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From “Informed Choice” to “Social Hygiene”: Government Control of Cigarette Smoking in the US

CHRISTOPHER J. BAILEY

In 1964 US Surgeon General Luther L. Terry published a report on smoking and health which concluded that “Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action.”¹ Publication of this report marked the beginning of contemporary governmental efforts to control smoking.² Over the next 40 years a range of legislative and regulatory action at all levels of government sought to restrict an activity that had become widely identified as the leading cause of preventable death in the United States.³ Warning labels were required on cigarette packages, restrictions placed on advertising, controls introduced on the sale of cigarettes, lists of additives in cigarettes submitted to the federal government,

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¹ US Department of Health, Education, and Welfare, *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*, US Public Health Service, Centers for Disease Control, 1964, 33.

² Considerable regulatory activity to control cigarette smoking had taken place between 1890 and 1917. See Cassandra Tate, *Cigarette Wars: The Triumph of the Little White Slaver* (New York: Oxford University Press, 1999); Peter D. Jacobson, Jeffrey Wasserman, and John R. Anderson, “Historical Overview of Tobacco Legislation and Regulation,” *Journal of Social Issues*, 53 (1997); Gordon L. Dillow, “The Hundred Year War Against the Cigarette,” *American Heritage*, 32 (1981), 94–107.

³ See US Department of Health and Human Services, *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General*, US Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1989; J. M. McGinnis and W. H. Foege, “Actual Causes of Death in the United States,” *JAMA*, 270 (1993), 2207–12; Stanton A. Glantz et al., *The Cigarette Papers* (Berkeley, CA: University of California Press, 1996); Larry C. White, *Merchants of Death: The American Tobacco Industry* (New York: Beech Tree Books, 1988); and Elizabeth M. Whelan, *A Smoking Gun: How the Tobacco Industry Gets Away with Murder* (Philadelphia: George F. Stockley, 1984).

excise taxes increased, and restrictions introduced on smoking in public places. Efforts to assert some control over the content of cigarettes, however, were unsuccessful. Exemptions for tobacco products can be found in virtually all federal consumer safety laws.⁴

Although the precise pace and shape of these efforts to control smoking have been determined by a complex matrix of economic, social, and political variables that defy easy characterisation, a clear shift in what constitutes “appropriate remedial action” is identifiable.⁵ Governmental action in the period immediately following publication of the 1964 Surgeon General’s Report emphasised the need for smokers to make decisions about their habit on the basis of “informed choice.” The assumption was that smokers would give up their habit if properly informed about the health risks associated with smoking cigarettes. This emphasis on consumer education was supplemented by an increased willingness to treat smoking as a “social hygiene” issue from late 1970s onwards. Smoking began to be regarded as a problem akin to cholera, polio, or malaria, that required government action to safeguard the public health. Federal, state, and local governments proved increasingly willing, as a result, to exercise their police powers to protect non-smokers, vulnerable populations such as children, and even smokers, from the dangers of smoking.

⁴ Tobacco products were explicitly excluded from the 1966 Fair Labeling and Packaging Act, the 1970 Controlled Substances Act, the 1972 Consumer Product Safety Act, and the 1976 Toxic Substances Control Act. A 1976 amendment to the Hazardous Substances Labeling Act also exempted tobacco products.

⁵ The most detailed account of government efforts to control cigarette smoking in the United States is Richard Kluger, *Ashes to Ashes* (New York: Vintage Books, 1997). Other studies include Jacob Sullum, *For Your Own Good: The Anti-Smoking Crusade and the Tyranny of Public Health* (New York: The Free Press, 1998); Robert L. Rabin and Steven D. Sugarman, eds., *Smoking Policy: Laws, Politics, and Culture* (New York: Oxford University Press, 1993); and Ronald J. Troyer and Gerald E. Markle, *Cigarettes: The Battle Over Smoking* (New Brunswick, NJ: Rutgers University Press, 1983). These studies offer details and insights into anti-smoking efforts in the United States, but do not offer systematic characterisations of the different phases of smoking control. An attempt to characterise phases or stages of smoking control can be found in Richard McGowan, *Business, Politics, and Cigarettes* (Westport, CT: Quorum Books, 1995); and Constance A. Nathanson, “Social Movements as Catalysts for Policy Change: The Case of Smoking and Guns,” *Journal of Health Politics, Policy and Law*, 24 (1999), 421–88. Neither of these studies characterises the phases of smoking control in terms of “informed choice” and “social hygiene.” The growing view of tobacco as a “social menace” is noted by Donley T. Studlar, *Tobacco Control: Comparative Politics in the United States and Canada* (New York: Broadview Press, 2002). Studlar does not, however, offer a distinction between “informed choice” and “social hygiene.” None of these studies shows how the change in stress from “informed choice” to “social hygiene” has given the issue the characteristics of morality politics.

A growing appreciation that the promotion of informed consent would not reduce smoking rates sufficiently to meet public health goals lay behind the shift in the emphasis of government efforts to control smoking in the late 1970s. Cigarette smoking proved a "stubborn norm" capable of resisting consumer education campaigns.⁶ The 1979 Surgeon General's Report *Healthy People* noted that "formidable obstacles" stood in the way of improved public health.⁷ "Prominent among them are individual attitudes toward the changes necessary for better health," the Report observed. Despite increased public awareness that smoking caused lung cancer, heart disease, emphysema, and bronchitis, Americans continued to smoke in considerable numbers. The effort to reduce smoking appeared to have "foundered on a traditional American libertarian ethic: 'It's my body and I'll do with it as I please'."⁸ Faced with this reality, public health campaigners sought to re-frame cigarette smoking as a social hygiene issue that emphasised the government's authority to protect the population from disease. This had two aspects. The first involved taking action to protect those populations unable to give informed consent to smoking: children and non-smokers. Growing evidence that exposure to "environmental tobacco smoke" (ETS), or passive smoking, had adverse health effects provided a rationale for bans on smoking in public places. The second involved suggesting that smokers were incapable of informed choice. Smokers were characterised as addicts who were either incapable of reasoned decision-making, or else suffering from an illness and in need of care. "Tobacco use is a disorder which can be remedied through medical attention," stated the 1988 Surgeon General's Report.⁹

This shift in the meaning of "appropriate remedial action" has added an important ideological dimension to efforts to control smoking.¹⁰ Critics contend that the use of the government's police powers to achieve smoking reduction goals not only represents a willingness to impose a particular set

⁶ US Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (2000), 40.

⁷ US Department of Health, Education, and Welfare, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (US Public Health Service, 1979), 11–12.

⁸ Allan M. Brandt, "The Cigarette, Risk, and American Culture," *Daedalus*, 119 (1990), 167. See also Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1989).

⁹ US Department of Health and Human Services, *The Health Consequences of Smoking: Nicotine Addiction, A Report of the Surgeon General*, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office of Smoking and Health (1988), i.

¹⁰ See Clifford E. Douglas et al., "Bridging the Ideological Divide: An Analysis of Views on Tobacco Policy Across the Political Spectrum," American Council on Science and Health (August 2000).

of values on a recalcitrant population, but also threatens to erode civil liberties.¹¹ The switch from promoting “informed consent” to treating smoking as a social hygiene issue is claimed to be indicative of the rise of “hygienic ideologies.”¹² Such claims suggest that efforts to control smoking have increasingly assumed the characteristics of morality politics.¹³ Morality politics involves questions of “first principles” that motivate high levels of citizen participation. These issues arouse a strong populist constituency that can often overcome resistance from traditional elites or other entrenched interests by using instruments of direct democracy such as referenda. The politics surrounding smoking control can no longer be explained simply in terms of traditional political economy models that stress the economic power of “Big Tobacco.”

PROMOTING INFORMED CHOICE

Publication of the 1964 Surgeon General’s Report on Smoking and Health legitimised concerns that cigarettes posed a serious risk to the health of smokers. The Report reviewed the literature on the medical effects of smoking, and concluded that: “cigarette smoking contributes substantially to mortality from certain specific diseases and to the overall death rate.” The Report confirmed that: “Cigarette smoking is causally related to lung cancer in men; the magnitude of the effect of cigarette smoking far outweighs all other factors. The data for women, though less extensive, point in the same direction.” The Report claimed that: “In comparison with non-smokers, average male smokers of cigarettes have approximately a 9- to 10-fold risk of developing lung cancer and heavy smokers at least a 20-fold risk.” Smoking was also identified as the most important cause of chronic bronchitis. Increased incidents of oesophageal cancer, bladder cancer, coronary artery disease, emphysema, and peptic ulcers were also found to be associated with cigarette smoking although there was insufficient evidence available to posit a causal link. The overall death rate of smokers in a given year was estimated to be 70 percent higher than non-smokers.¹⁴

Cigarette sales fell in the immediate wake of publication of the 1964 Surgeon General’s Report. The *New York Times*, for example, reported an

¹¹ Richard Klein, *Cigarettes Are Sublime* (Durham, NC: Duke University Press, 1993).

¹² J. C. Whorton, *Crusaders for Fitness: The History of American Health Reformers* (Princeton: Princeton University Press, 1982).

¹³ See Christopher Z. Mooney, “The Public Clash of Private Values,” in Christopher Z. Mooney, ed., *The Public Clash of Private Values* (Chatham, NJ: Chatham House, 2000).

¹⁴ *Smoking and Health*, 28–33.

18 percent decline in New York State’s cigarette tax revenue for February 1964 compared to the previous year.¹⁵ In the country as a whole per capita consumption of cigarettes fell 3.5 percent between 1963 and 1964.¹⁶ These figures persuaded anti-smoking campaigners that smokers would give up their habit if properly informed about the risks they were taking. “We believe in the freedom of the individual in the matter of cigarette smoking”, the president of the American Cancer Society (ACS) informed a congressional committee in 1964, “We are opposed to legislation that would prohibit the smoking of cigarettes ... To achieve our goal we rely upon persuasion and public and professional education.”¹⁷ Few believed that the “appropriate remedial action” called for in the Surgeon General’s Report required anything more than ensuring that smokers were able to make an “informed choice” about their habit. “[T]he presumption was widely held that smokers – now apprised of the risks – would quickly quit,” Allan M. Brandt has noted.¹⁸

Government efforts to promote “informed choice” about smoking focused initially upon ensuring that purchasers of cigarettes were informed about the health risks associated with smoking. In June 1964 the Federal Trade Commission (FTC) issued a “Statement of Basis and Purpose” for a “Trade Regulation Rule for the Prevention of Unfair or Deceptive Advertising and Labeling of Cigarettes in Relation to the Health and Hazards of Smoking” that found that: “cigarette manufacturers have made no effort whatever to inform the consuming public of the mounting and now overwhelming evidence that cigarette smoking is habit-forming, hazardous to health, and once begun, most difficult to stop.”¹⁹ The FTC announced that it would require warnings on cigarette packages and in advertisements that cigarette smoking is dangerous to health. Heavy lobbying by the tobacco industry, however, led Congress to pre-empt the FTC’s authority to act. The Federal Cigarette Labeling and Advertising Act of 1965 required the warning “Caution: Smoking May Be Hazardous to Your Health” to be placed in small print on one side of a cigarette packet, forbade state or local governments from mandating additional labelling requirement, and suspended the FTC’s authority to require health warnings on cigarette advertising for three years. The law also required the FTC to submit an annual report to Congress on the effectiveness of cigarette labelling.

¹⁵ *New York Times*, 9 April 1964, A1. ¹⁶ *Reducing the Health Consequences of Smoking*, 268.

¹⁷ Cited in Sullum, 64.

¹⁸ Brandt, 163.

¹⁹ *Federal Register*. Federal Trade Commission, “Advertising and Labelling of Cigarettes” (16 CFR 408), 29 *Fed. Reg.* 530, 1964.

Enactment of the Federal Cigarette Labeling and Advertising Act of 1965 is evidence of the political power of tobacco industry. Not only was the labelling requirement weaker than that proposed by the FTC, but the pre-emption of state and local authority also protected the industry from having to deal with a multitude of different labelling requirements. The suspension of the FTC's authority to insist on health warnings in advertisements represented a further triumph for the industry. In a contemporary account of the passage of the 1965 law, Elizabeth Drew argued that it was "an unabashed act to protect private industry from government regulation."²⁰

The political power of the tobacco industry in the 1960s derived from its size, the positions of authority occupied by its allies in Congress, and the weakness of the anti-smoking movement. The tobacco industry in the 1960s was an \$8 billion industry that employed approximately 2 million people directly or indirectly. Supporters of the industry occupied one-third of the committee chairs in the US House of Representatives and one-quarter of those in the US Senate.²¹ Ranged against these forces were a number of organisations and individuals that lacked coherence. An Interagency Council on Smoking and Health had been formed in 1964, but the group lacked the unity and resources needed to confront the tobacco industry effectively. The refusal of the powerful American Medical Association (AMA) to endorse the findings of the 1964 Surgeon General's Report, or to support the FTC's proposed labelling requirements, further weakened the cause of anti-smoking advocates.²² Anxious to secure sufficient votes in Congress to defeat the Administration's Medicare proposals, the AMA had no wish to alienate lawmakers from tobacco-growing states.²³

The tobacco industry's influence in Congress prompted a number of anti-smoking campaigners to explore alternative means of promoting "informed choice." Prominent among these campaigners was John F. Banzhaf III who filed a complaint with the Federal Communications Commission (FCC) in 1966 calling for the Fairness Doctrine to be applied to cigarette advertising.²⁴ The Fairness Doctrine, first articulated by the FCC in 1949, stipulated that broadcasters had an obligation to present both sides of an argument whenever they aired material dealing with a controversial issue of public importance. Although the Fairness Doctrine had not previously been applied to

²⁰ Elizabeth Drew, "The Quiet Victory of the Cigarette Lobby," *Atlantic Monthly*, September 1965.

²¹ Kluger, 264.

²² J. C. Burnham, "American Physicians and Tobacco Use: Two Surgeons General, 1929 and 1964," *Bulletin of the History of Medicine*, 63 (1989), 1–31; Kluger, 286.

²³ See James L. Sundquist *Politics and Policy* (Washington, DC: Brookings, 1968), 315–16.

²⁴ T. Whiteside *Selling Death: Cigarette Advertising and Public Health* (New York: Liveright, 1971).



Figure 1. Per Capita Cigarette Consumption in the United States, 1960–2000.
Source: US Department of Agriculture, "Tobacco Situation and Outlook Yearbook," Economic Research Service, September 2000

advertising, the FCC agreed with Banzhaf's complaint and in June 1967 ordered broadcasters to provide "a significant amount of time" for anti-smoking messages.²⁵ The FCC determined that a ratio of one anti-smoking "public service announcement" (PSA) to every three cigarette advertisements would be appropriate. This ruling was upheld in *Banzhaf vs. FCC*, 405 F.2d 1082 (1968).

Application of the Fairness Doctrine to cigarette advertising forced the broadcasting industry to supply an estimated \$75 million in airtime for anti-smoking PSAs in the late 1960s.²⁶ The effect of these messages was significant. Exposed to anti-smoking PSAs during primetime television, Americans began to take greater note of the health effects of smoking. Opinion polls conducted in the late 1960s and early 1970s revealed a rise in knowledge of the link between smoking and health. In 1970 87 per cent of adults agreed that smoking was harmful to health compared to 81 per cent in 1964.²⁷ The number of Americans who believed that smoking caused lung cancer rose from 50 per cent in 1960 to 70 per cent in 1969.²⁸ Smoking rates declined as a result (see Figures 1 and 2). Between 1967 and 1970 per capita consumption

²⁵ *New York Times*, 3 June 1967, A1.

²⁶ Kenneth E. Warner, "Clearing the Airwaves: The Cigarette Ad Ban Revisited," *Policy Analysis* (Fall 1979), 435–50. ²⁷ *Reducing the Health Consequences of Smoking*, 180.

²⁸ The Gallup Organization, "Long-Term Gallup Poll Trends: A Portrait of American Public Opinion Through the Century," 20 December, 1999, www.gallup.com/poll/releases

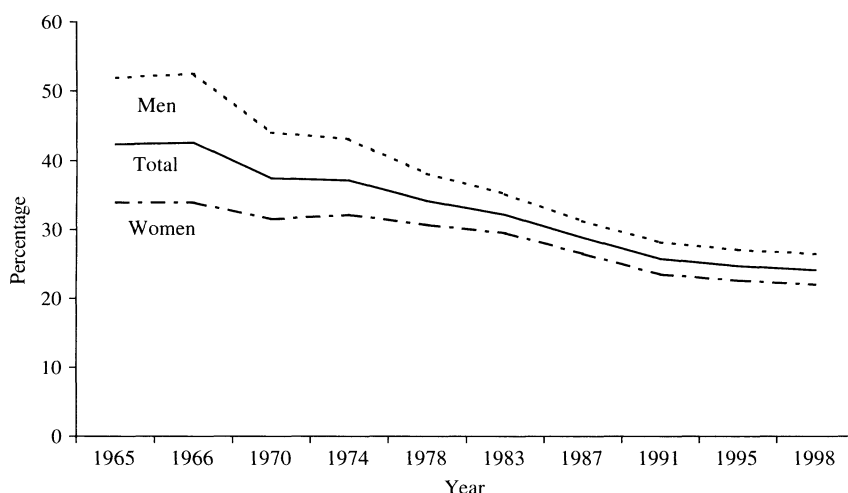


Figure 2. Percentage of adults who smoked, 1965–98.

Source: *MMWR*, vol. 49, no. 39, October 6, 2000

of cigarettes fell from 4,280 to 3,985, and the percentage of the population that smoked dropped from 40.7 per cent to 37 per cent. In 1970 44.3 per cent of men smoked compared to 50.8 per cent just four years earlier.

The effectiveness of anti-smoking PSAs had an important impact on government efforts to promote “informed choice” as it weakened the tobacco industry’s resistance to calls for a ban on cigarette advertising on television and radio. The FTC recommended a ban on such advertising in 1968, and the FCC followed suit in 1969.²⁹ Both agencies concurred that a ban was necessary because cigarette advertisements continued to stress “the relative safety of smoking” and failed to mention associated health hazards.³⁰ Recognising that a ban on broadcast advertising would mean an end to anti-smoking PSAs under the Fairness Doctrine, the tobacco industry agreed to stop advertising on television and radio by September 1970. Legislation containing such a ban was enacted in 1970. The Public Health Cigarette Smoking Act prohibited cigarette advertising in the broadcast media after 2 January 1971. It also strengthened slightly the warning labels on cigarette packages, and gave the FTC authority to require that these warnings appear in cigarette advertisements in magazines, newspapers, and on billboards.

²⁹ Sullum, 90.

³⁰ Federal Trade Commission, *Report to Congress: Pursuant to the Federal Cigarette Labeling and Advertising Act*. Washington: FTC (1967).

Enactment of the Public Health Cigarette Smoking Act proved a double-edged sword for anti-smoking proponents. On the one hand, the public health establishment had succeeded in removing cigarette advertisements from television and radio. Not only did this mean that seductive images of smoking were no longer shown on the country's most important medium of communication, but it also had a symbolic value as the ban helped to promote the notion that cigarettes were different from other legal products. On the other hand, the loss of anti-smoking PSAs under the Fairness Doctrine removed a vital opportunity to inform the American public of the health hazards associated with smoking. In a dissenting opinion in a 1971 case that upheld the constitutionality of the law, Judge J. Skelly Wright asserted that the tobacco companies actually welcomed the advertising ban because the anti-smoking PSAs had been very effective.³¹ Some evidence for this view can be seen in the fact that per capita consumption of cigarettes increased between 1971 and 1973 before resuming a gradual decline (see Figure 1). Not until 1978 did per capita consumption fall back to the level of 1970.

The Public Health Cigarette Smoking Act ushered in a new stage in the battle to convince Americans to stop smoking as the broadcasting ban prompted a shift in tactics by the tobacco industry. Money that had been spent on television and radio advertising was diverted to buy space in the print and outdoor media. Perhaps more significant, the industry began to switch resources from advertising to promotional activities. Sports sponsorship and branded merchandise not only exposed vast audiences to cigarette brand names, but also subverted government stipulated health warnings. Events such as the Virginia Slims tennis tour juxtaposed images of athletes with cigarette brands in a way that suggested that smoking was compatible with good health. Sponsorship of art and cultural events further sought to associate cigarettes with positive images.

An FTC staff report issued in May 1981 castigated the tobacco industry's advertising and promotional activities for undermining government efforts to promote “informed choice.”³² The report stated that: “The dominant themes of cigarette advertising are that smoking is associated with youthful vigor, good health, good looks and personal, social and professional acceptance and success, and that it is compatible with a wide range of athletic

³¹ *Capitol Broadcasting Co. vs. Mitchell*, 333 F. Supp. 582 (1971). The Public Health Cigarette Smoking Act was challenged by the broadcasting industry on the grounds that it discriminated against the electronic media as no corresponding ban on cigarette advertising applied to the printed media.

³² Matthew L. Myers et al., *Staff Report on the Cigarette Advertising Investigation* (Washington, DC: Federal Trade Commission, 1981).

and healthful activities.”³³ Although cigarette advertisements contained the mandated government health warnings, the report claimed that the efficacy of these warning was lost among the plethora of positive images. The report called for a new series of short, rotating health warnings to replace the existing “worn out” messages. This recommendation was eventually included in the Comprehensive Smoking Education Act of 1984, which required four specific, rotating health warnings on all cigarette packages and advertisements.³⁴

The claim in the 1981 FTC staff report that cigarette advertising and promotion was at odds with government health education programmes reinforced the view among anti-smoking activists that such activity was pernicious.³⁵ In testimony submitted to a congressional committee in 1982 on behalf of Action on Smoking and Health (ASH), John F. Banzhaf III claimed that cigarette advertising was inherently misleading. He asserted that as there “are not any real, absolute, positive qualities or attributes in a cigarette,” the purpose of cigarette advertisements was to “reduce objections” to their use by portraying smoking in a positive way.³⁶ The belief that advertising subverted public health messages led a number of health organisations to call for a ban on all advertisements. In 1985 the AMA, the ACS, the American Heart Association (AHA), the American Lung Association (ALA), and the American Public Health Association (APHA) called for a complete ban on tobacco advertising and promotion.³⁷ These calls prompted the introduction of a small number of bills in Congress in the late 1980s that proposed significant restrictions or bans on cigarette advertising, but none progressed very far.³⁸

³³ *Staff Report on the Cigarette Advertising Investigation*, 2–3.

³⁴ An excellent account of the machinations behind the enactment of the Comprehensive Smoking Education Act of 1984 is Michael Pertschuk, *Giant Killers* (New York: Norton, 1987).

³⁵ See Larry C. White, *Merchants of Death: The American Tobacco Industry* (New York: Beech Tree Books, 1988), 159.

³⁶ US House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Comprehensive Smoking Prevention Education Act*, Hearings, 97th Congress, 2nd session, 1982, 262. Statement submitted for the record by Action on Smoking and Health.

³⁷ R. J. Troyer, “The Surprising Resurgence of the Smoking Problem,” in J. Best, ed., *Images of Issues: Typifying Contemporary Social Problems* (New York: Aldine de Gruyter, 1989), 159–76.

³⁸ The following bills introduced in the 100th (1987–88) and 101st (1989–90) Congresses sought to restrict or ban cigarette advertising: HR 1272 (1987) introduced by Rep. Synar; HR 1532 (1987) introduced by Rep. Whittaker; HR 5113 (1988) introduced by Rep. Luken; HR 1250 (1989) introduced by Rep. Luken; HR 1493 (1989) introduced by Rep. Synar; HR 3297 (1989) introduced by Rep. Stark; and HR 5041 (1990) introduced by Rep. Waxman.

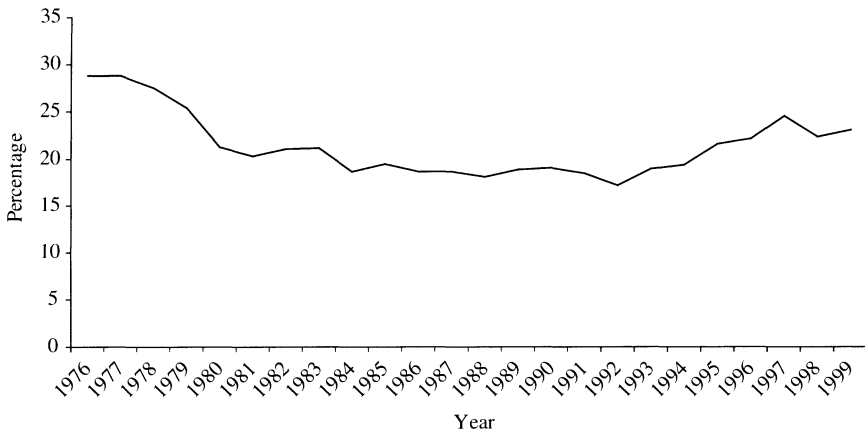


Figure 3. Prevalance (%) Of Daily Cigarette Smoking Among High School Seniors, 1976–99.

Source: University of Michigan, Institute for Social Research, Monitoring the Future Project, 1976–1999, Volume 1: Secondary School Students

Efforts to restrict or ban cigarette advertising and promotion received an important boost in 1988 when R. J. Reynolds introduced the cartoon camel character Old Joe (usually referred to as Joe Camel) to promote Camel cigarettes. The fact that a number of studies suggested that the use of Joe Camel had led to an increase in under-aged smoking allowed anti-smoking campaigners to frame calls for an advertising ban in terms of a need to protect children.³⁹ In March 1992 the Coalition on Smoking and Health petitioned the FTC to ban further use of Joe Camel on the grounds that the campaign improperly targeted minors. Although the petition was backed by US Surgeon General Antonio Novello, the AMA, and the FTC's staff, the Commission voted in June 1994 not to issue a complaint against R. J. Reynolds. The FTC found that under-aged smoking had actually decreased during the first five years of the Joe Camel campaign. Subsequent evidence that rates of under-aged smoking had increased after 1992, however, forced the FTC to reconsider the issue. Between 1992 and 1996 the percentage of high school seniors who reported smoking rose from 17.2 percent to 24.6 percent (see Figure 3). With two new commissioners appointed by President

³⁹ Paul M. Fischer et al., "Brand Logo Recognition by Children Aged 3 to 6 Years," *JAMA*, **266** (1991), 3145–53; Joseph R. DiFranza et al., "RJR Nabisco's Cartoon Character Promotes Camel Cigarettes to Children," *JAMA*, **266** (1991), 3149–53; D. L. Breo "Kicking butts – AMA, Joe Camel, and the 'Black-flag' War on Tobacco," *JAMA*, **270** (1993), 1978–84.

Clinton, the FTC voted in May 1997 to issue a complaint against R. J. Reynolds charging that “the purpose of the Joe Camel campaign was to reposition the Camel brand to make it attractive to younger smokers ... The Joe Camel campaign induced many of these children and adolescents under the age of 18 to smoke Camel cigarettes or increased the risk that they would do so.”⁴⁰

Evidence of increasing rates of under-aged smoking prompted the Clinton Administration to launch a “War on Tobacco.” In August 1996 the Food and Drug Administration (FDA) issued regulations that imposed extensive restrictions on cigarette advertising and promotion. Designed to reduce the attractiveness of cigarettes to children and adolescents the regulations banned outdoor advertising within 1,000 feet of a school, prohibited promotional items such as hats and T-shirts, forbade brand-name sponsorship of sporting events, and banned all print advertisements except those in adult-oriented publications. The tobacco companies subsequently challenged the authority of the FDA to issue such regulations. In *Coyne Beahm, Inc. vs. US Food and Drug Administration*, 966 F. Supp. 1374 (1997) a federal district court ruled that the FDA possessed the statutory authority to regulate cigarettes as “drug delivery devices,” but had no corresponding authority to regulate the advertising and promotion of cigarettes. The restrictions on advertising contained in the FDA’s regulations, however, were accepted by the industry as part of a liability settlement negotiated with the attorneys general of most of the states in 1998.

In an attempt to resolve litigation brought by state governments to recoup Medicaid costs for smoking-related illnesses, the tobacco industry negotiated a Master Settlement Agreement in November 1998 with 46 states, the District of Columbia, and five territories.⁴¹ The tobacco companies agreed to pay the states \$246 billion over 25 years and implement a number of public health provisions. Prominent among the latter were restrictions on advertising and promotion aimed at children and adolescents. The Settlement banned the use of cartoon characters to promote tobacco products, ended brand name sponsorship of events with a significant youth audience, banned the use of tobacco brand names in stadiums, required the removal of outdoor advertisements, and banned the distribution and sale of merchandise with brand name tobacco logos. The industry was also required to contribute

⁴⁰ *Tobacco Products Litigation Reporter*, “Proposed Tobacco Industry Settlement,” 12.3 *Tobacco Products Litigation Reporter*, 3.203 (1997).

⁴¹ See Carrick Mollenkamp, Adam Levy, Joseph Mann, Jeffrey Rothfeder, *The People vs. Big Tobacco* (Princeton, NJ: Bloomberg Press, 1998); Peter Pringle, *Cornered: Big Tobacco at the Bar of Justice* (New York: Henry Holt, 1998).

\$1.45 billion over five years to support the National Public Education Fund carry out a sustained advertising and education programme to counter under-aged tobacco use.

The emphasis on under-aged smoking in government efforts to counter cigarette advertising during the 1990s represented a departure from traditional approaches to promoting informed choice because such action was predicated on the assumption that children are not sufficiently mature to make a choice about smoking. President Clinton made this point when commenting on the FDA’s proposed restrictions on advertising in August 1996. “The cigarette companies still have a right to market their products to adults,” he noted, “But today we are drawing the line on children, fulfilling our obligation as adults to protect them from influences that too often are stronger than they are.”⁴² Focusing on children’s health allowed public health campaigners to re-frame cigarette smoking as a social hygiene issue that stresses government’s power to protect a vulnerable population from disease. FDA Commissioner David Kessler notably claimed in August 1996, for example, that smoking is a “paediatric disease.”⁴³ In a similar vein Donna Shalala, Clinton’s Secretary of Health and Human Resources, likened the campaign against under-aged smoking to the battle to eradicate polio in the 1950s.⁴⁴

Placing the emphasis on children served the campaign against cigarette smoking in two ways. First, it proved an effective strategy for garnering public support. The protection of children is a “motherhood and apple pie” issue that few people could legitimately oppose. Second, it offered the possibility of employing a wide range of policy tools in the battle against smoking. “Let’s do what it takes to bring teen smoking down,” President Clinton stated in his 1998 State of the Union Address, “Let’s raise the price of cigarettes by up to \$1.50 a pack over the next ten years, with penalties on the tobacco industry if it keeps marketing to our children.”⁴⁵ The focus on children provided both legitimacy and opportunity for stronger government action to reduce cigarette smoking by shifting the debate away from the promotion of informed consent towards the promotion of social hygiene.

⁴² The White House, Office of the Press Secretary, “Remarks by the President During the Announcement of Food and Drug Administration Rule on Children and Tobacco,” 23 August 1996.

⁴³ Food and Drug Administration, Press Release, 23 August 1996, 3.

⁴⁴ The White House, Office of the Press Secretary, Press briefing by Secretary of HHS Donna Shalala, FDA Commissioner of Food and Drugs, Dr. David Kessler, and Assistant Secretary of HHS, Dr. Phil Lee, 23 August 1996, 1.

⁴⁵ President William J. Clinton, State of the Union Address, 27 January 1998.

THE PROMOTION OF SOCIAL HYGIENE

The focus on under-aged smoking in the 1990s constituted part of a campaign that had begun in the 1970s to re-frame the debate about smoking in terms that would legitimise more coercive governmental action. Following publication of the 1964 Surgeon General's Report the tobacco industry had managed to frame this debate in a way that emphasised the personal freedom of smokers to enjoy their cigarettes.⁴⁶ The rugged individualism portrayed in the "Marlboro Country" advertisements, for example, helped to reinforce a libertarian ethic that denied the legitimacy of government efforts to regulate smoking. The industry also resourced a number of grassroots groups to champion smokers' rights.⁴⁷ The National Smokers Alliance, created by Philip Morris in 1993, became the most prominent of these groups.

Concern that this emphasis on personal freedom undermined efforts to reduce levels of smoking forced anti-smoking campaigners to pursue a number of strategies to change the terms of the debate. First, they challenged the idea that smokers exercised choice either by emphasising the addictive nature of cigarettes or characterising smoking as an illness. Second, they seized upon evidence that passive smoking caused health problems to show that the activity harmed non-smokers as well as smokers. Third, they highlighted the social costs of smoking to suggest that smoking was a burden that all members of society had to bear. These strategies sought to shift the debate about smoking away from the rugged individualism of Marlboro Country onto grounds that legitimised greater government intervention. They treat smoking as a social hygiene issue similar to campaigns to eradicate infectious diseases and not a matter of personal behaviour.

Efforts to characterise cigarette smoking as addictive have formed an important part in the campaign to transform the debate about smoking. Portraying smokers as addicts not only allows campaigners to employ the emotive language associated with drugs like heroin, but also fundamentally undermines the idea that smoking is a matter of personal choice.⁴⁸ Addiction means that smoking cannot be regarded as "a private-regarding vice" as informed consent to the risks involved cannot be given.⁴⁹ As Rep. John Bryant (D. TX) told tobacco industry Chief Executive Officers at a 1994 congressional

⁴⁶ Peter D. Jackson, Jeffrey Wasserman, and Kenneth Raube, *The Political Evolution of Anti-Smoking Legislation* (Santa Monica: RAND, 1992).

⁴⁷ See Stanton A. Glantz, "The Politics of Local Tobacco Control," *JAMA*, 266 (1991), 2110–17.

⁴⁸ Jordan Goodman, *Tobacco in History: The Cultures of Dependence* (London: Routledge, 1993), 243.

⁴⁹ Robert E. Goodin, "The Ethics of Smoking," *Ethics*, 99 (1989), 574–624.

committee hearing: "The fact of the matter is that you can't sit here today and say to us that people made a free choice to smoke if you also concede that once a person starts, they are addicted."⁵⁰ Characterising smoking as addictive allows smoking to be defined as an illness and not a choice. It means that smoking can be viewed as a disease rather than a cause of diseases.⁵¹

Early efforts to characterise smoking as addictive foundered on a distinction between "drug addiction" and "drug habituation" contained in the definition of addiction formulated by the World Health Authority (WHO) in 1957. This distinction was based on factors such as the level of intoxication involved, the strength of the compulsion to take the drug, the degree of tolerance that developed, and whether consumption of the drug harmed the individual or society. On the basis of these criteria the 1964 Surgeon General's Report determined that: "The tobacco habit should be characterised as an habituation rather than an addiction."⁵² WHO abandoned the distinction between "addiction" and "habituation," however, shortly after publication of the 1964 report, and recommended the use of the term "drug dependence." Claims that smoking constituted a form of drug dependency followed. The 1979 Surgeon General's Report reviewed the burgeoning literature on the subject and concluded that: "It is no exaggeration to say that smoking is the prototypical substance-abuse dependency."⁵³ This claim found support among other professional and public health organisations. In 1980 the American Psychiatric Association included "tobacco dependence" as a "substance abuse disorder" in its *Diagnostic and Statistical Manual of Mental Disorders*.⁵⁴ The National Institute on Drug Abuse (NIDA) described nicotine as a prototypic dependence-producing drug in a 1984 report to Congress.⁵⁵ Finally, the 1988 Surgeon General's Report concluded that: "Cigarettes and other forms of tobacco are addicting", and the "processes

⁵⁰ US House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and Environment, *Hearing, "Regulation of Tobacco Products,"* 103rd Congress, 2nd session, 14 April 1994.

⁵¹ See John D. Slade, "A Disease Model of Cigarette Use," *New York State Journal of Medicine*, 85 (1985), 294–97; Byron J. Bailey, "Tobaccoism is the Disease – Cancer is the Sequela," *JAMA*, 255 (1986), 1923.

⁵² *Smoking and Health*, 34.

⁵³ *Healthy People*, 10–18.

⁵⁴ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington, DC: APA, 1980).

⁵⁵ US Department of Health and Human Services, *Drug Abuse and Drug Abuse Research, Triennial Report to Congress from the Secretary, Department of Health and Human Services*, US Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse (1984).

that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin.”⁵⁶

The tobacco industry vigorously contested claims that cigarettes were addictive. Although a Brown and Williamson internal memorandum shows that the industry recognised that nicotine was an “addictive drug” in 1963, the industry publicly denied such claims.⁵⁷ The Tobacco Institute dismissed the conclusion of the 1988 Surgeon General’s Report by claiming that it “runs counter to common sense, as proved by the fact that people can and do quit smoking when they make the decision ...”⁵⁸ Data contained in the 1989 Surgeon General’s Report, for example, estimated that 44.8 percent of smokers, just over 43 million Americans, had stopped smoking by 1987.⁵⁹ Perhaps the most famous industry denial that cigarettes were addictive occurred in 1994 when the chief executives of the seven main tobacco companies swore on oath before a congressional committee that cigarettes were not addictive.⁶⁰ Leaks to the press and the release of incriminating documents in trials during the 1990s, however, finally forced the industry to concede that cigarettes were addictive. Liggett admitted that cigarettes were addictive in March 1997 as part of a legal settlement, and the other companies soon followed suit.⁶¹ In May 1998 Philip Morris, for example, agreed to confirm the addictive nature of cigarettes to settle a case brought by Minnesota.⁶² In October 1999 the company posted a message on its website stating that “cigarette smoking is addictive, as that term is most commonly used today.”⁶³

Two factors underpinned the tobacco industry’s reluctance to admit that cigarettes were addictive. First, an admission that cigarettes were addictive would undermine their standard defence in product liability cases that

⁵⁶ US Department of Health and Human Services, *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General*. Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office of Smoking and Health (1988).

⁵⁷ “Moreover, nicotine is addictive. We are, then in the business of selling nicotine, an addictive drug effective in the release of stress mechanisms.” Internal memo by Addison Yeaman, Vice-President and general counsel, Brown and Williamson, 1963. Cited in James Walton, ed., *The Faber Book of Smoking* (London: Faber, 2000) 111. See also Glantz et al., chapter 3.

⁵⁸ Cited in Kluger, 672.

⁵⁹ *Reducing the Health Consequences of Smoking*, 285–86.

⁶⁰ US House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and Environment, *Hearing*, “Regulation of Tobacco Products,” 103rd Congress, 2nd session, 14 April 1994.

⁶¹ Liggett admitted that cigarettes were addictive in order to settle claims arising from the class action suit *Castana vs. American Tobacco Co.* No. 94-1044 (E.D. La., 17 Feb. 1995).

⁶² *Minnesota vs. Philip Morris Inc.* No. CI-94-8565 (Minn., Ramsey City, 29 Nov. 1994).

⁶³ <http://www.philipmorris.com>

smoking was a voluntary act. The industry had successfully argued in a number of court cases that smokers had freely chosen to smoke and therefore had assumed responsibility for whatever risks might be associated with smoking.⁶⁴ Second, the industry feared that greater regulation would follow an admission that cigarettes were addictive. Although the Comprehensive Smoking Education Act of 1984 required the tobacco industry to submit lists of additives contained in cigarettes to the Secretary of Health and Human Resources, exemptions had been granted to tobacco products in all major consumer product safety laws. The industry feared that this privileged regulatory position would be threatened if cigarettes were shown to be addictive. A particular threat came from the possibility that cigarettes might fall under the purview of the Food, Drug and Cosmetics Act of 1938 if shown to be addictive.

The Food, Drug and Cosmetics Act gave the FDA authority to regulate a product other than food if a manufacturer intended that it "affect the structure and function of the body" when used. Traditionally the FDA had interpreted this clause to mean that it had no authority to regulate cigarettes as long as the tobacco industry made no explicit health claim about the product.⁶⁵ Evidence that the industry knew that cigarettes were addictive raised the possibility of FDA intervention, however, as the manufacturers could be accused of knowingly selling a product that affected "the structure and function of the body." In 1988 the Coalition on Smoking or Health (CSH) petitioned the FDA to assert its regulatory authority by arguing that the development of low-tar and low-nicotine cigarettes provided *prima facie* evidence that the industry knew how its products affected the body and sought to manipulate their components to suit its purpose. Although the anti-regulatory ethos of the Reagan-Bush administrations ensured that the FDA took no action on this occasion, CSH's petition had shown that cigarettes might be vulnerable to regulation under the Food, Drugs, and Cosmetics Act, given the political will.

The evidence needed to assert the regulatory authority of the FDA had been available since the 1950s when the Consumer Union and *Reader's Digest* began compiling tables detailing variations in the nicotine and tar levels of

⁶⁴ See Robert L. Rabin, "Institutional and Historical Perspectives on Tobacco Tort Liability," in L. Rabin and D. Sugarman, eds., *Smoking Policy: Law, Politics and Culture*, 110–30; G. E. Kelder and R. A. Daynard, "The Role of Litigation in the Effective Control of the Sale and Use of Tobacco," *Stanford Law and Policy Review*, 8 (1997), 63–98.

⁶⁵ The FDA had claimed jurisdiction in 1953 when it was claimed that Fairfax cigarettes prevented respiratory and other diseases, and in 1959 when Trim Reducing-Aid cigarettes were claimed to aid in weight reduction.

cigarettes.⁶⁶ Such variation strongly suggested that the tobacco industry manipulated nicotine levels with the intention of altering the affect of different brands on the smoker's body. Not until the election of President Clinton did the political will exist, however, to challenge the claims of the tobacco industry that cigarettes were not drugs as defined by the Food, Drugs, and Cosmetic Act. In February 1994 FDA Commissioner David Kessler announced that the FDA would investigate whether to assert jurisdiction over cigarettes after evidence emerged in a court case that the tobacco industry had manipulated nicotine levels to promote addiction.⁶⁷ The FDA announced the results of this investigation in August 1995. "Nicotine in cigarettes and smokeless tobacco products is a drug and these products are nicotine delivery devices under the Federal Food, Drug, and Cosmetic Act," the agency reported.⁶⁸

The tobacco companies immediately filed suit in federal court to challenge the FDA's claim that tobacco products were "drugs" or "devices" within the meaning of the Food, Drug, and Cosmetic Act. In April 1997 the Federal District Court in Greensboro, North Carolina, rejected the industry's argument, and upheld the FDA's authority to regulate cigarettes.⁶⁹ Judge William L. Osteen ruled that the FDA had demonstrated that tobacco products are "intended to affect the structure or function of the body." He also ruled that the FDA could regulate these products as medical devices. The tobacco companies subsequently appealed the decision to the Court of Appeals in Richmond, Virginia. In August 1998 the Court of Appeals overturned the lower court decision, and ruled that the FDA lacked the authority to regulate tobacco products.⁷⁰ Judge H. Emory Widener found that the FDA's claim of authority was based on a literal reading of "drug" and "device" in the Food, Drug and Cosmetic Act which failed to take into account statutory language as a whole, the legislative history, and congressional action in this area. The Supreme Court upheld the decision of the Court of Appeals in March 2000.⁷¹ Justice Sandra Day O'Connor, writing for the majority, observed that the FDA "has amply demonstrated that tobacco use ... poses perhaps the single most significant threat to public health in the United States," but that

⁶⁶ Kluger, 742.

⁶⁷ *Cipollone vs. Ligett Group, Inc.*, 789 F.2nd 191 (1986).

⁶⁸ *Federal Register*, US Department of Health and Human Services, Food and Drug Administration, "Analysis regarding the Food and Drug Administration's jurisdiction over nicotine-containing cigarettes and smokeless tobacco products," 60 *Fed. Reg.* 41453 (1995).

⁶⁹ *Coyne Beabm, Inc. vs. US Food and Drug Administration*, 966 F. Supp. 1374 (1997).

⁷⁰ *Brown & Williamson Tobacco Corp. vs. Food and Drug Administration*, No. 97-1604 (4th Circ., 1998).

⁷¹ *Food and Drug Administration vs. Brown & Williamson Tobacco Corp.*, 529 US 120 (2000).

"Congress, for better or worse, has created a distinct regulatory scheme for tobacco products, squarely rejected proposals to give the FDA jurisdiction over tobacco, and repeatedly acted to preclude any agency from exercising significant policymaking authority in the area."

The defeat of the Universal Tobacco Settlement Act (S. 1415) in June 1998 provides an example of congressional determination to maintain "a distinct regulatory scheme" for cigarettes. Introduced by Senator John McCain (R. AZ) to give statutory authority to a settlement negotiated between the states and the tobacco companies, S. 1415 included provisions that would have established a new regulatory regime for tobacco products to be administered by the FDA. S. 1415 gave the FDA authority to promulgate performance standards, including "the reduction or elimination of nicotine yields" and "the reduction or elimination of other constituents or harmful components of the product." The Bill also gave the FDA authority to eliminate "all cigarettes, all smokeless tobacco products, or any similar class of tobacco products." Not surprisingly, the tobacco industry bitterly opposed S. 1415. To defeat the measure the industry launched a multi-million-dollar lobbying campaign that included a \$40 million advertising campaign that portrayed the measure as vast "tax-and-spend" proposal.⁷² When it became clear that the bill's supporters did not have enough votes to break a filibuster lead by senators from tobacco-growing states, Majority Leader Trent Lott (R. MS) withdrew S. 1415 from the floor.

On one level, the defeat of S. 1415 coupled with the Supreme Court's rejection of the FDA's claim to jurisdiction over tobacco products represented a defeat for anti-smoking campaigners who believed that characterising smoking as addictive would legitimise greater government intervention. No significant change in the regulatory regime governing cigarettes occurred as a result of the successful characterisation of cigarettes as addictive. On another level, the transformation in the debate about smoking that has flowed from the characterisation of cigarettes as addictive represented a success for anti-smoking campaigners. Smokers have been increasingly regarded as addicts and the tobacco companies portrayed as drug dealers. Sympathy for both has eroded as a result.⁷³

An attempt to undermine sympathy for smokers also constituted an important part of the campaign to regulate exposure to environmental tobacco

⁷² Public Citizen, "Blowing Smoke: Big Tobacco's 1998 Congressional Lobbying Expenses Skyrocket," <http://www.citizen.org/tobacco/oct98lobby.htm>

⁷³ In 2001 a Gallup Poll found that 38 per cent of Americans claimed that they lacked sympathy towards smokers compared to 32 per cent in 1994, <http://www.gallup.com/poll/indicators/indtobacco>

smoke (ETS). The possibility that non-smokers might be harmed as a result of exposure to ETS provided a means of denouncing smokers for causing harm to others. Some campaigners even described under-aged exposure to ETS as a form of child abuse.⁷⁴ Language of this sort posed a threat to the tobacco industry because it undermined completely notions of “informed consent” and acceptance of risk. “What the smoker does to himself may be his business, but what the smoker does to the non-smoker is quite a different matter,” a report commissioned by the Tobacco Institute concluded in 1978.⁷⁵ ETS raised the possibility that smoking would be regarded as an environmental issue involving broad social concerns rather than a matter of personal behaviour. The industry also feared that successful efforts to restrict the areas where smoking could take place would lead to a reduction in smoking rates. Faced with ostracism in the workplace, restaurants and public buildings, smokers might decide to abandon cigarettes.

The first official suggestion that exposure to ETS posed a health threat to non-smokers came in the 1972 Surgeon General’s Report with a warning that smoking in a closed room or car might lead to the accumulation of dangerously high levels of carbon monoxide.⁷⁶ Subsequent epidemiological studies provided sufficient evidence of a link between ETS and health problems to enable the 1986 Surgeon General’s Report to claim that “involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers,” and that “The children of parents who smoke compared with the children of non-smoking parents have an increased frequency of respiratory infections.”⁷⁷ A 1986 report by the National Academy of Sciences similarly claimed that exposure to ETS increased the risk of lung cancer in non-smokers by 30 percent and adversely effected the respiratory health of children.⁷⁸ Two further government reports in the early 1990s provided additional ammunition for campaigners against ETS. In 1991 the National Institute for Occupational Safety and Health (NIOSH) published a report

⁷⁴ See Jon D. Andeson, “Parental Smoking: A Form of Child Abuse?” *Marquette Law Review*, 77 (1994), 360–84.

⁷⁵ The Roper Organization “A Study of Public Attitudes Toward Cigarette Smoking and the Tobacco Industry in 1978,” May 1978.

⁷⁶ US Department of Health, Education and Welfare, *The Health Consequences of Smoking. A Report of the Surgeon General: 1972*. Public Health Service, Health Center and Mental Health Administration (1972), chapter 8.

⁷⁷ US Department of Health and Human Services, *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General*, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office of Smoking and Health, 1986, 7.

⁷⁸ National Academy of Sciences, *Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Risks* (Washington, DC: National Academy Press, 1986).

that concluded that ETS could cause lung cancer and other health problems.⁷⁹ Even more important, the Environmental Protection Agency (EPA) released a report in 1992 that identified ETS as a "Class A" carcinogen.⁸⁰ The EPA estimated that each year 3,000 non-smokers died and 300,000 children suffered from lower respiratory tract infections as a result of exposure to ETS.

Although the link between ETS and ill health proved contentious, particularly the EPA's finding that ETS was a carcinogen, the prominence given in the media to these government reports served to mobilise public opinion.⁸¹ Between 1974 and 1987 the number of Americans who believed that passive smoking is hazardous to non-smokers' health rose from 46 per cent to 81 per cent.⁸² Demands for action to protect the rights of non-smokers accompanied this growing perception of the hazards of ETS. In 1988 60 per cent of Americans favoured a total ban on smoking in public places compared with 16 per cent in 1978.⁸³ Concern about ETS also led to the formation of interest groups. Grassroots groups such as GASP (Groups Against Smokers' Pollution) emerged in the 1970s to lobby for state and local smoking restrictions. These groups coalesced as Americans for Nonsmokers' Rights in 1986.

Public concern about ETS produced a flurry of legislative activity at the state and local level to restrict smoking. The first restrictions on public smoking were introduced in the 1970s. Arizona passed the first statewide ban on smoking in public places in 1973 while Berkeley, California, became the first community to introduce restrictions on smoking in restaurants in 1977.⁸⁴ The number of state laws and local ordinances limiting public smoking increased rapidly in the wake of publication of the 1986 Surgeon General's Report, and rose further following publication of the EPA's 1992 report. By the beginning of 2000 laws restricting public smoking in some way

⁷⁹ National Institute for Occupational Safety and Health, *Environmental Tobacco Smoke in the Workplace: Lung Cancer and Other Health Effects*, US Department of Health and Human Services, Public Health Service, Centers for Disease Control (1991).

⁸⁰ US Environmental Protection Agency, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders* (Washington, DC, 1992).

⁸¹ In *Flue-Cured Tobacco Cooperative Satbilization Corp. vs. United States Environmental Protection Agency*, 4 F. Supp. 2d 435 (1998) Judge Osteen annulled large sections of the EPA's report. He ruled that the EPA had not only violated administrative procedures but had also drawn conclusions before conducting a scientifically sound risk assessment.

⁸² *Reducing the Health Consequences of Smoking*, 201.

⁸³ *Ibid.*, 233.

⁸⁴ R. W. Schmidt, "The US Experience in Non-Smokers' Rights," *American Lung Association Bulletin*, 61 (1975), 11–16; Michael Pertschuk, eds., *Major Local Tobacco Control Ordinances in the United States* (US Department of Health and Human Services, Public Health Service, National Institutes of Health, 1993). NIH Publication No. 93-3532.

had been enacted in 47 states and the District of Columbia. California and Utah passed laws that made it illegal to smoke in most public areas. Other states passed laws that restricted smoking in public areas, required the strict separation of smokers and non-smokers, or required some lesser form of action such as the provision of designated, but not strictly separated, smoking areas. Only Alabama, North Carolina, and Wyoming failed to legislate against public smoking.

The first federal action to restrict public smoking came in 1971 when the Interstate Commerce Commission required designated smoking sections on interstate buses and trains. In 1973 the Civil Aeronautics Board followed suit and ordered all US airlines to provide non-smoking sections. Following publication of the 1986 Surgeon General's Report the federal government began to take more concerted action against public smoking. In 1987 Congress enacted legislation to ban smoking on domestic flights lasting 2 hours or less, and two years later extended the ban to cover domestic flights lasting 6 hours or less. Congress took further action against smokers in 1993 when it enacted legislation to ban smoking in WIC (Special Supplemental Food Program for Women, Infants, and Children) clinics. The Pro-Children Act of 1994 extended this ban to all federally funded children's services. Bans on smoking in government buildings were also introduced from the late 1980s. Smoking was banned in all Department of Health and Human Services buildings in 1987, in Post Office buildings in 1993, and in indoor military facilities in 1994. President Clinton finally issued an executive order in 1997 that banned smoking in all federal facilities.

The widespread adoption of restrictions against public smoking at all levels of government is testimony to the success that anti-smoking campaigners have had in changing the terms of debate about smoking. ETS provided campaigners with an opportunity to avoid arguments about personal choice and to focus instead on the harm that smokers do to others. This tactic also underpins arguments that emphasise the social costs of smoking. Anti-smoking campaigners argue that smokers take more sick leave and generate higher medical expenses than non-smokers. The annual health bill associated with smoking has been estimated to be \$50 billion.⁸⁵ When lost economic activity is added to health care the cost of smoking rises dramatically. The Coalition on Smoking or Health claimed in 1995 that: "the

⁸⁵ Vincent Miller, Carla Ernst, and Francois Collins, "Smoking Attributable Medical Care Costs in the USA," *Social Science & Medicine*, 48 (1999), 375–91; Kenneth E. Warner, Thomas A. Hodgson, and Caitlin E. Carroll, "The Medical Costs of Smoking in the United States: Estimates, their Validity, and their Implications," *Tobacco Control*, 8 (1999), 290–300.

total economic cost of tobacco exceeds \$100 billion per year."⁸⁶ The purpose of such claims is to show that smoking is not simply a matter of personal choice but that it imposes a burden on others.

Claims that smoking involves substantial social costs serve to legitimise calls for increases in cigarette taxes. Anti-smoking campaigners argue that higher taxes not only ensure that smokers "pay their own way," but also reduce consumption by raising the price of cigarettes. Recent econometric studies suggest that a 10 per cent increase in price will reduce overall cigarette consumption by 3–5 per cent, and under-aged consumption by 6–7 per cent.⁸⁷ According to the Campaign for Tobacco-Free Kids, a tax rise of this magnitude "would reduce the number of kids who become regular smokers by over a million."⁸⁸ The tobacco industry claims that increased cigarette taxes will fall most heavily on lower income groups, and will inevitably lead to bootlegging or smuggling. Some support for the industry's position can be found in a number of government studies. A 1990 study by the Congressional Budget Office concluded that cigarette taxes were slightly regressive while reports of the Advisory Commission on Intergovernmental Relations in 1977 and 1985 noted the black market activity that occurred when neighbouring states imposed different taxes on cigarettes.⁸⁹ Congress enacted the Trafficking in Contraband Cigarettes Act of 1978 in an effort to deal with organised smuggling, but casual "butt legging" has continued.

Many state governments have proved willing to raise cigarette taxes in an effort to reduce smoking. Publication of the 1964 Surgeon General's Report, for example, prompted 22 states to raise their cigarette taxes in 1965. Similar activity occurred in the late 1960s in response to the PSAs that were broadcast

⁸⁶ Cited in Sullum, 130. The economic cost associated with smoking is fiercely contested. See Kenneth E. Warner, "The Economics of Tobacco: Myths and Realities," *Tobacco Control*, 9 (2000), 78–89.

⁸⁷ The literature on the price elasticity of tobacco products is reviewed in US Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*, US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health (2000).

⁸⁸ Campaign for Tobacco-Free Kids, "New Study Proves Higher Cigarette Prices Prevent Teens from Becoming Smokers," <http://www.tobaccofreekids.org/Script/DisplayPressRelease.php3?Display=356>

⁸⁹ Congressional Budget Office, *Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels* (Washington, DC: CBO, 1990); Advisory Commission on Intergovernmental Relations, *Cigarette Bootlegging: A State and Federal Responsibility* (Washington, DC: ACIR, 1977); and Advisory Commission on Intergovernmental Relations, *Cigarette Tax Evasion: A Second Look* (Washington, DC: ACIR, 1985). See also Michael J. Licari and Kenneth J. Meier, "Regulatory Policy When Behavior is Addictive: Smoking, Cigarette Taxes and Bootlegging," *Political Research Quarterly*, 50 (1997), 5–24.

under the Fairness Doctrine.⁹⁰ The use of cigarette taxes as a policy tool became even more explicit in certain states in the wake of rising publicity about ETS during the late 1980s and 1990s. In 1988 California's voters approved Proposition 99, which imposed a 25 cent increase in the price of a packet of cigarettes. Massachusetts's voters passed a similar measure in 1992, and Michigan and Arizona followed suit in 1994. Oregon's voters approved Measure 44 in 1996, which increased cigarette taxes by 30 cents per pack, and California's voters approved a further 50 cents rise in cigarette taxes in 1998. Large tax rises were also enacted during the 1990s in Alaska, Maine, Maryland, New Jersey, and New York.⁹¹ Not all states, however, have proved willing to raise cigarette taxes to reduce smoking levels. Twelve states have not increased their cigarette taxes since the 1980s, and Virginia had not raised its tax on cigarettes since 1966. In 2002 Virginia imposed an excise tax on cigarettes of 2.5 cents per packet compared to \$1.11 per packet in New York.

The federal government has also proved reluctant to use cigarette taxes to reduce consumption. Explicit attempts to raise cigarette taxes to reduce smoking levels were included in President Clinton's 1993 health care proposals and Senator McCain's 1998 Universal Tobacco Settlement Act, but both were rejected. Congress has raised cigarette taxes several times during the last two decades, but these have been motivated by a need to raise revenue. The Tax Equity and Fiscal Responsibility Act of 1982 doubled the federal cigarette tax, and the Omnibus Budget Reconciliation Act of 1990 included two further tax increases. The 1998 budget agreement also included increases in the federal tax on cigarettes in 2000 and 2002. These rises mean that the federal excise tax on a packet of cigarettes has risen from 8 cents in 1982 to 39 cents in 2002.

The greater use of taxes by the states as an explicit tool to reduce smoking is similar to the lead played by state and local governments in responding to ETS. This pattern suggests that anti-smoking campaigners have found it easier to achieve their objectives at the state and local level than at the federal level. The explanation for this development lies in the greater openness of most state and local governments. Instruments of direct democracy at the sub-federal level, such as propositions and initiatives, facilitate grassroots activity that circumvents traditional power structures dominated by allies of the tobacco industry. A significant number of the tax increases imposed on cigarettes in recent years, for example, have occurred as a result of successful

⁹⁰ *Reducing Tobacco Use*, 339.

⁹¹ Campaign for Tobacco-Free Kids, "Raising State Cigarette Taxes Always Increases State Revenues and Always Reduces Smoking," <http://www.tobaccofreekids.org/reports/prices>

propositions. The fact that these instruments of direct democracy are not available at the federal level has made it more difficult to circumvent the influence of the tobacco industry in the corridors of Congress.

Over the last four decades anti-smoking campaigners have had considerable success in re-framing cigarette smoking as a social hygiene issue rather than a matter of individual choice. This transformation in the debate about smoking has altered the structure of politics surrounding the issue. Explanatory models of policy-making that emphasise political-economic variables have increasingly seemed less relevant to smoking politics than models based on morality politics. This transformation in the structure of smoking politics has been most evident at the sub-federal level where opportunities for successful grassroots activity have been greatest, but can also be seen to a lesser degree at the federal level. The result has been an increased willingness to employ more intrusive government powers to reduce smoking levels. “A comprehensive approach – one that optimises synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies – has emerged as the guiding principle for future efforts to reduce tobacco use”, declared the 2000 Surgeon General’s Report.⁹² Pursuit of such “a comprehensive approach” will hasten the transformation of smoking politics into a form of morality politics as ideological differences about the appropriate role of government in regulating personal behaviour become more acute.

⁹² US Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General – Executive Summary*, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (2000), 18.