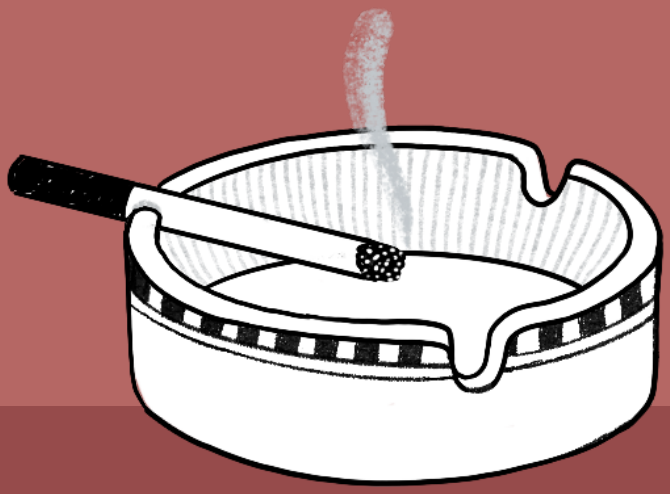
World Health Organization
REGIONAL OFFICE FOR Europe

Tobacco control in the WHO European Region



Cultural Contexts at a Glance, No. 2

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Introduction

This paper examines some of the historical and cultural contexts of tobacco control in the WHO European Region. It aims to bring longer-term and more culturally nuanced perspectives to contemporary debates, and to highlight the centrality of tobacco control to the development of public health in European society since the Second World War. In charting the rapid growth of tobacco consumption, particularly in the 19th and 20th centuries, and the anti-tobacco initiatives that arose in response, this paper brings attention to the role that European countries have played in the story of tobacco control, and draws some conclusions from national, regional and global efforts.

The growth of tobacco use in Europe and the United States

Europe has long had an important relationship with tobacco. Within 50 years of Christopher Columbus's first voyage to what is now known as America, tobacco made its appearance in Europe at the Portuguese court in Lisbon (1). It became accepted as a herbal therapy capable of curing an increasingly large number of ailments, and by 1571 Nicolas Monardes' history of medicinal plants of the New World located tobacco at the heart of the European materia medica. This Europeanization of tobacco proved essential to the plant's initial diffusion beyond the Americas (1).

In England, the country of widest diffusion, tobacco was a mass-consumption commodity by the late 17th century, when enough tobacco was available for 25% of the population to have a pipeful at least once daily. While less is known about tobacco consumption in other European countries, it is clear that the Dutch were avid consumers, as were the Russians under the tsars (2,3). The main smoking method was the clay pipe, although cigars were more popular in southern Europe and the papirosa, a style of filterless cigarette, was common in Russia. Chewing tobacco remained distinctly marginal in European culture, but snuff consumption expanded during the 18th century and may have led to the slowdown in per capita tobacco consumption in England at the time (1).

Annual consumption of one or two pounds of tobacco per capita was common in the 18th and 19th centuries in European countries and the United States of America. By the turn of the 20th century, only Denmark and the United States had per capita consumption exceeding 3 pounds, the latter with 5.3 pounds. By 1950, however, consumption in most European countries exceeded 3 pounds per capita, in many countries it approached 5 pounds per capita, and in several it was even higher. American consumption remained the highest at 7.5 pounds per capita (1,4).

The arrival of the Bonsack rolling machine in the late 19th century, which enabled the mass production of cigarettes, had contributed to this enormous increase in tobacco consumption and per capita use. By the first part of the 20th century, consumption patterns were shifting from smokeless tobacco towards the smoking of manufactured cigarette brands.

Although in many European countries the switch to the cigarette was relatively late, by the end of the Second World War smoking had become the norm among both men and women (1). This new technology and the development of the mass market gave rise to new methods of marketing, including packaging and advertising.

The beginnings of tobacco control policies

Controversy over whether tobacco was harmful or not dates back to the 17th century. A resurgence of resistance to tobacco use in the 19th century prompted anti-tobacco societies to spring up in the United States as well as in France, the United Kingdom and, to a lesser extent, other European countries. These societies aimed to inform the public about the dangers of tobacco and lobbied for legislation against its use. Their efforts were connected to the temperance movement, and the organizations were often headed by charismatic individuals. Yet by 1905, France's two main anti-tobacco societies were defunct, and Britain had seen limited success with the passing of the 1908 Children Act which, among other measures, prohibited the sale of tobacco to children (5).

The argument connecting cigarette consumption with national decline had surfaced in both Europe and the United States, but it was in Germany under the Nazi regime that scientific investigation into the health effects of smoking and a policy response were first launched. Concerns about racial hygiene and bodily purity led to scientific interest in areas such as cancer prevention and exercise, which would form part of the redefinition of public health elsewhere in Europe after the Second World War. Germany ran an anti-smoking programme with health education, bans on advertising and restrictions on smoking in public places. German scientists were among the first to link smoking to lung cancer (6,7).

The post-war period: developments in the United Kingdom

Germany's research and policy response prior to the Second World War were unknown in other countries at the time, and tobacco's cultural centrality in European societies persisted. The European Recovery Programme, also known as the Marshall Plan, which sought to rebuild a devastated Europe after the Second World War, included loans to buy American tobacco as well as food (8). In Britain in the 1940s and 1950s, pensioners received tobacco tokens as an economic supplement.

Developments in tobacco control in the United Kingdom, which took place at the same time as key research was being conducted in the United States, led the way for major developments in tobacco control in post-war Europe. Studies funded by the Medical Research Council and led by Bradford Hill and Richard Doll in the Statistical Research Unit of the London School of Hygiene and Tropical Medicine led to a seminal publication in the British Medical Journal in 1950. The authors concluded that there was a "real association" between smoking and carcinoma of the lung (9). Work by Ernest Wynder and Evarts Graham in the United States had come to similar conclusions (10). Hill and Doll then started a prospective study of British doctors in 1951 which published its results in 1954 and 1956 and ended in 2004, just before Doll's death in 2005. This study concluded that death rates increased with the amount of tobacco smoked, and decreased with the length of time smoking was given up (11).

This evidence about the harmfulness of smoking was not immediately translated into policy. Various explanations have been given for this delay, including the fiscal importance of tobacco and the Government's devotion to the tobacco industry. Yet this simplified theory views events from a present-day perspective. The tobacco industry was indeed an ally of the Government, and had played a central role in providing what was considered an essential item of consumption during the Second World War under strict government control (12). But other factors contributed to the lag between the emergence of evidence on the health effects of tobacco and the development of anti-tobacco policies.

Doll summarized these factors in evidence he gave to the House of Commons Health Committee in 1999. He commented that the

ubiquity of the habit, common among all levels of society, including doctors, made it appear normal and unproblematic. He also noted that the risk factor epidemiology applied for the first time to the study of noncommunicable diseases yielded findings that were undervalued as a source of scientific evidence. The use of Koch's postulates for determining causation meant that the presence of lung cancer in non-smokers was taken to show that smoking could not be the cause. Laboratory proof was demanded at the time; in some instances, Doll noted, we are still awaiting such proof (13). This historical assessment shows the complexity of the situation at a time when public health was positioned very differently than it is today.

Developments in Finland, North Karelia and Norway

The smoking–lung cancer connection was part of public health's post-war reorientation from a focus on tackling infectious diseases to an emphasis on studying and preventing chronic and noncommunicable diseases through the lens of risk factor epidemiology. One of the key developments in this shift took place in Finland.

Along with Greece, Italy, Japan, the Netherlands, the United States and Yugoslavia, Finland participated in the Seven Countries Study launched by American physiologist Ancel Keys in 1958. The Study's primary focus was the connection between diet and heart disease. At the time, Finnish men in the region of North Karelia were 30 times more likely to die of heart attacks than men in places such as Crete, Greece. The high-fat diet of men in Karelia was accompanied by a new habit – after the Second World War, more than half of the men of the region smoked tobacco (14).

The North Karelia Project in the early 1970s focused on food and diet, but also took aim at smoking. Workplaces were persuaded to adopt smoke-free policies. Smoking cessation programmes saw villages competing to see which could achieve the highest level of participation. Smoking rates dropped from 52% to 31% over this period (15).

Norway also took early action by setting up a parliamentary committee in 1965 to examine the issue of tobacco's impact on health. It published the classic report Influencing smoking behaviour in 1969 (16), and in 1971 set up the National Council on Tobacco and Health, a governmental office for tobacco control. The 1973 Tobacco Act, which came into force in 1975, introduced an advertising ban, labelling restrictions and a 16-year age limit for smoking, all publicized with an extensive media campaign (17).

The internationalization of tobacco control in the 1970s

The cross-national research of the Seven Countries Study began to influence policy-making. In the United Kingdom, initial policy action came from the Royal College of Physicians, which published its report Smoking and health in 1962 (18). Launched with unprecedented media publicity, the report led to further action by the Royal College, including the 1971 publication of Smoking and health now (19) and the launch of Action on Smoking and Health (ASH), a pressure group to lobby for change in government policies.

Most of the initial international contacts in the anti-tobacco movement were made on a personal Anglo American basis, and by the 1960s the networks now taken for granted within public health and in research were being established. The Surgeon General of the United States Public Health Service published the first smoking and health report in 1964 (20). The United States also funded and launched the World Conferences on Smoking and Health in the 1960s, which became an important vehicle for the dissemination of research and action. The first Conferences, held in London, United Kingdom, and New York, United States, gathered American, Australian, British, Canadian, Norwegian and Swedish representatives.

By the 1970s, WHO headquarters in Geneva, Switzerland, recognized the importance of tobacco control, although representatives of developing countries argued that malaria and family planning were more significant issues. Lars Ramström, Head of the Swedish National Smoking and Health Association, and Norwegian physician Kjell Bjartveit, Director of the National Council on Smoking and Health, were instrumental in bringing tobacco control high on WHO's agenda (21,22).

The 1970s also saw the development of an international public health coalition composed of Canada and the United States as well as Denmark, Norway, Sweden and the United Kingdom, all considered leaders in the so-called new public health. Australia also took part on the coalition (23).

Case study: Germany

In Germany, by contrast, pre-war research and anti-tobacco action under the Nazi regime did not lead to the early adoption of post-war anti-smoking policies. As late as the early 2000s, commentators expressed concern over Germany's lack of commitment to global tobacco control initiatives. Until 1999, the country had no national strategy to prevent smoking-related diseases, and before 2002, tobacco taxation was less than half that in the United Kingdom. Germany was a reluctant participant in both the European Union (EU) directives on smoking and the WHO Framework Convention on Tobacco Control (FCTC) (24).

Some anti-smoking campaigners point out that negative memories of the Nazi regime may have prevented post-war action on tobacco. However, recent historical work has discounted this argument. The close relationship between the cigarette industry and the West German Government under Helmut Kohl in the 1980s and 1990s has been offered as an alternative explanation. In fact, this relationship dated back to 1949–1955, when the first West German

Government was grappling with the legacy of the War and the experience of occupation, and struggling to find its direction (25,26). The extent of cigarette smuggling even after the currency reform of 1948 meant that much of the Government's concern around tobacco in the early 1950s was driven by the need to bring all tobacco consumption, particularly cigarette smoking, back under its fiscal jurisdiction. The cigarette industry in this period was very different to what it is today. Its key players were the West German family firm Reetsma and the cigarette manufacturers' association Verband der Cigarettenindustrie, mainly composed of West German manufacturers. The influx of Virginia tobacco into West Germany – legally through the Marshall Plan as well as illegally through smuggling – threatened both the domestic tobacco industry and trade negotiations with Turkey and Greece, Germany's traditional suppliers of tobacco. The Government addressed these multiple concerns through taxation policy, in particular the 1953 Tabaksteuergesetetz (tobacco tax law), which reduced tobacco taxation in order to expand the market for domestic tobacco products (25,26).

Health arguments, while present, were outweighed by more pressing domestic and international considerations. Cultural changes were also apparent, and the influx and popularity of Virginia cigarettes with their associations of liberalism and democracy represented a shift away from the values of the Third Reich. The lack of a Ministry of Health until 1961 meant that anti-smoking groups had no governmental focus for their efforts, while the tobacco industry maintained an influence within the Government (25,26).

West German policy was not framed in ignorance of what was going on internationally, as some commentators have claimed, but in full knowledge of it. However, economic issues, such as the commitment to free trade within the social market economy, worked against the introduction of restrictive practices. Hence health education, including the Neue Trend campaign run in the late 1960s and early 1970s, was based on the idea of citizens exercising choice. In 1974, the Government also put in place a consumer protection law prohibiting the advertising of cigarettes on television and radio (25,26).

Case study: France

In France, the unique organization of the tobacco industry influenced the course of tobacco control policy. Tobacco had been a state monopoly since the 17th century, and this arrangement remained relatively stable until about 1970. The Société nationale d'exploitation industrielle des tabacs et allumettes (SEITA), best known as the manufacturer of Gauloises and Gitanes, was created in 1926. SEITA had a monopoly not only on the manufacture and wholesale distribution of tobacco products and matches, but also on tobacco farming. In addition, the state was under an obligation to purchase the tobacco harvest. This obligation ended in 1971 along with the farming monopoly (27).

In 1976, under pressure from the European Community, SEITA gave up its monopoly on wholesale sales and distribution, which effectively opened the French industry to multinational competition. The market share and revenue of the company declined substantially over the next 20 years. In 1971, SEITA held 97% of the French tobacco market, but by 1986 this had dropped to 58%. On the date of its merger with the Spanish tobacco monopoly Tabacelera in 1999, SEITA's market share was down to just over 30% (27).

Both tobacco taxes and the total price of cigarettes paid by the consumer were controlled by the state during this time. The Ministry of Finance had a vested interest in holding down the price of cigarettes because they were included in the cost of living index, which played a major role in employer–employee relations over wages and salaries (27).

Medical pressure against this entrenched position achieved some early success, but the loi Veil, passed by Minister of Health Simone Veil in 1976 with relatively little opposition, was never implemented. As a piece of legislation it was ahead of its time, banning most outdoor advertising and restricting smoking in public places years before anything similar was passed elsewhere. However, powerful financial forces within the Government resisted the law and its provisions were largely ignored (27).

The loi Veil was replaced in 1991 by the loi Évin, named after Minister of Health Claude Évin who guided its adoption. Credit for this law belonged to a group of doctors who became known as les cinq sages (the five wise men). The group followed a path similar to that of the doctors who had pressed the Royal College of Physicians into action in the United Kingdom in the 1960s and 1970s. In France, the group placed a dual focus on alcohol and tobacco (27).

Claude Got, a professor of anatomy and consultant to the French Government on public health issues, and Gerard Dubois, an adviser to the system of national health insurance, used the power of medical lobbying. Their efforts were strengthened by pressure from the European Community, which had launched its Europe against Cancer programme to target health risks including tobacco smoking. In 1987, the report Lutter contre le tabagisme (28), the French equivalent of the British and American reports published two decades before, was released. Together with media pressure and insider lobbying, the publication galvanized the governing Socialist Party into supporting the loi Évin. Its most influential provision was to take tobacco out of the cost of living index, making it possible to raise the price of cigarettes. As a result, the cost of a pack more than doubled between 1992 and 2000 (27).

The 1980s: the era of regionalism

European regional organizations have been key players in the development of modern tobacco control. The WHO Regional Office for Europe, based at its inception in 1951 in Geneva, Switzerland,

and later relocated to Copenhagen, Denmark, took a leading role in this work in the 1980s. It was catalysed by the landmark 1978 Declaration of Alma-Ata, which articulated the core concept of primary health care and announced the goal of "Health for all by 2000" in response to the demands of developing countries for greater equity and social justice (29).

Primary health care in its broader sense was undermined by the notion of selective primary health care favoured by donor nations, which led to narrower and more technically focused programmes, tensions with the United Nations Children's Fund (UNICEF) and competition over which agency had the right to impose its definition of primary health care. But the Regional Office remained optimistic and, working with Canadian health scholars, revised and transformed the idea of primary health care by introducing the concept of health promotion. This first appeared in studies conducted and regularly published by the Regional Office's unit on health promotion in the late 1970s and early 1980s.

The health promotion movement culminated in the Ottawa Charter of 1986 (30). The Charter's five areas of action concentrated on the socioeconomic and environmental factors affecting living conditions, and as such placed less emphasis on individual lifestyle choices such as smoking. Yet in the United Kingdom, the Royal College of Physicians used the Ottawa Charter as a platform for policy development on tobacco control by emphasizing the environmental aspects of smoking. This was also a focus of the Europe-centred Healthy Cities movement, run from the Regional Office, and its symposia in Zagreb, Croatia, and The Hague, the Netherlands, in 1988 and 1989 (31).

The European Community, now known as the EU, also played a major role in the development of modern tobacco policy[1]. Like the Regional Office, in the 1980s the European Community was ramping up action on health. The 1987 launch of the Europe Against Cancer programme was one of the first visible outputs of a so-called social Europe. Established at the start of the European Community's new public health mandate, the programme initially functioned as a relatively independent unit in Brussels, Belgium. Its first Action Plan on Cancer (1987–1989), which made smoking a priority area, was shaped by several of the experts influencing French and Italian anti-smoking policy in the same period. The Bureau for Action on Smoking Prevention (BASP) was commissioned to provide an expert information service, and an EU liaison office in Brussels was set up and funded by international and European cancer organizations. These efforts were aided by the relative inaction of the tobacco industry within the European Community at the time. It was not until the mid-1990s that the industry's lobbying arrangements were fully functioning in Europe. Between 1989 and 1992, seven directives and one non-binding resolution on tobacco were adopted. These changes had a considerable impact on tobacco control. Labelling directives helped to lead countries with almost no tobacco control legislation, such as Greece and the Netherlands, to strengthen their health warnings and empowered local politicians to take action (32). The United Kingdom chose to enact legislation to supersede its voluntary agreements. The tax directives led to a reduction in price differentials among EU Member States and a price increase in countries with less expensive cigarettes.

After 1992, progress on tobacco control slowed considerably. Subsequent action plans were developed, but only three directives on tobacco were proposed between 1992 and 2001. Yet tobacco control lobbying groups continued developing an impressive network. A number of international groups established their headquarters in Europe, and Europe-specific groups, including those representing southern European countries, were in operation. The presence of the International Agency for Research on Cancer (IARC), a scientific arm of WHO based in Lyon, France, also helped ensure that health issues remained on the European agenda. Two more networks were established after the closure of the BASP in 1995: the European Network on Smoking Prevention and the European Network on Young People and Tobacco were both set up in 1997 (33).

Still, cigarette smuggling remained a contentious issue at the European level. In addition, while snus, a smokeless, moist powder tobacco, was banned in all EU Member States in 1992, it remained available Sweden (snus can still be purchased in Denmark and Norway). The use of snus in Sweden was associated with the very low and declining levels of cigarette smoking, although the interpretation of statistics was a matter of some controversy (34).

Changes in eastern Europe

Momentous changes took place in eastern European countries as communist systems crumbled and the former Soviet Union fell apart. Tobacco industry documents show how the industry engaged with the new situation in eastern Europe. For example, British American Tobacco (BAT) used what researchers have called flawed economic arguments to persuade cash-starved governments that they would reap rewards from its investment (35). This persuasion was facilitated by the naivety of post-Soviet governments and the support of international financial organizations, such as the International Monetary Fund, for rapid economic reform. This permitted tobacco transnationals to penetrate markets before effective competitive tendering processes had been established, giving them the opportunity to minimize prices and establish monopolies (35). Such activities were replicated in many east European countries (36,37).

[1]Prior to 2004, the EU consisted of 15 countries and represented a population of just over 377 million. In 2004, an additional 10 countries joined, primarily from eastern Europe.

Case study: Poland

Despite earlier attempts to tighten tobacco control and the existence of anti-tobacco organizations, Poland in the 1980s had a per capita consumption of around 3500 cigarettes per year and one of the highest rates of smoking in the world. As in other eastern European countries, the state had a monopoly on the production of cigarettes and prices were low. Transnational tobacco companies had entered the market in hopes of making up for the decline of smoking in western European countries. Yet in Poland, anti-tobacco activities were successful: the collapse of communism was followed by a decline in cigarette consumption in Poland of 10% between 1990 and 2000 (38–40).

In the 1990s, the Polish Parliament passed progressive anti-smoking laws prohibiting smoking in workplaces, banning tobacco advertising and mandating the largest packet warnings in the world. One catalyst for this approach was the summit of central and eastern European anti-tobacco advocacy leaders in Poland in November 1990. This conference was organized by the Polish Anti-Tobacco Society (PTP) under the patronage of Lech Walesa and in collaboration with the International Union Against Cancer and the American Cancer Society (38–40).

The Conference culminated in the Kazimierz Declaration, which called on the Polish Government and other governments in the region to implement comprehensive legislation and anti-tobacco programmes. Polish health advocates, who had coalesced around the newly formed Health Promotion Foundation, focused their efforts on lobbying politicians. During this period, Poland had one of the world's fastest declines in smoking prevalence among males (38–40).

Towards the WHO FCTC

WHO's global headquarters in Geneva, Switzerland, was less actively engaged in anti-tobacco initiatives in the 1980s and early 1990s, when Hiroshi Nakajima was Director-General. Still, in 1988 the Tobacco or Health programme was launched following the adoption of a resolution by the 41st World Health Assembly, which became the Tobacco Free Initiative in 1998 (23,41,42). The Organization's anti-tobacco efforts resumed when Gro Harlem Brundtland became WHO Director-General in 1996. While European countries with a long history of anti-tobacco efforts were still active, WHO's focus in this phase was less on Europe and the traditional tobacco-control countries (Australia, Canada, the United Kingdom and the United States) and more on developing countries, where the potential for both tobacco industry influence and tobacco control efforts was significant. Danish and Norwegian development agencies provided funds for anti-tobacco efforts in these countries (23,41,42).

Coalitions were also important in progress towards the WHO FCTC (24). European countries such as Finland, France and Switzerland made contributions that enabled the treaty to get underway. Consequently, in 1996, WHO voted to proceed with the development of the FCTC, which was subsequently adopted in 2003 and came into force in 2005 (23,24,41,42).

Recent developments

The importance of international action and networks was also demonstrated in the years following the WHO FCTC's coming into force. In March 2004, Ireland introduced the toughest anti-smoking laws in Europe with a complete ban on smoking in workplaces. Countries including Italy, Scotland and Turkey followed suit, and others that had initially opted for a "smoking room" route, such as Norway, eventually also moved to a full ban.

These European initiatives helped to push the Government of the United Kingdom into action in 2007. In England, efforts to promote comprehensive legislation were aided by the Health Select Committee, which built cross-party consensus. Effective campaigning by external pressure groups also took place. A key turning point came when the hospitality industry moved to support a comprehensive ban. This helped to shift public opinion in a similar direction, which in turn encouraged policy-makers to take decisive action (43).

Regulation in the EU has also changed in recent years. The 2001, the Tobacco Products Directive was revised and, in 2014, European Parliament Directive 2014/40/EU, which governs the manufacture, presentation and sale of tobacco and related products, entered into force (44). It requires an increase in graphic health warnings, bans promotions, and sets restrictions on the size and shape of cigarette and roll-your-own packets. As of 2018, all 28 Member States of the EU have incorporated the requirements for large graphic health warnings into their national laws.

In the eastern part of the WHO European Region, rates of smoking remain among the highest in the world. Overall smoking rates increased following the collapse of communism, in particular among women, and people began smoking earlier in life. Smoking rates among men failed to decline in this region in spite of such developments elsewhere. However, while progress in tobacco control was being obstructed by transnational tobacco companies, studies of public attitudes showed popular support for tobacco control measures and countries were either ratifying or acceding to the WHO FCTC (45). In recent years, countries such as Georgia, the Russian Federation and Ukraine have passed significant anti-tobacco legislation. Their successful implementation of various articles of the WHO FCTC has demonstrated that effective tobacco control measures can successfully be applied in different economic, sociocultural and political contexts (45).

Tobacco-control policies have contributed to the reduction of tobacco use in the WHO European Region, but the tobacco product landscape and patterns of tobacco use have also changed substantially in recent years. New nicotine and tobacco products in

particular have generated concern and presented new challenges to regulators. There are three distinct categories of these products: electronic nicotine delivery systems (ENDS), electronic non-nicotine delivery systems (ENNDS) and heated tobacco products (HTPs).

Debates have turned on whether policy-makers should ban the sale of ENDS in order to prevent their uptake among youth, or encourage smokers to use them for smoking cessation or harm reduction purposes (46). Divergent policies are rooted in disagreements about whether ENDS will reduce tobacco-related harm in the population by diverting smokers to a safer route, or increase harm by recruiting new, younger smokers and discouraging current smokers from quitting altogether (47). Policy-makers in high-income countries interpret the evidence on these competing scenarios differently. In some countries, ENDS can only be used if they have been approved as a medical product. This essentially amounts to a ban as no ENDS have been approved for medical use. In other countries, policy-makers have regulated ENDS as a consumer or tobacco product and allowed smokers to use them for smoking cessation or as a long-term substitute for smoking.

Within the EU, the Tobacco Products Directive regulates ENDS. It places limits on the sale and merchandizing of tobacco and tobacco-related products; prohibits the use of health or cessation claims when advertising ENDS; sets limits on the maximum concentration of nicotine allowed in liquids (less than 20 mg) and the maximum volumes of liquid that can be sold; requires medicinal licensing if health claims are made or if ENDS contain over 20 mg/ml of nicotine; and requires childproof packaging of e-liquids, purity of ingredients, devices that deliver consistent doses of vapour, and disclosure of ingredients and nicotine content. The Directive empowers regulators to act if these requirements are not met (44).

While WHO at the global level has taken a firm stance against ENDS, European Member States have taken diverse approaches, from regulations to bans. Croatia, Czechia, Finland, Georgia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal and Slovenia, for example, have amended their tobacco control legislation to cover these new and emerging products. The United Kingdom, a country where 5–7% of adults use ENDS (48), has adopted a harm-reduction approach. This variability in policy responses to ENDS relates to issues such as policy-making traditions, historical responses to nicotine, and different stances on drug use and harm reduction (49).

Rates of smoking in Europe have declined throughout the years, although variations between countries persist (49). These rates speak to changes in formal legislation and policy, but also, and importantly, to significant shifts in smoking culture. While tobacco control in Europe has been researched extensively, cultures of smoking, their role in population behaviour and their evolution remain rich fields of study. Situating research and action on tobacco within such contexts is critical to building understanding of how the culture of smoking, a crucial component of tobacco control, continues to change over time.

Conclusion

At the beginning of the third decade of the 21st century, tobacco's position within the cultural and policy landscapes of Europe differs dramatically from what it was in past centuries. The new emphasis on public health, individual lifestyle choices and long-term risk factors that arose after the Second World War contributed greatly to this shift. So, too, did scientific research on the negative health effects of smoking, particularly as it was popularized and promoted by doctors, health professionals and allied activist groups. Today, cross- and transnational policy initiatives, especially the WHO FCTC, characterize European and global approaches to tobacco control. Tobacco control has been central to the definition of public health in the modern era, and will likely remain so in the future.

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