WHO, What and Why?

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Transnational Government, Legitimacy and the World Health Organization

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Roger Scruton is a writer and philosopher who lives and works near Malmesbury. He has held professorships in London and Boston, and visiting professorships in many other places. He is currently living as a freelance writer and proprietor of an experimental farm. He is the author of over twenty books, and his writings have been translated into every major European language. His recent publications include *The Aesthetics of Music, An Intelligent Person's Guide to Modern Culture* and *Animal Rights and Wrongs.* His weekly column on countryside matters in the *Financial Times* Business magazine has secured a wide following, and he is a well-known commentator on radio and television.

FOREWORD

Since the early days of 'public choice' theory, economists have been concerned about the power of organised pressure groups. These groups – for example, companies or workers in a particular industry, 'environmental' campaigners or other collections of people with common interests – appear to have an influence on government policies out of all proportion to the extent to which they represent general opinion. Indeed, they can become means of forcing minority views on the populace at large through the medium of government. Consumers, on the other hand, evidently exert little influence on policy.

The key to these differential effects lies in the concentration of benefits on the members of the interest group as compared with the dispersed costs. If a group can mould government policy to its own ends, the benefits accrue primarily to its members. Lobbying thus appears to be an activity with a potentially high return. The costs – often heavy – are, however, dispersed over millions of consumers. Individuals are often too little affected for protest to seem worthwhile.

At one time, pressure groups concentrated on lobbying national governments. But nowadays, with the growth of supranational governments and transnational institutions, lobbying has moved where the power is. Interest groups have a strong presence in Brussels, for example, in the hope of influencing the many regulations which emanate from the European Union.

As Roger Scruton points out in Occasional Paper 113, it is not only the EU which receives the attentions of lobbyists. Regulation is being internationalised, particularly through the United Nations and related bodies. Lobbyists therefore see the opportunity to impose their views not just on particular countries but on the world as a whole. They are being helped by the fashion for appointing as leaders of transnational institutions ex-politicians who seem responsive to the views of interest groups. The institution itself can easily turn into a *de facto* lobbyist for actions which have profound effects on the citizens of many countries, even though it is not accountable to those citizens.

Roger Scruton uses the example of the 'Framework Convention on Tobacco Control' which is, he argues, being used by the World Health Organization (WHO) in an attempt to impose draconian controls on the tobacco trade. In his view, the tobacco industry is a 'questionable one', but that does not mean that the detailed controls urged by the WHO should be 'imposed by unelected bureaucrats'. He points out that there are few limits on this kind of WHO action: similar controls on other products – for example, alcohol, sweets, coffee and fatty food – are likely to follow. If there is to be action against such products, Scruton argues, it should be left to national electorates.

All IEA publications express the views of their authors, not of the Institute (which has no corporate view), its Trustees, Advisers or Directors. Roger Scruton's stimulating paper is published to contribute to the growing discussion about the powers being assumed by transnational institutions.

COLIN ROBINSON
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PREFACE

Why be interested in the World Health Organization and its attack on the tobacco industry? First, because the controversy over tobacco is of enormous social, political and fiscal importance, and has yet to be clearly stated and assessed. Secondly because the WHO has added to the confusion, by proposing massive legislative measures with no democratic mandate. The story that I tell in the following pages is meant as a warning. More and more legislation issues from bodies that are not accountable to those whom they seek to control. Only if we are aware of what this means in a particular case can we understand the more general threat to our freedom. To understand the particular case is hard, however. The facts are elusive, and there has been a lack of transparency among those who debate them. I have therefore had to wrestle with some difficult and abstruse material, and am very grateful for the help provided by Daniel Stander, in pursuing references and carrying out research. I am also grateful to those who read the pamphlet for the IEA and who made helpful suggestions. Any remaining mistakes are of course my own.

ROGER SCRUTON
Malmesbury, April 2000

SUMMARY

- Transnational institutions (the United Nations and its affiliates) are increasingly exercising their legislative powers, in order to bypass the constraints to which national legislatures are subject.

- The situation is made worse by the habit of conferring leadership of these institutions on ex-politicians, rather than on experienced civil servants.

- Such ex-politicians tend to be more responsive to the concerns of vocal but unrepresentative interest groups, who seek to impose their vision on the people of the world.

- The World Health Organization (WHO), after years of blatant corruption and abuse, has been put in the hands of Dr Gro Harlem Brundtland, ex-Prime Minister of Norway.

- The dangers of this are illustrated by the WHO's 'Tobacco Free Initiative', and its current attempt, eagerly pursued by Dr Brundtland, to secure a draconian convention against the tobacco industry.

- The grounds given for this are largely spurious, and in any case refer to matters which are outside the remit of the WHO.

- The effect of the proposals will be to confer massive legislative and policing powers on unaccountable bureaucrats, and also to drive the trade in tobacco underground.

- The proposed convention will do nothing to curtail the consumption of tobacco, and everything to escalate the criminal activities of smugglers and rogue producers.

- The time has come for the WHO to concentrate on its real mission, which is the prevention and cure of communicable diseases such as malaria and TB.

- Only this will answer the legitimate complaints of those who have seen the WHO squander millions on projects of little or no relevance to Third World countries.

WHO, What and Why?

1 INTRODUCTION

In this paper I consider a matter of growing concern to all who believe that legislators ought to be accountable to those for whom they legislate. I shall be considering the way in which a political agenda can be promoted without hindrance, once legislative powers are granted to transnational bodies answerable to no national electorate. And I shall focus on one example: the current attempt by the World Health Organization to impose, through the machinery established by the United Nations, punitive legislation directed against the manufacturers, distributors and users of tobacco products. There are other examples: European Commission directives, which have the force of law regardless of the will of national legislatures, may be used to advance the interests of lobbyists who have no accountability to those upon whom the directives are imposed; while the UN, through its commissions and ancillary institutions, is attempting to shape the law of its member states in accordance with an agenda set by Western pressure groups and political elites.

Nevertheless, the case of the WHO and tobacco is of particular significance, since it shows how an institution with a purpose that few would question can be turned in a wholly new direction, in order to impose the social and political agenda of a handful of activists. The case will therefore set a precedent, not only for further legislation by the WHO, but for an ever-expanding raft of laws

imposed on us by unelected, unaccountable and unejectable bureaucrats. The case is also interesting for another reason, in that it raises in an acute form the question of liberty. What philosophical principles govern, or ought to govern, legislation designed to limit our choice of lifestyle? When is such legislation justified, on what grounds, and by what legislative body? Current discussions concerning the legal status of cannabis, of prostitution, of proselytising in schools on behalf of homosexuality also raise these questions, and it is important to understand that they are, in the end, philosophical questions, which touch on our deepest experience of society.

I write as a citizen of a modern democracy, in which free speech is still assumed to be a necessary part of humane and rational government. But the subject of tobacco is one in which free speech is increasingly under threat. I do not refer merely to the proposed ban on tobacco advertising, though it is worth mentioning the oddness of a law which permits people to sell a good, but forbids them to say so. I refer more specifically to the tendency of pressure groups to demonise the things they dislike, and to blacken the character and question the motives of all who seek to defend them. Nobody who writes or speaks in any way that seems to promote the interests of 'Big Tobacco' can escape vilification from such organisations as ASH (Action on Smoking and Health), or from journalists like Nick Cohen of the *Observer,* who have so entirely accepted the case against tobacco as to look with amazement and contempt on anyone who appears to doubt it.[1]

1 See, for example, Nick Cohen, 'The Plot to Keep Us Puffing,' in the *New Statesman*, 17 January 2000, in which the impression is created that anyone prepared to question what is now the received wisdom about tobacco is serving the aims of a world-wide conspiracy.

Up to a point this is understandable. Tobacco is a threat to health; moreover, the knowledge of this fact is implanted and rehearsed at every hour of the day – by politicians, by journalists, by activists and NGOs, and by the tobacco industry itself, whose billboards contain no information other than the statement that smoking induces fatal diseases. In the world of sound-bites and images, where no question is pursued very far and statements must be short and simple if they are to be heard at all, the one medical opinion that everybody shares is the belief that smoking kills. In such a world the easiest way to pose as the friend of mankind is to join the campaign against smoking, and the surest way to invite abuse is to question whether the campaign is right or just or necessary.

But there is another cause of the existing censorship. Smoking belongs with those old and settled habits, like calling women 'ladies', getting drunk on Friday nights with your mates, staying married nevertheless and having babies in wedlock, which reflect the values of a society shaped by the division of sexual roles. It is a symbol of the old order, as portrayed by Hollywood and Ealing Studios in the postwar years, and its very innocence, when set beside cocaine or heroin, gives it the aspect of discarded and parental things.

Furthermore, tobacco advertising has in the past specialised in evoking old ideas of male prowess and female seductiveness: even now cigarettes are sold through a screen of fantasy, of a kind that stands opposed to the prevailing culture. In almost every way, tobacco offends against political correctness, and precisely because it seems to put older people at their ease and enables them to deal confidently with others, it raises the hackles of those who have never achieved that precious condition, and whose discomfort is

only increased by the sight of others so blatantly enjoying themselves.

To speak out against those who wish to control or forbid the use of tobacco is therefore to risk immediate demonisation[2]: and the WHO has played an active part in promoting this response, not entering into discussion with people who disagree with its own dogmatically held beliefs about their ill effect, and putting obstacles in the way of those like the International Tobacco Growers Association and the manufacturers of tobacco products, who ought, in the interests of natural justice, to be represented in any decision-making process that threatens their livelihood.[3] So let me begin by declaring my position on tobacco, if only to reassure the reader that my argument is not a defence of this particular product, but an attack on those who wish to remove the right of national legislatures and national electorates to decide how its sale and purchase should be controlled.

I like cigars, and will smoke a cigar if someone offers me one.

2 Nick Cohen, *ibid*. The Canadian equivalent of ASH, the Canadian Council on Smoking and Health, was criticised by the Ontario Liberal MP John Bryden in 1994 for misusing government grants to pay its staff. John Bryden was thereafter demonised by the anti-smoking lobby. See Charlotte Gray in *Canadian Medical Association Journal* 152, 15 June 1995, pp. 2021–3.

3 The Director of the WHO's anti-tobacco campaign, Dr Derek Yach (concerning whom see below), agreed to meet the Executive Director of the International Tobacco Growers' Association in 1999, though with no agreement to allow representation in the policymaking process. Until recently, this was the only concession made to the privately owned tobacco industry and Dr Yach's public pronouncements made it quite clear that he regards all association with the industry as a betrayal of the sacred cause: see especially his speech at the International Consultation on Tobacco and Youth, Singapore 1999. In March 2000 the Director General of WHO, Dr Brundtland, relented so far as to propose a forum at which all interested parties – including the tobacco industry – could discuss the issue.

All other forms of tobacco repel me, and I am persuaded that cigarette smoking on a regular basis is harmful. My father died of emphysema, no doubt exacerbated by the many cigarettes he smoked into middle age. He was 74 when he died, however, and had no regrets. I shall try to prevent my own children from smoking – partly because smoking begins as a kind of insolence. I welcome the law which obliges cigarette manufacturers to warn us against their own product, and often think that the same should apply to the manufacturers of junk food, motor cars and televisions. If it were shown that cigarettes posed a threat not merely to the body but also to the mental and moral health of those who smoked them, I would favour more severe restrictions on their sale and use, of the kind that exist (though with increasingly less effect, it has to be said) in order to control drugs like cocaine and heroin. I avoid places where people smoke, unless I am one of them, and am glad that efforts are being made to segregate smokers and to protect children from a habit which is quite reasonably regarded as a vice, and which has been so regarded since Sir Walter Raleigh first brought it from America. In short, I am against tobacco; though not so much as I am against hard drugs, mobile phones or hard-core pornography.

At the same time, I should want all legislation governing the sale, use and control of tobacco to originate in the elected government of those who are obliged to obey it. According to the Office of National Statistics, some 27 per cent of my fellow citizens are smokers who pay, through the excise tax on cigarettes, a quarter of the cost of the National Health Service. Their vice is a socially harmless one (compared, say, with drugs, pornography or promiscuous sex), which neither impairs their ability to work, nor erodes their consideration for others. Moreover, they themselves freely

engage in this vice, knowing the consequences. We may have a duty to educate them in the ill effects of using tobacco; but they have a duty to educate us in the benefits – one of which is that of innocent pleasure, a commodity not easy to come by. All in all, I cannot see that a transnational bureaucracy has any right to tell our government how it must proceed in dealing with this problem, not least because only an elected government can really see things as a whole, and know which interests must be balanced against which in order to achieve reasonable and socially acceptable legislation. I know that, in defending this position, I shall become the target of abuse and denigration from the anti-tobacco lobby, which does not, on the whole, recognise rational disagreement with its aims, but only enmity. But in matters of real public concern, those who see their opponents as enemies, to be defeated at all costs and without discussion or compromise, have already lost the argument. Only if you have no case, do you have to forbid discussion.

2 THE WHO AND ITS MISSION

Established in 1948 as a specialised agency of the United Nations Organization, the World Health Organization exists to promote international cooperation in the fight against disease. Its constitution declares that the WHO's objective 'shall be the attainment by all peoples of the highest possible level of health' – a goal which is clearly unattainable by any organisation that enjoys only limited resources. But its work is accepted and endorsed by modern governments for two powerful reasons: first because there are threats to health that can be effectively combated only by international efforts, and secondly because there are life-threatening diseases in the poorer countries that could be overcome without too much difficulty by a transfer of material, practical and intellectual resources.

Many children in Africa die because vaccines and medicines available at a low cost in the developed countries are unavailable locally. Many also die from diseases like malaria which can be effectively controlled only by international cooperation (in this case a concerted cross-border campaign against the mosquito). In such cases we who have the benefits of modern medicine have a clear duty to provide help, and the WHO was set up as one means of doing so. It is not the only means, and it may reasonably be doubted that it is the most effective means. Private charities like *Médecins sans frontières* and Sightsavers International, which

spend their money in the field and use the good will of committed people, probably achieve far more with far less, if only because they make a point of involving themselves directly with the victims, and not with the people who claim to speak for them. Moreover, it may quite reasonably be doubted that a bureaucratic institution situated in Geneva, paying its resident staff salaries of £100,000 per annum or more, and funded not by charitable donation but by a tax on national governments, is likely, given human nature, to spend resources on those who are most in need of them.

Nevertheless, the WHO can claim credit for some important results, such as the world-wide elimination of smallpox, which could not have been achieved without concerted transnational initiatives in which the governments of member states were recruited to the common goal. The question that we should consider, however, is that of priorities. Given the impossibility of providing the 'highest possible level of health' to everyone, and the sheer lunacy of trying to do so through an international bureaucracy, how exactly should the WHO be spending its resources? First some fundamental observations:

- People must die, and it is not necessarily in their interests, or in the interests of the rest of us, for them to 'strive officiously to stay alive'. It is more important, in general, that people should enjoy full, productive and happy lives, than that they should eke out their years to the point when nobody regrets their dying. Any measure of the health of a society which paid attention only to the average age at death would have left out most of what matters. Equally important are the strength, well-being and physical condition of the population during its active life.

- There is a vast difference in life-expectancy between people in developed and under-developed countries. Life expectancy for men in Japan is well over 80; in central Africa it is around 50, in the Indian sub-continent around 60, in Europe and North America between 75 and 80. In almost all parts of the world the life expectancy of women is significantly greater than that of men.
- There is also a threat in the under-developed countries from diseases that have proved to be curable elsewhere.
- There is a distinction to be made between communicable and non-communicable diseases, which must be taken into account in any allocation of resources. A communicable disease (such as TB or smallpox) threatens whole populations, and is therefore an immediate public problem. Non-communicable diseases (such as cancer or heart disease) become matters of public concern only when life-threatening communicable diseases have been held at bay.
- There is a further distinction to be made between diseases of old age, and diseases which threaten at every age, and which strike the old and the young indiscriminately. Diseases of old age tend to be non-communicable, like cancer and heart disease.
- Diseases which threaten the young tend to be communicable, like malaria, river-blindness or Aids.
- Finally, there is a distinction to be made between voluntary and involuntary risks to health. Some people are risk-averse, and place health at the top of their agenda, being unwilling to risk their health for any other good. They are not necessarily the happiest of people, and indeed hypochondria is a form of human misery, which not only fills the sufferer with fears but

> also cuts him off from human sympathy. Normal people are prepared to risk health for happiness. One of the largest causes of hospital treatment in the UK today is sporting accidents – rugby, football, cycling and horse-riding. Those who engage in these sports regard them as so fundamental to their well-being as to take the risk in their stride. It cannot be the function of a health bureaucracy to cure us of such self-imposed risks.

Those points seem like common sense. But they have important consequences for health policy, and in particular for the policy of an institution devoted to spreading the benefits of health-care to populations that have so far not enjoyed it. You could spend a lot of money on cancer treatment, and so increase the life expectancy of people in a developed country from 75, say, to 80. But the same amount of money devoted to a dangerous and communicable disease like malaria might increase the life-expectancy of people in an underdeveloped country from 35 to 50. That is surely a very good argument for spending money allocated to 'world health' on combating malaria rather than cancer. Moreover, when it comes to research, education and the provision of expertise, it is surely far more reasonable, as things are, to devote these to communicable rather than non-communicable diseases: for then you are sure that you are helping those who would otherwise be cut short in their prime, and who do not have what most of us have in the Western world, the opportunity to enjoy a full and healthy middle age.

Furthermore, we can see how important it is to moderate the rhetoric of health-care, if we are to make rational decisions about the allocation of scarce resources. To take statistics out of context,

without a full description of the reference class and with no attempt to identify the salient variables, is inevitably to provide a misleading picture. To say that 1 million people die each year from malaria, whereas 10 million die from cancer, and to conclude that therefore cancer is much the more dangerous disease, is to misrepresent the facts. For people who die from cancer tend to die in late middle age or later, while those who die from malaria never get that far. Indeed, if you allow yourself to specify 'old age' as a cause of death, and a distinct medical condition which can be treated (and this is every day becoming more true), then it is certainly the case that old age is, in the developed world, the greatest of killers – but also the one that is least in need of treatment. To die of old age is to die in old age: which is certainly not to die sooner than one should.

In the light of that, we should expect an institution like the WHO to address a given health-risk with the following questions in mind:

- Is it voluntary or involuntary?
- Is the resulting disease communicable or non-communicable?
- Is it a disease of old age or a disease that strikes at any time?
- Is it a disease associated with poverty and under-development?
- If so, is it easily tackled by a re-allocation of resources from rich countries to poor?

Most reasonable people would surely tend to the view that, if the WHO is to justify its existence, it should concentrate on

communicable diseases in developing countries which can be effectively tackled only by a transfer of resources, and which can strike their victims at any time. Diseases of old age can be left to the national budgets of developed countries; voluntary health-risks are of public concern only if they pose a threat to others; and non-communicable diseases are, in present circumstances, very low down the agenda. The last thing that we should expect the WHO to be doing is to prioritise smoking – namely, a voluntary health risk, the clinical effects of which tend to emerge after the age at which people in poorer countries can expect to die. So how has this policy come about?

3 THE MISSION BETRAYED?

In a study whose findings have not been effectively rebutted, Robert D. Tollison and Richard E. Wagner have shown the extent to which the WHO has devoted its resources to itself, its staff, its offices, its publicity and its image, rather than to the field-work necessary to improve the lot of poorer populations.[1] The two authors are professors of economics, heavily influenced by the 'public choice' analysis of James Buchanan, and they take the WHO as a test case for the theory of 'rent-seeking', which begins from the premise that the first item on the agenda of any normal bureaucrat is his own interest. Take away the constraints of accountability and election, and the bureaucrat becomes, in effect, the owner of a rent, and if he is able to work together with his kind, he will be able to increase this rent at the cost of all those would-be beneficiaries for whom the resources were intended. This, Professors Tollison and Wagner claim, is what we see.

Among their conclusions are these:

- In 1994–5, 76 per cent of the WHO's budget ($1.8 billion) went to paying its own staff
- $5.6 million dollars was allocated to stationery and office

1 Robert D. Tollison and Richard E. Wagner, *Who Benefits from WHO?*, The Social Affairs Unit, London, 1993 (published to coincide with the WHO's budget for 1994–5).

supplies, compared to $3.7 million to combating diarrhoeal diseases (a major cause of death among children in the Third World)
- Larger budgets were allocated to campaigns on smoking, safety belts and issues such as 'psychosocial health' (a catch-all phrase that covers causes of interest to political activists in the West) than to combating malaria.

'When overheads are included,' Tollison and Wagner argue, 'it costs WHO $8 for every $2 it spends on actual programmes.'[2] Even if we discount the enormous cost of salaries, much of the WHO's funds in the years examined were spent on itself. Staff meetings alone cost $15 million, and venues and topics are equally revealing: Health-for-All Leadership Development (Geneva), an International Conference on Safe Communities (Stockholm), a Workshop on Nursing Informatics (Washington DC), a Congress on Adolescent Health (Montreux), an International Conference on Aids (Florence), a Conference on Clean Air at Work (Luxembourg), and a Study Group on Ageing and Working Capacity (Helsinki). All the conferences took place in affluent and expensive Western cities while none of the topics (apart from Aids) was of interest to Third-World countries. Moreover, Aids, unlike malaria or beri-beri or river blindness, is a disease from which Westerners might suffer. The cost of the World Health Assembly for 1994–5 was $6.3 million, with another $5.4 million added for the executive board. Those figures should be compared with the amounts allocated to diarrhoeal diseases ($3.7 million), acute respiratory infections ($2.5 million), and TB ($4.8 million).

2 *Ibid*. p. 19.

Those figures are only part of the picture, however, and not, from the political point of view, the most important part. If the public choice theory of bureaucracies is true, they are exactly what we should expect – and what we find in all imperfectly accountable institutions, from the European Commission to the Chinese Communist Party. In an extended study, Rosemary Righter has shown that the UN institutions have become, since their inception, lucrative sources of income to the bureaucrats and politicians who have captured them, and that the purposes for which they were established have absorbed less and less of their internal budgets.[3] And the complaints made against the WHO by Tollison and Wagner echo similar complaints made against UNESCO, the World Bank and the UN itself.

More important, it seems to me, is the subtle change in the agenda of the WHO, from the honourable and necessary one of helping the poorer nations to the benefits of modern medicine, to the far more questionable one of announcing and imposing its own parochial view of how we should be governed. Thus, at the same time as reducing its fund for combating malaria by a third, the WHO allocated $2.7 million to 'increasing awareness of the health implications of the social and behavioural aspects of social action and change' – in other words, any kind of political activism that can be linked to problems of health. Money that might have gone to controlling new types of malaria transmission in Africa was redirected to a review of 'legislation from selected countries that require modification in order to enhance their positive effects on mental health'.

3 Rosemary Righter, *Utopia Lost: The United Nations and World Order*, New York, 1995.

More recent documents show a continuing shift away from the control of infectious diseases in developing countries, towards a vaguely specified social agenda, into which the standard preoccupations of Western socialists and the 'caring' industry can be easily inserted. Thus the current budget promises 'cross-cutting health promotion initiatives on such priority issues as ageing, tobacco, violence, and active living'.[4] The suggestion that a child born in central Africa, with a life expectancy of 45, and at serious risk of a far earlier death from diarrhoeal diseases or malaria, should see ageing, tobacco or 'active living' as a priority is laughable; and even the violence referred to in WHO's budget is not the kind which such a child has to fear every day, but rather the household violence that goes with Western affluence and the permissive lifestyle.

One explanation of this shifting agenda was advanced (though tentatively) by Professors Tollison and Wagner: namely, that the WHO is turning its attention to issues of concern to its principal donors. The contributions on which the WHO depends are weighted towards the richer countries, with the US, Japan and the Western European states between them meeting 75 per cent of the cost. This is surely only right and fair: the whole purpose was to secure a transfer of medical resources to places that need them but cannot afford them. But one result of this is that the WHO is staffed by people from the developed world, and headed by figures who represent the interests and pressures acting on the nations which provide most of the funding.

4 Proposed Budget for 2000–2001, WHO, Geneva, p. 51.

4 THE ACCESSION OF DR BRUNDTLAND

There is some truth in that explanation. Certainly it helps us to understand the WHO's policies after 1988 when, as a result of intense lobbying from the Japanese, Dr Hiroshi Nakajima was appointed to the position of Director General – a post which he held, despite near universal misgivings, for ten years.[1] But it is not the whole truth. For the fact remains that a large section of public opinion in the West would wish the WHO to stick to its old agenda, and to heal both the sickness of the poor and the conscience of the rich, by attending to the problem of infectious diseases in the Third World. The shift in the WHO's agenda would, if widely known, rapidly lead to a withdrawal of funding, of the kind that destroyed UNESCO some fifteen years ago. Moreover, if motivated by a desire to please Western governments, the WHO's policy in the mid-nineties was remarkably unsuccessful. The donor countries began to fall into arrears with their payments, the US (the largest single donor, accounting for 25 per cent of the organisation's income) deliberately withholding funds until managerial improvements could be shown.[2]

In fact the change of agenda has come about because the WHO has been politicised, in just the way that UNESCO was politicised,

1 See Rosemary Righter, *op. cit*., pp. 148–9.
2 *New Scientist*, editorial, 11 January 1997.

by activists who have seen it as an unassailable summit of power over national legislatures. The transformation of the WHO is not the result of social and economic factors only, but of an exercise of political will. And in recent years this political will has come not only from pressures at the lower level, but from active leadership at the top.

The practice has arisen in recent decades of entrusting international or transnational institutions to discarded statesmen or would-be statesmen. Those officers who should be the highest and most impartial of civil servants in fact turn out, as a rule, to be ambitious politicians, eager to assert control over ordinary people without the time-consuming business of seeking their vote. Thus the European Commission, which holds the administration of the European Union in trust for present and future citizens, is now led by people who, having failed to impose their agenda on a national electorate, enjoy far greater rewards through reshaping their schemes from a position that is effectively unassailable. The United Nations Commission on Human Rights is now headed by Mary Robinson, former president of Ireland, who is using the position to meddle in the affairs of states which would never have chosen her as their president.[3] And the WHO has now been placed in the hands of Dr Gro Harlem Brundtland, former Prime Minister of Norway.

Dr Brundtland owes her appointment to the votes of Western member-states, fed up as they were with the corruption and malpractice for which the WHO had become notorious. She has a reputation for probity, and an interest in environmental causes that can be used to purchase credibility from the otherwise sceptical Western media. At the same time, she continues to behave as a

3 See John R. Bolton, 'Speaking for Herself', *The Legal Times*, 1 November 1999.

politician in a post that requires the kind of humility which high-ranking politicians in general, and ex-politicians in particular, rarely exhibit.

Three momentous consequences followed from the appointment of Dr Brundtland: the proposal of a new and radical policy document which, if adopted by the World Health Assembly, would totally transform the objectives of the organisation; the active collaboration with other institutions and other forms of funding, so as to side-step financial penalties that the donor countries can still impose; and the increasingly belligerent posture of the WHO's tobacco supremo, Dr Derek Yach.

1 The policy document

This is entitled *Health for All in the 21st Century,* and is designed to supersede the last policy document of the WHO, *Health for All by the Year 2000,* which was adopted and endorsed by the World Health Assembly in 1981. The comparison of the two documents is revealing. That of 1981 proposed that the WHO should make primary health-care (local clinics, nursing, vaccinations etc.) available to as many people as possible by the turn of the century. The goal proposed by Dr Brundtland is not phrased in medical terms, but in terms of 'human rights', so authorising unlimited political intervention in the pursuit of it. According to *Health for All in the 21st Century* we each have 'the right to adequate food, water, clothing, health care, education, reproductive health and social services, and the right to security in case of unemployment, sickness, disability, old age, or lack of livelihood in circumstances beyond the individual's control.' To call these goods 'rights' is to ignore all the philosophical and judicial reasoning, from Grotius and Kant

to Hohfeld and de Jasay, which distinguishes rights from privileges, and vetoes from claims. It is to ignore all the concerns of those who wish to distinguish the sphere of individual freedom and responsibility from that of state control, and who believe that private enterprise rather than central administration is the key to prosperity and well-being. But this only emphasises the fact that Brundtland is proposing a world-wide socialist programme, and using the concept of a human right to imply that there is a moral and political duty to impose it. In the event her document was not accepted or endorsed by the World Health Assembly. Nevertheless it defines her long-term objective, and shows her determination to over-ride those national legislatures which offer resistance to her agenda.

2 Side-stepping the donors

Using her credibility as a former prime minister (three times elected) of Norway, Dr Brundtland has gone directly to prime ministers with her new proposals, and has been able to fund programmes (including the 'Tobacco Free Initiative' aimed at destroying the tobacco industry) through other UN channels, and also through business. The agencies in question include UNICEF, the UN Commission on Human Rights, the UN Development Programme, the IMF and the WTO. Although the practice of seeking 'extra-budgetary' funding for projects is not new, Dr Brundtland has radically expanded it, appealing directly to the self-interest of the pharmaceutical companies, three of which (Pharmacia-Upjohn, Novartis and GlaxoWellcome) have given $250,000 each to support the WHO's Nicotine Replacement Therapy campaign, from the success of which they stand to make a lot of

money.[4] Involvement of the WTO is partly due to similar interests, since the pharmaceutical companies are actively using the provisions governing 'trade-related intellectual property rights' (TRIPS) to impose a world-wide taxation on the use of drugs. The three 'cabinet projects' of the WHO (see below), which include the Tobacco Free Initiative, are to be funded largely in this way. Donor countries will therefore be powerless to put a stop to them.

3 Derek Yach

Dr Yach was a key drafter of *Health for All in the 21st Century*, and has consistently sought to remove the issue of tobacco control from the domain of national legislatures, arguing that national governments will be ineffective until joined to the global initiative that he and his team propose.[5] His language is the language of 'rights', and everything he proposes is offered as a right of the victim, with himself and his team as the self-appointed guardians. Here is an illustration, from his speech to the Singapore Consultation on Tobacco and Youth of September 1999:

> Work is ongoing to unleash [the] power [of the UN Convention of the Rights of the Child] to monitor the tobacco epidemic as it affects young people and to use the CRC provisions to call upon national governments to implement comprehensive tobacco control measures. By linking work on the Convention on the Rights of the Child to tobacco control, a broader constituency of advocates for action will be developed.[6]

4 *Marketing Week*, 18 March 1999.
5 Speech to the International Consultation on Tobacco and Youth in Singapore, September 1999.
6 *Ibid*.

Even if we agree with Dr Yach about the dangers of tobacco, we ought to be aware that this is a man with a non-negotiable purpose, who does not seek or require our consent for what he does.

Tobacco has been on the WHO's agenda for some time, and this is hardly surprising, given the many health-scares with which it has been associated. Little by little, however, it has moved up the scale of priorities. Now, under the new regime of Dr Brundtland, it has taken on the role of Public Enemy No. 1. It is not difficult to see why. People are making money out of tobacco. The tobacco giants are multinational corporations in fierce competition with each other, who engage in all the practices – from stereotyping adverts, to the sponsorship of pursuits like Formula 1 racing – which make big business contemptible in the eyes of those who depend for their living only on hand-outs from the public purse. Tobacco fits perfectly into the costume of the unscrupulous capitalist, as this was tailored by Marx and Engels. Unlike malaria, therefore, tobacco is the kind of thing against which you can declare war.

Dr Brundtland has publicly intimated that cigarettes should be available if at all only on prescription,[7] and she has seen in the anti-tobacco cause a way of imprinting on the WHO her own distinctive style of politics. And she shows us exactly what is dangerous in the structure of transnational institutions in the modern world: they have been given legislative or quasi-legislative powers without full accountability for their exercise. And they have been irresponsibly placed in the hands of career politicians: in other words, people who desire nothing so much as an opportunity to

7 See Brundtland's keynote address to the 9th International Conference of Drug Regulatory Authorities, Berlin, 27 April 1999.

legislate, without the tedious business of consulting those who will bear the burden.

At the same time Dr Brundtland is aware of the criticisms that have recently been levelled at the WHO, and of the need to improve its image. She understands full well that the real achievements for which the WHO can take credit – such as the world-wide elimination of smallpox, and the anticipated elimination of polio – are the kinds of thing that confirm the institution's legitimacy. She has therefore publicised these achievements widely, and dressed up the 'Tobacco Free Initiative' as one among several programmes devoted to the health problems of the Third World. The fact that this programme is unique in being a *legislative* rather than a medical initiative is revealed only in the small print.

She is also aware of the criticisms made of the WHO's rent-seeking habits, and of its tendency to spend money on itself. In the budget proposal for 2000–2001, therefore, she has reduced the amounts directly spent on 'General Management' and the Director General and Regional Directors by $25 million, while increasing the budget overall. On the other hand, the $25 million saving corresponds almost exactly to increases under the headings 'Evidence and Information for Policy', 'External relations and Governing Bodies' and 'Non-communicable diseases' (meaning, in effect, the Tobacco-Free Initiative which is the work, at present, purely of central bureaucrats). Moreover, the real increases in expenditure required by Dr Brundtland's 'cabinet projects' are to be met by extra-budgetary income, of the kind mentioned above. So the changes, we can assume, are largely cosmetic, and it is not likely, as a result of them, that many of the fat cats in Geneva will be driving jeep-loads of vaccine to the African villages for a merely local wage.

Furthermore, little has changed in the general posture of the WHO towards health and health-care. Social issues such as domestic violence, unhealthy lifestyles and the problem of ageing continue to creep up the agenda, while 'non-communicable diseases' are identified as a priority. The WHO budget introduces the issue with a significant assertion: 'Non-communicable diseases are responsible for nearly half of global deaths, and the proportion is increasing.'[8] If you think about this statement, you will begin to see that it is good news. It means that more people are dying of the diseases that tend to occur in middle life than of the diseases that strike the young. It means that infectious diseases are on the wane. It means that life-expectancy worldwide is increasing. In short, it means that the mission of the WHO is being accomplished.

Now no bureaucracy can contemplate with equanimity the thought that its mission is being accomplished. Who will pay you £100,000 a year for a job that has already been done? There is therefore an inherent need in the WHO to interpret the increasing proportion of deaths from non-communicable diseases as *bad* news, not good. With the right rhetoric, you can dress up any report of death as bad news, since few people can face the fact of death with serenity. Non-communicable diseases have therefore been put on to the WHO's agenda not as a growing cause for satisfaction, but as a growing cause for concern, requiring the urgent diversion of scarce resources.

Immediately after the quoted sentence the budget continues: 'The main challenge is to develop and test preventive strategies, which will address several major lifestyle-related diseases through

8 Budget, p. 3.

their common risk factors. Special emphasis will be given to cancer and cardiovascular disease, and to promoting international investment in tobacco control.' No such 'challenge' would be recognised as one urgently facing the WHO by an ordinary taxpayer – certainly not one who knows the truth about Aids in Africa, about the rise (due to the 'short-cut' use of antibiotics) of drug-resistant TB, or about malaria worldwide. And here we see why the war on tobacco ought to be taken seriously, even by those of us who are hostile to the manufacture and sale of tobacco products. For it heralds a more general policy, addressed to 'lifestyle-related diseases', and therefore to the lifestyles that allegedly cause them. It authorises a general shift in the WHO's agenda, from providing resources to combat communicable disease, to legislating our way of life. Alcohol and fatty foods are already subjects of discussion among WHO officials; but clearly exercise, travel, hours of work, marital habits, sports and a thousand other aspects of life have their 'lifestyle-related' disorders. And these too could be the subject of legislative initiatives from the super-nannies, without the possibility of opposing them.

Again, however, Dr Brundtland is careful to divert any possible criticism, and has initiated a programme for combating malaria (responsible for 1 million deaths annually, and mostly among children, as well as miserable and debilitating bouts of fever in adults). By giving this programme equal prominence to the initiative on tobacco, she hopes to satisfy those who might otherwise wonder why tobacco is on the agenda at all. Moreover, she has dressed up the problem of tobacco as a 'Third World issue', arguing that the main threat posed by smoking is now to people in the poorer countries, which are being targeted by the tobacco giants as the Western markets dwindle through regulation.

She has even expressed the view that smoking itself is a 'communicated disease', since the desire to smoke is spread by advertising![9]

The most important effect of Dr Brundtland's accession, however, has been to move the WHO from the sphere of charity into that of politics. It is difficult to escape the impression that she sees the WHO as an embryonic legislature, with herself as Prime Minister and her immediate colleagues (many of whom she brought with her to her new office[10]) as her cabinet. Two measures in particular are redolent of this: the adoption of 'cabinet projects', and the pressure towards UN 'conventions' as a means for imposing them. The purpose of cabinet projects, according to Mrs Brundtland, is 'to achieve rapid visibility and impact in selected areas of critical importance to global health. They represent a new way of creating unity of purpose throughout WHO.' This talk of 'unity of purpose' and 'visibility' may be appropriate in politics; but it is surely quite out of place in what is in effect a branch of the international civil service. Still less is it appropriate for people acting with genuine charitable concern: *Médicins sans frontières* has impact precisely because it avoids visibility. But Dr Brundtland's words make clear that cabinet projects are ways of organising the

9 Speeches to the International Policy Conference on Children and Tobacco, Washington DC, 18 March 1999, and speech to the Woodrow Wilson Center, Washington DC, 22 September 1998.

10 On her appointment as Director General of the WHO, Brundtland swept away the existing secretariat (though retaining some members as advisers), and announced her own carefully chosen 'cabinet'. Of the ten new appointments, eight came from outside the organisation. One appointment in particular has caused concern: Michael Scholtz, who is to be in charge of the WHO's initiative to provide poorer countries with affordable drugs, who comes from the pharmaceutical industry and has little experience of the developing world. See Fiona Godlee, 'Change at last at WHO. But will the Regions Play Ball?', *BMJ* Vol. 317, 1 August 1998, p. 296.

WHO from above, as an instrument of her own agenda. Conventions are a way of transcribing that agenda into law, binding all nation states, regardless of their national priorities, with legislation that they cannot easily overthrow.

Three 'cabinet projects' have been announced: the 'Roll Back Malaria' project, the 'Tobacco Free Initiative' and one dating from 1998 (the year of Brundtland's accession) and entitled 'Partnerships for Health Sector Development'. It is worth quoting the description of this third project, if only because it is a striking instance of bureaucratic Newspeak which can be adapted to any purpose, in particular the main purpose of the WHO, which is spending money on itself:

> This project will create a new understanding of health sector development throughout WHO. It will explore ways for headquarters and regional and country offices to work more synergistically in providing country advice and support, placing technical inputs in a broader political and economic context and cutting across traditional programme boundaries. Working with a wide range of partners, the project will provide the practical and conceptual basis for WHO to exert a more decisive influence in shaping the international debate on sector approaches to health development.[11]

Only three words in that piece of gobbledegook carry any clear indication of purpose, and they are 'WHO', 'headquarters' and 'offices'. To put the matter simply, the WHO has three 'cabinet projects', one to do the kind of thing it is supposed to do (tackle malaria), one to dictate our lifestyle (tobacco) and one to look after

11 Budget *op. cit.*, p. 5.

itself. It is only in the second of these cases that the WHO is pressing for a convention in order to fulfil its goal, so hoping to use its powers as a quasi-legislative body, on a par with the UN Commission on Human Rights and the International Labour Organisation.

5 THE TOBACCO FREE INITIATIVE

The WHO tells us that its policies result from requests from its member states, and that the Tobacco Free Initiative (TFI) is no exception.[1] Neither claim is true. First, there are many WHO projects which seem to have been requested by few if any of the member states. One such is the third 'cabinet project' just referred to. But there are other instances. For example, the organisation initiated a project devoted to 'Health Risks of Potentially Toxic Chemicals', despite the fact that in Africa no member state requested the assistance of this programme, and that only in South East Asia was there any interest – on the part of a single member state. Secondly, the TFI as currently conceived has only a tenuous connection with requests made to the WHO. Many tobacco-growing and cigarette-producing states are anxious for the WHO *not* to press ahead with this initiative. This is made clear by the French title of the Tobacco Free Initiative: *Initiative pour un monde sans tabac* – surely not something that would be requested by states like Malawi or Zimbabwe, whose export income depends upon the production of tobacco. And such requests as have been received for help in controlling tobacco use have for the most part stopped well short of what is now intended.

1 See Derek Yach, Project Manager, Tobacco Free Initiative, letter to *WSJ Europe*, 25 January 2000.

The 'Framework Convention on Tobacco Control' was called for in a resolution adopted in 1998, after Dr Brundtland's appointment as Director General. The WHO had often discussed tobacco before this. Nor is that surprising, given that the annual meetings of the World Health Assembly occur in well-appointed hotels in Western capitals, where the media and the politicians are interested in diseases which threaten the locals, and in practices that it would be thrilling to forbid. But it is due to Dr Brundtland and Derek Yach that tobacco is now at the top of the agenda, and that the solution to what the WHO describes as an 'epidemic' or even a 'pandemic' is to be sought through draconian legislation. Before considering the convention in detail, however, it is important to review the arguments put forward in its favour.

In all its recent literature the WHO reiterates the following statistics, which I give in the words of Dr Brundtland:

> It is estimated that 4 million deaths were attributable to tobacco in 1998. In the developed world, where data is available, 50 per cent of tobacco-related deaths occurred in middle age, when on average 20–25 years of life are lost prematurely. Over the next few decades declines in tobacco-related deaths in established market economies will be more than offset by deaths in emerging countries; in 2030 there will be about 10 million tobacco-related deaths, of which 70 per cent will occur in developing countries.[2]

Those statistics occur without references or any other kind of supporting evidence, and the fact that they are manifestly in need of interpretation goes unremarked.[3] Nevertheless, they are re-

2 'Tobacco Free Initiative,' report by the Director General, World Health Assembly, 18 March 1999.

peated unadorned in all of the WHO's anti-tobacco literature. It is reasonable, therefore, to question them.

Just when, for example, is middle age? Searching for the origins of the claim that 50 per cent of 'tobacco-related' deaths occur in middle age you will eventually come across a thinly argued and sensationally presented article published in the *Lancet* in 1992, in which 'middle age' is defined as anywhere between 35 and 69.[4] To say that 'on average' twenty to twenty-five years of life are lost by death in middle age is first to assume the life expectancy normal in a developed country, and secondly to put the average age at death of those who die between 35 and 69 as the mean between those figures, in other words 52. In fact, however, the average age at death for people who die between 25 and 69 is 62. This casts doubt on the claim that 'on average' twenty to twenty-five years of life are lost. Besides, if 69 is middle aged, when is old? Obviously we are not dealing with questions that are of the slightest relevance to people in Third World countries, where life expectancy may be 50 or less.

And what is meant by 'tobacco-related'? Anybody who has pursued that question with an open mind knows the extent to which the evidence against tobacco has been manipulated, often

3 The WHO has its own Division of Epidemiological Surveillance in Geneva, where Dr Alan D. Lopez has been working for many years on estimating the global burden of disease. In an academic paper published in the *World Health Statistical Quarterly* Vol. 43, 1990, 'Causes of Death: An assessment of global patterns of mortality around 1985', he argues that the methods available for estimating causes of death are not exact, even for industrial countries, and that 'the estimation of cause-specific mortality for the developing regions of the world is even less precise.' His arguments suggest that the confident statistics constantly offered by Brundtland are both *a priori* and phoney. Nevertheless the origin of these statistics is an article co-authored by Lopez himself – see footnote 4.

4 Richard Peto, Alan Lopez, William Boreham, Michael Thun and Clark Heath Jr., 'Mortality from Tobacco in Developed Countries: Indirect Estimation from National Vital Statistics,' *Lancet*, 23 May 1992, 339, no. 8804, pp. 1268–78.

by people with an emotional or political commitment to a pre-conceived result.[5] The *Lancet* article relies on statistical correlations which may or may not be causally significant, and which may or may not be as applicable to smokers as to non-smokers.[6] As a contribution to medical science, however, it is questionable in the extreme.

And what about those 4 million deaths? Stated thus baldly the statistic sounds appalling. It occurs, as do the others, in a report issued by the World Bank and entitled *Curbing the Epidemic,* which opens with the equally bald statement that:

> Smoking kills 1 in 10 adults worldwide. By 2030, perhaps a little sooner, the proportion will be one in six, or 10 million deaths per year – more than any other single cause.[7]

You will not find any proof of those statistics in the World Bank's report. Instead, you will discover repeated reference to 'smoking-related diseases', such as cardiovascular disease and lung cancer, and the unargued assumption that when a smoker dies of one of these diseases, then it is because he or she is a smoker. But what of those who die of such diseases but who are non-smokers? And what of all the statistical correlations between such diseases and other factors? Do smokers who die from 'smoking-related' diseases die earlier or later than non-smokers who die from the same diseases? If they die later, does that mean that

5 See the devastating analysis by Judith Hatton, in Ralph Harris and Judith Hatton, *Murder a Cigarette*, London, Duckworth, 1998.

6 Some of the criticisms of the WHO's epidemiological approach are contained in another article from the *Lancet* of 1992: Petr Skrabanek, 'Smoking and Statistical Overkill,' 14 November 1992, 340, no. 8829, pp. 1208–9.

7 Prabhat Jhal et al., *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, World Bank, Washington, 1999.

smoking is good for you? If they die earlier are there other factors at work besides smoking – poverty, for example, over-work, economic disadvantage of the kind that leads people to seek relief in smoking as their most reliable source of pleasure? Such questions, vital to any scientific treatment of the dangers of smoking, are not discussed either by the World Bank's report or by the WHO. And when you read that, in the US, the average age at death of a smoker with a 'smoking-related' disease is 72, that nearly 60 per cent of 'smoking-related' deaths occur at age 70 or above, 45 per cent at age 75 or above and 17 per cent at age 85 or above, and that, according to a study made in 1991, smoking reduces the life expectancy of an American 20-year-old by 4.3 years,[8] you might reasonably begin to wonder what is meant by the assertion that smoking 'kills 1 in 10 adults worldwide'. Is it any more meaningful than the assertion that 'death kills 10 in 10 people worldwide'? The only clear interpretation that can be offered is that 1 in 10 people who die are smokers: and that is true if 1 in 10 people smoke since everybody dies.

Of course, this is not the conclusion we are supposed to draw. The statistics presented by the World Bank's report, and by Dr Brundtland in her campaigns, create the impression that every time a smoker dies of some disease, the cause of death is smoking. Such a concept of causality is so far from anything recognised by scientific method, that one can only conclude that we are not in fact dealing with a scientific question. I seriously doubt that any amount of evidence would deter the WHO from its conviction that tobacco is such a major cause of disease and death, that only

8 See Robert A. Levy and Rosalind B. Marimot, 'Lies, Damned Lies and 400,000 smoking-related deaths', *Regulation*, Vol. 21, no. 4, 1998, p. 27.

drastic measures, of the kind that WHO alone is equipped to initiate, can overcome the problem.

The statistics form only a part of the WHO's argument in favour of its Tobacco Free Initiative. In a section of its World Health Report 1999, there is an attempt to summarise the evidence for the 'health and economic costs of tobacco use'.[9] Without naming sources, the document informs us that 'studies in the 1990s' suggest that one in two smokers die of their habit. This figure is repeated in all the anti-tobacco literature that I have come across. But I am unable to find any persuasive authority for it.[10] An official response to a House of Lords question fielded by the Health spokesman in July 1997 summarised the evidence then relied upon for the government's estimate that in Britain 120,000 smokers die each year from 'smoking-related illnesses'. The answer listed eight types of cancer and eight other diseases as 'smoking-related'. Subsequent investigation of these diseases and their distribution yielded the following startling conclusions:

- Of the total 630,000 deaths each year in the UK, almost two-thirds are from 'smoking-related diseases'
- Over half of all deaths of non-smokers are from 'smoking-related diseases'
- Even in smokers, the majority of deaths from

9 The World Health Report 1999, WHO, Geneva, ch.5, pp. 65–8.

10 The Report relies, like the WHO, on the article by Peto, Lopez et. al. referred to in note 4 above, and also on the *Morbidity and Mortality Weekly Report*, issued by the US Center for Disease Control and Prevention, 27 August 1993, which claims that 418,690 Americans died in 1990 from diseases contracted because they smoked. The claim has, however, been argued to be vastly exaggerated and methodologically unsound: see Robert A. Levy and Rosalind B. Marimot, *op. cit.*, pp. 25–6.

> 'smoking-related diseases' are not considered to be due to their smoking.[11]

In the light of that, the least that can be said is that the 'studies' upon which the WHO relies are in urgent need of further scrutiny. There is, to put it bluntly, a lack of transparency in the WHO's literature on tobacco, of a kind that is reprehensible in any institution vested with legislative powers.

The World Health Report goes on to repeat the arguments against 'environmental tobacco smoke' (i.e. second-hand smoke) as a major cause of anything from lung cancer to cot deaths. The US Environmental Protection Agency's study of 1992 is the source commonly relied upon for these conclusions. But that study has been thoroughly exploded.[12] The WHO has also commissioned research into second-hand smoke from the International Agency for Research on Cancer in Lyon (an agency of the WHO), spending money that might have usefully been devoted to the fight against malaria on the largest ever ten-year study of environmental tobacco smoke and lung cancer. The study has been concluded, and an official press release issued in March 1998. This was crowned by the following headline: *Passive Smoking Does Cause Lung Cancer, Do Not Let Them Fool You.* The text that followed informed the reader, however, that the slight increase in lung-cancer observed among those exposed to environmental tobacco smoke was not statistically significant.

Not surprisingly, given the WHO's determination to repeat

11 See Ralph Harris and Judith Hatton, *op. cit.*, pp. 9–10.

12 See Robert Nilsson: 'Is environmental tobacco smoke a risk factor for lung cancer?', in Roger Bate, ed., *What Risk?*, Oxford, 1997 and G. B. Gori and J. C. Luik, *Passive Smoke: the EPA's Betrayal of Science and Policy*, Ottawa, Canada, 1999.

the unfounded allegations against second-hand smoke, the report seems to have been shelved. Nevertheless, those who carried out the research published their results independently, and they cast serious doubt on the WHO's case.[13] It is interesting that second-hand smoke remains on the WHO's agenda, and that the draft Framework Convention on Tobacco Control currently displayed on the organisation's website proposes draconian legislation to ensure that non-smokers are protected from the dangers presented by other people's smoking.[14]

Elsewhere in WHO's current budget the case against tobacco is put in other terms. Nicotine is condemned as addictive – though with no attempt to explain what is meant by addiction.[15] Tobacco is even referred to as a 'psychoactive substance', in the same category as alcohol and illicit drugs.[16] If this is meant to imply that tobacco has a known disposition to cause abnormal states of mind such as paranoia, uncontrolled aggression, loss of concentration or psychosis (all of which are associated with cannabis, with heroin and, when taken in excess, with alcohol) then it is patently false. Do people commit crimes, drive dangerously or become violent 'under the influence of smoking'? But if the description is simply a way of reinforcing the observation that smokers become dependent on their habit, then it is of no greater medical significance than the fact that junk-food eaters, coffee-drinkers, readers

13 See Paolo Boffetta et al., 'Multicenter Case Control Study of Exposure to ETS and Lung Cancer in Europe', *Journal of the National Cancer Institute*, Vol. 90, no. 19, 7 October 1998, pp. 1440–50.

14 For website details, see footnote 1 on p. 47.

15 That the use of this term is questionable has been shown by H. J. Eysenck, *Smoking, Personality and Stress: Psychosocial Factors in the Prevention of Cancer and Heart Disease*, Munich, SpringerVerlag, 1991.

16 Budget, p. 81.

and joggers become dependent on theirs. The contrast with heroin and other hard drugs ought to be borne in mind: the heroin addict is someone who, when deprived of the drug or some equivalent, is unable to function normally, to the point of serious and sometimes life-threatening illness. The nicotine addict can be deprived of nicotine and suffer no harmful side-effects, beyond the urgent desire for more nicotine. To describe the two cases in the same terms is to overlook the very differences that could lead us to explain them.

It seems to be true, nevertheless, that people find special difficulty in kicking the habit of smoking, and this is a cause for concern. It is surely right and proper to warn would-be smokers of the possibility that they will acquire the habit, and not be able to relinquish it. Indeed smoking seems to be as addictive as television. As a university teacher, who has observed the effect of television – the loss of attention span, the decline in grammar, articulacy, and the ability to argue, and the enormous difficulty that young people experience in freeing themselves from the habit – I would welcome legislation which compelled manufacturers of this product to warn against the risks of using it. But I cannot help feeling that the warnings would go unheeded.[17]

The WHO also makes a case for the economic costs of tobacco use. This is important for the institution's purposes, since many

17 The European Research Institute and the Dante Alighieri Foundation have recently carried out an experiment in the Calabrian village of Cerisano, in order to see whether people can overcome television-addiction sufficiently to rediscover the art of speech. The results of the experiment are not yet available; the organisers, however, have had to design special hoods in order to conceal TV sets from those who would otherwise be tempted by them, and to offer substitute entertainments in the form of street theatre and shows in the main square – the visual equivalent of 'nicotine patches'. See report in *The Times*, 13 March 2000.

countries are dependent on tobacco either as a primary product for export, or as a source of excise duty. To show that the profits are offset by a huge but hidden cost is vital if sovereign states are to be persuaded to legislate against their seeming interests. To this end the WHO again relies on the report from the World Bank, which purports to show that there is an economic cost in tobacco use which stems directly from the premature death of otherwise economically active people. Until this report, econometric studies had found that smoking has net social benefits.[18] It is therefore of some importance to know whether the World Bank's analysis stands up to independent scrutiny – the more so in that there is a culpable failure to identify published sources for the statistics which are offered as the only proof. The report cites, without any reference, the ritual figures offered by Dr Brundtland: 4 million deaths, 1 in 10 adults, 10 million by the year 2030 etc.[19] Indeed, there is, in all passages which purport to describe the danger, an uncanny similarity of wording to the WHO's equally unsubstantiated claims, and attempts to trace authorities and studies peter out in self-referential footnotes. Not surprisingly, therefore, the report has already been subjected to very damaging review,[20] and could not be relied upon as authority for any of its more substantive claims. This is not to say that those claims are false, but only to remark that they are as unproven at the end of the report as they were at the beginning, and that they suffer from the same lack of

18 See W. Kip Viscusi, *Rational Risk Policy*, Oxford, OUP, 1998.

19 *Curbing the Epidemic*, *op. cit.*, p. 22.

20 Richard Tren and Hugh High, internet document, 'Smoked Out: Anti-Tobacco Activism at the World Bank. A Review of *Curbing the Epidemic: Governments and the Economics of Tobacco Control*' http://www.iea.org.uk/wpapers/smokeout.htm, 1999. Includes a preface by Deepak Lal.

transparency that infects the anti-tobacco literature from the WHO.[21]

Finally, it should be noted that both the WHO and the World Bank attempt to bolster their case by describing tobacco as an 'epidemic'. This emotive word helps to place tobacco on a par with malaria and Aids, and to obscure the fact that we are not dealing with an infectious disease, or a disease which seriously afflicts the people in the Third World countries which the WHO was designed to help. Even if we accept all the claims made by the anti-smoking lobby, tobacco is a cause principally of non-communicable diseases, which reveal themselves, as a rule, only when life expectancy has been raised way above the level that prevails in the poorer parts of the world.

We may, if we choose, describe these diseases as parts of an 'epidemic' should they be widely prevalent. But all that this means is that the 'science' of epidemiology is used to link them to their possible causes. It is necessary to place the word 'science' here in inverted commas for the very reason that epidemiology is so often abused, and especially in cases like the present one.[22] Although theories without statistics are empty, statistics without theories are blind. Epidemiological methods have been successfully used – for example by John Snow, in his famous demonstration that cholera was transmitted by contaminated water, thirty years before the bacteriological cause was known, or in the more recent identification of Aids as a disease and the proof that it was most

21 See W. Kip Viscusi 'The Governmental Composition of the Insurance Costs of Smoking', *Journal of Law and Economics* (Chicago), Vol. XLII, October 1999.

22 See Judith Hatton, in Harris and Hatton, *op cit.*, ch. 3, and the well-known arguments of Darrell Huff in *How to Lie with Statistics*, Harmondsworth, Penguin, 1973.

likely to be caused by a virus. But statistical correlations imply causation only in the context of an embryonic theory. Until the theory is produced they are merely curious facts, like the statistical correlation I have observed between a fondness for boiled eggs and a dislike of Wagner.

6 WHAT SHOULD WE THINK ABOUT TOBACCO?

It is very difficult for a layman to find his way through the mass of science, pseudo-science and sheer propaganda that now surrounds the issue of smoking. The normal and healthy reaction, which is to rely upon experts, is thrown into confusion by the discovery that so many of the experts are more wedded to their conclusions than to the methods that might confirm or refute them. Moreover there are powerful vested interests on both sides of the debate. The tobacco giants have an interest in concealing the harmful effects of their product, and the accusation is repeatedly made that they have, in the past, knowingly done so;[1] the WHO has an interest in exaggerating these harmful effects, and the evidence is before us that it does so. Moreover, as I earlier remarked, 'Big Tobacco' is an easily demonised opponent, and one currently as defenceless as a chained and baited bear. In these circumstance it is increasingly difficult to come to a rational decision about tobacco, or about the measures needed to control it. Nevertheless, two observations seem pertinent.

1 Disclosure of documents in recent American law-suits seems to suggest that tobacco companies have, in the past, known far more about the harmful effects of tobacco than they have openly confessed to. For more serious accusations, based on documents released as part of the State of Minnesota's recent lawsuit, see the guest editorial by J. Taylor Hays and Richard D. Hurt, 'Tobacco Legislation: Time to Right some Wrongs,' in *Postgraduate Medicine*, 104, 1 December 1998, pp. 11–12.

Firstly, the debate about smoking does not have the form of a scientific discussion. Although there are studies, statistics, even experiments of a kind, they are for the most part inconclusive, and seldom pursued beyond the point where political advantage can be gained, one way or another, through their immediate though premature publication. Theories are in short supply, and prejudices abundant. Many beliefs (such as those about second-hand smoke) are tenaciously adhered to long after the evidence against them has been made known. Important facts about the positive effects of smoking on mental well-being and even on physical health are not mentioned and indeed treated as unmentionable. And those who defend tobacco, on whatever grounds, tend to be subjected by their opponents to vilification of a kind that has no part in a scientific dispute. In short, the debate has the character of a religious rather than a scientific quarrel. Disagreement is not patiently refuted but immediately and vehemently punished, in the manner of heresy. Characters are destroyed and reputations jeopardised for the sin of entertaining the wrong opinion. Thus in the article by Nick Cohen referred to at the beginning of this paper,[2] Lord Harris of High Cross (Ralph Harris) is gratuitously described as a 'harrumpher from the port-soaked right', by way of discrediting his very real authority in the matter of tobacco and its effects. Lord Harris is in fact a liberal economist, a cross-bencher in the House of Lords, and a person who happens to disagree with Nick Cohen about tobacco. Cohen's authority throughout is Clive Bates, of ASH, whose method of discrediting scientists who support the tobacco industry is to show that the tobacco industry paid

2 See footnote on p. 2.

for their researches: as though results were the less valid in general when someone gets paid for producing them. How, after all, is an industry supposed to defend itself, if it cannot pay for advice and information? In effect the tobacco industry is being denied a voice, and St Augustine's principle of natural justice, *audi partem alteram,* is being wilfully flouted.

In the light of this we can conclude that, whatever the truth about tobacco, it is irrelevant to the policy of controlling it, which has been placed beyond science, in the arena of unshakeable faith. The WHO's legislative campaign must therefore be understood as a quasi-religious initiative, and dealt with accordingly. It is an attempt to impose legislation, which will survive any proof that the legislation is pointless. In this it can be likened to the imposition of Islamic law in a state where Muslim clerics have come to power.

Secondly, even if it is wise, in the present climate, to pay lip-service to the politically correct opinion, rational people ought nevertheless to try to see the situation as it is. Having decided not to pay lip-service to opinions that seem to me to be unfounded, I shall, for the benefit of other and more cautious people, summarise what I think.

There seems to be substantial evidence that smoking is one among several factors which create a risk of cancer. The concept of a 'smoking-related disease' is, however, an empty one, since all the diseases that occur in this category have many possible causes, and for none of them has smoking been identified as the principal cause.[3] Moreover, in most cases we are dealing with

3 See the argument of Hans J. Eysenck in 'Smoking and Health', in Robert D. Tollison, ed., *Smoking and Society: Towards a More Balanced Assessment*, Massachusetts, 1986, pp. 17–88.

non-communicable diseases, whose aetiology is still poorly understood, and which no doubt do not respond in an incremental way to environmental changes, but are triggered when some factor reaches a threshold. Hence it is impossible to deduce from the fact that heavy smoking is a cause of cancer that the same is true of occasional smoking. It may be; but as yet we do not know. As for passive smoking, it is probably more of a nuisance than a danger.

All in all, then, I am of the view that smoking poses a risk to health, perhaps less of a risk than eating junk food or taking no exercise, but a real risk all the same, and maybe enough of a risk to justify the measures – such as health warnings on cigarette packets – which are currently widely accepted as necessary. I am also impressed by the statistics which suggest that smokers have a 50 per cent less chance of developing Alzheimer's disease, and a reduced risk of Parkinson's disease,[4] and am dissuaded from smoking more heavily as a result only by my suspicion of statistics. For there is no doubt in my mind that the greatest threat to people like me is that of living too long – and in particular of living beyond my own capacity to understand myself as living. If the choice is between death and Alzheimer's, I know where my preference lies.

Moreover, although I am persuaded that smoking is a health risk, my reading of the figures suggests to me that the annual death-toll has been greatly exaggerated. The claim that 400,000 Americans die every year from smoking will not stand up.[5] Exactly what the figure should be is far from clear, though let us suppose that, as a result of smoking, 100,000 Americans die younger than

4 See Tage Voss, *One Doctor's View*, London, Peter Owen, 1992, and the summary of evidence in Harris and Hatton, *op. cit.*, pp. 112–15.

5 See footnote 8 on p. 33.

they might otherwise have died. Of course that is not a statistic that helps the tobacco industry: so you only kill 100,000 each year? Nevertheless, a great many legally sold products pose a risk of death, and we ought to be aware of this. American smokers die, on average, at the age of 72; moreover they die of a voluntary habit. Victims of motor-car accidents die in America at the rate of 40,000 a year – many more are grievously injured. Their average age at death is 39, and the majority are victims of someone else's driving. Which, would you say, is the more dubious trade: tobacco or the motor industry? Add the catastrophic effect of cars on the environment, on other species, on the appearance and longevity of the planet, and there is no doubt whatsoever in my mind. But then, by what right do we penalise a trade that plays such an important part in the lives and obsessions of so many?

As for the economics of smoking, it seems absurd to suggest that there is an overall social cost to a habit which is so heavily taxed. Moreover, although it seems that a majority of heavy smokers would like to shake the habit if they could, it is also true that they obtain from it a consolation which, however weird it may seem to those who console themselves in other ways, keeps them peaceful and contented in circumstances which may be vastly less comfortable than those of a transnational bureaucrat living in Geneva. This is surely a massive social benefit, achieved at no cost to others. Finally, the often repeated view that smokers place an additional burden on the health services is surely no more than a piece of sophistry. If it is true, as the anti-smokers claim, that smokers tend to die of such non-communicable diseases as cancer and heart disease, only rather earlier than the rest of us, then they surely represent a substantial saving in health care. For we too will die of those diseases, which are the normal diseases of old age. Yet,

in dying later, we are more of a burden. Even if that commonsense observation is wrong, it needs extensive research, rather than unargued assertion, to disprove it.[6]

6 See again the article by W. Kip Viscusi, note 21 on p. 38 above.

7 THE FRAMEWORK CONVENTION ON TOBACCO CONTROL

The Tobacco Free Initiative was first introduced in 1993, and the idea of a convention was mooted in a resolution of the World Health Assembly adopted in 1996, which calls for a 'binding international instrument' on tobacco control. With Dr Brundtland's accession this project was suddenly accelerated. The Framework Convention on Tobacco Control is to be proposed as a binding instrument, to be ratified in 2003 and incorporated as law by the member states of the WHO. According to its constitution the WHO has 'authority to adopt conventions' if they are approved by a two-thirds majority. The convention proposed is, however, a framework convention, the first ever proposed by the WHO, under article 19 of its constitution. It does not have the form of a law but is rather an open-ended authorisation to invent laws whenever the goal would seem to be advanced by them. Here are the key items:[1]

- Excise tax to be harmonised worldwide, at a level which will be at least two-thirds the package price. This, the WHO tells

1 A draft of the proposed convention can be found on http://www.who.int/wha 1998/Tobacco/second/Sanglais.htm. The language of the draft being far from transparent, I have also referred to the current literature on the Tobacco Free Initiative, distributed by the WHO's Geneva office. The two sources do not agree in every particular, though the principles advanced remain the same.

us, will lead both to a fall in consumption and a rise in government revenues[2]
- Strict controls on transit, designed to counter the contraband that is the inevitable consequence of raising excise tax
- A total global ban on advertising and sponsorship, and a prohibition of vending machines
- An obligation on producers to disclose all ingredients and to report 'all major toxic constituents, using international accepted testing methods' – this to be overseen and controlled by an international commission of 'experts' appointed by the WHO
- No use of 'light', 'low tar' etc. on packages or any other words that 'falsely communicate safety'; health warnings to take up 25 per cent of the surface of packaging
- Eventual elimination of subsidies to tobacco growers and a policy of agricultural diversification instead
- Non-smokers to be 'guaranteed' protection from Environmental Tobacco Smoke
- The establishment of a 'Center for Tobacco Control Facilitation', and of 'national commissions' of tobacco control
- Governments can take additional steps besides those agreed, but cannot do less without penalty.

Even if tobacco were as dangerous a substance as the WHO alleges, these proposals are surely not the kind of thing that should be imposed by unelected bureaucrats. They are, for one thing, an

2 This could indeed happen, depending on the elasticity of demand. But it is very unlikely to happen, and again there is no transparent discussion of the arguments leading to the conclusion that it *would* happen.

incentive for smokers to take up smuggling and for criminals to do so on a grand scale. After all, 27 per cent of people smoke, and they are persuaded that the use of tobacco is morally innocent and mentally consoling. They are scarcely likely to believe, therefore, that there is any absolute moral interdiction against obtaining tobacco cheaply and by-passing controls which effectively eliminate the natural market. Already the governments of Hong Kong and Canada have discovered that raising excise taxes leads to a fall in revenue, and that the level of consumption remains more or less constant nevertheless, on account of contraband.[3] The customs and transit controls proposed will offer an unparalleled vehicle for organised crime – unparalleled because of the quantities of goods, the ease of shifting them (since they are legally possessed and legally sold) and the readiness of the market. Already tobacco smuggling is causing an estimated loss of revenue of £2.5 billion annually to the UK government, and has given rise to a burgeoning criminal network in the channel ports.[4]

The other restrictions proposed may or may not be justified. But since no proof has been given of the urgency of the problem (no proof, for example, that the problem of tobacco is really more urgent than that of junk food or alcohol), we may wonder whether such draconian measures are really needed. The least that can be said is that, before imposing them, the tobacco industry ought to be allowed to state its case. However, until March 2000, the WHO has excluded representatives of the industry from its meetings,

3 Document presented to the Hong Kong Government by the Tobacco Institute of Hong Kong Ltd in 1999, offering unambiguous statistics from local markets and also from Canada, where taxes were first raised and then lowered in response to a massive rise in contraband.

4 Report in *The Times*, 16 September 1999.

and refused to discuss the Tobacco Free Initiative with anyone outside its narrow circle of committed activists. There is a crucial lack of transparency in the arguments and proposals emanating from the WHO on the subject of tobacco, and a clear intention to impose its legislation come what may. Whatever the arguments, it may reasonably be doubted that a committee of unelected bureaucrats has the right to nanny us in such a way, and to impose regulations that ought to be the business of national governments.

This brings us to the crux, which is the proposal to make these far from well-thought-through measures into laws, binding on all the national legislatures. How is this to be done?

8 NATIONAL COMMISSIONS

The WHO proposes the establishment of 'national commissions', either as separate entities appointed by and financed by, but independent of, national governments, or as extensions of existing commissions established to monitor human rights, the environment and labour relations. It argues that this would not be an innovation, and that it is indeed a necessary part of giving force to its Framework Convention on Tobacco Control. It justifies both the convention and the commissions in the same way, namely by emphasising that tobacco is a threat to health that can be countered only by measures conceived and applied in a global way. It gives no real grounds for this judgement, or for thinking that such threats as are posed by tobacco cannot be dealt with by national legislatures in the manner most suited to their citizens' priorities and needs. It simply reiterates as dogma the unfounded assertion that national legislatures are not equal to the task and that a global convention is therefore necessary. If that is so, however, why think that national commissions will be better able to answer to the perceived threat?

The answer is simple. A national legislature has the overriding and difficult task of balancing competing interests against one another, of legislating not for the benefit of this or that pressure group but in the interests of society as a whole, and therefore of establishing priorities and seeking compromises, in order to

promote a peaceful settlement of social conflicts. A national commission would be bound by no such constraints, and would have the status of a single issue campaign raised to a supra-parliamentary position, able to dictate to the legislature regardless of all countervailing needs and interests. It would be an instrument with which to coerce national governments, regardless of the desires or needs of an electorate. The WHO has perceived that, left to themselves, electorates do not want the kind of nannying that it seeks to force on them, and do not regard tobacco control as the most important of all social measures – more important, say, than the control of narcotics, domestic violence or pornography. Hence it is seeking to by-pass the opinions and desires of people who, in their benighted state, do not recognise its benevolent intentions. In effect, it is saying, 'we have ways of making you put tobacco control at the top of your agenda'.

Much emphasis is laid, in the WHO's document, on the role of national commissions in enforcing other conventions, in particular the UN Convention on Human Rights, and the WHO's convention on tripartite consultation. It is important to see that these cases are in no way comparable to the Framework Convention on Tobacco Control. The UN Convention on Human Rights already has the form of law, prescribing rights and duties which it fully identifies. As soon as adopted, therefore, it becomes the law of the land, and can be sued for in the national courts by the individuals affected. This means that a national commission does not operate outside or above the legislature, but simply as a form of assistance to the litigant. It does not by-pass the legislature or attempt to impose on it new laws, but assists in the enforcement of existing legislation.

Likewise with the WHO's convention: once adopted as law it specifies immediately the rights and duties of employees and em-

ployers, and any commission has its role clearly defined as an adjunct to the judicial process. Moreover – and this is very significant – the convention is there not to ensure an *outcome,* but to guarantee a *process,* whereby conflicts can be resolved and agreements reached to the satisfaction of all the parties.

The proposed Framework Convention on Tobacco Control is quite unlike that. Its aim is not to lay down rights and duties which can be adopted by national legislatures, but to press towards a non-negotiable outcome – namely the restriction and if possible the elimination of tobacco use. The fact that this outcome will always elude us, since people actually want to smoke despite being aware of the dangers, so that smuggling will in any case take over from the legitimate trade – this fact is brushed aside by the WHO as a matter for technical adjustment.[1]

It is important to recognise the duplicitous language with which the WHO is advancing its proposal. The give-away phrase occurs in the document introducing the national commissions, where their composition is discussed.[2] These, it tells us, should 'ensure a broad cross-sectoral representation of the civil society involved in tobacco control'. Decoding this collection of buzz-words, we note that its effect is to exclude from 'civil society' – that is, the body politic – all those who are not committed to tobacco control. In other words the intention is to press for the disenfranchisement of the smoker.

1 In the draft convention currently available on the WHO's website, for example, there is a wonderfully naïve summary of 'proposed technical components of a protocol on the elimination of tobacco smuggling', the main provision of which is that 'each party shall take all practical and effective measures to combat smuggling of tobacco products'. It is so obvious that this will solve the problem that it is amazing to think that nobody had ever thought of it before.

2 p. 34.

The powers being proposed for the commissions exceed any that are currently exercised in the name of the UN human rights convention or the ILO convention. For example, 'they should be able to submit opinions on proposed or existing legislation, to initiate or assist in the drafting of new legislation, or to intervene (for example, as *amicus curiae*) in legal proceedings involving questions of tobacco control.'[3] Put more directly, the commission would have direct legislative and judicial powers. Moreover it 'would need to be granted the legal capacity to discover whether [complaints from individuals against those obstructing its goal] are founded, and if so, which authorities or private entities are responsible. In addition, it could itself initiate and conduct investigations or public enquiries.'[4] In other words it is not only law-maker and judge, but also policeman.

The bare-faced effrontery of this beggars belief, and it is only a reflection of the weakness of Western democracies that their elected politicians are not up in arms against an institution that assumes the right to address them in this way. In any other field a collection of unelected bureaucrats, appointed to perform a task quite different from the one that obsesses them, who announce their intention of making, imposing, adjudicating and policing the law of sovereign and democratic states would be told to take a long holiday from duties which had clearly over-taxed them. Only because of the image of tobacco and the utility of this image in diverting attention from the far more pressing problems of drugs, crime and illegitimacy, can the WHO expect to be taken seriously.

Suppose, however, that the WHO succeeds in its goal. It will

3 p. 33.
4 pp. 33–4.

set a precedent for a wholly new kind of international politics. Pressure groups which capture international institutions could then work for conventions that impose law on all national governments, and for the creation of commissions that will police people regardless of their desires and without the possibility of gaining relief through the legislature. This could easily happen in the matter of the environment, with unelected Greenpeace-style activists controlling everything we do – regardless of whether they have got it right, and regardless of all other interests. (Some argue that this is already happening, with the Rio and Kyoto conventions dictated largely by interest groups and the bureaucrats who speak to them.) Add the animal rights lobby (a UN convention on animal rights, for example, enforced in England by the RSPCA), and any number of conventions that could be dreamed up by WHO (on alcohol, on fatty foods, on caffeine or foie gras or honey) and any number of new and artificial rights to be added to the UN Convention, and we quickly arrive at a version of 1984, in which parliaments become irrelevant, and the courts no more than adjuncts to the system of control by unelected bureaucrats (who always appear in court as '*amici curiae*' when they want to put us away). Faced with this prospect you might reasonably take to smoking 50 cigars a day – but alas it will not kill you so quickly that you will escape the Brave New World to come.

9 THE WAR ON TOBACCO

Why should a bureaucracy like the WHO seek to impose its will, regardless of the wishes of national electorates, and without consulting the other interests that might be affected? Some of the impetus for the measure comes from Dr Brundtland, and her disposition to carry over into her new career as a civil servant her old priorities as a politician. But that is not the whole story. The WHO's attack on tobacco preceded her arrival, and will survive her departure.

It is necessary, I believe, to return to the idea of political correctness, and to its function in filling the vacuum left by the disappearance of religion from the modern world. While science tells us to question, religion invites us to accept. The scientific world-view is based not in faith but in the assessment of evidence, and in the rigorous proof of results. Someone who offers absolute truth and unquestionable authority is not appealing to the spirit of scientific enquiry, but to the religious need that lingers in an age of scepticism and which still hungers for a target. Politically correct campaigns tend to regard their goals as non-negotiable. They are not in the business of compromise, or of balancing their demands against the opposing demands of other and equally deserving causes. They are in the business of imposing their agenda. This is why NGOs, however well intentioned, are potentially destabilising and why the English law of charity has always distinguished chari-

table from political purposes – the first being instruments of social healing, the second causes of division and strife.

Dr Brundtland often refers to the need for an alliance between WHO and the NGOs (although doubtless she is very careful about which NGOs she would like to work with). And her instinct is right. She is aiming to build an alliance of forces outside parliaments and unaccountable to national electorates. NGOs are already carving out for themselves the role of citizens' representatives in the bid for global governance.[1] Moreover, the political correctness that is fostered within NGOs ensures cohesion, provides a substitute for moral choices, and offers easy enemies in the place of difficult dependents. Someone who truly cared about the health of the poor in Africa would not be collecting a substantial salary for attacking the tobacco giants. But the immeasurable difficulty of the one task, and the simplicity of the other, combined with the instantly available rhetoric whereby to pose as a moral crusader, ensure that the normal bureaucrat will always be tempted in this direction. And that explains why political correctness, which defines the project of the modern NGO, is also the ideology of the new bureaucracies.

That does not explain the *vehemence* of the war against tobacco, however. Any politically correct cause would have been just as useful to the rent-seeking bureaucrat. Fully to understand the war against tobacco, it seems to me, we should see that it is really a diversion. Ask parents what most concerns them among the dangers confronting their children and you will surely find smoking very low down the list. Far higher, and probably near the top, will

1 See Hazel Henderson, 'Global Networks and Citizens: organisations are joining forces around the world and becoming a new form of global governance', *In Context*, 36, January 1993, pp. 45–7.

be drugs and the culture which glamorises them. Hard drugs like heroin kill the user, usually at a young age. But before doing so they rob him of his faculties, of his peace of mind, of his conscience and consideration for others, of his ability to love and be loved. They send the body to extinction already deprived of the soul. And they threaten the lives and the happiness of others – whether parents, lovers or friends.

To tackle the problem posed by drugs is hard: international criminal networks make fortunes from their exploitation. Indeed the profits of the drug industry may be greater than those of any other business in the modern world. The UN has made efforts to address the problem. The Narcotics Convention, adopted by the UN in 1971, and subsuming the pre-UN Shanghai Convention and subsequent conventions adopted by the UN, was designed to prevent the passage of essential drugs like morphine into the illicit channels. It proved ineffective, as did the 1988 convention on drug trafficking. These conventions imposed enormous costs on the legitimate trade in drugs – since inevitably only law-abiding businesses conformed to them – while bringing no gains in the control of the illicit trade. They provide a very good illustration of the ineffectiveness of transnational legislation in rectifying the evil to which it is addressed, and its effectiveness, nevertheless, in curtailing the freedom of law-abiding people.

This helps to put the war against tobacco in another light. It is a war against a legal trade that is responsive to government: you can identify your enemies, and also punish them through laws with which they will try to comply. Unlike the drug barons, the tobacco giants pay taxes (vast amounts of them), and are anxious for recognition as legitimate businesses – which means that they do extraordinary things to build their image, even denouncing their

own product on the packages that sell it. When was the last time you came across a wad of cannabis or a tab of LSD with a health warning?

But the effect of the WHO's initiative will be to destroy this legitimate trade, not so as to free the world of tobacco, but so as to free the world of *legally sold* tobacco. Tobacco will become contraband, like drugs; it will move around the world as before, offering its consolation to those who seek it, but paying nothing in taxes, and arriving in packages that neither warn against the use of it nor offer any guarantee concerning the toxic quality of the contents. Already there are some 200 rogue manufacturers of cigarettes in China. If the Framework Convention on Tobacco Control is adopted, these manufacturers will have a global market at their disposal.

Paradoxically, therefore, this war which has the effect of diverting our attention from drugs to tobacco, will end by transferring the trade in tobacco into the hands of those who run the trade in drugs. If that is what we want, we should be clear about it. But I suspect that, were these issues to be discussed where they should be – not in the comfortable offices of a transnational bureaucracy, but in the debating chambers of national legislatures – we should quickly see that it is not what we want at all.

10 CONCLUSION

In our secular age it is more than ever necessary to safeguard the old idea of law, as a guardian of individual freedoms, rather than an instrument of enforced conformity. Wherever legislation is unnecessary it is wrong. And the decision whether it is necessary should be ours, and made through our elected legislatures.

The tobacco industry is a questionable one, and governments are unlikely to protect it, except for the sake of its revenues, upon which all governments depend. The temptation, therefore, is to ignore the WHO's Framework Convention on Tobacco Control and to let the industry wriggle out of the problem as best it can. However, not only will the fiscal consequences of this be extremely serious; the precedent will have been created for a new kind of legislation. Already the WHO has begun to attack alcohol, to advocate curbs in advertising and promotion of alcoholic drinks and to press for increases in duties. Many other products could fall under the same interdiction, on the grounds that they are 'addictive' and also damaging to health: sweets, chocolate, coffee, fatty food and so on.

McDonald's has raised the hackles of French farmers and restaurateurs. A ruthless and greedy image, combined with an unhealthy and 'addictive' product, is enough to attract the nannies. Soon 'Big Burger' could join 'Big Tobacco' in the stocks. In neither case is this necessarily a bad thing. But any legislative response

should lie with the electorate and not with a transnational bureaucracy. For only by appealing to electorates can we balance the many interests involved, and achieve a reasonable compromise between what people want and what is good for them.

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