Determinants of Policy on Smoking and Health

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Smoking cigarettes is arguably the greatest public health hazard in developed countries and may become so in much of the developing world. The International Agency for Research on Cancer (IARC) identifies some 30 diseases or groups within ICD rubrics as being positively associated with smoking, most causally. Excess deaths attributable to smoking run into tens of thousands every year in the UK alone.

Faced with this scourge governments have appeared to act with an almost uniform timidity: ‘paltry and hesitating’ even in the measured language of the Royal College of Physicians. Many critics however do not understand the factors which government weigh in formulating policies. In this article I try to describe simply these often competing determinants, and government’s response to them, since the results of the early case-control studies on lung cancer and cigarette smoking became parliamentary currency in 1951.

I deal exclusively with the UK where I have been concerned in the government’s principal scientific advisory machinery as a member, and from 1981 chairman, of the Independent Scientific Committee on Smoking and Health. Comparison with practices in other countries would be instructive but is beyond the scope of this review.

THE VIEW FROM GOVERNMENT

The mounting evidence during the early 1950s incriminating cigarette smoking in lung cancer set difficult problems for government, the tobacco industry, the medical profession, and (not least) the smoker. The critical factors were seen to be:

(i) smoking was widespread: in 1950, 77% of men and 38% of women smoked, mostly (in the case of women exclusively) cigarettes;

(ii) smoking was not a passing fad but a widely accepted and growing habit;

(iii) tobacco products were advertised without restraint and lawfully marketed to all over 15,

(iv) the public favoured strong, non-filtered cigarettes,

(v) the irritant properties and alien aroma of tobacco smoke were offensive, but not harmful to non-smokers,

(vi) death rates from lung cancer were increasing sharply, especially in men; and

(vii) cigarette smoking and lung cancer risk were seemingly dose-related with no threshold effect.

Medical and some lay opinion considered that these demanded action; it was less certain what this action should be. Government on the other hand was instinctively cautious since each of the above had a wider, political, perspective. Thus (i) above, to the doctor an index of high and increasing public health risk, was to the politician a measure of the widespread popularity of smoking. There was no popular mandate to move against it, only political risk. For (ii), nicotine was known to be an habituating drug but in the (small) doses involved in smoking it was considered to be harmless. Moreover, like alcohol, it had a long history of popular acceptance. Addictive or habituating properties, however, were not per se a ground for action; that nicotine acts as a proxy for harmful tobacco products and could be considered on this basis was too subtle a concept for an unreceptive legislature. For (iii), the facts did not warrant any infringement of the industry’s existing commercial freedom. For (iv), there was no reliable evidence relating strength of tobacco products to their toxicity. For (v), tobacco smoke, while offensive to a minority, harmed only the smoker, and self-poisoning was no longer a crime. Furthermore, the putative tobacco-related diseases were non-contagious. As then seen by government the smoker polluted nothing and infected nobody: to constrain his smoking may or may not have protected his inalienable right to life but would certainly have infringed his equally inalienable rights to liberty and the pursuit of happiness! Even for (vi) and (vii) the message was qualified: for (vii) the evidence was tenuous until
the results of later prospective studies; while the role of smoking in (vi) had many distinguished sceptics — including R.A. Fisher, Circumspection, but not inaction, was adopted as government’s watchword. In 1951 they responded to the initial incriminating research findings by referring the matter to their Standing Advisory Committee on Cancer and Radiotherapy, then to a panel under the Government Actuary, meanwhile stonewalling in parliament. Then, as the facts became incontrovertible and on the advice of the Chief Medical Officer (CMO), the Minister of Health (Iain Macleod) on 12 February 1954 stated ‘I accept the [Standing] Committee’s view that the statistical evidence points to smoking as a factor in lung cancer ...’. He now moved positively if cautiously and counselled further research, announced a research grant of £250,000 from the tobacco companies to the Medical Research Council, and waited on events. It is true that tobacco duty (then some 30% of all government taxes on expenditure and 12% of total government revenue) gave government a vested interest and that introducing even a degree of substitute taxation would have been difficult and unpopular in the fiscal circumstances of the time, but even in retrospect the initial government response seems judicious rather than supine.

Supine or judicious, certain principles were clear and were acted on. The young had to be protected; the Children and Young Persons Act, 1933, forbad tobacco sales to children under 16 years and though widely flouted by inanimate vending machines and animate retailers alike (the average annual prosecutions under the Act, 1945–52, was only 201), it was considered adequate in the circumstances. The public had to be told the medical facts, and here government were to their detractors neglectful. They were certainly wary. Despite heavy pressure in and out of parliament they refused to sponsor or encourage supporters scrupulous, to their detractors neglectful. They still however saw themselves as judicious rather than supine. With the harsh judgement of hindsight government, in their policies on smoking, were poor custodians of the public health in the 1950s and 1960s. Smoking-related diseases rose inexorably. Much of this increase was due to earlier exposure for which post-1950 governments could not be blamed, but the number of the young entering the smoking ranks could be affected by government policies and here the situation had grossly deteriorated: the percentages of men who smoked in (vi) had many distinguished sceptics — including R.A. Fisher, Circumspection, but not inaction, was adopted as government’s watchword. In 1951 they responded to the initial incriminating research findings by referring the matter to their Standing Advisory Committee on Cancer and Radiotherapy, then to a panel under the Government Actuary, meanwhile stonewalling in parliament. Then, as the facts became incontrovertible and on the advice of the Chief Medical Officer (CMO), the Minister of Health (Iain Macleod) on 12 February 1954 stated ‘I accept the [Standing] Committee’s view that the statistical evidence points to smoking as a factor in lung cancer ...’. He now moved positively if cautiously and counselled further research, announced a research grant of £250,000 from the tobacco companies to the Medical Research Council, and waited on events. It is true that tobacco duty (then some 30% of all government taxes on expenditure and 12% of total government revenue) gave government a vested interest and that introducing even a degree of substitute taxation would have been difficult and unpopular in the fiscal circumstances of the time, but even in retrospect the initial government response seems judicious rather than supine.

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* This was for 1956 and 1971; reliable prior data are not available. For manufactured cigarettes, the almost exclusive tobacco product smoked by women, the 1951 and 1971 figures were 28% and 48%.
the tobacco manufacturers spent some £63m on advertising and sales promotion, government and its agents less than £0.5m. Small wonder the CMO (George Godber) called this situation 'incredible'. Moreover, during these two decades tobacco products relative to wages had become much cheaper, the rate of duty had hardly changed, and tobacco taxation as a proportion of total expenditure on tobacco products actually declined. Not surprisingly tobacco consumption increased during the 1950s and when it did start to fall in the mid-1960s it was mainly in higher social class men and in response to medical opinion. Of the seven courses of 'possible action by government' recommended in Smoking and Health in 1962, at most only three had been acted on by 1970. A far more forceful policy from government was needed and was soon to be demanded with medical professional bodies in the van.

THE VIEW FROM INDUSTRY

The demonstration of the association of smoking with disease had immense implications for the whole tobacco industry. Its common policies, and those of its principal constituents, are only known from actions and statements; much crucial material lies in classified and restricted archives. It is, however, broadly true to say that the tobacco manufacturing industry has followed a two-prong policy: (i) to make cigarettes 'safer' (or putatively 'safer') to smoke — in this way the increasingly health-sophisticated public might continue to smoke them; and (ii) to market alternative tobacco products for those who wished to remove themselves from the hazards of smoking cigarettes without at the same time removing themselves from the pleasure of smoking. Naturally the manufacturing companies competed vigorously with each other for market share, and naturally they also robustly defended their perception of their shareholders' interests, and their fiduciary responsibilities, in their dealings with government, the medical profession, and the public. They had, however, and still have, no desire to sell a harmful product either in the shorter or longer term when they can sell a 'safer' one, and they invested very heavily in research and development into tobacco toxicity as well as product acceptability. In 1954, under government pressure, they gave £250,000 (over seven years) to the MRC 'for research into the causes of lung cancer'; in 1956 they coordinated their research through a Tobacco Manufacturers' Standing Committee (the Tobacco Research Council since 1963, now the Tobacco Advisory Council), in 1962 they opened research laboratories at Harrogate with 250 staff, by 1969 they had committed some £6 million in out-of-house research over and above their in-house R and D, and today they are by a very long way the largest sponsors of research into smoking and health in the UK. Though much of their effort is directed to their credo that most smokers will continue to smoke some form of tobacco unless deterred by its continued toxicity, a credo justified by events certainly until the 1970s, they have substantially increased our knowledge of nearly every aspect of tobacco toxicity. The industry, therefore, found themselves in part-chorus with government, the smoking public, and the medical profession: all wanted safer smoking but for different reasons! They were however in discord over anti-smoking objectives which were seen at the time in very simple, and in retrospect simplistic, terms.

How well in the 1950s and 1960s did the policies of the tobacco manufacturers succeed? Undoubtedly very well. Aggressive marketing converted the smoking population to filter tips: 2.3% of all tobacco products by weight in 1956 they were 64.5% in 1970 by which time four of every five cigarettes smoked was filtered. Each cigarette was 'safer' than its unfiltered counterpart less through absorption of noxious substances than because the filter tip displaced a significant weight of tobacco. To compensate for this tobacco loss more cigarettes were bought; between 1956 and 1970 the total weight of cigarette tobacco consumed declined by 9.6% but the number of cigarettes sold increased by 28.5%. Furthermore, the industry's second prong — developing alternative products — was also successful. In 1961 the number of 'cigars and cigarillos' sold was 315 million; in 1967, only six years later, it was 1135 million, meeting the demands of many ex-cigarette smokers not least doctors. While all the time the industry was garnering information through its substantial R and D programmes and supplying, and to an extent creating, the smoking market's needs. Its success was as marked as was the failure of the government's anti-smoking policies.

THE NEW INITIATIVES

In the early 1970s renewed pressure in parliament and from the profession forced government's hand. Their first action, in March 1970, was necessary though modest: they appointed a Senior Medical Officer to coordinate inter-departmental work on smoking and health. More significant action was not long delayed: in June 1971 the Minister (Keith Joseph) announced details of an agreement with the industry on the labelling of cigarette packets and adverts with appropriate health warnings. This was the first of the 'voluntary agreements' — portrayed as gentlemen's agreements they were (and are) toughly negotiated compromises — presaged four years previously by which to the present
day government has sought to effect its smoking and health policies in preference to enforced action.

Government now acted with more vigour. They had, since 1954, warned of the risk to cigarette smokers of lung cancer; now in 1973 they told the public which cigarette brands contained the most tar and nicotine by publishing a brand league table — which is now a biannual series with (from 1984) carbon monoxide yields added. They also, belatedly, recognized the need for systematic and above all impartial scientific advice, and in 1973 established the Independent Scientific Committee on Smoking and Health (ISCSH): 'independent' in that its members are not from government, the civil service or industry, are unpaid, and it reports directly to the health ministers; and 'scientific' in that the members are prominent scientists from cognate disciplines and the Committee's advice is based wholly, necessarily, and exclusively on the scientific evidence without regard to any other consideration. Its general terms of reference are to advise the health ministers 'and where appropriate, the tobacco companies' on the scientific aspects of matters concerning smoking and health. It has no role in making recommendations on other prongs of government policy, ie in advertising products or in fiscal policy, though it has a role in commenting where relevant on health appraisal and health education. Apart from ad hoc advice it has published four scientific reports which have had considerable influence on government policy,50-53 with up to £7 million supplied by TAC under the 1980 and 1984 voluntary agreements it sponsors, through the Tobacco Products Research Trust, 25 research projects, and has sponsored an international symposium on the role of nicotine in the product modification programme54 and is organizing another on the role of smoking in hormone-related diseases.

This Committee at once tackled the basic irony of smoking, namely that most scientists agree (with the exception of one important group55) that it is tar that confers undoubted benefit to smokers and may improve the role of smoking in hormone-related diseases. A priori modification) based on increasingly sound toxicology of additives. In July 1977 two large tobacco manufacturers marketed cigarettes containing respectively the 'substitutes' Cytrel and New Smoking Material (NSM) — these cigarettes were a commercial failure and were eventually withdrawn losing for the companies concerned many millions of pounds, for a decade something of their zeal for such radical change, and possibly something of their admiration for the fledgling ISCSH! This caused some strain but government, wisely in my view, resisted pressure for more rigorous alternative action, and in many ways endorsed its own faith in voluntary agreements. Government in fact had come a long way since 1970: it now had a clear and agreed scientific policy (product modification) based on increasingly sound a priori grounds; it had the means of implementing it (voluntary agreements); and it had reasonably coherent general strategies. Most importantly it has supported the ISCSH: it has widened its terms of reference, has only once failed to accept the Committee's advice and that unimportantly,56 and in March last year accepted the recommendations in the Committee's Fourth Report. If government was laggardly up to 1970 it has since done more, and often much more, than most advanced
countries and in the past decade has seen its policies produce a 25% reduction in total smoking, an average tar reduction per cigarette of 30%, a substantial decrease in lung cancer in younger age groups, and the transition of smoking from social norm to a minority indulgence. Only in the lower socioeconomic groups and in young women has progress been disappointing. It is mere speculation as to whether the more robust measures that some recommend would have produced more beneficial results or been counterproductive.

Having failed with substitutes the Committee, government and the industry espoused systematic gradualism. Under repeated voluntary agreements sales-weighted tar, nicotine and toxic gases were reduced gradually, tar most of all (Table I). Full details of this product modification programme are in the Committee's Fourth Report. Briefly, there are two pre-conditions for its success. First, that the Committee's scientific assumptions are correct: these are, that the noxious materials in tobacco are in the tobacco tar and/or are products of its combustion; and that there is a dose response with the diseases they cause (most particularly lung cancer) without a significant threshold of safety. Second, that the programme develops in the context of an increasingly sympathetic environment for less smoking and for lower-tar products and is not so ambitious as to prompt significant resistance from the consumer. This 'consumer resistance' operates through so-called 'compensatory smoking', ie mechanisms by which the smoker maintains the nicotine dosage which his body is conditioned to need for optimum efficiency, effectiveness, and contentment. It is a crucial phenomenon and is briefly as follows.

There are three main mechanisms: first, the smoker can simply smoke more cigarettes; second, he can switch to a stronger brand; third, he can 'oversmoke' a cigarette — longer and more frequent pulls, shorter butts, etc. Each of these increases his tar exposure; combating them is a cornerstone of the Committee's policies. The ISCSH can have little to say on obvious measures to limit the number of cigarettes confirmed smokers smoke other than in health awareness fields but it can adopt policies with respect to the other two mechanisms of 'compensatory smoking'. One such means is to ensure that stronger brands are not on the market. For some years this has held for new brands, but last year ISCSH recommended an upper tar limit of 16mg per cigarette for all brands 'as soon as possible' and reducing to 14mg after four years. Another is to gradually reduce tar levels in popular brands though without risking significant switching to higher tar brands. This is being done by ingenious tobacco technology. Another is to develop the market for low tar cigarettes by selective advertising and brand promotion supplementing the health education message. The industry, despite its critics, has been active: by February 1986, 33 of 138 brands included in the Laboratory of the Government Chemist biannual survey were low tar (0—9.99mg per cigarette) as against 19 of 114 ten years previously, though since about 1980 their market share has plateaued at about 13%. (Some are unhappy with 'selective' advertising on the grounds that it is still advertising of tobacco: this issue is too complex to discuss here). Yet another is to exploit the desire for nicotine of irrevocable smokers as a means of reducing their tar exposure: since nicotine plays an important role in influencing 'compensatory smoking' it follows that by maintaining the nicotine yields of cigarettes while pari passu lowering the tar yield (by sophisticated tobacco and cigarette technology), tar intake can be reduced more than by lowering nicotine and tar in equal proportions. This in fact has been pursued over the last few years (Table I).

There are technological limits to this approach and it sets moral, philosophical, and political problems concerning using an habituating drug in this way especially in the young and new smoker, as recently discussed; nevertheless the Committee recommends some limited trials.

This product modification policy based on gradualism has proved robust and effective. The low tar programme has contributed significantly to the reduction in lung cancer mortality in the younger age groups (who have not been exposed to high tar products in their shorter smoking history) and possibly also to the reduction in chronic obstructive airway disease. Its role in ischaemic heart disease, however, is equivocal. Further information will emerge from on-going studies worldwide including many of the 25 projects sponsored by the Tobacco Products Research Trust on behalf of ISCSH.

### Table 1 Annual sales-weighted tar, nicotine, and carbon monoxide yields (mg/cigarette) of manufactured cigarettes in the UK

<table>
<thead>
<tr>
<th>Year</th>
<th>Tar</th>
<th>Nicotine</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1934-40</td>
<td>32.9</td>
<td>2.00</td>
<td>18.6</td>
</tr>
<tr>
<td>1955-61</td>
<td>30.4</td>
<td>2.03</td>
<td>20.6</td>
</tr>
<tr>
<td>1965</td>
<td>31.5</td>
<td>2.08</td>
<td>18.8</td>
</tr>
<tr>
<td>1970</td>
<td>22.5</td>
<td>1.56</td>
<td>17.1</td>
</tr>
<tr>
<td>1975</td>
<td>17.9</td>
<td>1.34</td>
<td>16.2</td>
</tr>
<tr>
<td>1980</td>
<td>16.3</td>
<td>1.30</td>
<td>16.6</td>
</tr>
<tr>
<td>1982</td>
<td>15.4</td>
<td>1.32</td>
<td>15.2</td>
</tr>
<tr>
<td>1984</td>
<td>14.6</td>
<td>1.28</td>
<td>14.1</td>
</tr>
<tr>
<td>1985</td>
<td>14.4</td>
<td>1.31</td>
<td>14.7</td>
</tr>
<tr>
<td>Now*</td>
<td>13.55</td>
<td>1.21</td>
<td>14.42</td>
</tr>
</tbody>
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CURRENT PERCEPTIONS

Anti-smoking groups argue that the above approach merely plays at the margins. They seek more direct government action including draconian increases in tobacco duty arguing that until about 1980 tobacco products were becoming cheaper in terms of disposable income, that tobacco taxation as a share of total expenditure on tobacco products was actually falling, and that swingeing increases in duty had helped control the gin-swilling epidemic in the mid-eighteenth century. They also emphasize that the perceptions on which government originally devised its strategies have drastically changed especially since the early 1970s. These two contentions are now examined together with recent proposed EC Directives.

Change in Strategic Perceptions

Of the seven 'critical points' listed at the start of this article and which influenced government policy in the 1950s, all but two had changed by the 1980s; some through government action. The two which remain as irrefrangible fact are: the non-contagious nature of tobacco-related diseases; and the acceptance of a low or zero threshold effect of cigarette smoking and lung cancer. Such a dramatic change in strategic perceptions would alone make a reassessment of policy timely; recently government has merely pressed on along established paths and tightened existing screws. There is another, more pressing, reason, viz environmental tobacco smoke (ETS, also called 'passive' or 'involuntary' smoking) has since 1986 been generally accepted as a health hazard: a (small) increased risk of lung cancer in consistently exposed non-smokers, and respiratory symptoms, episodes of respiratory illness, and decrements in lung function in similarly exposed young children. The argument that smokers poison only themselves (or their unborn children?) can no longer be convincingly sustained. The conceptual framework within which government, industry, and the profession have worked, is fundamentally changed. Naturally the industry opposes the belief that ETS is harmful to health and seeks vigorously to dismiss the supportive scientific findings as methodological artifacts, and some workers agree. It is easy to see why the industry's opposition is total. It is also easy to see why many call for more dynamic action from government. It is, however, less easy to foresee how and to what extent government will respond. In March 1987 they accepted the ISCSH Interim Statement incriminating ETS and in March 1988 also the Committee's Fourth Report (including a detailed re-statement of its earlier position) now with specific recommendations, which will probably form a basis for formulation of government policies. Only one of these, viz possible segregation of smokers from non-smokers in work and indoor leisure environments may lead to more direct action. The question of ETS is undoubtedly the most difficult one for the tobacco industry and its formal and informal regulators since the causal association of cigarette smoking and lung cancer was demonstrated.

Tobacco Duty

The effect of changes in overall cigarette price (largely dictated by tax) on the amount and distribution of smoking is, like that of advertising, complex. Some facts are not in dispute. Tobacco tax though far from a negligible source of revenue — equivalent in 1986–7 to about 4p on the basic rate of income tax or raising VAT from 15% to 20% — now provides only some 4% of government revenue as against over 16% 40 years ago: VAT and petroleum revenue tax are greater. Cigarettes are far cheaper now in terms of wage rates and at least 25% below their 1948 price level in real terms. Low income groups spend a larger proportion of their income (on average) in taxes on tobacco but they reduce their smoking more in response to tax increases; some even hold that the downward drift in real cigarette prices has been a major factor in widening the gap between upper and lower class smoking patterns and largely negating the benefits of health education programmes. Furthermore, if, against the evidence, tax increases led to diminishing returns, losses could now easily be recouped from other sources. Econometricians have recently tried to quantify the relationships with varying results though most agree that the higher the price of tobacco the less will be smoked and that there would be no significant diminishing tax returns in the shorter run. One group suggested that a 10% real increase in taxation would cut tobacco consumption by 5–6% and increase tobacco revenue by up to 7%. This would be a highly desirable public health outcome: better health and more tax revenue! Why then has government been reluctant to sanction significant increases in tobacco excise duty (there was a 16% increase between 1980 and 1981 but since then the average increase in real duty per cigarette has only marginally exceeded inflation) or institute a full-blooded policy of differential duty dependent on tar strength — that on cigarettes yielding more than 20mg tar, imposed in September 1978, was withdrawn in 1981 — especially since the net effect on the overall economy by further reduction in tobacco manufacturing and distributing activity would be minor. The main reasons seem to be: (i) a political caution at 'over-taxing' what is still a widely practiced indulgence (alcohol is a similar case), (ii) a belief that if price response is low then tobacco
tax is regressive and socially inequitable, and (iii) its effect on RPI. The first lies in social attitudes which can and should be changed. Recently (ii) has been challenged, and (iii) may be that modern work will remove the 'regressive' argument. While on (iii) a recent government estimate is that an increase of 30p duty on a packet of 20 cigarettes would increase RPI by 0.7%. The economic argument against fiscal measures to reduce smoking is not impressive.

**EC Directives**

On 4 February 1988 the Commission of the European Communities submitted to the Council draft Directives to approximate the laws of member states on (i) labelling of tobacco products and (ii) the maximum tar yield of cigarettes. The former, if accepted, will require all units of packaging of tobacco products to carry the message 'Tobacco seriously damages health' in the official languages of the country and, in the country's own language, as a minimum one of two specific warnings, viz 'smoking causes cancer' and 'smoking causes heart disease'. Also, tar and nicotine yields are to be indicated on each packet of cigarettes which are unlikely to cause serious problems in the UK. The latter draft Directive, however, if accepted, will. It specifies an upper limit of tar yield for all cigarette brands (15mg by 31 December 1992 and 12mg by 31 December 1995) without mention of sales-weighted average tar levels which in the UK in 1988 was about 13mg per cigarette and is recommended by ISCSH to be reduced to about 12mg by end-1991. If accepted in its present form this Directive could be retrogressive in the UK by allowing manufacturers if they so wish to increase the tar levels of many of their brands in the Low to Middle Tar (10—14.99mg per cigarette) range and, without countervailing change in market profiles, the sales-weighted average tar levels would increase. Representation on these lines has been made in Brussels.

In addition two further Directives are being drafted, one on curtailing smoking in public places, the other on preventing sales of tobacco to those under 16 years of age. In principle neither would cause problems to current government thinking although in the former the use of mandatory directives rather than discretionary lines of sectoral action might. Only on the matter of tar levels may harmonization 'post-1992' lead to problems for the UK anti-smoking policies as the Directive is currently drafted.

**COMMENT**

Government has a responsibility to improve the public health. Smoking tobacco, especially cigarettes, has for nearly 40 years been a demonstrable health hazard to the consumer, and recently ETS has been increasingly accepted as a health hazard to exposed non-smokers through 'involuntary' smoking. This third party risk introduces a new dimension to the traditional problem of smoking and health which the tobacco industry has been quick to perceive in its publicity campaigns and in the thrust of much of its sponsored research towards questioning the methodology of the supportive studies. Hopefully government will be as alert in discharging its own responsibilities.

There are many means by which tobacco consumption can be reduced and these depend upon action by smokers, non-smokers, educators, health care professionals, and most importantly government - who should consider all means open to it to effect a reduction in smoking. Part of government's past failure and seeming dilatoriness has been the diffusion over several bodies of responsibility for effective action: thus taxation, art and sport sponsorship, health education among the young, sales promotion, and environmental restrictions, the armoury of government's anti-smoking campaign, are the responsibility of various departments other than the Department of Health. These structural problems have undoubtedly compounded any lack of political will and deprived government policies of much necessary focus, cohesion, and impetus.

One area which is however very much a Department of Health responsibility is the toxicity of tobacco smoke in marketed products, and the product modification programme. The importance of this issue is often paid only lip-service by anti-smoking lobbies - and (for different reasons) also some pro-smoking lobbies — since they hold that espousing it weakens all-out resolve to terminate smoking. They argue that commitment to cessation and not to encouragement of 'less hazardous' smoking with its tolerance to (low tar) advertising and its countenancing of continued smoking, is needed. I have explained in this article why this criticism is based on a misinterpretation of the ISCSH policies. The Committee perhaps keeps too low a profile since often its work seems not just misunderstood but hardly even to be known — the latest (1983) report of the RCP in its discussion on product modification is an example — yet raising it might compromise the excellent working relations it has developed with all parties which has ensured the quality and acceptance of its advice.

More valid is the criticism that whatever is the strength of the a priori case for a low-tar programme, product modification, the key ISCSH policy, has not been shown to have contributed to a reduction in smoking-related disease. After the Committee's Fourth Report this no longer holds for cancer of the lung and chronic obstructive pulmonary disease: the situation concerning
ischaemic heart disease is more equivocal and the undoubted role of smoking in its aetiology is still an enigma.60

While the search for the cancer producing agents in tobacco continues the reduction of tar and other 'noxa' must continue also. Such empiricism is not new in public health. But should it be effected through voluntary agreements or legislation? As things stand I can see no advantage, and some disadvantages, in the latter. Government, as already noted, has been able to incorporate in its four voluntary agreements with the industry all but one of the ISCSH recommendations and has accepted the recent Fourth Report completely. If the situation changed, however, I might think differently! In any event the 'post-1992' situation which the current and proposed EC Directives foreshadow, will lead to a new situation.

Less conjectural is the Committee's need to continue to supply government and the industry with the best scientific advice as its brief demands. In the important and intensely complex field of smoking and health the Committee needs to be enabled to sponsor research and not have to rely on an eclectic choice from the often unsystematic and unhelpful (in the context) world literature. The UK is an acknowledged leader in 'less hazardous' smoking policies; crucial population research is not likely to be centred elsewhere. The monies supplied by TAC to ISCSH since 1981 for research to monitor the effects on human health of product modification and which supports 25 projects are now fully committed. It is vital to the whole future of national public health policies in smoking and health that further funds from some source be made available to the Committee under terms which it can accept without compromising its status or standards. We must await the terms of any new voluntary agreement which may replace the one which expired at the end of 1987.

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