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How does a culture of health change? Lessons from the war on cigarettes

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ABSTRACT

This paper focuses on one of the most dramatic changes in the culture of health in the U.S. since World War II: the reduction of adult cigarette smoking from close to half of the population to under 20 percent between the 1960s and the 1990s. What role does culture play in explaining this shift in smoking from socially accepted to socially stigmatized? After surveying how culture has been used to explain the decline in smoking in the fields of tobacco control and public health, we argue that existing concepts do not capture the complex transformation of smoking. We instead suggest a micro-sociological view which presumes that culture may change in response to spatially organized constraints, cajoling, and comradeship. By reviewing two major drivers of the transformation of smoking - the Surgeon General's Reports and the nonsmokers' rights movement - at this micro-sociological level, we show how culture works through social spaces and practices while institutionalizing collective or even legal pressures and constraints on behavior. This conclusion also seeks to explain the uneven adoption of non-smoking across classes, and to reflect on the utility of presuming that a uniform “culture” blankets a society.

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In contemporary public health efforts and public health research, there is a growing focus worldwide on non-communicable diseases. This has been called the “new public health,” dating to the 1970s. (Cairney and Studlar, 2014, p. 315). How do we understand and how can we do more to prevent the harm caused by tobacco, alcohol, and processed food and drink industries linked to obesity, diabetes, hypertension, and the tobacco-linked cancers, heart disease, and emphysema? The new public health (NPH) suggests focusing on changing human behaviors one by one. Instead of improving health care or eradicating infectious diseases, proponents of the NPH seek a healthy society through publicizing potential risks and promoting better choices in life (Petersen and Lupton, 1996).

Telling people what is in their own best interest is not in itself enough. Sometimes that does not even work with people who are in pain, seek the advice of a doctor, and receive prescriptions. Compliance in taking doctor-prescribed medication as directed is about 50 percent, with 20–30 percent of prescriptions never even filled. Rates of non-compliance with prescriptions for chronic diseases, like hypertension or diabetes-related illness, are extremely high, in the range of 90 percent (Becker and Maiman, 1975).

And yet—sometimes “telling” works. Sometimes news about famous politicians, athletes, and actors with serious health problems leads people to respond—as, for instance, thousands of people did in scheduling appointments for colonoscopies after President Reagan's 1985 diagnosis of colon cancer (Brown and Potosky, 1990). Moreover, we have the example of a remarkable cultural change in smoking—from the 1950s, 1960s, and into the 1970s when more than 40 percent of American adults were smokers to 2013 when it was just 18 percent. Why did smoking decline? Why did about half of all living adults in the United States (U.S) who had ever smoked stop smoking by 2000? (Cummings, 2002, p. 7350)

Usually lauded as “the first major success” of the NPH movement (Studlar, 2014), one could count a myriad of factors that stirred this relatively rapid decline in smoking: shifts in the public agenda, changing socioeconomic circumstances, influential policy networks, active governmental institutions, and new ideas affecting policy (Cairney et al., 2012). But consider that as cigarette smoking declined, more and more non-smokers reported that “being near a smoker makes them feel sick.” (Lader, 2009). This seems a notable indicator of a change in the meaning of and attitudes toward smoking away from a still recent time when smokers

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were icons of sophistication and people did not “feel sick” near them. How can we explain this cultural shift? Was it a consequence of the successful policy instruments used in tobacco control? Or were those policy instruments successful because of the cultural transformation?

Our effort in this paper is to review the decline in smoking in the light of sociological research and theorizing on cultural change. Distinguishing policy from culture is not easy and may not be helpful. Keeping various components of tobacco control in mind—laws passed to prohibit smoking in restaurants, office buildings, schools, hospitals, public parks; rising scientific knowledge; warning labels, public service advertising, news about smoking; increases in taxation on cigarette sales; and organized anti-smoking groups—we will ask: How have the symbolic boundaries and collective images, attitudes, beliefs, and predispositions around health and smoking been influenced by tobacco control advocacy in the last fifty years? What can we learn from this remarkable transformation to understand the relationship between culture and public health? And what does the uneven adoption of non-smoking across classes tell us about the utility of explanations that imply that a uniform “culture” blankets a society?

We have two goals in this paper. First, we review how “culture,” as an analytical category, has been taken up by public health scholars who have studied the decline of smoking in Europe and North America. After demonstrating the shortcomings of existing approaches, we suggest an alternative view from cultural sociology, which, we believe, better illuminates the complex socio-cultural transformation of smoking. Second, we examine what many judge to be two major culture-related drivers of tobacco control in the U.S. — *the Surgeon General's 1964 Report on Smoking and Health* and the nonsmokers' rights movement— to illustrate why our proposed micro-sociological concept of culture is more supple and sensible for explaining the character of smoking decline than concepts deployed by other scholars.

Our focus on the U.S. reflects our U.S.-centered expertise, it does not imply that U.S. tobacco control represents “best practice.” On the contrary, among all the developed countries that have shifted their attitude toward cigarettes since the 1970s, the U.S. has neither the lowest per capita consumption nor the fastest rate of decline (Pierce, 1989). In tandem with our argument, we certainly do not suggest that a uniquely American culture fully accounts for either the decline in U.S. smoking or the still significant resistance to anti-smoking efforts. The transformation of beliefs and attitudes about smoking in the U.S. mirrors similar trends in European countries, albeit in varying degrees. We believe the way we propose to think about culture, not the specific content of American culture, can be generalized to other national contexts, and can open up the possibility of comparative studies.

1. Three ways to think about culture and smoking

In his magisterial account of the cigarette in American history, *The Cigarette Century* (2007), Allan Brandt observed that American society became “far more health-conscious since the 1960s—and more risk averse.” (p. 295) Cigarettes had been a symbol of elegance, of social acceptability, of glamour for close to half a century but no longer: “The cigarette had little standing in a health-conscious culture, increasingly skeptical of an industry whose self-interest had long since been exposed.” (p. 297) Overall, as Brandt efficiently puts it, “The product and its consumer had moved from the normative to the stigmatized” (p. 308).

About that conclusion, there is no dispute. But along the route to it, Brandt sometimes employs the concept of culture in a casual fashion that does not live up to *The Cigarette Century*'s overall sophistication. Brandt deploys “culture” as a factor to explain why Americans took so long to stop smoking after *the Surgeon General's 1964 Report* made it clear that cigarettes kill; for Brandt “American culture” is unusually voluntaristic and presumes it is an individual's responsibility to take up the habit or to quit it. Brandt refers to “widely shared libertarian attitudes about both the role of the state and the behavior of individuals” and what he dubs “the American individualist credo, ‘It's my body and I'll do what I please’” (p. 280). Although Brandt recognizes ambivalence in American culture over voluntarism, especially over addictions, he concludes, “As a culture, we seek to insist—despite much powerful evidence to the contrary—that smoking remains a simple question of individual agency, personal fortitude, and the exercise of free will” (p. 443).

Brandt's task was not to elucidate a theory of culture, but nevertheless he operated with one, even if he marshaled it rather gently, and even if his epilogue recognizes that the theory needs to be altered, if not abandoned. His conception of a deep-seated, largely uniform, change-resistance culture—which we will call the “deep values” approach—usually appears in the literature on tobacco control with references to “American individualism” (Bayer and Colgrove, 2004) or “American Puritanism” (Kluger, 1996) or “American anti-paternalism” (Kagan and Vogel, 1993). In each case, culture seems to be a much more coherent “thing” than it is, even in the face of observations that “American culture” has many, and contradictory, strands.

We think there are good grounds for putting aside this “deep values” approach to explain the decline in smoking. It implies a cultural homogeneity that does not exist in reality. Not all Americans are preoccupied with the language of the individual or personal; some are attached to social justice, biblical or civic-republican commitments (Bellah et al., 1985; Horowitz, 1983) or to forms of fraternal solidarity around unions or neighborhood loyalties. Moreover, it lacks specificity with respect to how culture works (Schudson, 1989). For example, if American culture is a set of general abiding values that characterizes the society as a whole, such as individualism, voluntarism, Puritanism, and anti-paternalism, why is the change in smoking more pervasive among more affluent and educated Americans? Why do these values fail to prevent a sharp move away from pro-smoking attitudes?

Another concept of culture in the literature on tobacco control emphasizes that “(persuasive) messages” can change health-related attitudes and beliefs. Scholars cite communication of scientific facts about smoking, their diffusion across various media and borders, and all the other promotional ways of “telling” as processes through which the meaning of smoking changes (Studlar, 2014). The *Surgeon General's Report on Smoking* in 1964 (USDHEW, 1964), in this vein of explanations, marks the beginning of a dramatic, authoritative, and well-publicized telling. The *Report* has been called the “first salvo in a public health campaign” (Stobbe, 2008, p. 46). The New York Public Library named it one of the top 100 books of the twentieth century (Warner, 2014). And scholars have called it a “landmark report” that “gave tobacco control a higher agenda status, and prompted new ways to consider it.” (Cairney et al., 2012, p. 131).

In the first three months after the publication of the *Report*, per capita cigarette consumption dropped 15 percent. Some who quit in those months, however, quickly relapsed, and by the end of the year the total decline was just five percent. Still, the *1964 Surgeon General's Report* is understood to be a notable example where “telling” made an impact. More generally, as Kenneth Warner writes, “information transmission played a significant and likely substantial role in altering, in order, knowledge about, attitudes toward, and behavior regarding smoking, especially among the more educated members of society” (Warner, 2006, p. 22). The Surgeon General's influence was not minimal, but it was by no means an inoculation that provided instant protection. Focusing on

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