CHAPTER 11

Conclusions

Public policy scholars propose that policy change emerges from the interaction of five elements: (1) the policy context, which can be more or less conducive to tobacco control policy change; (2) the workings of the institutions involved in the process of policymaking; (3) the diffusion of knowledge and ideas which highlight the urgency of a problem and inspire policy solutions; (4) the organisation and advocacy potential of coalitions; and (5) the relative success of opposing coalitions in setting the agenda of policymaking through issue framing (Cairney, Studlar, & Mamudu, 2012; John, 2012). I presented a general framework in Chap. 1 to illustrate how these elements are related and influence each other over time (Fig. 1.1). The reader may want to occasionally consult the framework while reading this concluding chapter.

Context and Institutions

Stable environmental factors rarely change within periods of a decade or less, and directly or indirectly influence all aspects and stages of the policymaking process. The dominant type of governance system is one such all-encompassing stable environmental characteristic. The preference for self-regulation can be explained by the Dutch corporatist tradition of policymaking, where the business community is allowed to deal with a problem before the state intervenes. This means that interest groups are

M. C. Willemsen, *Tobacco Control Policy in the Netherlands*,
Palgrave Studies in Public Health Policy Research,
https://doi.org/10.1007/978-3-319-72368-6_11

integrated into the policymaking process itself and need to rely less on outside pressure strategies. Most often, negotiations with the industry over self-regulation pre-empt formal regulation by the state. Dutch policymakers are content with this arrangement because they want to avoid polarisation and conflicts between groups by trying the least controversial option first. As a consequence, most of the time tobacco control has advanced in small incremental steps, to prevent clashes with tobacco interest groups defending the status quo and at the same time trying to pacify groups that want to advance tobacco control. This preference for seeking compromise (*polderen*) explains why it has been difficult in the Netherlands to move from an entrenched system of corporatism, with tobacco companies close to policymakers, to a system that no longer allows tobacco industry representatives to be consulted.

Although corporatism is considered a relatively stable characteristic, over a long period of time its importance in the Netherlands is believed to decline. With the increasing fragmentation of parliament, cabinets can no longer rely on comfortable majorities, and the influence of opposition parties in parliament has grown. This is seen in other corporatist countries in Europe as well (Christiansen et al., 2010; Kurzer & Cooper, 2016; Rommetvedt, Thesen, Christiansen, & Nørgaard, 2012). In the Netherlands there is increased lobbying at the expense of corporatism, evidenced by more frequent, more intense contact between interest groups and parliamentarians, a greater use of the legislative arena, and a reduced role for institutionalised "old school" corporatist policymaking practices where civil servants act as policy brokers between competing coalitions. The judicial venue (taking the industry or the government to court) is increasingly used to enforce breakthroughs when policymaking is slow. The pressure on the government (including the use of legal action) to adhere to Article 5.3 of the Framework Convention on Tobacco Control in the Netherlands fits in perfectly with these developments. Political parties have become more central to policy change and the influence of public opinion and media advocacy has grown. Tobacco control policymaking has moved from closed meetings and the internal workings of governmental bureaucracy to parliament and the wider society, benefiting tobacco control groups.

A second important stable environmental factor is cultural values, which permeated tobacco control policymaking in many ways. Christian and liberal principles that have had a profound mark on Dutch tobacco control policymaking are rooted in the unique combination of individualistic and "feminine" (egalitarian) values. There is less societal,

and hence less political support, for measures with paternalistic overtones or that are considered particularly harsh for smokers. Such values explained why Dutch governments were reluctant to initiate hard-hitting risk awareness campaigns.

Various important relatively dynamic context factors have also been identified. The Advocacy Coalition Framework (ACF) defines major policy change as an alternation in "policy core beliefs", provoked by external events (Sabatier & Weible, 2007; Weible, Sabatier, & McQueen, 2009). The most important external event is a change of government, when opportunities for policy change arise (advocates may get tobacco control into a coalition agreement) and any change of ideology may be more advantageous to one interest group than another—it may favour tobacco control, or favour a laissez-faire approach. The Dutch case presented three examples of major policy change following a regime change. The first was when the Purple cabinet came to power. For the first time in history, Christian Democrats were no longer part of the ruling coalition. This shattered the tobacco industry coalition's decade-long grip on tobacco control policymaking. The new government appointed a health minister (Els Borst) dedicated to a strong tobacco control agenda and achieved a major focal shift by removing tobacco control from the supervision of the Ministry of Economic Affairs and handing it over to the Ministry of Health. Economic considerations were superseded by a public health frame of reference. A second window opened in 2007 when the tobacco control coalition succeeded in getting the idea of a smoking ban in pubs into the coalition agreement. However, when Minister of Health Ab Klink attempted to implement this, the health coalition failed to use media advocacy in a way that would consolidate the ban and prevent the industry from hijacking the issue. A few years later in 2010 a window of opportunity opened for the tobacco industry to frustrate tobacco control, when Edith Schippers of the *Volkspartij voor Vrijheid en Democratie* (People's Party for Freedom and Democracy) (VVD) was appointed minister of health in 2010. She had opposed most tobacco control proposals as a VVD parliamentarian. This led to chaos and a weakening of the tobacco control coalition, and gave the tobacco industry's policy agenda a temporary advantage.

The Dutch example testifies to the fundamentally ideological nature of decision-making concerning smoking, which is regarded as a difficult, politically contested subject matter, and illustrates how outcomes very much depend on the prevailing ideology of politicians and policymakers.

Dutch policymakers always had to find compromises between economy, public health, and ideology. Dutch governments have almost always been centre-right oriented with a majority backing in parliament. Politicians and policymakers were preoccupied with promoting a strong economy, alongside a trust in the power of the free market. This made it difficult to advance a tobacco control agenda. Even when ministers had personal motives to combat smoking, as did liberal–conservative Minister Hoogervorst (2003–2007), a non-smoker who was inspired by the fight against smoking when he went to university in the United States, they were unable to accomplish much without support from parliament.

Policy was for the main part determined by what is written in coalition agreements, which are the basis for state governance. Tobacco control was mentioned only three times in the coalition agreements of the 15 cabinets since 1972, and on only two occasions was it a positive statement for tobacco control. The importance of getting the topic in a coalition agreement was paramount: one resulted in the important 2002 Tobacco Act and the other led to a smoking ban in bars and restaurants. That tobacco control had not been included in more coalition agreements might suggest that the tobacco control lobby has been weak, but it also reflects a political environment not open to legislative tobacco control, with few windows of opportunity for control advocates.

Other relatively dynamic factors that followed from the ideological preferences of governments and have come to define the Dutch policy context are retreating government and the accompanying process of decentralisation and the sharing of responsibility with lower levels of governance and civil society. These processes have inhibited state-led tobacco control ambitions and leadership. Subsequent cabinets increasingly shared responsibility for disease prevention with local governments, the private sector, and civil society—and when health promotion was decentralised, it no longer was only a national priority. These ideological trends went against the need for a strong and well-coordinated strategy from the state to combat national smoking rates, as was emphasised by the FCTC. The process of handing over the responsibility for tobacco control to non-governmental organisations has already reached a point where central oversight over tobacco control has become scant and increasingly complex.

Much of tobacco control has become a Brussels affair. European Union (EU) governance became increasingly important, since EU directives cannot be ignored by the government. Tobacco industry lobbying has also

focused more and more on the EU level: much of the national industry lobby is directly or indirectly aimed at influencing EU policymaking. In contrast with EU tobacco control initiatives, the FCTC treaty is more easily ignored by the government, and as the Dutch example demonstrates, signing the treaty does not mean much unless there is a policy environment conducive to its implementation. Although FCTC requirements are legally binding, in practice they were more or less ignored since there are no sanctions for non-compliance and much room for discussion about implementation, despite detailed WHO guidelines. While the FCTC was ratified in 2005 by the Dutch government, it took another five years before representatives from the tobacco control network began to give it the attention it deserved (Heijndijk & Willemsen, 2015; Rennen & Willemsen, 2012; STIVORO, 2010), indicating that proper implementation of FCTC in the spirit of WHO intentions must be enforced by civil society. Clean Air Netherlands (CAN) took the government to court over the proper interpretation of FCTC's Article 8.2 (about smoke-free bars), and the Youth Smoking Prevention Foundation prompted the government to a better and more extensive implementation of Article 5.3 of the FCTC, making it more difficult for tobacco industry representatives to contact Dutch government officials.

Diffusion of Knowledge and Ideas

The final acceptance of the health risks of active and passive smoking as scientific fact occurred later in the Netherlands than in leading tobacco control countries such as the United States and the United Kingdom. The Health Council was over-cautious and slow in acknowledging and warning against the public health risks. The government did not publicise the scientific evidence with clear statements about the damage of smoking, and failed to produce authoritative reviews of the literature on the health risks of smoking like the UK and US reports. In addition, there were few leading scientists who publicly spoke out against tobacco and the medical community remained reticent and did not involve itself in the fight against tobacco. Perhaps even more important was the fact that the authorities hid behind the health charities and the *Stichting Volksgezondheid en Roken* (Dutch Smoking or Health Foundation) (STIVORO) to communicate with the public about health risks, giving the false impression that the matter was not to be taken too seriously, and giving the industry leeway to cast doubt on links between smoking and health, whittling away at any political

support for tobacco control. STIVORO was not permitted to communicate in a confrontational and clear-cut manner about the health risks of smoking, in line with Dutch "feminine" (egalitarian) cultural values mentioned before. All of these factors might have contributed to the slower start to regulate tobacco, compared to many other countries, until the mid-1990s.

Dutch government officials had an adequate understanding of evidence-based tobacco control policy measures. The government was already familiar with most options in the 1970s, and the evidence concerning effectiveness has accumulated since then. Dutch civil servants were generally well informed through their contacts with the national and international tobacco control epistemic community, and had organisations such as the *Rijksinstituut voor Volksgezondheid en Milieu* (National Institute for Public Health and the Environment) (RIVM) and STIVORO at its disposal to quickly provide up-to-date information about aspects of tobacco control. The government looked at what the effective measures were, but chose which to implement mainly on ideological grounds. Most Dutch health ministers lacked a public health or medical background, which may have further contributed to the inclination to give more weight to ideological and political considerations such as reducing the role of government through deregulation and decentralisation.

Governments need basic national tobacco control capacity to be able to develop and deliver a comprehensive tobacco control programme in accordance with the FCTC. Such capacity rests on three pillars: a good infrastructure, access to empirical evidence and expertise, and leadership (Wipfli et al., 2004). The Dutch government has abundant access to evidence, and the necessary infrastructure to build tobacco control interventions is generally well developed. The weak pillar is undoubtedly leadership and coordination by the government. The government left it to charities and STIVORO to communicate about health risks, but these organisations were not in the same strong position to put the issue firmly and authoritatively on the societal, let alone the political, agenda. Remarkably, given the relatively high contribution of smoking to the national burden of disease, there has never been a distinctly identifiable tobacco control unit at the Ministry of Health—it has always been part of a larger department that deals with lifestyle and addiction. Before 2000 the unit was understaffed and not sufficiently equipped to negotiate with the tobacco industry, leading to delays in the drafting of regulations. Changing jobs

within the government's bureaucracy further hampered a continuous development of a coherent tobacco control policy, while industry lobbyists remained at their post for decades.

Problem Identification

Most of the time Dutch politicians and policymakers regarded smoking as a chronic condition that did not involve a crisis or present itself as a pressing concern. Each new government recognised that it remained a serious public health problem, evidenced by Public Health Status and Foresight (VTV) reports which it could not ignore, but the lack of a feeling of urgency made it less likely that a government put it high on the agenda. This caused difficulties for tobacco control coalitions, who had to flog a dead horse, while the industry exploited direct contacts with government and politicians to obstruct any inclination for tobacco control progress.

The interest of policymakers in tobacco control was weakened by several factors. First, the impact of governmental interference with smoking takes many years to appear in national statistics, so it gains policymakers no political credit. Second, smoking kills quietly, so that the direct consequences are not always visible to everyone. Third, smoking is increasingly marginalised in the public domain, reducing the chance that politicians and policymakers will personally experience problems with tobacco smoke and feel a need to take action. Fourth, the VTV reports after 2002 characterised trends in adults and youth in a less alarming manner than before, although smoking rates were still regarded as too high. In the national prevention policy documents tobacco control had to compete with other issues such as alcohol, depression, obesity, and diabetes, and since 2007 the government did not want to commit to a quantifiable target, further reducing the feeling of urgency about tighter tobacco control. This is despite the fact that the number of people in the Netherlands who are chronically ill or die prematurely because of smoking remains high, and tobacco continues to be the largest cause of preventable death in the Netherlands (RIVM, 2017). These factors combined to lead politicians to believe that there is no great urgency, either politically or medically, to deal with smoking and undermined the tobacco control coalition's abilities to convincingly frame smoking as an important health problem.

Coalitions, Issue Expansion, and Framing

The Dutch tobacco control subsystem brought forward two separate coalitions: one of the three health charities (cancer, heart, lung) (coordinated first by STIVORO, more recently by the *Alliantie Nederland Rookvrij* (Dutch Alliance for a Smokefree Society; ANR)), and one led by the tobacco manufacturers. In later years a third tobacco control coalition emerged, instigated by two lung physicians Wanda de Kanter and Pauline Dekker (the *Stichting Rookpreventie Jeugd* or Youth Smoking Prevention Foundation: SRJ), with somewhat different core values and preferred strategies than those of the main tobacco control coalition. The main difference is that the SRJ coalition remained an outsider group, whereas STIVORO and ANR are insider groups. Insider groups are not part of the formal governmental bureaucracy but are nevertheless regarded as legitimate stakeholders, are consulted regularly by the government, and are expected to play by the "rules of the game" (Buse, Mays, & Walt, 2012, pp. 114–115). Insider groups are generally considered to be more effective than outsider groups in corporatist political environments.

What constitutes a successful coalition? Scholars have identified several important characteristics. Shiffman et al. (2015) list distinguished leadership, governance, composition, and framing strategies: a network is more effective when it has capable, well-connected and widely respected leaders, when there is a governing structure in place that is able to organise collective action, can resolve disputes, and links a diversity of actors. Such diversity, which facilitates access to scientific knowledge, also increases the likelihood that solutions to problems will be found. Finally, the network is more likely to be effective if its members know how they can frame an issue in such a way that it resonates well with society and politicians. These factors are congruent with the strategies of ACF theory, which identifies similar necessary conditions for success: having the right allies, having shared resources, and being able to develop a common lobby and advocacy strategy (Sabatier & Weible, 2007).

"Public policy and management scholars have long recognized the importance of effective leaders in agenda setting and organizational effectiveness, as well as their rarity" (Shiffman et al., 2015) and for most of the time, the Netherlands has had no such clearly identifiable effective tobacco control leaders, which have a claim to being heard, are well connected with coalition building, have great rhetorical skills, and are able "to articulate vision amidst complexity" (Shiffman et al., 2015). Leaders must be

able to operate effectively within the particular Dutch policy environment, with its corporatist features and emphasises on compromise seeking. The relatively effective leaders were those who organised and lobbied behind the scenes, such as STIVORO's director Boudewijn de Blij.

With respect to governance structure: the decision in 1974 to locate tobacco control in the one organisation, STIVORO, controlled by three charities and the government, thwarted the emergence of a broad nationwide tobacco control coalition. STIVORO was a semi-governmental organisation responsible for executing the lion's share of the government's tobacco policy. In its 40 years of existence, it tried to balance the competing interests of its three "mothers" and the government. While the government and parliament regarded health education as its sole task, the charities expected STIVORO to lobby against the tobacco industry, but also in parliament and against the government, for better tobacco control policy. Only STIVORO's directors were responsible for lobbying and advocacy, which they had to combine with many other demanding tasks. This made the tobacco control coalition vulnerable. Only since 2006 has lobbying been carried out with support from a professional bureau, while the tobacco manufacturers have been employing professional dedicated lobbyists since the 1970s. I noted the few mentions of tobacco control in coalition agreements, which suggests that the tobacco control coalition might have been more successful if it had professionalised its lobbying sooner.

A tobacco control coalition is stronger if it incorporates scientists who are quickly able to deliver evidence that counters industry arguments, and who can convincingly speak with politicians and policymakers. In the Dutch culture of consensus seeking, experts, both scientists and doctors, were not as inclined to become involved with tobacco control advocacy in the same way as their counterparts in countries with more pluralistic traditions, where interest groups are experienced and may be more comfortable in challenging policymakers directly.

In Chap. 10 I tried to capture how tobacco was framed by the two opposing coalitions, and how these frames resonated with those used by the government. The tobacco industry has been successful in framing tobacco control as an infringement on individual liberty and attracting libertarians to its arguments, from individuals fighting for the right to enjoy smoking to organisations that oppose government regulation. Dutch tobacco control advocates have been only moderately successful in setting the agenda, struggling to find the one frame that resonates with policymakers, politicians, and the various tobacco control organisations.

Until the 1970s they used a medical frame, but replaced it with a broader public health frame in the 1980s that remained the dominant frame of reference for many years. In the 2000s smoking as an addiction was added to the repertoire of arguments once science had showed convincingly that nicotine is a highly addictive substance. This stimulated activism among tobacco victims and health professionals and neutralised the industry's frame of smoking as an individual lifestyle choice. It also contributed to finally getting the medical community on board. The public health frame that was effective in the 1990s, when smoking rates were high and the issue of passive smoking was still a noticeable problem for wide segments of society, has now lost most of its appeal. An attempt was made around 2010 to use the frame of an immoral and evil tobacco industry, but this resulted in confrontation and STIVORO lost its insider status with the government's bureaucracy. Most recently, around 2013, the tobacco control organisations reorganised and found a more successful frame in the image of the need to protect vulnerable children from exposure to tobacco smoke and from the seduction of tobacco products. This resulted in the appealing concept of a smoke-free generation, and made tobacco control a just and legitimate cause for a broad range of societal organisations. The preceding illustrates what is sometimes called "issue expansion," which is an important contributing factor for policy change (Baumgartner & Jones, 1993). A coalition can expand an issue by reframing so that groups in society, previously uninvolved, become champions of the cause.

Further Study and Food for Thought

The aim of this book was to understand tobacco control policymaking from the point of view of the government, in the specific context of the Netherlands. However, while much has been uncovered and explained, new questions arose during the process of writing. The role of coalition building received sparse attention here, and it would be worthwhile to examine the characteristics of effective tobacco control coalitions, including the role of leadership, in more detail. A related issue is the role of the scientific and the medical community in tobacco control advocacy in the Netherlands. Other interesting lines of scientific inquiry relate to the success of issue framing by the two opposing coalitions (tobacco control and tobacco industry) over time, and the role of media advocacy in this. Another issue, alluded to in the book but not extensively explored, is the transition from a dominant corporatist policy system to a system with

more lobbyist characteristics, and how this influences the effectiveness of pro- and anti-tobacco coalitions. The role that national cultural values and ideology play in tobacco control policymaking is another under-explored area. A final intriguing question is whether the process of decentralising tobacco control responsibilities and the increased dispersion of tobacco control tasks among governmental and civil society contributes to controlling the tobacco epidemic or might be counterproductive.

Closing Remarks

Despite worldwide convergence of tobacco control policies, accelerated by the ratification of the FCTC treaty by most nations, governments develop approaches to tobacco control in line with cultural values and ideological and political preferences. There is no one-size-fits-all approach. The main message in this book is that what works in any one country is contingent on its specific policy environment and the specific cultural values at its core. This book has recounted how the Dutch used various universal tobacco control building blocks to create a unique blend of tobacco control measures. Especially in the beginning of the 2000s, tobacco control was well financed and comprehensive, revolving around yearly smoking cessation mass media campaigns in combination with evidence-based youth prevention programmes, supported by a broad range of smoking cessation counselling options from which smokers could choose. It combined education with a soft, non-patronising and non-confrontational advocacy approach. This was fairly effective, with smoking rates after 2002 in line with the downward trend of other Organisation for Economic Co-operation and Development (OECD) countries. The period between 2002 and 2013 were golden years for Dutch tobacco control, when STIVORO became an example for other countries in Europe. However, the model only worked as long as there was sufficient moral and financial support from the Ministry of Health and political support from parliament. With a retreating government, the model could no longer be sustained.

Another major lesson from the Dutch example is that the process of policy change in the Netherlands was subject to a policy environment not conducive to tobacco control, rooted in values of individual freedom and corporatist traditions where policymakers felt most comfortable when they involved all stakeholders in policymaking. Policymakers in the Netherlands do not march ahead of the troops. In such an environment,

securing sufficient, and broad, support in society for policy proposals is crucial for tobacco control advocates. The battle is ultimately fought in society, where hearts and minds must be won, and is no top-down affair controlled solely by the state. When civil organisations are able to show convincingly that society wants to be smoke-free, policymakers will follow.

Around 2013 the three charities aligned and professionalised their tobacco control advocacy capacity, forming a powerful and much broader tobacco control coalition than had existed before. A new issue frame was found in the protection of young people from tobacco, and this resonates better with politicians and society than the worn-out public health frame of death and disease. It ignited an unprecedented number of tobacco control activities at the local level, and civil organisations such as the major health charities have become increasingly important as catalysts for Dutch tobacco control, boosting both local and national efforts. However, the health ministry continues to face major challenges. Most importantly, a quarter of all adults still smoked at the time that this book was completed. The Netherlands still has many places where smoking is condoned, tobacco products are still on display in most shops, and tobacco taxation is rarely deployed as a control instrument. Ever since the adoption of the revised Tobacco Act in 2002 the government has not formulated inspiring prospects or new concrete ambitions. Time will tell whether civil society and the government will find new ways of collaboration which will bring the Dutch closer to a smoke-free Netherlands.

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