From Protective Health to National Recovery?

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2.1 We have seen that the 30 years following immediate post-war recovery, 1948-77, were both good and bad for the British people. They were good years, in that the country did well by the two main indicators of domestic well-being then current. In 1948-73 real income-per-person almost doubled, and in 1972-77 income inequalities substantially narrowed. Yet for Britain 1948-77 was a bad period internationally, despite her success in decolonisation and in avoiding major wars. It was bad for reasons that decision-takers in Britain hardly understood.

Those decision-takers saw the problem as a loss in competitive power, status and respect. They diagnosed that loss was due to endless foreign borrowing, that is to a bad and worsening balance of payments. They attributed the latter to economic growth that (while by historical standards rapid and smooth) was slower than the growth of major competitors, and was less effectively channelled away from consumption towards investment and skill-formation. Thus, it was argued, Britain's machines had to be more slowly modernised, her human skills more slowly augmented, than those of major competitors such as Germany and Japan.

All this, as a diagnosis of the 'British sickness' of 1948-77, was not so much wrong as diversionary, uncreative, and therefore unlikely to lead to a cure. Here was a nation enjoying unprecedented prosperity and steady growth; initially confident after success in war, followed in 1945-7 by rapid transformation of public-sector production and of social security; and with a falling (though large) share of GNP that had to be diverted to military outlays. If such a nation could not mobilise big economic surpluses—and, when it did, wasted them in consumer booms such as that of 1952-61 —what hope was there? From the perspective of 1977, how could anybody suppose, unless blindfolded with euphoria, that the coming 'oil bonanza' would be used less wastefully than the terms-of-trade windfall of 1952-55, or the international loans of 1974-77?

2.2 It was Britain's associations, good and bad, with the Third World that led to more constructive diagnoses. By the late 1970s, the Third World's persistent poverty was increasingly explained, not by too *little* surplus (of capital, skills, etc.), but instead by inefficient *use* of the surplus: its use to generate unwanted skills, and to invest in steel-and-concrete white elephants. Misallocation of resources, above all between city and village, came to be seen as more important than inadequancy of resources in explaining the poverty of the poor. Misallocation also *caused* inadequacy; for why should the State or the individual strain to push resources into schools that produced educated unemployed, or steel mills that stood half-idle?

After 1977, there were two main areas in which that lesson from the Third World came to benefit Britain. The first was labour mobility. In the Third World in the 1970s, many foreign (including British) observers commented on the co-existence of unemployment in some areas and activities with excess demand for workers in others. Workers or their families in depressed regions or sectors, could not rapidly respond to opportunities in progressive regions or sectors. This labour immobility reduced the efficiency with which economic surplus was turned into output (and hence the incentive to produce for such a surplus instead of for immediate consumption).

Slowly, British decision-takers began to see how their own economy, too, was harmed by lack of labour mobility. Such mobility was especially necessary in Britain. Population and labour-force were hardly growing at all. Early economic maturity had exhausted the agricultural labour reserve (even by the early 1960s only one in twenty workers was engaged in farming). Restraints on immigration had by the mid-1960s removed that source of workers too. So an industry seeking to expand had to draw its workforce from other industries, usually in other parts of Britain.

Yet—in this situation where Britain needed mobile labour even more than her competitors—workers were discouraged from changing jobs, mainly through the means by which social services, in themselves desirable, were provided. School curricula, rights to security of tenure in privately rented housing, subsidies in public housing; all were specific to the place where a person lived.

From 1977 to 1980, Britain drastically reformed these modes of provision; multiplied tenfold its outlays on retraining and resettlement of persons changing jobs; and thus made it much easier for workers to learn, and move to, new jobs.

2.3 In the second area, Third World experiences taught British decision-takers a deeper, more dramatic lesson; and there was a clearer turning-point, almost a shock of recognition. The lesson was that the impact of an economic surplus depended, not just on its size and composition, its yield and management, but on getting right the thing into which it was to be transformed: not just output, but human welfare, physical, mental and spiritual. Extra output was, given the realities of politics, a necessity for extra human welfare; but it was not a sufficient condition. Growth of GNP had to be sought, but not enthroned.

True for poor countries, this was even more important for Britain, in a sense, it was just the rediscovery of Matthew Arnold's dictum in *Culture and Anarchy* (1859) that Britain's well-being (he said 'greatness') was not, could not be, founded on coal, or in general on 'machinery'. As 'machinery' and its beneficiaries took power, Arnold's insight was almost forgotten. One of the few who kept it alive was F. R. Leavis (1897-1998), with his reasoned yet passionate onslaughts on 'technologio-Benthamism'. However, few of his economist contemporaries read him, or learned from him. For, paradoxically, a narrowly mechanistic culture could not be disabused of the mechanistic fallacy by an onslaught on that fallacy, but only by an awareness that the mechanical pursuit of output broke down even those purely physical, 'human-machine' characteristics that such a pursuit supposedly served.

It was in the area of health that this lesson was first learned, and first transformed into policy. As in poor countries, so in Britain too; growth not as such but because it was unthinkingly structured and striven for, damaged even the *physical* capacities of its alleged beneficiaries to enjoy its fruits.

One can time precisely the political moment of awakening: the afternoon of 3rd October, 1978, when (following the electoral triumph of his party) the new Minister of Health outlined his programme. The speech, based on long-known facts, could have been made by any Minister, from any political position—as the terms in which the speech sought consensus made clear—provided only that the Minister (a) was able and willing to follow the facts where they led, and (b) even if those facts, together with reasonable value-judgements, required measures harmful to powerful interests was prepared to seek ways to defeat or to buy off those interests.

The speech could as well have been made by an intelligent politician of the radical left or of the radical right: by, say, Mrs Judith Hart or Sir Keith Joseph. However, the speech could not have come from the confused, non-radical 'centre' of British politics in the 1970s. That 'centre'—having made a consensus of the unconstructive, though not actually incorrect, diagnosis of the 'British disease' of 1948-77 as too-slow growth owing to an inadequate economic surplus—could not have produced the radically different view that the prior need was not 'more' skills or capital for 'growth', but a more efficient transformation of human power (including skills and capital) into human welfare. Human welfare embodied, not just 'commodities' made from Arnoldian 'coal' by Arnoldian 'machinery', but also the physical and socio-spiritual health to enjoy those commodities.

A mechanistic age can best grasp this truth by looking at physical health, which can, to a great extent, be reduced to figures. And British decision-takers were readiest to learn these lessons by drawing the appropriate inferences from other, poorer countries where they had worked, analysed and advised. It was because he seized on these two crucial points that the Minister of Health's speech was so important. It is therefore reproduced, in part, below.

2.4 "In the last few years, we have grown sceptical of the capacity of British governments to deliver sustained rises in welfare. A Minister may propose, but it is world prices, and domestic pressure-groups—some indict the trade unions, others big business—that dispose. During the five years that this government will run [interruptions], there is little that the macro-economic Ministers can do to increase economic welfare. North Sea oil will mean more output, much of it replacing imports and thus saving foreign exchange. But almost all these gains must be directed either to discharge our short-term international obligations, or to build up and modernise our capacity, in machinery and in skills, for future expansion in output.

"Improvement in welfare, to the extent that governments bring it about, will therefore come, during the next five years, from Ministries with a sectoral or social remit, not from macro-economic Ministries. People will become happier through our impact upon the content and quality of buildings and transport; of school and university teaching and curricula; and of human health, the concern of my Department.

"It is an old joke, indeed a sick joke, that the Ministry of Health and the National Health Service would be better termed the Ministry of Illness and the National Illness Service respectively. Today I shall explain why these priorities need to be reversed; I shall outline the Government's proposals to reverse them: and I shall show how, even on the gloomy assumption that no growth in consumption is possible over the next five years, these proposals for protective and positive health can in that period raise the level of personal well-being—the true standard of living—by some 20-25 per cent.

"Let me make a couple of preliminary remarks. First, I hope this programme will be non-partisan.

"All of us should be horrified by the mass of sickness and death that is caused by known, easily remediable features of the personal environment—cigarettes, cholesterol, careless driving. It would be easy, however, to make party-political propaganda against my proposed attempts—or any attempts—to correct this terrible situation. One side of the House could inveigh against 'nanny State'; and could defend the freedom of advertisers to entrench fatal habits. The other side of the House could argue that employment, even in making the instruments of self-destruction, was paramount; and that restraints upon the poor man's pleasures, such as alcohol and cigarettes, should not be carried too far.

"I hope Members will avoid such reactions if I remind them of four among the frightening, known facts of our self-destruction in Britain. Cigarette smoking, which raises the age-specific death-rate by at least 25 per cent, is increasing among school children, and by 1972 one in ten boys of fourteen smoked daily. Excess weight of 30 per cent raises the age-specific death-rate by one-third, and now affects over one-seventh of the British population. Of that population, the 35 per cent or so who take no exercise suffer seven times the risk of coronaries of those taking vigorous exercise regularly. Fourth, some 2,000 road deaths would be prevented each year by two steps—Swedish-style laws against driving after alcohol, and a country-wide speed limit of 50 m.p.h. All this is too serious for partisan politics.

"My second preliminary remark is this. Apart from its obvious effects in reducing human misery in the short term, a drastic improvement in Britain's health has longer-term importance for the country.

"First, the world may be moving into an era when scarcities of mineral resources, or dangers of environmental pollution, render rapid, conventional economic growth either risky or (if such scarcities and dangers are to be avoided) very costly. Moreover, there is a justified move to redirect such growth as is obtainable to the poorer countries of the world. Hence the capacity to generate rising levels of welfare in richer countries, such as Britain, may increasingly depend on the capacity to produce brains, bodies and minds that can make better use of whatever output they have. Better health is of the essence here. Yet life-expectancy and death-rates in Britain have hardly improved for 15 years. And the incidence of bedfastness has risen!

"Second, it is not jingoistic or self-regarding to ask what Britain, as a small country without imperial or warlike ambitions, can contribute to the world. Have we, not a role or a part to play, but things we want to do that will set an example, and win back some of the respect we have lost since the War [interruptions]—yes, lost under governments of every political colour? To become the first healthy nation; the first nation to improve and finance the *content* of education so as to maximise literacy, numeracy and independent-mindness; the first nation with a civilised urban-industrial environment. These should be the domestic goals that Britain, as a small but ambitious country, strives for. They depend for their achievement, in part, on parents, managers, teachers, doctors. But they depend, too, on sectoral and social Ministries, and critical parliamentarians, who will concentrate on the content of health and education rather than on its organisational forms, and on the meaning of the evidence rather than partisan shibboleths. . . .

"You may be surprised to learn that, in responding to facts of this sort, rich countries such as Britain have lagged behind poor countries. That is odd, because the central importance of improving the personal environment in the prevention of disease was perhaps first realised during the great improvements in public health and sanitation in nineteenth-century Britain. But we forgot our own discovery, and it was in poor countries that it was recently rediscovered. We in Britain have come to believe that better health depends mainly on more and better doctors, drugs and hospitals. Poor countries followed that incorrect belief until about 10 years ago. Now they realise that most of their death and disease is caused by undernutrition, dirty drinking-water, and parasites carried by snails and insect pests. In most poor countries, health policy is increasingly directed towards preventing these causes of human suffering. The task is slow, difficult, and opposed by sectional interests. But the point is that poor countries have learned the lesson—which we learned in the nineteenth century and

then forgot—that prevention is usually more cost-effective, as well as more humane, than cure.

"When we speak of 'prevention' in British health care, we tend to think of general medical check-ups, screening against particular forms of cancer, mass chest X-rays, and so on. These activities have their place, but they are very costly. Probably one can prevent more death and disease, per £mn, by curative medicine than by these conventional pieces of preventive technology.

"A much wider concept of disease prevention is needed. It is bound to depend upon a nation's history and geography, economic and social as well as medical. For nineteenth-century Britain, it centred on improving sanitation, cleanliness in childbirth, and nutrition. In the developing countries today, disease prevention requires mainly better nutrition, cleaner drinking water, and control of insects that carry diseases. In Britain today, as in most Western countries, disease prevention means reducing or removing the causes of what have been termed 'the diseases of civilisation'. Though the diseases are acute and horrible—coronary thrombosis, lung cancer, road accident trauma—the causes are chronic, and operate slowly and insidiously. These causes are cigarette smoking; overeating; diets rich in animal fats and sugar and poor in roughage; risky driving; excessive alcohol consumption; physical inactivity; and stress.

"The exact amount of harm done by these causes remains controversial. So-called conservative medicine—which takes the view that possible risks should be assumed actual, and avoided—would blame most heart diseases and strokes, all lung cancer, and much bowel cancer and diabetes upon these seven causes. Between them, they are probably now responsible for about one in three of all deaths in Britain. They are responsible for a much larger proportion of deaths of men, and increasingly women, in the prime of productive life and of family responsibilities: between the ages of 30 and 60. Apart from mental illnesses, of which I shall say more later, these preventible causes of disease are responsible for more days of bedfastness, and for more lost workdays, than all other causes combined. The impact on human suffering is enormous.

"All this has to be the concern of governments. It is a sham to have a vast, costly so-called 'National Health Service' that does almost nothing about the major causes of death and of physical disease. Moreover, these causes do not confine their effects to the individual addict of cigarettes or cholesterol, or even to his family. His treatment is paid for by the taxpaper, including the non-smoker, as massive medical resources are used up in caring for the unnecessarily ill. These people's efforts in the workplace are sapped first by incipient illness, and later (if they are lucky) by the fight for recovery. Complex and integrated economic activities, dependent on the skills and knowledge of key people, slow down or stop when those people are rushed to hospital, to be treated for coronaries or cancers that could and should have been avoided. When the consequence is death or premature retirement, the social services are called on to support whole families—for, at present, it is male heads of lower-income households who are especially prone to die because they incur undue stress, or smoke cigarettes, or eat unwisely. However devoted to individual freedom of action a Government may be, it cannot see the decision to smoke or to overeat as a purely private decision.

"Despite the inefficiency and injustice produced by these unnecessary diseases, which are paid for by the victim's relatives and fellow-taxpayers, a liberal individual might have qualms. Should not each person decide, in increasingly full knowledge of the facts, whether to take a health risk? Can a government properly intervene in the individual decision in such matters? Three points are in order here.

"First, many people, especially the less well educated, receive little clear information about the medical risks of various forms of behavour. They are thus hardly equipped to make choices in the markets for, say, cigarettes or vigorous leisure activities. In the past decade, the higher income-groups have somewhat reduced their cigarette consumption. The lower income-groups, who are less well informed, have not.

"Second, on the other hand, a company producing dangerous products is permitted to advertise them. It thus encourages their use.

"Third, this government—and the European Economic Community—itself alters the pattern of incentives. For instance, the consumption of butter is subsidised, although high butter consumption, in a very careful Belgian enquiry, seemed to shorten life expectancy by over two years. Conversely, we tax cigarettes heavily, although the response of male British smokers to price-levels seems to be negligible.

"All these circumstances suggest action, which I shall outline. But the overriding factor is that we are dealing, not with a series of free decisions, but with *addiction*. Hence an individual's initial decisions to experiment leave him or her progres-

sively less and less free to resile. In Britain, 85 per cent of those who smoke even one cigarette become addicts; and only one in seven cigarette smokers succeeds in giving up his addiction. Of children who become obese by overeating, 80 per cent become obese adults; and only one in four of them succeeds in losing weight and keeping it down. Alcohol is plainly addictive in many cases; stress is more subtly addictive, through the operation on the body of the so-called 'kick hormone', novadrenalin; inapropriate diets and risky driving are addictive only in a secondary sense, through the formation of tastes and the acquisition of assets, from fast cars to outsize suits, that the owners want to use fully. . . .

"We in Britain want human well-being to increase rapidly. Our recent growth has not been very fast; and anyway growth, while necessary to increase resources that may bring extra human well-being, is not sufficient for this purpose. Hence we cannot rely on achieving rapid rises in human welfare mainly through higher incomes. Yet certain harmful addictions prevent most British adults from attaining, or retaining, the health or fitness they need to enjoy, to the full, the income they have. Moreover, these addictions are encouraged by private persons, to obtain profit; and by governments, to increase tax-revenue and to appease vested interests. And the cost of addiction is largely imposed on other people: members of one's family, of one's firm, or one's taxpaying community that finances public medicine.

"The government to which I belong can no longer tolerate this situation, and it is not too proud to learn from developing countries the lesson that Britain has forgotten: the lesson of positive preventive medicine. I shall now outline the proposals on which we have agreed. Some of these come into force at once, while others require legislation, to be laid before you in this Session of Parliament. All these proposals have been developed by a special Cabinet Committee on Positive Preventive Health. This Committee is chaired by the Prime Minister, and I am the Deputy Chairman. The Committee includes, for reasons that will become clear if they are not already, the Ministers of Agriculture, of Education, of Finance and Planning, of Industry, of Overseas Development, of Sport, of Trade, and of Transport. [laughter] Yes, Members may well be surprised, as I was. But when one defines a problem such as that of positive preventive health, instead of operating conventionally, the boundaries of demarcation between conventional Ministries become irrelevant, and the same applies to the boundaries between conventional disciplines. That is another lesson we have learned from the poor countries of the world. Researchers from medicine, economics, sociology, human physiology, and educational psychology have advised the Cabinet Committee in working out these proposals, and will continue to do so we implement and amplify them.

"We shall also continue to operate two further committee procedures. First, several Members represent constituencies producing products likely to endanger health. Such Members have been, and will be, consulted in advance about proposed legislation. Let me stress that this is not done in order to modify such legislation. Law-makers should not kill some people to employ others. The aim of the consultation is to identify losses in employment, and in returns to capital, that may arise as unwelcome side-effects of measures for positive preventive health; and to derive ways in which the losers can be fully compensated for their losses. It is not the farmer or the farm labourer, the manager or the employee at a cigarette factory, who is to blame for the damage done by butter or by smoking. The community gains enormously by preventing such damage, and there will be plenty to spare to compensate any losers.

"The second consultative committee involves the health ministers of all EEC countries. We shall continue to see that our measures are so coordinated as to minimise possibly harmful side-effects, both within countries (especially poor countries) supplying the EEC with products on which health restrictions are imposed, and in the EEC itself. Indeed, sets of proposals roughly similar to my own are today being announced in several other EEC parliaments. Let me emphasize, however, that—while I shall consult patiently and reasonably both with other EEC countries and with possibly aggrieved or damaged interests in Britain—this Government has the prime responsibility to implement, without unnecessary delay, measures to safeguard and improve the health of the population to which it is responsible.

"Hence these proposals have a firm target, to be achieved during the lifetime of this government. The target is to increase, by at least three years, the expectation at birth of healthy life, i.e. of life free from institutionalisation, bedfastness, or major disability. Statistics for this have been collected in the USA, and will be prepared for the UK by this Department on a regular annual basis, disaggregated by regions.

"I have decided to present my proposals, not by topic (for instance cigarettes, cholesterol, etc.), but by type. The proposals are of three types. Some affect the pattern of price incentives; others

the size and structure of government outlays; others again, the laws affecting what is allowed and what is forbidden. The need for all three sorts of measures, indeed, is another lesson we have learned from experience in poor countries.

"For example, the International Labour Office in 1971 sent to Sri Lanka a team of specialists with many different ideological preconceptions. Would they seek to attack the underutilisation of labour by measures correcting price disincentives that discouraged its use? Would they recommend a big shift in the composition of public outlays? Would they advise structural change in the pattern of ownership, such as the division of large farms into small, labour-intensive units? Faced with a large and intractable problem, the team had to combine all these approaches, ideologically unpalatable as such a combination must appear to almost everybody! A similar need arises here. One cannot efficiently prevent unnecesary suffering—whether unemployment in Sri Lanka or disease in Britain—with one hand tied behind one's back by a rope of ideology, be it liberal, interventionist or participatory.

"Here, then, in the briefest of outlines, are the measures the Government is taking. Details will be supplied later in the debate.

"First, as regards price, some direct incentives to ill-health will be removed forthwith. The duty-free customs allowance for cigarettes (but not for other forms of tobacco), and for spirits (but not for lighter alcoholic drinks), are withdrawn. The government is allowing rises to full EEC levels in prices of dairy and meat products, other than poultry (which is low in cholesterol), immediately. Conversely, and pending a longer-term arrangement, we have obtained the Commission's agreement to introduce off-setting measures designed to avoid a sharp rise in the cost of living: subsidies for edible fats rich in polyunsaturates, and a 2 per cent reduction in VAT on non-food items.

"Price policy also has substantial leverage upon motorists' decisions: a package of offsetting taxes and subsidies, designed to encourage the use of accessories that stimulate safer motoring, and to deter speed. will be announced.

"The most important uses of price policy, however, are not to restrict or deter, but to promote substitution and to compel people to bear the full social costs of their actions. In order to promote the substitution of cigar and pipe tobacco for cigarettes, the tax rates are being adjusted, so as to shift half the tax yield now obtained from other forms of tobacco on to cigarettes. The tax rates on cigarettes will increase with tar content, nicotine content, and carbon monoxide inhaled, instead of (as at present) with the weight of tobacco used. It is not intended to increase the real value of the total tax taken from tobacco, because this has been shown to be ineffective in deterring the consumption of cigarettes.

"Price policy can encourage employers, as well as workers, to make substitutions. This is of special importance in helping people to undertake higher levels of physical activity, and thus to reduce drastically the risk of heart disease. Such physical activity is useful only if undertaken regularly, three or four times a week, and vigorously. For most people, this is easiest if facilities are provided at or near the workplace. Employers will benefit from more active and vigorous workers in the long run, but in the short run an incentive is needed. Accordingly, National Health Service funds will be made available to provide full remissions upon corporation tax for two items: interest and depreciation on the capital cost of constructing sports facilities at or near the workplace; and the annual running cost of such facilities.

"However, much the most important area of health price policy, in which serious inequalities and misincentives prevail, concerns insurance. Public health insurance at present involves a vast subsidy from those who adopt healthy styles of life to those who do not. (It might be objected that the healthy are more likely to survive to pensionable age; but they are much less likely, at that age, to retire from work and hence to draw substantial tax-financed benefits.) Private insurance of life, of motor vehicle use, and of other contingencies involves savage discrimination: against non-smokers and the non-obese; against careful drivers in small, slow cars; and in general against responsible people, who pay premia out of all proportion to their relative risks.

"The government is correcting its own price malpractices in the field of insurance, and is legislating against those of the private sector.

"As regards national health and social-security contributions, these will be dependent on the contributor's style of life, as it affects likely demands on the national health service. Let me give an extreme example. A person smoking 30 cigarettes or more daily, 30 per cent overweight, taking no regular exercise, drinking heavily, and consuming a diet rich in animal fats (I shall spell out the details later), and driving a car of 3,500 c.c. or more, would pay NHS contributions of £5.50 per week. A non-smoker, less than 5 per cent overweight, taking regular vigorous exercise,

drinking little, consuming few animal fats, and driving a small car, would pay £0.75 per week. These costs reflect the best estimates we can make of the relative burdens that these two people are likely to place upon medical and social-security services. Each contributor will be expected to make annual statements regarding the areas of behaviour specified above, since all these are likely to affect his or her NHS requirement substantially. All of them can be simply checked in a brief physical examination, and 1 in 50 NHS contributors will be randomly checked in this way each year. This sort of substantial difference in weekly payments—a reminder of the costs to the community—will both improve equity in NHS funding and, perhaps, deter dangerous practices, as a few pennies on a packet of cigarettes, for instance, clearly do not.

"I now pass to the measures of restrictive legislation. These are put before you reluctantly, and have been kept to a minimum. Health should be fun, and measures to improve it should arise, where possible, from free and informed decisions. Puritanism about pleasures, restrictions, the 'nanny State'—such an approach could give health a bad name. Indeed, research suggests that the words 'Government Health Warning' on cigarette packets actually attract customers.

"However, where the actions of some damage the health of others, we are in the area normally reserved, not for private incentive, but for public law. The smoking of a cigarette may be expected to reduce life expectancy by 5½ minutes. A non-smoker, by spending an hour in a roomful of cigarette smoke, is exposed to just as much heart-lung pollution as if he had himself smoked one cigarette. It is intolerable that, in their places of work or elsewhere, non-smokers should involuntarily face such risks. Legislation will be presented that sets out stringent minimum requirements for ventilation in offices, shops, factories, restaurants, canteens, and places of entertainment where smoking is allowed. It will inevitably be expensive to install equipment sufficient to meet these requirements. The alternative is to prohibit smoking in unventilated areas.

"Legislation to prohibit cigarette smoking by women, if they have good reason to believe they are pregnant, is also proposed. Of 8,000 perinatal deaths each year, about 1,500 are caused by such smoking.

"The principal restrictive legislation regarding cigarettes, however, will apply to producers. Britain will forthwith join the dozen countries that have banned all advertising of cigarettes. I am not sure how much this advertising increases total cigarette consumption; certainly it does not decrease it. Furthermore, during the next year, the sale of cigarettes of 'middle tar' content and above will be phased out. Again, one cannot be certain of a large beneficial effect. Smokers may simply smoke more if they switch to lower-tar cigarettes, although this is unlikely, because the addictant in cigarette smoke is not tar but nicotine. Again, the health damage may not fall if it is due to nicotine or carbon monoxide, not to tar. However, since at least 18 carcinogens have been isolated in tar, some legislation on this matter is indicated.

"Legislation is also required with regard to what one might call the carriers of the cigarette disease. Teachers and members of school staffs who smoke in the presence of pupils, doctors and nurses who smoke in surgeries or hospitals, already break the moral code. Shortly, they will also be breaking the law. . . .

"It is more difficult to legislate in matters of diet. Nobody needs cigarettes to live, but people do need nutrients. These nutrients are tied together in complex foods, which unlike cigarettes are healthy in moderation, and harmful only in excess, when they induce obesity, and over-concentration of cholesterol and tri-glycerides. Nevertheless, something can be done. Butter, cream, eggs, well-marbled beef—all these delicious goods would probably not be admitted under existing food drugs legislation, if they were to be introduced as new products. I am investigating the possibility of restricting their use in packaged foods, probably my means of general laws affecting the proportion, by weight, of saturated fatty acids. This will go alongside research into the commercial development of acceptable and safe substitutes, notably by adapting the feed or genetic background of cattle and poultry.

"The health hazards of sugar, in respect of diabetes and tooth decay, are well known. As a major cause of obesity, sugar also contributes indirectly to heart disease. More controversial is the alleged direct link of refined sugar to heart disease. However, no Health Minister seriously concerned to reduce illness, and to save money, could ignore these dangers. They are certainly much greater than any that might attach to the consumption of cyclamates or saccharin. Accordingly, the use of cyclamates will be permitted in Britain, as it is in many countries where no link with human illness has ever been seriously suggested; and the use of saccharin will not be restricted. Restrictions will, however, be introduced to limit the sugar content of the major prepared

foods that now contain it: jams, soft drinks, cakes, confectionery, and prepared desserts.

"Motor vehicle accidents are the main hazard from which immediate relief to innocent persons can be secured by law at once. The legal upper limit of alcohol in the blood of drivers will be reduced to one-quarter of its present level—still considerably above the legal limit in Scandinavia. The speed limit will be set at 50 m.p.h. on all roads except motorways, and at 60 m.p.h. on motorways. Both these pieces of legislation will be enforced by regular random police checks. Despite the opposition of the motoring organisations to safety legislation, public opinion polls have shown that their members welcome it. As regards seat belts, insurance companies will be freed from liability for the first £1,000 of personal injury charges, including NHS costs, to any injured person not wearing a seat belt; such charges will be transferred to the person injured.

"Legislative restriction has little scope for attacking the other major killers, inactivity and stress. Local authorities, however, will be instructed to make arrangements to open all possible school sports facilities to the public, outside school hours, and some central government money will be available to pay for this.

"This brings me to the third and most important area in which governments can take positive action to induce health: not price policy or restrictive legislation, but public activities, preferably costing less than the saving of NHS expenditure that they permit. Education is a particularly clear case. At present, the resources devoted to physical education in State schools are still unduly directed towards producing sports talent in a few stars, rather than towards gradually inducing progressively higher levels of overall fitness among the whole school population. Research has shown that patterns of physical activity—or inactivity—learned at school are usually retained in later life. The Minister of Education, in consultation with the Schools Council, is preparing guidelines for schools in the State sector, and associated examination procedures, to ensure that all schoolchildren without physical handicap are taught to attain and retain reasonable levels of heart-lung fitness. As always, the methods of teaching are up to the school, but the objectives of the educational system are up to the electorate.

"The main government activity proposed, and the most important part of this plan for positive health, is the redesign of the National Health Service. As from next month, 5 per cent of the total resources of this Service are being placed at the disposal of a Division of Positive Health. This Division will seek to increase security against needless disease and death. Its targets will include diets restructured to reduce obesity, to improve the structure of the intakes of sweeteners and fats, and to prevent diseases caused by inadequate intake of fibres and by other deficiencies; drastic reduction of deaths and injuries due to cigarette smoking, stress, and motor, home, and industrial accidents; and regular, safe, and widespread physical exercise. The Division's methods will include promoting research; developing and testing new products; negotiating with pressure groups; advertising; and preparing new legislation. The Division will be judged mainly by its impact on death and illness, but its future will depend in part on its success in covering its costs to the Exchequer, by reducing outlays for hospitals and surgeries; and its costs to the country, by reducing sickness and hence by increasing effective work. It is my hope that the Division can ultimately absorb 20 to 25 per cent of all NHS costs, and in so doing can make the NHS much more effective in reducing death and disease, at no extra expense to taxpayers.

"I come now to a detailed assessment of costs and benefits, first to the Exchequer and second to the country as a whole, of the actions outlined so far. . . .

"Measures such as I have outlined will be unpopular at first, though benefits will appear later. Such measures can only be carried out at the beginning of a government's term of office. They involve consumers in substantial changes in lifestyles. They also require producers to change, though I must stress that the government will help to retrain, retool and diversify affected sectors of the economy—cattle farmers, motor manufacturers, cigarette makers. This pledge applies to employers as well as employees. The plea for positive health does not aim to punish producers, or to restrict consumers. It seeks to enable all the people to enjoy an increasingly full, fit and happy life.

"The pledge to help 'all the people' to greater fitness cannot, as yet, be fulfilled in the case of sick people whose conditions have been neglected by past research. Half the hospital beds in Britain are occupied by the physically ill; the programme which I have outlined will make much of that illness unnecessary. However, the other half are occupied by the mentally ill. At present they enjoy less than one-tenth of outlays on medical research in Britain, as elsewhere. Mental-health research, though seldom glamorous, is promising, and is constrained largely by

funds sufficient to attract numerous able researchers and students. These funds will, during the next few years, be greatly increased, partly at the cost of the very large outlays now undertaken, at very low return in reducing human suffering, for research into some of the rarer diseases, and for technically sophisticated medical hardware connected with heart and kidney conditions. . . .

"The well-being of a nation depends on three things. The first is its output of goods and services. The second is their distribution among persons. The third is the volume and distribution, not of output, but of people's capacity to enjoy what they get—to absorb goods and services, and to transform them into physical and spiritual welfare.

"There have been increasingly severe constraints on our capacity, as a rich country in an energy-starved world, to raise output. We shall go on trying, but dramatic success may elude us.

"Redistribution of purchasing-power over output was very substantial in 1939-45, and again in 1972-77. Opinion is divided about how much more is possible without serious damage to incentives.

"Hence growth in welfare in Britain is likely to depend, in the coming decades, mainly on improvements in the people's physical ability to transform output into happiness—in the amount and distribution of health and fitness. Yet these have improved very little in post-war Britain. Governments have chronically neglected them. Both in volume and in distribution they do badly despite growth, and perhaps *because* of some sorts of growth. In the last two decades, life-expectancy in Britain has hardly altered. That of the poorest has declined. Their growing incomes, often achieved through greater stress, have brought these people—especially the women—access to more cigarettes, butter, sugar and inactivity. Such styles of living, or rather of dying, have been impressed upon the poorest by advertising and by the desire to emulate; impressed, often, upon people with little education, and with few alternative pleasures. While the richer classes give up cigarettes and take more exercise, the poor accept rising risks of bed-disability, sickness, and early death. Disraeli's 'two nations' were seldom so clearly divided, or so viciously. Disraeli, indeed, would have been as likely as Engels to have enquired how much of the growth, especially in the incomes of the rich, was linked to products—whether to cigarettes, fatty foods, or cars—that damaged the health of the poor.

"There is no conspiracy, no conscious evil here. It is a systemic wickedness as characteristic of communism as of capitalism. For instance, the USSR has done nothing effective to reduce cigarette consumption, and I understand that China Airways gives away free cigarettes to passengers!

"The problem is different. For many years, governments have sought to 'hold the ring' in the battle among interests. More recently, some governments have sought to raise or stabilise output and to improve its distribution, among other things, by National Sickness Services and Ministries of Disease. So far, governments have not accepted a general responsibilty to improve the capacity of the governed for the absorption of welfare. This Positive Health Programme is the first such attempt. I hope its success will make Britain a useful example for others."