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Perspective

The Ethics of Not Hiring Smokers

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Finding employment is becoming increasingly difficult for smokers. Twenty-nine U.S. states have passed legislation prohibiting employers from refusing to hire job candidates because they smoke, but 21 states have no such restrictions. Many health care organizations, such as the Cleveland Clinic and Baylor Health Care System, and some large non–health care employers, including Scotts Miracle-Gro, Union Pacific Railroad, and Alaska Airlines, now have a policy of not hiring smokers — a practice opposed by 65% of Americans, according to a 2012 poll by Harris International. We agree with those polled, believing that categorically refusing to hire smokers is unethical: it results in a failure to care for people, places an additional burden on already-disadvantaged populations, and preempts interventions that more effectively promote smoking cessation.

One justification for not employing smokers, used primarily by health care organizations, is symbolic. When the World Health Organization introduced a "nonsmoker-only" hiring policy in 2008, it cited its commitment to tobacco control and the importance of "denormalizing" tobacco use. Health care organizations with similar policies have argued that their employees must serve as role models for patients and that only nonsmokers can do so.

A second, more general, argument is that employees must take personal responsibility for actions that impose financial or other burdens on employers or fellow employees. Accordingly, smokers should be responsible for the consequences of their smoking, such as higher costs for health insurance claims, higher rates of absenteeism, and lower productivity. These costs amount to an estimated additional $4,000 annually for each smoking employee.

Yet it seems paradoxical for health care organizations that exist to care for the sick to refuse to employ smokers. Many patients are treated for illnesses to which their behavior has contributed, including chronic obstructive pulmonary disease, heart failure, diabetes, and infections spread through unprotected sex or other voluntary activities. It is callous — and contradictory — for health care institutions devoted to caring for patients regardless of the causes of their illness to refuse to employ smokers. Just as they should treat people regardless of their degree of responsibility for their own ill health, they should not discriminate against qualified job candidates on the basis of health-related behavior.

The broader claim that it is

fair to exclude smokers because they are responsible for raising health care costs is too simplistic. It ignores the fact that smoking is addictive and therefore not completely voluntary. Among adult daily smokers, 88% began smoking by the time they were 18,[1] before society would consider them fully responsible for their actions. Much of this early smoking is subtly and not so subtly encouraged by cigarette companies. As many as 69% of smokers want to quit,[2] but the addictive properties of tobacco make that exceedingly difficult: only 3 to 5% of unaided cessation attempts succeed.[3] It is therefore wrong to treat smoking as something fully under an individual's control.

In addition, all other diseases — and many healthful behaviors — also result in additional health care costs. People with cancer burden their fellow workers through higher health care costs and absenteeism. People who engage in risky sports may have accidents or experience trauma routinely and burden coworkers with additional costs. Having babies increases premiums for fellow employees who have none. Many of these costs result from seemingly innocent, everyday lifestyle choices; some choices, such as those regarding diet and exercise, may affect cancer incidence as well as rates of diabetes and heart disease.

We as a society have rejected the notion that individuals should be fully responsible for their own health care costs. In instituting health insurance, we acknowledge the fragility of health and the costliness of restoring it, and we minimize catastrophic consequences. The United States has chosen to pool risk predominantly through employers rather than the government. Consequently, U.S. law requires firms with more than 50 employees to provide risk-pooled insurance.

Finally, although less than one fifth of Americans currently smoke, rates of tobacco use vary markedly among sociodemographic groups, with higher rates in poorer and less-educated populations. Some 42% of American Indian or Alaska Native adults smoke, but only 8% of Asian women do. Among adults with less than a high school education, 32% are smokers; among college graduates, smoking rates are just over 13%. More than 36% of Americans living below the federal poverty line are smokers, as compared with 22.5% of those with incomes above that level. Crucially, policies against hiring smokers result in a "double whammy" for many unemployed people, among whom smoking rates are nearly 45% (as compared with 28% among Americans with full-time employment).[4] These policies therefore disproportionately and unfairly affect groups that are already burdened by high unemployment rates, poor job prospects, and job insecurity.

So what should employers do? We believe that offering support for healthful behaviors is the best approach. Central in this regard is assisting employees by providing evidence-based smoking-cessation programs, removing cost barriers, facilitating access, and providing necessary psychological counseling and other support. For example, many employers, such as Walgreens, provide free nicotine-replacement therapy and smoking-cessation counseling to employees.

Recent research also indicates that financial incentives can effectively promote smoking cessation. For example, a randomized, controlled trial involving employees of General Electric showed that a combination of incentives amounting to $750 led to cessation rates three times those achieved through information-only approaches (14.7% vs. 5.0%).[5]

But General Electric's experience also reflects the political challenges of instituting policies regarding smokers. When the company decided to provide the program to all employees, nonsmokers objected to losing out on what would effectively be lower insurance premiums for their smoker colleagues. In response, the company replaced the $750 reduction with a $625 surcharge for smokers.[5]

Just like policies of not hiring smokers, penalties imposed on smokers raise serious ethical and policy concerns. The Department of Labor is considering whether to permit employers to penalize smokers with a surcharge of up to 50% of the cost of their health insurance coverage (typically more than $2,000 per employee per year). Yet even rewards for quitting are hard to sell to nonsmokers, who might also object to free smoking-cessation programs that they subsidize indirectly through their insurance premiums. Underlying such opposition is a distorted notion of personal responsibility and deservedness, according to which refraining from smoking results from willpower and active choice alone. Although some employees may be nonsmokers through such efforts, most should have the humility to recognize that "there but for the grace of God go they."

Given nonsmokers' resistance, it would be helpful if employers providing smoking-cessation support engaged in early outreach

emphasizing that helping smokers to quit adheres to the principle of risk pooling underlying health insurance. Successful cessation programs could lead to higher productivity and lower insurance contributions for nonsmokers, thereby benefiting all employees.

The goal of reducing smoking rates is important. Although smoking rates among U.S. adults have decreased from 42% in 1965 to 19% today,[5] more remains to be done, particularly for low-income and unemployed populations. Promoting public health is a shared responsibility, and employers have a social obligation to contribute to the public health mission outlined by the Institute of Medicine: "fulfill[ing] society's interest in assuring conditions in which people can be healthy." By cherry-picking "low-risk" employees and denying employment to smokers, employers neglect this obligation, risk hurting vulnerable groups, and behave unethically. The same goes for imposing high penalties on smokers under the guise of providing wellness incentives.

We believe that employers should consider more constructive approaches than punishing smokers. In hiring decisions, they should focus on whether candidates meet the job requirements; then they should provide genuine support to employees who wish to quit smoking. And health care organizations in particular should show compassion for their workers. This approach may even be a win–win economic solution, since employees who feel supported will probably be more productive than will those who live in fear of penalties.

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