Letter from . . . Finland

Smoking control policy and legislation

KIMMO LEPPÖ

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Finland's infant mortality rate ranks among the lowest in the world, 10 per 1000 live births in 1976; yet the adult male mortality rate is the highest in Europe. Much of the excess mortality is due to smoking-related diseases: the death rate for coronary heart disease is the highest in Europe and for lung cancer second only to that of England and Scotland. There is a striking difference from other Nordic countries. Differences in past smoking habits probably explain part of this—indeed most of it in the case of lung cancer. Finland's cigarette consumption was the highest in the world in the 1920s, and much higher than in other Nordic countries until the late 1930s.^{1 2} Until 20 years ago cigarettes were mostly of Russian type with a high tar content (35-45 mg).³

In the 1950s, after the publication of the pioneering studies in Britain and elsewhere on the health hazards of smoking, responsible bodies in Finland began to call for antismoking measures. In fact, in 1961 the Finnish Parliament unanimously called on the Government to institute strong measures to reduce smoking, and to consider legislation for restricting sale of tobacco to minors and for limiting advertising of tobacco products. Successive commissions, committees, and working parties then made proposals and recommendations for increasing health education; restricting advertising, sales to minors, and smoking in public premises; and increasing taxation. Any report suggesting drastic measures was accompanied by a strong dissenting opinion from representatives of the tobacco industry and trade, and sometimes even from the Treasury. Although few practical results followed, there were, for example, restrictions on television advertising and voluntary agreements on advertising standards between the tobacco industry and the Ministry of Trade. Health education activities remained scattered and uncoordinated, lacking funds, organisation, and leadership. Cigarette consumption increased year by year, except when tax increases were made for fiscal reasons.

Reporting in 1973, a Ministry of Social Affairs and Health committee recommended a variety of measures, which for the first time included concrete proposals for legislation. In spite of the minority report by representatives of the Treasury and the Ministry of Trade presenting legal and technical arguments, the Ministry of Social Affairs and Health called for a comprehensive health-oriented smoking control policy and, if this required legislation, a draft Bill. Proposals for legislation were prepared in 1974 and after wide consultations a government Bill was published in 1975. The Act was passed by Parliament in August 1976—15 years after it had demanded strong measures.

Health Department, Ministry of Social Affairs and Health, Helsinki, Finland

KIMMO LEPPÖ, MD, deputy director

Strategy

To achieve a reduction in smoking and its health hazards four major sets of measures were proposed by the Ministry of Social Affairs and Health—namely, health education, price policy, restrictive measures, and supporting research and development. A combination of these measures was thought desirable because none of them was likely to succeed in isolation. Moreover, comprehensive and synergistic policies probably work better than campaigns on a single front when there are conflicting influences.^{1 4}

HEALTH EDUCATION

In health education the main problems were lack of resources, deficiencies in organisation, and lack of defined responsibilities, leadership, and co-ordination; without these there is little chance of success, however convincing the message. The chief needs therefore were for funds and other resources and for co-ordinating activities among separate branches of administration. Provisions concerning funding and organisation of health education activities could be incorporated in any wider legislation.

PRICE POLICY

In price policies two measures were considered to be paramount: obligatory price checks on cigarettes at least twice a year and a differential taxation based on the content of harmful substances. Both measures required new legislation. This was proposed by the Ministry and met with fairly broad approval from the Cabinet but was postponed, mainly because an overall revision of the excise duty legislation as a whole was under scrutiny by a state commission.

RESTRICTIONS

Only limited restrictions on *industry and trade* could have been carried out without new legislation. Our experiences of voluntary restraint on advertising and sales promotion in general has been discouraging. Apart from differential taxation, the best way to influence the type of cigarettes produced seemed to be to set upper limits for harmful constituents to phase out the brands with greatest hazards, and to classify the remaining products as either "very harmful" or "harmful" according to their constituents (tar, nicotine, carbon monoxide, etc). Health warnings and declaration of contents on the packets would reinforce the health education messages. This policy would not be possible without legislation giving new powers to the authorities concerned.

Restrictions on *smoking in public premises and transport* were motivated partly by knowledge of the harmful effects of passive smoking but more by the "rights of the non-smoker" argument,

and perhaps most by the expected impact on public opinion. Personally, I believe that, although the direct health impact of such restrictions is limited, their indirect influence is very important because of their visibility and propaganda value. We were not, however, able to work out a practicable formula for restricting smoking in work premises, potentially the most important restriction of all. Extensive restrictions in public premises and the prohibition against selling tobacco products to minors were proposed and passed into law without any protests.

RESEARCH AND DEVELOPMENT

Research and development, as we found, are necessary to any evolving policy. Apart from the international scientific evidence,⁵⁻⁸ the most powerful evidence was from the half-yearly Finnish surveys from 1974 onwards,⁹⁻¹¹ covering smoking habits and opinions about policy measures. These showed alarming trends in smoking and at the same time a readiness of the public to accept strict control measures. Those who claimed that legal restrictions on advertising ran against the basic values cherished by the Finnish people had to shift their ground when constant monitoring of public opinion showed 85-90% of the adult population to be in favour of them. Critical evaluation and monitoring of responses to the implementation of policies are of the utmost importance. Then policies can be further examined and strategies improved.

Legislation and its implications

The main regulations embodied in the new law are:

- (1) except for excise duties, the administration of tobacco affairs is mainly in the hands of the health authorities;
- (2) a sum corresponding to at least 0.5% of the tobacco tax revenue is to be set aside annually in the State budget for the development of health-orientated tobacco policy—that is, health education, research, and evaluation (in 1977 temporarily 0.1%, about \$250 000);
- (3) the advertising and sales promotion of tobacco are prohibited from 1 March 1978;
- (4) the Government is responsible for fixing the limits of harmful components of tobacco products—that is, tar, nicotine, and carbon monoxide—and tobacco products can be classified as “very harmful” or “harmful” on the basis of the amounts of harmful constituents, subject to a government decision on the criteria for such classification;
- (5) the marketing of tobacco products requires a certificate obtainable from the central health authorities after inspection of goods in the State Research Centre (the permit is given provided that the composition of the cigarette smoke meets government specifications);
- (6) tobacco products shall be permanently subject to quality control;
- (7) a warning of harmful effects of smoking shall be printed on retail packages;
- (8) the sale of tobacco products to persons under 16 is prohibited;
- (9) the sale of tobacco products from vending machines is permitted only where the machine is under supervision;
- (10) smoking is prohibited in all public spaces and public transport facilities except in separate areas allowed for it;
- (11) the central agency of health administration, the National Board of Health, will be responsible for nationwide educational measures to reduce smoking as well as for the co-ordination of necessary research activities and critical evaluation of the developments in smoking patterns and smoking-related diseases.

One element in a truly health-orientated smoking control policy is missing—namely price policy. There is growing evidence on the importance of price policy as a determinant of cigarette

consumption, especially among young people; and my personal guess is that the time will be ripe for new legislation on price policy in a few years. Meanwhile price policy measures that can be carried out under the current legislation will be used so far as politically possible.

Massive publicity in Finland has surrounded the Government's policy and the Tobacco Act. Like the Norwegians,¹² we feel that the public debate itself is contributing to change. No one can say any longer, in response to the scientific arguments, “If it really is true that smoking is as dangerous as it is claimed, why doesn't the Government do anything?” And, interestingly, the proportion of people who say in surveys that there is conclusive evidence on the role of smoking in cancer and heart disease suddenly rose recently at the time when the new legislation was receiving publicity.¹⁰

On the whole the new strategy and legislation has been well received by the public and its implementation has proceeded smoothly without any major problems or fuss. The enthusiastic activity and co-operation of health and education authorities and voluntary organisations and their personnel at all levels have been encouraging. We are training personnel on a massive scale and launching health education programmes directed at specific groups of the public, partly on the basis of the experiences gained in the North Karelia project for heart disease control.¹³

Politically the process has been interesting. The strategy was initiated by a coalition government of the moderate left and the centre parties. The Bill was presented by a caretaker government and carried through Parliament (which has a non-socialist majority) by a unanimous vote. The Act was implemented by a minority government of centre parties.

On law and liberty

The philosophy in our approach has been one of “rule-switching”: instead of allowing smoking unless specifically forbidden the general rule now is that smoking in all public places is *prohibited unless specifically allowed*—and then it must be in separate areas provided for it. “No smoking” now prevails in nurseries, schools, hospitals and other health facilities, cinemas and theatres, and conference halls, and also in the waiting rooms of such premises to which the public has free access.

The provisions for no-smoking areas have been overwhelmingly welcomed even though they restrict individual liberty. The question of principle is, of course, whether individuals are free to cause harm or nuisance to other individuals, and the unequivocal answer in our country was “no.” But these questions were never even raised in the Cabinet or in Parliament. This suggests that the time was long overdue for introducing such measures. There was, in fact, a profound debate in Parliament on the issues of freedom and constitutional liberties but on a quite separate issue, that of advertising and sales promotion. The Parliament's Select Committee on Constitution decided, after a thorough examination of the matter, that the constitutional liberties of free speech, freedom of the press, and freedom of expression are not jeopardised by restrictions on sales promotion or advertising, and that the restrictions can be looked on as normal legal regulation of business and trade, not requiring the complicated procedure of constitutional legislation. The original purpose of these constitutional liberties was to guarantee free criticism of the Government and authorities and not of the sales promotion of life-endangering substances.

Many of the burning issues of future health policies concern changes in life style, patterns of consumption, and social circumstances that would conflict with the interests of industry and commerce. The decisions of Parliament are an important step in the long process *from an implicit tobacco policy serving predominantly commercial and fiscal interests towards an explicit health-oriented smoking control policy*.¹⁴ The principles adopted

in this policy and legislation would be applicable in other fields of a so-called "structural health policy."¹⁵

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Dynamic Approach to Adolescence

The adolescent process

K S PERINPANAYAGAM

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Treating the disturbed adolescent means looking at different aspects at the same time. To discover the best way of handling him within his total situation many different factors must be taken into account—notably the adolescent process, the pathology of the adolescent, and the force of the ripples he creates in those around him that rebound on him.

If drugs have to be used, then these, with their pharmacological and multiple psychological effects on him and those around him, will further complicate the picture.

A time of rapid change

Several rapidly occurring changes and new capacities develop in the adolescent all at once. He must exercise and test out his new capacities and, at the same time, try to adjust to these continuing changes. The greatest physical and intellectual growth occurs during these years; there are also hormonal changes and their consequences and intrapsychic conflicts.

Rapid physical growth and body changes alter his body image, strength, agility, and speed, while rapid intellectual development increases his thinking ability. He becomes critical in his thinking and interested in philosophical ideas, and may participate in idealistic ventures. He begins to realise that his parents are not the omnipotent, omniscient creatures he thought they were, and he becomes critical not only of what they are doing now but also of things in the past.

The activity of the endocrine glands produces the beginning of sexual maturity, with development of the sexual organs and their functions and the secondary sexual characters. Powerful sexual feelings re-emerge, taking the form of the only such

feelings he has experienced—infantile ones; but this time, being modified by the demands of society, the attitude of his family, and his own sense of decency, they appear in a disguised and acceptable way. The Oedipus complex—love for the parent of the opposite sex and rivalry with the parent of the same sex—rarely appears in this clear and simple manner. Nevertheless, these elements are almost always present, and in their modified and well-defended form they are often experienced as denial,¹ so that the adolescent resents any signs of closeness or affection from the parent.

He looks forward to his impending independence, freedom, and adulthood, but is frightened of the new world ahead of him, afraid of letting go the only security he knows, his dependence and relationship with his parents and home, even though he does not think much of these.

Anger and ambivalence

He is an intensely angry young person because he is bursting with energy and excitement, wanting to rush out, experiment, and live, but is being curbed by everything around and within him—by society, the law, lack of money, his parents and the authorities, and most of all his own fear and feelings of inadequacy. Parents are felt to be the chief offenders and bear the brunt of this anger and rebellion. At the same time he still loves his parents and needs them, and feels bad about his feelings of anger. He becomes depressed, confused, and insecure, particularly when he does something that he does not like doing; so he joins groups and gangs to gain their support. Such activity leads to agonies of guilt, which is denied because it is too painful. These powerful ambivalent feelings are sometimes split and attached to different people, and he may intensely love one adult and intensely hate another. He may attach the different valences of his feelings to his parents if the parents do not get on well with each other. These feelings are often displaced on to authority figures in schools and inpatient units. Some adolescents find the angry feelings about their parents so unacceptable that these feelings remain unidentified and they become inexplicably unhappy and depressed.

Brookside Young People's Unit, Goodmayes, Essex IG3 8XJ

K S PERINPANAYAGAM, MB, MRCPsych, consultant psychiatrist and medical director