Smoking denormalization and tobacco endgames

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Once a common practice, smoking prevalence has declined since its peak in the 1960s, after the serious health risks it poses became clear. Government policies and social marketing campaigns have progressively reduced smoking's acceptability; however, slow reductions in prevalence have seen inequities persist and led some governments to adopt tobacco endgame strategies that rapidly reduce smoking prevalence by a specific date.

Achieving endgame goals will bring profound health benefits but face opposition. Tobacco companies have simultaneously opposed core endgame measures, attempted to metamorphose into public health allies, and tried to shape social norms by framing smoking is a personal choice. In this blog, we expand on research exploring smoking's trajectory and declining social acceptability, and consider challenges that tobacco endgame strategists will need to address.

Social norms govern many aspects of our everyday lives by defining what practices we view as acceptable (or not) and how we feel others perceive us.[1] Norms lead us to modify our behaviour as we move from one setting or social role to another; for example, the roles we play at home, as a parent or partner, vary from those we perform at work or in social gatherings. While smoking and drinking norms may connect peers in social settings, other social norms may inhibit these connections from occurring within work settings. Similarly, social norms mean smoking with a group of workmates will be a very different experience to smoking alone outside a home, which people do to comply with norms valuing smoke-free homes for children.[2]

As well as shaping how and where people smoke, norms affect smoking's broader social acceptability, which has changed greatly over time.[3] Initially an aspirational social practice largely confined to upper class men who had the money and social cachet to afford tobacco, smoking became more prevalent and normalised in many countries during the first half of the 20th century. Three key reasons underpinned this change. First, technological innovations enabling mass production of cigarettes lowered costs and increased supply; second, intensive marketing presented smoking as an attractive lifestyle practice; finally, social environments, often facilitated by merchandise such as ash trays from tobacco companies, signalled smoking's acceptability. As evidence of smoking's harms grew; government public health measures, including bans on tobacco marketing, began marking tobacco as an abnormal consumer product and smoking as a socially unacceptable practice.

Tobacco companies tried to maintain smoking's social acceptability and prevalence by launching extraordinary attacks on public health researchers and promoting "innovations" such as filter cigarettes that falsely implied smoking's risks had diminished.[4-9] Nonetheless, smoking prevalence and social acceptability continued to decline; this final stage, known as denormalisation, has coincided with policy measures encouraging smoking cessation and reducing youth smoking initiation.[3]

In the nearly 30 years since Lopez et al developed their insightful analysis of the smoking epidemic's trajectory, many countries have moved beyond measures that will only gradually reduce smoking prevalence by establishing endgame goals.[10-12] Indigenous advocates concerned that traditional measures, such as mass media advertising and individual cessation support, have not reduced inequities in smoking prevalence have been powerful proponents of endgame approaches.[13, 14] Our recent peer-reviewed article analysed these changes and explored how endgames offer innovative new solutions to the

smoking epidemic, but also outlined how tobacco companies are already positioning themselves to present their ideas and products as preferable, responses.[15]

Aotearoa New Zealand's Smokefree 2025 Action Plan outlines changes to tobacco products' design and constituents, and how these are sold, and could potentially transform the tobacco marketplace by making smoking easier to stop and more difficult to commence.[14] Endgame measures such as minimising the nicotine content in tobacco products so these become non-addictive would remove the reward smoking offers, and cue people to quit or encourage them to move to reduced harm products.[16] The Action Plan will also see the number of retail outlets selling smoked tobacco products decrease to just a small fraction of those currently operating, thus explicitly recognising tobacco as a toxic substance that kills two thirds of its long-term users.[17] To maintain the declines in smoking prevalence that will follow these measures, Aotearoa New Zealand will also introduce a Smokefree generation policy and create a cohort of young people who will never reach the age at which they may be legally sold tobacco.[14, 18]

Endgame measures aim to end the harms tobacco companies have knowingly caused to generations of people who became addicted to tobacco products without ever understanding what that addiction would mean.[19] Yet these measures face powerful opposition. Despite claims they are transforming and hope to "unsmoke" the world, tobacco companies have embarked on a deliberate process to renormalise themselves, position themselves as public health allies, and regain the political influence that denormalisation eroded.[20]

Indigenous peoples, who bear a disproportionate burden of harm from tobacco products, have raised important questions about industry initiatives, querying the contributions that industry-funded 'research' centres and 'harm-reduced' products will really make to public health.[21, 22] Aggressive targeting of these latter products at young never-smokers has seen youth vaping escalate and the overall proportion of young nicotine users increase markedly in Aotearoa.[23, 24] Furthermore, transforming tobacco companies would logically embrace measures that would reduce smoking, such as those included in Aotearoa's Smokefree Action Plan, and ceasing production and marketing of smoked tobacco products.[20] Yet tobacco companies and the lobby groups they support have vigorously opposed the Action Plan's endgame measures and show no sign they are withdrawing their smoked tobacco products from sale.[25, 26] Their corporate metamorphosis appears to comprise surface efforts, such as funding environmental initiatives to clean up tobacco product waste (rather than genuine change that addresses the problem's cause, such as removing non-biodegradable filters).[27]

Perhaps the most sinister element of tobacco companies' renormalisation strategy is their claim that smoking is an individual choice, a message that implicitly ignores addiction and blames people who smoke for harms they experience.[28] After decades of denying the harms smoking causes and questioning scientific evidence documenting those harms, tobacco companies now argue that because smoking's harms have been well-known for some time, people who smoke do so understanding the risks they face.[29, 30] One NZ legal judgment has upheld this reasoning. Justice Lang, who presided over the case brought by Janice Pou against the tobacco companies whose products had killed her stated: "Informed consumers are entitled to exercise an autonomous right to purchase and consume products that are lawfully sold, notwithstanding the fact that such products may be harmful to their health. The purpose of a duty to warn is not to prevent or preclude consumers from purchasing or using products that carry the risk of danger. Rather, it is to place them in an informed position so that they can exercise their right to purchase

products of their choice with knowledge of those risks." Personal choice narratives focus attention and responsibility away from tobacco companies, ignore the addictiveness of their products, and implicitly invite judgment of people who smoke, which may increase the stigma they experience and undermine the self-efficacy they need to make a sustained and successful quit attempt.[31]

Personal choice has also become conflated with freedom, a popular trope used to resist wider public health measures. For example, BAT NZ's submission on the Smokefree Action Plan proposals opposed the Smokefree generation policy because it would restrict young people's "personal freedoms, their right to autonomy in their private lives, and amounts to age discrimination". They show no understanding that this measure will free young people from the risk of addiction that so often follows smoking experimentation.[25]

These challenges raise important questions for public health strategists in Aotearoa and elsewhere. What is the most effective way to counter aggressive industry renormalisation tactics? We suggest a three-pronged approach: first, implementation of the Action Plan's bold policies that will transform the tobacco market-place by reducing the addictiveness, appeal and availability of tobacco products. Second, ensure (as Aotearoa NZ's Action Plan does) that communities most harmed by tobacco are empowered to recognise and reclaim norms that prevailed prior to smoking's encroachment on their communities. Finally, continue exposing and countering tobacco companies' specious "transformation" narrative, which thus far shows the leopard's spots are yet to change.[32]

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References

References

1. Nyborg K, Anderies JM, Dannenberg A*, et al.* Social norms as solutions. *Science* 2016;**354**(6308):42-43.
2. Thomson G, Wilson N, Howden-Chapman P. Population-level policy options for increasing the prevalence of smokefree homes. *J Epidemiol Community Health* 2006;**60**:298 – 304.
3. Lopez AD, Collishaw NE, Piha T. A descriptive model of the cigarette epidemic in developed countries. *Tobacco Control* 1994;**3**(3):242.
4. Michaels D, Monforton C. Manufacturing Uncertainty: Contested Science and the Protection of the Public's Health and Environment. *American Journal of Public Health* 2005;**95**(S1):S39-S48.
5. Brandt AM. Inventing conflicts of interest: a history of tobacco industry tactics. *American Journal of Public Health* 2012;**102**(1):63-71.
6. Samet JM, Burke TA. Turning science into junk: the tobacco industry and passive smoking. *American Journal of Public Health* 2001;**91**(11):1742-1744.
7. Harris B. The intractable cigarette 'filter problem'. *Tobacco Control* 2011;**20**(Suppl

1):i10-i16.

8. King B, Borland R. What was "light" and "mild" is now "smooth" and "fine": new labelling of Australian cigarettes. *Tobacco Control* 2005;**14**(3):214-215.

9. Kozlowski L, Goldberg M, Yost B*, et al.* Smokers' misperceptions of light and ultra-light cigarettes may keep them smoking. *Am J Prev Med* 1998;**15**:9 – 16.

10. Malone R, McDaniel P, Smith E. It is time to plan the tobacco endgame. *BMJ* 2014;**348**:g1453.

11. Malone RE. Imagining things otherwise: new endgame ideas for tobacco control. *Tobacco Control* 2010;**19**(5):349-350.

12. Malone RE. Tobacco endgames: what they are and are not, issues for tobacco control strategic planning and a possible US scenario. *Tobacco Control* 2013;**22**(suppl 1):i42-i44.

13. Gifford H, Bradbrook S. Recent actions by Māori politicians and health advocates for a tobacco-free Aotearoa/New Zealand, A brief review (Occasional Paper 2009/1). 2016.

14. New Zealand Government. Smokefree Aotearoa 2025 Action Plan. Wellington: Ministry of Health, 2021.

15. Hoek J, Edwards R, Waa A. From social accessory to societal disapproval: smoking, social norms and tobacco endgames. *Tobacco Control* 2022;**31**(2):358-364.

16. Benowitz NL, Henningfield JE. Reducing the nicotine content to make cigarettes less addictive. *Tobacco Control* 2013;**22**(suppl 1):i14-i17.

17. Banks E, Joshy G, Weber M*, et al.* Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. *BMC Medicine* 2015;**13**(1):38.

18. Berrick A. The tobacco-free generation proposal. *Tobacco Control* 2013;**22**(suppl 1):i22-i26.

19. Gray R, Hoek J, Edwards R. A qualitative analysis of 'informed choice' among young adult smokers. *Tobacco Control* 2016;**25**(1):46-51.

20. Edwards R, Hoek J, Karreman N*, et al.* Evaluating tobacco industry 'transformation': a proposed rubric and analysis. *Tobacco Control* 2022;**31**(2):313-321.

21. Waa A, Robson B, Gifford H*, et al.* Foundation for a Smoke-Free World and healthy Indigenous futures: an oxymoron? *Tobacco Control* 2020;**29**(2):237-240.

22. Waa A, Maddox R, Nez Henderson P. Big tobacco using Trojan horse tactics to exploit Indigenous peoples. *Tobacco Control* 2020;**29**(e1):e132-e133.

23. ASH NZ. Year 10 Snapshot Survey 2021 Topline – Youth Smoking and Vaping. Auckland: ASH NZ 2022.

24. Hoek J, Ball J, Roberston L*, et al.* Daily nicotine use increases among youth in Aotearoa NZ: The 2021 Snapshot Y10 Survey. *Public Health Expert*. Wellington: University of Otago 2022.

25. British American Tobacco. Proposed smokefree Aotearoa 2025 Action Plan Submission British American Tobacco 2021.

26. NZ Initiative. Submission: Proposals for a Smokefree Aotearoa 2025 Action Plan. 2021.

27. Hoek J, Gendall P, Novotny TE*, et al.* The Case for Banning Cigarette Filters: Addressing a Consumer Fraud, Smoking Decoy and Environmental Hazard. *Public Health Expert*. Wellington: University of Otago 2021.

28. Friedman LC, Cheyne A, Givelber D*, et al.* Tobacco industry use of personal responsibility rhetoric in public relations and litigation: Disguising freedom to blame as freedom of choice. *American Journal of Public Health* 2015;**105**(2):250-260.

29. Proctor R. Golden holocaust: origins of the cigarette catastrophe and the case for abolition: University of California Press 2011.

30. Proctor RN. "Everyone knew but no one had proof": tobacco industry use of medical

history expertise in US courts, 1990–2002. *Tobacco Control* 2006;**15**(suppl 4):iv117-iv125.

31. Evans-Polce RJ, Castaldelli-Maia JM, Schomerus G*, et al.* The downside of tobacco control? Smoking and self-stigma: A systematic review. *Social Science & Medicine* 2015;**145**:26-34.

32. Robertson L. Need for continued tobacco industry monitoring. *Tobacco Control* 2022;**31**(2):382-382.

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