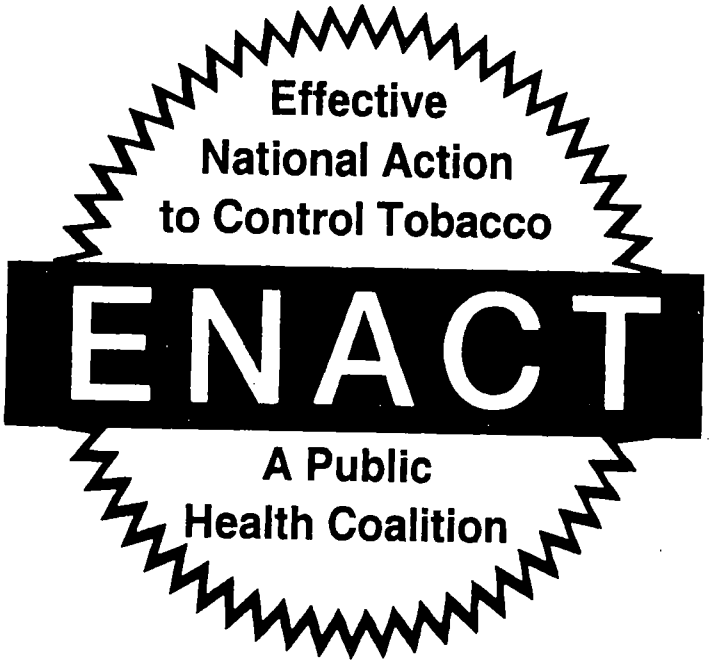
ENACT



MEDIA BRIEFING/LUNCHEON
March 13, 1998

Speaker List

Cass Wheeler
Chief Executive Officer
American Heart Association

Matthew Myers
Executive Vice President and General Counsel
Campaign For Tobacco-Free Kids

Samuel Spagnolo, M.D.
Professor of Medicine
The George Washington University
Member
American College of Chest Physicians

Jud Richland
President
Partnership for Prevention

ENACT Coalition Members

March 9, 1998

- Allergy and Asthma Network - Mothers of Asthmatics, Inc.
- American Academy of Child & Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Association for Respiratory Care
- American Association of Physicians of Indian Origin
- American Cancer Society
- American College of Cardiology
- American College of Chest Physicians
- American College of Occupational and Environmental Medicine
- American College of Physicians
- American College of Preventive Medicine
- American Heart Association
- American Medical Association
- American Psychiatric Association
- American Psychological Association
- American School Health Association
- American Society of Anesthesiologists
- American Society of Clinical Oncology
- American Society of Internal Medicine
- Association of American Medical Colleges
- Association of Black Cardiologists, Inc.
- Association of Maternal and Child Health Programs
- Association of Schools of Public Health
- Association of State & Territorial Health Officials
- Campaign for Tobacco-Free Kids
- Children's Defense Fund
- College on Problems of Drug Dependence
- Community Anti-Drug Coalitions of American (CADCA)
- Council of State & Territorial Epidemiologists
- Family Voices
- Federation of Behavioral, Psychological and Cognitive Sciences
- The HMO Group
- Interreligious Coalition on Smoking OR Health
- Latino Council on Alcohol & Tobacco
- National Association of Children's Hospitals
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- National Hispanic Medical Association
- National Mental Health Association
- Oncology Nursing Society
- Partnership for Prevention
- Society for Public Health Education
- The Society for Research on Nicotine and Tobacco
- The Society of Behavioral Medicine
- Summit Health Coalition

A number of the nation's major public health organizations have formed ENACT (Effective National Action to Control Tobacco). This growing coalition has pledged to work with the Congress, the Administration, the public health community and the American people to pass comprehensive, sustainable, effective, well-funded national tobacco control legislation.

Consensus Statement of ENACT

Building on decades of work by the public health community, the 1996 assertion of jurisdiction over tobacco by the U.S. Food and Drug Administration, the principles in the recent Koop-Kessler Report, and the June 20 agreement negotiated between the state Attorneys General and the tobacco industry, President Clinton announced on September 17 his support for comprehensive federal legislation based on five key elements to reduce tobacco use among all Americans, but particularly among children.

Our organizations support the President's call for bipartisan legislation and pledge to work with the Administration, Members of Congress, the public health community and the American people to achieve this goal.

We have a historic opportunity to prevent and dramatically reduce tobacco use among children and adults of all cultures and communities and reduce secondhand smoke in public places and worksites. Our priority is the enactment of comprehensive, sustainable, effective, well-funded tobacco control legislation.

This is a singular and unique opportunity to protect children and save lives. Therefore, we are committing our resources, including our millions of members, volunteers and staffs to the opportunity for fundamental change that is possible now, while pledging to continue to work on longer term public health goals.

The following are important elements for effective legislation and must be adequately funded:

- **Full FDA Authority**: The FDA must have full jurisdiction over all tobacco products and nicotine delivery devices. Furthermore, the FDA must be permitted to use the same procedures in regulating tobacco, and its decisions should be subject to the same standard of review that generally apply under the Food, Drug, and Cosmetic Act.

- **Tough Penalties**: The tobacco industry must be subject to significant penalties if tobacco use among children does not drop substantially. The penalties should be non-tax deductible, uncapped, escalating and brand-specific to youth tobacco use to give the tobacco industry the strongest possible incentive to stop targeting children.

- **Price Increases**: The cost of tobacco products should be increased well beyond the $0.62 per pack projected under the state Attorneys General agreement in order to deter children from taking up their use, whether through an increase in state and federal excise taxes, modifications in the tax treatment of annual payments, and/or price hikes from the tobacco companies due to increased settlement costs.

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- **No Marketing to Children**: Tobacco marketing and advertising to children must be prohibited.

- **Document Disclosure**: To ensure that patterns of corporate malfeasance are disclosed and effectively checked in the future, tobacco legislation must provide for broad disclosure of industry documents, especially those containing scientific or other health information or relating to the industry's attempts to market tobacco to children.

- **No Preemption**: Any federal legislation should explicitly provide that state and local governments are not preempted from establishing or retaining requirements equal to or more stringent than any federal requirement (including taxation) relating to tobacco control, other than requirements regulating the content of tobacco products.

- **Public Health Initiatives**: Legislation should include improved warning labels, provisions to eliminate youth access to tobacco, culturally sensitive and specific public education, tobacco use cessation, research, and state and local tobacco control activities.

- **International Leadership**: A portion of any funds should be earmarked for international organizations and federal agencies for the implementation of international tobacco control initiatives. Furthermore, the President should issue an Executive Order prohibiting the U.S. Trade Representative, the Department of Commerce, U.S. Embassies, and other federal agencies from interfering in any efforts by foreign national governments to curb tobacco use.

- **Secondhand Smoke**: The public's protection from secondhand smoke hazards should be included as an integral part in any national tobacco policy. This should include federal environmental tobacco smoke restrictions for restaurants without preempting tougher local and state laws.

- **Protection of Tobacco Farmers and Their Communities**: The impact of the legislation on tobacco farmers and their communities should be addressed.

Our first priority is to ensure the passage of comprehensive tobacco control legislation in this session of Congress. If there are provisions that address the tobacco industry's liability, they must not weaken the ability of the civil justice system to protect public health or weaken the rights of victims of the tobacco industry to seek compensation for their injuries. We are committed to evaluating any legislation in its entirety based on its overall impact on the public health.

Each organization has identified additional ways to achieve our shared goal, and will work to implement those provisions which are unique to its constituency and goals.

Together, we are committed to improving public health; our organizations have long been devoted to reducing the use of tobacco, particularly among children. We join together now to support an effective national policy on tobacco control.

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M. CASS WHEELER
CHIEF EXECUTIVE OFFICER
AMERICAN HEART ASSOCIATION, INC.

M. Cass Wheeler became chief executive officer of the American Heart Association on October 1, 1997.

Wheeler is a 1963 graduate of the University of Texas at Austin with a business degree in advertising. Shortly after graduation, he joined the American Cancer Society where he was a field representative, a metropolitan fund-raising director and then a metropolitan executive director.

From 1969 to 1973, Wheeler was a stockbroker in Dallas with two New York Stock Exchange firms. He joined the American Heart Association at the Texas Affiliate in Austin where he became deputy executive vice president and later executive vice president.

Wheeler moved to the American Heart Association's National Center in Dallas in 1982 as deputy executive vice president, where he managed day-to-day operations at the AHA's headquarters.

As deputy executive vice president, he guided National Center resources to create a greater market focus for the organization. His vision of corporate roundtables, underwriting and licensing opened up significant avenues that will be important for the association in the years to come. He also introduced a strategic plan for information technology that combines the technology of 200 sites into a common, tightly integrated operation. Wheeler also oversaw the expansion of the National Center in Dallas and the construction of a distribution center-printing plant in the suburb of Mesquite. He recreated internal systems in a variety of support functions in human resources, training, purchasing, finance and accounting. day-to-day operations and all functions of the National Center.

Wheeler became senior vice president for field operations in 1996 when the American Heart Association reorganized its staff as part of a major effort to meet the challenges and opportunities of the 21st century. As a result, he worked with volunteers and staff to create a new structure for the organization for the next century. In addition to field operations, Wheeler was also responsible for revenue generation. The American Heart Association experienced a significant increase in public support in 1996-97.

He has been a guest lecturer at Harvard's Graduate School of Business and its Graduate School of Public Health and at the University of Texas at Dallas School of Management. He was also a speaker at the Distinguished Lecture Series at the University of Texas at Austin Graduate School of Business.

A native Texan, Wheeler is an elder in the First Presbyterian Church of Dallas and is a runner, skier and bicyclist.

MATTHEW LOUIS MYERS
EXECUTIVE VICE PRESIDENT AND GENERAL COUNSEL
CAMPAIGN FOR TOBACCO-FREE KIDS

Matthew Myers is Executive Vice President and General Counsel of the National Center For Tobacco-Free Kids, a privately-funded organization established to focus the nation's attention and action on reducing tobacco use among children. Mr. Myers serves as the Center's chief legal counsel and oversees all of its advocacy, outreach, and grass roots development efforts.

From 1981 to 1996, Mr. Myers was partner in the law firm of Asbill, Junkin & Myers, in Washington, D.C. He specialized in complex commercial litigation and cases concerning employment law, the Privacy Act, health law, and First Amendment issues.

In 1982, Mr. Myers began representing the Coalition on Smoking OR Health, an organization comprised of the American Cancer Society, the American Lung Association, and the American Heart Association. In 1991, he became counsel to the Coalition and has represented its member organizations in Congress and before executive branch agencies.

Mr. Myers is a nationally recognized tobacco-control advocate. In 1996, he received the Smokefree America Award as the lawyer who had made the greatest contribution to tobacco-control efforts in the United States. In 1989, he was awarded the prestigious Surgeon General's Medallion from Dr. C. Everett Koop, for contributions to the public health of the nation. Mr. Myers' legislative advocacy efforts are featured in *The Giant Killers*, by Michael Pertschuk, former chairman of the Federal Trade Commission (FTC). He is published widely in health and medical publications, and appears regularly on national news programs to discuss tobacco issues.

In 1973, Mr. Myers began his career as a law clerk to the Chief U.S. District Court Judge in Rhode Island. From 1974 until 1977, he was an attorney for the American Civil Liberties Union Foundation National Prisoner Project, and from 1977 to 1980, he was their chief counsel. In 1980, Mr. Myers joined the FTC in the Division of Advertising Practices. A year later he was named the acting Deputy Assistant Director of the FTC's Division of Advertising Practices.

He holds a B.A. from Tufts University and a J.D. from the University of Michigan Law School, where he was awarded the Order of the Coif and served on the staff of the *Journal of Law Reform.*

Mr. Myers and his wife, Louise, reside in Washington, D.C. They have two children.

BIOGRAPHICAL SKETCH *SAMUEL V. SPAGNOLO, M.D.*

Dr. Spagnolo is Professor of Medicine at George Washington University School of Medicine and Health Sciences and Attending Physician at George Washington University Medical Center & the Department of Veterans Affairs Medical Center in Washington DC. From 1975 to 1993, Dr. Spagnolo was the Director of the Division of Pulmonary Diseases and Allergy at George Washington University School of Medicine & Health Sciences and Director of the Division of Pulmonary Diseases and Allergy at the George Washington University Medical Center. During this period, he was also the Chief of the Pulmonary Section at the Department of Veterans Affairs Medical Center in Washington, DC.

Dr. Spagnolo's administrative responsibilities have included direction of the clinical, teaching, and research functions of the Division, the clinical practice of pulmonary faculty, and the pulmonary fellowship education program. He has been actively involved with both the full-time and part-time pulmonary and allergy faculty responsible for providing leadership for the division and supervision of the pulmonary function laboratories and the respiratory care section of the Division. He was also responsible for similar duties and responsibilities at the Veterans Affairs Medical Center.

Dr. Spagnolo has made significant contributions in a variety of fields:

> *As a teacher, he has personally directed the training of more than 75 pulmonary specialists and critical care specialists and is an active lecturer on the subject of pulmonary and critical care medicine.*
>
> *As a researcher, he has directed major research projects funded by foundations and grants, supervised the publication of, or authored, more than 200 publications, three textbooks and a number of book chapters. He has been active in a variety of areas including the diagnosis and treatment of tuberculosis, clinical uses of laser in lung cancer, supportive care for the lung cancer patient, the use of new antimicrobial agents, and the use of fine needle lung biopsy for the diagnosis of chest x-ray abnormalities.*
>
> *As a clinician, Dr. Spagnolo has a worldwide reputation as a therapist and consultant. In these roles he serves an international patient community in Europe and the Middle East. Consulting activities have included the Will Rogers Institute, the U.S. Department of Labor and the Walter Reed Army Medical Center. He has also served as a consultant to the White House physicians during the presidency of George Bush. In 1981, he served as the medical chest consultant in the care of President Ronald Reagan following the attempted assassination. His involvement was reviewed in Mortal Presidency by Robert Gilbert, Basic Books, New York, NY, 1992.*

Dr. Spagnolo has demonstrated consistent academic progress commencing with a Harvard Fellowship in 1971-72 at Massachusetts General Hospital in Boston. Earlier training gave him communicable disease experience at the U.S. Communicable Disease Center (CDC) in Atlanta, GA. He joined the George Washington University School of Medicine in 1972 and has held an appointment as Professor of Medicine since 1981. During his 25 years at the university, he has been a member of numerous committees and Chairman of several major committees. He is the recipient of numerous honors and frequently responds to requests from the public media, professional organizations and the United States Congress. In addition to his memberships in various professional societies, he has served as President of the District of Columbia Thoracic Society, President of the National Association of Veterans Affairs Physicians & Dentists, and served for five years as the Governor of the District of Columbia for the American College of Chest Physicians.

Dr. Spagnolo's long and distinguished academic career and his dedication to clinical care of patients, teaching, and research has given him extensive experience in participating in conferences around the world and he has made numerous radio and television appearances. Because of these interests, he founded the International Lung Foundation in 1991. Dr. Spagnolo is listed in Marquis "Who's Who in America, Who's Who in Medicine and Healthcare, & Who's Who in Science & Engineering" as well as Medical Sciences International Who's Who. Born in Pittsburgh, PA, Dr. Spagnolo earned his BA degree at Washington and Jefferson College, and his MD degree from Temple University. He is board certified in Internal Medicine and Pulmonary Diseases.

JORDAN (JUD) RICHLAND, MPA
PRESIDENT
PARTNERSHIP FOR PREVENTION

Jud Richland is the President of Partnership for Prevention, which he joined in 1995. He leads this national nonprofit organization whose mission is to increase the priority for disease prevention and health promotion in national health policy. Partnership's members include some of the nation's preeminent companies, leading national health associations, and many of the nation's state health departments.

From 1987-1995, Richland served as Deputy Director and Acting Executive Director of the Public Health Foundation. From 1979-1987, he worked at the U.S. General Accounting Office where he authored numerous reports to the Congress recommending policy and management improvements in many federal programs.

Mr. Richland received his B.A. in Economics from the University of California at Berkeley and his Master of Public Affairs degree from the Lyndon B. Johnson School of Public Affairs at the University of Texas.

(Note: This document was originally released on January 28, 1998)

TOBACCO UNDER OATH - ROUND II: NEW EVIDENCE...NEW LIES?

On April 14, 1994, CEOs from seven tobacco companies appeared before the Health and Environment Subcommittee of the U.S. House of Representatives' Commerce Committee. Their testimony was as unequivocal as it was controversial -- all testified that nicotine is not addictive, and several denied that tobacco companies have ever marketed their products to kids.

On January 29, 1998, CEOs from the five leading U.S. tobacco companies will again swear to tell the truth before the House Commerce Committee. But this time they will have to deal with admissions by the Liggett Group and recently revealed internal industry documents that clearly demonstrate that their companies' representatives were, at best, disingenuous and, at worst, lying when they testified before Congress just four years ago.

Not one of the CEOs who testified in 1994 still serves in that capacity; however, their successors at five of the tobacco companies will appear before the Committee. How will these new CEOs reconcile the 1994 testimony of their predecessors with the truth revealed by their industry's own documents?

The following is a comparison -- on the central issues of nicotine addiction and youth marketing -- of what was said under oath in 1994, and what has been revealed through formerly secret industry documents.

The seven executives who testified in 1994 were:

- William Campbell, President and CEO, Philip Morris USA
- James W. Johnston, Chairman and CEO, RJR Tobacco Company
- Joseph Taddeo, President, U.S. Tobacco Company
- Andrew H. Tisch, Chairman and CEO, Lorillard Tobacco Company
- Edward A. Horrigan, Chairman and CEO, Liggett Group Inc.*
- Thomas E. Sandefur, Chairman and CEO. Brown & Williamson Tobacco Corporation
- Donald S. Johnston, President and CEO, American Tobacco Company*

**Note: Liggett and American (since purchased by Brown & Williamson) will not be represented at the January 29, 1998 hearings.*

- more -

NICOTINE ADDICTION

April 14, 1994:

Rep. Wyden: Let me begin my questioning on the matter of whether or not nicotine is addictive. Let me ask you first, and I'd like to just go down the row, whether each of you believes that nicotine is not addictive. I heard virtually all of you touch on it. Just yes or no. Do you believe nicotine is not addictive?

Mr. Campbell: I believe nicotine is not addictive, yes.

Rep. Wyden: Mr. Johnston?

Mr. J. Johnston: Congressman, cigarettes and nicotine clearly do not meet the classic definitions of addiction. There is no intoxication.

Rep. Wyden: We'll take that as a no and, again, time is short. If you can just -- I think each of you believe nicotine is not addictive. We just would like to have this for the record.

Mr. Taddeo: I don't believe that nicotine or our products are addictive.

Mr. Horrigan: I believe that nicotine is not addictive.

Mr. Tisch: I believe that nicotine is not addictive.

Mr. Sandefur: I believe that nicotine is not addictive.

Mr. D. Johnston: And I too, believe that nicotine is not addictive.

Evidence from the Industry:

"Moreover, nicotine is addictive. We are, then, in the business of selling nicotine, an addictive drug effective in the release of stress mechanisms."

(July 17, 1963 memo by Brown & Williamson General Counsel Addison Yeaman commenting on research by Battelle Memorial Institute.)

"There is increasing evidence that nicotine is the key factor in controlling, through the central nervous system, a number of beneficial effects of tobacco smoke, including its action in the presence of stress situations. In addition, the alkaloid (nicotine) appears to be intimately connected with the phenomena of tobacco habituation and/or addiction."

(May, 1993 report from Battelle study for BAT, parent company of Brown & Williamson, on nicotine.)

"In a sense, the tobacco industry may be thought of as being a specialized, highly ritualized, and stylized segment of the pharmaceutical industry. Tobacco products uniquely contain and deliver nicotine, a potential drug with a variety of physiological effects."

(Memo by RJR executive Claude Teague, Jr., "RJR Confidential Research Planning Memorandum on the Nature of Nicotine and the Crucial Role of Nicotine Therein".)

"There are broadly two sets of problems which attend the concept of a safer cigarette. The first is concerned with the ethical question: 'Is it morally permissible to develop a safe method for administering a habit-forming drug, when, in so doing, the number of addicts will increase?' The second relates to the technical feasibility of achieving greater safety..."

(May 15, 1976 document by Dr. D.H. Corning (Liggett document #LG 0203041), "The Concept of Less Hazardous Cigarettes".)

"...do we really want to tout cigarette smoke as a drug? It is, of course, but there are dangerous FDA implications to having such conceptualization go beyond these walls."

(Internal memo from Philip Morris scientist William Dunn.)

"Without nicotine...there would be no smoking."

(Philip Morris researcher William Dunn, "Motives and Incentives in Cigarette Smoking," summary from Center for Tobacco Research Conference, 1972.)

"Smoking is a habit of addiction."

(Sir Charles Ellis, BAT science advisor, 1962 BAT research and development conference.)

MARKETING TO KIDS

April 14, 1994:

Mr. J. Johnston: We do not market to children, and we will not.

Mr. J. Johnston: We do not survey anyone under the age of 18.

Mr. Taddeo: As to the allegation that U.S. Tobacco markets its products to persons under the age of 18, that allegation is absolutely false. We strongly believe at U.S. Tobacco that those who enjoy our products should be adults.

Evidence from the Industry:

"Evidence is now available to indicate that the 14-18 year old group is an increasing segment of the smoking population. RJR-T must soon establish a successful new brand in this market if our position in the industry is to be maintained in the long term."

(March 15, 1996 document, Planned Assumptions and Forecast for the Period 1977-1986 for RJ Reynolds Tobacco Company.)

"...to ensure increased and longer-term growth for Camel Filter, the brand must increase its share penetration among the 14-24 age group, which have a new set of more liberal values and which represent tomorrow's cigarette business."

(1975 memorandum to RJR vice president for marketing C.A. Tucker.)

"Men become smokers earlier and consume more cigarettes per capita than women. Cigarettes aimed at the female market exclusively have been flops. Marketing programs have been slanted at certain types of men, but always basically at the male market. The cigarette market may be broken down into age brackets as follows: 16-21 – the formative years; smoking starts and brand preferences are developed..."

(1963 report by Arthur D. Little, Inc. (Liggett document #LG0412562), "Development of Cigarette Packaging".)

Contrary to its claims to have never surveyed underage smokers, the recently released Mangini documents revealed that RJR conducted surveys of the smoking habits of teenagers for decades. A 1976 survey of over 11,000 teenagers aged 14-17 produced the "Smokers Screening Profile (14-17).

(January 14, 1998 letter from Representative Waxman to Representative Bliley transmitting documents from the Mangini trial.)

"We must sell the use of tobacco in the mouth and appeal to young people. We hope to start a fad."

(1968 U.S. Tobacco meeting summary.)

"Skoal Bandits is the introductory product, and then we look towards establishing a normal graduation process."

(1985 UST internal newsletter describing what has been referred to as the company's "graduation" process.)

"Cherry Skoal is for somebody who likes the taste of candy, if you know what I'm saying."

(Former UST sales representative, quoted in a 1994 *Wall Street Journal* article on UST's graduation strategy.)

"Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while still in their teens...The smoking patterns of teenagers are particularly important to Philip Morris."

(1981 Philip Morris internal document.)

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ENACT POLICY STATEMENTS

Tobacco's Toll in America

FDA Regulation of Tobacco Products

Increasing Prices on Tobacco Products

Setting Penalties for Missing Youth Smoking Targets

Public Education

Youth Access to Tobacco

Restrictions on Tobacco Marketing and Promotion

Tobacco Use Cessation

Environmental Tobacco Smoke

Tobacco Legislation and Tobacco Growing Communities

Preemption of State and Local Tobacco Control Regulations

International Issues

Effective National Action to Control Tobacco
ENACT
A Public Health Coalition

TOBACCO'S TOLL IN AMERICA

Tobacco Kills

- Tobacco kills more than 400,000 Americans every year -- accounting for one out of every five deaths in the country. This figure represents more deaths than from AIDS, alcohol, car accidents, murders, suicides, drugs and fires -- combined.[1]

- Tobacco kills Americans in the prime of their life; 27 percent of Americans who die between the ages of 35 and 64 die from tobacco-related diseases.[2]

- Smoking also puts nonsmokers at risk. Research has clearly established secondhand smoke as a causal factor for lung cancer and heart disease in otherwise healthy nonsmokers.[3]

- These facts, along with over three decades of research on the health consequences of smoking, led former Surgeon General C. Everett Koop to conclude that smoking is "the chief, single avoidable cause of death in our society and the most important public health issue of our time."[4]

Tobacco is a Pediatric Problem

- Each day, 3,000 kids become regular smokers.[5] That's more than one million kids a year. One-third of them will eventually die from a tobacco-related disease.[6]

- More than 5 million children under age 18 alive today will eventually die from smoking-related disease, unless current rates are reversed.[7]

- 4.1 million kids age 12-17 are current smokers.[8]

- Almost 90 percent of adult smokers began at or before age 18.[9] Among high school seniors who have ever used smokeless tobacco, almost three-fourths began by the ninth grade.[10]

- 86 percent of children who smoke prefer Marlboro, Camel, and Newport -- the three most heavily advertised brands -- compared to only about one third of adult smokers. Sixty percent of youth smokers use Marlboro, while only a fourth of adult smokers choose this brand.[11]

- Smoking among African American high school boys nearly doubled between 1991 and 1995, from 14.1 percent to 27.8 percent.[12] Frequent smoking[13] among African American high school boys increased as well, from 4.5 percent in 1991 to 8.5 percent in 1995.

- Between 1991 and 1995, smoking among Hispanic high school students increased from 25.3 to 34.0 percent.[14] Rates for girls and boys are nearly the same, with females at 32.9 percent in 1995 (up from 22.9 percent in 1991) and males at 34.9 percent in 1995 (up from 27.8 percent in 1991).

- The Centers for Disease Control report smoking rates for students in grades 9-12 increased from 27.5 percent in 1991 to 34.8 percent in 1995.[15]

- The University of Michigan recently reported that smoking among high-school seniors is at a 19-year high -- 36.9 percent. Since 1991, past-month smoking has increased by 35 percent among eighth graders and 43 percent among tenth graders.[16]

- Twenty percent of U.S. high school boys (grades 9-12) are current spit (smokeless) tobacco users. In some states, smokeless tobacco use among high school males is particularly high -- Wyoming (40%), Montana (36%), and West Virginia (35%).[17]

- Since 1970, spit tobacco has gone from a product used primarily by older men to one for which young men comprise the largest portion of the market. In 1970, males 65 and older (12.7%) were almost six times as likely as those ages 18-24 (2.2%) to use spit regularly. By 1991, however, young males (8.4%) were 50 percent more likely than the oldest ones (5.6%) to be regular smokeless users.[18]

Tobacco Costs

- Health care expenditures caused directly by smoking totaled $50 billion in 1993[19]. Forty-three percent of these costs were paid by government funds, including Medicaid and Medicare[20].

- Lost economic productivity caused by smoking cost the U.S. economy $47.2 billion in 1990[21]. Adjusted for inflation, the total economic cost of smoking is more than $100 billion per year. This does not include costs associated with diseases caused by environmental tobacco smoke, burn care resulting from cigarette smoking-related fires, or perinatal care for low-birthweight infants of mothers who smoke.

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[1]Office of Technology Assessment. "Statement on Smoking-Related Deaths and Financial Costs: Office of Technology Assessment Estimates for 1990 before the House Committee on Ways and Means," November 18, 1993, p. 2.
[2]CDC. "Medical-Care Expenditures Attributable to Cigarette Smoking - United States, 1993," *Morbidity and Mortality Weekly Report,* July 8, 1994.

[3]CDC. "Facts About Secondhand Smoke.".
[4]"How Effective are Excise Tax Increases in Reducing Cigarette Smoking," *American Journal of Public Health*, Vol. 82, No. 1, 1992, p.19.
[5] Pierce, J.P., et al., "Trends in Cigarette Smoking in the United States: Projections to the Year 2000," *JAMA*, vol. 261, No. 1. 1989.
[6]CDC. "Projected Smoking-Related Deaths Among Youth-United States," *Morbidity and Mortality Weekly Report*, November 8, 1996.
[7]CDC. "Youth Risk Behavior Survey, 1995," *Morbidity and Mortality Weekly Report*, November 21, 1996.
[8] "National Household Survey on Drug Abuse: Population Estimates 1996," *Substance Abuse and Mental Health Services Administration*, U.S. Department of Health and Human Services.
[9] "Preventing Tobacco Use Among Young People" *A Report of the Surgeon General, 1994.*
[10] "Preventing Tobacco Use Among Young People" *A Report of the Surgeon General, 1994.*
[11] CDC. "Changes in the Cigarette Brand Preference of Adolescent Smokers, U.S. 1989-1993," *Morbidity and Mortality Weekly Report*, August, 1994.
[12] Youth Risk Behavior Surveillance - United States, 1991, 1995.
[13] Defined as having smoked >20 cigarettes in the past 30 days.
[14] Youth Risk Behavior Surveillance - United States, 1991, 1995.
[15]CDC. "Tobacco Use and Usual Source of Cigarettes Among High School Students--United States, 1995," *Morbidity and Mortality Weekly Report*, May, 1996.
[16] "The Monitoring the Future Study," *University of Michigan, 1997.*
[17]CDC. " Youth Risk Behavior Surveillance – United States, 1995." *Morbidity and Mortality Weekly Report*, September 27, 1996/Vol. 45/No. SS-4.
[18]CDC. "Surveillance for Selected Tobacco-Use Behaviors – United States, 1900-1994." *Morbidity and Mortality Weekly Report*; November 18, 1994/Vol. 43/No. SS-3.
[19]CDC. "Medical-Care Expenditures Attributable to Cigarette Smoking - United States, 1993," *Morbidity and Mortality Weekly Report,* July 8, 1994.
[20]Office of Technology Assessment. "Statement on Smoking-Related Deaths and Financial Costs: Office of Technology Assessment Estimates for 1990 before the Senate Special Committee on Aging Hearing on Preventive Health: "An Ounce of Prevention Saves a Pound of Cure," May 6, 1993, p. 7.
[21]Hodgson, Thomas A., "Cigarette Smoking and Lifetime Medical Expenditures," *The Milbank Quarterly*, Vol. 70, No. 1, 1992, pp. 81-125.

FDA REGULATION OF TOBACCO PRODUCTS

Background:

Although tobacco use causes over 400,000 deaths each year, tobacco products have escaped even the most common sense public health regulations. Despite overwhelming evidence about the dangers of their products, tobacco companies have enjoyed special protections not granted to manufacturers of other consumer products that are not nearly as dangerous. It is time to bring the regulation of tobacco in line with other consumer products.

ENACT believes that the authority of the Food and Drug Administration (FDA) is at the heart of any meaningful comprehensive national approach. The record demonstrates that in the absence of FDA-level oversight the tobacco industry cannot be trusted to tell the truth to the American public, cannot be trusted to take reasonable steps to minimize the harms of its products, and cannot be trusted not to market to children. Without FDA jurisdiction tobacco manufacturers are not required to disclose what is in each brand of its products, not required to disclose the research in their own files about the health effects of their products, not required to disclose whether they are able to make less hazardous products, not subject to even basic oversight for health and safety purposes, and not subject to any meaningful oversight by any federal agency.

The Food, Drug, and Cosmetic Act provides the FDA the authority to regulate a wide array of consumer products including foods, drugs, medical devices, and cosmetics. In August 1996 FDA asserted its jurisdiction over cigarettes and smokeless tobacco under the drug and device provisions of the Act.

FDA asserted jurisdiction over tobacco products after the emergence of a scientific consensus that cigarettes and smokeless tobacco cause addiction to nicotine and the disclosure of thousands of industry documents detailing that these products are intended by the manufacturers to affect the structure and function of the human body. Under the Act, a product is a drug or device if it is an article (other than food) "intended to affect the structure or any function of the body." The FDA has rightly concluded that (1) nicotine in cigarettes and smokeless tobacco does "affect the structure and function of the body," and (2) these effects on the structure and function of the body are "intended" by the manufacturers. FDA concluded that the nicotine in cigarettes and smokeless tobacco is a drug, that causes addiction, and that the cigarette and smokeless tobacco products are devices that deliver drug nicotine to the body.

The benefit of FDA oversight of tobacco products is a coordinated comprehensive approach to reduce tobacco use among children, encourage and assist adults to quit, and to reduce the harm to the American public caused by the products that remain on the market.

ENACT Recommendations:

As a broad general principle, ENACT supports reaffirming FDA's authority over nicotine and nicotine containing tobacco products. FDA's authority should not be curtailed. Key markers of the adequacy of any legislation concerning FDA include:

Scope of Authority FDA must have full authority over all nicotine containing tobacco products, including but not limited to cigarettes, smokeless tobacco products, roll your own cigarettes, cigars, and pipes.

Nicotine as a Drug and Tobacco Products as Drug Delivery Devices The nicotine in tobacco products shall be a "drug" under the FDCA and "nicotine containing tobacco products" shall be "devices" under the FDCA. The FDA should have the authority to treat nicotine containing tobacco products under either its "drug" authority or its "device" authority at the discretion of the agency. There should not be a separate chapter in the FDCA just for tobacco in which tobacco is treated as neither a "drug" nor a "device".

Safety Standard The standard which FDA applies to drugs and devices is whether there is a "reasonable assurance that a product is *safe and effective*." There is no such thing as a safe cigarette. The goal of the agency with regard to tobacco products is to reduce the harm or risk to the American public from these products.

While the FDA has flexibility under its "restricted device" authority to balance health concerns in making its "safety and efficacy" determinations, for tobacco products, greater flexibility would be achieved by replacing the "safety and efficacy" standard with a standard that is explicitly keyed to "Reducing the overall health risk" to the American public.

The "overall health risk" must be measured by looking beyond the risk to current tobacco users to include the consideration of whether a product change or new rule will reduce or increase the overall number of tobacco users.

Tobacco manufacturers should have the "burden" of proving that a proposed product performance standard or a rule related to tobacco does not "reduce the overall health risk to the American public".

Authority to Reduce and/or Eliminate Harmful Components, Including Nicotine The FDA's authority over tobacco products should include the authority to reduce and, where appropriate, eliminate the harmful components of the tobacco product, including nicotine, the component of the tobacco product that is the primary agent which causes addiction. A decision to reduce or eliminate a harmful component of a tobacco product, including nicotine, should not be considered to be a ban on the sale of tobacco products to adults.

Procedural Fairness FDA's ability to regulate tobacco products should not be subject to different or more onerous standards or procedures than are applied to "drugs" or "devices".

The FDA should be empowered to "consider" all factors the Secretary deems relevant to the rule's or standard's overall impact on the public health, including but not limited to technological feasibility, the likely response of consumers to the proposal, and the likelihood that the change will result in the creation of a substantial black market. But the Secretary should not have the burden of making a formal determination with regard to any of these factors.

Procedurally, the Secretary should be entitled to establish "product performance standards" through the use of "notice and comment rulemaking." Tobacco product performance standards should be subject to the same level of Congressional and judicial review as is applied to other products, but no greater. It shall not be a requirement that a tobacco product performance standard, including a standard that requires the elimination of a harmful component of a tobacco product, including nicotine, can take effect only upon an affirmative vote of Congress.

Authority Over Youth Access and Tobacco Advertising and Marketing FDA should be the federal agency with primary rulemaking and enforcement authority over restrictions on a) youth access to tobacco products, b) tobacco advertising and marketing that appeals to children.

Health Information Disclosure FDA should be entitled to receive from the tobacco industry all documents and information in the tobacco industry's possession relevant to the health effects of tobacco products, nicotine and its effect on the body, addiction, marketing to children and the effect of marketing on children, and such other information that the Secretary deems necessary to permit the FDA to protect the public health. FDA should have the authority to subpoena this information when necessary. None of this information should be withheld from the FDA on the ground that it is confidential, represents a trade secret, or is subject to a claim of lawyer client privilege.

Respecting legitimate trade secrets and legitimate claims of lawyer client privilege, the FDA should have the authority to make information and documents available to the public as the FDA deems to be in the public's interest.

The authority to develop accurate measures and test for tar, nicotine, carbon monoxide yields, as well as other components of tobacco products and tobacco smoke, should be transferred from the FTC to the FDA.

Ingredients FDA should have the authority to require the tobacco industry to provide it with a complete list of all tobacco ingredients and additives, by brand and by quantity, and should be entitled to require that this information be disclosed to the public in a manner that does not disclose legitimate trade secrets. It should be illegal for any tobacco manufacturer to use any ingredient or additive that is harmful or which contributes to the harm of the product or which boosts the impact of nicotine. The burden should be on the tobacco manufacturer to demonstrate to the FDA that each ingredient and additive is safe in the quantity used under the conditions of intended use.

Health Warnings FDA should have the authority over health warnings on tobacco product packages and advertisements, including the power to revise and add health warnings and to alter the format for displaying health warnings.

Health Claims and Lower Risk Products FDA should have the authority to prohibit or restrict unsubstantiated health claims or health claims that have an adverse effect on the overall risk to the American public by discouraging people from quitting or encouraging them to start. The tobacco industry should not be permitted to make any direct or indirect health claim without the approval of the Secretary. FDA should also have the authority to encourage the development of products that reduce the health risk to consumers and that serve as a less harmful alternative to traditional nicotine containing tobacco products.

Preemption As a basic principle FDA's rules should not be preemptive of stronger or more stringent state or local tobacco control laws, except that state and local governments should not have the power to require health warnings in addition to or in a format different than that which is required by the federal government, and should not be entitled to have product performance standards or Good Manufacturing Practices that differ from or are inconsistent with product performance standards established by the FDA.

Public Support:

Surveys consistently show that Americans strongly support FDA Authority to regulate tobacco, as well as many of the specific provisions of the FDA Rule:

- A September, 1997 survey conducted by Market Facts' TeleNation found that 60 percent of the American public favors full authority of the FDA to regulate tobacco as it does other drugs and devices, with no special restrictions on the agency. Just 28 percent oppose this authority; the balance were undecided.

- In a March, 1997 survey, also conducted by Market Facts' TeleNation, 73 percent of Americans agreed that tobacco is an "addictive drug that should be regulated like other drugs," and 70 percent agreed that the FDA should have authority to regulate the sale and marketing of tobacco products.

In August, 1996, at the time of the announcement of the FDA Rule, 85 percent of the American public expressed support for "the new Food and Drug Administration policy to reduce the appeal of tobacco to kids and to make it harder for kids to get."

INCREASING PRICES ON TOBACCO PRODUCTS

The Problem:

Numerous studies show a strong connection between the price of tobacco and the level of consumption. The Institute of Medicine of the National Academy of Sciences, a National Cancer Institute Expert Panel on cigarette excise taxes, and the tobacco industry, in its own documents, have stated that increased tobacco prices are probably the most effective deterrent to tobacco use. Despite this, at an average price of less than $2.00 per pack, cigarettes in the United States are easily affordable to adults and children. The price of tobacco products in the United States is dramatically lower than in most industrialized nations, primarily due to the low (24 cents per pack) federal excise tax on cigarettes.

ENACT Recommendations:

- A minimum $1.50 per pack increase in the price of cigarettes over the next three years in order to reduce teen smoking and raise significant new revenue for programs to reduce tobacco use.

- Raising the price on all other tobacco products -- including snuff, chewing tobacco, roll-your-own tobacco, pipe tobacco and cigars -- to rates comparable to those imposed on cigarettes.

- Ensuring that the price of tobacco products will increase at regular intervals after the first three years in order to, at minimum, keep pace with inflation.

- Ensuring that the price increase is separate from any penalties to the industry if youth reductions are not achieved.

- Ensuring that the revenues generated by tobacco price increases are used first and foremost to reduce the use of tobacco and its attendant harmful effects, with special attention to those targeted by the tobacco industry.

- Implementing measures to discourage smuggling comparable to those that the federal government already undertakes for other sensitive products such as alcohol.

Price Increases Can Reduce Tobacco Use:

- Independent studies of past tax increases show that for every 10 percent increase in the price of a pack of cigarettes, overall cigarette consumption falls approximately four percent[1].

Increases in the price of smokeless tobacco also have been shown to reduce consumption.[2]

- Because children have less disposable income, it has been found that each percentage point increase in cigarette prices leads to a roughly proportional reduction in the smoking participation of youth[3].

- According to one study, a 75-cent tax increase would cut the number of teen smokers by almost 1.6 million. Using conservative estimates, that translates to preventing nearly 400,000 people from dying prematurely from smoking[4].

- A 1995 article in the *American Journal of Public Health* estimated that a 25 cent increase in the California cigarette tax reduced sales in the state by 819 million packs over a two and a half year period, while the state's anti-smoking media campaign exerted an additional independent impact.[5]

- Since 1993, when the Massachusetts cigarette tax was raised 25 cents, cigarette sales declined by 17 percent. That decline is three times the national rate of decline over the same period.[6]

- Canada is a clear example of how increasing tobacco taxes reduces use. From 1981 to 1992, due to several major cigarette tax increases, smoking declined by 38 percent overall and by 60 percent among teenagers.[7] In February 1994, the Canadian cigarette tax was sharply reduced. Since then the health costs of the tax rollback have been extraordinary. According to a government report, smoking has increased by nearly 10 percent after nearly 15 years of continuous decline.

Public Support:

- A September, 1997 survey of 1,000 U.S. adults conducted by Market Facts' TeleNation showed that by a margin of almost two-to-one (59% favor vs. 33% oppose), the American public supports price increases of up to $1.50 per pack if youth smoking does not decline.

- A March, 1993 USA Today/CNN poll found that 83 percent of the voting public favored raising tobacco taxes.

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[1] National Cancer Institute. "The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults." Rockville, MD: Division of Cancer Prevention and Control, National Cancer Institute, 1993.
[2] Chaloupka, F., Grossman, M, and Tauras, A., "Public Policy and Youth Smokeless Tobacco Use," National Bureau of Economic Research, Working Paper 5524, April, 1996.
[3] Sweanor, D. "Why Raise Cigarette Prices." *World Smoking and Health: Taxing Tobacco.* Vol. 15, No. 3, 1990, p. 6.
[4] Chaloupka, F.J., Grossman, M. "Price, Tobacco Control Policies and Youth Smoking," National Bureau of Economic Research Working Paper Number 5740, September 1996.
[5] Teh-wei Hu, , Hai-yen Sung, and Keller, T. "Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-Smoking Media Campaign," *American Journal of Public Health.* September, 1995.
[6] Centers for Disease Control. "Cigarette Smoking Before and After an Excise Tax Increase and an Antismoking Campaign - Massachusetts, 1990-1996," *Morbidity and Mortality Weekly Report.* November 8, 1996, p. 966-970.

[7] Sweanor, D.T., Martial, L.R. "The Smuggling of Tobacco Products: Lessons from Canada." Non-Smokers' Rights Association. Ontario, Canada, 1994.

SETTING PENALTIES FOR MISSING YOUTH SMOKING TARGETS

Background:

ENACT's policy statement, several bills introduced in the Congress, and the proposed tobacco settlement include a wide range of traditional public health strategies to reduce youth tobacco use. Each of these documents also includes a relatively new and potentially highly effective tobacco control strategy, commonly referred to as the "lookback" approach. The "lookback" provision is the only strategy that gives the tobacco companies themselves an incentive to reduce youth tobacco use. The "lookback" approach sets specific targets for reducing youth smoking and youth smokeless tobacco use. Penalties would be imposed on the industry if the targets are not met.

Decades of experience make clear that the tobacco industry will attempt to undermine and circumvent any effort to reduce tobacco use and the terrible toll it takes on our nation. We must fundamentally change the way the tobacco companies do business. The tobacco companies must be given powerful economic incentives to reduce youth tobacco use.

Years of sophisticated marketing by the tobacco companies have created the social norms that make tobacco appealing to youth. The tobacco companies have hooked generation after generation and misled the American public about the dangers of their products. Tobacco industry marketing has resulted in unacceptably high rates of underage smoking and smokeless tobacco use. The industry must now be held accountable for reducing the use of these products by underage youth.

Tobacco companies have many tools at their disposal to reduce youth tobacco use, such as raising the prices of their products or re-orienting their advertising to discourage underage tobacco use. The "lookback" offers the best hope for giving the tobacco industry strong incentives to prevent kids from getting hooked in the first place.

ENACT Recommendations:

Youth Smoking Targets

- The Secretary of the Department of Health and Human Services (HHS) should be required to conduct a survey each year beginning in the second year after enactment of legislation to determine current youth smoking levels and the proportion of underage smokers who use each manufacturer's products. The survey should include sufficient sample sizes to monitor trends in subgroups defined by gender, age, race/ethnicity, and socio-economic status.
- To hold the tobacco companies accountable for the recent increases in tobacco use by young people, ENACT recommends using the weighted average of smoking prevalence measured over a five- or 10-year period to calculate baseline prevalence levels from which declines are

measured.

- Overall youth smoking must be reduced from the baseline level by at least the following amounts:

At the end of:	Reduction target:
Year 2	15%
Year 3	20%
Year 4	25%
Year 5	30%
Year 6	40%
Year 7	50%
Year 8	55%
Year 9	60%
Year 10	65%

- The Secretary should be required through rulemaking to set youth smoking targets for Year 11 and beyond. The targets must aim for progressively steeper reductions in youth smoking beyond the 65 percent reduction target set for Year 10.

Penalty Levels

ENACT recognizes that there are many different ways the penalties to be imposed on manufacturers could be calculated. Any penalty structure must give the tobacco manufacturers powerful incentives to ensure that the youth smoking targets are met.

- The Secretary shall assess penalties on each manufacturer when overall youth smoking levels fail to meet the specified targets.
- The penalty assessed on each manufacturer should be based on the proportion of youth smokers using each manufacturer's products in the year for which the penalties are assessed.
- The penalties must not be capped.
- The penalties must not be tax-deductible.
- The penalties must not be abated if the youth smoking targets are not met. Consideration should be given, however, to giving manufacturers financial incentives for exceeding the targets.
- As with the targets and penalties for underage smoking, targets and penalties should be established that give manufacturers a powerful incentive to reduce underage smokeless tobacco use.

Will Lookback Provisions Work?

Because incentives have never been used to encourage tobacco companies to reduce underage tobacco use, there is no empirical evidence to tell us how effective the lookback provision will be. There is good reason to believe, however, that a lookback provision that provides economic incentives to reduce tobacco use will be effective.

Perhaps the most compelling evidence is that the tobacco industry has a long track record of successful marketing to increase use of a product among children. For example, R.J. Reynolds Tobacco Company's Joe Camel advertising campaign was highly successful in increasing Camel's market share among underage smokers. The marketing skill that the tobacco companies have demonstrated could, if the companies wished, also be put to use to reduce youth smoking. In addition, there are many other strategies the industry could employ to reduce underage smoking if it had the appropriate financial incentives.

Public Support:

The public supports holding tobacco companies responsible if tobacco use among youth does not decline. According to a national telephone survey conducted by Market Facts' TeleNation, 57 percent of Americans favor stiff penalties if tobacco use does not to target levels, while only 34 percent are opposed.

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PUBLIC EDUCATION

The Problem:

The tobacco industry spends over five billion dollars a year marketing and advertising its products.[1] In 1995, an article in the *Journal of the National Cancer Institute* found that tobacco marketing has a greater influence than exposure to parents or peers who smoke in spurring kids to take up smoking[2], and other studies have shown the vast majority of young smokers prefer one of the three most heavily advertised brands of cigarettes[3] -- the result of a deliberate strategy on the part of tobacco companies to attract the youth market.[4]

While there are a handful of state-level public education initiatives which attempt to counter the tobacco industry's substantial marketing efforts, there is no national anti-tobacco public education campaign to counter this pro-tobacco imagery. While the state-level programs can be effective, relatively few states have the resources to mount comprehensive counter advertising campaigns, and national media buys are much more cost effective. Therefore, national action is needed to combat the tobacco industry message in every state.

ENACT Recommendations:

Comprehensive efforts to reduce tobacco use should include a sustained, highly visible and well-developed public education campaign as a complement to increased prices, restrictions on youth access to tobacco, and the elimination of the tobacco marketing that has made tobacco products attractive to kids.

Public Education campaigns play a vital role in reducing the appeal of tobacco products. Current programs share a trifold intent: to keep kids from picking up a tobacco habit, to encourage adults and youth to quit using tobacco, and to change the social context of tobacco use so that it is no longer a favorable, or acceptable, activity.

The standard for public education in the tobacco arena is a multi-pronged model, incorporating mass media (radio, newspaper, and television) prevention and cessation advertising, school-based information programs, lifeskills training, parental interventions, community programs, and clinical (e.g., doctors, nurses) involvement.

ENACT believes that a national anti-tobacco public education campaign is vital to the nation's public health. For such a campaign to be effective, it must contain, at a minimum, the following elements:

- It must include the country's largest ever counter-advertising campaign that should be well-integrated and complementary with all of the other components outlined above.

- It must be grounded in rigorous and state-of-the-art research on effectiveness.
- It must be well-funded over the long term from a reliable source.
- It must exist completely independent of tobacco industry input.
- It must target both adults and kids, in the areas of both prevention and cessation.
- It must address the dangers of secondhand smoke.
- It must address high risk and special populations with culturally sensitive language.
- It should include national campaigns complemented by state-level programs that address local issues.
- It should include a retailer/vendor education component.
- It must contain a method for reliable evaluation and modification.

Public Education Campaigns Can Reduce Tobacco Use:

Several states are undertaking anti-tobacco campaigns. Minnesota was the first to use tobacco excise taxes to carry out such a program. More recently, California, Massachusetts, and Arizona, have adopted state-based public education programs, and several other states are initiating them. While it is too early to evaluate the effects of many of the programs, the available data demonstrate that both the California and Massachusetts programs, as well as other public education campaigns, have been effective in reducing tobacco use.

- A study published in the *American Journal of Public Health* found that the California anti-tobacco media campaign reduced sales of cigarettes by 232 million packs between the third quarter of 1990 and the fourth quarter of 1992. This effect was independent of the decreases in consumption brought about by the tax increase.[5]
- Cigarette smoking prevention programs have consistently shown reductions in the proportions of students who begin regular smoking, and there is clear evidence that school-based programs are most effective when supplemented by mass-media interventions.[6-10]
- In terms of cost per years of life gained, mass-media and education campaigns are among the most cost-effective smoking prevention and cessation methods currently available.[11]
- Three years after Massachusetts began its public education and tobacco control campaign, an independent evaluation[12] found that:

- Tobacco consumption in Massachusetts declined at a rate three times that of rate for the rest of the nation (20% vs. 6%, excluding CA).

- Smokers were smoking less. The proportion of light smokers (less than half a pack of cigarettes a day) increased from 21 to 34 percent of all smokers, while the proportion of heavy smokers (more than a pack a day) dropped from 26 percent to 13 percent.

- While smoking among high school students increased dramatically on the national level, it did not increase significantly in Massachusetts.

- Doctors and dentists are advising more patients to quit smoking.

- Workers are less exposed to environmental tobacco smoke.

- Compliance with youth access restrictions has improved. The proportion of retailers making illegal sales dropped from 48 percent to 19 percent.

- A 15-year follow-up study recently reported in the *American Journal of Public Health* showed that a school based education program combined with community and mass media interventions could have long-term smoking prevention effects. Mean lifetime cigarette consumption was 22 percent lower among program subjects than among control subjects. Even among 28 year olds, the intervention that began 15 years earlier still resulted in significantly lower rates of smoking.[13]

Overall, studies in the U.S. and abroad have demonstrated that public education campaigns work.[14] They increase knowledge and decrease consumption.[15] No such nationwide program currently exists in the United States.

Public Support:

A public opinion poll conducted by Market Facts' TeleNation in September of 1997 found that nearly 70 percent of adults support a national prevention and education program on tobacco, with 43 percent strongly favoring such a program and 27 percent somewhat favoring such a program.

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[1] Federal Trade Commission, "1997 Federal Trade Commission Report to Congress for 1995, Pursuant to the Federal Cigarette Labeling and Advertising Act," 1997.

[2] Evans N, Farkas A, Gilpin E, Berry C, Pierce JP "Influence of Tobacco Marketing and Exposure to Smokers on Adolescent Susceptibility to Smoking" *Journal of the National Cancer Institute*, 87(20):1538-1545 18 October 1995.

[3] CDC "Changes in the Cigarette Brand Preference of Adolescent Smokers, U.S. 1989-1993," *Morbidity and Mortality Weekly Report*, 43(32): 577-581 August, 1994.

[4] RJR Industry documents released 15 January 1998, as reported in *Washington Post, New York Times, Wall Street Journal.*

[5] Teh-Wei Hu, Hai-Yen Sung, Keeler TE. "Reducing Cigarette Consumption in California: Tobacco Taxes vs an Anti-Smoking Media Campaign." *Am J Public Health* 1995; 85(9):1218-1222

[6] Flynn BS, et al., "Prevention of Cigarette Smoking Through Mass Media Intervention and School Programs." *Am J Public Health*, 1992; 82:827-834.

[7] Bauman KE, LaPrelle J, Brown JD, Koch GG, Padget CA. "The influence of three mass media campaigns on variables related to adolescent cigarette smoking: results of a field experiment." *Am J Public Health* 1991; 81:591-604.

[8] Flynn BS, et al., "Mass Media and School Interventions for Cigarette Smoking Prevention: Effects 2 Years after Completion." *Am J Public Health*, 1994; 84:1148-1150.

[9] Flynn BS, et al., "Long-Term Responses of Higher and Lower Risk Youths to Smoking Prevention Interventions." *Preventive Medicine*, 1997; 26:389-394.

[10] Worden JK, et al., "Using Mass Media to Prevent Cigarette Smoking Among Adolescent Girls." *Health Education Quarterly*, 1996; 23(4):453-468.

[11] Secker-Walker RH, Worden JK, et al., "A Mass Media Programme to Prevent Smoking Among Adolescents: Costs and Cost Effectiveness." *Tobacco Control*, 1997; 6:207-212.

[12] Abt Associates, Inc., "An Independent Evaluation of the Massachusetts Tobacco Control Program;" Third Annual Report: Summary; January 1994 to June 1996.

[13] Vertiainen, E. et al. "Fifteen-Year Follow-Up of Smoking Prevention Effects in the North Karelia Youth Project." *Am J Public Health 1998; 88;1:81-85.*

[14] Reid DJ, McNeill AD, Glynn, TJ. "Reducing The Prevalence Of Smoking In Youth In Western Countries: An International Review." *Tobacco Control* 1995; 4:266-277.

[15] Flay BR, Koepke D, Thomson SJ, Santi S, Best JA, Brown KS. "Six-Year Followup Of The First Waterloo School Smoking Prevention Trial." *Am J Public Health* 1989; 79:1371-6.

YOUTH ACCESS TO TOBACCO

The Problem:

Studies show that it is far too easy for children and youth to buy tobacco. For example, a 1996 Centers for Disease Control and Prevention (CDC) study[1] revealed that:

- Sixty-two percent of 12-17 year old smokers reported usually buying their own cigarettes, and another 16 percent said they had bought their own cigarettes but did not usually do so. Only 2 percent said they had tried and never succeeded.

- Of those who had ever tried to buy cigarettes, almost one-half (45%) had NEVER been asked to show proof of age.

- Of those who usually bought their own cigarettes, 89 percent often or sometimes bought from small stores, 37 percent from large stores, and 13% from vending machines. (Young adolescents (12-15) are more likely than older adolescents (16-17) to purchase from vending machines (18% v. 10%).

A review of 13 other studies of over-the-counter sales of tobacco found that, on average, children and adolescents were successful in buying tobacco products 67 percent of the time.[2]

The tobacco industry and others reap enormous profits from the illegal sale of tobacco products to minors. The CDC estimates that 256 million packs of cigarettes are illegally sold to minors each year, resulting in almost $500 million in sales.[3]

ENACT Recommendations:

While there have been numerous state and local efforts to limit youth access to tobacco, many have been sporadic and under-funded. A comprehensive national plan, building on the Food and Drug Administration's (FDA) tobacco rule, to reduce youth access to tobacco is needed.

Without preventing state and local governments from imposing stricter measures, national legislation should:

- Reaffirm the FDA's current authority and regulations regarding youth access to tobacco and provide adequate funding for FDA enforcement.

- Establish 18 as the minimum age for purchasing tobacco products and require that retailers check the photo identification of anyone buying tobacco products who appears younger than 27. Require enforcement of this law with sufficient vigor to maintain compliance above 90 percent.

- Hold retailers responsible by penalizing them for illegal sales to kids.

- Establish the basic requirement of face-to-face transactions for all sales of tobacco products. This is intended to eliminate self-service displays which facilitate illegal sales to minors by allowing children to buy tobacco without having to ask for it.

- Ban all sales of tobacco products through vending machines.

- Prohibit free-giveaway of tobacco products, also known as "sampling"

- Ban the sale of tobacco products from opened packages to eliminate the sale of individual cigarettes, which are more affordable for children.

- Ban the distribution of tobacco products through the mail to ensure that photo identification can be checked during face-to-face transactions.

- Establish a minimum package size of 20 cigarettes to prevent the sale of "mini" packs that would be cheaper and more affordable to kids, as well as easy to steal and/or hide.

- Mandate minimum federal standards for a retail licensing program that the federal government and state and local authorities would enforce and which would include penalties for violations and suspension or revocation of licenses.

Do Youth Access Provisions Work?

Several studies have shown that strong, strictly enforced youth access laws can reduce illegal sales to minors. Some studies have also suggested that these laws can contribute to reduced tobacco use among minors.

- A 1991 study published in the *Journal of the American Medical Association* demonstrated that a comprehensive merchant education, community education, and enforcement program in Solono, CA resulted in reducing underage sales to 24 percent. The results also showed that merchant education alone, without compliance checks, had a limited impact on reducing illegal sales. [4]

- Another study, also published in *JAMA*, found that a comprehensive youth access program in Woodridge, IL, reduced sales to minors from 70 percent to less than 5 percent over a year and a half, with a corresponding decrease in regular tobacco use among youth of over 50 percent.[5]

- A recent study in Massachusetts, published in the *New England Journal of Medicine*, failed to demonstrate an effect of a youth access intervention on perceived access to tobacco or tobacco use by kids but did show a significant increase in merchant compliance regarding tobacco sales to minors.[6]

- A recent study of 14 Minnesota communities, presented at the 1997 annual meeting of the American Public Health Association, showed that an intervention involving local ordinances and enforcement to limit youth access to tobacco had a significant impact on smoking rates, perceived availability of cigarettes from commercial sources, and reported use of commercial sources of cigarettes.[7]

While youth access provisions alone are unlikely to solve the problem, they are an essential part of any comprehensive tobacco control policy. Aside from their effects on sales to minors and use by children, when strictly enforced, they send a clear message to children and adults about the hazards of tobacco use. Conversely, minimum-age laws that are not enforced convey the message that the law is not to be taken seriously, undermining efforts in schools and communities to educate youth about the serious health hazards of tobacco.

Public Support:

Surveys consistently show that youth access provisions are among the most strongly supported of tobacco control policies. A national survey conducted by Market Facts' TeleNation in September of 1997 revealed that 85 percent of the public supports a national minimum age of 18 with required ID checks, while 83 percent support a ban on vending machines and placing all tobacco products behind the counter.

A June survey by the same organization revealed strong support for many of the specific access provisions and strict enforcement, as well as deep concern about the problem, as illustrated below:

National Minimum Age and ID Checks

- Nearly all Americans (92%) agree that young people should be required to show a photo ID to buy tobacco products.

- Eighty-seven percent of the public agree with the FDA policy setting a national minimum age of 18 for the purchase of tobacco products and mandating ID checks of all tobacco purchasers who appear to be under age 27.

- Three-fourths agree that it is important to have a national policy prohibiting tobacco sales to children rather than leaving it to the individual states.

Enforcement

Large majorities of the public believe it is easy for teenagers to buy tobacco and that stores are willing to sell to them unless they fear fines. Thus, the public's overwhelming support for enforcement is not surprising.

- Eighty-two percent of those surveyed agree that it is easy for teenagers to buy tobacco, and 82 percent agree that, if stores are not afraid of being fined, they will sell tobacco to minors.

- Ninety percent of the public believe stores that illegally sell tobacco to minors should be fined.

- Ninety percent also believe that stores that are repeat offenders in selling tobacco to minors should have their license to sell tobacco suspended.

- Nearly two-thirds (64%) of those polled believe the federal government should provide money to the states to enforce rules prohibiting stores from selling cigarettes to minors.

Perception of the Problem

- Eighty-four percent of the public believe that stores selling tobacco products to children and youth is a serious problem.

- A large majority (61%) believe that if minors are unable to buy cigarettes in stores, fewer of them will smoke.

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[1] CDC. "Accessibility of Tobacco Products to Youths Aged 12-17 Years – United States, 1989 and 1993," *Morbidity and Mortality Weekly Report*, February 16, 1996.

[2] "Preventing Tobacco Use Among Young People" *A Report of the Surgeon General, 1994.*

[3] Cummings, et al., "The Illegal Sale of Cigarettes to US Minors: Estimates by State," *American Journal of Public Health.* 1994;84:300-302.

[4] Feighery, E; Altman, DG and Shaffer, G. "The Effects of Combining Education and Enforcement to Reduce Tobacco Sales to Minors." *Journal of the American Medical Association* 266:22:3168-3171. December 11, 1991.

[5] Jason, LA; Ji, PY; Anes, MD; Birkhead, SH. "Active Enforcement of Cigarette Control Laws in the Prevention of Cigarette Sales to Minors." *Journal of the American Medical Association* 266:22:3159-3161. December 11, 1991.

[6] Rigotti NA et al. "The Effect of Enforcing Tobacco-Sales Laws on Adolescents' Access to Tobacco and Smoking Behavior." *The New England Journal of Medicine* 337:15:1044-1051. October 9, 1997.

[7] Forster J et al. "The Effects of Community Policies to Reduce Youth Access to Tobacco" Presentation at the American Public Health Association 125th Annual Meeting and Exposition, November 10, 1997, Indianapolis, IN.

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RESTRICTIONS ON TOBACCO MARKETING AND PROMOTION

The Problem:

Tobacco companies spend roughly $5 billion each year (over $13 million every day) promoting their products in order to replace the thousands of customers who either die or quit each day.[1] Numerous tobacco industry documents make clear that the industry has perceived kids as young as thirteen as a key market, studied the smoking habits of kids, and developed products and marketing campaigns aimed at them:

"Evidence is now available to indicate that the 14-18 year old group is an increasing segment of the smoking population. RJR-T must soon establish a successful new brand in this market if our position in the industry is to be maintained in the long term." ("Planned Assumptions and Forecast for the Period 1977-1986 for RJ Reynolds Tobacco Company," March 15, 1976)

"This young adult market, the 14-24 group,...represent[s] tomorrow's cigarette business. As this 14-24 age group matures, they will account for a key share of the total cigarette volume – for at least the next 25 years." (Presentation from C.A. Tucker, Vice President of Marketing, to the Board of Directors of RJR Industries, September 30, 1974)

"To ensure increased and longer-term growth for the Camel Filter, the brand must increase its share penetration among the 14-24 age group which have a new set of more liberal values and which represent tomorrow's cigarette business." (1975 Memo to C.A. Tucker, Vice President for Marketing, RJR)

"Cherry Skoal is for somebody who likes the taste of candy, if you know what I'm saying." (former UST sales representative, quoted in a 1994 Wall Street Journal article on UST's graduation strategy)

"Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while still in their teens ... The smoking patterns of teenagers are particularly important to Philip Morris." (1981 Philip Morris internal document)

In addition to the industry's own statements, the evidence is compelling that much of their advertising and promotion is directed at kids and that it is very successful in recruiting new tobacco users to years of addiction.

- Eighty-six percent of kids who smoke prefer Marlboro, Camel and Newport -- the three most heavily advertised brands. Marlboro, the most heavily advertised brand, constitutes almost 60 percent of the youth market but only about 25 percent of the adult market.[2]

- Each day, 3,000 kids become regular smokers.[3] Since 1991, past-month smoking has increased by 35 percent among eight graders and 43 percent among tenth graders, while smoking among high seniors is at a nineteen year high.[4]

- Almost 90 percent of adults who have ever been regular smokers began smoking at or before age 18.[5]

- Thirty percent of kids (12 to 17 years old), both smokers and nonsmokers, own at least one tobacco promotional item, such as T-shirts, backpacks, and CD players.[6]

- Between 1989 and 1993, when advertising for the new Joe Camel campaign jumped from $27 million to $43 million, Camel's share among youth increased by more than 50 percent, while its adult market share did not change at all.[7]

- A study published in the *Journal of the National Cancer Institute* found that teens are more likely to be influenced to smoke by cigarette advertising than they are by peer pressure.[8]

- A 1996 study in the *Journal of Marketing* found that teenagers are three times as sensitive as adults to cigarette advertising.[9]

- A 1994 article in the *Journal of the American Medical Association* documented a rapid and unprecedented increase in the smoking initiation rate of adolescent girls subsequent to the launch in the late 1960's of women's cigarettes brands like Virginia Slims.[10]

- A new (1998) longitudinal study of teenagers in the *Journal of the American Medical Association* showed that tobacco industry promotional activities influenced previously non-susceptible non-smokers to become susceptible to or experiment with smoking.[11]

- The development and marketing of "starter products" with features such as pouches and cherry flavoring have resulted in smokeless tobacco going from a product used primarily by older men to one for which young men comprise the largest portion of the market.[12] Twenty percent of high school boys are current smokeless tobacco users.[13]

ENACT Recommendations:

ENACT recommends strict limits on tobacco marketing an promotion that influences kids. National legislation should build on the Food and Drug Administration's (FDA) regulations. FDA should have full authority over enforcement of these restrictions and for penalizing violations. Recognizing the tobacco industry's history of creatively circumventing policy, the FDA would have the authority to revisit restrictions after five years. If extraordinary circumstances warranted, the FDA could address the marketing and promotion restrictions sooner. At a minimum, the restrictions should include the following:

Advertising

- Eliminate all billboards and outdoor signs, including all signs in stadiums and arenas and signs that face outwards in enclosed areas, such as stores.

- Eliminate all human images, and cartoon characters from all advertising and from all cigarette packages, including cartons.

- Restrict tobacco product advertising to black and white text only in publications read by a

significant number of young people (defined as youth readership of either 2 million or 15 percent). FDA must approve the methodology of surveys used to determine youth readership.

- Restrict point of purchase advertising to limit their size and number, remove them from the line of sight of children and remove them from close proximity to candy and other goods likely to attract children.

- Eliminate internet advertising and use whatever technology available to make tobacco advertisements placed on the internet from foreign countries inaccessible in the United States.

- Prohibit the use of brand names associated with non-tobacco products as brand names for tobacco products.

- Require cigarette, cigar and smokeless tobacco products and advertisements to carry the FDA-mandated statement of intended use "Nicotine Delivery Device"

Marketing

- Prohibit marketing and promotion of all non-tobacco products, services, goods and other items that carry tobacco brand names, logos, or imagery (e.g., Camel Cash, Marlboro Gear or travel).

- Prohibit tobacco manufacturers, distributors, or retailers from sponsoring any athletic, social or cultural events (or any entry or team in any event) using the brand name or brand imagery of any tobacco product.

- Prohibit any payments or fees to celebrities to use tobacco in the movies, on TV or any other entertainment, media or technology markets (e.g., music videos, live or recorded entertainment, video games, etc.) or to any other person or entity to glamorize tobacco use in movies, on TV or any other entertainment, media or technology markets. Prohibit any "in-kind" actions to accomplish any of these same purposes.

- Ban offers of non-tobacco items, gifts or services (e.g., travel) based on proof of purchase of tobacco products.

- Ban all sales of tobacco products through mail-order or on the Internet and other electronic systems.

Packaging and Warning Labels

- Provide FDA with the authority to prohibit or restrict unsubstantiated health claims or health claims that have an adverse effect on the overall risk to the American public by discouraging people from quitting or encouraging them to start.

- Establish a new warning label system. The warnings would appear in the Canadian format

(top of the front with white lettering on black background). The warning would occupy at least 25 percent of the front of the package. All warnings would appear simultaneously on tobacco packages and cartons and would be rotated quarterly on ads by brand.

For cigarettes, the warnings would include, but not be limited to:

"WARNING: Cigarettes are addictive"
"WARNING: Tobacco smoke can harm your children"
"WARNING: Cigarettes cause cancer"
"WARNING: Smoking during pregnancy can harm your baby"
"WARNING: Smoking can kill you"
"WARNING: Quitting smoking now greatly reduces serious risks to your health"
"WARNING: Tobacco smoke causes fatal lung disease in non-smokers"
"WARNING: Cigarettes cause strokes and heart disease"
"WARNING: Cigarettes cause fatal lung disease"

For smokeless tobacco the warnings would include, but not be limited to:

"WARNING: This product causes mouth cancer"
"WARNING: This product causes gum disease and tooth loss"
"WARNING: This product is not a safe alternative to cigarettes"
"WARNING: Smokeless tobacco is addictive"

For cigars, the FDA would have the authority to develop appropriate warnings.

Are Marketing and Promotion Restrictions Effective?

The tobacco industry has been very successful in blocking efforts to restrict tobacco advertising so there have been few studies of the effects of such restrictions. One study found a small decrease in smoking by youth following the ban on radio and television advertising in 1971[14], and smoking among U.S. adults has decreased from 37 percent to 25 percent since the television advertising ban[15]. However, other factors are clearly involved, and the tobacco companies have developed new methods, such as the use of promotional products and reward programs (e.g., Camel Cash, Marlboro Gear), to promote their products.

Several quantitative studies from other countries show that tobacco advertising restrictions and bans can reduce youth smoking.

- A large, multinational study commissioned by the New Zealand Government found that in countries where advertising was totally banned or severely restricted, the percentage of young people who smoke decreased more rapidly than in countries where tobacco promotion had been less restricted and that there appeared to be a greater decrease in smoking uptake in those countries with the most stringent measures compared with those countries where advertising had not been affected.[16]

- Another study by the Government of Great Britain found that restrictions on advertising tend to decrease tobacco use beyond what would have occurred in the absence of such restrictions. An in-depth analysis of various forms of advertising restrictions in four Western European countries showed that such restrictions, including bans on some or all forms of advertising, led to a reduction in consumption.[17]

- A follow-up to the British study above demonstrated drops in overall consumption of between 11 percent and 37 percent since advertising bans were introduced in Norway (1975), Finland (1978), New Zealand (1990), and France (1993). In three of these countries, smoking prevalence among young people also decreased, while in one, it remained stable.[18]

Public Support:

Survey results consistently show that most Americans, including adults, teens, and even advertising industry executives, believe the tobacco companies deliberately market tobacco products to kids. It is therefore not surprising that the public supports restrictions on the marketing of these products to kids.

- A national survey of 1,000 adults by Market Facts' TeleNation in September of 1997 showed that nearly two-thirds of the public favors the elimination of outdoor tobacco advertising. By large margins, the public also favors limits on tobacco print advertising (55% v. 29% oppose) and sponsorship of sports and entertainment events (51% v. 36% oppose).

- Another national survey by the same firm in March of 1997 showed that 70 percent agree that the Food and Drug Administration should have authority to regulate the sale and marketing of tobacco products.

- A Bruskin-Goldring poll of 1,000 adults in August of 1996 revealed large majorities who agreed that image advertising by the tobacco companies should not be allowed:

    - in magazines read by kids (79%)

    - on t-shirts, hats, backpacks, or other items kids may wear or use (72%)

    - within 1,000 feet of schools or playgrounds (78%)

    - in the sponsorship of sporting events that large numbers of kids attend (70%)

- A telephone survey of 300 advertising industry executives in agencies with billings of more than $10 million was commissioned by the New York advertising firm of Shepardson, Stern, and Kaminsky in December of 1996 and revealed the following.

    - Eighty-two percent believe advertising for cigarettes and tobacco products reaches children and teenagers in significant numbers.

- Seventy-eight percent believe current tobacco advertising makes smoking more appealing or socially acceptable to kids.

- Seventy-one percent believe that tobacco advertising changes behavior and increases smoking among kids.

- Seventy-nine percent favor limitations on the style and placement of advertising for cigarette and tobacco products to minimize impact on children and teenagers.

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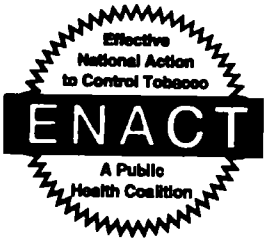
[1] Federal Trade Commission, "1997 Federal Trade Commission Report to Congress for 1995, Pursuant to the Federal Cigarette Labeling and Advertising Act," 1997.
[2] CDC. "Changes in the Cigarette Brand Preference of Adolescent Smokers, U.S. 1989-1993," *Morbidity and Mortality Weekly Report*, August, 1994.
[3] Pierce, J.P., et al., "Trends in Cigarette Smoking in the United States: Projections to the Year 2000," *JAMA*, vol. 261, No. 1. 1989.
[4] The Monitoring the Future Study, University of Michigan, 1997.
[5] "Preventing Tobacco Use Among Young People," *A Report of The Surgeon General, 1994*
[6] Gallup International Institute, "Teen-age Attitudes and Behaviors Concerning Tobacco," September, 1992.
[7] CDC. "Changes in the Cigarette Brand Preference of Adolescent Smokers, U.S. 1989-1993," *Morbidity and Mortality Weekly Report*, August, 1994.
[8] "Influence of Tobacco Marketing and Exposure to Smokers on Adolescent Susceptibility to Smoking," *Journal of the National Cancer Institute*, October, 1995.
[9] Pollay et al., "The Last Straw? Cigarette Advertising and Realized Market Shares Among Youth and Adults," *Journal of Marketing, Vol. 60, No. 2.*
[10] Pierce, J., L. Lee, and E.R. Gilpin, "Smoking Initiation by Adolescent Girls, 1944 Through 1988," *JAMA*, vol. 271, No. 8, pp. 608-611, 1994.
[11] Pierce, J. et al, "Tobacco Industry Promotion of Cigarettes and Adolescent Smoking," *JAMA*, Vol. 279, No. 7, pp. 511-515, 1998.
[12] CDC. "Surveillance for Selected Tobacco-Use Behaviors – United States, 1900-1994." *Morbidity and Mortality Weekly Report*; November 18, 1994/Vol. 43/No. SS-3.
[13] CDC. "Youth Risk Behavior Surveillance – United States, 1995." *Morbidity and Mortality Weekly Report*, September 27, 1996/Vol. 45/No. SS-4.
[14] Lewit, E.M., Coate, D. & Grossman, M. "The Effects of Government Regulation on Teenage Smoking." *Journal of Law and Economics*, Volume 24.
[15] CDC. "Cigarette Smoking Among Adults – United States, 1994." *Morbidity and Mortality Weekly Report*,. July 12, 1996.
[16] "Health or Tobacco--An End to Tobacco Advertising and Promotion," Toxic Substances Board Wellington, New Zealand, May 1989.
[17] Department of Health, "Effect of Tobacco Advertising on Tobacco Consumption," London, 1992.
[18] "The Effectiveness of Banning Advertising for Tobacco Products." UICC/ECL EU Liaison Office, October, 1997.



TOBACCO USE CESSATION

The Problem:

Approximately 48 million Americans currently smoke cigarettes, but most smokers are either actively trying to quit or want to quit. While prevention programs can prevent young people from ever becoming addicted to nicotine, 10-20 million current smokers will die from tobacco-related diseases unless treatment efforts are increased. Tobacco use cessation or treatment programs offer the best hope for preventing these people from dying from tobacco-related diseases.

Quitting smoking or the use of other tobacco products results in significant and immediate health benefits both for healthy people as well as for those suffering from tobacco-related diseases. For those who quit smoking, for example, the risk of death for ex-smokers is similar to the risk for people who have never smoked after a 15 year time frame. In addition, the health benefits of quitting tobacco are significant for the unborn children of pregnant women and for children exposed to environmental tobacco smoke from smoking by household members. In order to quit tobacco use, physiological dependence on nicotine as well as the psychological gratification received from tobacco products must be overcome. The fact is that half of Americans who ever smoked have quit, thus causing a substantial decline in smoking over the last 30 years.

A number of barriers prevent the delivery of effective tobacco use cessation services:

- Clinicians do not consistently assess whether their patients use tobacco, nor do they offer smoking cessation treatment to every smoker at every office visit. Evidence shows that 70 percent of U.S. smokers see their physician each year[1], and 60 percent of the U.S. population aged five and older is seen by a dentist[2], giving physicians and dentists considerable access to smokers. If only half of all the U.S. physicians and dentists gave brief advice to their patients and 10 percent of them were successful in quitting, there would be nearly 2 million new nonsmokers in the U.S. each year.[3]

- Inadequate training, lack of time and lack of reimbursement for services have made it difficult for physicians and other health care professionals to provide adequate smoking cessation counseling and treatment.

- Surveys indicate that smoking cessation therapy is not consistently provided as paid services for subscribers of health insurance packages despite the fact that tobacco use cessation is considered a highly cost effective service. One survey demonstrated that as few as 11 percent of health insurance carriers provide coverage for treatment of nicotine addiction;[4] another survey of 105 health maintenance organizations found that few knew about the

prevalence of smoking within their membership and general cessation services were offered by two-thirds of the plans.[5] In addition, a 1994 study of California health insurance plans found that only two percent of the 48 insurance companies sold any policies that covered smoking cessation treatment.[6] Even Medicare and Medicaid do not routinely cover smoking cessation services.

- Smokers of low socioeconomic status also tend to be underserved by tobacco use cessation programs. They may be less likely to have health insurance; they may be unable to afford over-the-counter smoking cessation products; or they may live in areas where these products are less easily obtainable and cessation services less accessible.

- Little evidence exists regarding the safety and efficacy of psychosocial or pharmacological cessation interventions with children and adolescents. Additionally, children and adolescents are difficult to recruit and retain in formal cessation programs because of peer pressure and because parental approval is required in many instances.[7] Additionally, nicotine replacement therapy among pregnant women is controversial because of the possible health effects of nicotine use.[8]

ENACT Recommendations:

ENACT supports a national comprehensive tobacco use treatment program which provides grants to states and localities, including public health departments, health professions schools, local organizations and worksites, which have expertise in developing and administering tobacco use treatment programs designed for high risk population groups addicted to nicotine. Grant recipients would be responsible for creating programs which are accessible, culturally sensitive and language appropriate. A national comprehensive tobacco use treatment program should be established to identify the programs, interventions, medications and devices shown to be safe and effective, based on the best available scientific evidence, and to build the necessary public health infrastructure required to allow for the delivery of services by well trained personnel. A national resource center or information clearinghouse should be a part of the comprehensive tobacco use treatment program.

ENACT recommends that a national tobacco use treatment program be administered by the U.S. Department of Health and Human Services via various federal agencies which would be responsible for administering the comprehensive grant program. The goal should be to offer the most effective programs with maximum flexibility at the service provider level to assure the most appropriate intervention.

ENACT believes that accessible and effective delivery of services will be achieved if the following distinct and comprehensive components are included in a national tobacco use treatment program:

- reimbursement for services and treatment;
- education and training of service providers;

- research and evaluation of pharmacological devices and counseling techniques.

ENACT believes that no tobacco user should encounter financial barriers in seeking effective treatment for his or her nicotine addiction and that the first priority be placed on those populations which do not currently have access to tobacco use treatment programs. ENACT recommends that tobacco use treatment and counseling be covered benefits under the Medicare and Medicaid programs, financed by the tobacco industry. Veterans Administration Medical Centers should provide cessation treatment for every veteran requesting assistance. Other federally financed health providers such as Community Health Centers and state and local public health providers should assure access to tobacco cessation programs on a contract basis if services are not provided on clinic premises. ENACT also encourages that reimbursement continue to be provided and further expanded by the health insurance industry so that cessation counseling and treatment can be arranged for by all managed care organizations for the managed care patient population as well as by the private practitioner to individual patients.

ENACT supports the accepted tobacco use treatment methods as outlined in the 1996 Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline on Smoking Cessation, and recommends that grant recipients who develop and administer such programs mirror these and/or other similar evidence based guidelines. AHCPR's cessation guidelines recommend that clinicians record the tobacco-use status of every patient and offer smoking cessation treatment to every smoker at every office visit. Any national cessation effort must ensure that health care systems are doing everything they can to identify and intervene with tobacco users. A mechanism must be established that will continue to update guidelines as new research becomes available regarding tobacco use treatment methods. Furthermore, outreach to clinicians must continue as new therapies become available.

In order to carry out AHCPR's guidelines successfully, ENACT believes that a public health infrastructure is needed to ensure the accessibility and availability of tobacco use treatment. Through grants to health professions schools and primary care residency programs, the Health Resources and Services Administration (HRSA) in conjunction with the Centers for Disease Control and Prevention (CDC), should be responsible for the training and education, including technical assistance, of current and future health care professionals including instruction regarding environmental tobacco smoke, prevention of youth access, and changing public policy and social norms. Funding for activities such as the development of medical, residency and continuing medical education curriculums which address tobacco use prevention and cessation, faculty development, and residency training in the area of nicotine addiction counseling, treatment and prevention to all populations should be components of such grants. Special emphasis on outreach and treatment to youth, women, underserved and minority populations should be considered, especially as new and possibly more costly medications become available.

ENACT believes that the National Institutes for Health (NIH), CDC, and AHCPR should be the primary agencies responsible for population based research in the following areas related to nicotine addiction and tobacco use treatment: new drug treatment therapies, the behavioral and social effects of such treatment on various population groups, the effectiveness of non-pharmacologic methods in tobacco cessation, the appropriateness and effectiveness of the delivery of tobacco related health care services, and the monitoring and evaluation of smoking

reduction targets through such programs. New scientific evidence regarding nicotine addiction and tobacco cessation therapies on various population groups must be extensively disseminated to all health care providers and consumers.

Additionally, ENACT supports AHCPR's recommendation for important research regarding the safety and efficacy of psychosocial or pharmacological cessation interventions with children and adolescents. It is important to acknowledge that children and adolescents become addicted to nicotine, and similar to adults, experience relapse and withdrawal symptoms when trying to quit. Providing tobacco use treatment services to other selected sub-populations such as pregnant women, also raises a number of difficult issues and requires further research. For example, the health benefits of quitting smoking are greatest when pregnant women quit since smoking is a leading cause of low birth weight births.

Finally, ENACT believes that tobacco use treatment programs are most effective when they take place in coordination with other tobacco control outreach efforts that can increase tobacco users' readiness and willingness to quit. Individuals may be more likely to want to quit smoking if, for example, they work in companies with strong worksite smoking policies or if they are exposed to repeated anti-smoking messages in the media, through a public awareness and motivation campaign which focuses on the negative health consequences of tobacco, the benefits of cessation, and the resources available to help the tobacco user quit. This is particularly important with respect to maternal smoking cessation intervention -- quitting for good, not just during pregnancy, is the message which needs to be conveyed. As part of the same message, parents must learn to never allow infants and young children to be exposed to environmental tobacco smoke. A national media campaign should be designed to stimulate all tobacco users at all the various "stages of change" to progress toward a tobacco free state.

Will Cessation Programs Work?

An extensive body of research demonstrates that tobacco use cessation treatment programs are successful in enabling smokers and other tobacco users to quit. Tobacco use treatment programs are most effective when they utilize multiple interventions, including pharmacologic and behavioral interventions. In general, more intense treatments are more effective in producing long-term abstinence from tobacco. The three most effective components of tobacco use cessation treatment are pharmacologic treatments, clinician-provided social support, and skills training regarding techniques to achieve and maintain abstinence.

Tobacco use treatment is cost effective. Compared to the estimated $50 billion in direct medical care spent annually on smoking-related illnesses and another $47 billion accounted for lost productivity and forfeited earnings caused by smoking-related disabilities, the average estimated per smoker cost for smoking cessation is $165.[9] The cost of each intervention varies according to the amount of counseling, whether and which pharmaceutical adjuncts are offered, and effectiveness of the intervention. For every dollar invested in a smoking cessation program for pregnant women, about $6 is saved in neonatal intensive care costs and the long-term care associated with low birth weight.[10]

The U.S. Food and Drug Administration (FDA) has approved over-the-counter sales of a number of nicotine replacement products, including transdermal patches, chewing gum, and nasal sprays. The FDA has also approved one non-nicotine drug available by prescription to help people stop smoking. Studies published in the *New England Journal of Medicine*[11] and the *Journal of American Medical Association*[12] have documented increased quit rates using the nicotine patch. According to another study published in *JAMA*, nicotine gum can also increase long-term smoking cessation rates.[13] Researchers have also found that the recently-approved drug bupropion increases quit rates when used alone or in combination with nicotine replacement products. Hypnosis and acupuncture are also frequently used techniques for cessation. To date, however, these techniques have not been proven to be consistently effective.

When financial barriers are removed, participation increases. For example, when Group Health Cooperative of Puget Sound included smoking cessation as a covered benefit, its program participation jumped ten-fold, from 175 participants to over 2,000 in the first year. In groups with a $42 co-payment, about 30 percent of registered participants did not participate. By contrast, only one percent of those with no co-payment do not participate after registering.[14]

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[1] U.S. Dept. of HHS. "Smoking Cessation: Clinical Practice Guideline." AHCPR Publication # 96-0692. Rockville, MD: U.S. Dept. of HHS, Public Health Service, AHCPR and CDC, 1996.

[2] Dolan, T., McGorray, S., Grinstead-Skgen, C., Mecklenburg, R. "Tobacco Control Activities in U.S. Dental Practices." *JADA*, vol. 128, December 1997, p. 1676-77.

[3] Bartosch, W., Fiore, M., Hasselblad, V., Baker, T. "Cost Effectiveness of the Clinical Practice Recommendations in the AHCPR's Guideline for Smoking Cessation." *JAMA*, December 3, 1997, vol. 278, No. 21, p. 1759.

[4] Gelb, B.D. "Preventive Medicine and Employee Productivity." *Harvard Business Review* 1985; 64 (2): 12-6.

[5] Corporate Health Policies Group, Inc. "Smoking Cessation and Managed Care." Bethesda, MD. 1995.

[6] Schauffler and Gentry. "Smoking Control Policies in Private Health Insurance in California: Results of a Statewide Survey." *Tobacco Control*, 1994; 3:124-129.

[7] U.S. Dept. of HHS. "Preventing Tobacco Use Among Young People: A Report of the Surgeon General, 1994."

[8] Lando, H.A. and Gritz, E. "Smoking Cessation Techniques." *JAMWA*, 1996; 51:31-14.

[9] Cromwell, J., Bartosch, W., Mitchell, J. "The Cost-Effectiveness of AHCPR's Smoking Cessation Guideline" Health, Economics, Research, Inc. Waltham, MA. December 1996.

[10] Marks, J., Coplan, J., Hogue, C., Dalnat, M. "A Cost Benefit/Cost Effectiveness Analysis of Smoking Cessation for Pregnant Women." *American Journal of Preventive Medicine*, Vol. 6, No. 5, Sept/Oct. 1990.

[11] Tonnesen P., Norregaard J., Simonsen K., et al. "A Double-Blind Trial of a 16-Hour Transdermal Nicotine Patch in Smoking Cessation." *New England Journal of Medicine* 1991; 325:311-315.

[12] Transdermal Nicotine Study Group. "Transdermal Nicotine For Smoking Cessation: Six-Month Results From Two Multicenter Controlled Clinical Trials." *JAMA* 1991;266:3133-3138.

[13] Oster G., Huse D.M., Delea T.E., et al. "Cost-Effectiveness Of Nicotine Gum As An Adjunct To Physician's Advice Against Cigarette Smoking." *JAMA* 1986; 256:1315-1318.

[14] Sophian, Neal, et al. "Telephone Smoking Cessation Intervention: The Free and Clear Program." *HMO Practice*. September 1995, Vol. 9, No. 3.

ENVIRONMENTAL TOBACCO SMOKE

The Problem:

Environmental tobacco smoke (ETS) is defined as the combination of mainstream smoke, that exhaled by a smoker, and sidestream smoke, from the burning end of the cigarette. There is evidence that ETS contains higher levels of carcinogens and irritants than secondhand smoke alone, due to the lack of filtration from the burning end of the cigarette. While ETS is more diluted than mainstream smoke, exposure occurs for as long as an individual is in a contaminated area.[1]

Toxicity

- In 1992, the Environmental Protection Agency (EPA) classified ETS as a Group A carcinogen[2], a substance with no safe level of exposure, that causes cancer in humans.

- Tobacco smoke contains more than 4,000 chemical compounds, over 50 of which cause cancer in humans and animals.[3]

Morbidity and Mortality

- Infants whose mothers smoke are at an increased risk of dying of Sudden Infant Death Syndrome (SIDS). This risk is independent of other known risk factors for SIDS, including low birth weight and low gestational age, both of which are specifically associated with active smoking during pregnancy.[4]

- In children, exposure to secondhand smoke is estimated to cause between 150,000 and 300,000 respiratory infections each year, leading to between 7,500 and 15,000 hospitalizations.[2]

- An EPA report estimated that ETS exposure exacerbates symptoms of asthma in about 20 percent of the two million to five million asthmatic children in the United States.[5]

- According to the *Journal of the American Medical Association*, current smokers' arteries thicken 50 percent faster than they do in individuals who have never smoked. In non-smokers exposed to ETS, the arteries thicken 20 percent faster than they do it non-smokers with no ETS exposure.[6]

- ETS is linked with approximately 37,000 heart disease deaths[7] and 3,000 lung cancer deaths each year.[2]

- Some studies estimate that ETS is the third leading cause of preventable death in the U.S., killing up to 53,000 non-smokers each year.[8] This includes, but is not limited to, deaths from heart disease and lung cancer.

- Relative to those not exposed to ETS, exposure to ETS is associated with a 20 percent increase in the progression of arteriosclerosis.[9]

ETS in the Workplace

- The Centers for Disease Control and Prevention estimates that workers exposed to ETS on the job have a 34 percent higher risk of lung cancer than those in smoke-free workplaces.[7]

- About 80 percent of most non-smokers' exposure to ETS happens at work.[10]
- Separating smokers and non-smokers who share the same air space reduces but does not eliminate non-smokers' exposure to the toxic components of ETS[9].

- Current ventilation standards for tobacco smoke are largely designed to reduce the odor of smoke, not to remove the toxins in it.[11]

- EPA notes that tobacco smoke is the largest source of indoor air pollution and presents a serious and substantial risk to the public health.[2]

- Smoking in the workplace increases property maintenance and cleaning costs by approximately $500 per smoker per year[12] and results in lost-productivity costs among non-smokers as well. [11,13]

ENACT Recommendations:

ENACT believes the public's protection from the hazards of environmental tobacco smoke must be included as an integral part of any national tobacco policy. This should include federal ETS restrictions for all public places, including restaurants and bars. The ENACT position includes many of the provisions of the Smoke-Free Environment Act of 1997, introduced in the House (H.R. 1771) by Representative Waxman and in the Senate (S. 826) by Senator Lautenberg on June 3, 1997. Essential elements of any proposal to address environmental tobacco smoke include the following:

Prohibitions on Smoking in Public Places

- The owner or lessee for each workplace or public facility shall adopt and implement a smoke-free environment policy which prohibits the smoking of cigarettes, cigars, and pipes, and any other combustion of tobacco, within the facility and on facility property within the immediate vicinity of the entrance and post a clear and prominent notice of the smoking prohibition in appropriate and visible locations at the public facility.

- Public facility means any building regularly entered by 10 or more individuals at least one day per week, including any such building owned by or leased to a Federal, State, or local government entity. It also includes outdoor stadiums or arenas used for sports, entertainment, or other events that may be used less than one day per week. Public facilities do not include any building or portion thereof regularly used for residential purposes.

- Smoking should be prohibited in all areas (indoors and outdoors) of elementary and secondary school campuses.

Transit

- Smoking should be prohibited on any plane, bus, or train traveling within the United States and on any U.S. owned carriers, including cruise ships, originating in or arriving at any point in the United States.

Enforcement

- The Administrator of the EPA should be authorized to promulgate regulations as the Administrator deems necessary to carry out the restrictions on environmental tobacco smoke. These regulations should include enforcement authority for the agency, as well as for state and local authorities.

Preemption

- The ETS provisions must be expressly non-preemptive. Nothing in the legislation shall preempt or otherwise affect any other Federal, State or local law which provides protection from health hazards from environmental tobacco smoke.

Public Education Efforts

- The public education efforts on tobacco should include campaigns designed to educate the public regarding the hazards of environmental tobacco smoke in worksites, other public places, and homes. Particular efforts should be directed at discouraging smoking around children and pregnant women and discouraging smoking inside homes that include children.

Research

- Funding for research should include funds for continued research on the health and economic effects of ETS.

ETS Restrictions Can Improve Public Health:

Health Problems and Costs Reduced

- Strong clean indoor air ordinances are linked with decreased cigarette consumption and smoking prevalence and reductions in employees' ETS exposure.[14]

- EPA estimates that eliminating ETS exposure in the workplace would save between $35 billion and $66 billion per year due to decreased illness and premature deaths avoided.[15]

No Economic Losses

- Scientific studies indicate that smoke-free ordinances do not create economic losses for restaurants or other businesses. A study published in the *American Journal of Public Health* that compared 15 cities with smokefree restaurant ordinances to 15 control cities with no ordinances found no significant economic impact on restaurant business.[16]

- Studies have shown that even smokers do not avoid locations that have smoke-free ordinances in place.[17]

- A survey of forty convention groups asked whether they would avoid holding their meetings in a smoke-free locality; only one group, representing the candy and tobacco industries, would refuse to book a meeting in that location.[18]

- A new study from Massachusetts, published in the *American Journal of Public Health*, indicates that if restaurants and bars were to become smoke free, over 90 percent of patrons (98% of non-smokers and 68% of smokers) would maintain or increase their use of restaurants and 89 percent (97% of non-smokers and 56% of smokers) would maintain or increase their patronage of bars and clubs.[19]

Public support:

- Almost 80 percent of American adults believe a national tobacco policy should include restrictions on smoking in public places.[20]

- Eight out of 10 non-smokers are annoyed by others' tobacco smoke.[21]

- Almost 90 percent of adults believe people have a right to breathe smoke-free air.[22]

- Only 5 percent of Americans oppose restrictions on workplace smoking.[19]

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[1] NIOSH Publication No. 91-108, June 1991.
[2] United States Environmental Protection Agency, "Fact Sheet: Respiratory Health Effects of Passive Smoking." Document EPA-43-F-93-003, January 1993. http://www.epa.gov/iedweb00/pubs/etsfs.html
[3] The National Clearinghouse on Tobacco and Health, "ETS in Home Environments," Canadian Council on Smoking and Health, 1995.
[4] National Cancer Institute, NIH
[5] US Environmental Protection Agency (1992). Respiratory health Effects of Passive Smoking: Lung Cancer and Other Disorders. Washington, DC: EPA Office of Research and Development, December.
[6] Howard G, Wagenknecht LE, Burke GL, Diez-Roux A, Evans GW, McGovern P, Nieto FJ, Tell GS. "Cigarette Smoking and the Progression of Atherosclerosis." *JAMA* 1998; 279:119-124
[7] American Association for World Health, "Fact Sheet: Environmental Tobacco Smoke." 1993
[8] Glantz SA, Parmley WW. Passive smoking and heart disease. Epidemiology, physiology, and biochemistry. *Circulation* 1991 Jan; 83(1):1-12
[9] Howard G, Wagenknecht L, et al., Cigarette Smoking and Progression of Atherosclerosis. JAMA1998;279:119-124
[10] Americans for Nonsmokers' Rights. "Clean Indoor Air Policies." April 22, 1996

[11] American Society of Heating, Refrigerating and Air-Conditioning Engineers. *ASHRAE Standard 62-1989: Ventilation for Acceptable Indoor Air Quality*, revised. Atlanta, GA: ASHRAE, 1990.
[12] Jackson, F. N., and Holle, R. H. O. "Smoking: Perspectives 1985." *Primary Care* 12:197-216, 1985.
[13] Kristein, M. M. "How Much Can Business Expect to Profit From Smoking Cessation?" *Preventive Medicine* 12:358-381, 1983.
[14] Siegel, M. "Involuntary Smoking in the Restaurant Workplace: A Review of Employee Exposure and Health Effects." *JAMA* 270:490-493, 1993.
[15] US Environmental Protection Agency. "The Costs and Benefits of Smoking Restrictions: An Assessment of the Smoke-Free Environmental Act of 1993 (HR 3434)." Office of Air and Radiation. Washington, DC: USEPA, April 1994
[16] Glantz, S. A., and Smith, L. R. A. "The Effect of Ordinances Requiring Smokefree Restaurants on Restaurant Sales in the United States." *Am J Pub Health* 84:1081-1085, 1994.
[17] Taylor Consulting Group. "The San Luis Obispo Smoking Ordinance: A Study of the Economic Impacts on San Luis Obispo Restaurants and Bars." San Luis Obispo, CA: Taylor Consulting Group, January 1993.
[18] Task Force for a Smoke-Free San Diego. "The Economic Implications of a Smoke-free San Diego." San Diego, CA: TFSFSD, October, 1992.
[19] Biener, L., and Siegel, M. "Behavior Intentions of the Public after Bans on Smoking in Restaurants and Bars." *Am J Pub Health* 87:2042-2044, 1997.
[20] Market Facts' TeleNation poll, commissioned by the Campaign for Tobacco-Free Kids, September 19-25, 1997. TeleNation conducted a random national survey of 1000 adults.
[21] U. S. Department of Health and Human Services and Centers for Disease Control and Prevention. "It's Time to Stop Being a Passive Victim." 1994
[22] Ekos Research Associates Inc. "An Assessment of Knowledge, Attitudes and Practices Concerning Environmental Tobacco Smoke," Final Report, March 1995. Ekos Research conducted a survey of 2300 parents of children aged 12 years and younger and 700 extended family members in the winter of 1995.

TOBACCO LEGISLATION AND TOBACCO GROWING COMMUNITIES

The Problem:

As recently as 1969, U.S. manufactured cigarettes contained 90 percent American grown tobacco. In the 1990s, that figure has dropped below 60 percent. The number of U.S. tobacco farmers has also dropped dramatically, from 512,000 in 1954 to 124,000 in 1992. The economic contribution that tobacco makes to the various tobacco producing states, though significant, has also been dropping. For example, in North Carolina, tobacco's contribution to the economy dropped from 11.3 percent in 1960 to 7.8 percent in 1993, and farm cash receipts dropped from 47 percent to 19 percent.

These American farm families continue to rely on the growth and production of tobacco. Many communities remain dependent on tobacco as the primary means of support. However, since release of the landmark Surgeon General's Report in 1964, more and more evidence has been accumulated that shows smoking and the use of smokeless tobacco is addictive and a major cause of cancer, heart disease, chronic obstructive lung disease, emphysema, and stroke.

The seriousness of the epidemic and the need for strong policies and programs to discourage and prevent the use of tobacco has put the tobacco farmer, his family and his community in a difficult situation with difficult choices. The farmer has had virtually no real options to get out of the tobacco business, often being used as a political pawn by the tobacco industry at the national, state and local levels. For years, health groups have been portrayed by the tobacco companies as trying to put the tobacco farmer out of the business regardless of the economic consequences on the tobacco farm family, and the tobacco farming community.

Recent dialogue between public health groups and tobacco farmers have the potential to reduce the production and growth of tobacco while at the same time ensuring economic stability for the tobacco farming community. Reducing America's dependence on the growing of tobacco, giving farmers options to get out of the business over a long period of time will help in changing the climate and environment as we continue to work towards reducing tobacco use.

ENACT Recommendations:

The goal of tobacco legislation as it affects tobacco farmers should be to discourage growth and production of tobacco while providing assurances to the farmers that their economic well-being will not be sacrificed. ENACT supports the following principles:

- The federal government should no longer bear the costs for the administration or operation of the no-net-cost tobacco price support program.

- There should be greater cooperation between the tobacco growing community and the public health community to ensure that quality control and health and safety standards are maintained in the production of tobacco and that industry information and research (for both foreign and domestic) are made available for public review.

- Sufficient funding should be allocated so that tobacco growing states and communities have options and opportunities to ensure their economic viability into the 21st Century. Funds should be used for financing pilot projects and programs for economic development, creation of alternative economic infrastructures, agricultural supplementation and diversification, and worker retraining. There must be significant involvement of tobacco growing communities in determining the allocation of these funds. Decision making for plans to enhance the economic infrastructures of affected communities should be governed primarily through community-based input. Agricultural-based development in particular ought to be given a high priority.

- Tobacco quota holders and tobacco lease holders should be given the opportunity to have their quotas compensated at a fair and equitable level. The protection of tenant farmers should be given special consideration as part of this process to ensure that they are not adversely affected.

- ENACT is committed to working with tobacco farming communities and policy makers in developing and enacting legislation which promotes and protects the public health of this nation, while at the same time provides options and opportunities to tobacco farmers and their communities for rebuilding their economic infrastructures in a less tobacco-dependent environment.

Public and Grower Support:

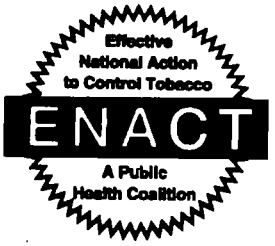
Farmers are aware of the current realities of tobacco growth, and the prospect of national tobacco control legislation, each potentially resulting in the reduction of tobacco consumption and increasing doubts about the future of their livelihood.

In 1997, the Bowman School of Medicine surveyed 1,200 tobacco growers:

- While many farmers believed that they would be growing tobacco ten years from now (80%), when asked if they would recommend to their children that they continue growing tobacco, only 60 percent said they would.

- Many farmers are interested in trying other on-farm activities and alternatives to supplement their tobacco income (60%). But these farmers also noted that that there are many barriers that need to be addressed in order to make that possible.

In a more recent survey conducted by Market Facts' TeleNation in September of 1997, 78 percent of the public supported using funds from a national tobacco policy to help farmers develop alternatives to tobacco.



PREEMPTION OF STATE AND LOCAL TOBACCO CONTROL REGULATIONS

Background:

More than 1000 localities have adopted ordinances that provide for clean air in public places or restrict youth access to tobacco.[1] To counteract effective local ordinances, the tobacco industry has advocated for weaker state and federal laws that preempt stronger local ordinances,[2-7] and has had some success at these levels,[8-12] but historically has been unable to significantly influence local policy.[13]

ENACT believes a strong comprehensive national tobacco control policy is necessary to effectively combat tobacco use, because it will ensure that all communities are protected, and recognizes that certain vital tobacco control measures cannot be implemented at the local level. However, it is still essential that state and local governments retain the authority to enact stricter provisions that are deemed necessary by the community and that address the particular needs of local areas.

Policy Recommendations:

- Federal tobacco control legislation, including federal laws that give the Food and Drug Administration authority to regulate tobacco products, should explicitly and unambiguously specify that state and local governments are not preempted from establishing or retaining requirements equal to or more stringent than any federal requirement (including taxation) relating to tobacco control.

- Federal legislation should provide incentives for states to repeal laws that preempt local tobacco control ordinances, to provide localities with maximum flexibility in this realm.

- The preemption clause in the Federal Cigarette Labeling and Advertising Act should be repealed to allow state and local governments to restrict tobacco advertising for health and other appropriate purposes.

Local ordinances can be effective:

Though strong comprehensive federal legislation should provide an effective tobacco policy for the country, local and state governments should be free to continue to enact stronger ordinances to further improve the public health. There is evidence that local and state regulations can reduce youth access to tobacco, create smokefree public areas, reduce tobacco consumption through excise taxes, and control tobacco advertising. Further, local efforts to adopt and implement stronger measures can have the effect of educating the local community about the dangers of tobacco use.

- A 1995 article in the *American Journal of Public Health* estimated that a 25 cent increase in the California cigarette tax reduced sales in the state by 819 million packs over a two and a half year period.[14]

- A study in the *Journal of the American Medical Association* revealed that a comprehensive youth access program in Woodridge, Illinois, reduced sales to minors from 70 percent to less than 5 percent over a year and a half, with a corresponding decrease in regular tobacco use among youth of over 50 percent.[15]

- Researchers in California conducted a study that showed that nonsmoker exposure to tobacco smoke at work ranged from 24.5 percent in areas with strong local tobacco control ordinances to 34.8 percent in areas with no ordinance. The percentage of indoor workers working in a smoke-free workplace decreased from 40.3 percent for those covered by a strong ordinance to 31.1 percent where there was no ordinance.[16]

- Two studies, using data drawn from the National Health Interview Survey, found significant reductions in cigarette consumption in areas where clean indoor air laws were in effect.[17-18]

Public support:

Polls by Americans for Non-Smokers' Rights and the Coalition on Smoking or Health found that 81 percent of Americans want communities to have "the option of passing laws to protect people from secondhand smoke and protect children from tobacco." [19]

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[1] Siegel M, Carol J, Jordan J, Hobart R, Schoenmarklin S, DuMelle F, Fisher P. "Preemption in Tobacco Control: Review of an Emerging Public Health Problem." *JAMA*. 1997; 278:858-863.

[2-7] 2 Conlisk E, Siegel M, Langerich E, MacKenzie W, Malek S, Eriksen M. "The Status of Local Smoking Regulations in North Carolina Following a State Preemption Bill." *JAMA*. 1995; 273:805-807.

3 Skolnick AA. "Cancer Converts Tobacco Lobbyist: Victor L. Crawford Goes on the Record." *JAMA*. 1995; 274:199-202.

4 Fielding JE. "Revealing and Reversing Tobacco Industry Strategies." *Am J Public Health*. 1996; 86:1073-1075.

5 Bearman NS, Goldstein AO, Bryan DG. "Legislating Clean Air: Politics, Preemption, and the Health of the Public." *N C Med J*. 1995; 56:14-19.

6 Freyman R. "Butting in: The Tobacco Lobby Shows No Sign of Flickering in its Push to Move Smoking Regulation Out of City Halls and Into Statehouses." *Governing*. November 1995; 9:55-57.

7 Jordan J, Pertschuk M, Carol J. "Preemption in Tobacco Control: History, Current Issues, and Future Concerns." Berkeley, CA: Western Consortium for Public Health, 1994.

[8-12] 8 Califano JA Jr. "Revealing the Link Between Campaign Financing and Deaths Caused by Tobacco." *JAMA*. 1994; 272:1217-1218.

9 Wright JR. "Contributions, Lobbying and Committee Voting in the US House of Representatives." *Am Polit Sci Rev*. 1990; 84:417-438.

10 Glantz SA, Begay ME. "Tobacco Industry Campaign Contributions are Affecting Tobacco Control Policymaking in California." *JAMA*. 1994; 272:1176-1182.

11 Monardi FM, Glantz SA. "Tobacco Industry Political Activity and Tobacco Control Policymaking in Washington: 1983-1996." San Francisco, CA: University of California School of Medicine, Institute for Health Policy Studies, 1996:

12 Monardi FM, O'Neill A, Glantz SA. "Tobacco Industry Political Activity in Colorado: 1979-1995." San

Francisco, CA: University of California School of Medicine, Institute for Health Policy Studies, 1996.

[13] Siegel M, Carol J, Jordan J, Hobart R, Schoenmarklin S, DuMelle F, Fisher P. "Preemption in Tobacco Control: Review of an Emerging Public Health Problem." *JAMA*. 1997; 278:858-863.

[14] Teh-wei Hu, , Hai-yen Sung, and Keller, T. "Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-Smoking Media Campaign," *American Journal of Public Health*. September, 1995.

[15] Jason, LA; Ji, PY; Anes, MD; Birkhead, SH. "Active Enforcement of Cigarette Control Laws in the Prevention of Cigarette Sales to Minors." *JAMA* 266:22:3159-3161. December 11, 1991.

[16] Pierce JP, Shanks TG, Pertschuk M, et al. "Do Smoking Ordinances Protect Non-Smokers from Environmental Tobacco Smoke at Work?" *Tobacco Control*. 1994; 3:15-20.

[17-18] 17 Wasserman J, Manning WG, Newhouse JP, Winkler JD. "The Effects of Excise Taxes and Regulations on Cigarette Smoking." *J Health Econ*. 1991; 10:43-64.

18 Chaloupka FJ. "Clean Indoor Air Laws, Addiction, and Cigarette Smoking." *Appl Econ*. 1992; 24:193-205.

[19] Christoffel T. *Health and the Law*. New York, NY: Free Press, 1982.

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[8-12] 8 Califano JA Jr. "Revealing the Link Between Campaign Financing and Deaths Caused by Tobacco." *JAMA*. 1994; 272:1217-1218.

9 Wright JR. "Contributions, Lobbying and Committee Voting in the US House of Representatives." *Am Polit Sci Rev*. 1990; 84:417-438.

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11 Monardi FM, Glantz SA. "Tobacco Industry Political Activity and Tobacco Control Policymaking in Washington: 1983-1996." San Francisco, CA: University of California School of Medicine, Institute for Health Policy Studies, 1996.

12 Monardi FM, O'Neill A, Glantz SA. "Tobacco Industry Political Activity in Colorado: 1979-1995." San

Francisco, CA: University of California School of Medicine, Institute for Health Policy Studies, 1996.

[13] Siegel M, Carol J, Jordan J, Hobart R, Schoenmarklin S, DuMelle F, Fisher P. "Preemption in Tobacco Control: Review of an Emerging Public Health Problem." *JAMA*. 1997; 278:858-863.

[14] Teh-wei Hu, , Hai-yen Sung, and Keller, T. "Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-Smoking Media Campaign," *American Journal of Public Health*. September, 1995.

[15] Jason, LA; Ji, PY; Anes, MD; Birkhead, SH. "Active Enforcement of Cigarette Control Laws in the Prevention of Cigarette Sales to Minors." *JAMA* 266:22:3159-3161. December 11, 1991.

[16] Pierce JP, Shanks TG, Pertschuk M, et al. "Do Smoking Ordinances Protect Non-Smokers from Environmental Tobacco Smoke at Work?" *Tobacco Control*. 1994; 3:15-20.

[17-18] 17 Wasserman J, Manning WG, Newhouse JP, Winkler JD. "The Effects of Excise Taxes and Regulations on Cigarette Smoking." *J Health Econ*. 1991; 10:43-64.

18 Chaloupka FJ. "Clean Indoor Air Laws, Addiction, and Cigarette Smoking." *Appl Econ*. 1992; 24:193-205.

[19] Christoffel T. *Health and the Law*. New York, NY: Free Press, 1982.

INTERNATIONAL ISSUES

The Problem:

Tobacco use is rising worldwide, and rising sharply among children and women in developing nations. All but 4 to 5 percent of the world's smokers live outside the United States. Today, tobacco kills approximately 3 million people per year, with most of those deaths occurring in developed nations; by 2025, based on current smoking rates, tobacco will kill about 10 million people annually, with more than 70 percent of those deaths occurring in developing nations.[1] Of all the people alive in the world today, tobacco is expected to kill about 500 million, including more than 200 million of today's children and teenagers.[2] The total will exceed deaths from HIV, malaria, tuberculosis and maternal conditions combined.[3]

Two of the top three global tobacco companies are American. In all, U.S. companies supply about one-fifth of the nearly six trillion cigarettes smoked in the world each year.[4] U.S. companies exported about 11 billion packs of cigarettes from U.S. plants in 1997,[5] and manufacture more cigarettes overseas than in the United States. In 1996, more than 70 percent of cigarettes sold by Philip Morris, and 57 percent of those sold by RJR Nabisco, were sold overseas.[6]

U.S. companies, supported in some instances by past U.S. administrations, have used political influence to defeat public health laws designed to protect children from tobacco marketing and to reduce tobacco use in many nations. In addition, U.S. companies have launched aggressive advertising campaigns designed to appeal to traditionally nonsmoking women and children. Marketing efforts typically associate smoking with the United States, affluence, sex appeal, freedom and liberation. In many markets, American companies reach youthful audiences through television and radio advertising, product placement in movies and other methods that are outlawed in the United States. Joe Camel, although withdrawn from the U.S. market, is still used by RJ Reynolds overseas.

The U.S. government has used the threat of trade sanctions to force open cigarette markets in China, Thailand, Taiwan, South Korea and Japan. Econometric analysis shows that smoking rates are about 10 percent higher in markets forced open by the U.S. government than they would have been in the absence of U.S. market entry.[7] These elevated smoking rates are expected to result in millions of additional deaths in these countries in the future.[8]

Despite the magnitude of the worldwide epidemic of tobacco addiction, there are no significant programs in place by any U.S. public or private agency to help address tobacco use internationally.

ENACT Recommendations:

The United States cannot, by itself, solve the global problem of tobacco addiction. However, there are steps the U.S. can and should take that will have significant benefits for public health worldwide. ENACT's position is based on two fundamental principles:

- Do no harm. The United States government must consider the health implications of any actions relating to tobacco, and must take steps to ensure that none of its actions, domestic or international, will add to the global burden of death and disease caused by tobacco.

- Promote tobacco control internationally. The United States should promote tobacco control internationally, including financial and diplomatic support appropriate in light of the threat tobacco use poses to world health.

ENACT favors the following provisions in national legislation:

- End U.S. Government support for tobacco abroad. The federal government should be prohibited from promoting the sale or export of tobacco abroad and from opposing tobacco control laws in other countries. The primacy of health concerns should be clarified by requiring the Secretary of Health and Human Services to certify that a tobacco-related foreign law is not a reasonable protection of public health before the U.S. government may take action to oppose it.

- Provide significant funding for tobacco control internationally. ENACT supports major funding for public education, technical assistance, cessation and research internationally, with a special focus on developing nations. The magnitude of the problem requires significant funding through numerous channels: nongovernmental organizations, federal agencies (primarily the departments of Health and Human Services, Treasury and State) and multilateral agencies such as the World Health Organization, World Bank and UNICEF. Funding should include strong U.S. government support for international agreements to address tobacco and health issues. Funding allocation decisions should be made by leading public health experts on the basis of the best scientific knowledge with maximum flexibility to pursue effective strategies and minimal political interference.

- Maintain and strengthen FDA authority. The Food and Drug Administration's (FDA) limited authority over drug and device exports under sections 801 and 802 of the Food, Drug and Cosmetic Act (the Act) should not be weakened or eliminated. The agency has the authority to prevent the export of drugs and devices that do not meet FDA standards unless the Secretary of Health and Human Services determines "that exportation of the device is not contrary to public health and safety and has the approval of the country to which it is intended for export."[9] The agency also requires exported drugs and devices to be labeled for export only and to be in accordance with laws of the country of destination and the specifications of the foreign purchaser.[10]

ENACT supports strengthening FDA authority to the extent that sound and effective measures can be devised to require U.S. tobacco companies to observe ethical business practices in their export and overseas operations.

- Respect legal rights of foreign parties. The existing limited right of access of foreign parties to the U.S. court system should not be compromised.

- Prevent international smuggling. While the U.S. ensures that other sensitive exports such as firearms and alcohol are not diverted into black markets, comparable efforts are not taken with respect to U.S. cigarette exports. As a result, more than one-fourth of all exported cigarettes end up in the hands of smugglers.[11] As the world's leading cigarette exporter, the U.S. should apply to tobacco products the provisions that have proven effective in controlling smuggling of other products, including export permits, product identification markings, record-keeping requirements, increased penalties, and funding to adequately enforce these measures.

- Prevent corporate misconduct. ENACT supports measures to control misconduct by U.S. tobacco companies overseas. To the extent possible under U.S. law, U.S. companies should be prohibited from marketing tobacco products to children in any nation. They also should be required to respect the public health, antismuggling and anticorruption laws of all the nations in which they operate.

- Lead international efforts. ENACT urges President Clinton to convene a summit meeting of leaders of major tobacco-producing nations, and to lead efforts to restrain harmful tobacco industry behavior worldwide through international agreements.

- Other provisions. ENACT remains open to additional measures to reduce tobacco use and protect public health internationally.

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[1] Peto, R., et al., Mortality from Smoking in Developed Countries 1950-2000, Indirect Estimates from National Vital Statistics, New York: Oxford University Press, 1994.
[2] World Health Organization, "Tobacco-Attributable Mortality: Global Estimates and Projections." Tobacco Alert 1991, 1: 4-7 (revised October 1993).
[3] World Bank, "World Development Report," 1993.
[4] World Tobacco File, 1994, International Trade Publications Ltd., United Kingdom, 1994.
[5] U.S. Department of Agriculture, Tobacco Yearbook, U.S. Department of Agriculture, Economic Research Service, December, 1997.
[6] Based on data from 1996 annual reports of Philip Morris Companies and RJR Nabisco.
[7] Chaloupka, F., Laixuthai, A., "U.S. Trade Policy and Cigarette Smoking in Asia," National Bureau of Economic Research, 1996.
[8] Coalition on Smoking OR Health, "Trade Policy on Tobacco Exports." Public comment on Federal Register notice (Vol. 59, No. 083, 59 FR 22714) May 27, 1994.
[9] Section 801(e)(2), Food, Drug and Cosmetic Act, 21 U.S.C. S. 381 (e)(2).
[10] Section 801(e)(1), Food, Drug and Cosmetic Act, 21 U.S.C. S. 381 (e)(1).
[11] Joossens, L, Raw, M., "Smuggling and cross-border shopping of tobacco in Europe," *British Medical Journal*, Vol. 310, pp. 1393-1395. May, 27, 1995.