CHAPTER 10

Problem Identification and Agenda Setting

Tobacco is a highly contested topic. Lobbyists present their policy solutions to politicians and government officials who weigh the evidence against what they believe is feasible or desirable, much like solving a complex puzzle (Kingdon, 2003). Such puzzles take considerable time. In the meantime, the many other concerns that a government is confronted with compete with tobacco control for a place on the policy agenda. The public policy literature distinguishes different stages of agenda setting: issues move from the public agenda to the political agenda, move again to the formal (sometimes called institutional or governmental) agenda, and finally reach the decision agenda. The public agenda consists of issues that have achieved a high level of public interest and visibility, while the formal agenda lists the topics that decision makers are actually working on (Cobb, Ross, & Ross, 1976). For an issue to reach the formal agenda, decision makers must be aware of the underlying problem, and consensus must be reached that acting upon the problem is possible and necessary and that the solution falls within the government's responsibility.

This chapter starts with an examination of the process of problem identification, which is the first step in agenda setting. Problem definition is central to understanding agenda setting, and refers to what Rochefort and Cobb (cited in Cairney (2012)) describe as "what we choose to identify as public issues and how we think and talk about these concerns." Attention from the government is often drawn to an issue when new statistics surface

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which show that the issue is problematic. This will be explored for Dutch tobacco control by looking at the presentation of four-yearly data from the *Rijksinstituut voor Volksgezondheid en Milieu* (National Institute for Public Health and the Environment) (RIVM) on the public health status of the population and how successive governments translated this into quantitative national targets for tobacco control. I then consider why tobacco control seems to be a "low issue" topic most of the time and explore the reasons for this. Is it not seen as urgent? Is smoking not regarded as a legitimate target for state interference? This brings me to consider if the low urgency for tobacco control might be explained by the political orientation of Dutch governments (left/progressive vs. right/conservative), and whether it might be further explained by a related factor, which is how governments deal with times of economic recession. I present evidence that the Dutch governments least active in tobacco control were at the time preoccupied with economic crises.

Government attention is not automatically directed at what the facts tell us, but depends on how successful various interests groups are in drawing attention to an issue. This chapter therefore closes by discussing how framing of the smoking issue influenced agenda setting. Framing is "a strategy that interest groups employ to further their interests by generating powerful beliefs and ideas which function as a framework for the public's way of thinking" (Grüning, Strünk, & Gilmore, 2008). How was smoking framed by tobacco control organisations and by the tobacco industry, and which was most successful? Some attention will also be paid to the role of media advocacy as an important tool in communicating specific frames and in setting agendas.

Problem Identification

For something to become a policy issue, it must first come to the attention of policymakers. This may be triggered by the publication of new statistics (Kingdon, 2003). Main statistical indicators in our case are the proportion of smokers in the adult and youth population and smoking-related morbidity and mortality statistics. The Netherlands was one of the first countries to build its public health policy in a systematic manner on epidemiologic data. Following the Public Health Act, every four years the *Rijksinstituut voor Volksgezondheid en Milieu* (National Institute for Public Health and the Environment) (RIVM) publishes *Volksgezondheid Toekomst Verkenning* (Public Health Status and Foresight) reports (VTV). Since 1992 these comprehensive and detailed reports have outlined the public health priori-

ties of the next four years for the Ministry of Health.[1] The first was Health Minister Els Borst's *Healthy and well* policy document (VWS, 1995), which identified specific conditions that must be met before a topic may be identified as a policy priority: the health problem must concern a serious problem that concerns a large group of people, it must be preventable and modifiable, efficacious prevention methods must be available, prevention must result in improvement in public health, and the policy methods must be legally, ethically, and societally acceptable.

To date, six VTV reports have been issued. Table 10.1 summarises the main statements about the tobacco problem.

In the first three RIVM reports smoking was singled out as a public health problem to be addressed urgently. These reports included alarming messages, since adult and youth smoking was not going down and compared unfavourably with other countries. RIVM experts warned that the Netherlands had lost its top position regarding general life expectancy in Europe and was facing the possibility that life expectancy might decline for the first time in history (RIVM, 2002). Later VTV reports noted a decline in tobacco use following the implementation of the revised Tobacco Act in 2002, and characterised trends in adults and youth in a less alarming manner, although smoking rates were still regarded as high compared with those of other countries and smoking remained the most important preventable cause of death and disease. A consequence was that the feeling of urgency for tighter tobacco control became less poignant.

National Targets for Tobacco Control

The Ministry of Health's policy documents with intentions in the field of public health and disease prevention, listed in Table 10.2, carry political weight and are discussed in parliament. The first was the *Nota 2000* of 1986 (WVC, 1986). The report recognised that the Dutch tobacco policy lagged behind other countries, especially Scandinavian countries. Despite smoking being recognised as the number one cause of death, and the setting of an aspirational target of reducing the smoking population to 20% in 2000, tobacco control was not yet mentioned as a national policy priority. The government was hesitant, wanting to wait until the Tobacco Act was implemented in 1990 in the hope that this would increase public support for new measures. In 2003 the prevention documents included a list of unhealthy lifestyle behaviours that were the priority targets for the next four years: smoking was listed next to obesity and diabetes (VWS, 2003). In 2006 the list was extended to include alcohol and depression (VWS,

Table 10.1 Tobacco problem indicators in the Public Health Status Forecasts reports by the National Institute of Health and the Environment (RIVM)

Year	*Title of report (translated in Dutch)*	*Problem indicators (as they are formulated in the report)*	
		Smoking prevalence	*Smoking and health*
1993	*Public Health Forecast: The health of the Dutch population in the period 1950–2010* (RIVM, 1993)	– While tobacco use continues to decline in various European countries, it stagnates in the Netherlands at around 40% in men and more than 30% in women. – Among youth, it seems to start to rise.	– Smoking constitutes the largest demonstrable contribution to total mortality in the Netherlands (about one-quarter of all deaths). – Smoking is responsible for about 29,000 deaths in 1990.
1997	*The sum of the parts* (RIVM, 1997)	– An unfavourable development in the adult population is that the number of smokers has not gone down for a number of years. – There are clearly unfavourable developments in youth smoking, where the number of smokers has started to increase (already 28% of 10–19-year-olds are smoking).	– A major cause of mortality can be attributed to smoking (circa 23,000 per year).
2002	*Health on track?* (RIVM, 2002)	– The long-term reduction in smoking rates in the adult population (1980–2000) has halted. The trend is unfavourable. – Smoking rates in women in low socioeconomic groups are increasing. – Smoking rates among young people are a cause for concern. – The Netherlands occupies the sixth position in the EU concerning the proportion of smokers who are 15–16 years old (36% are smokers).	– Lung cancer deaths in men remain one of the highest in Europe. In women it increases faster than the European average. Women die more often from chronic lung disease. Both diseases are primarily attributable to smoking. – The difference in life expectancy between low and highly educated men is five years.

(*continued*)

Table 10.1 (continued)

Year	*Title of report (translated in Dutch)*	*Problem indicators (as they are formulated in the report)*	
		Smoking prevalence	*Smoking and health*
2006	*Care for health* (RIVM, 2006)	– The trend is favourable: smoking is going down among both men and women (1990–2004). – However, smoking, especially among women, still compares unfavourably to the average in the EU. – Notable is the widening of differences in smoking rates between those of high and low education between 1990 and 2007. – Trends are much less positive for the young. Many young people smoke.	– Smoking is the single most important cause of death and disease, responsible for 20.9% of lost life years, 7.1% of total sick years, and 13% of the disease burden.
2010	*From health to better* (RIVM, 2010)	– The general trend in smoking seems favourable. – Over the past four years a minor improvement can be reported with respect to smoking, but that does not change the fact that the Dutch still smoke more than those living in countries nearby. – The ambition in the previous prevention *nota* to reduce smokers to 20% in 2010 has not been accomplished. – Despite policy efforts, health differences between the high and low educated have not diminished in recent years, and with respect to smoking the differences have widened.	– Smoking causes the greatest disease burden. If no one smoked, the healthy life expectancy of the population would increase by two years.

(*continued*)

Table 10.1 (continued)

Year	*Title of report (translated in Dutch)*	*Problem indicators (as they are formulated in the report)*	
		Smoking prevalence	*Smoking and health*
2014	*A healthier Netherlands* (RIVM, 2014)	– For many years now the percentage of smokers has declined. The percentage of Dutch male smokers is now slightly lower than in other EU countries, and the percentage of female smokers is about average. – People with low education have a 1.5 times higher rate of smoking than those with high education, a disparity that has widened slightly from 1990 to 2012. – Youth smoking is going down. The proportion of 10–19-year-olds who smoke has reduced from 27% in 2000 to 18% in 2012.	– Smoking remains by far the major cause of death and illness, causing 13% of the disease burden.

Table 10.2 Quantitative goals for tobacco control in national prevention policy documents

Year	*Minister/state secretary*	*Prevention policy document*	*Proportion of smokers in the year preceding the policy document (%)*	*Policy goal*	*Result*	*Ambition*[a]
1986	Joop van der Reijden	*Nota* 2000 (WVC, 1986)	40	20% smokers in 2000 (WHO target)	Failed	−1.4
1991	Hans Simons	*Health with tact* (WVC, 1991)	31 (women) and 39 (men)	25% female smokers and 32% male smokers in 1993	Failed	−2 (women) and −2.3 (men)
1995	Els Borst	*Healthy and well* (VWS, 1995)	34	No new target	–	–
2001	Els Borst	*Policy agenda 2001* (VWS, 2002)	33	28% smokers in 2004	Succeeded	−1.3
2003	Hans Hoogervorst	*Live a longer healthy life* (VWS, 2003)	31	25% smokers in 2007	Failed	−1.2
2006	Hans Hoogervorst	*Choosing healthy living* (VWS, 2006b)	28	20% smokers in 2010	Failed	−1.6
2007	Ab Klink	*Being healthy, staying healthy* (VWS, 2007a)	28	No targets	–	–
2011	Edith Schippers	*Health close to people* (VWS, 2011)[b]	26	18% in 2025	–	−0.6

(*continued*)

Table 10.2 (continued)

Year	*Minister/state secretary*	*Prevention policy document*	*Proportion of smokers in the year preceding the policy document (%)*	*Policy goal*	*Result*	*Ambition*[a]
2013	Martin van Rijn, Edith Schippers	National Prevention Programme "Everything is health"[c] (VWS, 2013)	23	No targets	–	–

[a] "Ambition" is the intended reduction in percentage of smokers per year

[b] The 2013 prevention document does not mention a concrete target, but in response to questions from parliament, a long-term goal of 30% reduction in smoking prevalence in adults in 2025 was mentioned, referring to a voluntary agreement with WHO at the 66th World Health Assembly (WHO, 2013). This amounts to 18% smokers in 2025

[c] Proceedings II, 2013–2014, 32,793, nr. 114

2006b). These five topics were repeated in the two following prevention documents (VWS, 2007a, 2011). The most recent document added physical activity and emphasised the importance of exercise, diluting the relative importance of tobacco control as a public health policy goal despite the fact that smoking continued to have the greatest impact on the disease burden in the Netherlands (RIVM, 2014). While smoking continues to be listed in the prevention policy documents as one of the priorities, this has not yet resulted in new action plans for tobacco control since the failed *Nationaal Programma Tabaksontmoediging* (National Program of Tobacco Control) (NPT) of 2006 (VWS, 2006a). Time will tell if this well happen with the upcoming 2018 prevention policy document.

Of the nine public health policy documents since 1986, six stated quantitative targets for tobacco control but only one has ever been reached. Table 10.2 includes the tobacco control policy goals as stated by the government. Levels of ambition should be compared with the long-term trend of a declining smoking rate, which was on average −0.7% per year between 1958 and 2006 and less than −0.5% between 1990 and 2010 (Willemsen, 2010). Health Minister Borst was able to accelerate this to a staggering −1.3% per year, from 33% in 2000 to 28% in 2004. She was the only minister who ever succeeded in reaching a tobacco control target.

The NPT programme during the office of Minister Hoogervorst aimed at an unrealistic reduction of 1.6% per year, more an aspirational target than a realistic one, but one of the reasons why the NPT programme was destined to fail. Such unrealistic short term ambitions inevitably lead to disappointment. More recent cabinets did not want to set targets or resorted to extremely unambitious goals, with a projected trend which did not even challenge the naturally occurring downward trend (VWS, 2011).

The most recent *Everything is health* prevention policy programme projected that the proportion of smokers would be 19% in 2030 (from 23% in 2012) if no new initiatives were undertaken (VWS, 2013). It aimed to improve this "significantly" but did not mention a concrete goal, despite an explicit and urgent call in August 2010 from the *Raad voor de Volksgezondheid en Zorg* (Council for Public Health and Health Care) (RVZ)[2] that "the cabinet [should] commit to a quantifiable target … and a balanced mix of instruments with which it can obtain visible results in 2020" (RVZ, 2010, p. 39). The RVZ report referred to data from the Organisation for Economic Co-operation and Development (OECD) that showed that the prevalence of smoking in the Netherlands was higher than the OECD countries average, which signalled a need for the government to initiate a tobacco control policy with concrete targets. Another report from the RVZ emphasised that setting quantifiable targets for smoking is certainly feasible, given the high quality level of monitoring data available in the Netherlands (RVZ, 2011). The tobacco control coalition had started to collect reliable yearly population data about smokers in 1978, through the *Stichting Volksgezondheid en Roken* (Dutch Smoking or Health Foundation) (STIVORO). The fact that smoking rates were collected from the 1970s onwards, and that they were conducted with sufficient statistical power to be able to detect increments of 1% in the yearly adult smoking rate, was unique.

The absence of targets in tobacco control in the Netherlands seems symptomatic of the lack of political will in recent years. Through ambitious but realistic targets, governments can show leadership and provide a sense of strategic direction and focus to the policy domain, while they can be held politically accountable (Van Herten & Gunning-Schepers). A prerequisite "is political will and daring. Without political commitment and the will to execute a health target approach, a policy will be doomed to fail" (Van Herten & Gunning-Schepers). Political will and daring are indeed crucial, since setting quantifying targets in public health is sometimes seen as "political suicide" (RIVM, 2006). Political will is linked to

ideology: whether one believes in the idea of a malleable society and whether one believes that achievement of a goal is sufficiently under the control of the state (Maarse, 2011).

Tobacco a "Low Politics" Issue

As shown in Chap. 3, tobacco control follows policy cycles that may last for a decade or more, so the policy process is slow, complex, and contested. There is continuous tension between the recognition that smoking remains a public health problem for each new government, evidenced by VTV reports that the government cannot ignore, and the realisation that there is no easy, quick fix.

The issue of smoking slumbered in the background of day-to-day concerns of politicians and policymakers ever since it became a societal issue in 1964. It is rare that Dutch politicians identify tobacco as an urgent problem: the notable exception was the administration under the leadership of Health Minister Els Borst, who was confronted with stagnating smoking rates and increased smoking among young people. Smoking does not involve fundamental or key questions relating to the state's national interests or security. Issues such as the national economy and urgent foreign political matters are sometimes referred to as "high politics" (Walt, 1994), while smoking is a typically "low politics" concern.

Although the smoking rate is regarded as a chronic condition, it is relatively insensitive to policy measures and remains a low-profile issue on governmental agendas (Studlar, 2007b). In the eyes of policymakers, the chance that a "condition" will turn into a problem is greatest when there is a crisis (Kingdon, 2003, pp. 94–100). There is the perception of a crisis when policymakers feel that failure to act will lead to an even greater disaster. With tobacco control, policymakers rarely feel that this is the case. Smoking rates tend to go down most of the time, giving policymakers the impression that doing a little bit is good enough. There was a downward trend between 1960 and the end of the 1980s, and again between 2000 and 2014. However, the flywheel model of tobacco control (see Chap. 4) predicts that the decline in smoking rates will slow and stop in the absence of new impactful tobacco control measures. This is indeed what happened in the long period in the 1990s when no measures were taken and what we also seem to witness in most recent years.

The time lag between cause and effect is decades, so the benefits of policy measures only become noticeable long after a cabinet has resigned.

This has been mentioned as one explanation for the Dutch administrations' lack of enthusiasm in dealing with smoking (Meijerink & Vos, 2011). The treatment of smoking-related, life-threatening illness such as heart disease has steadily improved, and this may have further reduced any feeling of urgency in controlling tobacco (Meijerink & Vos, 2011).

A related reason why politicians and policymakers tend to underestimate the seriousness of the smoking problem is that smoking kills quietly: deaths of smokers go relatively unnoticed. People who have a chronic smoking-related disease such as emphysema hardly get out of the house, and out of sight is out of mind. This is why many people, including politicians, find it hard to imagine that smoking causes suffering on the grand scale as the statistics indicate.

Legitimacy

One of the main reasons why governments are unwilling to address certain topics may be a lack of perceived legitimacy (Hall, Land, Parker, & Webb, 1975). This means that the government feels an issue is not something that the state should be involved in. The line between what the Dutch government sees as its responsibility and what is not is subtly drawn, but most of the time in the background is the wish not to interfere with freedom of choice. For example, when the government defended her proposal to ban smoking in private workplaces (31 May 2001), Health Minister Borst said about cultural venues and theatres:

> It doesn't necessarily need to be totally smoke-free. Ideally yes, but through self-regulation theatres can make arrangements so that there will be no complaints. Dressing rooms are not open to the public. Men who sing as Louis Armstrong can continue to sing with a nice hoarse voice. That is not something that we want to interfere with.

On another occasion, when she defended her bill in the senate, she tried to reassure liberal–conservative politicians:

> One of our guiding principles is that grown-ups, people who are well educated and who know the risks but want to smoke anyway, should be left in peace as long as they don't bother other people. The [proposed] measures are aimed at protecting youth against the temptation to smoke. They are

> further aimed at protecting the non-smoker. A third goal is to help those who wish to quit smoking.[3]

In 2007 an influential advisory report in the Netherlands analysed whether and how prevention policy can be made more efficient (Werkgroep IBO preventie, 2007). The report, written by an interdepartmental workgroup, the *Interdepartementaal Beleidsonderzoek* (Interdepartmental Policy Research) coordinated by the Ministry of Finance,[4] identified two rationales that legitimise governmental interference in unhealthy lifestyles. The first is if an information shortage leads to a situation in which people cannot make informed decisions. The second is if a person's unhealthy behaviour affects other people. In the case of smoking, the workgroup noted that the information shortage is less relevant, as the message that smoking is harmful is widely known. It concluded that the only time the government may intervene is to protect non-smokers from passive smoking (protection from an external threat), to protect young people or to target low-educated smokers if the government considers the existence of health inequalities a problem. Indeed, in liberal societies such as the Netherlands and the United Kingdom, "an important dimension of public health policy is … to balance the liberal emphasis on choice and autonomy with the imperative to support those who do not have the opportunities to choose, because of, for instance, poverty or dependency" (Nuffield Council on Bioethics, 2007). The government took the report by the workgroup as its starting point for prevention policy from 2007 onwards (VWS, 2007b). It relied heavily on citizens' self-reliance and ability to make good choices, and stressed that "a free lifestyle choice must not be impaired, the balancing of positive (pleasure) with negative (cost and health) aspects is surely a personal one to make" (VWS, 2008, p. 14). However, the government was criticised by the *Wetenschappelijke Raad voor het Regeerbeleid* (Scientific Council for Government Policy) (WRR), an independent think tank of the government, for having unrealistic expectations about citizens' coping capabilities and self-control (WRR, 2017). The WRR argued that the government is especially legitimate in helping young people's determination not to smoke by limiting the instances when they are confronted with temptation to smoke or buy cigarettes.

Left–Right Orientation of the Government

If ideology is important, one might expect that left-wing governments are more likely to adopt strong tobacco control programmes since they are most open to imposing legislative measures to protect public health.[5] Several international studies have looked at the relationship between a government's political orientation and its tobacco policy. There is anecdotal evidence from Canada and Australia that provinces or territories controlled by the left are more likely to adopt tobacco control measures, although the relationship is not very strong (Studlar, 2007a). In the United Kingdom, conservative governments opposed tobacco control regulation between 1979 and 1997, while subsequent Labour governments introduced a range of measures which resulted in the United Kingdom becoming Europe's tobacco control leader (Asare, Cairney, & Studlar, 2009). In the United States, associations are found between Republican dominance at state level and lower cigarette taxes (Morley & Pratte, 2013), and between a legislator's being Republican and his or her intention to vote against tobacco taxes (Flynn et al., 1998). In Europe, in the period between 1996 and 2003, left-wing governments were more likely to adopt tobacco control measures than were right-wing governments (Bosdriesz, Willemsen, Stronks, & Kunst, 2014).

To the extent that a left-wing political orientation in government is beneficial for tobacco control, the Netherlands has not been in a very good position to advance tobacco control. Between 1972 and 2017 the Netherlands had 15 governments and in all of them either the conservative–liberal *Volkspartij voor Vrijheid en Democratie* (People's Party for Freedom and Democracy) (VVD) or the *Christen-Democratisch Appèl* (Christian Democratic Party) (CDA),[6] or both, was part of the ruling coalition. The Labour Party was only involved in seven instances, while the CDA took part in 12 cabinets and the VVD in 10. What is more important, perhaps, is that the Netherlands has had only one truly "progressive" cabinet, which was the Den Uyl cabinet (Labour Party), which lasted from 1973 until 1977. It had ten ministers from left-wing parties, six from Christian parties, and no liberal–conservative ministers. In Chap. 2, I narrated how this cabinet presented the most comprehensive set of tobacco control ambitions ever in Dutch history, but was not in power long enough to realise any of it.

Tobacco Control in Times of Economic Recession

An interesting question is whether tobacco control policy is lower on the political agenda during periods when the government struggles with economic hardship. In such times, Dutch governments tend to resort to a policy of budget cuts, privatisation of government tasks, and economic stimulation by introducing business-friendly policies. Although the obsession with wealth and economy is increasingly criticised by politicians from the left (Klaver, 2015; Thieme & Engelen, 2016), economic considerations and citizens' purchasing power continue to dominate the political discourse in the Netherlands. The following is an account of the economic situation of the various cabinets since the early 1970s (Van den Braak & Van den Berg, 2017) in relation to their accomplishments in tobacco control.

The Den Uyl (Labour party) government (1973–1977) was confronted with a blow to the national economy when Arab countries boycotted the Netherlands in 1973 by increasing the price of petrol and reducing the supply (the "oil crisis"), which was followed by an economic crisis, staggering inflation, and alarming prognoses of unemployment. However, the Den Uyl cabinet ignored the crisis and increased spending. It developed a far-reaching tobacco control agenda, in line with the ideology of the *maakbare samenleving* (a just and modifiable society).

The conservative Van Agt (CDA) cabinets (1977–1982) had to deal with a second oil crisis (1979) and exploding unemployment; and in 1982, at the end of the second Van Agt cabinet, the Netherlands was in its deepest recession since the 1950s. Extra budget cuts were deemed necessary at around 13 billion guilders (a value of around €11 billion in 2016). Under these conditions it was not politically feasible to increase spending on tobacco control. The feeling was that any execution of a tobacco control agenda would hurt the economy and employment.

The first Lubbers (CDA) cabinet (1982–1986) regarded it as its mission to get the economy back on track. This was done through a neoliberal "no nonsense" austerity programme with a pledge to cut seven billion guilders (around €6 billion), far-reaching privatisation of the public sector, and a business-friendly policy of deregulation. Despite economic growth, the second Lubbers cabinet (1986–1989) was unsuccessful in addressing the high unemployment rate. This led to a further decision to cut state spending in the beginning of the 1990s, which was also in response to demands from the European Union (EU) to reduce the state

budget deficit. In 1991 the third Lubbers cabinet (1986–1989) announced new drastic cuts in government spending and increased burdens on citizens, such as higher taxes and fewer subsidies, which lasted until 1994. Tobacco control was put on the back burner during these cabinets. A Tobacco Act was adopted and implemented in 1990, but was insufficient to control smoking since it relied strongly on industrial self-regulation. Smoking rates went up between 1988 and 1996.

The first Purple cabinet Kok (Labour) (1994–1998) was an economic success, enjoying a miraculous growth in employment and a budget surplus. This was partly ascribed to the successful outcome of negotiations between employers and employees (the *polder* model). During this cabinet, Health Minister Els Borst and Minister of Economic Affairs Hans Wijers presented unprecedented tobacco control policy intentions. The economy was still booming during the first years of the second Kok cabinet (1998–2002). This opened up another window of opportunity to advance the tobacco control agenda. The fact that state finances allowed for a more generous budgetary allocation to tobacco control, in the way of extra campaigns and education, was crucial in getting support from the CDA for the most far-reaching legislative part of the new Tobacco Act: the workplace smoking ban.

During the first Balkenende (CDA) cabinet (2002–2003), economic growth came to a virtual standstill, resulting in considerable budget cuts, limits on state spending, and reforms of social security and the health-care sector. The last Balkenende cabinet (2007–2010) was faced with the international financial crisis of 2008. Spending on tobacco control was less than in the previous cabinet, and no new legislation was realised. The first Rutte (VVD) cabinet (2010–2012) regarded its main task to be fighting the crisis through cuts in government spending and reducing the size of the government. During this cabinet, all health promotion non-governmental organisations (NGOs) were confronted with cuts in governmental subsidies, while support for the *Stichting Volksgezondheid en Roken* (Dutch Smoking or Health Foundation) (STIVORO) was completely withdrawn and financial reimbursement to smokers for smoking cessation counselling was discontinued. The second Rutte cabinet (2013–2017) continued to emphasise getting government finances in order, partly through reforms to the health sector. There was little room for new tobacco control initiatives on the part of the government.

From the preceding description it might be concluded that during economically prosperous times the government is more generous and inter-

ested in a tobacco control agenda, although this is somewhat confounded by the political orientation, discussed in the preceding paragraph, which offered an alternative explanation. In any case, when "the economy" is at the top of cabinets' agendas, it seems more difficult to advance tobacco control.

Framing the Smoking Problem

In the previous chapter I explored the importance of research and statistics, and concluded that there is a gap between knowledge about effective tobacco control and if and when it appears on the government's executive agenda. It is not so much that the evidence does not find its way to the policy deciders; rather, it is determined by the ways in which arguments and evidence are constructed and framed by policy networks, and whether and how they resonate with policymakers (K. E. Smith, 2013). Coalitions differ in their capacity to discover and use such issue frames (Shiffman et al., 2015). Indeed, "if the tobacco control community is disbelieved, it may not be the result of being wrong, but rather from a failure to frame ourselves in such a way that our goals and our approaches resonate with the public" (Fox, 2005). Policy frames have been described as "weapons of advocacy" (Weiss, 1989). Unfortunately, the framing of tobacco control by Dutch pro- and anti-tobacco coalitions has not yet been subjected to systematic scientific research. The following is an attempt, based on a reading of official documents and reports of debates with health ministers in the parliament, to reconstruct the major changes to how the smoking problem was portrayed by the tobacco industry on the one hand and the Dutch tobacco control community on the other. The results are summarised in Table 10.3.

The government's take on smoking was first aligned with the industry framing that smoking was good for the economy. Until the 1980s, the tobacco industry and the government formed a policy monopoly in which tobacco was portrayed as a positive contributor to the economy. The government continued to use industry frames way into the 1990s. This monopoly was challenged by medical specialists who used a medical frame: that smoking is harmful to individuals. In the 1980s and especially in the 1990s the debate increasingly turned to the issue of the danger of passive smoking. Health organisations framed smoking as a problem for non-smokers, while the industry used a "tolerance frame": common courtesy between smokers and non-smokers should solve most problems. This

Table 10.3 How smoking has been framed in the Netherlands by the tobacco control coalition, the government, and the tobacco industry

Years	*Ministers*	*Tobacco control coalition*	*Government*	*Tobacco industry*
1950s–1970s		Medical frame: Smoking is harmful to individuals.	Economic frame: Smoking is good for business and the economy.	Economic frame: Smoking is good for business and the economy.
1980s	Joop van der Reijden, Dick Dees	Public health frame: Smoking is harmful to the population and to non-smokers.	Mixed public health and economy frame: Smoking is harmful to public health but good for business and the economy. Personal freedom frame: Smoking is one's own responsibility.	Economic frame: Smoking is good for business and the economy. Personal freedom frame: Smoking is one's own responsibility. Tolerance frame: Common courtesy between smokers and non-smokers solves most problems with tobacco.
1989–1998	Hans Simons, Els Borst	Public health frame: Smoking is harmful to the population and to non-smokers. Non-smokers are cool.	Combination of a public health frame and a personal freedom frame: Smoking is harmful to the population and non-smokers, while tobacco use remains an adults' own responsibility.	Personal freedom frame: Smoking is one's own responsibility. Tolerance frame: Common courtesy between smokers and non-smokers solves most problems with smoking.

(*continued*)

Table 10.3 (continued)

Years	*Ministers*	*Tobacco control coalition*	*Government*	*Tobacco industry*
1998–2003	Els Borst, Eduard Bomhoff	Public health frame: Smoking is harmful to the population and to non-smokers.	Public health frame: Smoking is harmful to the population and to non-smokers. Youth frame: Measures are necessary to protect youth.	Legal and libertarian frames: Tobacco is a legal product and smoking is a free choice for adults.
2003–2006	Hans Hoogervorst	Public health frame: Smoking is harmful to the population and to non-smokers. Addiction frame: Tobacco is addictive, not a free choice.	Public health frame: Smoking is harmful to the population and to non-smokers. Economic frame: Smoking is bad for the economy and for employers.	Legal and libertarian frames: Tobacco is a legal product and smoking is a free choice for adults.
2007–2010	Ab Klink	Public health frame: Smoking is harmful to the population and to non-smokers.	Fairness frame: Tobacco control measures must be implemented fairly.	Legal and libertarian frames: Tobacco is a legal product and smoking is a free choice for adults.
2010–2013	Edith Schippers	Public health frame: Smoking is harmful to the population and to non-smokers. Tobacco industry demonising frame: The tobacco industry is deceptive and capitalises on the addiction of children.	Libertarian frame: Smoking is a free choice for adults.	Legal and libertarian frames: Tobacco is a legal product and smoking is a free choice for adults.

(*continued*)

Table 10.3 (continued)

Years	*Ministers*	*Tobacco control coalition*	*Government*	*Tobacco industry*
2013–2017	Martin van Rijn	Youth frame: Children deserve to grow up in a smoke-free environment.	Youth frame: Children deserve to grow up in a smoke-free environment.	Legal and libertarian frames: Tobacco is a legal product and smoking is a free choice for adults. Health frame: Smoking is harmful: The best solution is to reduce its harm by product innovations by the industry. Effectiveness frame: Tobacco control might be supported as long as it is evidence-based.

industry frame resonated well in the Dutch society. In these years the government approached the issue with a mixed economic and health frame: tobacco control is good for public health but must not harm business and the economy. This ended at the end of the 1990s when the World Bank published its influential report *Curbing the Epidemic*, which concluded that tobacco control is good not only for public health but also for national economies. In 1991 State Secretary Hans Simons emphasised that smoking substantially contributes to societal costs.[7] This was calculated for 1987 at around one billion guilders per year, two-thirds in the health-care sector and one-third through productivity loss (Meijer & Tjioe, 1990). For Simons this was an important reason to intensify tobacco control.[8] Around 1996 the industry could no longer use the tolerance frame, since Philip Morris lost all credibility in a failed campaign where it compared the risks of passive smoking to that of eating cookies (see Box 8.1 in Chap. 8). The government adopted the passive smoking frame of the health coalition, which carved the way for smoking bans.

One particularly powerful industry frame is the notion that smoking is an adult's personal lifestyle choice, which must be respected at all times as long as the smoker does not harm others. For many years the industry succeeded in presenting smoking as an adult "guilty" pleasure, no worse than coffee, good food, or a moderate alcohol intake. At the basis of this notion lies the idea that smoking is a habit, a learned behaviour that can be unlearned. Internationally, this conception was gradually replaced in the 1980s by the notion that smoking is a true addiction. This became more widely accepted in Europe at the end of the 1990s, and this made it easier for conservative politicians and the medical sector to support tobacco control initiatives. The Dutch tobacco control coalition was relatively late in promoting the addiction frame (see Box 10.1).

Box 10.1 Smoking is an addiction

International recognition that smoking is addictive did not occur overnight. It was preceded by a period in which researchers tried to find and answer to the question of why it was so difficult for people to quit (Krasnegor, 1979), and in which the industry denied that nicotine is addictive. This was an important issue for the industry: "We can't defend continued smoking as 'free choice' if the person is 'addicted'" (Knopick, 1980). The breakthrough came when the US Surgeon General's report on the addictive properties of tobacco concluded in 1988 that nicotine addiction was an addictive disorder to which the same standards applied as to heroin, cocaine, and other drugs (U.S. Department of Health and Human Services, 1988). The tobacco industry continued to deny the addictiveness of tobacco, culminating in 1994 when the heads of the major US tobacco companies gave sworn testimony before the US Congress that they did not believe nicotine was addictive. The revelation that they lied under oath was a devastating blow to the industry's reputation. US experts understood that the evidence—that smoking is addictive and that most smokers start smoking during childhood—morally legitimises a youth-centred tobacco control strategy (Lynch & Bonnie, 1994). In 1996 US President Bill Clinton declared nicotine an addictive drug, and addiction was regarded by scientists as "a brain disease" (Leshner, 1997). This challenged the mantra of free choice and went against the public's view that people who cannot

quit smoking are weak or bad, unable to break the habit. In Europe the breakthrough came with the publication of clinical guidelines for the treatment of tobacco addiction in England (Raw, McNeill, & West, 1998). Soon after, the Royal College of Physicians published a report, *Nicotine Addiction in Britain* (Britton et al., 2000), and WHO presented recommendations on how to treat tobacco dependence (WHO, 2001). A Dutch guideline, similar to the UK one, was published some years later by the Partnership Stop Smoking (CBO, 2004, 2006). It was endorsed by 19 professional organisations covering all medical disciplines. The Dutch guideline "deliberately [chose] a different perspective: not that of the smoker who is responsible for his own behaviour, but that of an addiction for which help is necessary."(CBO, 2006, p. 11)

The dominant "public health frame" adopted by the government was effective until around 2006. Health Minister Els Borst (D66) (1994–2002), a medical doctor, was most outspoken about the public health dangers of smoking. On many occasions she talked about smoking as the number one cause of death, more deadly than alcohol, drugs, traffic accidents, and HIV combined.[9] In a debate in parliament she used the image of crashing jumbo jets, each week causing 441 deaths,[10] and pointed out that smoking is the biggest epidemic that humankind has called upon itself, that death and disease by smoking are avoidable, and that government has a duty to act, especially to protect young people. She urged tobacco control using a combination of arguments: the high number of deaths, the health risks for non-smokers, the fact that smoking rates were not going down and were higher than in many other European countries, the notable increase in youth smoking, the high economic costs to society, and the heavy burden on the health-care system. She supported this with statistics made available by STIVORO. She made the problem tangible:

> These seem emotionless statistics, but this changes if one looks at them differently: 23,000 deaths means 23,000 times a premature death, so 23,000 times a man or a women, often of middle age, who leaves behind a partner or a family. A dear family member, a valuable partner, friend or lover who passes away before his or her time has come. It is a great drama, first of all for the smoker who often dies in miserable conditions, and second for those who are left behind.[11]

Irritated by the obstinate stance of the liberal–conservative VVD party, she added at one point in the debate, "Confronted with 23,000 deaths, the government cannot remain aloof and say: the people have to sort it out themselves. A minister of health who does not try to do something against such a great number of deaths is not worth a penny." As a liberal-democratic politician, Borst choose her wording carefully and avoided being associated with nannyism. The solution was to present her proposals as policies to protect youth, since "for adults … we think these matters are not very sensible, but for them one's own choice is paramount and, in addition, adults can do some things moderately, making it less harmful to them."[12] The next minister, Eduard Bomhoff (LPF) (2002), adopted Borst's position that tobacco had created the biggest epidemic that humankind had ever called down upon itself. His temporary replacement, State Secretary Clémence Ross-van Dorp (CDA) (2002–2003), also used the general public health frame of 23,000 deaths caused by smoking.

At the beginning of the 2000s, in an attempt to retrieve its battered reputation, the tobacco industry initiated corporate social responsibility programmes, using their own version of health frames (Tobacco Free Initiative, 2003). The industry publicly acknowledged that smoking is harmful, and tried to promote an image of responsibility by declaring an interest in reducing youth smoking (McDaniel, Cadman, & Malone, 2016). Industry representatives approached the government with offers to cooperate with preventing young people from smoking (See Chap. 8, where the industry's "Platform Prevention of Youth Smoking" was discussed).

Health minister Hans Hoogervorst (VVD) (2003–2007), whose previous appointment was as minister of finance, frequently framed the need for tobacco control in economic terms. He occasionally mentioned the serious public health consequences of tobacco use and the need to protect non-smokers, and sometimes applied an addiction frame, but was most convincing when pointing to the fact that smoking substantially contributes to total health-care costs and is bad for employers (at the time estimated at €105 extra costs per smoking employee) (Hoogervorst, 2005). Tobacco control is good for the economy since "health generates wealth" (VWS, 2005), a frame he hoped would appeal to his VVD rank and file.

Health Minister Ab Klink (CDA) (2007–2010) seldom used a public health or addiction frame. He distanced himself from anti-tobacco statements and was reluctant to initiate new policy that did not fit his wish to deliver "positive stimulants" to smokers (Klink, 2008). Instead he was

most comfortable with a fairness frame. One of his biggest challenges was the implementation of the smoking ban in the hospitality sector. He took non-smoking employees' right to work in a smoke-free environment and "level playing field" considerations between small and large bars as starting point, but seldom talked about health risks.[13]

Minister Edith Schippers (VVD) (2010–2012), who was trained as a political scientist, consistently used a libertarian frame, emphasising that state interference with tobacco use is nannyism, and consenting adults must decide for themselves if they want to smoke or not. She said, "If adults decide on Friday evening to smoke together with their glass of beer in a small pub, who am I to forbid this?" (VARA, 2011).

During most of the time, the tobacco control coalition continued to use a general public health frame of deaths caused by smoking. When its appeal was worn-out, the tobacco industry demonising frame was used as well. In some countries, tobacco control advocates have been successful in challenging the tobacco industry frames through counter-frames such as protection of the vulnerable against a merciless industry (Cohen et al., 2000; Fox, 2005; Jacobson & Banerjee, 2005; Katz, 2005). The tobacco industry has been effectively portrayed as a deceptive industry that capitalises on addiction, and such portrayal invokes anger and activism (Malone, 2014). Such a frame was used by the tobacco control organisations in the Netherlands around 2011, when Schippers was portrayed in a TV documentary as "minister of tobacco" (VARA, 2011) and the *Stichting Rookpreventie Jeugd* (Youth Smoking Prevention Foundation) (SRJ) began to name and shame everyone with affiliations to the tobacco industry. SRJ used the addiction frame to make the case that children are hooked on nicotine by the tobacco industry. This gave renewed impetus to viewing tobacco and the tobacco industry as morally bad, which made it more difficult for the industry lobbyists to find the ear of policymakers and politicians.

Most recently, with the advance of the *Alliantie Nederland Rookvrij* (Dutch Alliance for a Smokefree Society) (ANR), tobacco control in the Netherlands has been framed in terms of protecting young people, which appeals to the general public and a wide range of societal organisations, and also to local and national government. The Ministry of Health adopted the idea of a "smoke-free generation" and State Secretary Martin Van Rijn (Labour party) (2013–2017) used the phrase "smoke-free generation" in communications with parliament.[14] In the meantime, the tobacco industry tried to show goodwill by promoting less harmful product innovations such as electronic cigarettes and heat-not-burn products. They also

employed an effectiveness frame: tobacco control measures are acceptable, but only when their effectiveness is proven beyond any doubt.

One may conclude that Dutch tobacco control advocates have not been very successful in setting the agenda by issue framing, struggling to find a frame that resonated with policymakers, politicians, and the public during times when the government was less open to tobacco control, too long holding on to a general public health frame.

A Health Inequality Frame?

It is remarkable that the portrayal of smoking as a fundamental cause of health inequalities has rarely been used in the Netherlands. The social gradient in smoking emerged as an important policy problem in most European countries in the 1990s, and again at the beginning of the twenty-first century (Brown, Platt, & Amos, 2014). The Netherlands is no exception. Health inequalities are substantial: life expectancy among low-educated people is six years shorter than among the highly educated (RIVM, 2014). A reduction in health disparities was considered an important task for the Dutch government around 2005 (VWS, 2006b, 2008). Dutch politicians on the left who valued social equality argued that tackling inequalities in smoking helped to reduce health inequalities, and urged the government to act.[15] This did not result in concrete tobacco control policy proposals from the government; although it acknowledged that the differences are substantial: while only 17% of the highest educated smoke, the rate is 31% among low-educated groups (VWS, 2013). Recent data (covering the years until 2011) show that inequalities in smoking have further increased (Bosdriesz, Willemsen, Stronks, & Kunst, 2015).

The dominant right-wing governments in the Netherlands have not been receptive to the argument that smoking must be targeted as a means to reduce health inequalities. This is in contrast to the United Kingdom (Department of Health, 2011) where this argument has broadened support for tobacco control in society (K. Smith, 2013) and has resulted in a national budget to set up smoking cessation support programmes in disadvantaged areas. In response to calls for a prevention policy that reduces health inequalities, the Dutch government did set up broad community-based projects in municipalities (*Kracht wijken*),[16] similar to the "New deals for communities" programme in the United Kingdom, but without specific aims for tobacco. The government has further integrated the issue of health inequalities into its decentralised health

strategy *Everything is health* (VWS, 2013), which aims to stimulate integrated local health promotion initiatives. A recent initiative is a national incentive programme, *Healthy in the City*, which supports local approaches to tackling health inequalities. A total of €44 million was made available between 2014 and 2017, most of which went directly to the municipalities, which were given ample freedom to choose programmes and measures that they believed were best tailored to the problems they encountered in their respective communities (Van Berkum, 2016). There were no distinct incentives to tackle smoking. The programme is illustrative of the current approach to health promotion and disease prevention in the Netherlands: to give optimal responsibility and freedom at the local level without setting national targets or providing blueprints for local targets (see also Chap. 5 on decentralisation). Time will tell if this approach is effective.

Media Advocacy

According to the agenda-setting theory, if a topic is covered frequently and prominently by the media, the general public will regard it as important. In the words of one of the founders of the agenda-setting theory, "elements prominent on the media agenda become prominent over time on the public agenda. The media not only can be successful in telling us *what to think about*, they also can be successful in telling us *how to think about it*" (McCombs, 2005, p. 546). Activists and lobbyists try to persuade the mass media to adopt their take on a problem and to promote their policy solutions. The media can also magnify movements that have already started (Walt, 1994), and can be especially important in encouraging government to act on low-level political issues such as smoking (Buse, Mays, & Walt, 2012). A study of how newspaper coverage affects support for tobacco control in the Netherlands (Nagelhout, Van den Putte, et al., 2012) found that most newspapers wrote in a negative manner about the smoking ban for pubs and restaurants implemented in July 2008, mostly approaching the topic from an economic perspective and highlighting potential negative economic effects. Readers of these newspapers adjusted their support for the ban downwards. The tobacco control network missed an opportunity to influence public opinion about the ban because it lacked a good media advocacy counter-strategy. Pro-smoking interest groups were able to dominate the media by focusing attention on staged "problems" with the ban and presumed resistance from small bar owners

(discussed in Chap. 8). This was relatively easy, since problems are more newsworthy than successes.

Politicians and policymakers are sensitive to how an issue is covered in the press, and can hardly ignore media attention. Newspaper coverage is often a trigger for parliamentarians to ask questions to the responsible minister or state secretary. The influence of the media on the parliamentary agenda in the Netherlands has grown considerably over time (Van Noije, Kleinnijenhuis, & Oegema, 2008). Dutch parliamentary questions are, indeed, almost always inspired or influenced by media attention (Van Aelst & Vliegenthart, 2013). Figure 10.1 shows the number of written questions asked by Dutch members of parliament about tobacco control.[17] I counted the number of parent questions (they typically consist of three to seven sub-questions) submitted at one point in time by a member of parliament.

The number of questions is remarkably modest, considering the major health consequences associated with smoking. It is also modest in comparison to the total number of parliamentary questions, which is between 1400 and 2600 per year, with recent years seeing more activity. Until 2008 there were few questions on tobacco, with the exception of the year 2000 when liberal–conservative parliamentarians questioned Health Minister Els Borst regarding her attacks on the tobacco industry. The first peaks occurred in 2008 and 2009, caused by media attention to the troublesome implementation of the smoking ban in bars. About half the questions were by the opposing right-wing populist *Partij voor de Vrijheid* (Freedom Party) (PVV). Soon after the Rutte cabinet (2010–2012) was installed at the end of 2010, and Edith Schippers became health minister, Socialist and Labour party members asked parliamentary questions about Schippers' presumed ties to the tobacco industry in 2011. The year 2012 continued with more questions on tobacco industry lobbying, prompted by a series of critical articles in the media. The peak in 2013 was partly caused by concerns about the electronic cigarette.

When the Labour party (28), Socialist Party (25), Green–Left party (2), Christian Union (3), and D66 (6) are taken together, there were 74 questions from the left /progressive flank. On the right/conservative flank, I counted 38 questions (13 by PVV, 12 by CDA and 13 by VVD). This suggests that tobacco control coalition organisations have been more successful in putting pressure on the government by raising the attention of parliamentarians, especially through the Labour and Socialist Parties.

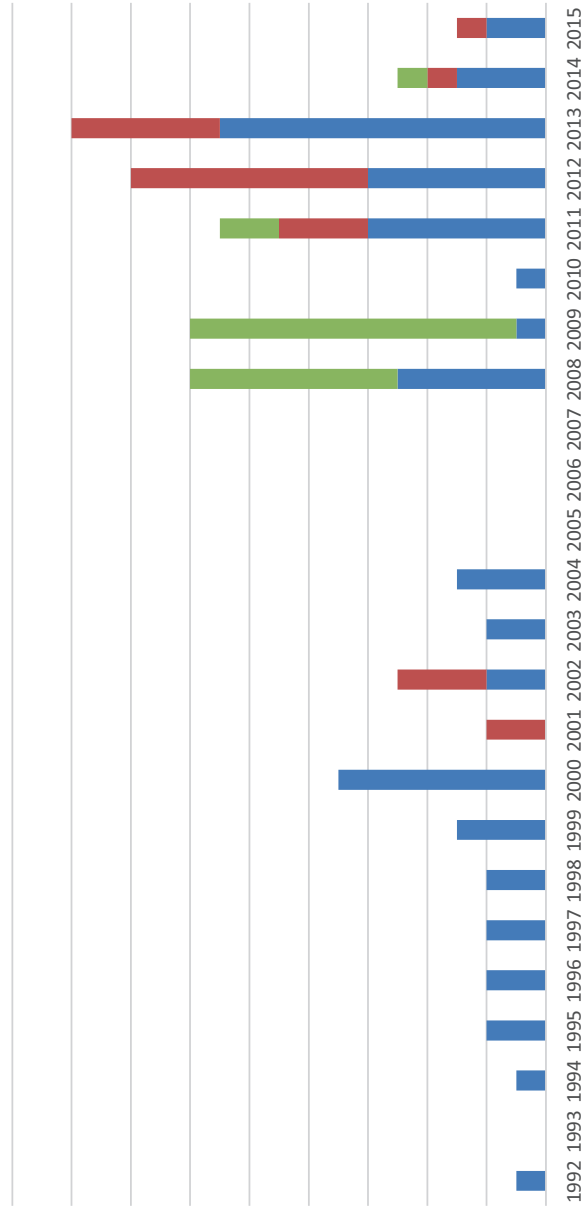

Fig. 10.1 Number of parliamentary questions since 1992 on tobacco policy, by year. Source: https://zoek.officielebekendmakingen.nl/zoeken/parlementaire_documenten

Conclusion

According to Kingdon's multiple streams analysis, major tobacco control policy changes will only happen when a window of opportunity opens and three "streams" come together (Kingdon, 2003). There must be increased attention to the tobacco problem, a clear solution must be readily available, and policymakers must have both the motive and opportunity to adopt a new policy. Such moments have rarely occurred in the Netherlands. Dutch governments treated smoking most of the time as a low-level issue, a chronic "condition" and not a pressing political concern. The Dutch political landscape has been dominated by coalitions that executed neoliberal agendas. Conservative governments tend to regard tobacco control legislation and regulation as infringements on citizens' freedom, and tobacco control measures with paternalistic undertones were time and time again bluntly rejected by parliament. Tobacco control remained low on the policy agenda, especially in times of economic hardship. Only once there was a "natural" feeling of urgency, when smoking rates did not go down for several years in a row at the end of the 1990s. During the Kok cabinets (1994–2002), a window of opportunity opened: the ruling coalition was relatively progressive and smoking rates had been going up at an alarming rate—something had to be done. An important beneficial factor was personal commitment to tobacco control by a determined Health Minister Els Borst. The fact that the economy was prospering was important as well, since this made it possible to invest money in education and campaigns, which was crucial in obtaining support from the CDA for the revised Tobacco Act, to which the liberal–conservative VVD was opposed. A particularly strong and consistent public health frame used by the tobacco control coalition supported the government's tobacco control ambitions.

In later years the tobacco control coalition has been less successful in finding frames that strike a chord with political parties. The once effective public health frame used by the coalition to argue for tobacco control in the 1990s did not inspire society and politicians to support tobacco control in the 2000s. When the fourth Balkenende cabinet with Health Minister Ab Klink (2007–2010) came to power, a second window of opportunity opened for tobacco control: the policy intention of banning smoking in bars and restaurants was part of the coalition agreement, and the health minister seemed open to tobacco control. However, the industry was successful in framing tobacco con-

trol as contradictory to libertarian values and Klink was portrayed as a moral crusader, which shut the door to further tobacco control initiatives. The tobacco control coalition was less successful in media advocacy and lost its grip on the implementation of the smoking ban in bars. Only very recently, by portraying tobacco control as necessary to protect children against smoking, has the tobacco control coalition found a more effective strategy.

Notes

1. Parliamentary papers II, 1992–1993, 22,894, nr. 1.
2. RVZ is an independent advisory body for government and parliament.
3. Proceedings I, 26 March 2002, 24–1273.
4. IBO stands for *Interdepartementaal Beleidsonderzoek* (Interdepartmental Policy Research). IBO reports are mandatory for all ministries and have the explicit aim of finding cost reductions and concrete proposals to increase the efficiency of governmental policy. On average, ten IBO reports are written each year and they cut across all branches of government (Van den Berg & Kabel, 2010).
5. The economic left–right dimension as the main aspect of "ideology" is outdated. For the Netherlands, other important dimensions have to do with cultural orientation, economic equality, libertarianism, self-determination, and populism (Laméris, Jong-A-Pin, & Garretsen, 2017).
6. The CDA did not yet exist in 1972. The 1972 government included two Christian parties (KVP, ARP) that would merge in 1977 into the CDA.
7. Parliamentary papers II, 1990–1991, 19,243, nr. 14.
8. Proceedings II, 1991–1992, 22,300 XVI, nr. 7.
9. Proceedings II, 1998–1999, 26,472, nr. 3; Proceedings I, 26 maart 2002, 24–1257; Proceedings II, 1999–2000, Aanhangsel 3301; Proceedings II, 2000–2001, Aanhangsel 1696.
10. Proceedings II, Tabakswet 31 mei 2001 TK 82-5210.
11. Proceedings I, 26 March 2002, 24–1257.
12. Proceedings II, 31 May 2001.
13. Proceedings II, 14 May 2009, 84–6613.
14. Proceedings II, 2014–2015, 32,011, nr. 46.
15. Parliamentary papers II, 2007–2008, 22,894, nr. 176.
16. Parliamentary papers II, 2007–2008, 22,894, nr. 176.
17. The data were generated by searching the parliament database, using search terms such as tabak*, sigaret*, and roke*.

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