking by raising the state's tobacco tax.

It would be unconscionable, and utterly senseless, to move our state backward at a time of such momentum forward.

Yet even despite this trajectory for positive change and decades of hard-fought progress against an industry that peddle deadly addiction for profits, nearly 17,000 California kids start smoking every year. One-third of them will eventually die from tobacco-related disease.

Tobacco companies spend $9 billion annually to market their deadly, addictive products. Now tobacco companies are targeting kids for a lifetime of addiction with candy-flavored electronic cigarettes containing nicotine. Teen use of e-cigarettes tripled between 2013 and 2014. Teens who use e-cigarettes are twice as likely to start smoking traditional cigarettes. Scores of scientific studies from independent academic institutions are funding mounting evidence of the dangers of these products.

Because of smoking, California taxpayers spend $3.5 billion dollars each year on treating cancer and other tobacco-related diseases through Medi-Cal. Tobacco has a profound negative impact on California's entire economy to the tune of $20 billion in lost productivity, premature mortality and increased healthcare costs.

CalPERS has been an international model of acting with a conscience while being fiscally prudent. It would be a tragedy to reverse this, and send a dangerous message to the global investment community that Californians' health is secondary to the earnings margins of the largest U.S. Public Pension Fund.

We strenuously urge you to reject any further consideration of this losing investment for California.

Sincerely,

Terry Brennand
Sr. Government Relations Advocate

TOBACCO FREE
Portfolios

7 April 2016

CalPERS
400 Q Street
Sacramento
CA 95811, USA

Dear Chairperson and Directors of the Board,

As a medical specialist and founder of Tobacco Free Portfolios I am writing to express my **deep concern** in relation to possible changes to CalPERS tobacco-free investment mandate.

My work with Tobacco Free Portfolios has seen over 35 Australian Pension Funds divest tobacco stocks in just the last four years, creating what is considered a 'new norm' in the Australian pension fund community. Due to this momentum and interest in tobacco-free investment the Union for International Cancer Control (UICC), established the Global Task Force for Tobacco Free Portfolios in 2015, with a clear mandate to encourage and assist sovereign wealth funds and large pension funds implement tobacco-free investment mandates.

At this precise moment, there is **unprecedented good will and positive collaboration** between the finance sector and the health sector, regarding the issue of tobacco. There is growing acceptance and acknowledgement of the fact that no decent individual or organization actively associates itself with the tobacco industry.

Individuals and organizations that invest money in a company have a vested interest that company. Investors want to see that company grow and thrive. They want the company to sell more of its product. They want the company to attract new customers. We must ask ourselves as a global community – is that we want for the tobacco industry? This world is on track for an estimated one billion tobacco related deaths this century. A problem of that scale simply cannot be ignored by any sector of society.

It would be incongruous for the pension funds of Californians, a State with one of the lowest smoking rates in the world, a State that is globally lauded for its exemplary leadership in tobacco control, to reverse or re-consider tobacco investment. The principles that underpinned progressive and innovative decisions made in 2000, are still just as relevant today, perhaps even more so.

I would like to draw your attention to the following important considerations:

- **Regulatory Risk:** In recognition of the global tobacco epidemic, in 2005 the World Health Organization established the Framework Convention on Tobacco Control (WHO FCTC), the world's first legally binding health treaty. There are 180 Parties, which makes it one of the most widely embraced treaties in United Nations' history. Parties have committed to implementing a broad range of tobacco control measures; therefore the long-term risks of tobacco investment are even more pressing and evident than in 2000 when CalPERS first implemented a tobacco-free investment mandate.

TOBACCO FREE
Portfolios

- **Litigation Risk:** Major class actions against tobacco companies continue to pose considerable financial risk. Of particular note just last year, the Canadian court ordered three big tobacco firms to pay $16.1 billion USD to smokers in Quebec Province.

- **Engagement is futile:** Whilst engagement is a common investment practice employed to mitigate risks associated with investment in a company, this strategy is not applicable to tobacco companies. Positive influence of the industry through professional engagement is futile, as the only acceptable outcome would be for tobacco companies to cease their primary business.

  This position is supported by the World Health Organization (WHO): "The tobacco industry is not and cannot be a partner in effective tobacco control".[1]

  According to WHO, "A large body of evidence demonstrates that tobacco companies use a wide range of tactics to interfere with tobacco control. Such strategies include direct and indirect political lobbying and campaign contributions, financing of research, attempting to affect the course of regulatory and policy machinery and engaging in social responsibility initiatives as part of public relations campaigns.[2]"

- **Tobacco Stands Alone:** There is no safe level of exposure to tobacco. When used as intended, tobacco will have contributed to the early death of two out of three smokers[3]. The scale of negative impact of tobacco is profound, causing an estimated six million deaths per year globally.[4]

- **Human Rights Abuse:** A very influential issue of concern when considering tobacco investment has been the fact that almost no cigarette can be guaranteed to be free from child labour.[5] It is estimated that 33 million people are engaged in tobacco farming worldwide.[6] In 2006 the International Labor Organization estimated that children constituted up to 60-percent of this workforce.[7] With many financial organizations adopting Human Rights Policies, investment in tobacco stands in clear breach of human rights principles.

I hope you might consider the issues outlined above in relation to this important matter. I would be most pleased to meet with or present to your Board or investment team as I have much experience and expertise in this area, and of course first-hand experience as a practicing radiation oncologist of the devastating impact of tobacco on individuals and families.

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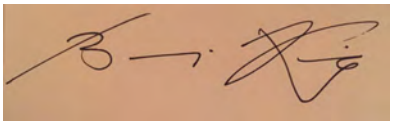
[1] http://www.who.int/tobacco/resources/publications/Tobacco%20Industry%20Interference-FINAL.pdf Pg. 22.
[2] http://www.who.int/tobacco/resources/publications/Tobacco%20Industry%20Interference-FINAL.pdf Pg. V
[3] Banks et al, Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. BMC Medicine (2015) 13:38 <http://www.biomedcentral.com/content/pdf/s12916-015-0281-z.pdf>
4 Oberg M, Jaakkola MS, Woodward A, et al, *Worldwide burden of disease from exposure to second-hand smoke: a retrospective analysis of data from 192 countries*, (Lancet, 2011) 2011:377 (9760), 139-46.
[5] Graen, L. (2015, January 27). BMJ Group blogs. Retrieved August 30, 2015, from http://blogs.bmj.com/tc/2015/01/27/tobacco-industry-confronted-with-child-labour/?q=w_tc_blog_sidetab
[6] Jha, P., & Chaloupka, F. (1999). *Curbing the epidemic Governments and the economics of tobacco control.* (p. 68). Washington, DC: World Bank.
[7] Amon, J., Buchanan, J., Cohen, J., & Kippenberg, J. (2012). Child Labor and Environmental Health: Government Obligations and Human Rights. *International Journal of Pediatrics, 2012*(938306), 1-8. doi:10.1155/2012/938306

TOBACCO FREE
Portfolios

I look forward to hearing from you and engaging further on this matter.

Kind Regards,



Dr Bronwyn King, MBBS, FRANZCR
Founder and CEO Tobacco Free Portfolios
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TOBACCO FREE
Portfolios

10 November 2016

CalPERS Board and Management
C/o Office of Stakeholder Relations
400 Q Street
Sacramento, CA 95811
CalPERS_Stakeholder_Relations@calpers.ca.gov

Dear Sir/Madam,

Re: CalPERS and tobacco-free investment

Further to my letter dated 7 April 2016 (attached), I thank you for the opportunity to contribute further to the discussion regarding the issue of CalPERS and investment in the tobacco industry.

Mission Vision Beliefs
CalPERS' stated Mission, Vision and Beliefs consistently refer to the themes of ethics, innovation, a forward-thinking approach and sustainability. In 2016, a tobacco-free investment position strongly aligns with these concepts and stands as an excellent example of an organization actively living its values.

Healthcare Interest
Given that Health Programs constitute a significant part of CalPERS' activities, affiliations with the tobacco industry, including holding tobacco stock, would present an obvious conflict. As you are no doubt aware, tobacco causes the deaths of an estimated 40,000 Californians per year and remains the leading cause of preventable death within the state and country, as well as around the world.

It is important to note that reduced smoking rates translate to reduced health costs. For example, between 1989 and 2008 the Californian tobacco control program resulted in savings to the community of an estimated $7 Billion per year, thus benefiting CalPERS Health Program, amongst other organizations that incur the costs of the profound health burden of tobacco.

Consistency with state policy
California is globally lauded for its exemplary leadership on tobacco control policy, which has resulted in the State of California having one of the lowest smoking rates in the world. In the united battle that is required to address the global tobacco epidemic, it is imperative that Governments and their related institutions, including pension funds, remain aligned and committed to de-normalization of associations with the tobacco industry.

Engagement futile
We acknowledge that 'engagement' is a preferred practice with regard to responsible investment, however tobacco presents an exception. According to the World Health Organization Directive, "*The tobacco industry is not and cannot be a partner in effective tobacco control."*

Leadership
CalPERS is admired as a leader, particularly in relation to responsible investment. As a Founding Signatory of the UN PRI, one of the first to sign the Montreal Pledge and having admirably ambitious targets with regard to the Sustainable Development Goals (SDGs), it would be incongruent to re-invest in an industry responsible for 6 million deaths per year.

It is important to note that achievement of fourteen of the seventeen SDGs will require significant progress on tobacco control. Addressing financial support of and investment in tobacco is critical to comprehensive and cross-sector tobacco control efforts.

The Movement
Although some have questioned the impact of CalPERS divestment of tobacco stocks in 2001, many believe this created significant momentum in the sustainable investment movement. CalPERS leadership on this important issue is referenced constantly in the discussions of our Tobacco Free Portfolios team, resulting in 35 Australian pension funds, representing 40% of the Australian pension fund sector (combined total assets of approximately $550Billion AUD) implementing tobacco-free investment mandates in the past five years. More will soon follow.

The tobacco-free investment conversation has expanded to include insurers (notably AXA implemented a tobacco-free investment policy in May 2016), banks (notably ANZ New Zealand implemented a tobacco-free investment policy in October 2016), city councils (notably Copenhagen city council implemented a tobacco-free investment policy in October 2016) and Sovereign Wealth Funds (notably Sweden's AP4 implemented a tobacco-free investment policy in November 2016). In response, fund managers are now coming to market with an increasing numbers of financial products with tobacco-free mandates. In addition, some fund managers have implemented completely tobacco-free policies across all offerings.

Tobacco Free Portfolios is now working with over 100 financial organizations. Whilst all are at varying points in the consideration of this issue, the trend is overwhelmingly towards tobacco-free investment.

With regard to the possible steps that CalPERS could take following consideration of this issue, Tobacco Free Portfolios strongly encourages extension of tobacco divestment to externally managed portfolios. Many large global fund managers now have tobacco-free products, responding to increasing demand.

I have attached an electronic copy of the Tobacco Free Portfolios Toolkit, which outlines key aspects of tobacco-free investment considerations. You are welcome to forward this to your Board and Executive Team. As discussed, I would also be delighted to present to the CalPERS board on December 19.

Yours Sincerely,

Bronwyn

Dr. Bronwyn King, MBBS, FRANZCR
CEO Tobacco Free Portfolios
Radiation Oncologist
Cancer Council Australia Tobacco Control Ambassador
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TOBACCO FREE
Portfolios

The toolkit.

OCTOBER 2016

Encouraging tobacco free investment.

Globally, the health sector collaborates to develop increasingly sophisticated cancer treatments. In recognition of the profound death and disease caused by tobacco, there are 180 parties to the UN Tobacco Treaty – the World Health Organisation Framework Convention on Tobacco Control, vowing to implement robust tobacco control regulation. In contrast - the global finance industry still invests in, and profits from, tobacco. But this is changing. Finance leaders are listening, acting and pleased to contribute to the comprehensive commitment from all sectors to end the global tobacco epidemic.

— Dr. Bronwyn King, MBBS, FRANZCR

Founder and CEO, Tobacco Free Portfolios
Radiation Oncologist, Peter MacCallum Cancer Centre and Epworth Healthcare
Cancer Council Australia Tobacco Control Ambassador

Contents

Tobacco Free Portfolios Overview

Addressing financial support of and investment in tobacco is a crucial, and to date, elusive piece in global efforts to control tobacco. Tobacco Free Portfolios professionally engages with the finance sector to encourage tobacco-free investment, playing a unique role in ensuring the finance sector aligns with governments, the health sector and non-government community.

Right: Clare Payne, COO, Tobacco Free Portfolios, Dr. Brownyn King, CEO, Tobacco Free Portfolios and Dr. Rachel Melsom, UK Director, Tobacco Free Portfolios at the UN World Health Organisation 2016 World Health Assembly.

Through pension schemes, sovereign wealth funds and other investments, many are unknowingly contributing to the global tobacco epidemic. Financial support of the tobacco industry stands in sharp contrast to global tobacco control efforts, increased community awareness of the dangers of smoking and the ongoing decline of tobacco smoking in developed economies.

Whilst there is general acknowledgement that global collaboration is needed, Tobacco Free Portfolios is the only organisation focused solely on tobacco-free investment and the vital role of the finance sector in tobacco control.

Who we are and how we work

Tobacco Free Portfolios is a not-for-profit organisation with a mission to inform, prioritise and advance tobacco-free investment by eliminating tobacco from investment portfolios across the globe.

Our Strategy is to engage with key leaders and influencers across the finance sector. We educate finance leaders about global tobacco control initiatives and the risks of tobacco investment and we encourage tobacco-free investment mandates.

The approach of Tobacco Free Portfolios is an advocacy and educative role. We pride ourselves on discretion and do not seek to accuse or shame trustees, investors or the finance industry. Instead we work collaboratively and professionally, so that the industry and its investors can make well-informed decisions.

Left: Dr. Bronwyn King, CEO, Tobacco Free Portfolios (left), pictured with Her Royal Highness Princess Dina Mired of Jordon (right), the Honorary Chair of Tobacco Free Portfolios, at a Union for International Cancer Control event in Geneva.

PHOTO COURTESY OF UICC COMMUNICATIONS

Tobacco Free Portfolios is led by Dr. Bronwyn King, a practicing Radiation Oncologist. Dr. King led much of the initial work of Tobacco Free Portfolios and has gained public international recognition for her leadership and advocacy. Ms. Clare Payne, the Chief Operating Officer of Tobacco Free Portfolios, has a background in law and business ethics and is World Economic Forum Young Global Leader. Dr. Rachel Melsom, contributes her combined corporate and clinical skills to the role of UK Director for Tobacco Free Portfolios.

2017 will see the continued expansion of the Tobacco Free Portfolios team with a colleague to join based in Geneva and potentially new colleagues based in other regions.

Progress and impact

Tobacco Free Portfolios has played an integral role in the decisions of over 35 pension funds in Australia to implement tobacco-free investment mandates. In 2016, Tobacco Free Portfolios was delighted to work with AXA, one of the world's largest insurers, and welcomed their decision to divest tobacco industry assets valued at 1.8 billion Euros, putting the issue firmly on the mainstream agenda.

Tobacco Free Portfolios is now engaging with large retail and investment institutions across the global finance sector and regularly presents at industry conferences and events.

Support and goodwill

The launch of the Global Task Force for Tobacco Free Portfolios, by the Union for International Cancer Control in 2015, provided the global platform to extend the reach and impact of Tobacco Free Portfolios. In 2016, Cancer Research UK kindly supported the UK Director role and other health organisations are considering similar support.

The personal support and endorsement of eminent ambassadors serves to create trust and profile for the initiative:

- Honorary Chair - Her Royal Highness Princess Dina Mired of Jordon; and
- Special Advisor - The Honourable Nicola Roxon, Former Attorney-General of Australia.

Tobacco Free Portfolios has received recognition and support from international health organisations, sovereign wealth funds and inspired business leaders creating much goodwill for both Tobacco Free Portfolios and tobacco-free investment.

Extending our impact

With much of the finance sector still invested in tobacco there is still great progress to be made, however, the support and goodwill for Tobacco Free Portfolios is a positive indication of what can be achieved.

In order to strategically harness the support and good will for tobacco-free investment, Tobacco Free Portfolios is now leading a Global Tobacco-Free Pledge in partnership with the UN backed Principles for Responsible Investment, the UN backed Principles for Sustainable Insurance and AXA, with the active contribution of the UICC.

We believe this initiative, to be launched in 2017, will bring global attention to financial investment in tobacco and encourage action. The Pledge will also draw attention to the Sustainable Development Goals, the World Health Organisation Framework Convention on Tobacco Control, and contribute to efforts to denormalise the tobacco industry.

In addition, Tobacco Free Portfolios is working with regulatory bodies to create an approved 'Tobacco-Free Portfolios Seal', which will be used by funds and investment institutions to publicly declare their tobacco-free position. The Tobacco-Free Portfolio Seal will also act as a guarantee to consumers and fund members seeking tobacco-free financial products.


2.

Tobacco Free Investment Framework

PRODUCT/
INDUSTRY

Tobacco

CONSIDERATIONS

Can the product be used safely?	Is there a UN Treaty applying to this product/ industry?	Can engagement be effective?
• There is no safe level of consumption. • When used as intended, tobacco will have contributed to the early death of two out of three smokers.[1]	• In recognition of the global 'tobacco epidemic' (6 million deaths worldwide each year[2] and an estimated 1 billion deaths this century[3]), the United Nations Tobacco Treaty was established —The World Health Organisation Framework Convention on Tobacco Control—The world's first global legally binding public health treaty. • 180 Countries are Parties to the Treaty, representing 89.4% of the world's population[4], which makes it one of the most widely embraced treaties in United Nations' history.	• The World Health Organisation has declared, "The tobacco industry is not and cannot be a partner in effective tobacco control".[5] • Positive influence of the industry through professional engagement is futile, as the only acceptable outcome would be for tobacco companies to cease their primary business.

Above: This is an epic battle between the protection of public health and the pursuit of corporate wealth. (...) Public health has the evidence and the right values on its side. The tobacco industry has vast financial resources, lawyers, lobbyists, and no values whatsoever beyond the profit motive."

Dr. Margaret Chan, opening speech, COP4, Punta del Este, Uruguay, November 2010.

The Sustainable Development Goals and Tobacco

The Sustainable Development Goals (SDGs) represent a global consensus on how to achieve a sustainable future.

- The SDGs contain a set of seventeen Global Goals with targets.
- The UN General Assembly formally adopted the SDGS in September 2015 and they officially came into force on 1 January 2016.
- All countries are expected to consider the SDGs when preparing plans and policies for the next 15 years.
- The international community, including the United Nations, the World Bank and regional development banks, as well as public and private donors, are expected to assist governments to reach the SDGs.

Tobacco use is the world's number one cause of preventable death. Tobacco use affects health and also impacts many other dimensions of development, including poverty and education, which are all essential to development.

1. No Poverty	Money spent on tobacco is money not spent on other household needs. In Thailand, low-income families spent 13.6% of their annual income on tobacco products (five times more than high income families), money that could be used for food, clothing and education[6]. In India, an additional 15 million people fall below the poverty line, once effects of tobacco within families are taken into account[7].
2. Zero Hunger	In 2005, Indonesian households with smokers spent 11.5% of their income on tobacco products, compared to 11% on fish, meat, eggs and milk combined[8]. In Kenya and Bangladesh, tobacco cultivation has replaced food crops and has led to local food insecurity[9].
3. Good Health and Well-Being	Tobacco use kills more than six million people every year, the majority in their most productive years. In this century, tobacco use will kill one billion people unless trends change[10].
4. Quality Education	In Malawi, at least 78,000 children are forced to work in tobacco fields, preventing most of them from attending school.[11] In 2005, Indonesian households with smokers spent 11.5% of their household income on tobacco products, compared to just 3.2% on education[12].
5. Gender Equality	In China, 53% of women of reproductive age were exposed to second-hand smoke at work, which raises the risk of complications in pregnancy[13]. In Uruguay, comprehensive tobacco control policies improved the health of newborns by encouraging pregnant women who smoke to quit.[14]
8. Decent Work and Economic Growth	In highly populated, developing countries like Pakistan, lost economic opportunities are severe with up to half of all tobacco-related deaths occuring during the population's prime productive years.[15] In 2006 the International Labour Organization estimated that children constituted up to 60% of the workforce on tobacco farms across the globe[16].
10. Reduced Inequalities	More than 80% of the world's smokers live in low and middle-income countries, which have fewer resources to devote to the health and other costs of tobacco.[17]

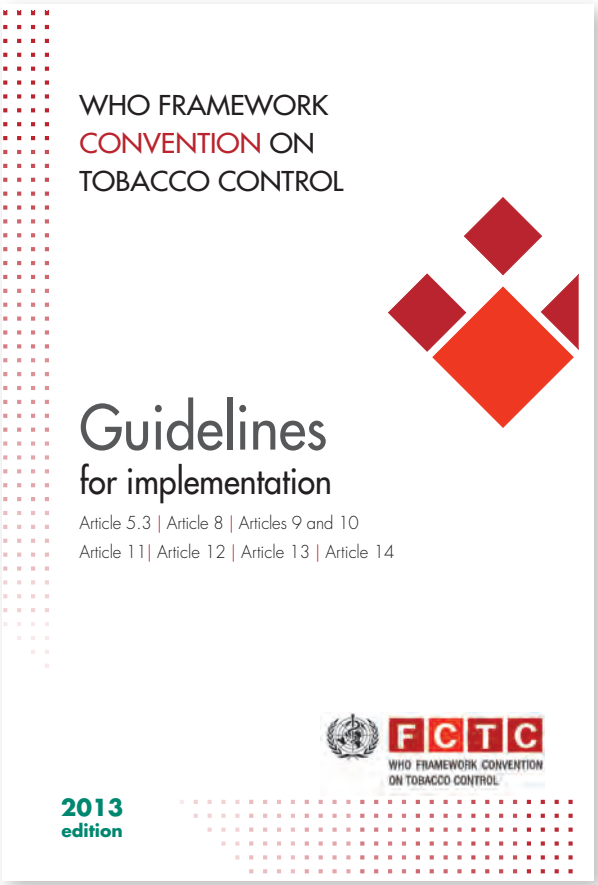
11. Sustainable Cities and Communities	Breathing in second-hand smoke is deadly. In Thailand, 68% of youth (age 13–15) are exposed to second-hand smoke in public places and 49% in their homes[18].
13. Climate Action	Tobacco cultivation accounts for 1% of the world's agricultural land use, yet it is responsible for 2-4% of global deforestation.[19]
14. Life Below Water	Cigarette butts are the number one littered item worldwide. They foul waterways, are toxic to the environment and are not biodegradable[20].
15. Life on Land	Tobacco growing is responsible for biodiversity losses, land pollution through the use of pesticides, as well as soil degradation, deforestation and water pollution[21]. Tobacco manufacturing is related to 30% of deforestation in Bangladesh[22].
16. Peace, Justice and Strong Institutions	In 2000, the European Community brought a case against tobacco companies Phillip Morris and RJ Reynolds for smuggling cigarettes, obstructing governments' tobacco control, bribing foreign public officials and illicit trade with terrorist groups[23].
17. Partnerships for the Goals	The UN General Assembly has endorsed the policies to increase tobacco taxes. Price and tax measures on tobacco are effective and an important means to reduce tobacco consumption and healthcare costs, and, in many countries, to raise revenue to finance development programmes[24]

For more information, please see:

- Framework Convention Alliance Advocacy Toolkit: www.fctc.org/images/stories/SDGs_ToolkitFINAL.pdf
- www.unfairtobacco.org (resources)

4.

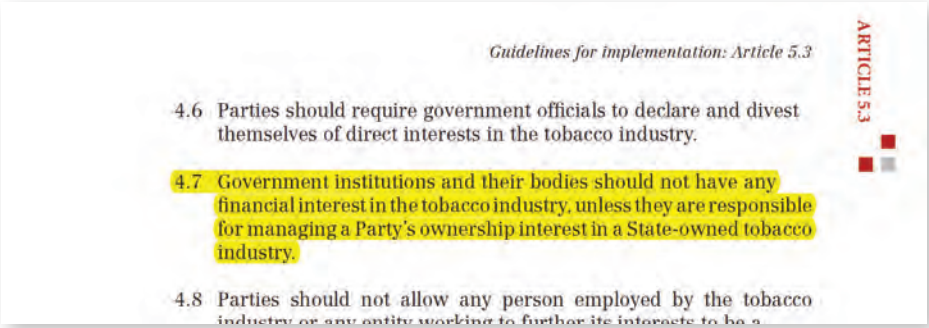
UN Tobacco Treaty



In 2005, the World Health Organization established the Framework Convention on Tobacco Control (WHO FCTC), the world's first legally binding health treaty. There are 180 Parties (Countries), which makes it one of the most widely embraced treaties in United Nations' history. Under the Treaty the Parties have committed to implementing a broad range of tobacco control measures.

The Guidelines of the WHO FCTC include a provision that stipulates Governments are required to not invest in the tobacco industry. This includes Sovereign Wealth Funds and Government pension funds.

Currently only three countries have implemented this part of the Treaty. They are: Australia, New Zealand and Norway. There is the opportunity for other nations to stand beside these nations and be profiled on the world stage as protecting their population and joining global cancer control efforts.



Guidelines for implementation: Article 5.3

ARTICLE 5.3

4.6 Parties should require government officials to declare and divest themselves of direct interests in the tobacco industry.

4.7 Government institutions and their bodies should not have any financial interest in the tobacco industry, unless they are responsible for managing a Party's ownership interest in a State-owned tobacco industry.

4.8 Parties should not allow any person employed by the tobacco industry or any entity working to further its interests to be a

Without prejudice to their sovereign right to determine and establish their economic, financial and taxation policies, Parties should respect their commitments for tobacco control.

Recommendations

7.1 Parties should not grant incentives, privileges or benefits to the tobacco industry to establish or run their businesses.

7.2 Parties that do not have a State-owned tobacco industry should not invest in the tobacco industry and related ventures. Parties with a State-owned tobacco industry should ensure that any investment in the tobacco industry does not prevent them from fully implementing the WHO Framework Convention on Tobacco Control.

Excerpt from the Guidelines for implementation of Article 5.3 of the WHO FCTC:

> There are two provisions relevant to the issue of tobacco-free investment, they are:
>
> - 4.7 - 'Government institutions and their bodies should not have any financial interest in the tobacco industry, unless they are responsible for managing a Party's ownership interest in State-owned tobacco industry.'
> - 7.2 - 'Parties that do not have a State-owned tobacco industry should not invest in the tobacco industry and related ventures.'

For more information, please see:

- The World Health Organisation Framework Convention on Tobacco Control: http://www.who.int/fctc/WHO_FCTC_summary_January2015_EN.pdf?ua=1
- The Guidelines: http://www.who.int/fctc/guidelines/adopted/guidel_2011/en/

5.

Human Rights and Tobacco

Almost no cigarette can be guaranteed to be free from child labour.[25]

Scale of the issue

It is estimated that 33 million people are engaged in tobacco farming worldwide.[26] In 2006 the International Labour Organization estimated that children constituted up to 60% of this workforce.[27]

Countries involved

The US department of Labor lists fifteen countries that use child labour to produce tobacco, spanning South America, Central America, Asia, Africa and the Middle East.[28]

A recent report, *Tobacco's Hidden Children - Hazardous Child Labour in the United States Tobacco Farming* by the Human Rights Watch, highlights the presence of child labour on American tobacco farms.[29]

Green Tobacco Sickness

The report also cited that of 141 child tobacco workers (aged seven to seventeen years) from four separate US states, nearly three-quarters of the children interviewed reported symptoms of 'green tobacco sickness.'[30]

'Green tobacco sickness' includes serious symptoms such as nausea, vomiting, headaches, dizziness and breathing difficulties. Longer-term health effects related to pesticide exposure include: cancer, reproductive health issues and problems with learning and cognition.[31]

Unacceptable work conditions

Alongside these significant health effects, exist numerous other risks associated with unacceptable working conditions. These include unreasonable work hours, insufficient water, sanitation and shade, the forced use of dangerous tools and machinery with inadequate safety training and a lack of personal protective equipment.[32]

Child tobacco workers are also subject to other forms of exploitation, such as forced or bonded labour. For example, of an estimated 325,000 children employed in tobacco production in the state of Tamil Nadu, India, it is estimated that 50 % are bonded labourers.[33]

A recent article, *Child farmworkers banned from handling pesticides, but not tobacco*, emphasises the role that a lack of legal protections for collective organising plays in exacerbating the situation. 'Child labor won't end until farmworkers themselves have a safe and effective way to speak out when abuses happen, without fearing retaliation from their employer.[34]

Ineffective initiatives

In October 2000, the Eliminating Child Labour in Tobacco Growing Foundation was established. In 2001, partners from the tobacco corporate sector joined this international initiative.[35] Despite this, little has changed in the past sixteen years, demonstrating 'the contradiction between what the tobacco industry says and what it does.[36]

Impact on Education

Child tobacco labour also has educational implications. Reports on the plight of children forced to work in Malawi's tobacco industry[37] describe that some children are forced to drop out of school to work as tobacco farmers.[38]

Engagement

"Where there has been engagement, it has invariably been counterproductive."

— Professor Mike Daube AO, Professor of Health Policy at Curtin University where he is Director of the Public Health Advocacy Institute and the McCusker Centre for Action on Alcohol and Youth.

Professor Daube has extensive national and international experience in public health. His current roles include President of the Australian Council on Smoking and Health and Co-Chair of the National Alliance for Action on Alcohol. He was Chair of the Australian Government's Expert Committee that recommended tobacco plain packaging. He has been a consultant for WHO, international health organisations and governments in more than thirty countries, and has received numerous awards for his work including the American Cancer Society's Luther Terry Distinguished Career Award.

World Health Organisation directive

"The tobacco industry is not and cannot be a partner in effective tobacco control"- World Health Organisation (WHO).[39]

According to WHO, "A large body of evidence demonstrates that tobacco companies use a wide range of tactics to interfere with tobacco control. Such strategies include direct and indirect political lobbying and campaign contributions, financing of research, attempting to affect the course of regulatory and policy machinery and engaging in social responsibility initiatives as part of public relations campaigns.[40]"

Public relations and attempts to influence policy

According to the 2012 Surgeon General's Report: "The industry uses these efforts to convey to the public, policymakers, judges, and the members of juries that it is doing something substantial about

the issue of youth's tobacco use. In this way, the programs serve to promote positive attitudes about the tobacco industry. Such positive attitudes could help to limit the industry's legal liability and make it easier for its views to be heard on legislative issues."[41]

The Paper, Eliminating child labour in Malawi: a British American Tobacco corporate responsibility project to sidestep tobacco labour exploitation' concluded that in Malawi, transnational tobacco companies are using child labour projects to enhance corporate reputations and distract public attention from how they profit from low wages and cheap tobacco.[42]

As stated in the World Health Organisation Report, Tobacco Industry Interference with Tobacco Control, "Reports from Corporate Accountability International summarize the range of strategies used by the tobacco industry to thwart legislation. They include subverting it and exploiting legislative loopholes, demanding a seat at government negotiating tables, promoting voluntary regulation instead of legislation, drafting and distributing sample legislation that is favourable to the tobacco industry, challenging and stretching government timetables for implementing laws, attempting to bribe legislators, gaining favour by financing government initiatives on other health issues and defending trade benefits at the expense of health."[43]

Marketing, advertising and promotion continues

In 2012 tobacco companies spent $9.6 billion USD – more than $26 million USD a day – on advertising and promotional expenditures for cigarettes and smokeless tobacco.[44]

According to the U.S. Federal Trade Commission, in 2012, cigarette companies spent 4,300 times more on product marketing and promotions than on youth prevention advertisements ($9.6 billion USD vs. $2.2 million USD).[45]

Ineffective campaigns and programs

In an exhaustive review of relevant studies, a comprehensive report released in June 2008 by the U.S Department of Health and Human Services - National Cancer Institute, titled The Role of the Media in Promoting and Reducing Tobacco Use, confirmed that tobacco industry-sponsored youth smoking prevention programs are "generally ineffective" at reducing youth smoking and may have caused some youth to start smoking.[46]

Avoidance of most powerful anti-tobacco themes

A systematic review of mass media campaigns on youth smoking published in 2008 found that tobacco industry-funded youth prevention campaigns had minimal impact on youth smoking because they avoided the most powerful anti-tobacco themes of health effects and industry manipulation.[47]

Prospective Investment Risks

Regulation: 'Unprecedented global cooperation to reduce tobacco use'

Legally Binding Public Health Treaty:

- In recognition of the global 'tobacco epidemic' in 2005 the UN Tobacco Treaty was established, the World Health Organisation Framework Convention on Tobacco Control (WHO FCTC), the world's first global legally binding public health treaty. There are now 180 Parties, representing 89.4% of the world's population,[48] including the European Community, which makes it one of the most widely embraced treaties in United Nations' history. Parties have committed to implementing a broad range of tobacco control measures to address the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke.

Assistance to developing nations:

- Multiple international health organisations (including the World Health Organisation and Bloomberg Philanthropies) are actively working with governments of the developing world to enhance tobacco control regulation and reduce tobacco consumption.

Regulatory developments - May 2016 alone:

- France and the United Kingdom of Great Britain and Northern Ireland each began implementation of plain packaging.[49]
- The US Food and Drug Administration (FDA) finalised a rule deeming tobacco products to be subject to the Federal Good, Drug and Cosmetic Act, which extends the FDA's authority to include the regulation of electronic nicotine delivery systems (such as e-cigarettes and vape pens).[50]
- The European Court of Justice upheld new tobacco control regulations regarding packaging, e-cigarettes and a ban on cigarette flavourings.[51]
- The Australian Government announced four annual 12.5% increases in tobacco excise.[52]

Implementation of the WHO FCTC, as evidenced above, will serve to reduce tobacco consumption worldwide and thus challenge the sales and business of the tobacco industry.

Litigation: 'Class-actions challenge the business model of externalising costs'

Major class actions against tobacco companies continue to pose considerable financial risk to the tobacco industry and challenge the business model, for example:

- In June 2015, a Canadian court ordered three tobacco companies to pay C$15.5 billion ($11.7 billion USD) - the largest award for damages in the country's history. The plaintiffs were Quebec smokers who argued that the companies did not properly warn their customers and failed in their general duty "not to cause injury to another person[53]."

Right: An example of plain brand packaging for cigarettes.

- In May 2016, the family of Hall of Fame baseball player Tony Gwynn filed a wrongful death lawsuit against the tobacco industry. The lawsuit seeks to hold Altria Group, Inc., formerly known as Philip Morris, and other parties accountable for Gwynn's death.[54]
- According to the British American Tobacco (BAT) Annual Report of 2014 the total number of US product liability cases pending was approximately 6,057. They state, 'since many of these pending cases seek unspecified damages, it is not possible to quantify the total amounts being claimed, but the aggregate amounts involved in such litigation are significant, possibly totalling billions of US dollars.' In addition, they warn, 'the consolidated results of operations, cash flows and financial position could be materially affected, in a particular fiscal quarter or fiscal year, by an unfavourable outcome or settlement of certain pending or future litigation.'[55]

The cost of tobacco is estimated at 2.1 trillion Euros per year, equalling the combined expenses of war and terrorism.[56] This is a cost that the tobacco industry could not afford to pay.

Human Rights: 'Tobacco industry use of child labour under the spotlight as supply chains analysed'

A very influential issue of concern when considering tobacco investment has been the use of child labour, particularly the following facts:

- Almost no cigarette can be guaranteed to be free from child labour.[57]
- It is estimated that 33 million people are engaged in tobacco farming worldwide.[58] In 2006 the International Labour Organization estimated that children constituted up to 60% of this workforce.[59]

With many organizations adopting Human Rights Policies, investment in tobacco stands in clear breach of human rights principles.

This issue was recently highlighted in international media, including the *New York Times*,[60] due to a 119-page report released by Human Rights Watch titled, *The Harvest is in My Blood: Hazardous Child Labor in Tobacco Farming in Indonesia*. The Report detailed that thousands of children in Indonesia, some just eight years old, are working in hazardous conditions on tobacco farms. They declared that Indonesian and multinational tobacco companies buy tobacco grown in Indonesia and none do enough to ensure that children are not doing hazardous work on farms in their supply chains.[61]

Reputation: 'The tobacco-free investment movement calls for others to follow'

Investment in tobacco companies implies endorsement of the product itself and of the industry as a whole. There is a growing tobacco-free investment movement. Of significance, in May 2016 the AXA Group announced its decision to divest tobacco industry assets, valued at approximately 1.8 billion Euros.

> Thomas Buberl, Deputy CEO and incoming CEO of AXA stated:
>
> *"We strongly believe in the positive role insurance can play in society, and that insurers are part of the solution when it comes to health prevention to protect our clients. Hence, it makes no sense for us to continue our investments within the tobacco industry. With this divestment from tobacco, we are doing our share to support the efforts of governments around the world. This decision has a cost for us, but the case for divestment is clear: the human cost of tobacco is tragic; its economic cost is huge. As a major investor and a leading health insurer, the AXA Group wants to be part of the solution, and our hope is that others in our industry will do the same."*[62]

This announcement followed the decisions of over 35 Australian Pension Funds to divest tobacco stocks worth over $1.8 billion AUD in just four years, creating what is developing as a 'new normal' in the Australian pension fund community.

Opposite: The Fiduciary Duty Report states that "Fiduciary duty is not an obstacle to action on environmental, social and governance factors."


FIDUCIARY DUTY
IN THE 21ST
CENTURY
United Nations
Global Compact
FINANCE
UNEP INITIATIVE
PRI
Principles for
Responsible
Investment
Inquiry: Design of a
Sustainable Financial System

Common Questions Answered

Investment in tobacco and performance of the stock

Why have tobacco stocks been so profitable?

The tobacco industry significantly relies on child labour in the production of tobacco and has a business model that externalises an estimated 2 trillion Euros of costs each year,[63] while internalising profits. The targeting of developing nations with large youth populations, poorer education levels, less awareness about the dangers of smoking and weaker regulations, including low taxes, has led to a large number of new customers in the past decade. An estimated 80,000-100,000 children start smoking every day, mostly in the developing world.[64]

Shouldn't financial institutions be trying to get the best returns for investment clients rather than allowing ethical considerations to drive investment philosophy?

Despite the apparent profitability of returns in the short-term, there is a clear business case for divestment from tobacco that includes the following prospective risks:

- *Regulation*: Unprecedented global cooperation to reduce tobacco use through the UN Tobacco Treaty: the World Health Organisation Framework Convention on Tobacco Control.
- *Litigation*: Class actions and litigation are challenging the tobacco industry business model of externalising costs.
- *Human Rights:* Tobacco industry use of child labour is under the spotlight as supply chains are increasingly scrutinised.
- *Reputation*: Investment in tobacco companies implies endorsement of the product itself and of the industry as a whole. Businesses across the globe are reconsidering this association.

We encourage investors and leaders of the finance sector to consider the investment from a long-term view, as the risks are most apparent from this perspective.

Research showed recently that CalPERS had foregone $3 billion USD in returns because of its decision to divest from tobacco. Doesn't that prove it's not a good decision?

Considering the profound health impacts of tobacco on our population, and the prospective risks associated with investment, we believe tobacco-free investment is a good decision that aligns with the UN Tobacco Treaty and the efforts of the health and government sectors in attempting to combat the tobacco epidemic.

It should be noted that following the CalPERS controversy, several other large investors subsequently reaffirmed their commitment to remain tobacco-free. In addition, AXA, one of world's largest insurers, announced their decision to implement a tobacco-free investment mandate in May 2016.

Divestment

What can divestment of tobacco hope to achieve?

Divestment can signal disapproval of the tobacco industry and serve to stigmatise tobacco companies. This plays an important role in de-normalising the industry and untangling the association between the 'average worker' and the tobacco industry.

In addition, generating stigma and de-normalisation can lead to greater popular and political support for the introduction of more robust tobacco control policies.

Will divestment of tobacco make the industry go bankrupt?

There is no suggestion that divestment of tobacco will lead to bankruptcy.

Will divestment of tobacco reduce the share price?

Divestment can send a strong signal from investors and may affect share prices. In addition, divestment can draw the attention of analysts who will incorporate factors, including the reasons for divestment, into their analyses and recommendations.

Will divestment of tobacco lead to others profiting?

We are not aware of instances of profits increasing as a result of divestment. In the case of tobacco with many control measures happening simultaneously (regulation restricting point of sale, smoking outdoors, plain packaging, etc.) divestment will be just one factor affecting the industry and stock values.

Could there be a backlash from countries dependent on tobacco revenue, for example in Asia? Can divestment cost jobs and livelihoods in low-income countries like Zimbabwe or Malawi?

We are not aware of instances of backlash from countries involved in tobacco production. It should be noted that 180 Countries are signatories to the UN Tobacco Treaty.

A tobacco-free decision aligns with the efforts of the health and government sectors. Tobacco use is a growing problem for emerging economies, in particular Asia and Africa, with all the health and economic problems that go with it.

Will divestment from tobacco drive illicit tobacco trade further underground? E.g. Indonesia, Malaysia, Vietnam, China, Thailand?

We are not aware of any link between divestment of tobacco stocks and increase in illicit tobacco trade.

Other Undesirable Industries

How is the tobacco industry different from other undesirable industries?

1. *No Safe Use:* There is no safe level of consumption. When used as intended, tobacco will have contributed to the early death of two out of three smokers.[65]
2. *UN Treaty:* In recognition of the global 'tobacco epidemic' (six million deaths worldwide each year[66] and a projected estimate of one billion deaths this century[67]), the United Nations Tobacco Treaty - the World Health Organisation Framework Convention on Tobacco Control - was established. This was the world's first global legally binding public health treaty. 180 Countries are Parties to the Treaty, representing 89.4% of the world's population,[68] which makes it one of the most widely embraced treaties in United Nations' history.
3. *Engagement is futile:* The World Health Organisation has declared, "The tobacco industry is not and cannot be a partner in effective tobacco control".[69] Positive influence of the industry through professional engagement is futile, as the only acceptable outcome would be for tobacco companies to cease their primary business.

Is tobacco really that bad? My grandfather smokes and he's 92.

When used as intended, tobacco will have contributed to the early death of two out of three smokers.[70] While some smokers will live long lives, they are far more likely than non-smokers to have a myriad of serious health problems and a reduced quality of life. In addition, their family members are more likely to suffer the consequences of passive smoking.

Will going tobacco-free 'open the flood gates' to other requests?

The case for tobacco divestment is unique. Our understanding is that making the decision to implement a tobacco-free investment mandate has not led to an increase in requests to divest from other industries or products.

Practical considerations

Is it difficult or costly to implement a tobacco-free investment policy?

As a result of increasing demand for tobacco-free products, fund managers have responded by creating tobacco-free collective investment vehicles. Increasingly these are available to smaller investors in the market (not just the largest institutional investors) and at low cost. In Australia, there are more than a dozen fund managers (some with extensive global operations) that offer tobacco-free mutual funds.

Tobacco Control

Will divestment of tobacco result in fewer smokers?

Tobacco-free investment is a component, and to date, elusive piece, in effective tobacco control. Other tobacco control measures include banning sale of tobacco to children, restricting smoking in venues and plain packaging. All the measures contained in the UN Treaty for tobacco control, which include tobacco-free investment for Governments, are proven to be effective and best practice to protect populations.

What are the world trends in tobacco control?

There are 180 Countries signed to the UN Treaty, representing 89.4% of the world's population, which commits them to implementing a broad range of tobacco control measures.

In addition, multiple international health organisations (including the World Health Organisation and Bloomberg Philanthropies) are actively working with governments of the developing world to enhance tobacco control regulation and reduce tobacco consumption.

In May 2016 alone, we saw the following regulatory developments:

- France and the United Kingdom of Great Britain and Northern Ireland each began implementation of plain packaging.[71]
- The US Food and Drug Administration (FDA) finalised a rule deeming tobacco products to be subject to the Federal Good, Drug and Cosmetic Act, which extends the FDA's authority to include the regulation of electronic nicotine delivery systems (such as e-cigarettes and vape pens)[72].
- The European Court of Justice upheld new tobacco control regulations regarding packaging, e-cigarettes and a ban on cigarette flavourings.[73]
- The Australian Government announced four annual 12.5% increases in tobacco excise.[74]

Are there ideas to end the tobacco epidemic?

There are proposals for a 'Tobacco Free Generation' where a point in time will be decided with those born after the date unable to purchase cigarettes.

Link for more information: http://www.tobaccofreegen.com

A 'Smoker's Licence' has also been proposed which would operate like prescription drugs with additional assistance to quit.

For more information, please see: http://theconversation.com/making-smoking-history-the-case-for-a-smokers-licence-42362

Other options: Environmental Social Governance (ESG) and Socially Responsible Investments (SRI)

Can't we just offer an ESG or SRI option?

Socially Responsible Investments (SRIs) and sustainable investment options are subject to broad and varied interpretations across the industry. They do not represent a defined and enforceable standard that can be trusted by investors and may include tobacco unless an exclusion policy is clearly specified.

In addition, many investors, particularly members of pension funds, are not engaged with their investments and tend to be in default or mainstream options. Many investors, especially members of compulsory pension funds, are not adequately financially literate to make informed decisions.

Why do tobacco companies perform well on ESG ratings?

Many ESG and 'sustainable' ratings are not tools to screen out particular industries or companies, rather a 'best of sector' approach is taken, which sees tobacco companies being rated only against each other. Many rating agencies use a system that awards top marks for at least one company in each sector, which sees tobacco companies with the least negative scores being given A's or five star ratings. In addition, the core purpose and impact of the business is not necessarily considered amongst the ESG/sustainability factors (for example, the fact that tobacco companies sell products that kill two out of three of their best customers[75] may not be considered). Other factors, such as flexible work practices, diversity on boards and employee compensation are rated, which sees several tobacco companies scoring high marks for 'Governance'.

Tobacco Free Portfolios is working with global data providers and rating agencies to revise this methodology.

Engagement

Why can't we use the approach of engagement with tobacco companies, rather than divestment?

The World Health Organisation (WHO) has issued a directive stating that the "The tobacco industry is not and cannot be a partner in effective tobacco control."

According to WHO, "A large body of evidence demonstrates that tobacco companies use a wide range of tactics to interfere with tobacco control. Such strategies include direct and indirect political lobbying and campaign contributions, financing of research, attempting to affect the course of regulatory and policy machinery and engaging in social responsibility initiatives as part of public relations campaigns."

The World Health Organisation has also released a report detailing tobacco industry interference: http://www.who.int/tobacco/resources/publications/Tobacco%20Industry%20Interference-FINAL.pdf

Legality and Personal Choice

Tobacco is a legal product so why shouldn't we invest in it?

Tobacco is legal because of an historical mistake. It is highly unlikely that tobacco would have been made legal had governments at the time known of the extraordinary harm caused by the product.

Tobacco is one of the most highly regulated legal products that exists, as governments across the world implement stricter tobacco controls in an effort to arrest the tobacco epidemic.

Legality is not always an indication of what is right – for example, slavery and Apartheid were both legal at different points in history.

Why don't we just make tobacco illegal?

Many smokers are regretful smokers who continue to smoke because they are addicted to the nicotine in cigarettes (over the years, it has been noted that the amount of nicotine in cigarettes has been increased).[76] In Australia, approximately 40% of smokers try to quit each year.[77] Health experts are focused on helping smokers to quit, not labelling them as criminals.

What about freedom of choice? Don't people have the right to smoke?

Yes – of course they do. We are simply encouraging tobacco-free investment. Tobacco is a children's issue with most smokers starting when they are young (in Pakistan, 40% of the population start smoking before the age of ten years),[78] well before they are able to fully understand the future, life-long risks they will face.

Country Taxes

Do countries really want to see the decline of tobacco when they collect so much from tobacco through tax?

The health treatment costs of smoking far outweigh government revenues from tobacco taxes. In other words, the tobacco industry is a net cost to society, and it may be the only industry in this position.

The additional healthcare costs as a result of smoking outweigh income from tobacco taxes with the total global economic impact from smoking estimated at 2 trillion Euros per year, the same as the cost of armed violence, war and terrorism and more than obesity, alcoholism or climate change.[79]

Fiduciary Duty

We are legally obliged to consider returns so are we even allowed to consider a tobacco-free investment mandate?

Decisions and guidance indicate that fiduciary duty can be maintained whilst implementing tobacco-free investment mandates. This is evidenced by the decisions of over 35 pension funds in Australia, comprising over 300 trustees and directors, implementing completely tobacco-free investment mandates.

Will the concept of fiduciary duty be changing?

According to the Report, Fiduciary Duty in the 21st Century by the Principles for Responsible Investment (PRI) with The United Nations Environment Programme Finance Initiative (UNEP FI), UNEP Inquiry and UN Global Compact, "Fiduciary duty is not an obstacle to action on environmental, social and governance factors."

According to Fiona Reynolds, Managing Director, Principles for Responsible Investment, "Recent studies have broadened the interpretation of fiduciary duty away from the narrow confines of past definitions, and have emphasised that there is no conflict between fiduciary duty and ESG considerations – there is a growing recognition that ESG issues are in fact financially material to a portfolio. Using the status quo as a reason for not integrating ESG is no longer acceptable." (http://www.unepfi.org/fileadmin/documents/fiduciary_duty_21st_century.pdf)

Implementation

Which companies do you classify as tobacco companies?

Tobacco manufacturers only – not retailers or companies associated with packaging, machinery or transport.

How long will it take to implement a tobacco-free investment mandate?

Depending on the complexity of investments, divesting can be as simple as making the request to a fund manager, for others it may involve the selling of stocks, and non-renewal of investments over time.

Why divest from the tobacco industry now?

The expectations of the finance sector are evolving with finance leaders increasingly being called upon to play their part in global priorities.

With more and more people dying of long-term, non-communicable diseases (like cancer, heart disease and respiratory illnesses) and with tobacco the primary risk factor for these diseases, tobacco control is considered a global priority, as articulated in the Sustainable Development Goals.

In addition, many fund members and investors are looking to ensure their own values are aligned with their investments.

Could this be a bad news story when people see how much exposure we had?

To date the decision to go tobacco-free has been largely positively received by members and the investment community. Some organisations have seen the implementation of the decision as an opportunity to highlight the decision and to encourage others to follow. Others have made and implemented the decision without any public announcement.

The Movement

Which other financial institutions have made this decision?

Over 35 pension funds in Australia (combined total assets > $520 billion AUD) now have tobacco-free investment mandates.

The sovereign wealth funds of Australia, New Zealand and Norway are also tobacco-free.

Among mainstream investors, the Dutch pension fund PFZW, CalPERS, CalSTRS and several university endowments in the USA have tobacco-free investment mandates.

In May 2016, AXA announced their decision to divest tobacco industry assets valued at approximately 1.8 billion Euros.

Our Team and Contacts

Tobacco Free Portfolios Team

Dr. Bronwyn King MBBS, FRANZCR, Founder and Chief Executive Officer, Tobacco Free Portfolios, Radiation Oncologist, Peter MacCallum Cancer Centre and Epworth HealthCare

Dr. Bronwyn King is a practicing Radiation Oncologist and Founder and CEO of Tobacco Free Portfolios. Through her collaborative work with the finance industry Bronwyn has played an integral role in the decision of over 30 Australian Superannuation Funds to divest tobacco stocks worth approximately $1.8 billion.

Her work inspired the Global Task Force for Tobacco Free Portfolios, an initiative of the Union for International Cancer Control.

Bronwyn is the Tobacco Control Ambassador for Cancer Council Australia. She represented Australia in swimming and was Team Doctor for the Australian Swimming Team. Bronwyn is an Australia Day Ambassador, an Ambassador for Big Brothers Big Sisters Australia, and in 2014 she was named an Australian Financial Review / Westpac 100 Women of Influence. In 2015 Bronwyn was awarded the VicHealth Award for Preventing Tobacco Use.

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Clare Payne, Chief Operating Officer, Tobacco Free Portfolios,
Founder and Board Member, The Banking and Finance Oath

Clare Payne is Chief Operating Officer of Tobacco Free Portfolios and Founder and Board Member of The Banking and Finance Oath. Initially practicing as an employment lawyer, Clare then managed the Integrity Office of a Global Investment Bank and was awarded the Inaugural Robin Cosgrove Prize for Ethics in Finance by the Observatoire de la Finance, Geneva for her paper titled, 'Ethics or Bust.' Clare also holds the position of Fellow for Ethics in Banking and Finance with The Ethics Centre and teaches business ethics at Macquarie University and The University of Melbourne, Australia. Clare was recognised as a World Economic Forum Young Global Leader in 2014 and was named an Australian Financial Review / Westpac 100 Women of Influence in 2016.

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Dr. Rachel Melsom, UK Director, Tobacco Free Portfolios

Dr. Rachel Melsom is a practicing clinician in Worthing, UK, in the Department of Elderly Care. Rachel started her career in media and finance in the 1980's, culminating in setting up and running her own media consultancy business. She subsequently trained as a doctor in 2008, with a desire to bring together the health and financial issues impacting on sustainable healthcare. Rachel also has a degree in Genetics, is a Business Leader with Founders 4 Schools, and has an active interest in developing technology to aid healthcare and training.

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CalPERS Stakeholder Relations

From: James Currie <JCurrie@coausphs.org>
Sent: Monday, November 07, 2016 12:36 PM
To: CalPERS Stakeholder Relations
Subject: Tobacco Stock Divestment
Attachments: doc00533320161107153547.pdf

Please see the attached letter. Thanks.

James T. (Jim) Currie, Ph.D
Colonel, USA (Ret.)
Executive Director
Commissioned Officers Association of the U.S. Public Health Service and
PHS Commissioned Officers Foundation for the Advancement of Public Health
8201 Corporate Drive, Suite 1170
Landover, MD 20785
(301) 731-9080

Commissioned Officers Association
of the U.S. Public Health Service

November 8, 2016

Office of Stakeholder Relations
CalPERS
400 Q Street
Sacramento, CA 95811

Dear CalPERS:

I recently attended the annual meeting of the American Public Health Association, and while there I heard that CalPERS is thinking about ending its ban on investments in tobacco and tobacco-related corporations. I hope that you will not do this for two reasons: (1) you will not gain investment income by providing financial support to entities that are killing hundreds of thousands of people a year with their products, and (2) you have such a presence in the world of investment that your decision might well trigger a stampede in that direction.

I address the first of these by saying that I direct a non-profit which divested itself just over 30 months ago of all tobacco and tobacco-related and e-cigarette-related stocks and bonds. Since that time we have found that our portfolio has performed as well as it did before the divestiture and has done as well as the stock indices that we follow.

Second, you all are the 500 pound gorilla in the room, and what you do greatly influences other institutional investors. If you abandon your principled stand against tobacco, then others may well follow your lead. That would be a disaster, because tobacco is still the worst public health problem in our country. It is a killer that costs billions of dollars and hundreds of thousands of lives. I doubt that there are many families that have not been touched by this plague.

I therefore urge you to back off from any thought of ending your anti-tobacco policy. You don't need to do it for investment reasons, and you should not do it for public health reasons.

Sincerely,

James T. Currie

Col. James T. Currie, USA (ret.)
Executive Director

8201 Corporate Drive, Suite 1170, Landover, Maryland 20785 • (301) 731-9080 • FAX (301) 731-9084

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May 14, 2016

Henry James
Chair, CalPERS Investment Committee
400 Q Street
Sacramento, CA 95811

Dear Mr. James,

I am writing to urge CalPERS, in the strongest possible terms, maintain its current policy of not investing in tobacco stocks. Such an investment will undermine California's longstanding tobacco control program, which will increase the amount of disease and death in California and would be in direct opposition of longstanding public policy in California to reduce tobacco use.

Denormalization of the tobacco industry has been a central strategy of the successful California tobacco control program since the very beginning of it after the voters stood up to Big Tobacco when they passed Proposition 99 in 1988. This theme remains a key element of the program to this day, as outlined in the current Master Plan for the California Tobacco Control Program.[1]

Continuing to support California's public policy of reducing tobacco use makes economic sense. Between FY 1989 and 2008 the California Tobacco Program led to cumulative savings in medical costs expenditure of $134 billion,[2] including money saved for CalPERS. Indeed, the fact that California's smoking rate is below the national average was associated with it spending $15.3 billion less on medical costs in 2009 alone.[3]

In addition to these obvious issues, CalPERS needs to carefully address possible undisclosed conflicts of interest for your investment advisors, Wilshire Associates, who have also worked for Philip Morris in the past, including helping them muster arguments against divestment in the late 1990s.[4] This is particularly concerning because the tobacco companies have a history of using seemingly "independent"

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[1] State of California Tobacco Education and Research Oversight Committee. *Changing Landscape, Countering New Threats 2015 -2017.* http://www.cdph.ca.gov/programs/tobacco/Documents/TEROC/Master%20Plan/MasterPlan_15-17.pdf

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[4] https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=jnjn0071 and https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=mnjn0071

investment advisors to provide testimony that supports industry interests to policy makers, as we described in our 2004 paper "The tobacco industry's use of Wall Street analysts in shaping policy."[5]

Another reason is that the tobacco companies are established racketeers under the federal Racketeer Influenced and Corrupt Organizations Act, and still under the supervision of Federal Judge Gladys Kessler.

The *Sacramento Bee* summed up the situation appropriately when it wrote:

> In 2008, when the California State Teachers' Retirement System contemplated reinvesting in tobacco, then-Treasurer Bill Lockyer issued a statement that summed up why it shouldn't:
>
> "In this country, the tobacco industry has a history of fraud and disregard for public health. That culture of deception has been exported to Europe, Asia and other parts of the globe, where the industry's marketing targets children."
>
> Lockyer won then. His successor, Treasurer John Chiang, is taking the same stand, as is controller and fellow CalPERS board member Betty Yee.
>
> "No public pension fund should associate itself with an industry that is a magnet for costly litigation, reputational disdain, and government regulators around the globe," Chiang said in a statement. The rest of the CalPERS board ought to follow Chiang and Yee's lead.[6]

At the very least CalPERS needs to do a thorough investigation of conflicts of interest for Wilshire (it took me less than 5 minutes to find the two cite documents in the UCSF Truth Tobacco Documents Library (http://industrydocuments.library.ucsf.edu/tobacco) as well as conduct a comprehensive analysis of the impacts that such a decision would have on all of CalPERS' responsibilities, including its impact on the State of California as a whole.

At a time that the Legislature has ended years of domination by tobacco interests[7] and passed a package of five strong tobacco control bills, it is, frankly, astonishing, that CalPERS is even considering this retrograde policy.

Sincerely yours,

Stanton A. Glantz, PhD
Professor of Medicine
Truth Initiative Distinguished Professor in Tobacco Control
Director, Center for Tobacco Control Research and Education

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[5] Alamar BC1, Glantz SA. The tobacco industry's use of Wall Street analysts in shaping policy. Tob Control. 2004 Sep;13(3):223-7. Available at http://www.ncbi.nlm.nih.gov/pubmed/15333876.

[6] Editorial Board. CalPERS should not take up the tobacco habit again. *Sacramento Bee*. April 6, 2016. Available at http://www.sacbee.com/opinion/editorials/article70340952.html

[7] Cox E, Barry R, Glantz S, Barnes RL. *Tobacco Control in California, 2007-2014: A Resurgent Tobacco Industry While Inflation Erodes the California Tobacco Control Program.* UCSF Center for Tobacco Control Research and Education. 2014. Available at http://escholarship.org/uc/item/4jj1v7tv