FOIA Number: 2008-1524-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: Office of Science and Technology Policy

Series/Staff Member: Jerold Mande

Subseries:

OA/ID Number: 13036

FolderID:

Folder Title:
Tobacco: Kargianis/Labor Suits [2]

Stack:	Row:	Section:	Shelf:	Position:
S	66	4	4	2

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	George Kargianis to Mande re meeting (partial) (1 page)	09/15/1997	b(6)

COLLECTION:
Clinton Presidential Records
Office of Science and Technology Policy
Jerold Mande
OA/Box Number: 13036

FOLDER TITLE:
Tobacco: Kargianis/Labor Suits [2]

2008-1524-F
kc1225

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PATTY MURRAY
WASHINGTON

COMMITTEES:
APPROPRIATIONS
BUDGET
LABOR AND HUMAN RESOURCES
SELECT COMMITTEE ON ETHICS
VETERANS' AFFAIRS

United States Senate

WASHINGTON, DC 20510-4704

August 20, 1997

Someone else

Mr. Bruce Reed
Assistant to the President for Domestic Policy
Office of Policy Development
Executive Office of the President
1600 Pennsylvania Ave., N.W.
Washington, D.C., 20500

Dear Bruce:

I am writing on behalf of Washington State Labor Council and their attorneys who have filed a class action suit against the tobacco companies. I have enclosed a copy of their letter to me, for your review.

It is my understanding that you are currently examining the proposed tobacco settlement and will be making recommendations to the President regarding legislation necessary to implement the settlement. As part of this review, I am requesting that you meet with the attorneys who are representing the Washington State Labor Council. I believe the concerns they raise regarding the potential loss of millions of dollars from labor union health care trust funds should be carefully reviewed by the Administration.

I am also enclosing a copy of Resolution #30 which was adopted by the Washington State Labor Council on July 11, 1997. This Resolution states that "all Taft-Hartley Health and Welfare Plans have full right of access to justice, including all legal rights and remedies, both substantive and procedural, that existed prior to the proposed settlement agreement..." Obviously the concerns raised in this Resolution must be part of any White House settlement review.

In order for the White House to have time to study the concerns of the Washington State Labor Council, I am requesting that this meeting be scheduled early in September.

I would appreciate being kept informed of your efforts to meet with these attorneys. If you have any questions or concerns, please feel free to contact me directly.

2930 Wetmore Avenue
Suite 903
Everett, WA 98201-4107
(259-6815

2988 Jackson Federal Building
915 2nd Avenue
Seattle, WA 98174-1003
(206) 553-5545

W. 601 1st Avenue
Suite 506
Spokane, WA 99201
(509) 624-9515

140 Federal Building
500 W. 12th Street
Vancouver, WA 98660-3871
(360) 696-7797

402 E. Yakima Avenue
Suite 390
Yakima, WA 98901-2760
(509) 453-7462

NEWS:

FROM THE COALITION FOR WORKERS' HEALTH CARE FUNDS

BACKGROUND

The Coalition for Workers' Health Funds is a grouping of labor-management health and pension trust funds created under the Taft-Hartley Act of 1947.

The purpose of the coalition is to provide coordination at the national level for funds throughout the nation seeking reimbursement through the civil justice system from tobacco companies for monies paid out as a result of smoking-related illnesses suffered by American workers and their family members.

There are approximately 2000 such funds in the 50 states, the District of Columbia and Puerto Rico paying the medical and hospital bills of some 30 million Americans: workers, retirees and their families. The industries represented are characterized by small employers and transient and intermittent work patterns , e.g. building and construction, trucking, maritime, service and clothing.

The funds are financed by contributions resulting from collective bargaining agreements entered into between working men and women and their employers.

The lineage of these funds can be traced to the passage in 1947 of the Taft Hartley Labor Relations Act. Their mission is to promote health and safety in the workplace and guarantee that a worker's medical and hospital bills would be paid.

From the beginning these funds have also had, as a prime focus, workplace safety because it was in this area that workers suffered the most. Great strides have been made in improving workplace safety conditions.

Indeed, such progress has been made that, in 1996, for the first time, statistics showed fewer accidents per capita in the construction industry than in the nation's manufacturing sector.

1920 L STREET N.W. • FOURTH FLOOR • WASHINGTON, D.C. 20036-5004

BACKGROUND 2-2-2-2-2-2

As progress has neem made in improving safety in the workplace the trustees of these funds began to look more closely at medical expenses that were non-safety related.

In every instance they found that by far the greatest cause of medical bills came from tobacco-related diseases. Coupled with the discovery that workers covered by the funds consumed tobacco at a rate roughly double that of the national average, it soon became apparent that something had to be done.

In September of 1996, a number of funds began to explore the question of filing class action suits against the tobacco companies to recover costs incurred for tobacco-related illnesses. The first such suit was filed in May, 1997 and others followed quickly.

The money to operate these funds is negotiated at the bargaining table, thus, every dollar spent treating tobacco-related diseases is a dollar that comes out of the worker's pay check.

Fund trustees have a fiduciary duty to manage costs in the best manner possible. They also have a moral duty to safeguard the health and safety of the workers.

These suits are an effort to fulfill both obligations.

#####

NEWS:

FROM THE COALITION FOR WORKERS' HEALTH CARE FUNDS

COALITION FOR WORKERS' HEALTH CARE FUNDS

REPRESENTING THE LABOR-MANAGEMENT HEALTH FUNDS THAT PROVIDE HEALTH CARE FOR 30 MILLION AMERICANS: WORKERS, RETIREES AND THEIR FAMILIES

Tobacco Project Mission Statement

Thirty million Americans--workers, retirees, and their family members--rely on labor-management, multiemployer health funds for health care coverage. That is, these collectively bargained trust funds pay the hospitals, doctors, and other health care professionals who provide medical care, prescription drugs, and health services to workers, retirees and dependents.

Multiemployer funds play a vital role in the health care system of our Nation, as recognized in current law and in various legislative proposals advanced by Congress and the Clinton Administration. But for these pooled, non-profit health funds, a great many more workers and their families would lack employment-based health care coverage and would have to depend on government programs for medical and related care. These funds cover millions of workers in industries characterized by small employers and transient work patterns: e.g. building and construction, trucking, maritime, service, and clothing. Several of these worker groups have been specifically targeted by the tobacco industry's marketing, and have higher than average rates of smoking and tobacco-related disease.

Multiemployer funds have incurred billions of dollars in health care costs for individuals suffering from tobacco-related disease. These costs to the funds are ultimately borne by the covered workers who have seen a growing share of their compensation.package absorbed by the collectively bargained contributions needed by the funds to keep pace with increases in health care costs.

These funds have claims against the tobacco companies for reimbursement of their health care costs for tobacco-related diseases. Reimbursement would enable the funds to provide smoking prevention and cessation programs for covered individuals, as well as reduce the cost burdens of tobacco-related disease on the funds.

Mission Statement: Page 2

The funds' claims are essentially the same as the reimbursement claims asserted by the 40 or so States that have filed suit against the tobacco companies. The States' lawsuits seek reimbursement of the costs incurred by the States' employee health plans and Medicaid programs in providing health care to government employees and public assistance recipients.

The settlement agreement negotiated between the States' Attorneys General and the tobacco companies provides for reimbursement to the States' employee health plans and Medicaid programs, as well as relief for certain private lawsuits brought by attorneys who were party to the settlement negotiations. Multiemployer funds, which were not represented in the negotiations, would not receive reimbursement under the settlement agreement.

The settlement agreement presumes to "legislatively settle" some lawsuits and to severely limit access to the courts and the relief available for cases not resolved by the agreement. For example, the agreement prohibits the filing or continuation of class actions against the tobacco companies, and further protects the tobacco companies from punitive damages for past wrongdoing. To the extent that the agreement purports to apply these limitations to the claims of multiemployer funds, it cannot be justified.

Before the settlement agreement was reached, multiemployer funds in several States filed class action lawsuits against the tobacco companies seeking reimbursement of health care costs. Several more reimbursement class actions will be filed shortly by multiemployer funds in other States. These lawsuits are similar to the reimbursement lawsuits filed by the States' Attorneys General.

The Coalition for Workers' Health Care Funds has been formed to represent these funds and coordinate their activities with regard to their reimbursement claims. The Coalition's mission is to seek for multiemployer funds equal treatment with the States' health care plans and programs with regard to reimbursement from the tobacco companies. While pursuing all available recourse through the courts, the Coalition intends to inform Members of Congress, the Administration, interest groups, and the public about the concerns of the multiemployer fund community.

It would be in the best interests of all concerned--the Federal Government, the States, the tobacco companies, the public health community, and the millions of families relying on multiemployer health funds--for the tobacco companies to provide fair reimbursement to multiemployer funds.

##########

KARGIANIS WATKINS MARLER, L.L.P., P.S.

Market Place Tower, Penthouse Suite A
2025 First Avenue
Seattle, Washington 98121
TEL (206) 448-7969
FAX (206) 448-7950
TOLL-FREE 1-800-424-3352
E-Mail: Kawama@msn.com
Web Site: http://www.k-w-m.com

Facsimile Transmission

To :	George Kargianis
Facsimile No. :	(202) 785-1255
From :	Richard
Date :	September 15, 1997
Subject :	Meeting with Mande
Pages:	8, including cover page
Comments :	I couldn't get through on the fax number I wrote down for Mr. Mande (456-7027) so I faxed the attached to Bruce Reed's number (456-2883). I'll call Mande at 9:00 EST tomorrow and fax to him as well. - Richard

KARGIANIS WATKINS MARLER, L.L.P., P.S.

Market Place Tower, Penthouse Suite A
2025 First Avenue
Seattle, Washington 98121
TEL (206) 448-7969
FAX (206) 448-7950
TOLL-FREE 1-800-424-3352
E-Mail: Kawama@msn.com
Web Site: http://www.k-w-m.com

Facsimile Transmission

To :	Jerold Mande Executive Office of the President
Facsimile No. :	(202) 456.2883
From :	Richard Piccioni for George Kargianis
Date :	September 15, 1997
Subject :	Tobacco Litigation
Pages:	7, including cover page
Comments :	Please see attached materials re Tuesday 16 September 1997 meeting with Paul Stritmatter, Victor Van Bourg and George Kargianis

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	George Kargianis to Mande re meeting (partial) (1 page)	09/15/1997	b(6)

COLLECTION:
Clinton Presidential Records
Office of Science and Technology Policy
Jerold Mande
OA/Box Number: 13036

FOLDER TITLE:
Tobacco: Kargianis/Labor Suits [2]

2008-1524-F
kc1225

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

KARGIANIS WATKINS MARLER, L.L.P., P.S.
ATTORNEYS AT LAW
MARKET PLACE TOWER, PENTHOUSE SUITE A
2025 FIRST AVENUE
SEATTLE, WASHINGTON 98121-2157

TEL (206) 448-7969
FAX (206) 448-7950
TOLL-FREE (800) 424-3352
WEB SITE http://www.k-w-m.com
E-MAIL kswams@msn.com

GEORGE KARGIANIS*
MICHAEL T. WATKINS**
WILLIAM D. MARLER
ANDREW WEISBECKER
DENIS W. STEARNS***
*ALSO ADMITTED IN DISTRICT OF COLUMBIA
**ALSO ADMITTED IN CALIFORNIA
***ALSO ADMITTED IN WISCONSIN

September 15, 1997

Jerold Mande
Executive Office of the President
The White House
Washington, DC

Dear Mr. Mande:

Enclosed for your ready reference is information we and co-counsel have forwarded to the President regarding the impacts of the proposed tobacco settlement on health and welfare trust funds.

The following people will be meeting with you:

Paul L. Stritmatter

Victor Van Bourg

George Kargianis

(b)(6)

I understand that our meeting is scheduled for 12:00 noon, Tuesday 16 September 1997.

Very truly yours,

George Kargianis
Enclosures

KARGIANIS WATKINS MARLER, L.L.P., P.S.
ATTORNEYS AT LAW
MARKET PLACE TOWER, PENTHOUSE SUITE A
2025 FIRST AVENUE
SEATTLE, WASHINGTON 98121-2157

TEL (206) 448-7969
FAX (206) 448-7950
TOLL-FREE (800) 424-3352
WEB SITE http://www.k-w-m.com
E-MAIL kawama@msn.com

GEORGE KARGIANIS*
MICHAEL T. WATKINS*
WILLIAM D. MARLER*
ANDREW WEISBECKER
DENIS W. STEARNS*
*ALSO ADMITTED IN DISTRICT OF COLUMBIA**
**ALSO ADMITTED IN CALIFORNIA
***ALSO ADMITTED IN WISCONSIN

August 6, 1997

President William J. Clinton
The White House
Washington, D. C. 20502

Re: Proposed tobacco settlement provisions — negative impact on labor health care trust funds

Dear President Clinton:

We are counsel for various labor union health care trust funds and their trustees, covering union family members in Washington State. We feel their interests have been adversely affected by certain provisions of the proposed tobacco settlement. We are requesting an opportunity to meet with you (and your advisers Messrs. Bruce Reed and Bruce Lindsey) to explain our concerns so that you may take them into account in your ongoing review of the proposed tobacco settlement.

By way of background, some thirty million Americans rely on labor-management health care trust funds for health care coverage. These collectively bargained for trust funds pay for all medical care and health services received by covered workers, retirees and dependents. These collectively bargained trust funds pay the hospitals, doctors, and other health care professionals who provide medical care, prescription drugs, and health services to workers, retirees and dependents. Federal law created these pooled, non-profit trust funds in order to ensure employment-based health care for working families. These funds typically covered workers in multi employer or transient-employment work patterns, such as the building trades, trucking, maritime, and service industries. Typically, the workers in these industries have far higher-than-average rates of smoking.

These trust funds have incurred billions of dollars in health care costs for individuals suffering from tobacco-related disease. These costs are ultimately borne by the covered workers and their families, who see a growing share of their compensation package absorbed by health care contributions.

In Washington, the Northwest Laborers-Employers Health & Security Trust Fund and the Carpenters Health and Security Trust of Western Washington and their trustees commenced a class action claim against the tobacco industry, under date of May 21, 1997 (No. C 97-849 WD, U.S. District Court, Western District of Washington). The Washington-Idaho Carpenters-Employers Health & Welfare Trust, and the Washington-Idaho Operating Engineers Health and Welfare Trust Fund, and their trustees, also have joined this suit. The suit is a class action on behalf of all labor union health care trust funds in Washington. We are attorneys representing such trust funds and trustees in this action.

Similar actions in upwards of 20 other states have been filed, involving trust funds covering tens of millions of Americans. These trust funds claimants seek reimbursement of health care costs for tobacco-related diseases. Reimbursement would allow the trust funds to provide smoking prevention and cessation programs and well as reduce the cost burdens of tobacco-related disease on the funds. Any recovery would inure to the benefit of the trust fund beneficiaries. At a time when health care benefits are a crucial cost item for employers and are the subject of intense bargaining by labor, any recovery of such trust funds ultimately would benefit both sides of the collective bargaining table.

The trust funds' claims are essentially the same as the reimbursement claims asserted by the 40 or so States that have filed suit against the tobacco companies. The State suits seek reimbursement of tobacco-related costs incurred by the States' employee health plans and Medicaid programs, in providing health care to government employees and public assistance recipients.

The settlement agreement negotiated between the States' Attorneys General and the tobacco companies provides for reimbursement to the States' employee health plans and Medicaid programs, as well as relief for certain private lawsuits brought by attorneys who were parties to the settlement negotiations. The labor health care trust funds, which were not represented in the negotiations, do not receive reimbursement under the settlement as currently written.

The settlement agreement proposal as currently written would severely limit access to the courts and the relief available for all private claimants not included in the settlement, including the labor health care trust funds in Washington and other states (referred to in the proposed settlement as "third party payor" claimants). These restrictions and limitations would legislatively settle these suits. For example, the proposal prohibits class actions, restricts the availability of punitive damages (arguably restricting availability of treble damages), and makes other changes in procedures and substantive rules of law for the labor health care trust fund suits and other private lawsuits against the tobacco companies. The proposed settlement applied these limitations and restrictions against the labor union health care trust fund claims, without any input and without compensating the trust funds for the billions of dollars they have expended in health care costs for beneficiaries suffering from tobacco related diseases.

We are enclosing a copy of the resolution passed July 11, 1997 by the Washington State Labor Council, opposing "any" legislation implementing the tobacco settlement that fails to recognize labor's right to access to the courthouse and right to share equitably in all settlement proceeds.

We understand that representatives of the Attorneys General, the tobacco industry and tobacco growers have met with you regarding the proposed settlement. We would like the same opportunity to meet with you, and to bring our clients and labor representatives to such a meeting, so that the voice of labor and the joint employer-employee health care trust funds also may be heard with regard to certain provisions in the proposed settlement.

Thank you in advance for your consideration of our request for a meeting at your earliest possible convenience. We look forward to hearing from you soon.

Sincerely,

George Kargianis

Lembhard G. Howell

Lembhard G. Howell

Paul L. Stritmatter

Cleveland Stockmeyer

Enclosures

cc: Members of the Washington State delegation
Trustees of the Northwest Laborers-Employers Health & Security Trust Fund,
the Carpenters Health and Security Trust of Western Washington,
the Washington-Idaho Carpenters-Employers Health & Welfare Trust, and
the Washington-Idaho Operating Engineers Health and Welfare Trust Fund.
Rick Bender, President, Washington State Labor Council

LAW OFFICES

CONNERTON & RAY

1920 L STREET, N.W.
FOURTH FLOOR
WASHINGTON, D.C. 20036-5004
(202) 466-6790
FAX: (202) 659-3458

ROBERT J. CONNERTON
JAMES S. RAY
PHILLIS PAYNE
TERESE M. CONNERTON
JOHN McN. BROADDUS

DANIEL S. KOZMA
DAVID L. MALLINOT†
MICHAEL BARRETT

JENNIFER M. ROOF
JACK CURRAN†
LEGISLATIVE DIRECTOR

† NOT A MEMBER OF THE BAR

June 19, 1997

The Honorable William J. Clinton
The White House
Washington, D.C. 20500

Re: **Tobacco Settlement/Workers' Health Care Trust Funds**

Dear President Clinton:

Thirty million Americans—workers, retirees, and their family members—rely on labor-management, multiemployer health funds and union-sponsored health funds for health care coverage. You recognized the vital role of these funds in the Nation's health care system in your historic proposal to comprehensively reform that system. But for these portable health funds, a great many more workers and their families would have to depend on government programs for health care coverage.

These health funds have incurred billions of dollars in health care costs for individuals suffering from tobacco-related disease; costs borne by the covered workers who have seen a growing share of their compensation package absorbed by the health fund contributions needed to keep pace with inflation. These funds have claims for reimbursement from the tobacco companies that are essentialiy the same as those asserted by the 40 or so States that have filed lawsuits. The States seek reimbursement of the tobacco-related health care costs incurred by their public employee health plans and Medicaid programs.

However, the settlement being negotiated between the States and the tobacco companies would provide upfront reimbursement only for the States' health plans. Multiemployer and union-sponsored funds would receive no such reimbursement under the settlement because representatives of these funds were not permitted to participate in the negotiations. Reimbursement would greatly assist the funds in providing smoking prevention and cessation programs for the workers, retirees and dependents that they cover, as well as help to reduce the cost burdens of tobacco-related disease on the funds and the covered workers.

These funds have been left with no choice but to file their own reimbursement lawsuits. Class actions have been filed in ten States; at least ten more class actions will be filed shortly. These lawsuits are modelled on those filed by the States.

The funds have also formed a coalition—the **Workers' Health Care Coalition**—to inform the Congress about the settlement's omissions and to urge that the funds and the working families they cover be extended equal treatment with the States' health plans with respect to reimbursement.

We urge you to oppose any settlement between the States and the tobacco companies that does not extend to multiemployer and union-sponsored health funds equal treatment with the States' health plans with respect to reimbursement. We urge you to insist on equal treatment for workers' health care funds.

Respectfully,

Robert J. Connerton

cc Dr. C. Everett Koop
Dr. David A. Kessler

CONNERTON & RAY
1920 L STREET, NW
FOURTH FLOOR
WASHINGTON, DC 20036-5004
202/466-6790
202/659-3458 - Telecopier

TELECOPY

September 11, 1997

TO: Bruce Reed, Assistant to the President for Domestic Policy

COMPANY: The White House

FAX #: (202) 456-2878

FROM: John Broaddus, Esq.

MATTER #: 1688.00

OF PAGES INCLUDING COVER SHEET: _____

PLEASE CALL SUSAN AT 202/466-6790 IF THERE WERE ANY PROBLEMS ENCOUNTERED IN THIS TRANSMISSION.

_____ For Your Information
_____ For Your Attention
_____ For Your Report
_____ For Your Comments/Consideration
_____ As You Requested

copy to Barb. Woolley

LAW OFFICES
CONNERTON & RAY
1920 L STREET, N.W.
FOURTH FLOOR
WASHINGTON, D.C. 20036-5004
(202) 466-6790
FAX: (202) 659-3456

ROBERT J. CONNERTON
JAMES S. RAY
PHILLIS PAYNE
TERESE M. CONNERTON
JOHN McN. BROADDUS

DANIEL S. KOZMA
DAVID L. MALLINOT
MICHAEL BARRETT

JENNIFER M. ROOF
JACK CURRANT†
LEGISLATIVE DIRECTOR

† NOT A MEMBER OF THE BAR

September 11, 1997

VIA FACSIMILE
(202) 456-2878

Bruce Reed, Assistant to the President
for Domestic Policy
Executive Office of the President
2nd Floor, West Wing
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Re: **Tobacco Litigation**

Dear Mr. Reed:

The "Coalition for Workers' Health Care Funds" represents labor-management health and welfare funds throughout the United States. We serve as national counsel to the funds which have brought class actions law suits in 22 states to recover damages from the tobacco industry for the tobacco-related illnesses suffered by their members and families.

For some time now, we have been attempting to arrange a meeting with you and your office but have been unsuccessful.

We believe it is important that you be apprised of the devastating affect the proposed global tobacco settlement will have on our claims against the tobacco industry. We are hopeful you will agree to meet with us before President Clinton issues his position on the proposed global tobacco settlement.

Thank you very much for your consideration.

Sincerely,

Bob Connerton

Robert J. Connerton

tobacco\1686.00\corresp\reed.911

COALITION FOR WORKERS
HEALTH CARE FUNDS

1920 L STREET, N.W.
FOURTH FLOOR
WASHINGTON, D.C. 20036-5004

Coalition for Workers' Health Care Funds

A Concept Paper

Strategy for Smoking Prevention and Cessation for Workers and Their Families[1]

1. The Issue. The workers we represent and their families mostly smoke at a rate that is more than twice the rate in white collar populations. While smoking among other population segments has declined significantly in the last 20 years, smoking among these workers has stayed the same--between 45 and 50 percent are current smokers, and an additional 25-30 percent are former smokers.

These rates of smoking are reflected in the mortality pattern of workers as well. With overall mortality rates that are two-to-three times higher than the average in the population and as much as four-to-five times higher than in occupations like physicians or teachers, it is obvious that workers face a host of threats to health. Smoking-related diseases in particular stand out as being significant to the overall higher mortality. It is also obvious that to date our efforts to prevent or stop smoking in working populations have been limited and largely ineffective.

In spite of the high rate of smoking in working populations, most research and demonstration programs directed at smoking prevention and cessation have been directed at other issues. It is not uncommon to hear researchers say the reason for this neglect is that, "... it is so hard to reach these populations."

This concept paper aims to provide an initial outline of a strategy to redress this problem. In basic terms the strategy would use the following approach:

---

[1]The workers and their families referred to in this paper are participants in multi-employer health and welfare plans. While these workers are mostly considered "blue collar," they span a wide range of occupations and industries, including building and construction, transportation, retail, food and commercial establishments, health care, apparel, maritime, arts and entertainment, etc.

- Develop programs that recognize that effective prevention and cessation programs must be grounded in the social context in which this smoking takes place.

- Use the structures already available to reach these workers on health-related matters to implement the programs.

- Seek the resources needed to carry out a massive program from the agents that have caused the problem--the tobacco industry.

- Design evaluation methods that can determine which approaches work best.

2. The Social Context of Public Health. The public health model uses a triangular design to find the best ways to focus on a particular problem. The three corners of the triangle are:

- The agent, which causes the disease. In this case it is tobacco.

- The vector, which transmits the disease to and between humans. In this case the vector is tobacco production and marketing.

- The host, which in this case is the smoker.

In the history of public health there have been few effective programs that have not addressed all of these, but often it has been emphasis on the vector that proved most effective. To prevent cholera it meant providing safe sources of drinking water; to stop malaria it meant eliminating the mosquitos that carry the disease by drying up their habitats or using insecticides. For maternal mortality it meant addressing poverty in the urban tenements.

Yet when it comes to tobacco the emphasis has been mainly on the host alone, that people will act on the information outlining the hazards without further inducement in most cases, and with a small added pharmacological aid using nicotine patches or gum for the hard core smokers. The vector--the tobacco industry and its marketing prowess--has been given a free reign.

This approach has bypassed most workers. Why is this the case?

Systematic smoking prevention and cessation programs began to be developed approximately twenty-five years ago. That coincides with the start of the plummeting of the standard of living for workers. It is interesting that today, real wages for workers are where they were in 1973, when adjusted for inflation. Thus, the advent of smoking cessation and prevention programs, which relied on great self-motivation and personal strength, began at the very time when the prospects of workers looked bleak, and became only bleaker. Those population segments that have experienced declining smoking rates also have experienced exceptional economic gains during this period, while workers were left behind, both in terms of economics, and in this case, public health.

It is no coincidence that workers have become more and more alienated from society at large, which is reflected in all kinds of aberrant behavior, from low voter participation to, in some cases, support for victim-blaming arguments focusing on minorities and preferential treatment, to joining militias and other such groups, to substance abuse and the like. It is this social context that the public health community finds it hard to deal with, but which the tobacco companies recognized almost immediately. While middle class, white collar market segments began to decline, tobacco companies switched emphasis to other segments, in particular white working class men and women, and their children. It obviously has worked. The symbolic emphasis on rugged individualism, the association with power sports and hunting, all have the same meaning. Smoking gives the appearance of being in control of oneself and/or in defiance of authority.

This same context applies to the children of workers. It is not a coincidence that smoking among youths from working families is much higher than for other population segments.

3. The Social Context for Workers. To be effective in attacking problems in working populations is no different than in other populations. We must find a strategy that is rooted in their social context, which they will take ownership of. With smoking prevention and cessation, where do we find this context?

The health and welfare funds that serve many working populations are likely to be the most effective vectors for smoking prevention and cessation. These funds were established by the workers to provide economic security in illness. They are

the source to which workers turn when they need medical care. The main contact that these funds have with a worker often is through the worker's family, usually through the spouse.

These funds also are the plaintiffs in over twenty-five state-wide class action law suits against the tobacco companies seeking compensation for the costs of providing medical care for the illnesses brought on by smoking. It is from judgments or settlements recovered in these suits that the funds should be provided by the tobacco companies to finance long-term public health programs directed at smoking cessation for workers and their families.

4. The Health and Welfare Funds as Context. The funds grew out of the post World War II period, when employment-based health insurance coverage began to gain momentum. A particular problem was finding ways to provide the insurance to workers in industries with a high degree of mobility in employment, such as construction, performing arts, the longshore trades, transportation, etc., and to sectors characterized mostly by smaller employers, like retailers. The solution came through collective bargaining over several years and emerged in somewhat different forms in different local areas and different industries. But they all had some things in common: they were trusts, and had to comply with the Taft Hartley Act, they therefore had a board consisting equally of representatives for the workers and the employers, the board defined the benefits to be provided workers covered by the trust, the employers paid a contribution sufficient to cover the benefits and the administration of the trusts, and that contribution was defined and enforced contractually by being included in the collective bargaining agreements. The trusts then either provide the benefits directly or they contract on behalf of the population they serve with a health insurance company, which then pays for the benefits, etc.

Over the years these funds have proven to have many excellent features: they are democratic in terms of decision-making structure and they typically are local and therefore close to the population they serve. As a result they tend to be more involved with their clients and more responsive to the clients' needs than might be the case with more impersonal, large insurance companies. Over the years they have set many examples to support what is being proposed here.

Finding ways to cover employees who might only work a short time with a particular employer was the first challenge. This is how these trust funds came about. Finding ways to provide coverage to these workers *between* employment was the next challenge. The solution to this was to develop *hour banks*; the worker must work for a certain period of time to build up a reserve of hourly contributions, which is then drawn against when there is no employment available.

The next challenge became health improvement for workers using these trusts as vehicles. In the mid-1950s, the Cannery Workers' Trusts in cooperation with the California State Health Department mounted the first large-scale multi-phasic health screening programs for their members and families, and this type of preventive medicine gradually spread. It seems like misguided policy today, placing too great expectations in medical care, but then it was highly advanced.

Throughout the years much emphasis has been placed on defining more broadly what a health benefit is, to take this concept beyond medical care to health promotion in general. A second step came in the 1970s, when much was done to work with researchers to detect asbestos-related diseases among construction workers and other trades. It was in the context of those programs that smoking cessation became recognized. For people with advanced obstructive lung disease caused by exposure to asbestos, there was not much more medicine could do than counsel smoking cessation.

With the recognition that health protection on the job had been inadequate, many new programs were instituted in the 1980s to monitor the health of workers. Cooperating with Federal agencies like the Centers for Disease Control and the Department of Labor, new forms of employment-specific medical examinations were made mandatory for workers in certain types of employment. In the course of conducting these examinations it became further evident that half the workers were active smokers, and often very heavy smokers.

As part of this effort, the funds began to analyze their data to understand better the health patterns of their members and families, and to address them. Gradually, new types of health programs emerged. In many trades, the funds formed national organizations to promote health, and it may be worth looking at one program in particular.

The safety and health experience of the construction trades has been poor throughout history. In the U.S. alone it was common to have 2,000 deaths and over 300,000 serious injuries each year. This was a need that everyone could agree to focus on: the workers needed better protection, the injuries were becoming a major cost factor so employers and organizations paying for construction begin to place a much greater emphasis on safety. In the late 1960s a fund in New York, with cooperation from the state, set up a group insurance plan for employers and the unions to work together on safety and workers compensation. They saw a decline in injuries and significant reductions in costs. They attributed the success to one simple design: all the interested parties working together towards a common objective. In other words, the success derived from the program being tied to those making decisions. It was grounded in the industry, the local community and it had the support and active involvement of the government agencies.

By 1990, many unions, in cooperation with the employers had large organizations with dozens of experts focused on improving safety and health. They obtained the active support of the agencies that are ultimately responsible, like the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health. And the payoff has been excellent. Since 1990, there has been a 34 percent decline in serious injuries in construction and now the number of deaths are down to approximately 1,000 per year. More needs to be done, but much has already been done in a short period of time, largely because these programs were grounded in the social contexts that drive construction. Much the same can be done for smoking.

5. The Strategy Against Smoking among Workers and Their Families.

When nicotine patches and gum first became available with a physician's prescription, one fund in Washington state redesigned its benefits to allow coverage of this type of treatment. It then sent information on this new benefit to the participants. The response was overwhelming, with twenty percent of all adult participants taking advantage of it in the first couple of months. About eight months later the fund did a survey of those who had taken advantage of the benefit. Of those, one third has remained quitters for at least three months, but more importantly, over 95 percent of those who had relapsed said they desired to quit, but needed more help.

It was at this time that many funds started to discuss ways in which they could create more effective programs dealing with a range of health issues, including addiction to tobacco, and they began to analyze their data to determine how much smoking-related illness there could be and how much these illnesses might cost. These considerations gave rise to the current lawsuits against the tobacco companies, because the funds concluded that without including the vectors of tobacco disease in the strategy to stop smoking, the anti-smoking programs would be ineffective against the overwhelming enticements of the tobacco companies. And, the only way to include the tobacco companies was to force them, and the only way this was going to happen was through litigation. And then, the only way they were going to be serious about their involvement was to force them to pay for the illnesses they have produced and to pay some more for the development and implementation of large-scale programs to prevent and stop smoking, and to stop using countervailing strategies that keep these populations hooked on smoking.

They concluded we need a Leadership Organization to be established using proceeds from this litigation as the endowment. The Leadership Organization will: 1) Be governed by the interested parties as agreed to in litigation; 2) have a scientific board of nationally recognized public health experts; 3) provide financial grant support to local organizations rooted in the workers' communities that would implement programs; 4) work with government agencies on the federal, state and local levels and interested voluntary organizations; 5) conduct and sponsor research on the prevalence of smoking and the prevention of smoking; and 6) finance smoking prevention and cessation programs.

The organization will work through national safety and health organizations that already are in place and that serve different segments of the working populations to coordinate the implementation of these programs, and these in turn will contract with the 2,000 local health and welfare funds that are the implementation arm of this program.

Leadership	Coordination	Implementation
		◗Health & Welfare Fund
	◗National Organizations	
		◗Health & Welfare Fund
Leadership Organization	◗National Organizations	
		◗Health & Welfare Fund
	◗National Organizations	
		◗Health & Welfare Fund

The smoking prevention and cessation programs will have the following:

- They will be specific to workers and their families. They would emphasize the contexts of family, work and solidarity that have been effective in other areas.

- They will be administered by the health and welfare funds to their populations. This ensures that the four factors most effective in terms of implementation are included: the programs will be local, they are run by organizations already entrusted by the workers with their health, they have the ability to obtain the buy-in of the key decision-makers that will need to change the social context in which the smoking takes place, and they can be held accountable. And, each of these 2,000+ funds will make their own decisions about which approaches work best for the populations they serve.

- The accountability is ensured through a carefully designed evaluation protocol that sets baselines and establishes benchmarks that should be achieved. Ultimately changes are measured in the patterns of illnesses paid for in the health plans.

The key to this strategy is involving the health and welfare funds. They are in every local community in the U.S. and they have very close ties to their populations. They have fifty years of experience serving these populations and involvement in their communities. But the most important aspect of their role in this program has to do with the following: the participants they cover include the most heavy smokers in our society, and the bulk of those participants are in the

child-rearing age groups. Through these funds it is possible to address simultaneously adult and childhood smoking, and this is important since they are closely linked.

6. Why is This Different from the Proposed Settlement? This strategy is very different from the proposed settlement between the states attorneys general and the tobacco companies in terms of two specific issues.

First, this strategy is population-specific. We will not attempt to address all needs of all people. But, we will address the population segments that are most exposed to smoking.

Today's worker is tomorrow's Medicare-covered person, the fund's retiree, and is the highest cost to the fund and the Government, to himself and to society. We cannot rely solely on addressing our youth. We cannot abandon tomorrow's retirees and their costs — including the loss of their productivity.

Second, we will place this program in the context in which this population lives and works, and in which childhood behaviors are reinforced. That has to be done locally, and we will use the more than 2,000 health and welfare funds that administer health benefits for these populations as the vector for smoking prevention and cessation.

The proposed settlement would prohibit any recoveries by the funds, and thus prevent the implementation of this strategy. As important, it would preclude workers' funds from forcing through litigation the tobacco companies to recognize the overwhelming problem of smoking in working populations and to agree to take steps to help ameliorate it.

The proposed agreement says nothing about workers and their families and would in all likelihood perpetuate the kind of benign neglect that has been given to this problem in the past. The tobacco companies would like this, because they would in effect protect their largest domestic market segment from being targeted.

While the agreement addresses childhood smoking from many aspects, it does not speak to one of the most important factors that we are concerned about in our populations, which is that children mimic parents and if the smoking prevention

and cessation effort is not placed in a family context we will not see a large decline in smoking among youths for generations to come.

The Coalition for Workers' Health Care Funds does not pretend to speak for all people, but we have more than 50 years' experience speaking for the health of the populations we serve. And, we think it would be tragic for the tobacco industry, the state attorney generals and the Costano lawyer group to conspire to deprive our class of workers and their families, unrepresented in their negotiations, of their right to seek justice from the tobacco industry.

T:\tobacco\legis\misc\concept.pap

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

National Coordinating Committee For Multiemployer Plans
Washington, D.C.

MULTIEMPLOYER HEALTH & WELFARE PLANS:

An Overview of Their Operations, Regulation and Concerns

Prepared For The

ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

September 9 & 10, 1997
Chicago, Illinois

LAW OFFICES

CONNERTON & RAY

1920 L STREET, N.W.
FOURTH FLOOR
WASHINGTON, D.C. 20036-5004
(202) 466-6790
FAX: (202) 659-3458

ROBERT J. CONNERTON
JAMES S. RAY
PHILLIS PAYNE
TÉRESE M. CONNERTON
JOHN McN. BROADDUS

DANIEL S. KOZMA
DAVID L. MALLINOt
MICHAEL BARRETT

JENNIFER M. ROOF
JACK CURRANt
LEGISLATIVE DIRECTOR

tNOT A MEMBER OF THE BAR

November 7, 1997

Jerold Mande, Senior Advisor to the Director
Office of Science and Technology Policy
Executive Office of the President
Room 436
The Old Executive Office Building
17th Street and Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Re: Proposed Tobacco Legislation

Dear Mr. Mande:

I am writing with further reference to our communication dated October 16, 1997, written on behalf of the Multiemployer Coalition for Workers' Health Care Funds.

We have focused our attention since that time upon the Congress -- and particularly the Senate. Now that Congress is about to leave town, things will slow down for a brief interlude. We are requesting a meeting at the earliest possible date with the White House Task Force dealing with tobacco, so that our group can make a full presentation of our position, and respond to any inquiries, proposals or suggestions.

As I indicated previously, the Coalition for Workers' Health Care Funds represents some 2,000 of 2,500 multiemployer funds jointly trusteed by labor and management which provide health care coverage to 30,000,000 American workers and their families.

Members of this coalition have filed thirty-two state-wide class actions against the tobacco industry seeking to recoup our costs for treating tobacco related diseases. Now, ten other state-wide class actions that we have been holding up will be filed. In addition, some funds involved in our current suits cover workers in five additional states -- where suits have yet to be filed because of the small number of funds. Litigation is now well underway.

The Coalition's suits are coordinated by the Multiemployer Fund Tobacco Litigation Group. Its efforts are controlled by an Executive Committee which consist of myself as chairman, Perry Weitz of Weitz & Luxenberg (NY), Mel Weiss of Milberg &

Weiss (NY and San Diego), Tom Lakin of St. Louis, Wendell Turley of Dallas Texas, Victor Van Bourg of Van Bourg, Weinberg, Roger & Rosenfeld in California, Marvin Gittler of Asher & Gittler in Chicago, Bill Cavanagh of Cavanagh & O'Hara in Springfield, Illinois, Paul Stritmatter of Stritmatter Kessler Whelan Withey, George Kargianis of Seattle Washington, and my partner, John Broaddus as Secretary. We would need three or four days notice in order to assemble our group. And, the attorneys who are handling the litigation in the other states have also been strong supporters of this President and his party.

We want to cooperate with President Clinton and with the Congress so that Congress can enact meaningful inclusive legislation in the coming session, but we do not want the tobacco companies to be granted immunity against our lawsuits. We know the tobacco industry struck a deal with the State Attorneys General through their law firms, in an attempt to avoid current and future liability from suits by our multiemployer funds. No only did they seek to quash our existing litigation without any compensation, but equally important, to grant immunity to the tobacco industry in the future. Thus, our funds would have faced the worst of all possible worlds: legislation without any compensation, and deprivation of our legal right to protect ourselves in the future from their targeting, etc.

We are enclosing some materials for your consideration before the meeting.

1. A proposal for an affirmative tobacco prevention and treatment program for our workers and their families, including their children. We believe that any tobacco legislation must go beyond measures to save our youth from the blandishments of the tobacco companies. Any national solution to the tobacco devastation must also embrace adults, hard core smokers, minorities, women and other targeted populations: must be locally based, with peer groups and the family. Our proposal contains these essential elements; and is based upon utilizing well established organizations with a successful history on health and safety problems;

2. A short paper describing our multiemployer funds; and

3. A short paper directed to a recent argument by the tobacco industry that our funds are the same as insurance companies.

At the meeting, we will be prepared to offer a report by Dr. Jeffrey Harris on damages to the funds; by Erwin Chemerinsky, professor of constitutional law at the University of Southern California School of Law on the constitutional issues posed if legislation approved payment to states while at the same time denying compensation to cities and counties and multiemployer funds, when all three groups have filed litigation to recoup funds expended by their health and welfare plans in treating tobacco related

diseases.

The tobacco companies have been arguing in Congress that they have no moneys to pay our claims -- that they have given their all to the State Attorneys General and their Castano lawyers, and that they cannot afford to expend additional moneys to litigate or settle suits by our funds and similarly situated groups. It appears at this stage that Congress could well decide to increase the tax on cigarettes to $1.50 or more per pack so youth smoking reduction goals are achieved. Clearly, sufficient monies could be allocated to pay the claims of our funds, along with other groups such as cities and counties. The settlement will cost the tobacco companies anywhere from $100,000,000,000 to $60,000,000,000, over 25 years, which they could afford to pay even without raising prices. They will likely be given passthrough authority. Finally, they have not even invoked their insurance coverage. And, absent a settlement agreement, our funds should not be deprived of their right to sue the tobacco companies.

Unlike the states which can spend moneys they recoup from the tobacco companies for any permissible legal purpose, any moneys our funds recoup must be dedicated to the sole and extensive purpose of providing health care benefits.

Your prompt response will be appreciated.

Sincerely,

Robert J. Connerton

RJC/dar
Enclosures
cc: Members of Executive Committee
T:\TOBACCO\1686.00\CORRESPO\MANDE.K07

COALITION FOR WORKERS
HEALTH CARE FUNDS

1920 L STREET, N.W.
FOURTH FLOOR
WASHINGTON, D.C. 20036-5004

Strategy for Smoking Prevention and Cessation for Workers and Their Families[1]

Nov. 7, 1997

[1]Note: This is a work in progress which we will continue to develop in the months to come. Additional analysis and refinement will likely result in changes in details both in terms of findings and conclusions; however, these are not likely to change the overall analysis presented. For additional copies or more information, please contact the Coalition for Workers' Health Care Funds, 1920 L Street, N.W., 4th Floor, Washington, DC 20036. Tel 202-293-1735. Fax 202-634-6759.

INTRODUCTION

An unusual and rather puzzling aspect of the intense national dèbate now going on following the revelation of the pact between the tobacco industry and 40 state attorneys general, is the virtual absence of any discussion about how to decrease adult smoking.

Surely if there were ever a time to concentrate on smoking cessation among adults it would be now.

A recent study in California has shown that reductions in adult smoking rates yield great benefits in fewer lives lost, fewer people suffering from tobacco-related diseases and fewer public dollars expended for health care.

The more than 5,500 "Taft-Hartley" health care funds that provide medical coverage for more than 33 million American union members, retirees and their dependents, care a great deal about the subject of smoking cessation among adults.

As the following pages and the statistics thereon will show, our membership is the very heart and soul of the hard core adult smoking problem in this country and the teen smoking problem as well.

We wholeheartedly endorse and support positions taken by President Clinton and others who have homed in upon the issues of youth smoking and FDA jurisdiction.

However, we must raise the issue of adult smoking.

Surely, in America of all places, a public health effort such as that currently being mounted against the scourge of tobacco, must embrace *all* aspects of the problem.

Surely we would not mobilize our national resources to address only one part of the population effected by a public health scourge such as tobacco and abandon others to their fate.

We feel that anyone who reads the following pages and the statistics therein cannot help but agree with us when we say that our population is the very heart and soul of the tobacco problem facing America today.

We believe that any attempted "solution" to this nation's number one public health scourge — tobacco — that does not address the full scope of the problem, including the issue of adult smoking in general, and our workers in particular, is doomed to failure.

##########

TABLE OF CONTENTS

THE PROBLEM

1. The Issue

The workers[2] we represent and their families smoke at a rate that is more than twice the average rate in the U.S. and almost four times as much as in white-collar professional populations (fig 1). While smoking among every other population segment has declined significantly in the last 20 years, smoking among-blue collar workers has remained steady. In fact, it has, alarmingly, begun to *increase* over the last five years (fig. 2).

Fig. 1: Smoking by Educational Attainment--Age 25 and Over

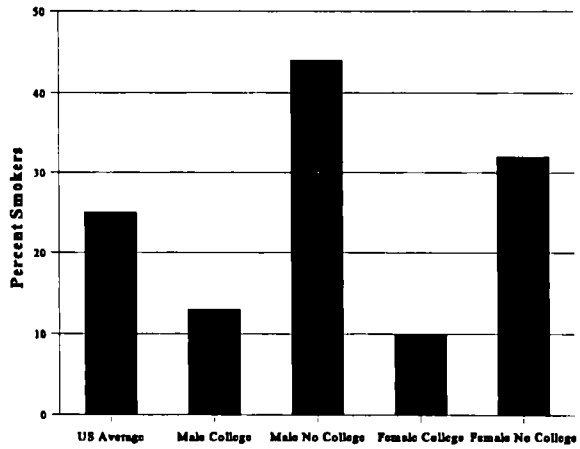
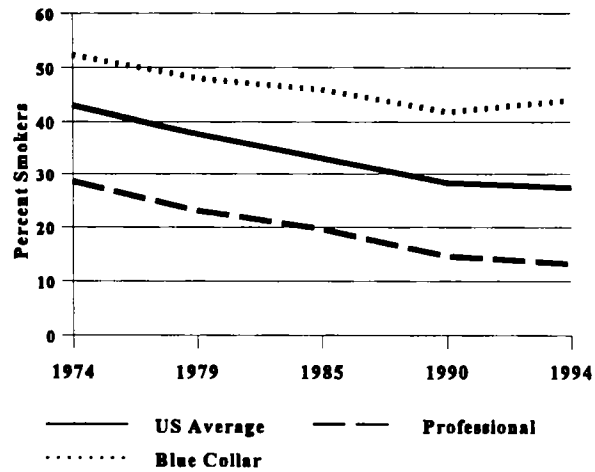


Fig 2: Trends in Current Smoking by Occupation, Males



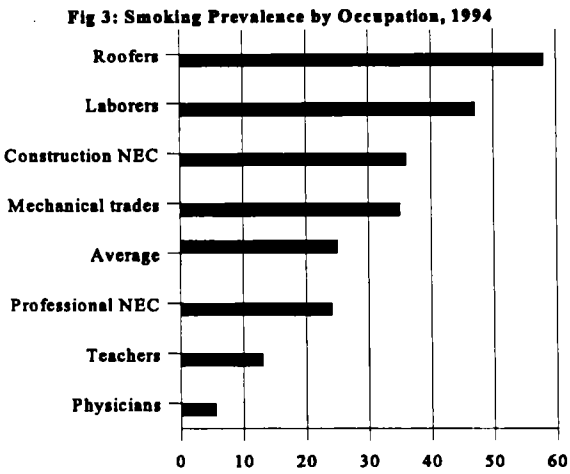
Source: *Health United States 1996-97.* Atlanta: USDHHS, CDC, July 1977

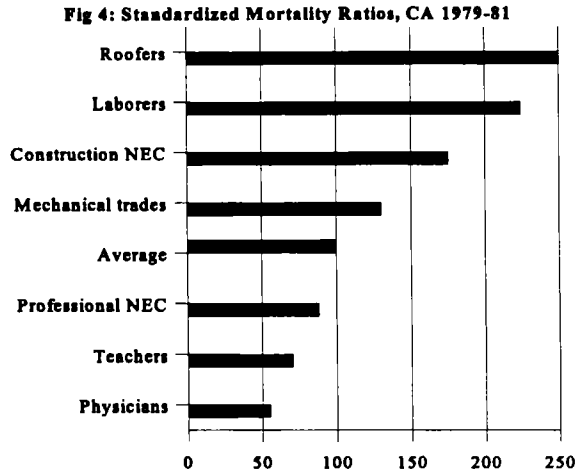
The rates of smoking are reflected in the mortality pattern of these workers. The most extensive study on occupational mortality has been done in California[3]. It shows that blue collar workers have overall mortality rates that are 2-3 times higher

[2]The workers and their families referred to in this paper are participants in multiemployer health and welfare plans. While these workers are generally considered "blue collar," they work in a wide range of occupations and industries, including building and construction, transportation, retail, food and commercial establishments, health care, apparel, maritime, arts and entertainment, etc.

[3]*California Occupational Mortality 1979-81.* Sacramento: California Department of Health Services, 1987.

than other groups in the general population and as much as 4-5 times higher than in professional occupations such as physicians or teachers (figs. 3 and 4). Smoking-related diseases stand out as being a significant contributing factor to the overall higher mortality.[4]





Source: Nelson DE et. al. Cigarette smoking prevalence by occupation. *Journal of Occupational Medicine* 36:516-525, 1994; : ***California Occupational Mortality 1979-81.*** Sacramento: California Department of Health Services, 1987

1.1 The Special Problem of Teen Smoking

Most smokers start when they are in their teens. Smoking among the children of smoking parents is much higher than smoking among children of non-smoking parents[5]. This becomes a critical factor when one considers the issue of how to reduce smoking among teenagers and sub-teens. Just as smoking levels among adult workers has remained high over the past twenty years, so has smoking among their children. And young people who seek or are recruited into blue collar occupations are more likely to be smokers than those who seek other careers.[6] Clearly, then, finding ways to reduce the smoking prevalence among adult workers bears a direct relationship to our efforts to attack youth smoking in *our* environment.

---

[4]Singleton JA, Beaumont JJ. COMS II: California Occupational Mortality 1979-81 Adjusted for Smoking, Alcohol and Socioeconomic Status. Sacramento: California Department of Health Services, 1989.

[5]Resnick MD, Bearman PS, Blum RW et. al. Protecting adolescents from harm. *Journal of the American Medical Association* 278: 823-832, 1997

[6]Approximately 40% of these youths become smokers in their teens. *Healthy People 2000 Midcourse Review and 1995 Revisions*, Objective 3.5a. Atlanta, USDHHS, Centers for Disease Control, 1995.

1.2 Workers: The Forgotten Cohort

In spite of the high rate of smoking among workers and their families, most research and demonstration programs aimed at smoking prevention and cessation have been directed at other segments of the population. It is not uncommon to hear researchers say the reason for this neglect is that, "... it is so hard to reach these (blue-collar) populations."

This concept paper will endeavor to provide the initial outline of a strategy to address this problem. In basic terms the strategy would use the following approach:

- Develop approaches that recognize that effective prevention and cessation programs must be grounded in the social, workplace and family context in which this smoking takes place.
- Use the structures already available to reach these workers on health-related matters to implement the programs.
- Design monitoring and evaluation methods that can determine which approaches work best.

2. The Market Share For Smoking

The very heart and soul of the cigarette smoking problem in this nation resides in the segment of the population we represent:

- It has the highest proportion of smokers of any population segment.
- These smokers consume far more cigarettes, per capita, than other smokers.
- The number of new smokers (teenagers) from this population is disproportionately high.

2.1 The Size of Our Population

Table 1 summarizes the key features of multi-employer health plans in the U.S. as a totality. There are more than 2,500 such funds which serve an estimated 33 million people and have over $33 billion in annual expenditures.

They represent approximately 25% of the total private employment-related health care market in the U.S.

Table 1
Estimated Size of Multi-employer
Health & Welfare Fund Community

Population	Number of funds	Number of participants	Estimated number of covered lives	Total payments for benefits
Sample	440	1,789,500	5,726,400	5,813,000,000
Extrapolated to all of U.S.	2547	10,358,764	33,148,044	33,649,341,000

Source: Sample is extracted from *1997 Group Insurance Plans, Entity C File.* Washington D.C.: Judy Diamond Associates Inc. This file covers Taft Hartley Funds labeled as "Multi-employer plan" based on their most recent submission of Form 5500 to the Internal Revenue Service. The term "covered lives" means the total number of participants and their depdendents who are covered by the funds. These data cover the year 1995, and includes all funds in the following states: AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD. The estimated total number of funds in the U.S. is derived from *Characteristics of Multiemployer Plans, Second Quarter, 1996.* Chicago: International Foundation of Employee Benefit Plans, 1996, which found that 68% of the 3746 welfare plans reported in the U.S. provide health care benefits.

2.2 Estimated Number of Smokers

As shown in Table 1, the Funds we represent cover 33 million lives. Some 20 million of these are over the age of 18. Of these, no less than 40% are current smokers.[7] As shown in fig. 5, these funds are the basic provider of medical coverage for 19%, or eight million, of the 42 million current smokers in the U.S.

Fig 5: Workers as Percent all Smokers

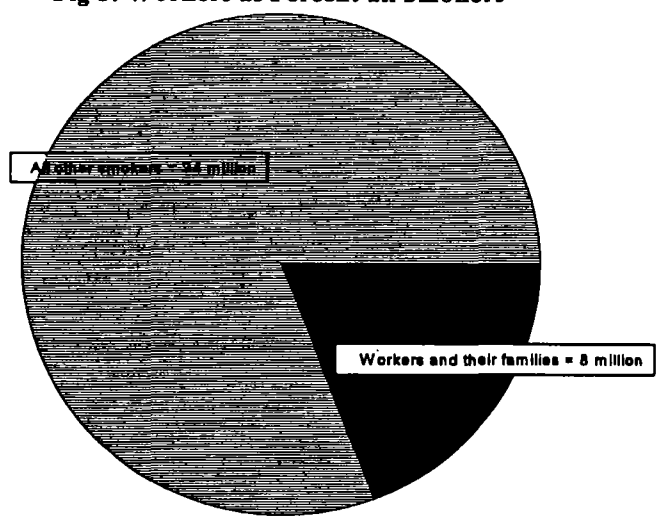
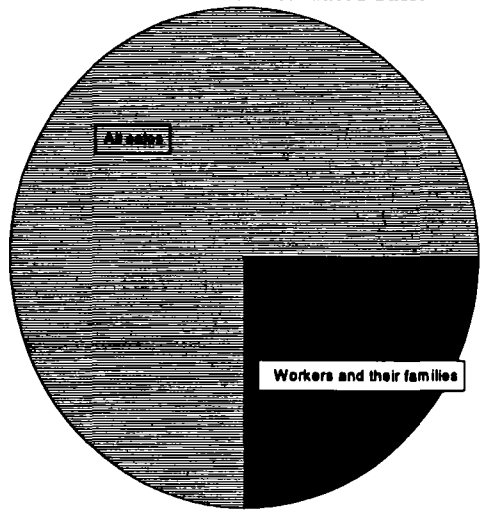


Fig. 6: Workers as Percent of Estimated Sales



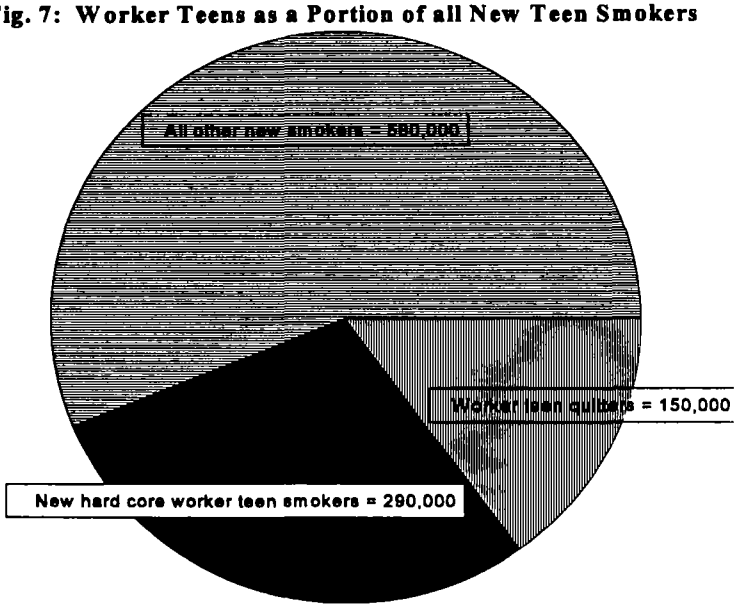
[7]Nelson DE et. al. Cigarette smoking prevalence by occupation. *Journal of Occupational Medicine* 36:516-525, 1994.

Because these eight million workers smoke far more than the average smoker, we calculate that they account for about 25% of all cigarette sales in the U.S. (Fig 6).

2.3 Youth Smoking

Some 38% --or 440,000-- of the dependents of our covered population who reach the age of 18 each year take up smoking.[8] This amounts to a staggering 42.6% of the 1.01 million new smokers in the U.S. each year. Of those teens from our population who take up smoking each year, only about 150,000 of them subsequently quit, leaving an annual influx of 290,000 who go on to become hard core, heavy smokers who are hooked for life.

Fig. 7: Worker Teens as a Portion of all New Teen Smokers



It therefore is little wonder that in the last twenty years the tobacco industry has shifted more and more of its advertisements towards the population we represent.[9] It provides them with a steady stream of new and heavy smokers.

2.4 Synergy With Race

Beyond occupation as a determining factor of high smoking prevalence, race is the second important demographic factor that we need to address. The populations that we represent generally have a higher than average minority participation. For African-Americans and whites alike there is a direct correlation between educational attainment and the likelihood that they will take up smoking. Most

---

[8] *Healthy People Midcourse Review and 1995 Revisions*. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, 1995.

[9] Warner KE, Goldenhar LM. Targeting of cigarette advertising in US magazines, 1959-86. *Tobacco Control* 1:25-30, 1992.

participants in our health plans have a completed education of high school or less. Table 2 shows smoking prevalence for blacks and whites by educational attainment. Typically, smoking prevalence among black males is 6-8 percentage points higher than for white males.

Table 2
Smoking Prevalence among Blacks and Whites by Educational Attainment. In percent.

Educational Attainment	Male		Female	
	Black	White	Black	White
Less than high school	51.6	42.6	30.1	33.0
High school	37.1	31.7	22.5	28.4
College	N\R*	12.7	11.3	10.8

Source: Health United States 1996-97. Atlanta: US Department of Health and Human Services, The Centers for Disease Control and Prevention, July 1997. *Not reliable due to small survey sample size. However, it is likely that the difference in smoking prevalence for college graduates is similar to the difference in other educational categories.

2.5 Smoking Among Women

Smoking among women of childbearing age is a major concern to public health, which becomes critical when women continue to smoke during pregnancy. As can be seen in table 2, women with a high school degree or less smoke at three times the rate of women with a college degree. Most of the adult women in our funds are in this high risk group. Because most of them are of childbearing age their smoking poses health risks not only to themselves but to their unborn children.

Women who smoke during pregnancy pose a special problem, and again it is much more prevalent among women of lower socio-economic status. As is shown in table 3, the lowest income women are much more likely to smoke during pregnancy than those in higher income groups. In Idaho this figure reaches 30%, and, in New York it jumps to an alarming 62%.

Table 3
Smoking Prevalence During Pregnancy
Idaho and New York 1988-89--In Percent

Annual Income	Smoking Prevalence (Percent)	
	Idaho	New York
<$25,000	21.3	35.3
$25,000-34,999	16.5	31.3
>$35,000	17.7	21.7

Source: Centers for Disease Control and Prevention. Cigarette smoking among reproductive aged women --Idaho and New York. *MMWR* 39:659-62, 1990.

2.6 Estimated Smoking-Related Costs

Studies of smoking-related costs that have been conducted for the general population have found that 7.1 % of all medical costs incurred in the United States each year can be attributed to smoking.[10] Adjusting this figure for the significantly higher prevalence of smoking in our populations, we can estimate that smoking-related medical costs in our funds amount to approximately 10 % of total medical costs. This means that the annual cost of providing medical care for smoking-related illnesses among participants and their dependents in our funds amounts to approximately $3.3 billion per year.

THE SOLUTION

3. The Approach To Smoking

The public health model uses a triangular design to finds the best ways to focus on a particular problem. The three corners of the triangle are:

- The agent, which causes the disease. In this case tobacco.
- The vector, which transmits the disease to and between humans. In this case tobacco production and marketing.
- The host, in this case the smoker.

---

[10]Bartlett JC, Miller L, Rice DP, Max WB. Medical care expenditures attributable to cigarette smoking, United States 1993. *MMWR* 43:469-471, 1994. For a lay-person's guide to estimating costs see *Measuring the Medical Costs of Smoking*. Berkeley, CA: Berkeley Economic Research Associates, 1997.

In the history of public health there have been few effective programs that have not addressed all of these, but often it has been emphasis on the vector that proved most effective. To prevent cholera it meant providing safe sources of drinking water; to stop malaria it meant controlling mosquitos. For mortality during childbirth in this country it meant addressing ignorance and poverty in the urban tenements.

3.1 Failure With The Blue-Collar Population

Yet when it comes to tobacco, the emphasis has been mainly on the host alone, apparently assuming that people will act on the information outlining the hazards, perhaps with a small added pharmacological aid of nicotine patches or gum for the hard core smokers. The vector--the tobacco industry and its marketing prowess--has been given a free reign. Thus, this approach has failed with most workers. Why is this the case?

The development of systematic smoking prevention and cessation programs began approximately 25 years ago. That coincides with the start of the recent decline in the standard of living for workers. Wages for blue-collar workers today are about where they were in 1973 when adjusted for inflation. Thus, the advent of smoking cessation and prevention programs, which depend upon self-motivation and will power, began at the very time when the prospects for workers looked most bleak. As smoking prevention and cessation picked up steam for the other segments of American society, life for blue-collar workers only became bleaker still. By contrast, those population segments of white-collar and professional groups that have experienced declining smoking rates also have experienced strong economic gains during this period, while workers were left behind, both in terms of economics, and in this case, public health.

It is this social context that the public health community finds hard to deal with, but which the tobacco companies recognized almost immediately as an opportunity to be seized upon and exploited. When the percentage of smokers among middle class and white collar market segments began to decline, the tobacco companies launched a major shift in the emphasis of their marketing, advertising and promotional campaigns to focus on working-class men and women and their children. Obviously this change in strategy has worked, with devastating success.

The tobacco companies achieved in the public mind the symbolic association of smoking with examples of rugged individualism, power sports and hunting. All have the same meaning -- smoking gives the appearance of being in control of oneself and/or in defiance of authority. And this at a time when most workers were beginning to feel as though they were losing control of their fate and facing increasingly bleak futures.

These campaigns were equally effective with the children of these workers. It is no coincidence that smoking among young people from workers' families is much higher than for other segments of the general population.

4. Role of Workers' Health Care Funds in the Fight To Reduce Smoking

The multiemployer health and welfare funds are clearly the most effective vehicles for the implementation of smoking prevention and cessation programs among blue-collar workers. These funds were first established by the workers themselves to provide protection against the catastrophic economic effects of illness and disease. They are the source to which workers turn when they need medical care. The main contact that these funds have with a worker often is through the worker's family, usually via the spouse.

In order to effectively attack a public health problem such as the epidemic level of cigarette smoking among workers, the method to be used must be one that has relevance and meaning to the workers themselves. We must find a strategy that is rooted in the day-to-day, real-world experiences of workers. It needs to be one which they can understand, trust and embrace. This is not an abstract theory. The workers' health care funds have learned over the years how to bring together all the interested parties involved in workplace safety and health to fashion and then implement programs that are effective.

The workers look upon these funds as being of their own creation. They have an economic stake in them and they trust them. For this reason they are the perfect medium through which to deliver a comprehensive and systematic public health program such as smoking prevention and cessation.

These programs would, of course, be created with the full and unfettered input of the public health community and of the relevant government agencies. This has been our practice in the past and will continue to be in the future.

5. The Background of Multiemployer Health and Welfare Funds

The funds grew out of the working environment that arose during World War II, when the idea of employment-based health insurance coverage began to gain momentum. A particular problem was finding ways to provide medical insurance in industries whose workers were highly mobile such as construction, performing arts, the long shore trades, transportation, etc., and to sectors characterized mostly by smaller employers. The solution was achieved through the collective bargaining process over a period of several years and emerged in somewhat different forms in different local areas and in different industries.

But they all had these things in common:

- they were trusts, and had to comply with the Taft Hartley Act;
- they therefore had a board consisting of an equal number of representatives for the workers and the employers;
- the board defined the benefits to be provided workers covered by the trust;
- the employers paid a contribution sufficient to cover the benefits and the administration of the trusts;
- the contribution was defined and enforced contractually by being included in the collective bargaining agreements;
- the trust then either provides the benefits directly or they contract with a health insurance company, which then pays for the benefits,[11]

Over the years these funds have proven to have many excellent features: they are democratic in terms of decision-making structure and they typically are local and therefore close to the population they serve. As a result they tend to be more involved with their clients and more responsive to the workers' needs than might be

[11]Ringen K et al. Health insurance and workers' compensation: the delivery of medical and rehabilitation services for construction workers. *Occupational Medicine: State of the Art Reviews* 10:435-444, 1995

the case with more impersonal, large insurance companies. Over the years they have set many examples to support what is being proposed here.[12]

5.1 The Funds as Vehicles for Public Health Programs

In the early 1950s, the Cannery Workers' Trusts, in cooperation with the California State Health Department, mounted what, for workers, was the first large-scale health screening programs for their members and families.

Under the old "reactive" system, a worker usually waited until he was seriously ill before seeing a doctor. The new Cannery trust programs were proactive. The workers were given regularly scheduled, general physical examinations and counseling designed to try and diagnose and treat problem areas before they became severe. This had the benefit of nipping many health problems in the bud, providing the worker with better health, which in turn, meant reduced medical expenses for the fund.

This type of preventive medicine gradually spread among workers' health plans throughout the country. For its day, this was an advanced and innovative health policy.[13]

Throughout the years the definition of a health benefit has been steadily expanded to include preventive medicine techniques and the promotion of general wellness. After the mid-70s, a great deal of research was being done to detect asbestos-related diseases among construction workers and other trades. For people with advanced obstructive lung disease caused by exposure to asbestos, there was not much more medicine could do than to counsel smoking cessation.

5.2 Growing Realization Of The Tobacco Menace

With the increasing recognition that health protection on the job had been inadequate, many new programs were instituted in the 1980s to monitor the health

---

[12]See also National Coordinating Committee for Multiemployer Plans. *Multiemployer Health and Welfare Plans: An overview of their Operations, Regulations and Concerns.* Presented to the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. September 10, 1997

[13]Breslow L. Multi-phasic screening examination: An extension of the mass screening technique. *American Journal of Public Health* 40:274-278, 1950.

of workers by working with our funds. Cooperating with Federal agencies like the Centers for Disease Control and the Department of Labor, new forms of employment-specific medical examinations were made mandatory for workers in certain types of employment. In the course of conducting these examinations and compiling statistics, it became evident that fully half the workers were active smokers, and usually very heavy smokers at that.

As a result, the funds began to analyze their data to better understand the health needs of their members and families, and to address the problems that became apparent. Gradually, new types of health programs emerged. In many trades, the funds formed national organizations to promote health. It may be worth looking at one program in particular -- construction.

The safety and health experience of the construction trades has traditionally been poor. In the U.S. it was common until very recently to have 2,000 deaths and over 300,000 serious injuries each year. This was a problem upon which everyone could agree to focus. The workers needed better protection. Because the injuries were becoming a major cost factor, employers and organizations paying for construction began to place a much greater emphasis on safety. In the late 1960s a fund in New York, with cooperation from the state, set up a group insurance plan for employers and the unions to work together to create and implement a series of innovative and effective workplace safety plans that proved to be dramatically successful. This resulted in a decline in injuries and significant reductions in costs.

5.3 The Secret Of Success Lies in Working Together

Success was attributed to one simple design: all the interested parties worked together towards a common objective. The secret lay in tailoring a site-specific safety plan for every construction job. Those directly involved whether belonging to management or labor, had a say both in creating the plan and in seeing to its implementation. It was grounded in the realities of the industry and the local job site and it had the support and active involvement of the government agencies.[14]

By 1990, many unions, in cooperation with employers, had large organizations employing dozens of experts focused on improving safety and health. They

---

[14]Harley JR, Rosenfeld SS. Negotiating workers' compensation: the success of management and labor at Local 3. *In Workers' Compensation Success Stories*. Cambridge MA: Workers' Compensation Research Institute, 1995.

obtained input from and the active support of the agencies that are ultimately responsible, such as the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health.

And the payoff has been excellent. Since 1990, there has been a 34 percent decline in serious injuries in construction and now the number of deaths has declined to approximately 1,000 per year nationwide.

5.4 A Model For Effective Anti-Smoking Programs

More needs to be done, but much has already been done in a short period of time, largely because these programs were so closely tailored to the real world realities of the construction industry.[15] Much the same can be done for smoking.

Again, this would be done with complete input from the public health community and the relevant governmental agencies.

6. The Strategy To Reduce Smoking among Workers and Their Families

When nicotine patches and gum first became available with a physician's prescription, one of our funds in Washington state redesigned its benefits to allow coverage of this type of treatment. It then sent information on this new benefit to the participants. The response was overwhelming, with 30% of all adult participants taking advantage of it in the first couple of months. About eight months later the fund did a survey of those who enrolled.

One third remained quitters for at least three months, but more importantly, over 95% of those who had relapsed said they still wanted to quit, but needed more help.

It was at this time that many of our funds began to discuss ways in which they could create more effective programs dealing with a range of health issues, including addiction to tobacco. They began to analyze their data to determine the

---

[15] *Construction Safety and Health: Five Years of Progress and Proposals for the Future.* Washington D.C.: The Center to Protect Workers' Rights, 1996

extent of smoking-related illnesses among our workers and how much the treatment of these illnesses might cost.

6.1 Organization of the Public Health Strategy

We propose to form an organization at the national level that consists equally of representatives from labor and management. This organization will be charged with the development and implementation of smoking cessation and prevention programs.

Just as with our earlier (and successful) safety and health programs developed in the 1980s and '90s, these programs will be developed with the advice and counsel of all pertinent national public health organizations as well as the relevant governmental agencies both federal and state and, of course, the funds themselves.

These programs along with the funding and other tools necessary to operate them, will be supplied to the workers' health care funds around the nation. The national organization will, in the same manner, develop programs designed to closely monitor and measure the efficacy of these programs at frequent intervals and to determine if a specific fund needs additional support or assets.

The organization will provide frequent and public reports on the progress that is being made and engage in an ongoing dialogue with the public health community and the relevant governmental organizations to discuss that progress and determine what changes, if any, might be necessary.

The smoking prevention and cessation programs will have certain key requirements:

- **They will be specific to workers and their families.** They will emphasize the contexts of family and work that have been effective in the past.

- **They will be administered by the health and welfare funds.** This ensures that the four factors most effective in terms of implementation are included:

    — the programs will be local, they will be run by organizations already entrusted by the workers with their health,

— they have the ability to obtain the buy-in of the key decision-makers that will need to change the social context in which the smoking takes place,

— and they can be held accountable.

— And, each of these 2,500 plus funds will make their own decisions about which approaches work best for the populations they serve.

- **There will be accountability**. A carefully designed evaluation protocol that sets baselines and establishes performance benchmarks will be developed with, as mentioned above, advice and counsel from the public health community and the relevant governmental agencies.

6.2 The Key To Reducing Youth Smoking

Ultimately, the key in the quest to reduce youth smoking is to involve the health and welfare funds. They are in every local community in the U.S. and they have very close ties to their populations. They have 50 years of experience serving these populations and involvement in their communities.

But the most important aspect of their role in this program has to do with the following: the participants they cover include the most heavy smokers in our society, and the bulk of those participants are in the child-rearing age groups.

Through these funds it is possible to address simultaneously adult and childhood smoking, and this is important since they are closely linked.

6.3 A Long-Term Commitment

The smoking problem did not arise overnight and is now so deeply embedded in our culture that a long-term, concerted effort, carried out over the next two generations will be required to make a significant dent in hard-core smoking among workers and their families. This means that from the start, we will need to commit ourselves to a time frame of thirty years or more in order to have a major and lasting impact.

6.4 Relationship of Strategy to National Objectives

In an effort to better direct the Nation's public health activities, the US Department of Health and Human Services has established performance goals to be achieved by the year 2000.[16] To reduce smoking prevalence among people aged 18 and over, objective 3.4 identified a number of special populations to target. Table 4 lists these targets and how our strategy might impact on them:

Table 4
Relationship of our strategy to *National Objectives*

Objective No.	Population	1987 Prevalence Baseline	How Strategy Applies
3.4a	**High school or less education**	34%	This applies to the majority of our population
3.4b	**Blue collar workers**	41%	This is our main population focus
3.4c	**Military personnel**	42%	Most discharged veterans enter the trades
3.4d	**African-American males**	30%	Our populations have a high African-American representation
3.4e	**Hispanic adults**	24%	Our populations have a high Hispanic participation in select locations
3.4f	**Native Americans**	42-70%	The unions are actively organizing Native Americans
3.4g	**Southeast Asian males**	55	Their participation in the trades is increasing
3.4h	**Women of childbearing age**	29%	Because our funds cover people during their working years, most adult females are in this category
3.4i	**Pregnant women**	25%	Smoking during pregnancy is disproportionately high

Source: Healthy People Midcourse Review and 1995 Revisions. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, 1995. 1987 Baseline Prevalence means the percentage of the particular population segment who were smokers in 1987.

In short, the health and welfare funds cover all of these target populations, and the ability to impact on all of these simultaneously strengthens the potential impact of the strategy we have proposed.

[16]The goals are known as *Healthy People 2000.* In 1994, the Assistant Secretary for Health conducted a progress review and issued midcourse revisions. These highlighted the problems we are attempting to address in this strategy. Washington, DC: US Department of Health and Human Services, 1988.

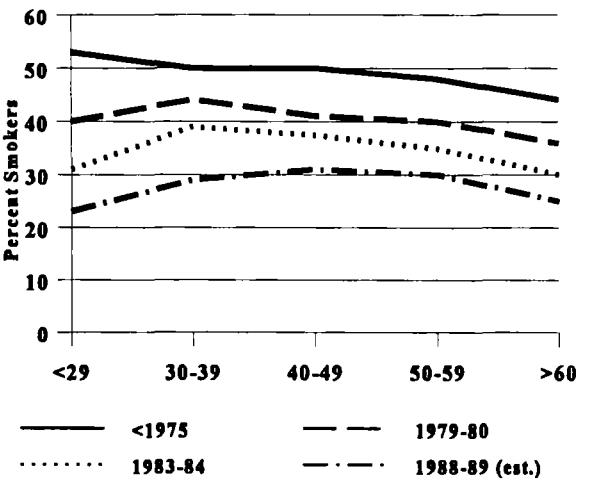
7. Evidence of Success from Sweden

Starting in 1969, the Swedish construction unions and construction employers entered unto an agreement to fund and jointly operate a preventive health care program in that country. A part of the program was a preventive health care check-up available to workers every two years. A health system employing three dozen physicians and over 200 nurses was organized. Data from the examinations were used to evaluate the group experience of the construction workers, as well as to show each worker how his or her health changed over time in relationship to the health of the group as a whole. This became an important health education tool. Each time the workers came for a check-up, the nurses would review with them individually their results and suggest ways to improve their health. One component of the program was smoking cessation.

At each examination, a health history including smoking was taken. All workers were also given a lung function test. The test showed how well or badly the lungs were functioning, and whether there was change over time. Deteriorating lung function is strongly associated with smoking, and by showing workers their actual test results compared to their peers, the nurses were able to help smokers decide to quit.

Figure 8 shows smoking prevalence by age for different period cohorts among the Swedish construction workers who participated in medical examinations. As the program progressed through the 1970s and 1980s, fewer and fewer workers smoked. Although some data are preliminary, they suggest that today, smoking prevalence among Swedish construction workers is roughly equivalent to smoking prevalence among Swedish white collar workers.

Fig 8. Smoking Prevalence in Sweden



This is a striking statistic when one compares it with the situation in the U.S. where smoking among blue-collar workers is twice as prevalent than it is among white-collar workers.

There are two aspects to the Swedish experience that need to be considered. First, in Sweden the construction trades are well regarded occupations, held in high social esteem. This almost certainly made the case of promoting non-smoking easier than in the U.S. But even in Sweden, results were not uniformly good.

The preventive health program for Swedish construction workers was designed to be voluntary. While it was promoted heavily, and made easily accessible to the workers through the use, for instance of mobile clinics that came to the work sites, no one was compelled to participate and 47 % of the workers declined. The overall status of their health was much worse than among those who participated. Table 5 shows overall mortality as well as mortality from cancer for tobacco-related diseases.

Table 5
Standardized Mortality Ratios for Non Participants and Participants
Swedish Construction Industry Preventive Health Program

Cause of Death	Standardized Mortality Ratios	
	Non-Participants	Participants
All Causes	1.29	0.75
All Cancers	1.24	0.93
Laryngeal Cancer	3.12	1.11
Esophageal Cancer	1.29	0.94

Source: Standardized mortality ratios are based on comparisons with the white male Swedish population. Cohort was established during 1971-79; mortality was followed through 1988. Stockholm: Bygghalsans Research Foundation

As is shown, while workers who participated suffered from lower rates of cancer on average than for the general population of Sweden, non-participants had much higher rates. In fact, mortality for non-participants is roughly 70 percent higher than for participants; however, increase in cancer mortality is less--34 percent--reflecting in part the higher smoking prevalence among all Swedish construction workers in the past.

The Swedish data provide us with two important findings:

- **Prevention.** They show that preventive health measures work when it comes to dealing with the health of workers.

- **Potential for Success**. They show that a health program, when organized appropriately to the target population, can significantly impact on the smoking problem among construction workers.

8. The Two Main Points of Our Strategy

First, this strategy is population-specific. We will not attempt to address all the needs of all the people. But, we will address the population segments that are most exposed to smoking. We aim to address the very heart of hard core smoking in America.

Second, we will place this program in the context in which this population lives and works. We will address the synergy of race and smoking. We will address the high rates of smoking among women in childbearing ages and pregnancy. And we will address the social structures in which childhood smoking behaviors are reinforced. To accomplish these objectives, we recognize that a long-term strategy spanning the two next generations —at least 30 years in duration — will be required.

Our approach is rooted in the local communities and social structures of workers. We will use the more than 2,500 health and welfare funds that administer health benefits for these populations as the main vehicle for smoking prevention and cessation.

##########