Politics, society, and preventive medicine

A REVIEW BY
ALFRED YARROW

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INTRODUCTION

Politics and policies

One of the greatest clichés of the day in relation to medical services is the almost universal stressing of 'prevention' in preference to cure. It is a cliché perhaps not quite of the same character as 'the advances of science' in medicine with its stimulation of our hope that scientists will help us towards a mythical nirvana of eternal life, but if implemented to the full extent of our knowledge, such a policy for prevention would probably be more crucial to the health of the population than pouring resources into traditional medical care buttressed by sporadic 'miracles' of science. Yet real effective implementation of policies designed for prevention is unfashionable except as a prospect in discussion, and the resources applied to prevention are dismally low. Indeed there is in effect little or no strategy for prevention at the operating levels of health care where action tends to be fudged because it is assumed that much of the prevention of ill-health, lies in the behaviour of the individual, and that society has ensured that the worst excesses of intervention or of environmental pollution, have been curbed by legal and administrative including fiscal measures.

Nevertheless for all the accent now on personal behaviour, the message of Dr Yarrow's essay is that preventive action as it relates to the health of the individual is intrinsically linked to politics, construed in the widest sense. While it is easy to accept that illnesses in individuals arise either from genetic defects or from environmental including behavioural causes, such a proposition covers a complex tissue of effects. Vested interests of differing character and origins are involved in the settling of current health-care priorities, as well as in the causes of ill-health, and this is the very stuff of politics in the frenetic run up to the end of this century when measures for the economic wealth of nations seemingly are to become the number one priority for society.

The social and philosophical context

The topics reviewed by Dr Yarrow in this monograph cover the major

'preventable' health problems and their causes, viewed against patterns of mortality and morbidity. Brooding over the tale are the political including the social and philosophical contexts against which the prospects for and rationality of preventive medicine have to be gauged in our society. The ever-changing perspectives are the resultants of forces many of which are born of policies remote from health. While it does not deal with the rising appeal of those preventive measures possible through forms of genetic engineering, the potential of which seems to be great and which because they introduce a dramatic quality are increasingly being brought into the public eye and so the political arena, it *is* concerned with the multitude of forces bearing down on conventional public health prevention.

The environmental causes fall naturally into two broad categories: personally-based and socially-based causes of ill-health. Society, is of course an aggregate of individuals, and self-inflicted ill-health, such as can be caused by excesses of smoking and drinking, can be related to strong social influences affecting individuals in different ways. On the other hand, society in its institutional role has a controlling influence on other sorts of social problems such as pollution, or poor water supply, etc, with a minimum prescription of personal behaviour.

The clash with 'freedom'

Inevitably the ghost of John Stuart Mill hovers over any discussion of personal freedom and prescription, and he is is summoned by Dr Yarrow to preside over the philosophical part of his disquisition. Yet there are problems these days in seeking to separate individual and social causation. Mill believed that actions and liberty for one person could not be interfered with, unless they affected others. Definitions of 'affecting others' can be relative and subjective. They also depend on multifactorial circumstances of widely varying import. Again, the direct influence of government has changed with the vast increase in bureaucracy beyond all recognition in the last 150 years. The intrusive bureaucrat is now part of the culture of modern society, with its tendency to produce social norms, which have become, part of life.

Paradoxically if one assumes the prohitions of actions interfering with others, almost all acts can be prohibited or restricted considerably.The question for preventive health-care is whether or not intervention in order

to 'prevent', constitutes a guarantee of, or an infringement of freedom. It can of course be either or even both. Theory is important but the abstract philosophical and ethical questions posed should not be allowed to hinder advances towards the inevitably convoluted solutions to many current pressing problems where preventive action can be taken to the benefit of the vast majority of individuals who constitute society.

Such dilemmas for government apply across the board to temper, if not actually to counter, efforts to address both 'personal' and 'social' causes of ill-health. Much has to be left to the individual relying on legal and fiscal inhibitions but there are however many areas where the issues of liberty are not clear-cut, and yet where intrusion may be justified. The policy implications in such areas are potentially great since they present options. Should government and public intervention be used to limit and prohibit, for example, industrial pollution, *or* to ensure that such industries to be specially taxed, with government compensating the victims? If the concept of 'property rights' applies, who has the over-riding rights? If it is 'the public', then the offending polluter has to pay; but if it is the industry, then the public through government would have to pay to have the pollution cease or reduced. What are the political considerations, if economic survival of the industry (or even in an extreme case, the state) is involved? It is clear discussion on this is avoided.

The control of the key influences

Again, in the case of 'personal' causes of ill-health, what are the considerations concerning the control of the '*social* influences' which lead to such causes or alternatively concerning the introduction of incentives or punishments to the *individual* to change behaviour. It is also evident that selective pressures on government may temper the attitude to preventive policies: for example where there are positive advantages from the viewpoint of fiscal policy (such as the application of income derived from tobacco and alcohol to finance government activities generally) in ignoring the positive signs that over-indulgence contributes to ill-health.

It is evident that the challenge is to provide a practical agenda, based on better appreciation of the facts, leading to action, taking account of the fact that radical preventive strategies may interfere not only with 'individual liberties' sincerely held and upheld, but with social norms. In the UK we have a system of general medical services provided under the

Family Practitioner Committees and of hospital and specialist services under Health Authorities covering the country. Have we really exhausted the potential of their functions in relation to the individual? Or do we even ensure that the individual understands where he is placed in relation to institutions concerned with health? Thus should a GP or a District Health Authority *press* on an individual the facts regarding all possible avoidable health risks, and seek thereby to persuade him/her to change behaviour, or is this too intrusive? It is possible that the questions raised at present by AIDS, a contemporary scourge which provides a graphic and dramatic example, may in the long run bring to the attention of the public the extent of the real dilemmas of prevention which in that case has a confusing moral dimension. This calls for much clearer definitions of how the role of government through the myriad of its institutions should be concerned in relation to the influences on health, uncontrollable by the individual, and at the same time how it can operate credible policies specifically through the bodies making up the NHS, or other organizations, public or private, to apply resources for specific programmes for prevention. The recent publicity given to the restrictions placed on environmental health officers concerning reports on hospital kitchens, provides a stark reminder from the world of governmental policies—in this case, on clear preventive issues—that the law designed for a limited purpose but applied to exclude government institutions altogether from specific actions can often be an 'ass'.

The main sources of influence

At present, the main thrust of prevention is through health education which is the responsibility of a 'quango', the Health Education Council which has no direct association with the NHS, although Health Authorities conceivably could, through grants or contracts, seek to utilize the Council's vast store of knowledge. General Prac-titioners—independent contractors who have direct access ultimately to all the population—can exhort their patients to preventive behaviour if they are so inclined. District Health Authorities can identify preventable conditions and implement preventive policies as they wish. The current separation of General Practice and Family Practitioner Committees from the District Health Authorities weakens the potential which might be gained from an organized preventive front, which was too vaguely

stitched together in the government's pamphlet *Prevention. Everybody's Business* (1978)—about which incidentally, little or nothing seems to have been done in practice. Again some of the factors seriously affecting health prevention, especially the social or environmental ones, are only tangentially affected by the NHS, since they come under the aegis of local government, and a variety of central government departments. Fragmentation seems almost to be seen as a virtue. It may not be an intended extension of the principle divide and rule, but it certainly seems to act that way.

Outside the UK, countries such as the US are renowned for having a more fragmented system of health-care delivery than Britain, but it is interesting to note that the Federal Government in the USA has a fairly strong stance on prevention, particularly through the Office of Disease Prevention and Health Promotion. Its promotional material, including its Monthly Reports in Disease Prevention/Health Promotion and its monthly Calendar of Prevention Actitivities, is impressive. If one excludes the Health Education Council—always pressed for money—there is no corresponding agency in the UK. American initiatives on prevention admittedly can sometimes reflect fads, because prevention is a vogue issue on which pieties can easily be mouthed. Nevertheless even in the face of several strong conservative 'lobbies' the Federal Department of Health and Human Services (HHS) does have a record of substantial effort to educate and to garner knowledge about prevention designed for application which Britain does not.

Moving towards a strategy

Any significant strategies for prevention in Britain would have to start with the DHSS—presumably through the NHS Management Board and the Regional Health Authorities for policies—but be based operationally upon Health Districts and Local Authorities working together. It will no doubt be accounted too difficult to make specific national resource allocations for prevention incorporated within (say) RAWP targets, because there is still a lack of specific data and of criteria by which results of preventive efforts could be compared with the immediate epidemiological results of more traditional care. Although strategies for preventing *some* diseases are clear, the results are undoubtedly vague. With the present low gearing of costing systems in health services it is

certainly not known if prevention in certain cases would be cheaper than cure and care; and the inevitability of higher spending, without ascertainable results is hardly a bull point for action, especially if no direct results are promised.

Yet it is surely not impracticable to draw up a practical list of priorities at Health Authority level—District—or, Regional. It would be comparatively simple to move slowly, but certainly. Such moves would have to consider risk factors in different areas of disease; prevention methods; methods of early detection (geared to secondary prevention); and the significant constraints upon action. While RAWP allocations from the centre to Regions are based on populations weighted principally by mortality data, sub-Regional allocations *at least* could reflect incentives for preventable morbidity, of the sorts not accounted for in mortality data. It has to be acknowledged however that the time factor for achieving results would likely be long, and regrettably therefore unless there is a lead from the centre, such a strategy is unlikely to get a high priority for executive action compared to problems for which quick solutions can readily be touted.

There is certainly no evidence of a strong political lead which perhaps reflects the fact there are no clear and immediate answers at this point in time. Yet an energetic attempt ought to be made to find a coherent place for prevention in medical care. The need for a 'positive discrimination' for prevention has been suggested as part of a co-ordinated effort for prevention within the General Medical Services which, because they cover the whole population, seem at first glance to be a suitable locus for attempts at modifying behaviour. Nevertheless it would probably fail unless deliberately implemented as part of an overall strategy.

What does seem urgently necessary is renewed effort comprising a discernable strategy for the promotion of better health, leading to action on the part of all authorities concerned with the health and well being of the population.

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A REVIEW BY

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FOREWORD

This essay is based on my experiences in senior posts in public health extending over 30 years, a little under half of these years outside the Civil Service and for the past 16 years within. For almost the whole of this period, I have been intimately concerned with preventive medicine and with one special arm of preventive medicine, health education. Personally, the papers represent a catharsis.

Achievements in preventive medicine within this period have been less than many had hoped and expected. Ministers have suffered intense criticism as have their civil servants, the faceless men of Whitehall. To a considerable extent, then, this work is also an apologia.

The Nuffield Provincial Hospitals Trust is not engaged, however, in providing finances for cathartic experiences and apologias. It was their hope and mine that an analysis and a better understanding of the relationship between preventive medicine and politics might lead to more rapid progress in the future than we have seen in the past, and to an improvement in the methods of those, inside and outside the administration, who seek to carry government into bolder administrative, legal, and fiscal action.

I have referred most frequently to my experiences within the United Kingdom because it is here that I was in service, but the work is not intended to be critical about the United Kingdom in particular; indeed, in my visits to Canada and the United States, and in discussions with colleagues from both these countries, it is clear there are close similarities in our experiences.

Nor is the work intended to be, and I do not think that it is, critical of any particular political party, any particular administration, or any particular set of health ministers. I have served, even-handedly, as a civil servant under six administrations, three Labour and three Conservative, and it would be difficult to single out any one of these as having forwarded or retarded the cause of preventive medicine. Parties in power are cautious and, in opposition, bold.

A considerable irritation throughout my years in the Civil Service was the search for perfection in writing papers, often at the expense of timely

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action. In other words, the perfect was, in my view, allowed to be the enemy of the good. Gordon McLachlan has made it clear that he would prefer a timely paper rather than putting the monograph through a large number of drafts. I have therefore written against the clock and hope my critics will forgive and overlook the imperfections.

Needless to say, the contents of this monograph represent the author's views alone and in no way commit the Department of Health and Social Security.

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Introduction

The major hypothesis within this monograph is that if the advances made in preventive medicine have been delayed and limited in past decades, as they have been both in the United Kingdom and elsewhere, an important factor contributing to these restrictions is the political one.

To a large extent, though by no means entirely, health problems in developed countries are concerned with life-style rather than with sub-nutrition, infectious diseases, and sanitation; to that extent their amelioration or prevention, depends on modification of that life-style. We as a society are burdened with gluttony and sloth, and with excessive consumption of drugs, including alcohol and tobacco, and we enjoy them.

This is very different from the health hazards of the 'third world' which are largely due to under-nutrition, infectious diseases, and an insanitary environment; but the United Kingdom of the early and mid-nineteenth century also faced the problems of an insanitary and unhealthy environment. It is also known that here too the same political and human factors that operate to limit advance now, operated then.

In several countries, especially Canada, the United States, and the United Kingdom, it is, perhaps paradoxically in view of what will follow, the politicians in Health Departments who have taken the initiative in outlining the problems, pointing out their preventable nature, and proposing preventive programs. Thus, in 1974 the Federal Ministry of Health published the so-called Lalonde Report in Canada (1). (Marc Lalonde was the then Minister of National Health and Welfare.) This was followed in 1976 by the publication of *Prevention and Health: Everybody's Business* in the United Kingdom (2), the first in a series of monographs on preventive medicine; and in 1979, the publication of *Healthy People* (3) in the United States.

All of these booklets have a remarkable similarity to each other in outlining the health problems facing the developed countries, in pointing

out the need for the individual to modify his life style, indeed to be encouraged so to do, and for the whole of government and not just the Health Department, to examine the consequences of its actions in a host of areas—fiscal, industrial, and agricultural—for the general health of the people.

Such initiatives, at least in the United Kingdom, have become embedded in the thinking of Health Department Ministers and Officials, and this is reflected in official documents and in advisory papers issued from the Health Departments, both to Health Authorities and to the people at large. Prevention has become a permanent and delineated part of health policy, at least as promulgated. Thus, in *Care in Action* (4), issued by the DHSS to the chairmen and members of incoming District Health Authorities in 1981, prior to the re-organization of 1982, prevention takes pride of place as the second chapter, preceded only by the chapter on resources. In the Introduction the then Secretary of State reminds us that 'we all have a personal responsibility for our own health;' and in the definitive chapter, he warns that 'Health Promotion and Preventive Medicine Programmes will not always be welcomed by those called upon to change their personal behaviour or their commercial activities. Health Authorities should not be deterred by this.' Brave words!

It is of interest that these initiatives should have followed each other in such quick succession, in historical terms almost simultaneously. It is no coincidence that in every developed country the soaring cost of treatment of disease, much of it preventable, has put governments at their wit's ends to find the necessary resources. Even if this was the *only* motive behind the preventive initiatives it would be both honest and honourable. I believe it is a cynic's view that this is the only, or maybe the major, motivation behind the preventive thrust. The primary function of Health Ministries is the altruistic one of informing and promoting public's knowledge of health, and it makes better intellectual sense to achieve this by preventing disease rather than by treating it after it has arisen, often in any event an impossibility. All ministers 'fight their corners'. This is the Health Minister's corner.

Health economists, both inside and outside Health Departments, have not been slow to point out that preventing mortality, as distinct from morbidity, in middle to late working life, simply transfers costs to later decades of life. Savings earned by prevention may simply be swallowed

up by payment of more pensions for longer periods, and by treatment of the degenerative diseases of the very elderly.

While it is a major purpose of this book to explore the hypothesis that preventive action is limited by political considerations and that reformers must learn to live with this and indeed to exploit it, it would be naïve in the extreme to regard political action in itself as the panacea in changing life-style. Political action may or may not be necessary, but it is not sufficient. The motives that induce individuals to follow an unhealthy life-style are complex. In cultures which approve the use of these substances, individuals would use cocaine or alcohol at least to some extent, even if this use was not promoted by the purveyors. It is surely part of the conspiracy theory of history to regard the brewer, for example, as the villain of the piece, and to regard government, at worst, as taking part in the conspiracy, or at best in acquiescing in it. People enjoy and seek the nirvana of cocaine, the oblivion of alcohol, and the well-being of the sweetness of taste induced by refined carbohydrate; and where governments have tried, for example in the case of alcohol, to limit or even prohibit consumption by legal or fiscal means, let alone prohibiting promotion, then men can, will, and do make alcohol themselves. Nothing is easier. If the problem of changing life-style was only one of promoting government action then the health educator would have little more to do. Sadly this is not the case, though the effectiveness of health education is limited without government approval expressed in something more than words.

There are loftier principles influencing government action or inaction. Again, critics almost always adduce the reasoning behind inaction as the power of vested interests; and, with respect to alcohol and tobacco, unwillingness to lose the revenue, and with the fear of the other economic consequences of curtailing commercial activities. No one who has attended a House of Commons debate, for example on seat-belt legislation, would doubt that many politicians, as do many citizens, feel a deep and genuine sense of unease at interfering with the liberty of the individual; and in the context of seat-belt legislation, commercial and fiscal consequences are hardly dominant. In other circumstances, and for similar reasons, they are, rightly or wrongly, reluctant to interfere with trade. If health promoters, both professional and lay, fail to recognize that these feelings are genuine they make their task that much more difficult.

Politicians who feel so deeply about liberty may sometimes be wrong; but they are wrong for the right reasons.

The behaviour change process

If government wishes people to change health-related behaviour it can do so in three ways. It can coerce them by legal methods, for example by compelling motor cyclists to wear crash helmets and, in the United Kingdom, the front-seat car passengers to wear seat-belts. It can use fiscal means; it can make indulgence in the habit of smoking expensive, by raising the taxes on tobacco and alcohol for example. Vice-versa it can encourage healthy habits by removing the tax on safety products. Finally, it can rely on persuasion and the strengthening thereby of social controls, in other words on health education in the broadest sense. Governments have largely chosen to rely on the education of those whose behaviour one wishes to change, but by making such a choice they have misunderstood the process of health education.

The health educator can only succeed wholly if the right climate of opinion, which is supportive to his efforts with the pin-pointed target group, can be created; for example the parents of children to be immunized. He needs the leadership and support of government—both in words and deeds, both local and central—to provide any necessary legal and fiscal framework; and to provide resources both for the educational process and for any health-related change in behaviour that might follow; for example, the increased provision of resources needed for immunization. Unless government is seen to lead in this way it is hardly to be expected that the man in the street will take the problem seriously. A decline in cigarette-smoking in Norway, for instance, coincided with debate on abolition of promotion in the legislature and preceded the actual legislation itself.

Secondly, there is a need for general public assent to what is proposed. It is most unlikely that the individual will change his personal behaviour if society at large does not recognize the need for change and does not show concern, or is indeed antagonistic to the action proposed. In order to secure general public assent and understanding the health educator needs to enlist the support of the Fourth Estate, the mass media; he cannot

afford the resources (in any sense of the word) to undertake this task himself. He needs also to convince health and education professionals in direct and frequent contact with the target group. They are his sales force. Only when all these conditions pertain are his efforts with the primary target group likely to be successful.

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On Liberty

Perhaps the most important single factor, that of liberty, is the one which is least considered by those most anxious for government intervention, both legal and fiscal, which is designed to encourage change in health-related behaviour, whether by coercion of the individual or by the restriction of trade. All governments receive a good deal of opprobrium, (and very little praise), because of reluctance to take legal and fiscal steps which might or might not control such behaviour. On such occasions the worst of motives are imputed and the argument sometimes dismissed out of hand. It is said that ministers are insincere and use this issue only as an excuse to avoid action which they are for other reasons unwilling to take, either because they are unduly influenced by industry or agricultural interests, or because they are unwilling to stand the loss of revenue that successful action might bring, or that they are unwilling to risk electoral unpopularity. While it is clear that governments are influenced by such considerations, critics are misguided in not accepting that ministers may be, and often are, quite sincere in advancing the liberty principle, and that in so doing they are perhaps more representative of the wishes of the electorate, or of a substantial part of the electorate, than are the critics. Almost never are governments given the benefit of the doubt.

There are at least three good reasons for governments to avoid coercing people into behaviour change. First, the law may be both unpopular and impossible to enforce. The Volstead Act, 'Prohibition' of manufacture and sale of beverage alcohol in the United States, earlier this century, is an awful and permanent warning to governments not to pass legislation which is both unacceptable to a large element of the public, and all too easily evaded. Bathtub gin is a reality. Governments, in this respect, are like parents and should not make threats they cannot carry out. Second, the law, even if enforceable and enforced, might conceivably contribute

less than is imagined to the solution of the problem simply because societal factors in the opposite direction may be more powerful, and this point will be considered in relation to the curtailment of promotion of cigarette and alcohol sales. Lastly, governments are often genuinely reluctant to use the law to compel individuals to act on what others deem to be in their best interests, purely on libertarian grounds.

In the United Kingdom it is characteristic both of government ministers, and of the senior civil servants with whom they regularly consult, that they share a common educational background. They are usually university educated, commonly in the liberal arts, in politics, economics or the law, and most frequently at two particular universities at that. This background includes, or appears to include, a detailed, if sometimes not too well-remembered, study of the work of John Stuart Mill, and, in particular, of his essay *On Liberty*. Ministers prepared to bring *dirigiste* legislation before Parliament, and those unwilling so to do must equally be able to exchange the dicta of J.S.Mill with their critics in the course of parliamentary debate. No other contributor to the discussion on liberty exerts such authority, nor is this general acceptance of the widespread impact, not necessarily the details, of Mill's message confined to the United Kingdom. On the contrary, it prevails in all those countries that style themselves western democracies, so far is his triumph complete. It is noteworthy that the Penguin edition of *On Liberty* (5) is edited by an American who writes, at the conclusion to the introduction, that the essay 'has become, perhaps by a process of cultural assimilation, the gospel of our own time even more so than in Mill's day. Like all gospels, it is frequently violated in practice and sometimes defied in principle. But liberty remains, for good and bad, the only moral principle that commands general assent in the Western world.'

It would be inappropriate for me to enter into any criticism of Mill's essay for which I am in any event untrained and unprepared. Nor is this necessary. But it is important to point out that neither at the time of publication, nor subsequently, has the essay been without critics and without criticism. Of particular relevance to this discussion was the fear expressed that unqualified and unmodified acceptance of its doctrine would block action being taken by government in situations where there was a clear social need; and indeed this has happened to a limited extent

with regard to seat-belt legislation in the United Kingdom where opponents of the measure made much of Mill's arguments.

Perhaps more important than these criticisms are the changes in society since Mill's essay was published. Mill wrote that 'the sole end for which mankind is warranted individually or collectively in interfering with the liberty of action, of any of their number, is self-protection. That the only purpose for which power can rightfully be exercised over any member of a civilized community against his will *is to prevent harm to others.* His own good, either physical or moral, is not a sufficient warrant.'

Mill could not have foreseen the extent of the welfare state, and would certainly have opposed it. Nor could he have foreseen the highly sophisticated and immensely expensive treatments which lead everywhere to a shortage of resources. For good or ill some form or another of health insurance system prevails in every western nation, along with a resulting interdependence of individuals as regards health care. Overall cost as well as overall effectiveness of care determines how much care can be provided 'at the margin'. Within such an aggregation, individual behaviour does affect other individuals. The man who injures himself because he objects to wearing a seat-belt, and thereafter requires orthopaedic surgery because of an accident, deprives someone else on the waiting list for routine surgery of the opportunity for treatment. Moreover, if he is away from his work he and his family, if any, will need to be supported by the state, that is the tax payers, who are in turn deprived of the tax on his income. Do these factors not constitute harm to others? Mill himself foresaw the difficulty in principle, if not in the particular circumstances outlined above, and wrote 'as soon as any part of a person's conduct affects prejudicially the interests of others, society has jurisdiction over it, and the question of whether the general welfare will or will not be promoted by interfering with it becomes open to discussion.' This general point is made even more strongly elsewhere in his essay.

The greater part of the essay on liberty is concerned with liberty of thought and of expression whether in speech or otherwise, and of liberty to live one's life in a manner which others might regard as nonconformist to the generality of society. Only to a limited extent, and largely in the last chapter, is there discussion of health-related behaviour and this is largely in relation to the use of alcohol. But Mill's views on the

application of his dictum to the use and marketing of alcohol are of interest and perhaps of more general application. He opposes prohibition of the manufacture and sale of alcohol which then prevailed in several individual American states on the grounds both of interference with the liberty of the subject and because of the impracticability of executing the law. But he recognizes that drunkenness causes harm to others, and particularly to the family, and here he is in a dilemma. There is a lengthy argument as to whether the state should discourage over-indulgence by means of what we call today legal and fiscal controls, the particular legal control in debate being limitation of number of outlets to which he was opposed. He was, however, in favour of fiscal controls and argued that if the state has to raise revenue, and if indirect taxation is a necessary part of the tax burden, then in deciding what to tax, the state might as well select a commodity whose use, except in moderation, is injurious, even if like all indirect taxes it penalizes the less well-off. The argument is somewhat sophisticated, but the net result is one that might well have been arrived at by discussion on pragmatic grounds.

Although most of the essay on liberty is concerned with liberty of the individual there is some brief discussion of restraints on trade, discussion of which is particularly relevant to the long-running debate on limitation of promotion of tobacco, although Mill's application is to alcohol. Here Mill writes 'whatever it is permitted to do, it must be advised to do. The question is doubtful only when the instigator derives a personal benefit from his advice, when he makes it his occupation, for subsistence or pecuniary gain, to promote what society and the State consider to be an evil.' He continues 'that persons shall make their own election either wisely or foolishly on their own prompting, as free as possible from the arts of persons to stimulate their inclinations for interested purposes of their own.'

This brief examination of Mill's application of his general views to health-related behaviour reveals that he was in practice a good deal more pragmatic than might be supposed, and rather more accepting of government intervention on health grounds than is usually argued. It is probably true to say that it is the general import of his views which is used in debate on health-related behaviour, rather than his views on specifics, precisely because it is the general thrust of his ideas which have gained

such universal acceptance. In practice, from the day of publication, and his essay does seem to have achieved its impact from the start, governments have made their decisions on pragmatic grounds. Thus we compel those occupying the front seats of motor cars to wear seat-belts but we do not compel mountaineers to wear safety equipment. The results of not wearing seat-belts constitute a major burden on the state and a major threat to the public health through death and disability; the results of mountaineering accidents are just as drastic but much less frequent. We legislate for the one but not for the other; it may be logically inconsistent but then we learn to live with inconsistency, and perhaps we should.

Some people might argue reproachfully that Mill's essay has been responsible for government inaction, just as was feared by some early critics, and therefore for many deaths and injuries. There is a need for public assent to legal and fiscal measures and there may need to be a period of years and a period of public debate and argument before the public will accept the requirement for controls, legal and fiscal. In the United Kingdom the public appreciate the need to be coerced into wearing seat-belts. Before the relevant legislation was passed education had convinced only about one-third of those concerned; after the legislation there has been very widespread adherence to the law. Recently cigarette smoking was banned on the London underground. Ten years ago that would have led to riots. Today it is publicly acceptable, even to smokers. This is not to argue for government to lag behind public assent, and on both these issues many critics would argue that government action has indeed been untimely. A nicety of judgement is required.

This chapter, then, is an appeal to those critical of government for reluctance to interfere, on libertarian grounds, with the individual or with trading interests to take the argument seriously because the general public take it seriously and ministers, as political animals, are aware of this. A detailed knowledge of Mill's essay and an understanding of ministerial considerations are likely to prove more fruitful of action, and of speedier action, than a dismissal out of hand of the relevance of the argument, and especially the more non-interventionist interpretation of Mill.

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Patterns of mortality and morbidity

The relationship between many of the so-called 'diseases of affluence' and life-style is a well rehearsed story; so well rehearsed, in fact, that it would be both tedious and no doubt boring to enter into an exhaustive analysis here, and the reader requiring such an analysis will find an excellent résumé in Chapter III of *Prevention and Health: Everybody's Business* (2).

Suffice it to say that coronary heart disease is a major cause of mortality both in middle life, and especially in men, as well as in later life, and there is well-attested evidence of aetiological links with cigarette-smoking, lack of exercise, and high fat intake. The cancers are another major cause of mortality and, again, cigarette smoking is an accepted causative factor in cancer of the lung and bladder, and there is evidence of a possible link between high fat intake and cancer of the breast and colon. There is an established relationship between sexual behaviour and the incidence of cancer of the cervix.

Other numerically less important causes of death linked with behaviour are road traffic accidents in which alcohol intake is a frequent aetiological factor and cirrhosis of the liver in which it is a usual cause though by no means invariable. Suicide speaks for itself, and is often alcohol and alcoholism associated. Chronic bronchitis, once the English disease, is now much less common, largely as a result of the Clean Air Act 1956 (see Chapter 7) but cigarette smoking is now the major aetiological factor.

Needless to say all the diseases mentioned above are also major causes of morbidity. But there are other causes of illness, not necessarily (or often) fatal, which are nevertheless a heavy burden on the individual, on the family and on society, and which are linked with behaviour. These include the very high incidence of sexually transmitted diseases.

Excessive alcohol intake and alcohol dependence are far more

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important as a cause of personal unhappiness, of family disruption, of chronic ill-health, and of social dislocation than as a cause of mortality. Indeed many would regard this as perhaps our most important preventable health problem, taking health in the widest sense. Drug-taking, both of pharmaceutical preparations and of illegally produced euphoriants and hallucinogens is widespread. There is a national epidemic of self poisoning, sometimes called para-suicide, said to be the commonest cause of admission of young women to acute medical wards.

Finally there is the high, though falling incidence of dental caries, said to be the most widespread of all diseases, and of which a high and frequent consumption of refined carbohydrate is an important causative factor.

The above list of diseases and conditions dependent on our health-related behaviour makes melancholy reading and it is not fully comprehensive. We should keep a sense of proportion. It accounts for a good deal of acute illness; but much illness, as far as we know, is not so dependent. Even if we were all to change our behaviour in the desired directions there would still be the mild inter-current infections, much mental ill-health and subnormality of which the aetiology is still not well-known, and of course the degenerative disorders of ageing. We should beware of falling into the same trap a second time. When the death rate from infectious disease fell, largely as a result of immunization, antibiotics, and improved environmental health and nutrition, it was forecast that disease would virtually disappear. Sadly this did not happen, and the reasons have been stated.

What needs to be done?

It follows that if, as a society, we wish to reduce the incidence of those disorders related to life-style then we need to avoid, moderate, modify, or eliminate harmful forms of behaviour. This hints at fire and brimstone but the remedies are not really so desperate as all that. The most important needs are to stop smoking cigarettes or, as second or third best to smoke lower noxious yield cigarettes; to drink alcohol only in moderation and only in appropriate circumstances; to avoid fun drugs and to use prescribed psychotropic drugs only for as long as is necessary; to take more exercise; to maintain an appropriate weight; and to consume a diet lower in fats, and especially saturated fats and, if necessary, to

make up for this by eating more unrefined carbohydrates and therefore more fibre. It does not look such a tall order. But it is proving extremely difficult to achieve. Why is this so?

Rationality

Looking back over the past twenty-five years or thereabouts since the first Report of the Royal College of Physicians on Smoking and Health (6) the extent of our naïvety seems too awful to contemplate. It is hard to believe that both health professionals and the health politicians were truly under the misguided impression that smokers would only need to be told of the increased risks they ran of dying of lung cancer and they would give up smoking in very short order if not overnight; and that children, if warned, would cease to take up the habit.

In March 1962 circulars were issued by the, then, Ministry of Health, following on the publication of *Smoking and Health.* Health Department action was limited to exhortation of the local Health Authorities to educate the public concerning the risks, and to the issue of notice-board sized posters to those same Health Authorities for distribution and display. In the education ministry field, the then Central Council for Health Education was given a small grant to enable it to buy a mini-van for use by two young graduates to tour the schools, on request of the Principal School Medical Officer, to demonstrate bottled specimens of cancerous lungs and to tell the children not to take up smoking or to quit if they had already started. (An Her Majesty's Inspectorate of Schools colleague estimated it would have taken 500 years to complete the tour of schools!) This response was of course woefully inadequate. But at that time the reason for this inadequacy was more the failure to perceive the size and even more the *nature* of the behavioural problem involved than either a lack of good intent, or the result of pressures applied to health ministers by other ministers, either of their own volition or as the result of lobbying by the tobacco industry.

Motivations

People—all of us—indulge in bad habits for a variety of reasons. But first and foremost we do so because we enjoy them. It is foolish to deny that

nicotine is an extra-ordinary drug with the apparently paradoxical ability to relax some individuals, to stimulate others, and, in some cases, to do both in different circumstances. It is silly to deny that we—most of us—enjoy the sensation of sweetness. Bears do not need to be persuaded to find honey. These are then physical and pharmacological effects. Alcoholic drinks are often both pleasant to drink, and intoxication too is deliberately sought.

Many of these forms of behaviour, and the mode in which we indulge in them, are socially dependent. The pressures on young people to take up smoking in adolescence are intense, though this is less true today than it was ten years ago. We secure the esteem of our co-evals in taking up the habit, and their contempt if we stand out, and this seems to be especially true if one is thirteen!

There is a vast amount of literature related to the meaning of alcohol consumption in different societies, and a great variety of patterns of consumption. But in those societies where early, frequent, and heavy consumption is the norm it is very difficult for the young person entering adolescence to stand out against peer and societal pressures; it is very difficult, almost insulting, for a guest to refuse his host's drink offering; and sometimes impossible for the recovered alcoholic to avoid falling back into his previous habits without abandoning his friends. And what applies to drink applies in many ways to food.

Finally, with regard to many forms of behaviour under consideration, the public is subject to heavy commercial pressures from vested interests to continue indulgence. Clearly the tobacco companies are most unwilling to see their markets disappear. The drink trades resist limitation on the size of this market, as do the sugar and related industries and the dairy industry. These products are heavily promoted with immense budgets, both by means of advertising, of sponsorship and by other more subtle means. But these commercial pressures need to be kept in proportion.

It is very well known that both tobacco use and alcohol consumption are very high, for example in Eastern European countries, where no form of commercial promotion is permitted and where governments keep the price high by taxation and pass Draconian laws against misuse, evidently both unenforced and unenforceable. It is clear that in such societies with very weak social controls, no form of commercial promotion is necessary.

Some critics of government, and especially those of a radical disposition, are unwilling to accept the importance of internal and societal, non-commercial pressures in inducing and maintaining ill-health related behaviour, and they put greater emphasis on the promotional efforts of industry and condemn governments for unwillingness to interfere with the market. They then condemn ministers and indeed health educators for exhorting people to 'behave better.' They call this 'blaming the victim.' It is for the reader to judge whether this is a true reflection of the determinants of our behaviour.

To summarize then, it is suggested that in the 1960's both health ministers and health professionals misunderstood the nature of the problems involved and, perhaps because of this, underestimated the resources required to bring about behaviour change because of a mis-guided belief in rationality, despite all the evidence of history. There are formidable pressures, both internal and external, pushing us towards damaging forms of behaviour. But the most important of such pressures are probably those that are internal and societal rather than purely commercial. If governments wish to bring about health-related behaviour change they may need to limit the ability of industry to operate and to promote their products in complete freedom; but it may be that such limitations are of greater symbolic than practical significance. This is not to argue against such actions. They are evidence of government intent and determination and therefore have an important educational effect, but we would be wise not to over-estimate the results. All this is without reference to government use of fiscal encouragements and discouragements. That is quite another story which will be discussed in due course.

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The government view

The health of the people is said to be the highest law. Those of us who believe this in its most simple interpretation are doomed to frustration as the history of the struggle for government action to reduce cigarette smoking, for example, or to compel the wearing of seat-belts has shown. It may be, and has been, possible to achieve such ends but it is unlikely to be achieved without considerable pressure on sometimes reluctant ministers from both intra- and extra-parliamentary sources. Why is this so when the ends to be gained seem so admirable and the means so obvious?

Prevention and Health: Everybody's Business (2) was precisely so entitled partly because Health Departments are so limited in the action they can take. In England and Wales, for example, fluoridation of drinking water is the responsibility of the Department of the Environment; seat-belt legislation and the laws on drinking and driving devolve upon the Ministry of Transport; the laws controlling the quality and safety of food and food information required to be given to the public are the joint responsibility of Health and Agriculture Departments, and so on.

Moreover, even where the Health Departments are primarily responsible there may be secondary consequences of their actions which are the concern of other departments, and it is necessary for Health Ministers to clear their lines of action with Cabinet colleagues. This issue will be explored in greater detail in later chapters. But even a moment's thought will make this obvious: a reduction in cigarette smoking 'brought about' by curtailing promotion by the Health Departments would result in reduced employment in tobacco manufacturing, with secondary effects on the suppliers, for example, of machinery and packaging, and in retail sales; it would threaten the possibility of reduced employment in the advertizing industry and therefore in the revenue accruing, for example,

to the Press, possibly posing a threat to the very existence of certain sections of that Press; it would reduce subventions to sport and the arts, and there would be a reduction in the tax revenue (unless tax rates are adjusted upwards). Ministers in Departments of trade, employment, sport, the arts, and finance would need to be strongly convinced of the need for such action. Possible objections by ministers on libertarian grounds have already been discussed at length. Ministers will argue that to state that the health of the people is the highest law is to over-simplify.

Unemployment has possible health effects as has reduced spending on participatory sports; a free press is necessary to national well-being, as is support of the arts. To state that some of this sounds like sophistry is not enough. The arguments are made and need to be rebutted.

Politicians are affected also by political considerations of a wider nature. The question will naturally be asked 'How does this measure affect the party image and its prospects?' Interfering, so it will be termed, with the right of the individual to indulge in habits which he enjoys, to compel the two-thirds of the population who are apparently indifferent to the health benefits of wearing seat-belts to wear such equipment, is hardly likely to gain votes, though it may not lose them. On the other hand it *might* lose votes. Why, it will be argued, should the government take chances. On health grounds? But the re-election of the governing party will bring prosperity to the country and prosperity brings its own health benefits. Thus the party leaders may argue that hardly anybody will vote for a party because it supports fluoridation, but there will be more than a few who would vote against any party which makes this measure mandatory.

Ministers who are doubtful of the need for the measure, or possibly opposed to it either on departmental or ethical grounds, will then go on to ask for proof, if such were possible, that it will actually result in the desired outcome, and such proof is not always easy to obtain. In the United Kingdom, often slow to move, it will sometimes be possible to analogize from the experience of other countries but this argument is not always convincing as other things may not necessarily be equal. A further counter-argument will be that perhaps the same end might be achieved by persuasion, either of industry to change its marketing methods or its products, or of the individual to change his habits, for example to give his children fluoride tablets or to wear seat-belts.

Party managers are also often reluctant to see their party labelled as kill-joys as might well happen if a series of health measures were legislated which, taken together, appeared to be directed at depriving the electorate of many of the simple, albeit destructive, pleasures of life. Of course to take such actions can be put forward as the image of a 'reform government' but Cavaliers are always, or almost always, more popular than Roundheads.

The net result of all this will be a weakening of the Health Ministry case. And the likely outcomes are either a rejection of the proposed measure and the substitution therefore of persuasive methods ('voluntary agreements' and health education); or partial assent with consequent reduction of impact. Very occasionally there is agreement to act boldly and definitively. The first two outcomes are delaying measures, sometimes permanent. Almost invariably agreement to take strong action has been preceded by partial measures or by the substitution of persuasion. Thus, in the recent past, and in the United Kingdom, agreement to compel the wearing of seat-belts by the occupants of front-seats in cars was preceded by several fruitless years of educational efforts; and the decision to remove all lead from petrol followed after successive steps compelling petrol refiners progressively to reduce lead levels in petrol.

The pressure group

When faced with governments resistant to argument and reluctant to act on what, on the face of it, is incontrovertible evidence of injury to the public health, the natural reaction of reformers, mainly but by no means entirely within the health professions, is to set up a pressure group.

Not infrequently the impetus for the setting up of such groups comes from the medical professional bodies themselves. In our day, the Royal College of Physicians took the lead in drawing to the attention of the public and of government the risks attached to cigarette smoking and the benefits to health and life in quitting. This effort will be examined in detail in chapter 5. But this was not the first time the College had taken the initiative in putting pressure on government to act in the face of a serious health problem. They had previously appealed to the government in the 1720's to stop the sale of gin at cheap rates, in the face of an epidemic of illness and family disruption on a national scale. What was

new in the 1970's was the translation of action into political terms in a manner new and unique to a professional body, by setting up, and temporarily under-writing, a subsidiary organization—ASH (Action on Smoking and Health)—which could challenge the tobacco companies using the same commercial expertise in lobbying and using the media in a manner quite unfamiliar to a professional body.

Of course, such pressure groups are by no means new. In the 1870's the Charity Organisation Society, under the leadership of Octavia Hill had been instrumental in pressurizing Richard Cross, the then Home Secretary, into Housing Reform—the Cross Act. (Incidentally, the memorandum from the Charity Organisation Society was supported by another, almost inevitably, from the Royal College of Physicians!)

In our own century the family planning voluntary organizations have been immensely successful, as was the National Society for Clean Air. But it was ASH which used twentieth-century methods for a twentieth-century problem and set the scene for a new model, and one which is now being copied by others—for example, the Coronary Prevention Group, the Conservation Society, and more recently Action on Alcohol and Alcoholism. Pressures on government can be expected to intensify accordingly.

Perhaps Health Ministers will welcome such pressures. They manifest themselves in the Houses of Parliament and in the media. Ministers thus find themselves in a stronger position in discussion with cabinet colleagues. It has been noteworthy, both in the past and in the present, that pressure groups, apparently a thorn in the flesh of government, often receive subventions and verbal encouragement from ministers in Health Departments. Is this merely paying Danegeld or a devious use of the democratic process?

5

David and Goliath

The battle against cigarette smoking is the perfect paradigm both of problems and possible solutions in prevention.

The tobacco industry in the United Kingdom is extremely powerful. It is an importa   employer of labour both directly and through its network of distributo , many self-employed. Indirectly, too many people in machine ma: facturing, packaging, printing, distribution, and especially in advertizin   are heavily dependent on cigarette sales and promotion for employmen· Because of the employment position the tobacco workers' unions are ¿   one with the employer. The taxation of tobacco is one of the most impr   ant contributors to the revenue and, because tobacco is widely reg;rded and accepted as a luxury, its taxation is felt almost to be justified so that increases in tax are borne with relatively little complaint from the smoking public. The tobacco manufacturers are important sponsors both of the arts and, more especially, of sports, both activities chronically underfunded. The companies have immense financial resources. Through their advertizing in the press they have influence, perhaps tacit, with the media. Finally they are involved in the sale of a product which is addictive, either physically or psychologically or both. No one would lightly take on such an adversary.

The basic facts concerning the link between cigarette-smoking and health, or rather ill-health, are so well-known as hardly to merit more than a brief résumé. Even before the Second World War, suggestions had been made, in Germany and in the United States, that the apparent increase in thoracic tumours might have some connection with cigarette smoking. By the end of the 1940's it was clear to every general physician and surgeon that the apparent increase was a real and full-blown epidemic. In the United Kingdom, by means of an elegant series of statistical analyses, Bradford Hill and Doll, in the 1950's, demonstrated the relationship to the satisfaction of all but a relative minority, and they

and others who confirmed their work in other countries showed that there was also an important link between cigarette smoking and coronary heart disease and with chronic obstructive lung disease, as well as with a number of other statistically less important causes of disease and death.

Bradford Hill and Doll were also able to demonstrate, in their study of British doctors, that stopping smoking was often able to halt, and even in some cases reverse the pathological processes.

Faced with these facts the reaction of most governments has been less than authoritative. In the United Kingdom the then government, noting the Bradford Hill and Doll paper, asked the Medical Research Council to comment; and when the Council Report confirmed the research findings the reaction of successive Health Ministers was 'to make the facts widely known to the general public' and to leave it to the good sense of the public to decide what to do.

In the face of this somewhat less than enthusiastic response, and the extent of the suffering involved, the Royal College of Physicians of London deemed it necessary to add its authoritative weight, the weight of 'real doctors', to that of mere epidemiologists and in 1962 published the Report of a Committee of which Dr Charles Fletcher was the Honorary Secretary, entitled *Smoking and Health* (6). This report made a number of recommendations to the government of the day for action, and the limited nature of government reaction to these proposals was catalogued in Chapter 3. In 1964 a similar report was presented to the United States government by the US Surgeon General (7).

As the decade moved on, and the apparent indolence of successive British governments in the light of an ever-worsening situation became apparent, the College decided on a new tactic. It was clear that exhortation, in the face of what appeared at best inertia, and at worst resistance, demanded new tactics. A second Report, entitled *Smoking and Health Now* (8), was published in 1971; but this time it was accompanied by the setting up of a pressure group, soon to become known as ASH, (Action on Smoking and Health), at first financed by and housed in the Royal College of Physicians. This pressure group consisted of a council of well-wishers, largely but by no means entirely health professionals, and a small secretariat, initially part-time and amateur. (I hope the incumbents will forgive me that adjective).

The subsequent history of the organization demonstrates many of the

features of the reality of political life set out in earlier chapters. Without further financial support not readily forthcoming from the usual voluntary sources it is unlikely that ASH would have become more than a nuisance, in the eyes of the tobacco companies a squalid nuisance. But successive Health Ministers have, by financial subventions, ensured its survival. Sometimes such subventions have served solely to demonstrate government good intentions. Sometimes by judicious increases ministers were able to ensure the heightening of the issue as a national problem.

The kind of action which was suggested to government in *Smoking and Health,* and its successive documents issued by the Royal College of Physicians, falls into four groups. First, the need for health education; second, the need to explore less dangerous forms of smoking and especially lower noxious yield tobaccos; third, the limitation or elimination of tobacco promotion; and fourth, the use of taxation as a punitive weapon.

Governments in the United Kingdom, as in most other advanced countries, have found it expedient to make modest subventions for health education and to negotiate lower noxious yield tobaccos by voluntary agreement. In the United Kingdom governments have also been able to negotiate modest limitations on tobacco advertizing, again by voluntary agreement; not unnaturally the tobacco companies are less than enthusiastic about accepting the invitation to fall on their swords. Moreover such limitations on advertizing as have been negotiated have been largely negated by the ability of the tobacco companies to switch expenditure away from direct advertizing, towards sports and arts sponsorship. Thus while it is illegal to advertize cigarette brands on radio or television, it is possible to sponsor a sport which achieves widespread media coverage provided the event is called after a tobacco 'house-name' which may differ only by a whisker from a brand name. Only in Norway and Finland has the government responded to the problem by the banning of all forms of promotion.

Subventions to the health education bodies, the Health Education Council and the Scottish Health Education Unit (now Group) have never been sufficient to achieve more than the most modest anti-cigarette media coverage. ASH changed all that by appointing as a full-time paid chief executive or Director, an expert in running a pressure group, equipped with a superb professionalism and the understanding that if the cigarette

industry was to be fought and beaten it would have to be beaten with the same weapons it employs itself: the use of the media, political organization and lobbying tactics. At the same time there needed to be the ever-present back-up of knowledgeable professionals of the highest reputation. Together this produced a unique partnership. Because of his previous experience and acquaintanceship, the Director was able to secure tremendous unpaid media coverage through the use of news-worthy items from an authoritative source. The few thousands of pounds put into ASH by the Health Department were thus transmuted into gold which multiplied the value of the subvention many times over. The media effort was of two kinds. The first was to tell the truth, effective enough, over and over again. The second was to deliberately set up a David and Goliath approach and thus to receive public sympathy and admiration.

The Director has himself set out the principles of the political struggle at some length (9) and I do not propose to repeat them here in full, but a few points are worth summarizing. First, and because governments are extremely sensitive to criticism from the legislature, that the support of a Parliamentary lobby must be obtained, and that such a lobby must be all-party and therefore the issue be divorced from partisan politics; these are not party political issues except that the party in opposition, whichever it is, is always more vociferous in its demands for action than the party in power!

Second, that it is important to be serious and persistent and to be regarded as serious and persistent but not fanatical. By working hand in glove with the sober-sided and sober-suited leaders of the medical profession, and by eschewing cheap gimmickry, it was possible to maintain the image of seriousness without attracting the label of crankiness or fanaticism; and attempts to present ASH as an organization representing only a fanatical minority of doctors putting forward the latest of many theories, shortly to be lost in limbo, have failed.

Third, the health pressure group has the difficult task of accepting financing from the Health Department, of castigating government for inaction, and of consulting quietly with ministers (as does the tobacco industry) while at the same time maintaining its independence and integrity. It must take money without being bought off. It can be done and it has been done because it sometimes suits ministers' purposes. Dr David Owen, then Minister of State for Health, once, and publicly, urged

ASH and the Health Education Council to keep up the pressure on him because of the leverage that it gave him with his colleagues.

By its work in the 1970's, ASH succeeded in two ways. First, it built up an effective Parliamentary lobby so that the issue is almost never out of discussion, either in the Houses of Parliament or in House committees. Second, it achieved tremendous media coverage which in turn has had the effect of keeping up pressure on government as a whole because it may be that departments other than health are under criticism. Thus it is the Department of the Environment which is responsible for sports sponsorship. At the same time the message of the importance of quitting smoking (or of not taking it up) and the feasibility of quitting have got over to the general public.

Changes in behaviour

Changes in behaviour in relation to cigarette smoking in the United Kingdom are well documented (10) and can be briefly summarized. There was a slow decline in cigarette smoking prevalence in the 1960's and then an accelerating decline in the 1970's and early 1980's. Whereas in 1962 over 60 per cent of adult males were cigarette smokers, in 1982 this was down to less than 40 per cent. In women the prevalence, which increased during and after the Second World War, never rose so high, perhaps to 45 per cent; in 1982 it was 33 per cent. Among those who continue to smoke, the non-filter tipped cigarette has all but disappeared and the average tar yield has fallen dramatically; this is partly due to industry moves in response to government requests, and partly to public preference for the milder and perhaps less harmful cigarettes.

Cigarette smoking is now a minority pursuit; if one counts children then it is very much a minority pursuit, and this is reflected in public attitudes and behaviour. Smoking in public places and in public transport is now either prohibited or limited, and any attempt to defy these rules, whether legally or socially based, meets with strong disapproval.

It would be foolish and unscientific to ascribe these changes entirely to the work of ASH, but insofar as governments have reached successive voluntary agreements on limitation of cigarette promotion, albeit limited in scope, in the provision of health warnings on cigarette packets and advertizing material; insofar as voluntary agreements have been reached

on product modification; insofar as finance ministers have raised or index-linked taxes, albeit never at punitive levels, then the influence of ASH both in Parliament and directly with ministers must surely have played its part.

Health education is not a laboratory activity and it is never possible to accurately ascribe cause and effect with any great reliance. But the profound changes in behaviour in relation to cigarette smoking recounted above, and their acceleration in the 1970's, need to be explained; and the most likely explanation is surely the continued recounting of the facts as known to the general public over many years, and by convincing the same public that both the health professions and government, or at least Health Departments, believe these facts to be true. The contribution of ASH to these ends is undoubted and ASH will now be the prototype of pressure groups.

The fact remains that some thirty-five years after the Bradford Hill and Doll paper linking cigarette smoking with lung cancer, it is still legal to promote this activity and the product. What would a Martian make of this? There is still work for ASH.

6

The problem of alcohol misuse

The literature relating to this subject fills whole libraries and any attempt to look at the problem in brief, even from a limited point of view, is bound to be circumscribed. The term 'alcohol misuse' is preferred to that of alcoholism, alcohol addiction, or dependence. Fully-developed alcoholism, as well as the misuse of alcohol—its consumption in excess, and/or, in inappropriate circumstances—causes a vast amount of ill-health, accidental injury, social and family disruption, and also the loss of industrial and commercial output.

Although mortality from either alcohol misuse, road accidents, cirrhosis, etc., is less important numerically than deaths due to cigarette smoking, as a disrupter of society and as a cause of morbidity, alcohol misuse is far more important. Comprehensive surveys of this aspect of the subject can be found in *Alcohol and Alcoholism* (11) and in *Drinking Sensibly* (12), the latter a Health Department publication in the 'Prevention and Health' Series. Perhaps one or two statistics might be quoted. In *Drinking Sensibly* it is stated that several studies in the United Kingdom in recent years have shown that between 15 and 30 per cent of all male admissions to general medical, orthopaedic, and casualty departments in hospitals were found to be either problem drinkers or physically dependent on alcohol. Second, it has been estimated, again by economists at the DHSS, that the resource cost to society at 1977/78 prices might be as high as £650m and clearly much more than that today; and this makes no allowance for the pain, the suffering, and the loss of life.

These two statements illustrate the gravity of the problem but they do not explain why it has become politically so important in the past decade. The reason for this is that the incidence both of morbidity and mortality have risen sharply in past decades and have risen particularly sharply in England and Wales; it was always a much more important problem in Scotland and Northern Ireland.

The alcohol problem differs from that of cigarette smoking in several important respects each of which has its political implications. In the first place, unlike cigarette smoking, beverage alcohol consumption in moderate quantities, except possibly in pregnancy and certainly when in charge of machinery including a vehicle, is harmless and indeed may be beneficial. Alcoholic drinks are enjoyed as thirst-quenchers, appetizers, relaxants, and social lubricants. The targets for most critics then—there are exceptions—are therefore immoderate drinking and drinking in inappropriate circumstances. This is quite different to cigarette smoking where the avowed aim both of external critics and of government is the reduction and eventual elimination of the habit.

Second, because of this vital difference, the declared attitude of the industry is quite different. Alcoholism is a poor advertisement for the trade. Industry therefore is only too happy to enter into a dialogue with government, and indeed with others, as to how the situation might be ameliorated. Sensitive to criticism about the quality of advertizing, the industry, largely on its own initiative, has entered into successive voluntary agreements which have largely eliminated the kind of advertizing which equates alcohol consumption with sexual success and heavy alcohol consumption with manliness. The critics would deny this but a glance at the advertizing of only ten years ago and today would surely make this apparent. Again, sensitive to the criticism that drinking should be offered as an integrated activity and not an end in itself, public houses increasingly offer both food and entertainment which, as it happens, also turns out to be good business.

Industry also offers subventions both for research and for professional education, albeit the latter is concerned largely with secondary prevention.

Having said all this it is also true that the industry, not surprisingly, is opposed to measures which would, or might, limit growth; it is opposed to restrictions on the volume of advertizing, and it is a bitter opponent of the theory linking overall consumption with harm, of which more anon, and it lobbies accordingly, which of course it has a perfect right to do.

Social, legal, and fiscal controls

The drinking of alcohol is an almost invariable characteristic of western societies, though within each society substantial minorities may abstain from alcohol or take it in negligible quantities.

Patterns of consumption, however, vary considerably. For example cross-cultural studies in the United States have shown that groups from different immigrant backgrounds have very different patterns of consumption. Thus, traditionally, drinking in Jewish communities, while almost universal, is related especially to ritual and to important social occasions and is almost always moderate; moreover, drunkenness is frowned upon. A similar pattern is said to be found in Chinese and Italian communities living in the United States, whereas its groups of Irish and Scottish descent have higher proportions of both abstainers and heavier drinkers and there is considerably greater tolerance of inebriation, which is indeed sought for its own sake. It is observation of these societal patterns, or social controls, which largely determines the way in which children form their own images of alcohol use and eventually their own adolescent and adult drinking patterns. Where social controls are weak the aim of the health educator is to strengthen them.

But because social controls may, in some communities, be very weak, and with consequent great social damage and harm to health, governments have instituted other means of curbing, or attempting to curb, the practice of harmful activities. There are legal controls over the production and sale of alcoholic beverages, over the number of outlets and their laws of sale, and over the age at which young people may legally purchase their own alcohol. The extreme method of legal control is prohibition. (There are other purposes in legal and fiscal controls but they are not our concern here.) The effect of legal controls is controversial. It is said that in the nineteenth century no other subject occupied more Parliamentary time than the licensing laws which were alternately restrictive and permissive. Consumption of alcohol, however, is said to have declined almost in a straight line over many years, and the reasons adduced for this phenomenon are, the provision of a pure water supply so that water was as safe to drink as beer, and improved housing allowing men, and women, to stay at home instead of seeking the warmer and more comfortable environment of the inn. The licensing laws appear to have

had little or no effect. Similarly it has been said (13) , at any rate in Scotland, that the laws relating to the legal age of purchasing alcohol, dictate only where young people drink and not whether they drink; restrictions substitute illegal and unsupervised drinking for legal drinking under supervision.

Finally, the possibility exists of using fiscal controls, the tax weapon, to restrict consumption, and the call to government by the Royal College of Physicians in 1725, to do just this has already been mentioned. No subject in preventive medicine is more controversial, fraught or politically sensitive. In societies with good social controls the tax weapon is unnecessary.

But there is a massive weight of pragmatic evidence that in societies with less effective social controls the quickest way to reduce harm is to reduce *overall* consumption, and the quickest way to reduce overall consumption is to raise taxes. It scarcely matters which index of 'harm' is considered, whether liver cirrhosis, road-accidents, admissions to mental hospitals for alcohol dependence, the general relationship seems to apply. Unfortunately there have been attempts to quantify this relationship in mathematical terms, surely an unlikely description of human behaviour, but which have enabled opponents of the relationship to cast doubts upon it. Nevertheless, when this mathematical model is abandoned, the general proposition seems to hold. As has been said, however, the use of fiscal controls in this way is fraught with political difficulties. It is based upon the theory that there is a continuum of drinkers from light to heavy for each level of price of alcohol. If the price falls there will be more heavy drinkers at the far end of the spectrum and some of these will topple over into alcohol dependence and misuse. Conversely if the price of alcohol is raised the continuum will move the other way with less consumption and less harm. It is unfortunately true that the light and moderate drinker is thus penalized in order to stop the heavier drinker falling off the edge! The health economists will also point out that raising indirect taxes bears most harshly, though not necessarily more heavily, on the poor (the rich drink more because they can afford more). They will also point to the 'inelasticity of demand'; in other words that it takes a lot of tax increase to push down sales!

It is fairly obvious that party strategists will be reluctant to risk political opprobrium by raising alcohol prices. And libertarians will object on

other grounds, though we know that Mill agreed that the use of the fiscal weapon in this situation could be justified. More importantly a prosperous drinks industry is of great economic importance both as an employer of labour, in agricultural production, in production, distribution, sale and advertizing of drinks, and in exports; and any decision deliberately to limit growth in the industry, let alone to rein it back is a difficult one for government to take.

Recent history

It has been pointed out that consumption of alcohol fell in the Victorian Era, but nonetheless continued at a fairly high rate until the First World War when, possibly due to new legal measures, the rate fell sharply until the end of the Second World War. Since that time, and until recently, there has been a continuous rise in alcohol consumption, reaching the highest level for 50 years in 1979, and this has been accompanied by large increases in cirrhosis of the liver, admissions to hospital for alcohol dependence, and other sequelae of heavy drinking. At the same time, and again until recently, there was a gradual but steady fall in the price of alcohol as a percentage of real *per capita* disposable income.

Faced with this situation government's first thought was to strengthen social controls by health education and in 1968, when the Health Education Council and the Scottish Health Education Unit (now the Scottish Health Education Group) were formed, this was one of the first tasks laid upon them. But if trying to get people to change their behaviour in relation to smoking is difficult, how much more so in relation to drinking. Smoking, and especially cigarette smoking, is a relatively recent phenomenon in historical terms in western societies and there were always substantial minorities of non-smokers. The significance of alcohol in the lives of many western communities is far greater than that of tobacco, and the sums of money made available to the health education bodies are very small, though it must in any case be doubted whether this problem can be solved by throwing money at it; and if it took twenty years before health education made an impact on the smoking problem, it would clearly be an even longer term solution to alcohol misuse. To attempt to get Scotsmen to drink like Jews it is necessary to get them to behave like Jews in other respects; the idea of Highland communities

crossing the glen on a Saturday morning to the little white synagogue in the heather is not one likely to appeal to many Scots. Furthermore the health educators have, again until relatively recently, had their flanks constantly turned by the falling price of alcohol; and this in turn undermined their contention that government was seriously concerned.

In April 1977, the Social Services and Employment Sub-Committee of the House of Commons Expenditure Committee issued a report on preventive medicine (14) with a number of recommendations related to primary prevention of alcohol problems; these covered health education, research, legal age of drinking, and finally, having had the evidence outlined to it the Sub-Committee recommended that 'the price of alcoholic drink should remain at the same level relative to average incomes as it now is, and should not be allowed to become a relatively cheap item in the shopping basket.' The government's response to this, published in December 1977 (15), was to keep this recommendation 'under consideration'.

In 1977 the Advisory Committee on Alcoholism (DHSS sponsored) made similar recommendations; considered the price/consumption/harm theory; and concluded that 'fiscal powers should be utilized to ensure that alcohol does not become cheaper in real terms' (16). The government response, quite properly, was that it was unlikely that *dirigiste* measures would be acceptable without considerable public debate, and promised a consultative document in the 'Prevention and Health Series'.

Before this document could be issued however, the Royal College of Psychiatrists, taking a leaf out of the book of the Royal College of Physicians, had produced their own report *Alcohol and Alcoholism* (11). On the fiscal argument this report went even further. It argued that, in the first instance, national per capita consumption should be kept from rising, and in the second place, and only after public debate and consensus, consideration should be given to an agreed reduction of consumption, possibly to that of 1969!

Drinking Sensibly (12), the promised consultative document was issued in 1981 and contained a whole chapter devoted to tax and price disincentives. But this chapter concentrates largely, though not entirely, on the defects and difficulties of a fiscal control policy. Little or no space is devoted to the solid evidence that such a policy actually works in practice.

What purports to be a further study of the misuse of alcohol policy by the former Central Policy Review Staff ('The Think Tank') has been printed by the University of Stockholm, reputedly from a pirated copy (17). Whether this is authentic or not, it is widely believed to be authentic and governments have been widely censured in the medical press for suppressing it. Its conclusions are unsensational but are in line with many of the recommendations previously quoted. There can of course be no guarantee, but it may be that if the public was really given the opportunity to consider the matter, and over a lengthy period of debate, it might just conceivably be prepared to pay more for its alcohol if the reward was a decline in alcohol problems. We shall never know if the issue is not debated. It is scarcely surprising then that the conference of presidents of the Royal Medical Colleges in the United Kingdom should have decided, in September 1983, to set up a new pressure group 'Action on Alcohol Abuse', AAA. It clearly faces a formidable task and perhaps will ensure the public debate on the fiscal issue that has so far been avoided.

7

Some illustrative health issues

In this chapter it is proposed to look briefly at a selective number of health issues, focussing particularly upon those aspects which illustrate the general points made in earlier chapters.

Smoke abatement

Records exist of the use of coal as a source of fuel in the United Kingdom extending back over a thousand years. For the same period of time it has been realized that its use could constitute both a hazard to health and a nuisance. From the thirteenth century onwards there are records of legislative powers being used to ban the use of coal, in London generally, and elsewhere as a fuel in metal-working. In Elizabethan times, owing to the shortage of wood, coal increasingly came to be used, much to the annoyance of the Sovereign, and the first attempts were made to use less smoky, natural fuels and 'smokeless' fuels. The industrial revolution required cheap power in vast quantities and coal is found in huge amounts in many parts of the United Kingdom. The result of the industrial revolution was to turn Britain into an urbanized nation, and the cities were blackened with smoke from both domestic and industrial chimneys.

The result was also a great deal of ill-health, particularly of respiratory disease. Until the very recent past chronic bronchitis was one of the most important causes of death in the United Kingdom, indeed it was known abroad as the 'English disease' (with apologies to other parts of the United Kingdom which were equally afflicted). But air pollution, particularly when in the form of 'smog', (in Britain, smoke and fog held over a city by so-called temperature inversion), also expedited the demise of many sufferers from heart disease and from acute respiratory infections such as influenza. Indeed, while it

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killed through chronic bronchitis insidiously, it killed more spectacularly in times of smog.

The nineteenth century, not surprisingly, provides a record of persistent legislative attempts, either unsuccessful or, when successful, largely ineffectual. Select committees were repeatedly appointed and duly reported. It provides also a record of exasperation with government, of the formation of parliamentary pressure groups, and of voluntary effort. A Smoke Abatement Committee was formed as early as 1881, the Coal Smoke Abatement Society in 1899, and the Smoke Abatement League in 1909. These bodies later coalesced and formed the National Smoke Abatement Society which issued its own journal.

Strangely enough there was both complacency and opposition to reform. Many industrialists and their employees would say with pride, 'Where there is muck there is brass (money)' and there was some truth in this: when the factory chimney smoked there was prosperity.* There is a similar pride in the density of London fogs to be found in the pages of Conan Doyle. Alas, the smoke rotted and made filthy the exteriors and interiors of the buildings, and certainly the lungs of the citizens.

Opposition, as opposed to complacency, respected the libertarian stance that it was every Englishman's right to a cheerful open-hearth coal fire. Vested interests played little part as there was no suggestion that coal, and even coal-fires should be abandoned, only that it be consumed at the power stations blessed with smoke washers and high chimneys or in the form of smokeless fuel.

It took an outrage to produce definitive action; and that outrage was the great smog of London in December 1952 during which, and following, there were some four thousand excess deaths. No one in London, in those few days, could forget that impenetrable wall of blackness.

The government of the day set up yet another committee which produced further reports, and produced them with speed. The National Smoke Abatement Society lobbied intensely. Even so it was the introduction of private members' legislation by the late Sir Gerald Nabarro which forced the government's hand. The private members' bill

*When I was a medical student in Edinburgh, in the nineteen-forties, it was known with pride as "Auld Reekie" and its handsome buildings were black with grime. Not so to-day.

was withdrawn and replaced by a government bill which eventually became the 'Clear Air Act'. Within twenty years Britain's cities became cleaner places and chronic bronchitis no longer a major killer.

The use of seat-belts

The story of Britain's late accession to the ranks of advanced nations compelling its citizenry to use seat-belts in the front seats of cars is a perfect example of delayed legislation largely because of libertarian considerations, vested interests being of almost negligible importance.

There is ample evidence from the experience of other countries that the use of seat-belts by drivers and passengers in the front seats of cars reduces both deaths and disabilities to the users in car crashes. That there might occasionally be disbenefits to the user is far out-weighed statistically by the benefits. Clearly then the use of seat-belts by an increased proportion of motorists and their passengers would bring considerable savings to a hard-pressed Health Service particularly in the use of orthopaedic facilities. It is in this clinical area where waiting lists are long, for example for hip joint therapy.

Unfortunately, legislation to compel the use of seat-belts lies not with Health Ministers but with the Ministry or Department of Transport. Faced with the knowledge of benefits, and reluctant to use compulsion, Ministers of Transport tried persuasion on a complacent population. However, even the most strenuous and expensive use of the mass media, and even when coupled with direct approaches, could not raise user figures above 33 per cent. The paradoxical situation had then been reached when it was compulsory for manufacturers to fit belts to cars, but not for car users to wear them.

Still governments, with one honourable exception, were reluctant to bring their own legislation before the House, preferring, at best, to allow private members' legislation or private members' amendments and thus to test the 'temperature of the House'. On each such occasion the Houses of Parliament showed clearly that they were prepared by a majority to over-ride Mill on pragmatic grounds and compel the electorate to wear seat-belts just as they had long been compelled to wear crash-helmets if riding motor-cycles. Opponents of the measure argued, strenuously quoting as always from *On Liberty*. On such occasions, Health Ministers

repeatedly made it clear that they were on the side of compulsion. Government always allowed a free vote, and not a whipped vote, on 'a matter of conscience'. Eminent members of the medical profession were deputed to attend on the Minister of Transport (sic!), though it was Health Ministers who picked up the bodies and the bill. Finally a free vote was allowed on an amendment to a Transport Bill and the appropriate legislation passed and made effective in February 1983. Statistics for the same year, 1983, show that deaths on the road were the lowest since 1956 and analysis indicates that this was a clear result of the new legislation.

In resisting earlier legislation many government ministers themselves reasoned and voted on libertarian grounds, and others, more cynically perhaps, might have reasoned that the proponents of libertarian views more closely represented the views of the electorate than did those who favoured legislation. There is certainly no evidence that either of these views is true. Once the legislation was made effective the British dutifully donned their seat-belts and it is hardly conceivable that more than a handful would have changed their party allegiance on this account. Delay in legislating must have cost many hundreds of lives and thousands of disabilities per annum.

Fluoridation of drinking water

This topic is unique in this chapter in that it demonstrates the power of a pressure group to exert its influence on government in the direction, not of implementing or securing legislation, but of preventing or subverting it. It still demonstrates, however, that politics and preventive medicine are bed-fellows.

That dental caries is almost ubiquitous in western societies, that the incidence of the disease can be reduced by fluoridation of drinking water supplies, and that the measure is both economical and effective can hardly be doubted. It is all, also, quite beside the point.

The Report of the Royal College of Physicians *Fluoride, Teeth and Health* (18) notes 'Objections to fluoridation have been made on the grounds that it is dangerous, unnecessary, uneconomic or of negligible benefit; or that even if safe and beneficial, it is unethical.' This sentence in my view, misses the point. Organized objectors to fluoridation, who had

best be nameless as they are highly litigious, are expert at throwing up objections to the measure, usually on the most alarmist of health grounds; but these are simply diversionary tactics and serve simply to exhaust the energies of proponents of the measure in disproving allegations which may be of little or no substance. Once one windmill has been destroyed another can easily be set up in its place. The strategy, the grand design, is to oppose the measure on libertarian grounds, that no government has the right to compel a whole population to play its part in a measure designed for the benefit of a minority, albeit an important and substantial minority, (but Mill argued that a whole population of drinkers might be taxed for the benefit of a small proportion of misusers). The fluoridation argument then, has never been in essence a health argument but always a political argument.

Fluoridation, in the United Kingdom, is supported by government but there is no national legislation compelling its introduction, although the Health Departments have promised to indemnify fluoridating Authorities from legal action. Instead local Health Authorities have been encouraged to press the Water Authorities to fluoridate their water supplies. I hope it is not unfair to say that Water Authorities do not see this measure as one of their highest priorities; at best their attitude is one of acquiescence. However, the Water Authorities distribute their water supplies without reference to administrative local government and Health Authority boundaries and it may be, and often is, necessary to secure a joint approach to a Water Authority by a number of neighbouring Authorities otherwise fluoridated water will go to an authority which has not requested it. This joint approach is not readily obtainable. Furthermore, Water Authorities considering fluoridation may then be threatened with legal action.

Again consider the local representative considering the introduction of fluoridation. On the one hand he is told the measure will prevent dental caries. On the other hand he is told there is evidence it will cause Down's Syndrome, and/or cancer. Small wonder if he votes against the measure, postpones the vote, or absents himself from it.

Proponents of fluoridation have formed their own Fluoridation Society but this has never been important nationally or particularly influential; the issue is not one on which the public feels deeply, unless they are opposed to it. On the other hand the skill of the anti-fluoridationists in

opposing the measure, most recently at the vast expense of the taxpayer in regard to the case before the Scottish courts, is such that even the ranks of Tuscany, while hissing rather than cheering, have had to admire that skill. It is said that the only solution to the problem is government legislation. But it must be highly doubtful that any *British* government would bring in such legislation, and if it did that it would do more than allow a free vote. If it did allow a free vote? Mill, thou shoulds't be living at that hour!

Coronary heart disease and diet

The facts concerning the importance of coronary heart disease are so well known that to dwell on them here would be gilding the lily. The disease has become much more common over the last half-century with the rise in incidence most marked in men, among whom the incidence rate is in any case much higher. It is the commonest single cause of death in middle-aged men in the United Kingdom and accounts for about two-in-five deaths in males aged between 45 and 64, more than thirty thousand deaths a year. The crumb of comfort is that death rates do appear to be falling in males in the age group 35–44. But against this has to be set the fact that the United Kingdom appears to be lagging behind several other countries and especially the United States where death rates from the disease declined by 27 per cent for both men and women between 1968 and 1976. As well as being a tragic cause of premature death the disease causes much morbidity and is a great burden on the health services.

In the face of this modern epidemic public health physicians, cardiologists, and many other doctors have attempted to unravel causation. Unfortunately this is multifactorial, and while there is general agreement over the importance of certain of these factors, there is greater division about others. I hope it would be true to say that most doctors concerned would agree on the importance of refraining from cigarette-smoking, on the control—if present—of high blood pressure, and on the reduction, if necessary, of the fat content of the diet, and especially of saturated fats. It is probably also true to say that most doctors would advise both the maintenance of optimum weight and the undertaking of regular physical activity which may be of value in relation to prevention of coronary heart disease and are certainly of value in the maintenance of

health and of fitness, which are not quite the same thing. Cigarette-smoking has been considered in Chapter 5. The prevention of hypertension also has political overtones, not least because of the cost of treatment. But in this chapter the other major political issue, diet and coronary heart disease, is the main point of contention.

It is well known that communities with a low death rate from heart attacks are those with low average levels of blood cholesterol and there is general but by no means unanimous agreement that a diet rich in fat, and especially saturated fat, may lead to high levels of blood cholesterol. Blood cholesterol can be reduced by reducing the level of saturated fatty acids in the diet and also by substituting foods containing polyunsaturated fatty acids for other foods containing chiefly saturated fatty acids, and especially for certain animal fats and dairy products. Whether advice should be given to the general public, and more especially what advice, has been the subject of great controversy. In the meantime, as has been stated, Britain has fallen behind other countries with regard to its prevalence rates for coronary heart disease.

In the United Kingdom advice on nutrition is given to the Chief Medical Officer to the DHSS, and to the Chief Medical Officers to the other Health Departments in Scotland, Wales, and Northern Ireland, by an eminent group of physicians and nutritionists called the Committee on Medical Aspects of Food Policy; the Chief Medical Officers, in turn, advise ministers, both in the Departments of Health and of Agriculture. As long ago as the early 1970's this Committee set up a panel to consider the relationship, if any, between diet and coronary heart disease. The Committee endorsed the panel's report and it was published by the DHSS in 1974 (19). The majority of panel members recommended a reduction in fat in the average UK diet, especially of saturated fat, from both animal and plant sources, but remained 'unconvinced ... that the incidence of coronary heart disease in the United Kingdom would be reduced in consequence of a rise in the ratio of polyunsaturated to saturated fats in the national diet.'

Not surprisingly, because of the agricultural, dairying, food, and manufacturing implications, the Report was the subject of much controversy both in 1974 and ever since. Some nutritionists and physicians have flatly refused to accept that there is any connection between consumption of dairy products and coronary heart disease, and

that any benefit to health would follow their avoidance. On the other hand, other doctors have attacked the Panel for rejecting the evidence that the substitution of polyunsaturated fats for saturated fats in the diet (consonant with an overall reduction) would be of value. The dairy industry, and in particular the butter industry, has been continuously at war with the vendors of certain soft margarines rich in polyunsaturated fats. Later in the decade, milk became another target of attack as an important source of saturated fat largely because it is drunk in such volume. At the same time concern was expressed at the high saturated fat content of butcher meats where it is apparent, and of meat products where it is hidden. Agriculture and many parts of the food industry felt threatened, while at the same time farming policy within the European Common Market was having the effect of vastly increasing the size of dairy herds and the output of milk and butter, matters which are the concern of the Ministry of Agriculture, and not directly of the Health Departments.

In 1976 a working party of the Royal College of Physicians and the British Cardiac Society (20) repeated the advice to reduce total dietary fat, and especially saturated fat; but they also recommended that people at risk of coronary heart disease should replace some foods rich in saturated fats with those rich in polyunsaturated fats.

In 1977, as controversy failed to abate, the Committee on Medical Aspects of Food Policy reconsidered and repeated its 1974 recommendations. In its Report on Preventive Medicine in April 1977 (14) the Social Services etc. Sub-Committee of the Expenditure Committee of the House of Commons considered this topic, among others, and recommended that 'Information about fats should be placed before the public in order to show up clearly the risks from a high intake of saturated fats, to encourage people to moderate their fat intake or switch to polyunsaturated fats.' This recommendation was considered in the DHSS response *Prevention and Health* (15) and the comment affixed, 'accepted with reservations'. But the 1977 Social Services Sub-Committee Report went further to the heart of the problem with the recommendation that 'the proportion of saturated and polyunsaturated fats should appear on the label of manufactured foods'. This was recorded as 'under consideration' in the response. While health education is the responsibility of the Health Departments, food labelling falls to Departments of

Agriculture, naturally acting in consultation with the Health Departments.

Still, the pages of the medical press reverberated with argument, faithfully picked-up and reported by health correspondents in the general press, to the bewilderment of the general public which was also being bombarded by advertizing by the vendors of butter and of soft margarines. In 1978 the Health Departments issued, in the Prevention and Health Series, *Eating for Health* (21); and in 1981, in the same series *Avoiding Heart Attacks* (22). These booklets of advice to the informed public repeated the recommendations of the Committee on Medical Aspects of Food Policy.

The sad fact, however, is that there was absolutely no decrease whatsoever in the decade 1970–80, and indeed up to 1982, in the proportion of energy in the diet derived from fat which remained at about 42 per cent. (It is true, however, that within this proportion, less saturated fat is being consumed, and slightly more polyunsaturated fat). The health educators appeared to be getting nowhere. This is hardly surprising, because the general public was getting confusing and conflicting messages. In any event, many foods were insufficiently labelled, or not labelled at all—with the fat content and type, and any criterion for choice was simply insufficient. Common Market food policies continued to be unhelpful, albeit to the financial advantage of dairy farmers. Not surprisingly in the circumstances, once again doctors, health educators, and others came together to form pressure groups. The first of these was the Coronary Prevention Group which promptly proceeded to lobby for better advice, for better labelling, and for changes in food policy. Food is always of interest to the media and, using the techniques pioneered by ASH, the air-waves and the newspapers began to be echoed with criticism of the government. Of course the Coronary Prevention Group, as its name implies, was not solely devoted to this one aspect of prevention but was also concerned with anti-smoking, with exercise promotion, and so on. It soon began therefore to receive financial support from the DHSS and moral support from the medical establishment.

The situation was clearly intolerable and at the end of 1981 a second panel on diet and coronary heart disease, the Committee on Medical Aspects of Food Policy, was convened and reported in July 1984. Before it could report yet another group, a joint advisory group on nutrition

education of the British Nutrition Foundation and the Health Education Council issued its own critical report, the NACNE Report (24), somewhat tempered by the knowledge that a more influential group was considering one particular aspect of its own rather wider remit.

The COMA Panel findings and its recommendations in relation to fats in the diet differed only marginally from the 1974 Report, but it is in its approach and its style that the second Report differs from the first, and indeed from other reports of this Committee. The second Panel noted that the first Report, while comprehensive, scientific and erudite, had had no practical consequences partly because its recommendations were in such general terms. The second Report is brief, short on explanation (this was after all a review) and long and detailed in its recommendations pinning down and allocating responsibility for implementation. In its recommendations to government, in particular, it details the need for consultation with the producers, manufacturers, and distributors of food which will lead to legislation and to Codes of Practice which will, *inter alia,* improve public knowledge of the composition of foods; such consultation should also lead to the provision of some foods with lower contents of saturated and of trans fatty acids and/or common salt.

There are also recommendations concerning the production of leaner carcass meat and concerning the Common Agricultural Policy of the European Community. For the first time too its recommendations concerning overall reduction of fat in the diet and, in particular of saturated fat, are expressed in quantitative terms which facilitate the assessment of changes. (Incidentally, as a by-product they have the effect of raising the proportion of polyunsaturated fat in the diet).

In other words, like the Reports of the Royal College of Physicians on Smoking, and of the Royal College of Psychiatrists on Alcohol this, although not a political Report, is a Report designed to lead to political action; and indeed, considering the nature of the subject it is very hard to see how it could be otherwise and still be effective. It is not often that a DHSS sponsored Report receives a cordial response in the medical press but this was certainly true in this case (25). There must now be every expectation that health behaviour changes in relation to consumption of dietary fats will follow in the next decade.

Firstly, for reasons concerned with the general agreement in the European Community that production of butter (and therefore of milk)

was absurdly and grossly expensively high, that which is recommended on health grounds also fits in with other aspects of government policy. Secondly, industry itself has seen the writing on the wall, and the more enterprising have noted opportunities for commercial advantage. Already low fat milks, low fat cheeses and yoghourts are not only being produced (they have been available for some time), but actively marketed. Again, the health message coincides with financial advantage. Finally, the health message is simple and clear, easier to give and easier to take. Meanwhile the Coronary Prevention Group, and behind it the wider medical profession, will be monitoring the situation and can no doubt be expected to maintain the pressure on government departments.

8

Family planning

The study of family planning would be largely similar to the British scene in any of the developed countries which adhere to the Anglo-Saxon tradition. It is a saga of effort, first by individuals and then by groups of individuals to form influential voluntary societies to exert pressure on government. Certainly in the United Kingdom the opposition to the movement came not from commercial vested interests, but largely from the churches and from the medical profession. If there was any vested interest involved it was that of the male sex in keeping women subjected to the ever-present threat of continued unwanted child-bearing; though it must be said that there were many women who sided with the men to argue against reform, and many men who sided with the women in favour of liberation. The story is lengthy and complex and will be told here in brief; it is the story of the family planning movement and not that of contraception, which is much older. By the time the family planning movement began, coitus interruptus, the condom, and some form of occlusive pessary were all well-known, as apparently were the prototypes of other methods used today though there was much confusion as to terminology partly because of ignorance and partly as a result of the secrecy which surrounded the subject.

The family planning movement in the United Kingdom really began in the early years of the nineteenth century with the writings of Bentham, Carlyle, and especially, Frances Place. Their views were largely Malthusian and were designed to limit population and thus to ameliorate the worst horrors of the industrial revolution taking place all around them. These reformers did not just preach; they wrote books and leaflets which gave practical information. John Stuart Mill was an early convert and was arrested at the age of seventeen for handing out birth control leaflets to the public.

Another of their disciples, Robert Dale Owen, son of the more famous reformer and industrialist, went to America and published his own book which prompted an American, Charles Knowlton, to publish the *Fruits of Philosophy* which refuted the argument that contraception promoted immorality. Despite persecution and prosecution the book sold in hundreds of thousands.

In 1877 Charles Bradlaugh and Annie Besant, styling themselves as free-thinkers, decided to publish the book in this country as a test case and after a trial and appeal were acquitted. This was the period of attack both by the churches and oddly enough, in view of their own behaviour, by the medical profession. Both the *Lancet* and the *British Medical Journal* in their editorial columns opposed contraceptive devices as medically dangerous and promoting immorality.

By 1880 then the two strands of the family planning movement had begun to emerge, the Malthusians and the women's liberationists, if one may use a more modern term. In 1880 the Malthusian League was established (or rather re-established, because it had had an earlier unsuccessful existence in the 1860's) and quickly formed a Medical and Scientific Branch. The response of the medical profession was to strike a member of the Branch, poor Dr Arthur Albutt, off the Medical Register for publishing a cheap handbook of general advice on maternal and child welfare including a brief chapter on contraception!

From 1880 onwards the tide began to turn and this was due partly to changes in ideas, but much more likely to an invention of the industrial revolution, the vulcanization of rubber, which quickly led to the production of cheap rubber condoms in place of their expensive predecessors. Ralph Waldo Emerson was reported to have said that—to paraphrase—'if a man . . . makes a better mouse trap than his neighbour . . . then the world will make a beaten path to his door.' The better mouse trap was the rubber condom and its use, without expensive marketing strategies and advertising campaigns, spread remarkably rapidly, first to the middle-classes and later to the working-classes. Distribution was via 'rubber shops', barbers, and by post, and no medical intervention was needed. Thus while at least some of the middle-classes continued to preach against contraception, they practised its use enthusiastically. Between 1881 and 1911 the birth rate in middle-class areas of London fell by half; and the 1911 census showed that doctors had

the smallest families of any occupational group! By the 1930's the working-classes had learned for themselves and the national birth rate had halved since the 1880's.

What the family planning movement was designed to do was twofold; first to put contraception within the prerogative of the female, and second to make it part of the maternal and child welfare services. In 1921 both the Malthusian League and the Society for Constructive Birth Control and Racial Progress, formed by the great woman reformer Marie Carmichael Stopes, had opened clinics in London. From the start both movements made it clear that they expected these to be prototypes to be replicated everywhere by the local authorities, which, in 1921, were responsible for maternal and child health.

This aim, eventually to be achieved, took over fifty years. The tide was clearly on the turn when in 1921 the King's Physician, Lord Dawson, addressing the Church Congress argued in favour of artificial birth control, without incurring immediate general condemnation. Under the guidance of one or the other of these two organizations or their successors, voluntary family planning clinics began to spring up all over the United Kingdom. In 1930 the Ministry of Health issued a Memorandum allowing local authorities to provide advice to limited categories of women. Some local authorities opened advisory clinics, but often with very restrictive services; and some local authorities, and Medical Officers of Health, interpreted the rules in a very restricted fashion. In the same year the Anglican Church, at its conference, publicly moderated its previous opposition to contraception provided Christian principles were adhered to. In 1930 the National Birth Control Council was formed incorporating the, by now, several voluntary groups and this became known in 1939 as the Family Planning Association. The Family Planning Association had a double function. It was responsible for the spread of family planning clinics alongside the network of local authority clinics where these existed; but it continued, as a pressure group, to press for a national service. Like other such pressure groups, it received central government support, in particular for its educational and informational services.

During the 1960's there was a rapid expansion of Family Planning Association clinics, often within local authority premises and with local authority assistance. The 1967 Family Planning Act gave local govern-

ment significant responsibilities for the first time, an opportunity which was seized with both hands. The final step towards the realization of the dream of the pioneer came in 1974 when, with National Health Service re-organization, the majority of the clinics, together with their by now formidably large staff of doctors and nurses, were transferred to the new Health Authorities. Family Planning had arrived. At the same time an alternative service was available through family practitioners, and women can now choose their advisors. Controversy, however, is not dead. Whereas the earlier Family Planning Association clinics ostensibly served only married women or those about to be married, the National Health Service clinics are allowed to provide a contraceptive service to all sexually active women (and indeed men). Some girls seeking advice are below the age of 16, and it is an offence to have intercourse with such a person. Herein lies the dilemma for government, and indeed for society.

That there have been profound changes in the attitude of young people to sexual activity in our time can hardly be doubted. Sexual activity for many young people, not all, is not confined to marriage.

It is scarcely surprising then that for many young people, unsophisticated, perhaps not well educated on sexual matters, early experimentation leads to pregnancy outside marriage. By the early 1970's, when the Abortion Act enabled statisticians better to appreciate the overall situation because the abortions were legal, it became obvious that the situation was alarming. Adding together abortions, illegitimate pregnancies, and pregnancies conceived outside marriage but legitimated by marriage, it could be said that about one in every four young women aged fifteen could expect to have an extra-marital pregnancy by the age of nineteen, scarcely a happy state of affairs. It is scarcely to be wondered then that voluntary groups should spring up like the Brook Advisory Clinics offering advice and, if necessary, contraception specifically to single young people. Again these clinics have received official support. Following the 1974 Act, and the change in policy allowing advice to be given regardless of status the statistics improved somewhat so that, in very round figures, it might be said that by the end of the decade 'only' one in five teenagers between fifteen and nineteen would become pregnant.

It is the policy of allowing advice to be given to girls aged fifteen or under without parental knowledge which has come in for particular attack especially by certain voluntary groups concerned. The number of

girls concerned seeking such advice is relatively small, though this does not imply lack of concern, just as the number of such girls becoming pregnant is relatively small compared to older groups. Furthermore, the proportion of such girls becoming pregnant has remained much the same over many years, after a bad period in the early 1970's.

Ministers are under considerable pressure to review and perhaps reverse policy in relation to girls under the age of sixteen from the well-meaning voluntary bodies who usually arrogate to themselves some such title as would indicate moral and social responsibility, with the implication that anyone who disagrees with their views is in favour of the opposite to these virtues. (In the 1920's the opponents of birth control formed the League of National Life; presumably those who opposed its views were in favour of national death). In this respect ministers face precisely the same dilemmas as society itself. In the most awkward position of all sit the doctors, actually having to deal with some of the most difficult clinical situations one could envisage, and coping as best they can. The struggle continues.

9

Conclusions

In the introduction to the book the hope was expressed that out of an examination of the relationship between preventive medicine and politics, would come pointers to more effective and more timely action in the future than has been seen in the past. What general conclusions might be drawn?

It is amply clear that many aspects of preventive medicine are inextricably linked with politics. They are indeed political issues, and it has been made quite clear that decisions to take effective public health action are taken in cabinet meetings. It follows from this that those who want to achieve advances in prevention would be well advised to spend as much time studying the political process as they do on scientific issues, which, sometimes at any rate, have relatively simple implications after initial research and clarification.

It is hoped that the point has been forcefully made, that in relation to some forms of human behaviour, too much reliance should not be placed on government action. Examples have been given of how the most Draconian action, legal and fiscal, has achieved only limited effects. In the end, public assent has to be obtained through a long process of education, and health education is a discipline still in its infancy.

It is clear that Health Departments do not and cannot act alone when the results of their action have considerable and formidable implications for other Departments of State. Fragmentation in government affecting both formulation of policy and implementation is a recurring problem with no magic solution, in that many reforms at central government level have their costs as well as potential benefits. It was also pointed out that on many preventive isssues Health Departments are not in the lead even though they must treat the casualties caused by the failure to act of those Departments of State which are responsible. In these circumstances they can only exhort and persuade.

Thus the long delay by the United Kingdom Ministry of Transport in obtaining seat-belt legislation was noted. It is not always thus. One subject not discussed at length in these chapters is the issue of lead and health where Departments of the Environment are those most closely involved with action. It is noteworthy that in the face of accumulating evidence—never conclusive and perhaps never likely to be—of risk to health, (and especially that of children) definitive action has been taken in a number of countries to reduce the output of lead into the environment. Here the arguments of Health Departments quickly over-rode economic and commercial considerations.

It may be of some interest to speculate as to what it is about health issues that in some cases moves government to speedy action and in others can apparently be tolerated for long periods and sometimes indefinitely. What is it about the nature of the threat that affects the perceptions of the politician? The answer to this lies, more often than not, in the drama. Anything that kills or maims quickly requires instant action. Poliomyelitis demanded unlimited funding and large-scale campaigns (once effective immunologicals became available). Tuberculosis of bone and joint, caused by infected milk, was tolerable and the compulsory pasteurization of milk was long opposed; the disease strikes slowly. Indeed pulmonary tuberculosis which, before streptomycin became widely available in the 1950's, killed tens of thousands a year in the United Kingdom never achieved the Parliamentary importance, say, of poliomyelitis. Indeed it was depicted in literature in a romantic light. As to cigarette smoking and lung cancer, thirty thousand deaths a year is apparently something that can be tolerated. Can one imagine the Parliamentary upheaval if the same number of deaths occurred due to smallpox?

Fortunately, infectious diseases are now rarely the cause of media concern.* Rather it is the rare environmental accidents causing great loss of life and/or threats of cancer and congenital malformation at a later date and in unborn generations that cause the greatest concern and demands for firm and early action. The great smog of London in 1952 was quoted but there are more recent and equally dramatic examples in

*This sentence was written before AIDS became such a justified focus of attention.

Italy and India. The lesson to public health would seem to be to learn to heighten the drama. 'Crisis politics' can speed results. But if everything becomes critical, will this always be so? Therein lies another dilemma. Priorities must be evolved, in an imperfect world. And rational evaluation of priorities sits increasingly with pressure group politics, itself often necessary to the task of instilling a sense of 'crisis'.

In these chapters the motivation of governments in taking or refraining from action has been somewhat simplified, as if there was a balance sheet of advantage and disadvantage drawn up and the appropriate decision taken on entirely rational grounds. There probably is such a balance sheet but it does not tell the whole story. Most of us, when we examine our personal lives, know that having drawn up a balance sheet, what finally motivates our actions is, as often as not, self-interest and personal preference and temperament; we study the motoring journal and then buy the car because we like the shape; and our capacity for rationalizing the decision is considerable. So it is with governments. Some obstetricians are interventionist by nature and some sit on their hands. So it is with governments.

A good deal of attention was paid to the libertarian argument and, at the end of chapter 2, a special plea was put in to those seeking government action to show a greater understanding that some of those who argue on libertarian grounds are perfectly sincere. On some issues, indeed, personal interest and vested interests scarcely enter the argument. On other issues it is difficult to disentangle self-interest from arguments about liberty. Nor is this a recent phenomenon. Every student of public health history will know of the arguments that raged in the nineteenth century, even before the bacteriology was conceived and unravelled, concerning pure water supplies. Apparently civilized members of both Houses of Parliament argued that despite cholera and typhoid, it was the God-given right of every Englishman to drink his own excrement. The same arguments could be heard at local level, as in the pages of Sir John Simon's commission of inquiry into the outbreak of cholera on Tyneside in the 1850's, where the Gateshead city fathers proved extremely reluctant on libertarian grounds to provide the admittedly large sums necessary to separate drinking water from sewage. But the objections

appear to have dissolved quite suddenly when, in the words of evidence of a sanitary official, the cholera reached Low Fell. Low Fell was then, and still is, the more salubrious part of Gateshead.

Similarly, in our own day, it is noteworthy that members of parliament, of both major parties representing constituencies in which tobacco factories are substantial sources of employment, almost invariably take the libertarian view. Indeed some will not accept the cigarette-disease link at all, even today. These individuals are not necessarily liars or sophists; we are all capable of such self-deception. They can be brought round, if at all, not by abuse but by persistent, patient, rational argument.

The fear of governments that taking legal and fiscal measures that have the effect of limiting the rights of the individual (and more particularly of vested interests) will secure them a bad or—worse still—Puritan image is a very real one. It is for the politicians to decide how far this is valid. A government can present itself as 'reforming' as an alternative to either inaction or timid action; but politics has its cycles, and 'reforming epochs' are not the only epochs. Finding the right time is a crucial skill, though an intangible one.

This was precisely what was done in the Disraeli administration that passed not only the Cross Act but also the great Public Health Act of 1875. In fact this Public Health Act was mainly consolidating legislation, but great credit was gained by putting it forward as a major piece of legislative reform. It may strike the reader as quaint that both this act and the corresponding Public Health Act of 1937 were legislated by Conservative administrations, as was the Clean Air Act of 1956 and, more recently, seat-belt legislation. Could governments take a leaf out of Disraeli's book and could pressure groups encourage them so to do?

On the other hand politicians, because it is their job to do so, are often more closely in touch with the public view and may decide that while action is appropriate it may need to be delayed until the public finds it acceptable. This time is not necessarily wasted. Here pressure groups may need to assist legislators by public education. Sometimes both politicians and public health officials misjudge the public mood and this can be quite counter-productive. An example was the very real mistrust, often by the more intelligent parents, of pertussis immunization. Both compensation, legislation, and a long period of patient public education have been

necessary to restore, at least partially, confidence in the procedure. Little was gained by apparent impatience and irritation.

In summary then, in relation to the libertarian argument, reformers must understand the arguments, accept the sincerity of those putting them forward, and be prepared to counter them; they must be prepared to consider the politician's viewpoint that the public is not yet ready for change but will be in due course, and assist in the public education that may be required. Finally they may try to persuade politicians that it may be turned to political advantage to make the best of an unpalatable medicine.

It is evident from these pages that pursuing the public health is—not infrequently—to threaten the livelihood of individuals and families working in enterprises which have, heretofore, perhaps considered themselves as public benefactors or, at the very least, harmless. Can those very enterprises do something to help themselves? The natural reaction to disquieting news from the epidemiologists is first to ignore it, then to disparage it and finally to deny it and organize in self-defence. In the end, as can often be long foretold, definitive action and adaptation will be necessary.

Would it not be better if industry was to 'ride with the punches' rather than stand and tràde punches? The drink industry has for some time adopted this attitude and, as has been seen, the food industry, or parts of it at any rate, are busy adapting to the new 'low-fat policy' rather than fight against it. Would the tobacco industry have done better to accept the anti-cigarette argument, at least in private, and to have looked for alternative and less harmful forms of tobacco use? Could promoters of the public health not encourage such attitudes? Sometimes, not always, they do prefer to crusade rather than negotiate. Alternative sources of employment or income are easier to portray in theory than in practice. But tangible alternatives always strengthen a case.

It has been noted that pressure groups are not a new phenomenon. The power of pressure groups to perform what apparently is impossible has been noted and we can expect to see the growth of such organizations. We can also expect them, increasingly, to have noted the lessons of ASH and to use the same successful techniques. Indeed the more resistant governments are to reform, or even to encourage informed debate, the

more important pressure groups will be and the greater the haste to bring them into being.

It has also been noted that these actions are sometimes not entirely unwelcome to Health Department Ministers in their battle to secure approval to their actions by colleagues, or by obtaining action from these same colleagues where the latter bear the administrative and legislative responsibilities. Financial subventions to pressure groups are a very old story.

Perhaps the lessons of ASH can be summarized to end this paper. First, that funding is required but this need be only a relatively small sum; a highly skilled team can keep itself in the public eye with relatively little expense. Second, that the techniques are not medical and not public health although the backing of medical experts is required. The techniques are political and based on public relations. Third, the pressure group must secure for itself an all-party political lobby. Fourth, it must, while seeking publicity, eschew gimmickry; and, while dogged and persistent, must avoid the appearance of fanaticism and austerity.

The conservatism of government when faced with changes is, as history shows, a reality. Therefore we must expect pressure groups to continue and, as new causes appear, to proliferate. They will be a continuing fact of life.

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