Total Pages: 17

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

URGENT

Tuesday, March 10, 1998

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer : See Distribution below

FROM: Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148
SUBJECT: **HHS Testimony on S1530 Placing Restraints on Tobacco's Endangerment of Children and Teens Act (PROTECT ACT)**

DEADLINE: **5:00 p.m. Tuesday, March 10, 1998**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: Hearing is before the Senate Judiciary Committee on Thursday, March 12th. Surgeon General Satcher is the witness.

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TO: **Robert J. Pellicci Phone: 395-4871 Fax: 395-6148**
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FROM: _____ **(Date)**

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_____ **Concur**

_____ **No Objection**

_____ **No Comment**

_____ **See proposed edits on pages** _____

_____ **Other:** _____

_____ **FAX RETURN of** ____ **pages, attached to this response sheet**

Thank you Mr. Chairman and members of the Committee for this opportunity to discuss the problem of tobacco use and comprehensive approaches to address this significant public health issue. I am Dr. David Satcher, Surgeon General and Assistant Secretary for Health in the Department of Health and Human Services

Tobacco Use: The Leading Threat to Our Nation's Health

Surgeons General of the United States have long recognized the devastating toll tobacco takes on our citizens. As the current Surgeon General, I take this problem very seriously. I am committed to doing all I can to mobilize resources and action to capitalize on this unique opportunity to begin to treat tobacco use commensurate with the harm that is causes. Mr. Chairman and members of the Committee, as much as we have all heard statistics about tobacco use, I ask that you take a moment to again listen to the data demonstrating how significant this problem is.

Since the release of the first Surgeon General's Report in 1964, the scientific knowledge about the health consequences of tobacco use has increased dramatically. The list of diseases that are caused by smoking continues to grow; cigarette smoking causes heart disease, chronic lung disease, and cancers of the lung, larynx, esophagus, mouth, and bladder. Cigarette smoking also contributes to cancer of the pancreas, kidney, and cervix. Smoking during pregnancy significantly increases maternal and fetal risk and is a significant cause of low birth weight births, the leading cause of death among infants in the United States. Smoking during pregnancy also causes spontaneous abortions and sudden infant death syndrome.

Cigarettes are not the only harmful tobacco products. Use of smokeless tobacco causes cancer of the gum, mouth, pharynx, larynx, and esophagus, and cigar use causes cancer of the larynx, mouth, esophagus, and lung. In addition, tobacco users are not the only people harmed by tobacco. Exposure to environmental tobacco smoke (ETS) is a serious health threat, particularly for our children. ETS exposure causes between 150,000 and 300,000 cases of lower respiratory tract infections (such as bronchitis and pneumonia) in infants and young children up to 18 months; 7,500 to 15,000 of these will result in hospitalization. ETS exposure also increases the frequency and severity of symptoms in asthmatic children, as well as being a risk factor for the disease in children who have not previously displayed symptoms. ETS exposure also is a major risk factor for sudden infant death syndrome.

Among adults, ETS exposure causes approximately 3,000 cases of lung cancer per year; in addition, there is a growing body of evidence linking ETS exposure with heart disease. Data indicate that the burden from ETS-related heart disease is likely to be considerably higher than that for lung cancer. Furthermore, data recently released in the Journal of the American Medical Association indicate that ETS exposure is associated with atherosclerosis which is not reversible. This means that individuals, including children, who are exposed to ETS will have an increased, and non-reversible, risk of developing heart disease.

The combined toll of these diseases make tobacco use the leading preventable cause of death. Over 400,000 Americans die each year of tobacco-related diseases representing over 5,000,000 years of potential life lost. In addition, recent estimates indicate that if current tobacco-use

patterns in this nation persist, an estimated 25 million persons, including 5 million who were aged 0-17 years in 1995, will die prematurely from a smoking related disease. Nearly all of these premature deaths are due to a decision made in youth.

The health hazards of tobacco use translate into economic costs as well. Direct medical costs attributable to smoking represent $50 billion per year; direct medical costs attributable to smoking during pregnancy are approximately $1.4 billion per year. Indirect costs due to tobacco use are at least as much as direct medical costs.

Tobacco use is a pediatric disease with its onset in adolescence. Most individuals start smoking as teenagers and most become addicted as teenagers. Indeed, among adults in the U.S. who have ever smoked daily, over three quarters tried their first cigarette before age 18, and over half became daily smokers before age 18. Each day 3,000 young people become regular smokers. Nearly 1,000 of them will have their lives cut short by tobacco-related diseases. Data indicate that if a person hasn't started to smoke in the teenage years, it is very unlikely that he or she will ever start.

Despite our knowledge of how harmful tobacco use is, tobacco use among teens has increased dramatically throughout the 1990's. Current data indicate that 35% of 9-12 graders are smokers and approximately 11% use smokeless tobacco. There is evidence of alarming levels of cigar use among youth as well. In 1996, 26.7% of 14-19 year olds had used a cigar in the past year. Our data also indicate that young people display symptoms of addiction just as adults do. For

example, among daily smokers aged 10-18, over 90% experienced symptoms of nicotine withdrawal during previous attempts to quit. These symptoms include cravings for tobacco products, feeling irritable, and finding it hard to concentrate. Young people are personally experiencing what was concluded in the 1988 Surgeon General's Report: "Cigarettes and other forms of tobacco are addicting," and "Nicotine is the drug in tobacco that causes addiction."

Before I leave the problem of tobacco use, I would like to remind you of the data on adult smoking, with a particular focus on poor, minority, and underserved populations. Based on widespread educational and public health efforts beginning with the publication of the 1964 Surgeon General's Report, the prevalence of smoking among adults declined steadily from the mid 1960's through the 1980's. However, smoking among adults appears to have leveled off in the 1990's. Currently, 24.7% of adults smoke; however, there are significantly higher levels of smoking among certain groups. The three groups with the highest prevalence of smoking are high-school dropouts (37.5%); American Indians/Alaskan Natives (36.2%), and people living below the poverty line (32.5%). Our public health efforts to address tobacco use must be particularly intensive in these and other underserved communities to close the dramatic gaps in tobacco-related disease and death.

I will now turn to solutions to this public health challenge. Let me remind you that if we can impact tobacco use patterns starting with the generation who are youth today, over time we can dramatically reduce the burden of tobacco-related disease and death.

Comprehensive Strategies for Addressing Tobacco Use

The only way to address this epidemic is by implementing a comprehensive public health strategy.

In the five principles contained in his September statement, President Clinton outlined the components for comprehensive tobacco legislation:

- A comprehensive plan to reduce youth smoking, including tough penalties and price increases, public education and counteradvertising campaigns, and expanded efforts to restrict access and limit appeal
- Full authority for FDA to regulate tobacco products
- Changing the way the tobacco industry does business, including stopping marketing and promotion to children and providing broad document disclosure
- Progress towards other public health goals, including reduction of secondhand smoke, promotion of smoking cessation programs, public health research, and strengthening of international efforts to control tobacco
- Protection for tobacco farmers and their communities

The scientific basis for tobacco use prevention and control efforts has been reviewed extensively and summarized in several publications. Among them are Preventing Tobacco Use Among Young People (CDC, Surgeon General's Report, 1994), Strategies To Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's, (National Cancer Institute, Smoking and Tobacco Control Monograph #1,1991), Growing Up Tobacco Free (Institute of

Medicine Report, 1994), and regulations promulgated by the Food and Drug Administration (FDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Many of these components are also supported by the Healthy People 2000 national health objectives. Although there remain gaps in our knowledge base regarding how to address tobacco use, we know enough now to make a difference. Our real challenge is putting in place now what we already know.

Effective programs to reduce tobacco use require a concerted and coordinated effort at the national, state, and community level. The desired outcomes of these programs are to prevent young people from starting to use tobacco, to help current tobacco users to quit, to protect the health of non-smokers by eliminating exposure to environmental tobacco smoke, to change the environmental and social factors that encourage and support the use of tobacco, and to address the health consequences of tobacco use, including cancer, cardiovascular disease and asthma.

The same public health approach that has been used to address significant infectious disease threats in the United States and throughout the world can be applied successfully to prevent and control tobacco use. Elements of this approach are:

- defining the problem through surveillance systems, epidemiologic studies and laboratory research;
- identifying causes;
- developing and testing promising prevention strategies; and,

- Implementing nationwide prevention programs.

Defining the Problem

Surveillance, or information gathering, forms the basis for defining the problem by measuring tobacco-related trends and assessing the impact of prevention efforts. Reliable data will guide program activities and allow HHS to evaluate the impact of all of these activities. In addition, surveillance efforts will be required to assess industry compliance with any lookback provisions that are established.

Components of comprehensive surveillance efforts include information on tobacco use behaviors, attitudes regarding tobacco use, exposure to environmental tobacco smoke, prevalence of tobacco control policies, implementation of tobacco control programs, changes in tobacco product composure, and the impact of media campaigns. Surveillance also includes monitoring of health behaviors and outcomes related to tobacco use, including: cancer, cardiovascular disease, SIDS and asthma. Special efforts are needed to ensure that we have accurate data on special at-risk groups, including pregnant women, infants and children, and racial and ethnic groups. Finally, both national and state-specific data are needed.

Identifying Causes and Developing and Testing Prevention Strategies

Continued research on why people use tobacco and effective tobacco control interventions can also be useful to refine prevention programs. Six broad categories of research are necessary, including biomedical, clinical, behavioral, health services, public health and community, and surveillance and epidemiology. Innovative approaches include qualitative research using focus

groups and marketing research. These research programs may explicitly address gender, racial, and socioeconomic differences in tobacco use and its consequences. Opportunities are also available to expand the science base on the health effects of tobacco use and exposure to environmental tobacco smoke.

Implementing Nationwide Prevention Programs

Controlled-design community research studies and recent evidence from Massachusetts and California have shown that comprehensive programs can be effective in reducing per-capita tobacco consumption. For example, data from Massachusetts and California indicate that: 1) increasing excise taxes on cigarettes is one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and to prevent initiation among youth; and 2) the ability to sustain this reduction in per capita consumption is greater when the tax increase is combined with a comprehensive antismoking campaign. These data indicate that California and Massachusetts have experienced a decline in per capita cigarette consumption that is 2-3 times the national average.

Additional research shows that community, school, and media programs have the most substantial and enduring impact on reducing tobacco use when they are combined and share common objectives. Analysis of multi-faceted youth tobacco use prevention programs (Minnesota Heart Health Program, Midwestern Prevention Project, University of Vermont School and Mass Media Project) documents that such efforts can reduce youth smoking by 20 to 40 percent. Such combined programs provide the infrastructure and foundation for all other

elements of a comprehensive approach, including price increases, advertising restrictions, access restrictions, limits on secondhand smoke exposure, and cessation.

State and community programs form the cornerstone of our efforts to address tobacco use. Such programs work to:

- prevent and reduce the use of tobacco products, especially among children and adolescents, and
- address the health outcomes related to tobacco use including, cancer, cardiovascular disease, and asthma.

Support to state programs includes core funding for staffing, training and technical assistance, projects for special populations and multi-cultural groups, and program evaluation. These programs would carry out essential activities that have emerged as best practices from the experience of the federally-funded ASSIST and IMPACT programs and state excise tax funded programs. Local coalition and community-based activities, conducted through States also permit local input, assuring that these programs are locally determined and consistent with community values. Local level activities can include: establishing state and local coalitions to implement programs that address retailer education and tobacco access programs; conducting community-based youth prevention programs in coordination with local schools; encouraging implementation of existing state and local smoke free laws and ordinances; and enhancing utilization of smoking cessation resources. Funding for national organizations to reach out to constituencies at high risk for tobacco use including minority populations, women, and youth also helps to support state and local efforts to reach communities at risk.

Studies have shown that research-tested school-based programs can produce consistent and significant reductions or delays in adolescent smoking. Positive outcomes have been shown across programs that vary in format, scope, and delivery methods in a variety of community cultures. However, most follow-up studies have shown that the effects of these programs dissipate over time. Further studies reveal that the effectiveness of school-based programs is strengthened by booster sessions or further application of the programs, and community-wide programs involving parents, school policies, mass media, youth access restrictions, and mobilization of community organizations.

Unfortunately, a very small proportion of schools currently are implementing proven, effective tobacco-use prevention programs. Priority must be given to broad-scale dissemination of programs with established efficacy and the provision of technical assistance to school systems in the design of curricula. The CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction provide practical recommendations for addressing tobacco use through our schools. I had firsthand experience with one of the recommendations addressed in the guideline before coming to CDC. This was a recommendation to institute a tobacco use policy to prevent exposure to environmental tobacco smoke among students, staff, and visitors. When I lived in Nashville, I used to volunteer in an elementary school. One day, when I was reading to several children, I smelled tobacco smoke in the vicinity. The schoolchildren told me that the smoke was coming from the teachers' lounge. Concerned regarding the hazards such exposure could pose to the children, I spoke with the principal who told me that the air exhaust system for the lounge did not work consistently. I raised the issue with the superintendent of schools who then

took action to protect the young people. It is the type of community action that is needed to address tobacco use among our young people.

Media campaigns can increase the effectiveness of school-based programs, provide smoking cessation motivation and assistance to adults, and foster public support for smoke-free environments. Campaigns also can address the health consequences of tobacco use (e.g., cardiovascular disease, cancer, asthma) by raising awareness about these leading killers and cripplers and drawing the link between these diseases and tobacco use. An example of the impact of media campaigns is found in the results of a study of a combination of media and school anti-tobacco programs. As compared to students who only received the school programs, students who received both the school and media programs in combination were 35% less likely to have smoked in the past week.

Messages and programs delivered to entire communities -- adults and adolescents, users and non-users of tobacco -- can affect the general norms of the community on tobacco control, which in turn can influence young people to decide against starting to use tobacco. The exposure of young people directly to messages and appeals intended for adults (e.g., smoking cessation, risks of environmental tobacco smoke) can have a strong influence on adolescents' normative perceptions of the prevalence and acceptability of tobacco use. Parents can be stimulated by community programs to become more involved in tobacco prevention efforts both within and outside the family.

Tobacco-use cessation programs are another important part of our public health efforts.

Over 45 million Americans are current tobacco users and need help to break their addiction. About 70 percent of adult smokers say they would like to quit completely. However, only about 2.5 percent of smokers who try to quit each year actually succeed. The good news is, there are quitting methods that work. Simple advice from a health provider boosts quitting 30 percent, while more intensive counseling or nicotine replacement therapy doubles quit rates. The more comprehensive the service, the higher the success rates. The data on cessation are summarized in the clinical guidelines available from the Agency for Health Care Policy Research. The challenge is for our health care system to take on smoking cessation with the full commitment it deserves.

Smoking cessation is not just an adult issue. About 3 million teenagers are regular cigarette smokers. Unfortunately, teens who smoke like adults become addicted like adults. Kids vastly underestimate the addictiveness of nicotine. Of those who think they will not be smoking in 5 years, 75 percent still will do so. Kids also have the same intense interest in quitting as do adult smokers. But at present we know little about effective ways to help these young people quit. Developing these approaches should be a high priority of tobacco-related research.

Additional Elements of Comprehensive Tobacco Control Efforts

Price Increases

Research has shown that price increases are a critical foundation of efforts to reduce tobacco use, particularly among youth. An increase in the price of tobacco products will reduce rates of use of both cigarettes and smokeless tobacco among both adults and youth. Experts agree that a 10

percent increase in the price of cigarettes will reduce overall smoking among youth by 7 percent and adults by approximately 4 percent. In the budget, the President has proposed a price increase of $1.10 per pack over five years. Coupled with proposed sales and advertising restrictions, this would reduce underage smoking by 39% to 46% in 20003. Almost one million of today's young people would be spared from premature deaths resulting from tobacco use.

Industry Accountability

Current legislative proposals include "lookback" provisions to hold the tobacco industry accountable to reduce tobacco use among young people. These provisions provide penalties at the industry and company level if reductions in teen smoking are not met. The industry must be held accountable if it doesn't shoulder its responsibility in reducing teen tobacco use.

Regulatory Actions

Unfortunately, we have not been able to implement the community, educational, media and deglamorization projects mentioned above in an environment free of easy access to tobacco products and tobacco advertising targeted at young people. Data from a national survey indicate that over-three quarters of young smokers were not asked to show proof of age during purchase attempts in the month prior to the survey. Data also indicate that advertising and promotional efforts impact youth. For example, teens are considerably more likely than adults to purchase the three most heavily advertised brands of cigarettes. Data like these indicate why it is so important to implement the FDA regulation to reduce the access and appeal of tobacco products to young people and to give FDA full authority to meet changing circumstances. We need to

level the playing field and allow prevention messages from parents, schools, and role models to take hold without the pervasive backdrop of pro-tobacco imagery and promotional messages.

International Tobacco Control

Comprehensive tobacco control programs should also include strengthening of international tobacco control efforts to offset projected increases in tobacco consumption in emerging global markets. According to researchers at Harvard University and the World Health Organization, the number of deaths per year caused by tobacco use around the world is expected to increase from 3,000,000 deaths in 1990 to 8,400,000 deaths in 2020. By 2025, tobacco will be the leading global cause of death and preventable illness. Seventy percent of those deaths will occur in developing countries, where people have not yet taken up the habit to the degree that we have in the United States and other developed countries. The opportunities for prevention are real. A problem of this scope merits a global approach similar to the worldwide efforts to eradicate smallpox and polio. We need to invest domestically so as to assist other countries interested in help to address tobacco use among their populations; in addition, we need to conduct public health efforts through the World Health Organization, UNICEF and other UN agencies, the World Bank, and other multilateral development agencies.

Conclusion

In conclusion, I would like to emphasize the importance of seizing this historic opportunity to address this critical public health problem. Tobacco use remains the leading preventable cause of death in this country, killing more than 400,000 Americans each year. Every day we do not take action means that another 3,000 young people will become regular smokers. To stop this

epidemic, we need to invest in tobacco prevention and education programs at a level commensurate with the harm caused by tobacco products.

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- Implementing nationwide prevention programs.

Defining the Problem

Surveillance, or information gathering, forms the basis for defining the problem by measuring tobacco-related trends and assessing the impact of prevention efforts. Reliable data will guide program activities and allow HHS to evaluate the impact of all of these activities. In addition, surveillance efforts will be required to assess industry compliance with any lookback provisions that are established.

Components of comprehensive surveillance efforts include information on tobacco use behaviors, attitudes regarding tobacco use, exposure to environmental tobacco smoke, prevalence of tobacco control policies, implementation of tobacco control programs, changes in tobacco product composure, and the impact of media campaigns. Surveillance also includes monitoring of health behaviors and outcomes related to tobacco use, including: cancer, cardiovascular disease, SIDS and asthma. Special efforts are needed to ensure that we have accurate data on special at-risk groups, including pregnant women, infants and children, and racial and ethnic groups. Finally, both national and state-specific data are needed.

Identifying Causes and Developing and Testing Prevention Strategies

Continued research on why people use tobacco and effective tobacco control interventions can also be useful to refine prevention programs. Six broad categories of research are necessary, including biomedical, clinical, behavioral, health services, public health and community, and surveillance and epidemiology. Innovative approaches include qualitative research using focus

groups and marketing research. These research programs may explicitly address gender, racial, and socioeconomic differences in tobacco use and its consequences. Opportunities are also available to expand the science base on the health effects of tobacco use and exposure to environmental tobacco smoke.

Implementing Nationwide Prevention Programs

Controlled-design community research studies and recent evidence from Massachusetts and California have shown that comprehensive programs can be effective in reducing per-capita tobacco consumption. For example, data from Massachusetts and California indicate that: 1) increasing excise taxes on cigarettes is one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and to prevent initiation among youth; and 2) the ability to sustain this reduction in per capita consumption is greater when the tax increase is combined with a comprehensive antismoking campaign. These data indicate that California and Massachusetts have experienced a decline in per capita cigarette consumption that is 2-3 times the national average.

Additional research shows that community, school, and media programs have the most substantial and enduring impact on reducing tobacco use when they are combined and share common objectives. Analysis of multi-faceted youth tobacco use prevention programs (Minnesota Heart Health Program, Midwestern Prevention Project, University of Vermont School and Mass Media Project) documents that such efforts can reduce youth smoking by 20 to 40 percent. Such combined programs provide the infrastructure and foundation for all other

elements of a comprehensive approach, including price increases, advertising restrictions, access restrictions, limits on secondhand smoke exposure, and cessation.

State and community programs form the cornerstone of our efforts to address tobacco use. Such programs work to:

- prevent and reduce the use of tobacco products, especially among children and adolescents, and
- address the health outcomes related to tobacco use including, cancer, cardiovascular disease, and asthma.

Support to state programs includes core funding for staffing, training and technical assistance, projects for special populations and multi-cultural groups, and program evaluation. These programs would carry out essential activities that have emerged as best practices from the experience of the federally-funded ASSIST and IMPACT programs and state excise tax funded programs. Local coalition and community-based activities, conducted through States also permit local input, assuring that these programs are locally determined and consistent with community values. Local level activities can include: establishing state and local coalitions to implement programs that address retailer education and tobacco access programs; conducting community-based youth prevention programs in coordination with local schools; encouraging implementation of existing state and local smoke free laws and ordinances; and enhancing utilization of smoking cessation resources. Funding for national organizations to reach out to constituencies at high risk for tobacco use including minority populations, women, and youth also helps to support state and local efforts to reach communities at risk.

Studies have shown that research-tested school-based programs can produce consistent and significant reductions or delays in adolescent smoking. Positive outcomes have been shown across programs that vary in format, scope, and delivery methods in a variety of community cultures. However, most follow-up studies have shown that the effects of these programs dissipate over time. Further studies reveal that the effectiveness of school-based programs is strengthened by booster sessions or further application of the programs, and community-wide programs involving parents, school policies, mass media, youth access restrictions, and mobilization of community organizations.

Unfortunately, a very small proportion of schools currently are implementing proven, effective tobacco-use prevention programs. Priority must be given to broad-scale dissemination of programs with established efficacy and the provision of technical assistance to school systems in the design of curricula. The CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction provide practical recommendations for addressing tobacco use through our schools. I had firsthand experience with one of the recommendations addressed in the guideline before coming to CDC. This was a recommendation to institute a tobacco use policy to prevent exposure to environmental tobacco smoke among students, staff, and visitors. When I lived in Nashville, I used to volunteer in an elementary school. One day, when I was reading to several children, I smelled tobacco smoke in the vicinity. The schoolchildren told me that the smoke was coming from the teachers' lounge. Concerned regarding the hazards such exposure could pose to the children, I spoke with the principal who told me that the air exhaust system for the lounge did not work consistently. I raised the issue with the superintendent of schools who then

took action to protect the young people. It is the type of community action that is needed to address tobacco use among our young people.

Media campaigns can increase the effectiveness of school-based programs, provide smoking cessation motivation and assistance to adults, and foster public support for smoke-free environments. Campaigns also can address the health consequences of tobacco use (e.g., cardiovascular disease, cancer, asthma) by raising awareness about these leading killers and cripplers and drawing the link between these diseases and tobacco use. An example of the impact of media campaigns is found in the results of a study of a combination of media and school anti-tobacco programs. As compared to students who only received the school programs, students who received both the school and media programs in combination were 35% less likely to have smoked in the past week.

Messages and programs delivered to entire communities -- adults and adolescents, users and non-users of tobacco -- can affect the general norms of the community on tobacco control, which in turn can influence young people to decide against starting to use tobacco. The exposure of young people directly to messages and appeals intended for adults (e.g., smoking cessation, risks of environmental tobacco smoke) can have a strong influence on adolescents' normative perceptions of the prevalence and acceptability of tobacco use. Parents can be stimulated by community programs to become more involved in tobacco prevention efforts both within and outside the family.

Tobacco-use cessation programs are another important part of our public health efforts.

Over 45 million Americans are current tobacco users and need help to break their addiction. About 70 percent of adult smokers say they would like to quit completely. However, only about 2.5 percent of smokers who try to quit each year actually succeed. The good news is, there are quitting methods that work. Simple advice from a health provider boosts quitting 30 percent, while more intensive counseling or nicotine replacement therapy doubles quit rates. The more comprehensive the service, the higher the success rates. The data on cessation are summarized in the clinical guidelines available from the Agency for Health Care Policy Research. The challenge is for our health care system to take on smoking cessation with the full commitment it deserves.

Smoking cessation is not just an adult issue. About 3 million teenagers are regular cigarette smokers. Unfortunately, teens who smoke like adults become addicted like adults. Kids vastly underestimate the addictiveness of nicotine. Of those who think they will not be smoking in 5 years, 75 percent still will do so. Kids also have the same intense interest in quitting as do adult smokers. But at present we know little about effective ways to help these young people quit. Developing these approaches should be a high priority of tobacco-related research.

Additional Elements of Comprehensive Tobacco Control Efforts

Price Increases

Research has shown that price increases are a critical foundation of efforts to reduce tobacco use, particularly among youth. An increase in the price of tobacco products will reduce rates of use of both cigarettes and smokeless tobacco among both adults and youth. Experts agree that a 10

percent increase in the price of cigarettes will reduce overall smoking among youth by 7 percent and adults by approximately 4 percent. In the budget, the President has proposed a price increase of $1.10 per pack over five years. Coupled with proposed sales and advertising restrictions, this would reduce underage smoking by 39% to 46% in 20003. Almost one million of today's young people would be spared from premature deaths resulting from tobacco use.

Industry Accountability

Current legislative proposals include "lookback" provisions to hold the tobacco industry accountable to reduce tobacco use among young people. These provisions provide penalties at the industry and company level if reductions in teen smoking are not met. The industry must be held accountable if it doesn't shoulder its responsibility in reducing teen tobacco use.

Regulatory Actions

Unfortunately, we have not been able to implement the community, educational, media and deglamorization projects mentioned above in an environment free of easy access to tobacco products and tobacco advertising targeted at young people. Data from a national survey indicate that over-three quarters of young smokers were not asked to show proof of age during purchase attempts in the month prior to the survey. Data also indicate that advertising and promotional efforts impact youth. For example, teens are considerably more likely than adults to purchase the three most heavily advertised brands of cigarettes. Data like these indicate why it is so important to implement the FDA regulation to reduce the access and appeal of tobacco products to young people and to give FDA full authority to meet changing circumstances. We need to

level the playing field and allow prevention messages from parents, schools, and role models to take hold without the pervasive backdrop of pro-tobacco imagery and promotional messages.

International Tobacco Control

Comprehensive tobacco control programs should also include strengthening of international tobacco control efforts to offset projected increases in tobacco consumption in emerging global markets. According to researchers at Harvard University and the World Health Organization, the number of deaths per year caused by tobacco use around the world is expected to increase from 3,000,000 deaths in 1990 to 8,400,000 deaths in 2020. By 2025, tobacco will be the leading global cause of death and preventable illness. Seventy percent of those deaths will occur in developing countries, where people have not yet taken up the habit to the degree that we have in the United States and other developed countries. The opportunities for prevention are real. A problem of this scope merits a global approach similar to the worldwide efforts to eradicate smallpox and polio. We need to invest domestically so as to assist other countries interested in help to address tobacco use among their populations; in addition, we need to conduct public health efforts through the World Health Organization, UNICEF and other UN agencies, the World Bank, and other multilateral development agencies.

Conclusion

In conclusion, I would like to emphasize the importance of seizing this historic opportunity to address this critical public health problem. Tobacco use remains the leading preventable cause of death in this country, killing more than 400,000 Americans each year. Every day we do not take action means that another 3,000 young people will become regular smokers. To stop this

epidemic, we need to invest in tobacco prevention and education programs at a level commensurate with the harm caused by tobacco products.