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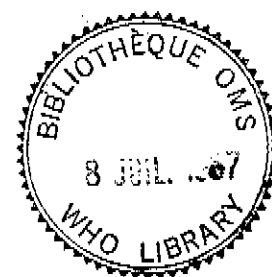
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COMPREHENSIVE SMOKING AND HEALTH PROGRAMME

PREVENTION: GOVERNMENT'S BUSINESS

by

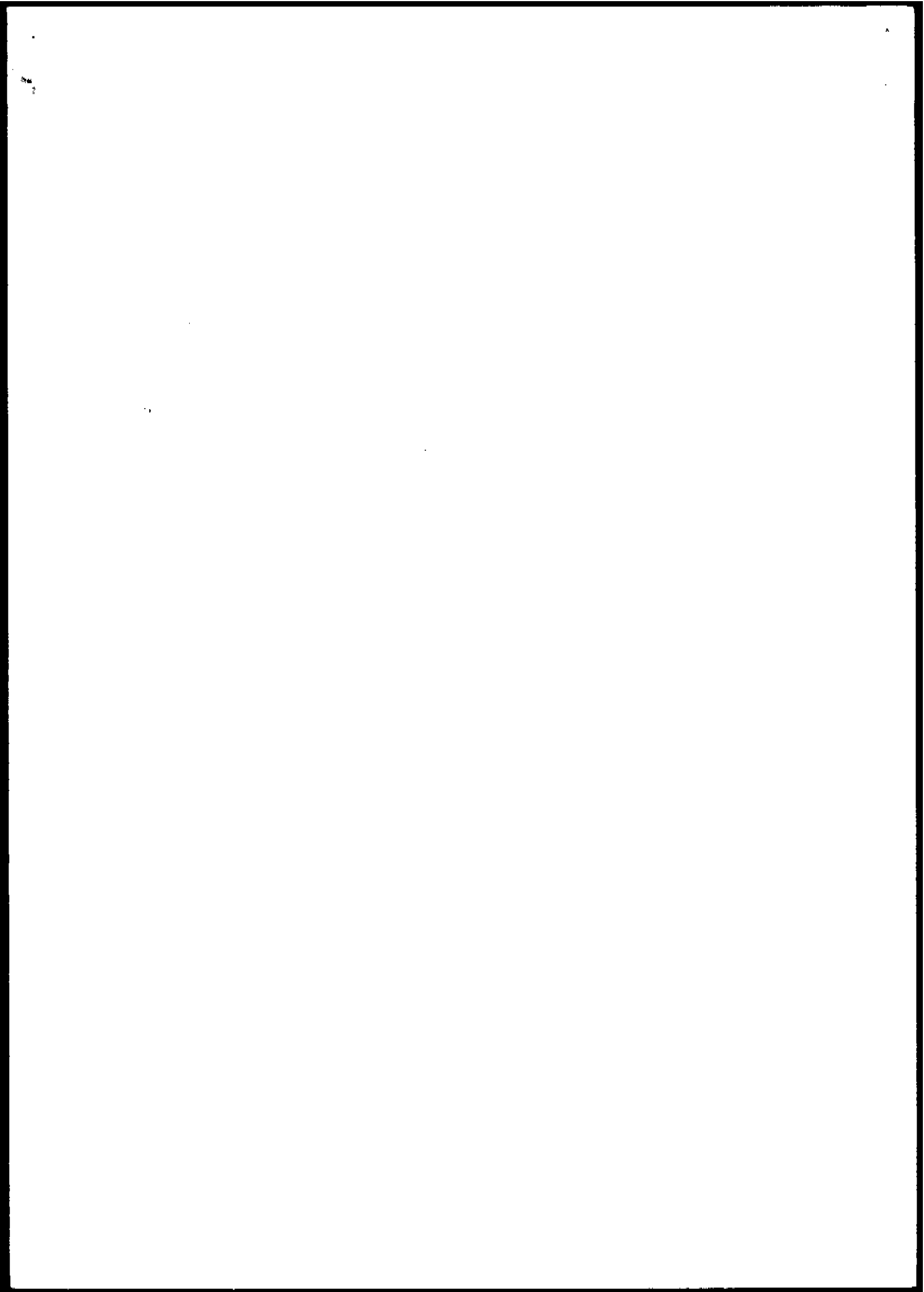
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A COMPREHENSIVE SMOKING AND HEALTH PROGRAMME

by Kjell Bjartveit, M.D., Oslo, Norway

First of all, I want to emphasize what this paper is not going to deal with. I shall not discuss the causative link between smoking and cancer, cardiovascular disease, respiratory diseases and the other smoking-related illnesses. I shall only remind you about the magnitude of this health problem, as expressed already in 1975 by a WHO Expert Committee (1):

" - smoking-related diseases are such important causes of disability and premature death in developed countries that the control of cigarette smoking could do more to improve health and prolong life in these countries than any other single action in the whole field of preventive medicine".

As far as cancer is concerned, the WHO Director-General says in his 1985-report (2):

"The use of tobacco, whether for smoking or for chewing, is cause-related to one-third of all cancers globally".

These statements make it imperative to control this global, manmade epidemic.

In this paper I shall try to review available smoking control measures. I hope you will bear with me that I use work in my own country as a framework for my presentation.

PLANNING OF A GOVERNMENTAL PROGRAMME

In Norway, work on a governmental programme started in 1967 when a committee, appointed at the request of the Parliament, presented a report entitled "Influencing Smoking Behaviour", recommending that smoking control strategy should be based on a combination of information, restrictive measures, and cessation activities (3). The effectiveness of this triple programme would be decreased if there were a lack of balance between the three components.

In 1970, the Norwegian Parliament endorsed the main points of this programme. An interdisciplinary Council on Smoking and Health was appointed by the Government, with the task of co-ordinating and supervising the Government's programme. The Council co-operates with various governmental agencies, and with voluntary organizations.

In 1974, to carry out the planning and execution of its activities, the Council acquired a permanent secretariat, with 5 full-time staff members.

A more detailed description of the Council's terms of reference will provide a review of the Norwegian governmental programme on smoking and health. Accordingly, we are going to deal with 5 main points, shown on the screen. This list will appear repeatedly in order to indicate how far we have progressed in this presentation.

INFORMATION CENTRE

First of all, the Council is required to obtain the latest information on research concerning smoking and health, and serve as an information bank. In this connection, when research findings and other news are released, the secretariat prepares summaries in special reports for the press.

EDUCATIONAL ACTIVITIES

Secondly, and of special importance, is the Council's obligation to develop and organize educational activities. I want to spend some time on this issue.

In a communication process, we are dealing with 3 factors:

- o Communicators, media
- o Receivers or target groups
- o Messages

Details on how this has worked within the Norwegian programme follow.

Communicators. Resources for information work will always be meagre, and this forced us to choose unconventional plans in order to meet the demand.

One of the cornerstones in this strategy was the establishment of a network of field-workers who are able to spread information and organize anti-smoking activities in their own communities. These field-workers are mainly public health nurses and schoolteachers with special abilities, who were trained in specially designed courses. A total of 300-400 field-workers have participated in the courses, and have been supplied, with informative material produced by the Council, including a collection of 80 slides. The field-workers are kept up to date on news in the smoking and health field, and the Council has advertised in newspapers that it is able to assist schools, parents' organizations, clubs etc. to obtain lecturers on the subject of smoking and health. The secretariat acts as liason arranging contact between various bodies and the local field-worker.

Also many other people are involved in information and education concerning smoking and health - for example, health and school personnel, voluntary organizations and mass media. It is mandatory to teach smoking and health in the basic schools.

In addition to these forms for direct communication, general information has been transmitted through series of large advertisements in all newspapers throughout the country. The advertisements have been designed in the form of interviews with prominent persons who state their views on smoking and health. Chosen persons include a popular radio reporter and a world skating champion. In connection with the International Year of the Child we printed advertisements emphasizing how smoking may affect younger generations.

In addition to these larger advertisements, shorter messages concerning smoking in relation to various diseases have been inserted in the newspapers.

Target groups. The Council has concentrated its educational material mainly on selected target groups. I shall mention 3 of them:

- (a) Opinion leaders, such as health and school personnel, politicians, media personnel and the large group of parents with small children.

The attitudes of opinion makers have an extensive radiating influence in the community; their example leads the course. Therefore, it is essential to reach these particular people.

The Council has carried out surveys on smoking habits among some of these groups, and has used the results in order to establish good contact with the many groups of opinionmakers, through various printed material.

(b) The next target group concerns students in schools and universities.

The Council has designed special informative material for schools, such as script and design kits for a puppet theatre.

(c) The third target group includes people who may be assumed to have strong motives for stopping smoking, in particular, patients with diseases related to smoking. A series of pamphlets for patients suffering from such diseases has been offered free of charge to physicians all over the country, the intention being that the physician himself should hand over the pamphlet to the patient, strongly advising him or her to break the smoking habit.

Messages. So far, we have discussed communicators, media and target groups. I should like now to consider the formulation of our messages. We have, of course, concentrated on the abundant material provided by statistical evidence. We very often feel that this message does not penetrate the mind of the general public, and particularly young people, whose reaction tends to be: This is just statistics, and statistics often lie; it won't happen me, and if it does, it will be in the very remote future when I'm going to die anyway.

For this reason, we have tried to formulate other messages, which may be easier understood, which talk about the immediate effect of smoking, which have a closer appeal to people's own situation - and therefore, hopefully, have a stronger motivating power. I shall give a few examples, illustrated by some of our educational material. We talk about the most common health consequence of smoking, cough, phlegm and chronic bronchitis - well known by the smokers. In this connection we explain what is happening to the cilia of every smoker - even the young ones, and our message is: You can get rid of these troublesome symptoms - almost immediately after you quit smoking. Closely linked to this message is the detrimental effect upon breathing and physical fitness, and how smoking causes emphysema - a disease which is not well known in Norway, but may be quite appalling if explained to the audience. Passive smoking is another problem, of which we feel people have become increasingly aware. We link the message to the

pollution problem and to the rights of the non-smokers to breathe in a smoke-free environment.

There is also the economic argument, which may be of some value in our country, where the price of a packet of cigarettes is relatively high, and we calculate the savings during the year at various consumption levels. Also, we underline the role of example and the responsibility to the next generation - no smokers want their own children to become smokers - and we know that many smokers have given up smoking for this very reason. We also point at a motive which may be decisive for many smokers: their own personal freedom, the right to be master in one's own house, and not slaves of an addictive habit, which is also harmful to health. As a whole, we try to find arguments which may provoke the smokers in their own situation.

RESTRICTIVE MEASURES

And now I shall leave information and education, and turn briefly to restrictive measures. This aspect will be dealt with tomorrow in another paper; here, I shall just mention that a Tobacco Act was introduced in Norway in 1975 resulting in total freedom from advertising pressure, and requiring health warnings on packets of cigarettes and tobacco (4,5).

CESSATION

The third part of a comprehensive anti-smoking programme, is cessation activities. I have to admit that this is the weakest part of our programme; much more advanced programmes have been launched in other countries using cessation clinics. In Norway, some pamphlets and "Help-quit-kits" are produced, and voluntary organizations run cessation courses.

As Michael Russel has pointed out, however, the most important step is that all practicing physicians involve themselves in smoking cessation, as an integrated part of their daily work (6).

EVALUATION

And now, the crucial question, what are the effects of a comprehensive programme? I am going to present some Norwegian data, but let me first say that I am quite aware that our figures are no proof - in the strict scientific sense - of a causal relationship with the introduction of the government programme. Only analysis of long term trends will one day perhaps make it possible to judge this difficult question.

But let me add another comment. Nobody ever expected the Norwegians to change their smoking habits overnight as a result of the Tobacco Act. In my view, freedom from advertising pressure, combined with our educational work, will essentially have an influence upon the young people who have not yet acquired the habit. Hence, it is clear that the effects on total tobacco consumption will appear gradually, as new generations replace older people with heavier smoking habits.

In this connection, it is of interest to look at the smoking rates for the youngest age group. Since 1957, nationwide surveys of smoking rates among students in the basic school have been conducted four times (7). Increasing rates were registered up to 1975, and smoking among girls in particular showed a dramatic and alarming increase, with rates in 1975 equal to or above those of the boys at all age-levels in the upper grades. In 1980, the rates were on the decline for both sexes, most pronounced for the girls, who at all age-levels were back again to lower smoking rates than the boys. Preliminary data from a new survey in 1985 shows a further decline in both sexes, but not so pronounced as between 1975 and 1980.

Sales figures also support a new trend after the Parliament decided to introduce a government programme (7). There was an increase in per capita tobacco consumption until 1970, the year when the Parliament discussed the issue and endorsed a government programme on smoking and health, including legislation. Since then, the per capita consumption has levelled out, and in recent years shown a tendency to drop.

The most important feature, however, is the extension of the regression line for the consumption from 1950 to 1970. If the upward trend for the 1950s and 1960s had continued in the 1970s and 1980s, we would have had today a per capita consumption which would have been about 25 per cent higher than it is. In my opinion, the shaded area illustrates what has been gained in recent years.

Per capita consumption in Norway today corresponds with the figures the United Kingdom experienced more than 30 years ago (7). Our figures are also below those of Britain in other respects; among males aged 60-69, the British lung cancer death rate is more than three times the Norwegian. Here again our figures are about 30 years behind the British.

What does this imply ?

It implies that, since the increasing trend in tobacco consumption has now been stopped, thus avoiding a rise to the level experienced in other nations with a history of longer and heavier smoking, there is no doubt that a considerable amount of human suffering has been avoided.

THE FINAL GOAL

And now, are we satisfied with this new development in the smoking epidemic ?

No, we are not.

In 1981, the Norwegian Medical Association passed the following resolution (8):

"The Representative Body of the Norwegian Medical Association urges the Government to work towards making Norway a smoke-free society by the year 2000.... Phasing out the consumption of tobacco is an important step towards improving the health of the nation".

This resolution has received extensive publicity. The doctors ask the Government not only to turn its attention to this avoidable health problem, but to rid the country of it within a reasonable time.

Recently, some World Health Organization groups (9,10) have proclaimed a smoke-free society, or eradication of smoking, as a target for preventive work; and in 1984, the US Surgeon General also declared that a smoke-free society was to be the goal of the United States of America (11).

Some will find this goal Utopian and unrealistic, and think that more time is needed to reach it. This may very well be so. The main point, however, is that

eradication has been set up as a attainable goal, and that this goal should be reached within the foreseeable future. This ought to be possible. With few exceptions, cigarettes started to invade the industrialized countries at the beginning of this century. It should be possible to get them out before we have gone too far into the next.

Now the questions arises whether or not the politicians are willing to take the necessary steps to reach this goal. Such steps could cost them their political career. We have already seen a couple of victims.

At the 4th World Conference on Smoking and Health in Stockholm, Sir George Young, the UK Junior Minister of Health, said that (12)

"... the solution to many of today's medical problems will not be found in the research laboratories of our hospitals, but in our Parliaments. For the prospective patient, the answer may not be cure by incision at the operating table, but prevention by decision at the Cabinet Table".

In 1980 in Oslo, at a World Health Day Conference, Sir George was given the topic: "Smoking or health - a choice for the politicians." He than said:

"The words might, I think, bear more than one meaning... Smoking is in every sense a political issue, and those politicians who concern themselves with it find themselves unexpectedly promoted or demoted."

Did Sir George have a presentiment ? One year later, Prime Minister Thatcher transferred him to another Ministry, where he would be less dangerous to the tobacco industry. Press-comments underlined the connection between this event and Sir George's commitment to anti-smoking legislation: "Representations by the tobacco industry against the Government's anti-smoking campaign are believed at Westminster to have played a part in persuading the Prime Minister to shift Ministers...". "I never knew the tobacco industry was so powerful," said a top civil servant (13).

MOBILIZING INTERNATIONAL ORGANIZATIONS

Defeats of this kind may imply temporary setbacks in our campaigns. More important obstacles, however, are that in many third world countries, tobacco production, manufacturing and trade count for a substantial

fraction of the gross national product, and provide the daily living for people who have no other alternative than starvation and hardship. The tobacco industry has indeed very cleverly utilized this situation.

With this background it seems at first glance hopeless to stem the epidemic.

What we need, therefore, is a worldwide political strategy for reaching the final goal.

We cannot expect the tobacco industry to support such a plan. They have had their chance, and have failed to show genuine concern about the serious health consequences of their products.

MOBILIZING POLITICIANS

What, then, are the prospects? The simple answer is that our goal will not be obtained unless politicians and the general public all over the world are mobilized on our side.

If we are to talk at all about reasons for failure of a government programme, the main one is that the programme has not been comprehensive enough, not radical enough, not global enough. The first to blame is the medical profession, which has been too passive and too soft. We have to realize that if we want to do something about the smoking and health problem, we are in politics. This will be dealt with in a paper tomorrow; in conclusion today, I shall underline that our task is to confront the politicians with the enormous magnitude of the problem, to get them to see what it is all about: the greatest epidemic of modern times. We have to get them out of a stage of only pretending serious concern, into a stage of active involvement and determination. Let us ask them: Do you really want to do something about the problem? Or is your involvement only a question of lip-service?

This does not mean that we have to become politicians. But we should realize that we all are political human beings, and utilize all possible channels to make the politicians stand up and take responsibility. One thing is for sure, without active political involvement, we shall never reach the final goal. Therefore, let us act, and let us act now.

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PREVENTION: GOVERNMENT'S BUSINESS

by Kjell Bjartveit, M.D., Oslo, Norway.

The organizers of this conference have not added a question mark to the title of my presentation. Obviously, they are convinced that this assertion is a matter of course; therefore, no need to question it.

I agree strongly in this view. When the community is facing serious epidemics and pandemics, government involvement is an urgent necessity. The whole community is under threat, and common action by the community, through its governing bodies, is imperative. This applies regardless of etiology, whether the epidemic is spread by a bacillus, or by a product, which again may be influenced by sales promotion, public attitudes, behaviour or fashion, the latter being sometimes even more contagious than microorganisms.

Traditionally, active government involvement in disease prevention implies a comprehensive programme, including health education and information, restrictive measures and legislation, as well as treatment; these elements being well balanced within the programme. The same principles apply also to the prevention of smoking.

In this context, restrictive and legislative measures are of particular interest.

What kind of legislative action can be used to combat the smoking epidemic? Professor Ruth Roemer has given a brilliant and thorough presentation of these measures; and here I shall just try to summarize them briefly. They can be grouped as follows:

Restriction of influences encouraging smoking

- (a) Reduction of explicit influence, for example, a ban on promotion. 15-20 countries have introduced this provision, which is in accordance with the recommendations from the World Health Organization Expert Committee: "There should be a total prohibition of all

forms of tobacco promotion". The Norwegian Tobacco Act ensures total freedom from advertising; this applies also to indirect advertising, i.e. tobacco products and scenes showing people smoking must not be included in advertisements for other goods or services.

- (b) Reduction of implicit influence, for example, freedom from smoking on television. Many broadcasting co-operations have rules which prevent reporters from smoking during programmes. It is more difficult to control films. Nevertheless, it is striking how little smoking there is in recent TV-series.

Requirements for influences discouraging smoking

- (a) Health warnings on tobacco-packets, including packets for export. Already in 1975, Sweden introduced a system of rotating warnings. Every brand shall carry 16 different warning texts, distributed equally at anyone time on the packets sent out on the market. The warning texts have been changed several times, in order to cover a broader range of health messages, and to attract greater attention. In Iceland, an even more sophisticated system of rotating warnings was adopted in 1985. Each of 8 different warnings must be printed in a specific colour, and include a drawing illustrating the message. In Norway, 12 different warnings were introduced in 1984, and since 1975, it is required that the warning on all packets shall include the official anti-smoking symbol. This symbol also appears on all official informative material on smoking and health. The idea is that this symbol will become so familiar to the public that its appearance will eventually serve as a message in itself.
- (b) Health warnings in such tobacco advertisements as are permitted in the absence of a ban. This provision is enforced in several countries.
- (c) Declaration on packets and in advertisements of emission levels of defined harmful substances. Swedish and Norwegian packets carry such declarations for tar, nicotine and carbon monoxide.

- (d) Mandatory health education, including mandatory funding. This is incorporated in the Icelandic and Finnish Tobacco Acts.

Sales restrictions

- (a) Limitation of sales outlets, i.e. number of shops permitted to sell tobacco, and of vending machines. In Iceland, it is prohibited to sell tobacco from vending machines, and to sell tobacco in schools and institutions for children and adolescents.
- (b) Limitation of hours of sale, for example, to normal opening hours for shops. So far, no country has introduced this provision.
- (c) Age limitations, i.e. prohibition of sales to minors. This is one of the most common restrictions; the Norwegian Act states that tobacco products may not be sold, or even handed over, to persons under 16 years of age.
- (d) An end to sales in health premises. Many hospitals are considering this step.
- (e) An end to duty-free sales. This seems, however, to be a sacred cow that no government has dared to even suggest.

Product restrictions

- (a) An upper limit of the ~~tobacco~~ content per cigarette (concerns also goods for export). So far, this has not been regulated by law.
- (b) An upper limit for emissions of defined harmful substances (concerns also goods for export). Finland has implemented a programme to gradually reduce such substances, and has now reached a maximum level of 15 mg tar emission per cigarette. In Oman, sales of cigarettes yielding more than 12 mg tar will be prohibited as from 1 January 1987. This means 70 per cent of all cigarettes now on the market.

Taxation

- (a) A general tax increase on tobacco products. This is undoubtedly one

of the most effective measures available, particularly with regard to young people. However, to achieve maximum impact and to prevent a waning of the effect over time, the exercise needs to be repeated at more or less regular intervals. In the U.K., a substantial decrease in consumption has occurred since the introduction of regular tax increases.

- (b) Selective tax increases, i.e. graded taxation depending on emissions of defined harmful substances. The U.K. has also implemented this kind of taxation, with successful results.

Restrictions on smoking

which establish non-smoking as a norm, and limit smoking to defined zones and/or times:

- (a) Restrictions on smoking in public places. This is included in the Icelandic and Finnish Tobacco Acts, and is introduced in many states in the United States.
- (b) Restrictions on smoking at places at work. In July 1985, the Norwegian Council on Smoking and Health proposed to the Minister of Health that a new section should be included in the Tobacco Act, establishing people's right to breathe in smoke-free indoor air, both in public places and at work. We are fairly hopeful that the Government will introduce a bill in accordance with the intention of this proposal.

This review of legislative measures - short version on the screen - presents an arsenal of potential weapons. The question now arises, what are their effects? Here we run into serious measurement problems. The usual requirement for scientific proof - a controlled trial - cannot be applied, as it is impossible to establish within one country two isolated communities, with identical demographic, social and cultural structure - as well as smoking habits - one subject to, and one not subject to, the legislative measure which we want to test. One possibility might be to study trends in consumption and smoking rates in comparable countries with and without a particular government action; however, here we face more difficulties: A government policy usually includes several elements, and analysis of trends does not tell us if a specific measure has been effec-

tive, has had no effect - or has been counter-productive. Also, most countries which are suitable for such a comparison of trends have introduced some sort of anti-smoking policy, although different weight may have been attached to the various components. Hence, it would always be possible to find explanations for dissimilarities - or similarities - in trends.

Some information may be obtained from specific studies, for example, on price elasticities, or from other fields where control of unwanted behaviour has been the target for government action. However, my point is that, since we have insufficient data from all these sources, we must reach a conclusion based upon observation of other barometers as well, where it may be impossible to express the readings in figures. I shall now refer to two of these.

First of all, we must not disregard people's experience - positive or negative - of various government measures. In this connection, I should like to emphasize that I am convinced that the ban on advertising in Norway has had an effect upon young people, who now grow up in an environment free from advertisements which glorify cigarettes as the key to success, self-confidence and adulthood. Also, the climate for information work was fundamentally improved; it became much easier to get the message through the usual barriers of inattention and ignorance.

This view is in agreement with the general concepts of the normative influence of legislation. Such action underlines how gravely the Government looks upon the problem; this reinforces and increases the effect of information work by giving the message the Government's sanction of authority. Here again, it is necessary to repeat an indispensable prerequisite for implementing legislative action: it must be integrated in a total, comprehensive, well balanced smoking and health programme, which includes both information and education, as well as cessation activities. People must be made aware of the motives for legislation, why the authorities have found this kind of action unavoidable. In such a comprehensive programme, legislation will function as a catalyst to the other elements of the programme.

We may ask if there are data to substantiate our general impression of a positive impact upon the smoking habits of the younger generations.

Nation-wide surveys of smoking rates among students in the basic school have been conducted five times since 1957 (fig. 1). Increasing rates were registered up to 1975, and smoking among girls in particular showed a dramatic and alarming increase, with rates in 1975 equal to or above those of the boys at all age-levels in the upper grades. During the preceding years, the tobacco industry ran extensive advertising campaigns aimed particularly at a potential female market, and without doubt, they were quite successful. In 1975, our Tobacco Act was enforced, ensuring freedom from this advertising pressure and introducing compulsory health warnings on all packets. In 1980, smoking rates among young people were on the decline for both sexes, most strikingly for girls. A further decline occurred in 1985, but not so pronounced as the drop between 1975 and 1980.

Since 1973, the Norwegian Central Bureau of Statistics has carried out annual surveys in representative samples of the entire adult population. Figure 2 gives the smoking rates for the youngest age group, 16-20 years. Because of the small size of the samples, somewhat more than 100 annually for each sex, the curves fluctuate. However, the trend is clearly downward for both sexes; if it continues, we may have a smoke-free young society by the year 2000 or shortly after.

Sales figures also support a new trend since the Parliament decided to introduce a government programme (fig. 3). There was an increase in per capita tobacco consumption until 1970, the year when the Parliament discussed the issue and endorsed a government programme on smoking and health, including legislation. Since then, the per capita consumption has levelled out, and in recent years shown a tendency to drop.

The most important feature, however, is the extension of the regression line for the consumption from 1950 to 1970. If the upward trend for the 1950s and 1960s had continued in the 1970s and 1980s, we would have had a per capita consumption today which would have been more than 30 per cent higher than is the case. In my opinion, the shaded area illustrates what has been gained in recent years.

The levelling off took place at a much lower per capita consumption than in the U.K.. Also lung cancer mortality is much lower in Norway, for males only one third of that in the U.K.. Taking into account the dynamics of the smoking epidemic, it is thus clear that we shall never reach the lung

cancer mortality level of the U.K.. An enormous amount of human suffering has been saved.

We could have done much better. Perhaps we did some pioneer work in the 1970s; during recent years, however, we have fallen behind. For example, we have lacked sufficient funds for education work, and we have not yet succeeded in obtaining active government involvement in work for smoke-free public environments.

So far the first barometer for judging the effect of government measures, people's experience.

The second barometer refers to reactions by our opponents, the tobacco industry.

We must realize that there are conflicting interests between the health authorities and health workers on the one hand, and the tobacco industry on the other. The health profession wish to maintain and improve health,

and therefore, for them, smoking must be reduced and in the long run eliminated. The industry wants to maintain and improve sales, and therefore, for them, smoking must increase. There is no way of harmonizing these conflicting interests, so there can be no peaceful coexistence between them. This can be illustrated by events which took place on 14 and 15 May 1986. On these days two meetings were held: One in Geneva, where the World Health Assembly, in its message to the Member States, adopted very strong resolutions directed at achieving a world-wide smoke-free society, and called "for a global public health approach and action now", as you see on the screen. At the same time, the tobacco industry organized a world symposium in Amsterdam, where one of the themes was "A global view of threats to the tobacco industry...". The programme preview said - here is a close-up: "Discussions will centre on the different ways of combatting anti-smoking groups". The outcome of these conflicting interests should be clear, as expressed by an editorial in The Times: "It is the industry that should be dying more quickly, not its customers".

Finally, I should like to deal with two professional groups which are crucial for government involvement. First, the politicians. As demonstrated in the beginning, prevention implies political decisions, which again depend upon the decision-makers' involvement, imagination, vigour and courage.

So far, the fight against this human tragedy has been characterized by a paralyzing passivity on the part of the decision-makers. With few exceptions, politicians have not fought alongside the crusaders and frontline soldiers, they have not been found among the leaders of the health forces. On the contrary, they have often been led by other influences and other pressures in their surroundings, and their contribution has been limited to lip-service and rhetoric.

Politicians should realize the statement by WHO's Expert Committee, that "Governments around the world have accepted the responsibility to protect public health, sometimes with measures that infringe the liberty of the individual far more than those commonly recommended to curb smoking."

Today, politicians and bureaucrats sit on the fence, saying: let us wait for results from countries which have implemented legislation already. However, politicians must have the courage to go in for legislation without advance proof of its effect. Let us take an advertising ban as example.

In my opinion, their decisions must be motivated for other reasons, and I shall put forward two of them:

- (1) If it is true that smoking is the cause of the greatest epidemic of modern times, then it is simply unethical to permit sales promotion of these deadly products. I think we should not make it more complicated than that. A child, a teenager, will argue along these lines, they will question the double set of morals of the government, and ask very logically: if you try to convince me that smoking is dangerous for my health, why don't you put a stop to advertising?

- (2) The industrialized countries should now become aware of the gigantic advertising campaign which the tobacco industry has launched in third world countries, in order to compensate for the market they are loosing in the rich countries. This campaign is the most cynical and reprehensible marketing activity I know of, because the tobacco industry is well aware of what the health authorities have predicted will be the result of increasing tobacco consumption: these areas, where smoking-related diseases are as yet relatively seldom, will come to experience them in only a few years. It would be impossible for the industry to introduce their products into third world countries at the same speed if they were unable to utilize their refined and skilled advertising techniques. The health authorities in these countries often look to the industrialized part of the world for signals to follow. If we don't ban advertising, it is not likely that they will do so. This forces us to review our attitude towards an advertising ban. We are dealing with a pandemic, and our responsibilities reach beyond our own borders.

Now, who have been the opinion-makers and creators of pressure in the politicians' surroundings? Without exception we find the tobacco industry on the spot. They are experts in lobbying activities and seem to have unlimited economic resources at their disposal.

This leads us to the other professional group we have to deal with. Who is going to tell the politicians the other side of the story, to inform them about the suffering and tragedies, misery and economic losses caused by smoking? Who is going to tell them about the enormous magnitude of the problem, to get them to see what it is all about: the greatest epidemic, the greatest pandemic, of modern times. The worldwide cost in lives now approaches 2.5 million per year. But this is only the tip of the ice-berg.

When the developing countries, where the masses live, come to pay the full toll of their recent increasing tobacco consumption, this figure will increase drastically.

Who is going to tell the politicians these medical facts, if not us - the health profession, the voluntary health organizations, the doctors?

What does this imply? It implies that if we want to do something about the smoking and health problem, we are in politics. We cannot leave the lobbying scene to the tobacco industry. We, too, have to be on the spot, in the politicians' surroundings, to pull them down from the fence, and challenge them to proclaim what side they are on. Doctors have lead the way by changing their smoking habits in a positive direction. They should also lead the way as opinion-makers, and by resisting the tobacco industry's attempts to influence a government's anti-smoking policy.

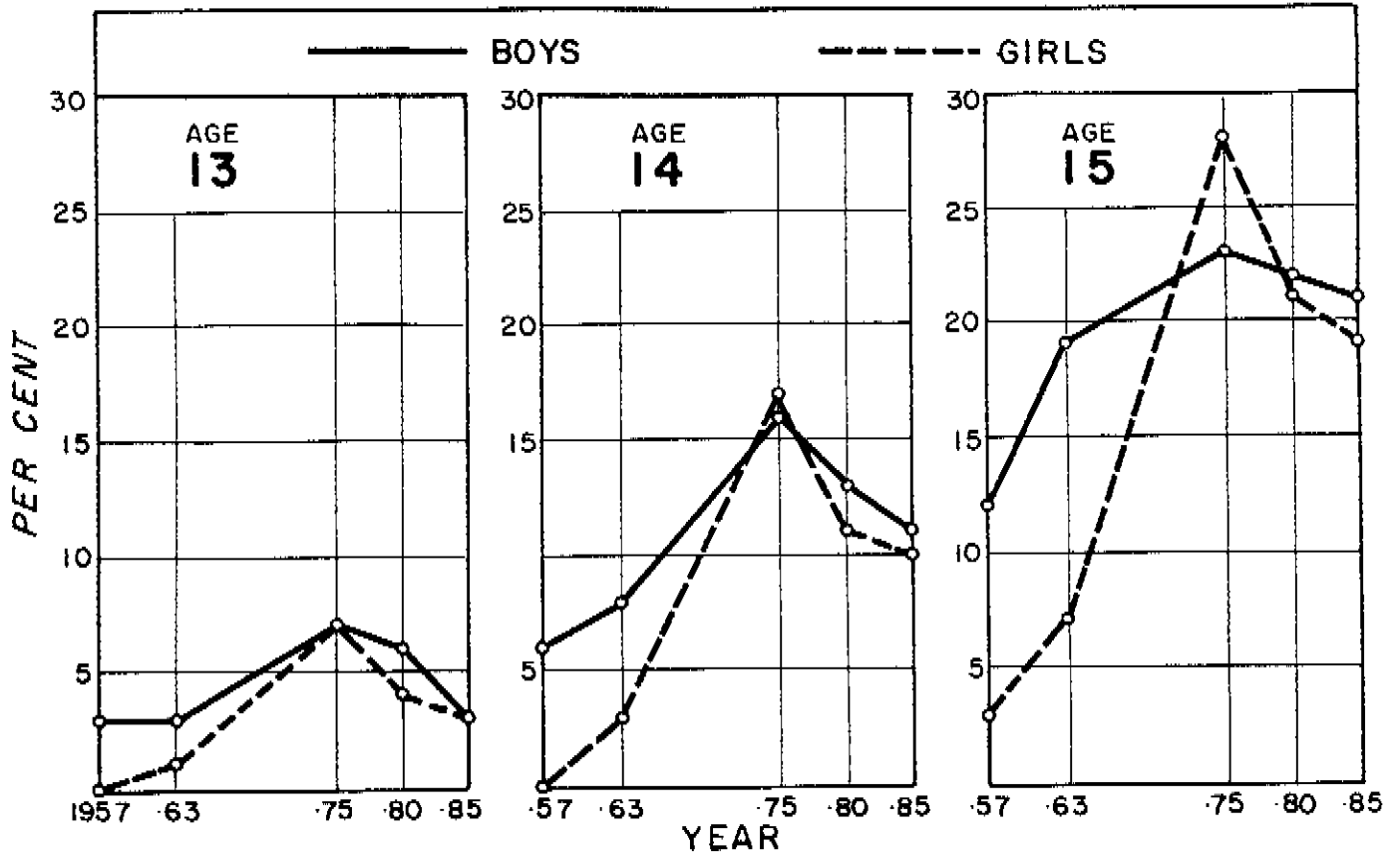
Many health professionals are scared of becoming involved in such lobbying activities, and think that our job is merely to supply the medical evidence. Involvement in political pressure is distasteful to and below the dignity of many professional people, who think that the medical journals are the only media acceptable as a channel of communication. In my opinion, such an attitude is out of touch with real life. The medical profession must step down from its pedestal. Otherwise, the tobacco industry will be left alone on the arena, and the battle will be lost.

The international unions against cancer and against tuberculosis have recently issued a pamphlet which doctors and other health professionals can use in their lobbying activities (text by Sir John Crofton). The unions recommend that this pamphlet is translated into as many languages as possible, and that it is used as an aid for personal contact with each politician. Their advice is: Phone the politician and ask for an appointment, which will take only 10-15 minutes. Prepare yourself carefully, do not give too many details, but restrict yourself to a few main points which may have special relevance for the politician you are going to brief. Don't attack the politicians, don't ask for promises, but ask for their help and leadership, and reward them in the media if they become involved. Keep to the time you agreed, and at the end, hand over the pamphlet, stating that it summarizes some important facts.

The two unions hope that world-wide systematic action can be organized to reach opinion-leaders. Such work has already started, and it has been demonstrated that it can be done. Politicians are reasonable people, they are open to arguments and to pressure based upon medical facts; otherwise they would face a very short political career. Sooner or later, they will be on our side and stand up and admit their responsibility.

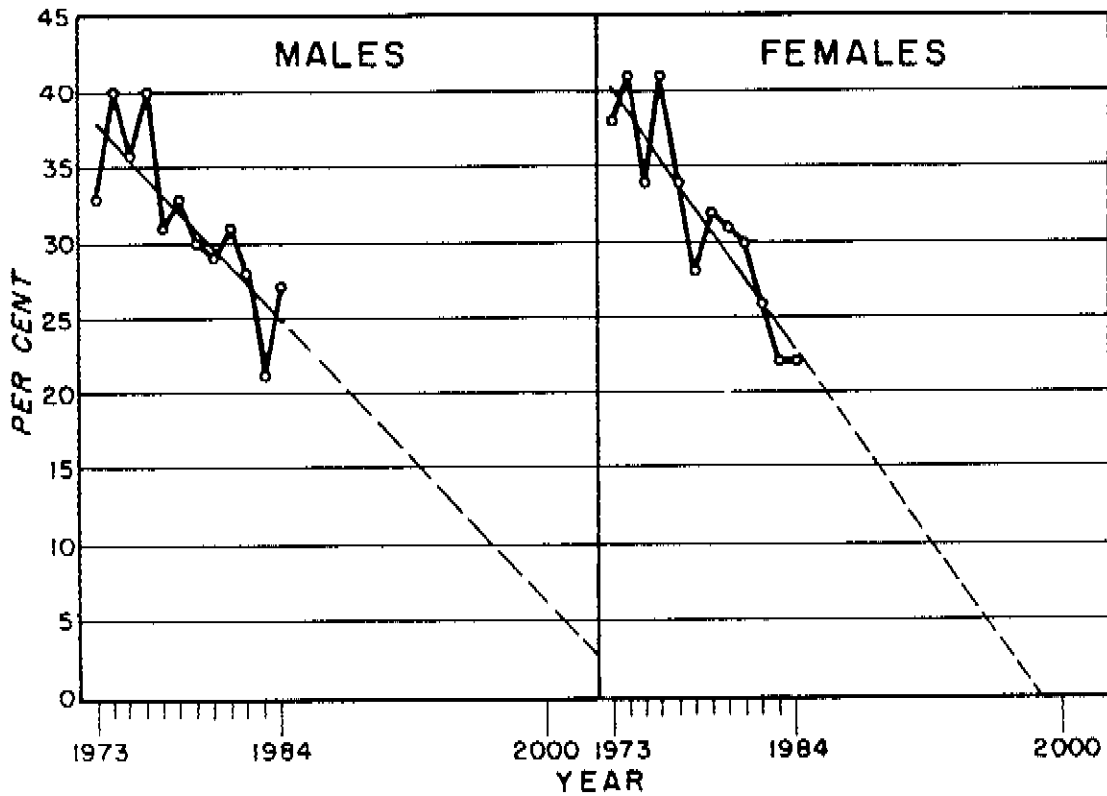
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PER CENT DAILY SMOKERS, SCHOOL STUDENTS, NORWAY, 1957-85



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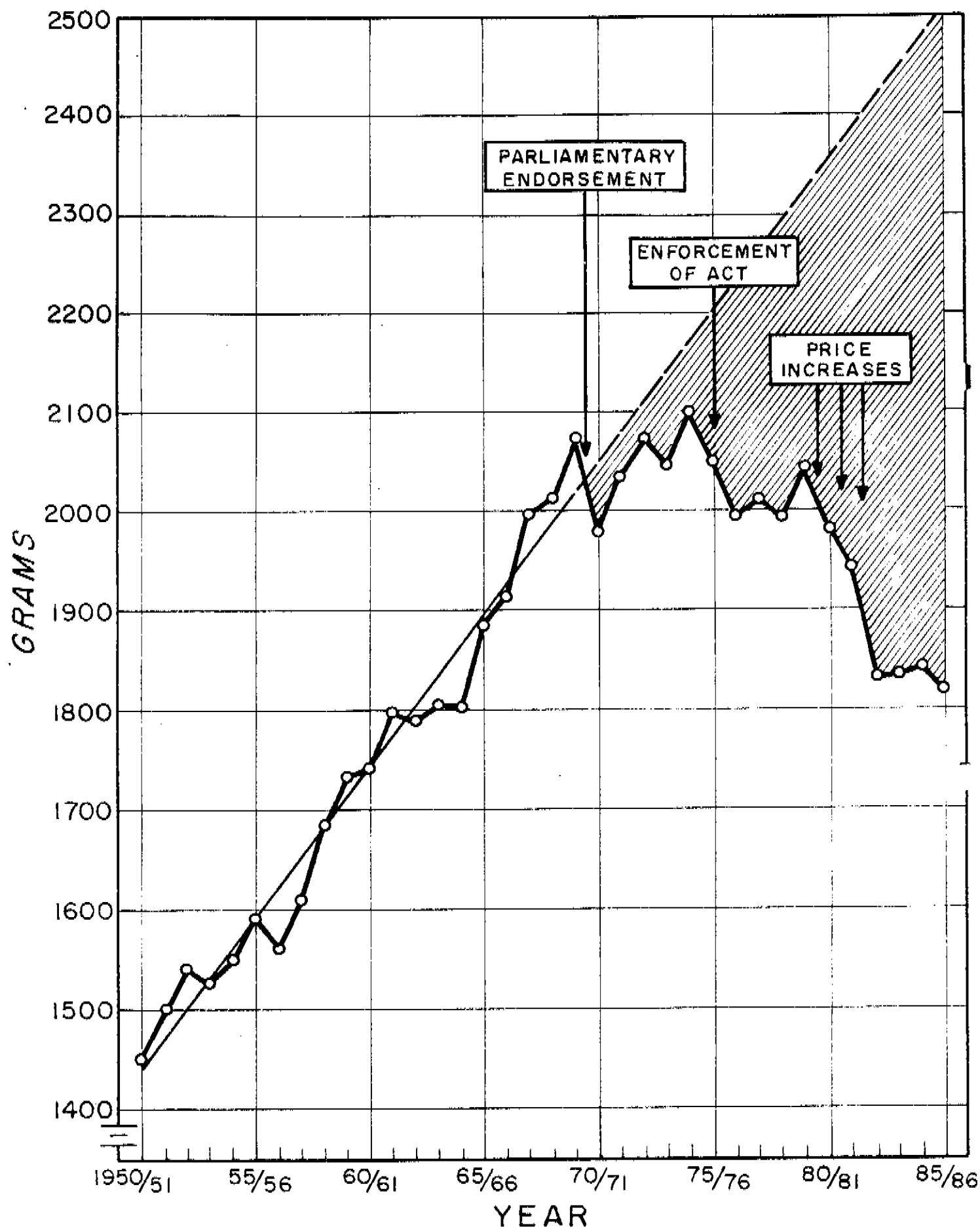
Percentage of daily smokers aged 16-20 years, by sex, Norway, 1973-83*



*Derived from interview surveys among representative samples of the Norwegian population, by the Central Bureau of Statistics/National Council on Smoking and Health, Norway.

FIG 3

PER CAPITA CONSUMPTION (AGED 15+) OF CIGARETTES + SMOKING TOBACCO NORWAY



Source: Directorate of Customs and Excise