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Overview

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Dimensions of the "Smoking Problem"

Risks to Self

In 1989, the U.S. Surgeon General released a report summarizing the progress achieved in the campaign to eliminate cigarette smoking that had begun twenty-five years earlier with the landmark publication of the 1964 Surgeon General's Report, *Smoking and Health* (U.S. DHHS 1989; U.S. DHEW 1964a). Although smoking had declined substantially during the ensuing years, the 1989 report was filled with arresting statistical evidence of the toll in mortality and disease associated with continuing tobacco use. In 1985, approximately 390,000 deaths in the United States could be attributed to cigarette smoking. Smoking was identified as the source of 87 percent of lung cancer deaths, 82 percent of chronic obstructive pulmonary disease fatalities, 40 percent of chronic heart disease deaths in individuals under 65 years of age, and a substantial number of other chronic diseases and deaths. More recent figures indicate cigarette smoking is responsible for an estimated 434,000 annual deaths in this country (U.S. DHHS 1992, p. 106).

By any measure, 434,000 annual deaths is a staggering number of fatalities. It exceeds the total U.S. battlefield casualties in World War II; it constitutes a mortality rate far greater than the sum of deaths that result from drinking, driving, working, and recreational activities. All told, more than one in six deaths from all causes can be traced to tobacco use. Plainly, smoking is the leading source—by a wide margin—of avoidable mortality (U.S. DHHS 1989, pp. 153–61).

Risks to Others

In addition to the risks to smokers, recent scientific findings show that nonsmokers also suffer adverse health effects from sustained exposure to environmental tobacco smoke (ETS). An important document summarizing these findings is another relatively recent Surgeon General's Report, *The Health Consequences of Involuntary Smoking* (U.S. DHHS, Surgeon General 1986). The report brought to public attention the notable findings that "side-stream" smoke is at least as rich in carcinogens as inhaled tobacco smoke, and that reliable studies indicate that "passive

smokers" have a significantly higher rate of lung cancer than those relatively unexposed to tobacco smoke, as well as suffering aggravation of various respiratory conditions (U.S. DHHS, Surgeon General 1986, Ch. 2; National Research Council 1986).

Even more recent inquiries, including a 1992 report prepared by the U.S. Environmental Protection Agency and a paper published by the American Heart Association, confirm the link between ETS and lung cancer, as well as a wide variety of respiratory conditions, and report on a linkage with heart disease (U.S. EPA 1992; "Environmental Tobacco Smoke" 1992). These studies attribute to ETS exposure approximately 3,000 annual lung cancer deaths, between 150,000 and 300,000 lower respiratory ailments in young children, and an estimated 37,000 annual cardiovascular disease-related deaths.

Risk Awareness

Public awareness of the dangers of smoking appears to be quite high, even though the initial federal warning requirement imposed in 1965 was rather bland. All that the much heralded Federal Cigarette Labeling and Advertising Act required was: "Caution: Cigarette Smoking May Be Hazardous to Your Health." Nonetheless, in the following years the media provided a steady flow of increasingly alarming reports on the risks of smoking, and, in 1984, Congress enacted a new set of rotating health warnings that are far more explicit about the hazards of smoking than the initial proviso.

At present, public opinion polls confirm that smoking hazards have become common knowledge; for example, by 1986, 92 percent of the public, including 85 percent of current smokers, believed that smoking causes lung cancer (U.S. DHHS 1989, Ch. 4). As for the perception of danger to others, a 1989 Gallup survey commissioned by the American Lung Association found that 86 percent of nonsmokers think that ETS is harmful ("Environmental Tobacco Smoke" 1992).

Smoking Patterns

Given the widespread acknowledgment of the dangers of smoking, it is not surprising that tens of millions of Americans have quit. In 1990, only about 25 percent of adult Americans smoked, according to the Centers for Disease Control, the lowest percentage recorded since the agency began tracking smoking data in 1955. Indeed, since 1987 the percentage of smokers has been dropping at 1.1 percent a year, more than double the rate of decrease in the preceding twenty years ("Smoking Declines at a Faster Pace" 1992).

Nevertheless, many of those who smoked in 1964 and who are still alive continue to smoke. Moreover, millions of Americans have taken up the habit since then, typically beginning in adolescence. As a result, tens of millions of Americans smoke today.

Regulatory Background

In the forty years before the publication of *Smoking and Health*, not only was there no serious thought given to banning cigarette smoking, but there was virtually no regulation at all of tobacco sale or use. To the contrary, for decades our government *promoted* smoking—from subsidies to tobacco growers through free distribution of cigarettes to soldiers during wartime. A tobacco prohibition movement had realized some success in several states before World War I. But by the 1920s, political initiatives aimed at regulating smoking were moribund, and earlier prohibitory laws were repealed. To be sure, laws remained on the books formally restricting the access of the young to tobacco products, but these appear to have been largely ineffectual.

Popular culture between World War I and Vietnam portrayed smoking positively. In movies of the 1940s and 1950s, the cigarette is as ubiquitous as the handgun. Indeed, from Humphrey Bogart to John Garfield to Robert Mitchum, smoking was an accepted symbol of being cool and in control of the situation. In fact, role models in all walks of life—the arts, sports, the professions—were promoting the smoking habit.

The regulatory politics of the era reflects that popular acceptance. Quite simply, the starting point for restrictive regulatory action is the perception of a social problem. As long as smoker's cough, tobacco after-taste, and smoke-filled rooms and sporting arenas were regarded at most as minor annoyances and only vaguely perceived as posing health concerns—annoyances and concerns that were far outweighed by the perceived pleasures and positive connotations of smoking—tobacco use was a highly unlikely candidate for regulatory sanctions.

The hard evidence that smoking is seriously harmful is relatively recent in origin. Although studies of the health consequences of smoking date back to the 1930s, the magnitude of the risks associated with tobacco use—in particular, the risk of lung cancer—as well as the extent of the causal connection were widely recognized in this country only with the publication of the 1964 Surgeon General's Report. That report stated, in unequivocal terms, that "cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."

The tobacco industry has long disputed the causal link between cigarette smoking and disease in the course of defending lawsuits for money damages brought by smokers and their survivors. Yet, as early as the 1964 report, a substantial body of data linked smoking and lung cancer. And by 1989, the Surgeon General was able to summarize twenty-five years of further studies and conclude that causal connections had been established between smoking and a range of cancer risks—lung, laryngeal, oral, and esophageal—as well as pulmonary diseases, heart disorders, and infant growth retardation. While it remains possible that some yet undiscovered personality or genetic constituent triggers both the propensity to smoke and the various diseases with which smoking has been linked, most of the scientific community rejects this possibility and considers the association between smoking and health risks well established.

With the widespread publicity of the findings in the 1964 report, tobacco use

was added, virtually overnight, to the political agenda. Since the mid-1960s social attitudes about smoking have changed dramatically, and political activity addressing the conduct of smokers and the tobacco industry has increased correspondingly. Within a year of the report, Congress enacted the Federal Cigarette Labeling and Advertising Act of 1965, requiring the initial health warnings on cigarette packages. This legislation was followed by the Public Health Cigarette Smoking Act of 1969, banning the advertising of cigarettes on television and radio. The ensuing years have witnessed an incessant stream of further initiatives, principally in state and local legislative arenas (as well as efforts in the courts), aimed at controlling the use of tobacco.

What is the theory behind this regulation, both existing and proposed? What are the justifications for restricting tobacco sale and use? As we discuss in the next section, there is no single answer to these questions, because there are many different senses in which the health risks of smoking can be viewed as "a problem" warranting governmental intervention. Furthermore, as we point out, each perspective in turn implies different governmental responses. The implications of this diversity of outlook and associated solutions, as well as the desirability of further regulation, are addressed in the final section of this chapter.

An Array of Perspectives on "The Problem"

The perspectives discussed in this section begin with those that treat smoking as a risk to self, and the interventions implied range from noncoercive measures to strongly paternalistic government action. The presentation starts with informed choice—the perspective linked to the least coercive of intervention strategies—and moves along a rough continuum to smoking as immoral behavior, the perspective associated with the most assertive level of government involvement. After discussing these various viewpoints on risk to self, we turn to a perspective that focuses on the harm to others from smoking.

Informed Choice

At first blush, the wonder may be that a product as lethal as cigarettes has been allowed to remain in the marketplace at all. Yet, as a general matter, our society does not lightly impose bans on dangerous and deleterious products; witness the continuing controversy over cheap and easily concealed handguns, and consider the exception that might well be taken to underscore the rule—the disastrous experience with alcohol under Prohibition.

Instead, the traditional social goal with respect to consumer goods in America is that product use should reflect informed choice. Although our society largely relies upon the competitive economy to ensure that choice, this does not mean there is no place for public policy interventions. On the contrary, certain "market failures" are customarily thought to justify government regulation. When a product is dangerous, competitors cannot necessarily be counted upon either to provide a safer version or to inform the public through advertising.

This concern is sometimes explained as "safety doesn't sell"—a slogan that rests on the assumption that any claim to have a "safer" variant of a product only serves to emphasize the inherent danger of the product, and to scare off buyers altogether. And if the sales people resist promoting safety, then the production people have less of an incentive to concentrate on safety, facing instead greater pressure either to cut costs or to emphasize style or performance. Alternatively, when an industry does market safety any genuine risk may be unduly downplayed.

In either case, where risks are small, a further concern is that consumers will have difficulty rationally deciding whether or not to run them—some people perhaps foolishly discounting the danger, others unnecessarily exaggerating it. These considerations help explain why we assign safety-promoting roles to federal agencies such as the Food and Drug Administration, the Consumer Product Safety Commission, the Federal Aviation Administration, the National Highway Traffic Safety Administration, and the Federal Trade Commission.

In the context of "the smoking problem" an informed choice perspective starts with the commitment that individuals should decide for themselves whether or not to smoke. It assumes that, even though smoking is very dangerous, it is not inherently an irrational choice; rather, as long as individuals understand the hazards involved, they should be free to engage in risky activity that provides them with personal satisfaction. But as a corollary to this perspective, government's role is then to ensure truly informed individual decision making. Such an outlook, of course, is consistent with the various warning requirements enacted to date.

Yet, perhaps merely telling people that smoking causes cancer, heart disease, and the like is not sufficient. The informed choice perspective arguably requires, among other things, that those who take up or resume smoking, as well as those who continue to smoke or consider quitting, understand the magnitude and potential time dimension of the risks of smoking, the methods of quitting and their availability, the relative riskiness of competing brands and methods of smoking, alternative sources of similar pleasures, and so on. Moreover, because true informed choice requires that people not be seduced into self-delusion about the dangers of smoking, there may be, from this perspective, a legitimate governmental interest in the way tobacco products are promoted that is not restricted to policing outright misrepresentation and deception.

In sum, relying on an informed consumer choice orientation, a case can be built for government intervention beyond the existing required warnings and the current ban on electronic media advertising.

Advocates who see the problem as one of insufficiently informed choice are likely to concentrate on policies such as publicly funded (possibly tobacco-tax funded) community- and physician-based education programs, additional required disclosures about product risk printed on tobacco product packages and promotional materials, further controls on the style and content of cigarette advertisements and promotions, and public health-oriented and information-based mass media campaigns about smoking, including such related matters as information about cessation programs and alternative products.

For many, however, the solution to the smoking problem goes beyond ensuring informed choice.

Prevention and Child Protection

A second perspective on the smoking problem concentrates on the young. We have a long tradition in America of governmental intervention to protect children and youth, drawing on the idea that their immaturity prevents minors from making the sort of informed choice adults can make. Immaturity can preclude adolescents from sensibly considering large consequences before they act—especially long-term consequences. Hence we force young people to stay in school; we restrict their right to marry and to work in certain jobs; we allow them to dishonor their contracts; we don't allow them to vote or purchase alcohol; we subject them to curfews; and so on.

The child protection perspective on smoking emphasizes the fact that an overwhelming proportion of smokers begin when they are minors and that teenage smokers probably discount the future risk to themselves—especially because they probably think they can always quit. Yet it turns out that large numbers do not (and perhaps cannot) stop smoking, even though most adult smokers say they want to quit and have tried, unsuccessfully, to do so.

The child protection view also dovetails with the goal of long-term elimination of tobacco use through prevention. The idea is that if we can keep teenagers from starting to smoke, then the smoking problem as a cause of disease and death will largely solve itself over time. This view assumes that, in the great majority of cases, if people do not begin smoking in adolescence, relatively few will ever start to smoke at all. Whatever the accuracy of that assumption, from this perspective current adult smokers are not the real concern; rather, public policy efforts should be aimed at the next generation.

Advocates of governmental policies targeting children are likely to promote a variety of initiatives: school and community education, restrictions or bans on advertisements and promotions thought to be attractive to youths (including tobacco company sponsorship of sporting and pop culture events, free distribution of cigarette samples, and billboard ads), public sponsorship of mass media antismoking advertising aimed at youths, bans or tight controls on sales of cigarettes through vending machines, stringent penalties and enforcement of laws forbidding the sale of tobacco products to minors, and steep taxes on tobacco products (on the assumption that young, would-be smokers are especially sensitive to price). The general idea here is to make smoking "uncool," and to combine that strategy with making teenage access much more difficult.

Some people who want government to serve the best interests of children view the key role as one of empowering parents, on the theory that parents, in general, can be most counted on to want the best for their children. But this vision has been largely absent from the tobacco debate, perhaps because it is not clear which policies would be appropriate to help parents influence their children's use of tobacco, or perhaps because young people are typically most rebellious against their parents at the age when they begin to smoke. Of course, parents who themselves smoke are thought to be part of the problem and not a likely source of the solution.

Even if people were inappropriately seduced into smoking as teens, if they all quit on becoming adults most people would probably consider the smoking problem

relatively trivial. But, although many teen smokers do later quit, many others do not. This brings us to a third perspective on the smoking problem.

Smokers as Addicted Victims

Our society often extends special compassion towards those who are considered "victims." Victims of violent crimes, accidents, fraud, and natural disasters are some obvious examples. Although "innocent" and "victim" are often conjoined, this is not always the case. Indeed, one way to try to elicit sympathy for people engaged in what is widely viewed as socially deviant or personally irresponsible conduct is to label them victims—drug abusers, unwed teenage mothers, and prostitutes come to mind. Victims are typically seen to be entitled to help from society, especially when they have been victimized by impersonal forces, either natural or social. They are also thought to have rights against identifiable victimizers.

In the context of smoking, the standard liberal position in American politics (as explained earlier) is that once adults have been assured informed choice, the role of government ends. After all, the adventurous among us get great satisfaction out of risky activities ranging from sky-diving to skiing, and most would agree that government has no business interfering with these informed choices. Why should smoking be regarded differently?

Those who see smokers as victims respond to this claim of individual autonomy by arguing that smoking is unlike these other voluntary activities because smokers are addicted to tobacco use, and, as a result, do not have the opportunity to exercise personal choice to quit. In short, current smokers have been duped. They were lured into smoking, and large numbers are now stuck with a habit they cannot seem to break. Whereas the informed choice viewpoint implicitly assumes that some people will truly prefer to smoke (notwithstanding its dangers), this perspective assumes that smoking is really in the self-interest of virtually no one. Smoking is effectively considered an irrational choice, one that nearly all smokers now regret (Goodin 1989, pp. 27–28).

The addiction claim draws heavily on studies summarized in the 1988 Surgeon General's Report, *The Health Consequences of Smoking: Nicotine Addiction*, and rests on two premises; namely, that a substance is "addictive" if: (1) once regular use has commenced, physiological effects, establishing a dependency, are evident in its users, and (2) when termination of use is attempted, physiological impediments arise which a user has a very difficult time overcoming (U.S. DHHS, Surgeon General 1988; Goodin 1989, pp. 25–28). Although the data in support of these two propositions appear to be very strong, the conclusions to be drawn from the empirical findings are less clear-cut than might appear on first impression.

The 1988 Surgeon General's Report provides voluminous evidence of the physical consequences associated with the use of nicotine, the prime addictive substance in tobacco. Through studies of animals and humans, cigarette smoke has been traced directly to the bloodstream and thence into the brain and nervous system where alterations in function have been clearly identified. Related studies have revealed two classic characteristics of addictive behavior: (1) the development of "tolerance," the graduated need for larger amounts of the substance (nicotine) to

reach a steady state of physical equipoise, and (2) the occurrence of "reenforcement," the ability selectively to discriminate among substances (in blind tests) to satisfy the craving for the substance.

Similarly, the empirical findings are impressive that a withdrawal syndrome occurs when nicotine use is terminated. Studies have documented changes in mood, behavior, and physical functioning, such as increases in restlessness, anxiety, irritability, somatic and physical complaints, and food intake, as well as lapsed concentration and weight gain. Other studies have documented involuntary physical reactions, including changes in heart rate, cortical arousal, psychomotor reactions, and sensitivity to visual stimuli. On the whole, these behavioral changes appear to be particularly pronounced in the first week or so of smoking deprivation, and seem to be rapidly reversed once smoking is resumed.

However, there are at least two problems with this analysis. First, what about the 50 percent quit-rate among smokers (U.S. DHHS, Surgeon General 1989, pp. 285–92)? Doesn't such a substantial population of ex-smokers largely undermine the argument that the physiological effects of withdrawal make it very difficult to quit? Indeed, this reaction seems to have motivated the juries which have been distinctly unsympathetic to victims' claims in the cigarette-cancer tort litigation. Put differently, even if it is hard to quit, just how difficult is it? Unfortunately, the Surgeon General's report doesn't really answer this question.

Second, it is possible to raise an objection to the 1988 report that cuts still deeper. Don't other personal obsessions that we would not dream of controlling in ways proposed for smoking also qualify as "addictions" under the report's definition? Consider the runner whose daily routine is incomplete without a five-mile early morning workout. It is not fanciful to think that such a person, upon being suddenly sidelined for an indefinite period, might suffer considerable anxiety, stress, irritability, difficulty in concentrating, and most of the other effects associated with nicotine withdrawal. Has not our runner experienced a "physiological" reaction? And what difference does it make whether we label it "physiological" or "psychosomatic"? Don't the sorts of behavioral manifestations associated with quitting smoking frequently accompany the sudden, permanent (or so perceived) cessation of many passionate "habits" that provide sustenance to an individual's basic psychic needs?

Yet our political culture has resisted telling individuals that to take up such habits is bad for them because later they will find it very hard to stop. We don't try to curtail skiing, for example, just because many children get the ski "bug" and some, as adults, go on to become ski "bums"—remaining "addicted" for longer than their bodies can take it and leaving the slopes only when injured. Or consider the avid mountaineer. Would high-altitude climbing be legislatively prohibited if new epidemiological data and lab studies indicated, to the chagrin of all concerned, that there is a significant relationship between such climbing and fatalities from coronary heart disease—and yet "hooked" climbers continued their sport in the face of these findings? It seems highly unlikely.

To be persuasive, then, the perspective that sees smokers as victims must be able to distinguish the case of tobacco use from other habits, routines, and even "addictions" that are, by consensus, regarded as best left unregulated. Such a case might

be built upon three related factors. First, consider the *magnitude of abuse*. Virtually *all* cigarette smokers are at risk of the most serious physical consequences; there is no documented safe level of smoking, and, in any event, almost all smokers quickly develop a tolerance that places them in the category of substantial users. Contrast, for example, the drinking habit. While excessive drinking is a serious social problem—generating a heavy toll on family life and worker productivity—and can be traced directly to a substantial number of deaths and physical disabilities, it remains the case that most individuals who regularly drink keep it under control, and that, in moderation, alcohol use has no harmful consequences.

A second factor that distinguishes tobacco use from most other hedonistic activities is the *magnitude of the risk* associated with smoking. It may be unwise to eat sweets or potato chips obsessively; it may be courting danger to sky-dive or ski at every opportunity. But the probability of very serious personal harm occurring from any of these activities does not come close to the risk of dire consequences associated with smoking. A recent study published by researchers at the National Cancer Institute estimated that more than 90 percent of the 92,000 expected lung cancer deaths among U.S. males and more than 78 percent of an estimated 51,000 deaths among women in 1991 would be attributable to smoking. Indeed, even without considering secondary smoke or coronary heart disease fatalities, smoking was estimated to account for 30.6 percent of the more than 500,000 total cancer deaths (Shopland et al. 1991). While these figures do not tell us the prospects of any particular individual contracting a smoking-related fatal disease, they indicate the singular dimensions of the aggregate risk associated with tobacco use.

A third distinguishing characteristic of tobacco use is the *magnitude of difficulty in breaking the habit*. Although the 1988 Surgeon General's report is disappointingly thin on this point, nonetheless, in the final analysis, smoking does seem distinctive on this dimension too. The crucial point is that smokers typically use cigarettes to deal with an exceedingly wide range of everyday social activities. Whether coping with bad news, enjoying a good meal, beginning a difficult work assignment, or simply facing the break of another day, the habituated smoker draws a measure of continuing sustenance, ego-strength, even companionship from a cigarette. By contrast, most forms of compulsive personal satisfaction, whether it be skiing, sky-diving, or some other activity, play a far more compartmentalized role in satisfying the emotional needs of "hooked" individuals—and consequently can be more easily targeted for replacement by substitute activities.

Like smoking, drinking seems to play a pervasive role as a multiple-function support system for a substantial number of dependent persons. Nonetheless, as we have indicated, most alcohol users simply do not fall prey to a multiple-function dependency syndrome.

It is precisely these multiple-function, nonsubstitutable characteristics of tobacco use that, we believe, best explain why large numbers of smokers continue to maintain the habit. In the crunch, the smoker concludes that the utility of smoking simply exceeds the perceived risks. Does that, in turn, mean that we would violate smokers' own risk/utility preferences by getting them to quit? Not necessarily, when one considers the latent character of the health risks.

Unlike the sky-diver, skier, or even the alcoholic, the typical smoker has no

feedback mechanism in the course of her daily routine to trigger a sense of imminent jeopardy to physical condition. Indeed, given the long-term nature of the harm from smoking, and the potential for avoiding serious physical consequences by quitting "soon," tobacco use takes on an especially sinister character: cumulative physical debilitation goes largely unnoticed, and, whenever extrinsic risk information is assimilated, a rationale is at hand for discounting one's concern—the risk can be addressed at a later point in time.

While these distinctive characteristics of smoking obviously do not suggest that quitting is impossible, they do make a strong case for giving greater credence to the confirmed smoker's expressions of regret than one might extend in other contexts.

What policies follow from the perspective that sees smokers as victims? For those adhering to this perspective, the tobacco companies are the primary wrongdoers; but, of late, others are also seen to victimize smokers by shunning them in various ways. Initiatives might include (a) allowing tort damage claims by smokers against the tobacco companies (or, in the alternative, creating a smoking victims' compensation fund, analogous to the federal Black Lung program for victims of mining-related diseases) and (b) adopting smokers' rights laws that protect smokers from discrimination in employment, and perhaps assure them a reasonable place to smoke during the workday.

Yet perhaps not all smoking "victims" need remain so. After all, victims of other "addictions" do sometimes solve their problems. Often they turn to support networks for help in this process. Alcoholics Anonymous and similar groups that have been set up for people with other "addictions" (such as cocaine and gambling) fall in this category. Indeed, Americans these days apparently join private self-help programs in droves whenever they are trying to break habits that, while providing some pleasure, are thought to be undesirable on balance. Weight loss programs for dieters are a prime example. The basic idea of these schemes is to impose constraints on one's own conduct in order to help achieve what one "really" wants.

In the tobacco context, the public policy problem would seem to be that, even if smokers mostly want to quit, the mere availability of schemes to help them do so does not appear to suffice. Hence, the "smokers as victims" perspective is also likely to favor the provision of free smoking-cessation programs—if not funded by the tobacco companies, then through employers or ordinary health insurance.

In any event, a perspective that depends upon some notion of addiction seeks to avoid the claim that its supporters are inappropriately paternalistic toward others. But not everyone finds paternalism objectionable—particularly, if it is addressed to behavior regarded as immoral.

Smoking as Immoral Behavior

Still another outlook, then, is that smoking reveals a self-destructive weakness of character; smoking, in short, is socially unacceptable, deviant conduct. It is one more form of "substance abuse" to be eliminated because of its degenerate quality. This, of course, is how many people feel about cocaine and heroin—quite apart from the question of whether their use leads to crime.

Our collective stance toward immoral conduct in America is highly variable—

putting aside such conduct that is condemned for its harm to others. While some want to restrict attacks on such behavior to rhetoric, religion, and individual conscience, others, notwithstanding the American experience with alcohol under Prohibition, are keen to use the muscle of the state against a wide range of conduct viewed as offensive to social norms.

This view seeks forcefully to pressure smokers to stop smoking, and would do so even if they were bothering no one else, and even if they continued to smoke in the face of the softer measures described above that might discourage teens from starting and help "victims" to quit.

Strongly coercive policies adopted from this perspective might include conditioning most jobs and other "essentials" on not being a smoker, adding onerous taxes to the sale of tobacco products, imposing radical limits on where tobacco products can be sold, and possibly even criminalizing of tobacco use (perhaps along with a "methadone" sort of strategy, under which smokers might be provided a nicotine arm patch while being weaned from cigarettes).

Protecting Non-Smokers

A final outlook sees smokers as villains. This perspective regards the central problem as one of smokers injuring innocent nonsmokers, rather than themselves. Smokers are considered much like other scoundrels in our society who violate the liberal maxim to avoid encroaching on the rights of others.

Grounding smoking regulation in the harm that it causes to others avoids the victimless-crime thicket confronting the previously discussed perspective. Once the rationale for regulatory action is located in the domain of general public health and welfare legislation, it takes on the coloration of a traditional exercise of the state's police power. Those who engage in activities imposing health and safety risks on the public have routinely been subjected to governmental control through regulatory standards backed up by criminal or other sanctions.

Lodging the strongest grievances here are those third parties who object to being involuntarily subjected to second-hand tobacco smoke. Their complaints have become conspicuously louder in the wake of the recent findings, discussed at the outset of this chapter, that "passive smoking" is not only an eye, nose, and throat irritant to many and a hazard to the allergic few, but also a source of cancer, heart disease and serious respiratory illnesses, just as it is to smokers themselves.

In addition, smokers are assailed for imposing financial harms on nonsmokers; for example, by disproportionately claiming benefits from public and group health insurance plans, thereby increasing their cost to nonsmokers, and by necessitating more frequent cleaning of clothes and other items that absorb smoke.

In the past, when smoking was widely accepted in the culture, the burden of avoiding harm fell on nonsmokers, who had the duty to get out of the way. But from a perspective that views smokers as injuring innocent third parties, the tables are turned: smokers must be made to stop their wrongdoing or at least to internalize into the cost of smoking those externalities they impose on others.

From a policy standpoint, however, the data on ETS, as alarming as they may sound, need to be kept in perspective. The studies summarized in the 1986 report,

indicating a statistically significant increase in lung cancer, as well as those showing less conclusive evidence of linkage to other serious diseases, draw exclusively on cohorts involving household exposure of nonsmoking to smoking spouses. More recent studies suggest similar adverse consequences for the children of parents who smoke. Without question, the elevated risk for nonsmoking spouses and children of long-term smokers is a finding of major import.

But what follows from such results? Is a spouse who continues to live with someone who insists on smoking in the home entitled to governmental help? Are parents who smoke around their children guilty of child abuse? Certainly our traditional answers to both of these questions would be "no."

Furthermore, it does not inexorably follow from the intrafamily studies that government should limit tobacco exposure in public spaces such as restaurants, common carriers, and sports arenas. To the contrary, occasional exposure to sidestream smoke by patrons of such facilities more likely has a *de minimis* effect on health, even among those who are heavily exposed in other settings.

On the other hand, under some circumstances, sustained worksite exposure may impose even greater health risks on employees than those experienced by nonsmoking spouses in the home. Many worksites are more enclosed and have poorer ventilation than the typical household setting. In many instances, the average number of hours per week of ETS exposure will be greater at work if smoking is allowed. And in many situations, the number of smokers per cubic foot of enclosed space will exceed that of the typical household. Brief reflection, however, makes it clear why reliable data on ETS health risks in the workplace are virtually impossible to collect. Nonsmokers rarely work in a fixed milieu over a long period of time, insulated from personnel changes among fellow workers and status changes in their own lives.

Despite the lack of data, it may well be that the various public spaces where there is least concern for health risks to *patrons* pose the strongest case for attentiveness to workplace health risks. In airplanes, restaurants, and enclosed sports arenas, for example, the turnover of minimally exposed patrons is irrelevant from the health perspective of the long-term service personnel whose average level of tobacco smoke exposure remains high.

The upshot is that, while public policies in furtherance of this perspective on the smoking problem are likely to focus on "zoning" controls on where people can smoke, it remains unclear just where those controls are justified. Should nonsmokers be assured the right to smoke-free use of public spaces, workplaces, public transit, and so on? The key question here is similar to many current issues of environmental risk assessment. Is government intervention warranted, based upon an extrapolation from reasonably clear cases to contexts where greater scientific uncertainty exists?

In the real world, of course, regulation is never undertaken in a political vacuum. And whatever the subtleties of the data, public opinion seems to have crystallized on the issue: 77 percent of nonsmokers (who now account for roughly three-quarters of the voting public) believe that smokers should abstain in the presence of nonsmokers ("Environmental Tobacco Smoke" 1992). This strong expression of sentiment against passive exposure to smoking undoubtedly reflects more than just a

reaction to the health data, however discerning that perception may be. Almost certainly, it also reflects a growing lack of tolerance for the "annoyance costs" of exposure to secondary smoke, as well—costs that were largely ignored a generation ago.

Moving beyond zoning to the financial side, some who see smokers as wrongdoers call for measures such as differentials in premium contributions to group health insurance by smokers and nonsmokers (to go along with existing differentials in individual health and life insurance policies) and special taxes or charges imposed on smokers to pay for the extra public medical costs they incur. This perception of unfair economic advantage (to smokers) reflects empirical assumptions that are not beyond dispute. It has been pointed out, for example, that smokers claim less from the Social Security and pension systems because they die earlier, and yet they pay premium contributions that fail to take this consideration into account. More generally, some economists have argued that the old-age cross-subsidization just mentioned, when combined with the special taxes exacted on cigarette consumption, offset the aggregate added health and other costs that smokers impose on nonsmokers (Manning et al. 1991).

In this section, our primary intention has been to examine the norms underlying the wide array of impulses to regulate. Next, we consider some implications of these perspectives in the arena of public policy.

The Policy Arena

Perspectives on the "Smoking Problem" Reflected in Current Policy

Law and policy making concerning smoking is a product of special interest politics. Smokers' rights groups, which might be regarded as analogous to the National Rifle Association or the Sierra Club, in fact are little developed, and have to date played no significant role in fighting antismoking laws. This perhaps is explained by the fact that, unlike those who love to hike or shoot, smokers don't really have the same unambiguously affirmative commitment to their behavior.

Instead, the lead has been taken by the tobacco industry—most importantly the manufacturers, but also the growers, retailers, and others who benefit from financially healthy tobacco companies. It should be noted, as well, that on advertising control and smokers' rights issues, the American Civil Liberties Union (ACLU) has thrown in with the tobacco industry, because the issues here are representative of that organization's broader Bill of Rights concerns.

On the tobacco control side, the dominant players are elite public health interests like the American Lung Association and the American Cancer Society, and more recently (as discussed by Helen Schauffler in chapter 9), related insurer and employer interests. (At the local level, grass-roots citizens groups do seem to be exercising growing power, as well.) Whether or not it is true that the increasing clout on the public health side can balance the power of the tobacco companies more effectively than in the past, as some believe, that hardly ensures current public policies that reflect current public opinion.

These caveats notwithstanding, and with due regard to the fact that tobacco

control policies are by no means uniform at the state and local levels, we find it revealing to consider the ways in which current policy reflects the array of perspectives just described.

One take on current policy is that there is not only substantial support for the informed choice model, but also a reasonably strong belief that informed choice exists. Consider, initially, the fact that lawsuits against the tobacco companies, as explained by Robert Rabin in chapter 6 and Gary Schwartz in chapter 7, have failed largely on the ground that juries conclude that smokers were aware of the risks they were taking and made the choice to smoke anyway. Consider also, that in the United States (as discussed by Robert Kagan and David Vogel in chapter 2), apart from the radio and TV ban, there is now little regulation of ads for tobacco products and only modest required disclosures of the risks of smoking on the product and in promotional materials.

At the same time, current policy does not much reflect the view of smokers as victims. Not only have their lawsuits failed, as just mentioned, but, as Helen Schauffler explains in chapter 9, smoking cessation is little supported either through coverage in health insurance plans or through direct public subsidy. By contrast, under the spur of state-mandated benefit laws, nearly all insured health plans cover treatment for alcoholism and drug abuse.

We take note of the fact, discussed by Stephen Sugarman in chapter 8, that many states have recently adopted smokers' rights laws. While these laws might be considered a countertrend, they seem more aimed at heading off the possibility of a strong movement to discriminate against how workers behave during leisure time than to enable smokers to fight back against widespread existing victimization.

On the other hand, protection of nonsmokers is a growing theme. One strategy of the strong and spreading attack on passive smoking is to designate where people can and cannot smoke—a strategy, as Robert Kagan and Jerome Skolnick explain in chapter 4, that seems to have been largely effective in the United States where enacted. A very different form of nonsmoker protection has been a focal point of recent attention: eliminating economic cross-subsidization by "making smokers pay," through, for example, differential group health insurance premiums. But this movement, as Helen Schauffler discusses in chapter 9, is still largely in the talking stage.

Despite the many laws on the books concerning the illegality of cigarette sales to minors, our society does not yet seem very serious about the child protection perspective. In most places, those laws are not effectively enforced; in only a limited number of areas are cigarette vending machines inaccessible to youths; in comparison with Canada and Europe, taxes on cigarettes remain low (as Robert Kagan and David Vogel show in chapter 2); and outside California it is not easy to find mass media campaigns against smoking aimed at teenagers. Indeed, to the contrary, as discussed by Michael Schudson in chapter 10, young people are very well aware of Joe Camel, the Marlboro Man, and other tobacco company-initiated advertising symbols.

Nor do we seem to be moving toward condemning smoking as immoral through coercive public actions. Again, smokers do not face daunting excise taxes, and efforts to condition jobs on nonsmoking status are being stymied. Yet, at the same

time, smoking is becoming an increasingly stigmatized form of conduct in the private culture—a theme explored by both Joseph Gusfield in chapter 3 and Franklin Zimring in chapter 5.

Value and Policy Conflict

Previously we set out several social outlooks on the smoking problem and suggested various specific policy initiatives that might be taken to correspond with the different perspectives. In this section, we want to suggest some of the ways in which the "fit" between values and policy may be far from perfect. By doing so, we hope to provide a clearer understanding of what is at stake in opting for one set of policy initiatives over another.

To begin with, similar policies may sometimes be invoked in support of dissimilar perspectives on the nature of the smoking problem. For example, a call for oppressive cigarette taxes may win the support of both those who connect smoking with the immaturity of children and those who connect it with the immorality of adults. These compatibilities may facilitate that special sort of political logrolling that sometimes infuriates students of the legislative process, in which the votes necessary to pass a certain law are obtained even though it is impossible to state a coherent legislative purpose that had the support of the majority.

On the other hand, some tobacco-control policies are quite incompatible with diverse perspectives on the smoking problem. High taxes may fit some outlooks as just noted, but not "informed choice" or "smokers as victims." Legal liability of tobacco companies to smokers may serve "smokers as victims" but not "informed choice"—assuming there was sufficiently informed choice in the first place. Smokers' rights laws may support "informed choice" and "smokers as victims" but hardly "smoking as immoral behavior."

Precision is important, because policies that may appear at first blush to be compatible with different outlooks turn out on more careful scrutiny to be irreconcilable. Consider, for example, the question of cigarette taxes. Modest taxes may be justified to provide "protection for nonsmokers" by making smokers pay their way, but not the heavy taxes sought by the "child protection" and "immorality" perspectives. Regulation of advertising provides another illustration. The sort of controls justified by the "child protection" perspective are quite different from those supported from the "informed choice" or the "smoking as immoral behavior" perspectives.

Because there are divergent views of the smoking problem, those who want public intervention may not agree readily on what that intervention should be. This is not to suggest, however, that a person cannot coherently believe that there is more than one aspect to the smoking problem. For example, in principle one could blend the viewpoints of "child protection" and "informed choice"; or hold both the outlooks "child protection" and "smokers as victims"; or endorse "smoking as immoral behavior," "protection of nonsmokers," and "child protection" perspectives. Nevertheless, as already suggested, any package of policies put together in support of multiple viewpoints is likely to create some internal tensions and inconsistencies.

This potential for tension is generally shown by the fact that the different

outlooks intersect the dimension of coercion at quite different points. Coercion is the antithesis of "informed choice," and it is not comfortably congruent with "smokers as victims"; on the other hand, the "smoking as immoral behavior" viewpoint seems consistent with strong coercive measures, while "child protection" endorses sharp coercion only of youths, and "protection of nonsmokers" favors coercion essentially only regarding location.

Sometimes policies advocated from differing viewpoints are neither mutually reenforcing nor incompatible. They are simply aimed at different targets. Consider, for example, tough enforcement of laws forbidding sales to minors and subsidization of smoking cessation programs. In more awkward fashion, this pattern may also pave the way to political logrolling. Yet the more general problem remains that differing outlooks do not make for a clear tobacco-control policy agenda.

Why are there competing outlooks on the smoking problem? At the most basic level, it is probably a matter of contrasting values. The respective ideas that smoking is immoral, a regrettable habit to be broken, or a perfectly permissible private adult behavior reflect very different starting points.

There may also be sharp disputes about "the facts." As discussed earlier, is smoking really a matter of choice, or is it largely an addiction? If the latter, smokers may seem less immoral, less like villains, and more like victims; so too, compensation rather than cessation may be the most feasible amelioration. By contrast, if smoking is better understood to be voluntary, then it becomes easier to support penalties for harming others and for bearing the consequences of harm to oneself; at the same time, it makes cessation appear more promising. And how powerful is tobacco advertising and promotion? Do relatively few people enter or remain in the market in response to it, or is marketing responsible for seducing countless youths and for keeping even more adults on the hook?

Finally, what does the existing patchwork pattern of governmental activity and social norms suggest about the need for continuing activity on the political front? Has the array of sensible political initiatives been utilized to full effect, or does much remain to be done in the public policy sphere? On this score there is disagreement as well, and it is to these questions that we turn in our final section.

Assessing the Need for Stronger Tobacco Control Measures

Since the Surgeon General's 1964 report, a sea change has taken place in attitudes toward smoking in America. As we noted at the outset, the proportion of adults who smoke is radically lower and continues to drop. Among elites, a smoker is increasingly the unusual exception. As Joseph Gusfield discusses in chapter 3, health and fitness are "in" and smoking is decidedly "out." Not only is smoking at odds with the images of today's leaders, heroes, and idols, but also it rarely seems part of the persona of today's attractive rebels. Smokers are increasingly marginalized and considered reckless, although perhaps viewed with sympathy, by America's cultural trend-setters. In such company, smokers are often on the defensive—apologetic, sheepish, and self-deprecating. In short, if the pattern of the past two decades continues much longer, smokers will be proportionately few indeed.

In view of this trend, perhaps all the agitation by antismoking advocates is

alarmist, seeking inappropriately strong government initiatives when such action may not be all that critical. Patience may accomplish the objectives of virtually all the perspectives on the smoking problem that we have discussed.

To be sure, this sharp downward trend in the proportion of Americans who smoke has come about in an environment of governmental policy interventions to reduce smoking. Thus, one critical question is whether those policies aimed at cutting the smoking rate have themselves made an important difference. Or, by contrast, has smoking behavior been transformed largely in response to a combination of the Surgeon General's reports and changing cultural norms, which, through subtle processes, make unfashionable certain behaviors that were formerly chic? Unfortunately, it is not easy to answer these questions. In chapter 5, Franklin Zimring cautions us that, *a priori*, it is as plausible that the widespread rejection of smoking by elites is what brings about antismoking legislation as it is that antismoking laws bring down the smoking rate.

Indeed, a host of critical policy questions remain unanswered. Do higher taxes on tobacco have any long-lasting impact on consumption levels? Or do people, if necessary, simply adjust by determinedly smoking more of each cigarette? Do advertising controls really curtail or prevent smoking? Michael Schudson in chapter 10 argues that advertising is almost surely far less persuasive than most people believe. Aren't teenagers primarily influenced by peers anyway, and don't they smoke at very high levels in many places where there is virtually no advertising, such as Eastern Europe? And regardless of what message the tobacco companies are trying to send, or conceal, aren't most people already aware of the information on the risks of smoking?

Robert Kagan and Jerome Skolnick, in chapter 4, observe that American laws restricting where people can smoke seem to have received a boost from catching the tide of cultural change at just the right moment. But then again, in the present climate in the United States, there may be no need to translate social pressures into further governmental edicts. After all, local ordinances or not, a growing number of employers are adopting smoking control policies, many of which radically restrict or prohibit smoking on the job; and a steadily increasing number of food and entertainment establishments are at a minimum assuring that nonsmokers can enjoy themselves in a smoke-free (or largely smoke-free) environment independent of local ordinances. For example, a 1991 survey found that 85 percent of responding companies had smoking policies, up from 36 percent in 1986. Moreover, 34 percent of the respondents prohibited smoking in all company buildings, as compared with only 2 percent in 1986 (BNA 1991).

Moreover, most of the smoking control measures that promise to be effective may already have been enacted. Similarly, most adult smokers who are most likely to be influenced to quit by public policy interventions may already have done so. If these two points are accurate, then new interventions will face a steep uphill battle, and the returns may be marginal compared with those of the recent past.

From still another perspective, some people who favor a smoke-free America would nevertheless want to restrict government's role to that appropriate to the informed choice approach, on the ground that, in the long run, the only really effective strategy is to convince people to decide for themselves that smoking is too

dangerous. From this vantage point, any heavier government pressure on people to stop smoking promises to be counterproductive.

There is also the question of civic relations. Although many nonsmokers feel validated by having legal rights to assert against smokers, this may not be the best way to resolve conflicts over social behavior in our society. It is not only that recognizing new legal rights contributes to our sense that America is drowning in law and litigation, but also that pursuing the "rights" approach may undercut modes of dispute resolution that help to ensure that both parties comfortably feel part of the same community in the long run.

Finally, smoking control policies carry costs. There are, of course, the direct financial costs that go along with educational programs, antismoking media campaigns, subsidized smoking cessation schemes, and the like—although these might well be funded out of cigarette taxes. And there are administrative costs, both public and private, that are almost always incurred in any regulatory program. But beyond these economic burdens, there are other important, albeit less tangible, costs associated with at least some of the policies discussed above. For example, as Stephen Sugarman discusses in chapter 8, when employers or insurers discriminate against those who smoke outside of work, various privacy losses are incurred by smokers (and sometimes nonsmokers as well), the social value of individualized fair treatment is threatened, and the principle of collective responsibility may be violated in areas of American life where it has long held sway. As a further example, discussed by Michael Schudson in chapter 10, certain proposed controls on cigarette promotion jeopardize traditional free-speech values. This is not to say that such controls would be unconstitutional; yet the values underlying the First Amendment may nonetheless be bruised. And as a final example, explored in somewhat different ways by Helen Schauffler in chapter 9, Franklin Zimring in chapter 5, and Stephen Sugarman in chapter 8, several tobacco control policies would have the *de facto* effect of bearing down hardest on ethnic minorities and the poor.

However, we are not necessarily opposing tougher antismoking public policies. After all, powerful responses are still available to those who are unpersuaded by this litany of caution. First, many of the tobacco control policies we have discussed in fact have only spotty adoption. While there are a burgeoning number of laws addressed to workplace and public space smoking controls, many states and communities are still without them. In like fashion, some states have raised tobacco taxes recently, but many others have not. Some states and localities have invested substantially in school-based antismoking education, or in antismoking ads on TV, or have banned cigarette vending machines from places readily accessible to children, but many have not. Therefore, for many tobacco-control advocates one part of getting the job done right is to make at least some of these extant policies far more comprehensive.

Second, despite the downward trend in smoking, tobacco control advocates are apt to have two major concerns. The initial fear is that if new smoking control programs are not adopted, the downward trend may be arrested. In the long run, perhaps one-quarter of all American adults might continue to smoke. In short, easing up on regulation in the hope that social disapproval will take care of things can be regarded as just too risky. This fear is fueled by the fact that new smokers are

increasingly from the ranks of poorer and less-educated young people. This leads to the further worry that, without continued pressure from smoking-control activists, the American middle class may lose interest in attacking the problem—particularly since cigarette smoking does not seem to promote criminal behavior in the way that illicit drug use does, and does not seem to promote the sort of threat of injury to innocent victims associated with alcohol abuse.

The other great concern is that even if the downward trend in smoking behavior continues on its current path, millions of people will die before the rate gets anywhere near zero. These deaths might be avoided if the downward rate can be accelerated by some combination of the policy initiatives discussed above.

What, then, is the appropriate public policy stance on smoking and tobacco? The chapters that follow are not centrally designed to provide a blueprint answer, even though some of the authors do include their own judgments along with their analysis. Rather, these studies describe and analyze several important policy choices. We present those appraisals to help decision makers fashion policy that is sensitive to the many competing perspectives in this critical area of social concern.