Critical analysis of the Finnish Tobacco Act: implementation and legitimacy, 1977–89

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Abstract

Objective **– Finland was among the first countries to start a comprehensive health-oriented tobacco policy by legislation in 1977. However, smoking did not decrease in the 1980s. This paper analyses the implementation and legitimacy of the Finnish Tobacco Act from 1977 to 1989.**

Methods **– Documents and studies concerning tobacco policy were analysed by qualitative content analysis.**

Results **– Initially, the act provided good opportunities to control smoking. Some problems were known from the beginning; for example, tobacco pricing policy did not feature in the legislation, which diminished the possibilities of smoking control. More problems were found in implementation: parliament reduced the resources for anti-smoking activities and allowed the funds to be used for general health education. The national health authorities allocated less funding for anti-smoking activities. The implementation of the advertising ban was ineffective. The implementation structure was centralised; legislative and marketing expertise – needed in the implementation of the advertising ban – was almost non-existent. No administrative body had smoking control as a primary interest. The "light cigarette" policy was implemented successfully but it may have contributed to higher smoking rates by implicitly promoting low yield cigarettes as an alternative to not smoking. The active planning of a health-oriented tobacco policy ceased, but nothing was brought in as a substitute. Monitoring was efficient but based on insufficient indicators. Changes in adolescent attitudes and school smoking policies suggest the decreasing legitimacy of the act in the minds of people.**

Conclusions **– To be effective, health-oriented tobacco legislation must include adequate provisions and it must be properly implemented. "Watch-dog" activity is needed to keep smoking in the limelight as a public health problem, and to monitor parliament and administration to assure maximum benefits from national tobacco control regulations and flexible responses to emergent tobacco control problems.**

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Introduction

Finland was one of the first countries to start a comprehensive health-oriented tobacco policy by legislative measures. The passing of the Finnish Tobacco Act[1] in 1976 was the accomplishment of a long term goal which had required major efforts by health administration and members of parliament as well as voluntary bodies.[2] The act restricted marketing and banned tobacco advertising. It allocated resources for smoking control, research, and development and gave a general framework for anti-smoking health education. In accordance with theories of rational planning, monitoring and evaluation were emphasised in the act.

This comprehensive legislation was regarded as a powerful tool for reducing smoking, and it was commonly believed that it would solve the smoking problem. This belief was supported by the fact that there was a sharp decline in smoking in the 1970s (figures 1 and 2), when the public debate on health hazards and on tobacco legislation was lively.[2] At the end of the 1970s consumption of tobacco products in Finland was among the lowest in Western European countries.[3] However, soon after the enforcement of the act the decreasing trend levelled off; at the end of the decade, female and adolescent smoking started to increase (figure 2). Although Finland still kept its position as a country with a low consumption of tobacco products,[3] it was far from a smoke-free society (figures 1 and 2). In 1989–90 smoking figures for 13 to 15 year-olds were the highest among 11 European countries and Canada.[4,5]

The possible reasons for this unexpected development include the following: (*a*) the provisions (policies) expressed in the act were inadequate; (*b*) the act was poorly implemented; (*c*) changes in Finnish society or in

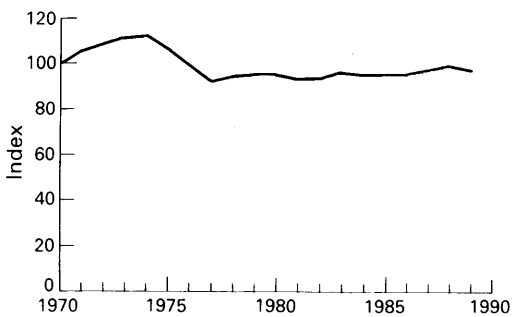

Figure 1 Index measuring the consumption of all tobacco products in Finland from 1970 to 1989 (index in 1970 is marked by 100)[6]

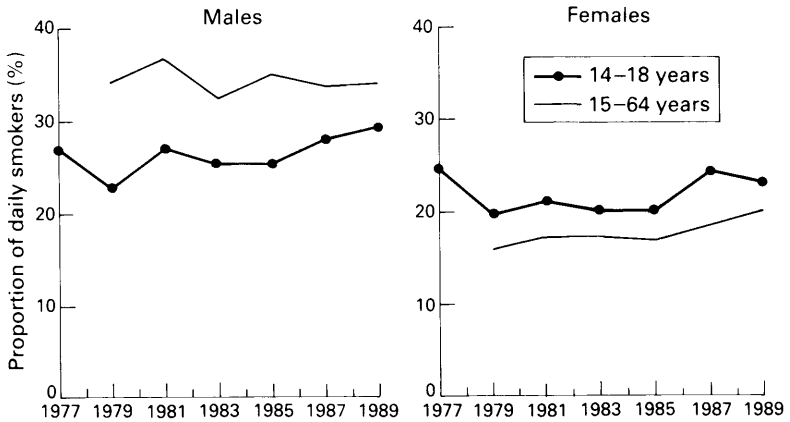

Figure 2 Proportion of daily smokers (%) in Finland from 1977 to 1989 among adolescents and adults[6,7]

other policies negatively influenced smoking rates; and (*d*) these factors, separately or in combination, could have weakened the legitimacy (acceptance and obedience) of the act in the minds of the people, and this contributed to the unexpected figures.

In her review of tobacco legislation in 1982, Roemer suggested that an important task for the future would be to examine the ways in which legislation is implemented.[8] However, because the implementation process of a public policy programme has been seen as a black box, and interest has been mainly directed towards the programme and its outcome objectives, it is natural that only a few studies have dealt with the implementation of tobacco legislation (for example, that by Leppo and Vertio[2]). The purpose of this paper is to analyse how the Finnish Tobacco Act was implemented and how the policies expressed in the act were redefined as time passed. Any signs of weakening in the legitimacy of the act are also examined.

Materials, methods, and concepts

Under the principles of implementation analysis[9] the following material was analysed by qualitative content analysis: (*a*) documents concerning national health administration: the Tobacco Act and Ordinance, the act, memos of the tobacco policy task forces and committees, yearly disposition plans of the §27 appropriation, orders and instructions issued by the National Board of Health, advertising cases reported to the National Board of Health, and other documents, as well as (*b*) statistics and previous studies.

Implementation was defined as a function of policy, formulator, implementor, outcome, and time.[9] As this was applied to the Tobacco Act, the policies were the goals of the act, the provisions of the act (means), and the goal-means relationships expressed in the legislation; the formulators were those who drew up more detailed programmes on the basis of the act; the implementors carried out the programmes; and the outcomes were the consequences of what had been done – for example, a reduction in smoking rates.

The distinction between policy formulation and policy implementation depends on the level of analysis in the administrative hierarchy. Here, the main emphasis was on the national health administration which implemented the policies of the government and parliament, but which was a policy formulator for provincial and municipal authorities. The formulators and implementors operate in an implementation structure. The implementation structure consists of the actors in one or various organisations who are responsible for the formulation and execution of the programmes.[9]

Implementation can be seen as evolution.[10] This means that the goals are redefined, the means to achieve them are changed, and the outcomes are reinterpreted as time passes. Fourteen years have passed since the enactment of the act. It is not appropriate to examine implementation without examining how the policies and programmes have been reformulated and changed.

Here, the concept "legitimacy of an order" introduced by Max Weber[11] (see also Berg[12] and Held[13]) is applied to the Tobacco Act. The act regulates the everyday behaviour of the tobacco industry, the retail trade, and people, especially smokers. The goals of the act cannot be achieved unless these groups adhere to the provisions of the act (orders). The provisions can be adhered to from motives of pure self interest or on a customary basis. But the adherence is much more stable if the provisions enjoy a prestige of being considered binding, or as called by Weber, of "legitimacy." "Legitimacy" refers both to people's opinions and to their behaviour. The legitimacy of an order is strengthened by sanctions, but the acceptance must not be based solely on fear of punishment but also on moral acceptance. If the act is considered a legitimate order, people and interest groups are compliant and obey the orders, they have positive attitudes towards the law, and they accept it.

The legitimacy can be ascribed to an order (here, the act and its individual provisions) in several ways, such as tradition, belief in an absolute value, and affectual attitudes. Today the most usual basis of legitimacy is the belief in legality and the readiness to conform to rules which are formally correct and have been imposed by accepted procedures – for example, laws passed by parliament, which is the case with the Tobacco Act.

The legitimacy of the act was operationalised here by measuring the attitudes towards the provisions of the act and by measuring the actual behaviours (compliance and obedience) of those whose actions the provisions of the act regulated.

Results

OUTCOME INDICATORS

The goal-means hierarchy of health-oriented tobacco policy (a modified version of that of Leppo and Vertio[2]) is presented in table 1. Outcome indicators were derived from that hierarchy. Lung cancer incidence would be a tobacco-specific indicator of public health.

*Table 1 Main means of reducing the health hazards of smoking**

Means	*In the Finnish Tobacco Act*
1 REDUCING SMOKING RATES	
1.1 Health education	Funds
1.1.1 Schools	
1.1.2 Health care	
1.1.3 Voluntary organisations	
1.1.4 Mass communication	
1.2 Total ban on advertising and sales promotion	Yes
1.2.1 Giving instructions (lower authorities, industry, trade; preliminary decisions guiding advertising practice)	
1.2.2 Supervision (of the act; prohibition to continue the activity in contravention of the regulations; reinforcement of the prohibition by a fine; possibility to revoke a certificate of inspection; fines and imprisonment for offences; possibility to oblige the manufacturer to correct misleading product information)	
1.2.3 Assurance of compliance	
1.3 Sale prohibitions	Yes
1.3.1 Giving instructions	
1.3.2 Supervision	
1.3.3 Assurance of compliance	
1.4 Smoking restrictions	Some
1.4.1 Supervision	
1.4.2 Signs showing the rule	
1.4.3 Assurance of compliance	
2 CONSUMPTION OF PRODUCTS CLAIMED TO BE LESS HAZARDOUS	
2.1. Changing the product	Yes
2.1.1 Upper limits for harmful substances	
2.1.2 Pre-market licensure	
2.1.3 Continuous quality control	
2.1.4 Possibility of banning harmful substances	
2.2 Product information	Yes
2.2.1 Classification of cigarettes	
2.2.2 Approval of product information on packages	
2.3 Health education	Funds
2.3.1 Product information printed on retail packages	
2.3.2 Other health education	
3 REDUCING INVOLUNTARY SMOKING	
3.1 Restrictions in public places, schools, nurseries, etc.	Yes
3.1.1 Supervision	
3.1.2 Signs showing the rule	
3.1.3 Assurance of compliance	
3.2 Restrictions in worksites, cafés, restaurants	No
4 PLANNING, MONITORING, AND RESEARCH	Funds
5 PRICE POLICY	No

* Modified from Leppo and Vertio.[2]

However, since the time lag between smoking and contracting cancer is at least 20 years, lung cancer cannot yet be used as an indicator of the effectiveness of legislation. Intermediate indicators[14] have to be used instead (table 1). Data from a limited number of indicators are available.

Use of tobacco

Tobacco consumption and juvenile smoking decreased in the 1970s before and after the enactment of the act and remained steady in the 1980s. Smoking increased in adolescents and females at the end of the decade (figures 1 and 2).[6,7,15]

Advertising ban

After the ban traditional advertising stopped, but the retail trade and the tobacco industry circumvented the ban by using new strategies.[2] Empirical data on the effects of the total ban on advertising and sales promotion were collected by surveys as late as 1989. They showed that advertising had not ceased. More than half of the adults and adolescents questioned had seen tobacco advertisements during the previous month.[16,17] Research also revealed some well-planned tobacco promotion strategies of the international tobacco industry.[18]

Sales prohibition

Tobacco sales to minors under 16 were prohibited in the act, but the percentage of 14 year olds who had been able to buy tobacco from kiosks and shops increased in the 1980s[7] (table 2).

Use of "light" cigarettes

In 1981 cigarettes were classified as "harmful" and "very harmful." The "harmful" cigarettes were those which had lower yields of harmful substances in standard measurements than the "very harmful" ones (see the "light cigarette" policy) and which – for that reason – are often called "light" or "low yield" cigarettes. In 1989 the upper limits for hazardous substances in "harmful" cigarettes were 10 mg tar, 0·8 mg nicotine, and 8 mg carbon monoxide. Cigarettes exceeding these limits were classified as "very harmful." The proportion of purchased cigarettes classified as harmful ("light" cigarettes) increased from 15% in 1982 to 40% in 1990.[6]

Involuntary smoking

There are few data on smoking restrictions in public places, but the general impression has been that these have worked well.[2] Negative trends were observed in schools[7]: towards the end of the 1980s the percentage of pupils who reported that smoking was allowed in some places in their schools increased (table 2). The number of restaurants and hotels reported to have non-smoking areas increased between 1986 and 1989. The proportion of the population exposed to tobacco smoke at work or at home did not change between 1986 and 1989, but a slight decrease was seen in 1990.[15]

ADEQUACY AND REVISION OF POLICIES EXPRESSED IN THE ACT

Four cornerstones of a health-oriented tobacco policy are price policy, health education, restrictions, and research and development.[2] The first was missing from the Tobacco Act, as well as smoking restrictions in worksites, cafés, and restaurants (table 1).

Originally, §27 of the Tobacco Act obliged the state to set aside an annual budgetary appropriation corresponding to at least 0·5% of the estimated revenue from tobacco excise taxes for the purpose of smoking control. Acting upon the initiative of the Ministry of Finance, parliament stipulated smaller percentages (0·2–0·45%) between 1978 and 1985 and in 1987 changed the law permanently to correspond to 0·45%.

Another initiative to change §27 came from the national health authorities which claimed that it was more effective to combine anti-

Table 2 Some indicators of the effects of the act and attitudes towards it from 1977 to 1989. Values are percentages of 14–18 year olds*

Indicator	1977†	1979	1981	1983	1985	1987	1989
Bought tobacco during the last month (14 year olds):							
In kiosks	12	8	11	13	—	14	15
In shops	10	6	6	7	—	6	8
Perceived that smoking was allowed in some places in their school:							
14 year olds	12	6	5	6	—	14	16
16 year olds, upper secondary school	—	31	33	45	—	64	76
Perceived that smoking prohibition in school was hardly enforced at all:							
14 year olds	—	14	12	11	—	19	22
16 year olds, upper secondary school	—	31	33	45	—	64	76
Agreement with the statement "It is right that the Tobacco Act prohibits smoking in schools with children under the age of 16" (% of 14–18 year olds)	—	86	—	83	—	—	—
Agreement with the statement "It is right that the Tobacco Act prohibits the sale of tobacco to persons under 16" (% of 14–18 year olds)	—	89	—	86	87	83	—

* From the Adolescent Health and Lifestyle Survey.[5,7]
† Measured before the Tobacco Act came into force.

Table 3 Estimated amount of money (million FIM) for health education and smoking control in the state budget if no reforms of the Tobacco Act and no other changes in the budget had been made, and the actual amount, in 1989

Source of change	Estimated amount if no changes had been made in §27 appropriation of the act or the state budget		Actual amount in 1989	
§27 Appropriation	Original 0·5% of the estimated revenue from tobacco excise taxes:	13·9	Changed to correspond to 0·45% of the estimated revenue:	12·1
Separate appropriation for health education	Kept in the budget:	2·0	Abolished from the budget:	0·0
Other changes in the budget	Not done:	−0·7	Done:	0·7
Total		15·2		12·8
			Difference	−2·4

smoking health education with other health education activities (a lifestyle approach). In 1987 the purpose of the appropriation was changed so that the money could be used for any health education. At the same time health education funds (a small appropriation in the budget) were combined with the §27 appropriation (based on remarks by the State Revision Office), and there were some other minor changes in the budget. As a result, the combined funds available for smoking control and other health education activities decreased by almost one fifth (table 3).

IMPLEMENTATION STRUCTURE

The health authorities were responsible for implementing all the measures included in the act. Responsibility nationally was with the Ministry of Social Affairs and Health and with the National Board of Health subordinate to it. Provincial and local boards of health were answerable at provincially and municipally. An Office of Health Education, established under the National Board of Health in 1976, was given the main responsibility. At the end of the 1970s the supervision of the act and the purposeful use of the §27 appropriation were seen as main tasks of the Health Education Office. When new health education challenges appeared in the 1980s, manpower resources were increasingly allocated to other fields and the equivalent of only 1·5 people had anti-smoking action as their main duty.

There was a provision in the act for the appointment of an Advisory Board on Tobacco Policy to issue reports, to develop new initiatives, and to provide advice on policies, programmes, and priorities, but this was not taken up. Instead, these tasks were given to the new Advisory Board of Health Education.

IMPLEMENTATION

Use of the §27 appropriation

Under the original Tobacco Act the §27 appropriation had to be used for work in combating tobacco smoking, including research, follow up, and information. The annual disposition plan was prepared by the National Board of Health and fixed by the ministry. To find out how this money was used, I classified the projects in each annual plan into three groups, according to their title and a short description: where smoking control was (*a*) the main topic, (*b*) one of several topics, and (*c*) not included. At the end of the 1970s this money was used exclusively for smoking control. In the 1980s it was increasingly allocated to projects in which smoking control was one of several issues, and often only a side issue (table 4). After parliament changed §27 in 1987 (see above), only a third of the funds was used directly for smoking control.

Planning of a health-oriented tobacco policy

The planning function was being adopted as a routine task by the state administration as the responsibility of a newly-established Health Education Office. At the end of the 1970s this function was being supported by tobacco policy task forces which produced comprehensive plans incorporating goals, policies, target groups, and evaluation. In the 1980s these task forces were no longer appointed. The only planning was for the annual disposition of the §27 appropriation. Until 1989 no goals were set and only some general remarks about target groups or long term plans were made.

Under the act the National Board of Health should lead and coordinate necessary research and development to minimise the dangers caused by smoking. The national health authorities had to follow up the effectiveness of control measures, price policy, and smoking rates. After enactment of the act they had an active role in initiating research and development. Regular surveys on adults[19] and adolescents[15] were started, official statistics on tobacco consumption were compiled, and harmful substances in tobacco smoke and the health burden caused by smoking were measured. A publication series on health education was established and a tradition of national health education seminars created. Later in the 1980s the role of the national health authorities became passive and the §27 appropriation was used very little for commissioning research or holding consultations.

Table 4 Use of the § 27 appropriation of the Tobacco Act in 1987–90. Values are percentages unless stated otherwise

Use of funds	*1987*	*1988*	*1989*	*1990*
Smoking control and related	74	50	42	34
Health education or health promotion where smoking control may be included	13	23	27	30
Administration, publications	13	13	10	11
Not related to smoking control	0	14	21	25
Total	100	100	100	100
Amount (million FIM) used for anti-smoking	6·5	5·4	5·1	4·1

Monitoring of compliance with the advertising ban

Supervision and guidance/counselling were the responsibility of health authorities nationally, regionally, and locally but only the national authorities could prohibit any advertisements and reinforce this prohibition by imposing a fine. In 1978–88 approximately 150 advertising cases were reported to the National Board of Health. An account of how these cases were handled follows.

After the ban came into force several advertising cases were reported, most of them probably arising from a lack of knowledge about the ban. The National Board of Health adopted the strategy of issuing instructions and advising the law breakers. Information about the ban and how to supervise it locally was circulated. Those who had defied the ban were asked for an explanation and sent information.

In 1980 the National Board of Health adopted a stricter policy, since the tobacco industry was continuously putting the ban to test by introducing new methods of sales promotion and negotiations with it were proving futile.[2] There were two instances of advertising being banned. These were challenged by the tobacco industry, but the Supreme Administrative Court decided in favour of the health authorities.

In the first half of the 1980s fewer advertising cases came to the notice of the national health authorities; these were not actively investigated and reporting was not encouraged. No advertising cases were prohibited and no active measures taken, except for negotiations with the tobacco industry on the interpretation of the ban. Advertising cases were not properly managed: sometimes no replies were sent to people who reported the cases, and nothing was conveyed to those who were accused of breaking the ban. Responses were mild and contained no information about possible penalties, only expressing the hope "that your company will no longer continue advertising." No follow up on subsequent compliance was conducted. Typically, the administration of these cases took a long time. Sometimes (during annual summer festivals) this meant that, when decisions on prohibiting sales promotion had not been made by the national authorities, and the local health authorities were afraid of being challenged by the tobacco industry, sales promotion campaigns could continue.

More advertising cases were reported after 1988, partly because shopkeepers and magazine publishers were complaining about their competitors. The national health authorities issued new instructions about the supervision of the ban, appointed a task force to monitor tobacco and alcohol advertising, and banned six advertisements in 1988. These were again challenged by the tobacco industry, but this time the Supreme Administrative Court decided in favour of the health authorities in only half of the cases.

From the small amount of information available on the supervision of the ban locally, it seems that local health inspectors were poorly motivated.

Monitoring of compliance with sales restrictions

In 1977 the National Board of Health issued instructions on the supervision of the sales restrictions provision. Once it had been shown that sales restrictions were being violated more frequently (table 2), a small amount of funds were allocated for a campaign. The supervision of sales restrictions is the responsibility of the local health boards. There are very few data on the extent of this supervision. A shopkeeper who sells tobacco to minors can be fined. The statistics showed only three cases since 1978, all of which were brought soon after the law was put into effect.

Mass communication campaigns and health education

Several mass communication campaigns were arranged or supported by the national health authorities between 1977 and 1984.[20] Some of them featured explicit health messages. Fewer mass media campaigns were arranged from 1985 to 1987. One concerning involuntary smoking received an advertisers' award for excellence in social marketing. In another major and expensive campaign, sporting organisations using the slogan "No smoking team" were sponsored but the implementation of this campaign was considered poor as well as the benefits in relation to the money used for it.[21] A message of this campaign and others from the late 1980s – for example, "Nicotine for hungry people" – was not explicitly a health message but could also be interpreted as a moral message.

Health education is an integral part of universal comprehensive primary school education, and part of the nationwide primary health care programme.[2] However, there are hardly any data on how health education in schools, in the health care system, and in voluntary organisations was accomplished, or how it changed in the 1980s.

"Light cigarette" policy

The "light cigarette" policy was implemented effectively. The government used the authority granted in the act and stipulated upper limits for harmful substances in cigarette smoke.[2] These were gradually lowered (now 15 mg tar,

1·2 mg nicotine, 12 mg carbon monoxide). The national health authorities had the means of making sure that the stipulated changes took place in reality. Before it could be marketed a brand needed a certificate of inspection verifying the required investigation by the State Technical Research Centre, and arrangements for quality control.[1] The product information printed on retail packages also had to be inspected.

Further product modifications were promoted in 1981, when cigarettes were classified as "harmful" or "very harmful" according to the assumed health risks. Before this classification came into force, the national health authorities arranged a mass communication campaign, using the slogan "There is no such thing as a safe cigarette."

THE LEGITIMACY OF THE ACT

The legitimacy of the act and of its individual provisions was measured from the actual behaviour of those affected by them (obedience, compliance) and by people's attitudes towards them. Only a limited amount of data is available.

At the end of the 1980s only 3% wanted to loosen the present advertising ban, 57% of adults were in favour of the ban, and 26% were even in favour of stricter regulations.[16] Approximately the same proportion was in favour of the ban at the end of the 1970s, but reliable conclusions on any changes cannot be drawn because the research methods were not comparable. The retail trade and the tobacco industry had a low regard for the legitimacy of the advertising ban. They put increasing efforts into attempting to circumvent the law.[18,22] However, even these groups oriented their behaviour towards the ban because they tried to find new, indirect ways of advertising.

Two provisions of the act concern adolescents under the age of 16: the prohibition of cigarette sales and the prohibition of smoking in schools. The attitudes of adolescents probably reflect the lowest acceptance level in the population. Towards the end of the 1980s an increasing proportion of 14 year olds were able to buy tobacco from shops and kiosks (table 2). This suggests that among retail trade staff the prohibition on tobacco sales to minors was considered less important (table 2). Two results suggested that schools adopted more negative attitudes towards the school smoking prohibition and that teachers were less willing to control pupils' smoking: an increasing proportion of pupils reported that smoking was allowed in some parts of their school yard, and an increasing proportion claimed that smoking prohibitions were not enforced in their schools (table 2).

Charges for offences against smoking prohibitions in public places can be brought at the request of the owner of the premises and a person can be fined for smoking misdemeanours. According to the crime statistics, this has been done only once or twice a year. Some of the cases concerned smoking in schools.

Discussion

The objective of this analysis was to answer the following questions: Are the policies embodied in the Tobacco Act adequate? Is the act being implemented efficiently? Are there signs of weakening legitimacy of the act?

Although the Finnish Tobacco Act was considered comprehensive, the task of controlling smoking was more difficult as tobacco price policy was not included in the legislation. Attempts to do so were not successful when the act was prepared,[2] and attempts to raise tobacco prices to support smoking control were not successful after enactment of the law – in spite of supportive research evidence.[23,24] If tobacco prices had been regulated by the Tobacco Act, better results would have been achieved.[23,25] On the other hand, price is just one factor affecting smoking rates, and poor price policy should not be used as an excuse for weak action in other areas.

Inadequate provisions of the act were not the only threat to a health-oriented tobacco policy in the 1980s. Parliament carried out several policy reformulations which watered down the original goals. The appropriation in the state budget for anti-smoking actions was diminished. The reasons were explicitly stated as fiscal, but since the economic situation in Finland was good, a more likely explanation could be connected with the "representatives" of the tobacco industry in the Ministry of Finance.[26]

A further reduction in the anti-tobacco appropriation was made by parliament with the blessing of the national health authorities: the funds were rechannelled into general health education. This process was accelerated by a new "lifestyle" approach in health education adopted in place of the behaviour-specific approach, which was considered to be old fashioned. In implementation, the national health authorities continued the policy direction adopted by parliament and an increasing proportion of the appropriation was rechannelled to fields of health education and health promotion other than smoking control. That this could happen in Finland, which had tobacco control very high on its political agenda in the 1970s, can be explained by three things: an almost non-existent anti-smoking lobby in parliament, a lack of tobacco-specific health-oriented organisations, and a scarcity of voluntary movements and activities. In addition, a general belief that legislation would solve the smoking problem was still strong.

Some administrative structures contributed to this process. The implementation of the act was largely seen as the responsibility of one body in the national health administration that had many other responsibilities. No administrative body had anti-smoking as a primary priority. It was easy to replace anti-smoking activity by something else. This centralised structure did not easily promote voluntary action or action at lower administrative levels. An establishment of a central body on smoking and health to develop policy and coordinate smoking control activities has been empha-

sised.[27] The Finnish experience strongly suggests that such a body should not have other duties.

In the 1970s national health-oriented tobacco policy was efficient but based on long term plans made with the assistance of expert groups. This planning function was completely stopped in the 1980s. No goals were set in the annual disposition plans of the §27 appropriation, which was the only planning function in the decade. The rational planning of health-oriented tobacco policy stopped, and nothing was brought in as a substitute.

The monitoring of the health-oriented tobacco policy was based on outcome indicators developed at the end of the 1970s, such as smoking rates and total tobacco consumption. These measured the total effect of all legislative measures and policies and were insufficient in the 1980s. The lack of process evaluation indicators – for example, anti-smoking activities, where, and by whom – made it difficult to assess where the greatest problems were when adolescent smoking started to increase. The lack of monitoring of tobacco sales promotion meant that systematic sales promotion strategies went unnoticed. When the measurement of public attitudes was minimal, the signs that the acceptance of the act was being questioned were not noticed. The lack of rational planning and evaluation of health-oriented tobacco policies was one of the things hampering the development of more representative indicators.

The implementation of the tobacco advertising ban was poor and actions taken were weak or neglected. When advertising and sales promotion efforts were not stopped at the outset the tobacco industry started massive sales promotion and sponsoring activity. However, it also modified its advertising behaviour according to the rules of the act or decisions of the court. It might be suggested that a more active strategy by the national health authorities would have hindered or at least diminished these sales promotion activities. The Finnish experience shows that an advertising ban alone is not enough to stop all forms of advertising. But an effective implementation is also needed.

However, effective implementation is difficult without sufficient legislative and marketing expertise in the implementation structure, which was lacking in Finland. An analysis of the total ban on advertising and sales promotion[16] and of the advertising cases challenged by the tobacco industry in the Supreme Administrative Court also showed that the ban was not total, and minor revisions of the act would have improved supervision. Activity by local people and provincial and municipal authorities would have been needed in the supervision, but the centralised structure did not encourage this.

The "light cigarette" policy consisted of two parts: lowering the upper limits of harmful substances in cigarettes and pushing the use of less harmful cigarettes if quitting was impossible. The policy was successfully implemented, and the upper limits for harmful substances in cigarette yields are still the lowest in the world. It seems clear that reductions in the harmful substances in cigarette smoke from the very high levels before the act to the present ones contributed to an improvement in public health.[28] It also seems as evident that the "light cigarette" policy had unintentional consequences.

When the act was drafted the production of a safer tobacco product was believed possible. However, there were no data on the extent to which the policy of lowering cigarette yields would produce health benefits. Cigarette yields are measured using a standard laboratory method in which a smoking machine imitates a human smoker.[29,30] The yields measured are assumed to measure the smoker's exposure to harmful substances. It was already evident at the beginning of the 1980s that human smokers did not smoke the new "light cigarettes" in the same way as they smoked the old, high tar ones.[29,31,32] Finnish studies confirmed these results for the "harmful" and "very harmful" brands.[33,34] This meant that the yields obtained by the standard measurement method did not correspond to actual exposure levels. The conclusion was that, in terms of cigarette yield and health risk, the differences between brands of Finnish cigarettes classified as harmful and very harmful were negligible.[28,33] These new research data were not taken into account in the implementation. The original health-oriented classification of cigarettes, and the product information on the harmful substances, were not abolished from the cigarette packages. Recent studies have shown that a large proportion of the population still believes that there are differences in the health consequences of cigarettes[35] and that the population groups which are assumed to be the most health-informed (well-educated, females) smoked "light" cigarettes most frequently.[36,37] It is probable that the message of a national campaign using the slogan "There is no such thing as a safe cigarette" must have changed the message to imply also "but some cigarettes are less dangerous than others." When smokers or potential smokers receive such a message, they may, instead of stopping smoking, switch to a brand thought to be less harmful or start smoking such a brand. Thus, the cigarette classification may have turned into a sales promotion opportunity rather than a means of restricting sales, as was intended.

There were several omissions from the act about involuntary smoking, including smoking restrictions in workplaces, cafés, restaurants, etc. Small achievements were made but voluntary agreements were not effective in restricting smoking in worksites (see also Leppo and Vertio[2]). Had such controls been incorporated into the legislation, attitudes might have changed and a more favourable basis for smoking control developed. On the other hand, smoking restrictions in schools loosened, although these were based on legislation. Either the provision of the act was reinterpreted by schools or health arguments

for smoking restrictions were no longer considered important.

Signs of the weakening legitimacy of the provisions of the act appeared in the 1980s. Small changes in attitudes and school smoking policies were alarming. In addition, the Supreme Administrative Court no longer decided in favour of the health authorities in all advertising cases. All this suggests that a gradual shift towards a society in which smoking is again felt to be a personal right, and the neglect of health risks caused by smoking is accepted, was taking place in the 1980s. Ineffective implementation was one of the factors which certainly contributed to the weakening legitimacy of the act. Although much has been done and many innovative developments have taken place during the last few decades, permanent social change, which would have turned the wheel towards a smoke-free society, has not been effected.

Major achievements in health-oriented tobacco policy took place in Finland in the 1970s and at the beginning of the 1980s. In the 1980s the interest of the national health authorities, parliament, and voluntary organisations moved to other fields of health promotion. Very few new innovations in the field of anti-smoking were developed. There are good reasons to believe that, if there had been strong "watch-dog" activity among people and voluntary organisations, the changes in the act and the ineffectiveness in its implementation would have been much more unlikely. However, this kind of activity did not feature in Finland at that time.

This analysis confirms previous conclusions[8,38] that legislation is a necessary but insufficient condition for an effective health-oriented tobacco policy (see also Leppio and Vertio[2]). To be effective, legislation must incorporate adequate policies, and it must be properly implemented. "Watch-dog" activity is needed to monitor the decision making and activities of parliament, public administration, and the tobacco industry and to keep smoking in the limelight as a public health problem.

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Translations of abstract

Analyse critique de la loi finlandaise sur le tabac: application et légitimité (1977–1989)

Arja H Rimpelä

Résumé

Objectif: Le Finlande a été parmi les premiers pays à mettre en place une politique globale de lutte contre le tabac, à partir de la loi promulguée en 1977. Cependant, le tabagisme n'a pas baissé dans les années 1980. Cette étude analyse l'application de la loi de 1977 à 1989.
Méthode: On a procédé à une analyse qualitative de documents et d'études relatives à la loi de 1977.
Résultats: Au début la loi a fourni de bonnes opportunités de contrôler le tabagisme.

On connaissait aussi certains problèmes: par exemple, aucune mesure relative au prix des cigarettes ne figurait dans la loi, ce qui diminuait son efficacité potentielle. Par la suite, le Parlement a décidé de réduire les crédits affectés à la lutte contre le tabagisme et de les allouer à des actions générales d'éducation à la santé. Le Ministère de la Santé a également progressivement réduit les fonds disponibles à la lutte contre le tabagisme. L'interdiction de la publicité n'a pas été appliquée. La structure chargée de l'application de la loi était centralisée. Il n'y avait aucun juriste, ni aucun spécialiste en marketing. Aucune administration n'avait vraiment compétence pour faire appliquer la loi. Les mesures relatives aux cigarettes légères ont été appliquées avec succès mais elles ont peut-être contribué à augmenter le taux du tabagisme en faisant implicitement la promotion de ces cigarettes légères, à la place du strict arrêt de fumer. La planification d'une véritable politique de lutte contre le tabac a été vite arrêtée et rien n'est venu combler ce vide. L'évaluation était sérieuse mais basée sur des indicateurs insuffisants. Les modifications dans les attitudes des adolescents et dans les réglements adoptés par les établissements scolaires suggèrent que la loi a progressivement perdu de sa légitimité dans l'esprit des gens.
Conclusions: Pour être efficace, une loi de lutte contre le tabac doit comporter tous les éléments nécessaires et doit contenir les modalités d'application adéquates. Il est nécessaire d'instituer un système de surveillance pour veiller à l'application de la loi, maintenir la lutte contre le tabac comme priorité, contrôler l'engagement du parlement et de l'administration. Cette vigilance est aussi indispensable pour répondre correctement aux problèmes nouveaux qui peuvent survenir.

Análisis crítico de la Ley Finlandesa acerca del tabaco: observancia y legítimidad, 1977–89

Arja H Rimpelä

Resumen

Objetivo: En 1977, Finlandia se encontraba entre los primeros países en comenzar una política integral antitabáquica orientada a proteger la salud mediante la legislación. Sin embargo, el tabaquismo no disminuyó en los años ochenta. En este artículo se analizan la observancia y la legítimidad de la Ley Finlandesa contra el Tabaco de 1977 a 1989.
Métodos: Se aplicó el análisis de contenido a documentos y estudios sobre la política respecto al tabaco.
Resultados: Inicialmente, la ley brindó buenas oportunidades para controlar el tabaquismo. Algunos problemas se conocieron desde el comienzo; por ejemplo, la política de fijación de precios del tabaco no figuraba en la legislación, lo que disminuyó las posibilidades del control del tabaquismo. Se encontraron más problemas en la aplicación: el parlamento redujo los recursos para las actividades contra el tabaquismo y permitió que los fondos se emplearan para la educación sanitaria general. Las autoridades sanitarias nacionales asignaron menos recursos financieros para las actividades contra el tabaquismo. La observancia de la prohibición de la publicidad era ineficaz. Se centralizó la estructura de ejecución; casi no había experiencia legislativa y ni de mercadeo, necesarias para aplicar la prohibición de la publicidad. Ningún cuerpo administrativo tenia el control del tabaquismo como interés primario. La política del cigarrillo (liviano) se ejecutó con éxito, pero puede haber contribuido a aumentar las tasas de tabaquismo al promover implicitamente este producto como opción de la abstinencia. La planificación activa de una política antitabáquica orientada hacia la salud cesó, y no fué sustituida. El monitoreo era eficiente pero se basó en indicadores insuficientes. Los cambios en las actitudes de los adolescentes y las políticas escolares contra el tabaquismo sugieren que la legitimidad del acto de fumar está disminuyendo en la mente de las personas.
Conclusiones: Para que sea eficaz, la legislación antitabáquica orientada hacia la salud debe incluir disposiciones adecuadas y debe ejecutarse adecuadamente. La actividad de vigilancia es necesaria para mantener el tabaquismo en la actualidad como un problema de salud pública, y para vigilar al poder legislativo y al Gobierno con el fin de obtener beneficios máximos de las reglamentaciones nacionales de control del tabaco y las respuestas flexibles a los problemas que vayan surgiendo.

The Chinese translation will be published in the next issue.