A Review of Current Issues about Tobacco Use

January 2005

A memo to the Kansas Health Foundation
KHI/M 05-1

Gianfranco Pezzino, M.D., M.P.H.

KANSAS HEALTH INSTITUTE

212 SW Eighth Avenue, Suite 300
Topeka, Kansas 66603-3936
(785) 233-5443
www.khi.org

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

TABLE OF CONTENTS

BACKGROUND AND SCOPE

The Kansas Health Institute has prepared this review to describe the major current issues about use of tobacco products in the United States. This report was prepared for a non-technical audience, to allow a quick overview, while directing to appropriate sources for additional information. While the main focus of the report is on cigarette smoking, some information on other tobacco products is included as well.

After a review of the health effects of smoking, the report discusses some of the legal issues that have surrounded tobacco products use in the past years, and moves on to describe the best evidence-based interventions to reduce tobacco use. Examples of tobacco control programs from Kansas and other states are presented. Finally, a brief review of emerging issues that could affect future tobacco use and tobacco control programs is included.

METHODS

The KHI project team conducted a review of recent literature addressing the health effects of tobacco use and strategies to reduce the use of tobacco in the population. Many of the documents consulted for this report are available on the Internet. Web sites from the Centers for Disease Control and Prevention, Campaign for Tobacco-Free Kids, and Kansas Action for Children provided most of the material for the report. In addition, personal interviews were conducted with 11 individuals with special knowledge of these issues in Kansas.

HEALTH EFFECTS OF TOBACCO

It is now known and accepted that tobacco use (regardless of the type of product) is bad for human health. In recognition of this fact, for years life insurance companies have charged higher premiums for tobacco users (currently in Kansas, a tobacco user pays, on average, a life insurance premium that is 2.4 times higher than that for someone who never used tobacco). In 1964 the first Surgeon General's Report reviewed and organized for the first time in a comprehensive fashion all the available evidence on the health consequences of smoking. That report, which is considered a milestone for public health in this country and abroad, was the

foundation of the subsequent concerted efforts that led, in the following decades, to a dramatic reduction in the number of people who smoke.

After the first report, 27 more reports were published by the Office of the Surgeon General over the following years, most recently in 2004, and the evidence of the negative health effects of smoking has grown considerably. The 1986 report was one of particular importance, because it focused on the effects of exposure to environmental tobacco smoke (ETS, also known as involuntary smoking or second-hand smoking), and provided evidence that smoking is not only a problem for those who are directly engaging in that behavior, but also for others who share the environment with smokers.

A full review of all the health effects of smoking is beyond the scope of this report. Below is a brief summary, based on current information, of the most important health consequences of smoking:

- 440,000 (one in five) deaths in the U.S. every year are accounted for by smoking. Almost 4,000 of those deaths occur in Kansas.
- Smoking deaths in the U.S. are responsible for 5.6 million years of potential life lost.
- Smoking has been demonstrated to cause lung cancer, cancer in many organs, including the bladder, kidney, uterine cervix, esophagus, larynx, mouth, pharynx, pancreas, and stomach, as well as leukemia.
- Smoking is also a major cause of serious respiratory and cardiovascular diseases such as chronic obstructive pulmonary disease, pneumonia, cerebrovascular disease, and coronary heart disease.
- The body of knowledge on the adverse effects of smoking has grown to such a point that it is now evident that virtually every organ is impacted and damaged, and as a result the health of smokers is reduced in general. The direct cost for these adverse health effects has been estimated at almost $90 billion in annual direct health care costs (including over $800 million in Kansas) and other hundreds of billions in indirect costs (such as productivity and property losses).
- An estimated 150,000–300,000 U.S. children younger than 18 months of age have respiratory tract infections caused by exposure to secondhand smoke, which also kills an

estimated 3,000 nonsmoking people from lung cancer and 35,000 from heart disease every year.

- Babies of women who smoke during pregnancy are more likely to have lower birth weights, an increased risk of sudden infant death syndrome (SIDS), and respiratory distress.

EPIDEMIOLOGY OF SMOKING IN THE UNITED STATES

Smoking prevalence has been closely monitored in recent years, mostly by the CDC's Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS). It is estimated that over 46 million adults currently smoke cigarettes, and that 70 percent of them want to quit (an indication of how addictive the use of tobacco products is). Since 1966, when the prevalence of cigarette smoking among adults was 42.6 percent, the number of smokers has progressively decreased to 22.1 percent in 2003. The decrease was sharper among men than women, and, as a result, the gap between smoking prevalence in the two sexes, which used to be in double digits, is now much narrower (24.8 percent among men and 20.3 percent among women). Smoking is not equally common among all population groups, as indicated by the following figures:

- In 2003, the state estimates for cigarette smoking varied widely, ranging from 12.0 percent in Utah to 30.6 percent in Kentucky. In Kansas, an estimated 20.4 percent of adults were current smokers in 2003. Smoking prevalence rates among both adults and youth in Kansas are comparable to rates in surrounding states.
- Whites tend to have slightly higher smoking prevalence than African Americans.
- American Indians have a high prevalence (40.8 percent), while Hispanics have a relatively low prevalence (16.7 percent).
- Smoking today is more common among adults with lower education levels and those who live below the poverty level.

Smoking prevalence among young people represents an important public health concern. The younger people begin smoking cigarettes, the more likely they are to become strongly addicted to nicotine. More than 80 percent of adult smokers tried smoking before they were 18 years old,

and over half of them became regular smokers by that age. Despite the fact that many teenagers who smoke believe that they would not smoke five years later, most of them do and are unable to quit. Of high school students who are current smokers (21.9 percent, or 3.5 million, in 2003), 54 percent have tried to quit in the past 12 months. In addition, 11 percent of male and 2 percent of female high school students use smokeless tobacco, which puts their health at risk and makes them more likely to become cigarette smokers. In Kansas, the most recent available data indicate that in 2002 21 percent of high school students were current cigarette smokers, down from 26 percent in 2000 (representing a reduction of 19 percent).

Appendix 1 contains an overview of the toll of smoking in Kansas, with more detailed information about our state.

LEGAL ISSUES RELATED TO SMOKING

Over the past decades, tobacco products have been at the center of several legal issues. The overwhelming evidence of the negative health effects of smoking caused several groups and government agencies to question the legal responsibilities of manufacturers of tobacco products. The following major legal and regulatory areas have considerably affected the sale and consumption of tobacco products, and are examined in this document:

- Master settlement agreement between states and tobacco companies
- Role of the U.S. Food and Drug Administration (FDA) in regulating the production and sale of tobacco products
- Smoking bans and restrictions
- Tobacco taxation
- Restrictions of youth access to tobacco products

Master Settlement Agreement

In 1994, Mississippi became the first state to file a lawsuit against the tobacco industry, on the grounds that the state has a right to recover the cost of treating diseases caused by tobacco use, particularly for Medicaid recipients. This groundbreaking legal initiative caused the 49 other states to file similar suits, asserting that taxpayers should not have to bear the financial burden of tobacco users, and that the tobacco companies should be held accountable.

Four of the states (Mississippi, Minnesota, Florida, and Texas) reached individual settlements with the tobacco companies, which totaled $40 billion. The remaining 46 states, Puerto Rico, and the District of Columbia reached a class action settlement with the tobacco companies in 1998 that has become known as the Master Settlement Agreement (MSA).

Rather than face litigation for several years or decades, the tobacco companies accepted to pay states included in the MSA $206 billion over 25 years. The original companies that were parties to the MSA were Philip Morris, R.J. Reynolds, Brown & Williamson, and Lorillard, but over 30 additional companies have joined the MSA. In addition to monetary payments, participating companies also agreed to restrictions on advertising, as well as the creation and funding of the American Legacy Foundation, devoted to public smoking education. In exchange, the states agreed to release all tobacco companies that participated in the MSA from their legal claims as well as any right to bring future lawsuits on such claims. However, the MSA does not protect the tobacco companies from individual or individual class-action lawsuits. In at least one recent case in Florida (now under appeal) a group of smokers was successful in bringing a class action suit against major tobacco companies.

While there is no requirement on how states should spend the revenue from the MSA, there is a clear expectation that transpires from the agreement's language that a substantial portion of these funds would be devoted to tobacco use prevention efforts. The CDC produced guidelines on how much money each state should consider investing every year in tobacco control programs, based on the combined revenue in the state from the MSA and tobacco excise taxes. Ultimately, state legislatures are responsible to allocate the money from the MSA as they see appropriate, and there are no penalties for states that allocate less than the recommended amounts for tobacco control programs.

Master Settlement Agreement Issues in Kansas

In Kansas, the MSA is expected to generate over $1.6 billion between 1998 and 2025. As a result of the MSA, the state legislature created the Kansas Endowment for Youth (KEY) Trust, where funds from the MSA are expected to be deposited, invested, and grow, with the purpose of

funding children's programs and tobacco control initiatives in the state. The Kansas Children's Cabinet and Trust Fund, a 15-member committee consisting of ex officio members and appointees of the Governor and Legislature, makes recommendations to state legislators on the best and most effective use of the money. The legislature has the ultimate authority to appropriate money from the KEY trust. Using that authority, several million dollars (over 60 million in 2003 and 50 million in 2004) have been used from the KEY fund to support a multitude of state activities, but a very small proportion of that money was spent on tobacco control activities. Based on CDC guidelines, *Kansas should spend approximately 18 to 45 million dollars per year on tobacco prevention programs; the actual spending in 2004 was about 2.2 million.* This money originates from different sources, including federal and private foundation grants, and covers the cost of running the Kansas Tobacco Use Prevention Program at KDHE. Included in this budget are $750,000 allocated directly from tobacco settlement funds to a pilot project in Salina (the only tobacco control money provided through state funds). According to the Campaign for Tobacco-Free Kids, Kansas ranked 42nd in 2005 for the percentage of CDC-recommended funding that is allocated in the state budget for tobacco prevention programs (which in 2005 represented about 4 percent of the recommended target). Similar to Kansas, many other states used part of their revenues from the MSA to fund programs other than tobacco prevention activities, but of the surrounding states only Missouri ranked lower than Kansas.

Role of the Food and Drug Administration (FDA)

For years, legal and public health experts have discussed the extent to which the production and sale of tobacco products should be regulated by government. Advocates for stricter tobacco control have proposed that nicotine is an addictive substance with important pharmacologic effects and health consequences, and, as such, it should be regulated by the FDA in the same way as other prescription drugs, including requirements for safety profiles and restrictions to access and sale. Opponents argue that nicotine and tobacco products are not used as other pharmacologic substances but rather for leisure, and should not be subject to those levels of restrictions and regulations.

In July 2004, the U.S. Senate voted 78-15 to approve a bill with provisions that would have given the FDA broad oversight authority over tobacco products, including restricting advertising, requiring more disclosure of the content of tobacco products, and requiring changes in the composition of tobacco products. After a complex series of legislative events, the provisions in the bill were not approved by the House and the conference committee. As a result, the FDA was not granted the authority to regulate tobacco products, in what many public health advocates consider a setback in the efforts to contain the negative effects of tobacco use. It is not anticipated that this issue will resurface on the legislative agenda anytime soon.

Smoking Bans and Restrictions

Although some smoking bans and restrictions are imposed by federal and state authorities, more extensive bans have been implemented through local ordinances, often causing intense debate and controversy. A barrier to efforts by local governments to adopt smoking bans is pre-emption, which is the presence of a state law that restricts smoking, but also prevents implementation and enforcement of more restrictive local laws. Eliminating preemption statutes is one of the tobacco objectives of Healthy People 2010. Kansas does not have a state pre-emptive law.

Another barrier to the adoption of local, state, and national smoking bans is political opposition by smokers, businesses concerned about potential changes in revenue, and tobacco industry sponsored groups. In November 2004, voters in six cities around the country were called to approve or reject community-wide smoking bans or restrictions in public places: in four of the six cities the bans or restrictions were approved.

In Kansas, the city of Lawrence in July 2004 passed an ordinance banning smoking from most public places; the issue may be put to a local vote in March 2005. Salina has also introduced restrictions on public smoking. In the Kansas City metropolitan area, a ban of smoking in public places is being considered that would only take effect after a certain number of jurisdictions approve the initiative.

Tobacco Taxation

For decades the sale of tobacco products has been targeted with federal and state taxes of various types, natures, and amounts. Taxes are an important component that affects the final sale price of tobacco products, particularly cigarettes. Since the sale price of cigarettes is an important element that affects whether people (both youth and adults) smoke, and how many cigarettes they consume, the issue of taxation is very important for tobacco control programs.

The taxation system for tobacco products is complex and varies between cigarettes and other tobacco products. Cigarettes are subject to special federal and state excise taxes, as well as the state sales tax. The following table compares the taxation level and final sale price of a pack of cigarettes in some selected states as of November, 2004.

Table 1. **Taxation level and final sale price of a pack of cigarettes**

State	Factory Cig. Price	Federal Cig. Tax	Distributor & Retailer Mark Ups	State Cig. Tax	State Sales Tax	Final Cig. Retail Price
New Jersey	$2.12	$0.39	$0.56	$2.40	$0.33	$5.80 U.S. highest
Kansas	$2.12	$0.39	$0.57	$0.79	$0.21	$4.08
Nebraska	$2.12	$0.39	$0.64	$0.64	$0.21	$4.00
Oklahoma	$2.12	$0.39	$0.49	$1.03	$0.15	$4.17
Colorado	$2.12	$0.39	$0.50	$0.84	$0.00	$3.85
Missouri	$2.12	$0.39	$0.48	$0.17	$0.14	$3.30

On January 1, 2003, the excise tax on cigarettes in Kansas increased from $0.24 to $0.79 per pack. In the election that took place in November 2004, Oklahoma and Colorado approved an increase of their state tobacco taxes. As a result, the price of a pack of cigarettes in Kansas, Oklahoma, Nebraska, and Colorado now ranges from $4.17 in Oklahoma to $3.85 in Colorado, and Kansas price is less than 6 percent higher or lower than the price in those three states. However cigarette price remains at a low $3.30 in Missouri, among the lowest in the entire nation.

Kansas ranks currently 24th in the amount of excise tax levied on cigarettes. Kansas also has a 10 percent tax on other (i.e., non-cigarettes) tobacco products, among the lowest in the country.

Governor Kathleen Sebelius' Proposal for an Increase in Cigarette Tax

In November 2004 Kansas Governor Kathleen Sebelius unveiled a comprehensive state health plan, and proposed to increase the cigarette tax by $0.50 and the tax on other tobacco products from 10 to 15 percent to fund some portions of the plan. With that increase, the price of a pack of cigarettes in Kansas would increase by about 12 percent to $4.58, higher than in any of the surrounding states and $1.28 higher than in Missouri, and Kansas would rank 14 for cigarette excise tax. This price change would be expected to result in a 5 percent decrease of overall cigarette consumption, and in a decrease of over 4 percent in the use of tobacco among adolescents. The Governor's proposed tax increases require legislative approval.

Restrictions of Access for Minors

Reducing the number of young people who smoke is an important element for tobacco control programs. Legal restrictions are used to prevent smoking in minors, including the following:

- Prohibition to sell tobacco products to minors exists in all 50 states and the District of Columbia. Enforcement varies widely.
- Prohibition for minors to possess tobacco products is present in 33 states, but penalizing minors for possession of tobacco has not been proven to be an effective technique to reduce underage tobacco usage.
- Prohibition of the free distribution of tobacco to persons under 18 years and within a certain distance of a school, playgrounds, or other locations used primarily by people under 18 years is present in 9 states. In Kansas, it is unlawful for any person to distribute samples within 500 feet of any school.
- Vending machines are often used by minors to procure tobacco products. Forty-six states, including Kansas (K.S.A. 79-3321), restrict the placement of tobacco product vending machines with the purpose of reducing accessibility by minors. The restrictions in place in Kansas, however, are fairly limited, and allow cigarette vending machines in practically any location with a locking device or in line of sight of store employee.

- Thirty-three states (but not Kansas) restrict the sale of cigarettes outside of their original package (for example, one or two cigarettes at the time).

Overall, Kansas laws restricting access of minors to tobacco products seem to be in line with those of neighboring states, but enforcement deficiencies are present in some areas and could cost the state several million dollars, as explained below.

Federal lawmakers approved a law in 1992, commonly called the Synar Amendment, requiring states to pass and enforce laws that prohibit the sale of tobacco to individuals less than 18 years of age. Compliance with the Synar Amendment is a condition of funding for states receiving the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant: 40 percent of the block grant funding can be withheld for not complying with the Synar Amendment. Some of the requirements for compliance include conducting annual, random, unannounced inspections of a probability sample among retail outlets to ensure that selected outlets are not selling tobacco products to minors. The Synar Amendment requires that states achieve a maximum sales-to-minors rate not greater than 20 percent by FY 2003.

In Kansas, the Department of Social and Rehabilitation Services (SRS) serves as the lead agency regarding the Synar Amendment, and has partnered with the Department of Revenue to enforce its requirements. The most recent results show that the FY 2004 non-compliance rate in Kansas is about 38 percent, much higher than the 20 percent maximum allowed by the Synar Amendment. Based on the federal formula, this could translate into a significant loss of the $12.5 million that Kansas receives from the SAMHSA block grant. SRS is negotiating with the federal government remediation actions to address this issue.

EVIDENCE-BASED INTERVENTIONS TO REDUCE TOBACCO USE

Task Force on Community Preventive Services Recommendations

Since the publication of overwhelming evidence on the adverse health effects of tobacco use and exposure to second-hand smoke, research has led to recommendations for certain evidence-based interventions. KHI found no program in Kansas currently including all these components in one comprehensive intervention.

In 2001, the U.S. Task Force on Community Preventive Services published a milestone report titled The Guide to Community Preventive Services: Tobacco Use Prevention and Control. The task force examined the best published evidence in support of different interventions targeting tobacco control. Based on the body of evidence, six interventions were classified as strongly recommended, organized into three types:

- Strategies to reduce youth initiation:
  - Increasing the unit price of tobacco products, particularly through raising federal and state excise taxes.
  - Developing extensive and extended mass media campaigns, particularly when they are the centerpiece along with other strategies.
- Strategies to reduce ETS:
  - Develop laws and regulations to restrict or ban consumption in workplaces and general areas used by the public.
- Population-based strategies for smoking cessation:
  - Using media campaigns to encourage people to "quit" along with other strategies.
  - Increasing the unit price of tobacco products.
  - Using provider education and having providers implement self-reminder systems to insure that this issue is raised during the clinical examination.
  - Providing telephone counseling and support services along with other strategies.

While other strategies listed in the report could be potentially effective in reducing consumption of or exposure to tobacco products, the evidence so far is not enough to support a strong recommendation for their use. In addition, the report emphasizes that many strategies have been shown effective only in the context of programs including multiple integrated interventions; therefore the task force recommends the use of comprehensive programs including more than one strategy, rather than single activities. A more detailed discussion of each strategy follows.

Increasing the Unit Price of Tobacco Products

Excise taxes on tobacco products make those products less attractive to all tobacco users, particularly adolescents and young adults with limited resources. Studies have shown that on average a 10 percent increase in product price would result in a 3.7 percent decrease in the prevalence of tobacco use among adolescents, and in a 4.1 percent decrease in population consumption of tobacco products. In several states, excise tax increases have provided revenue for comprehensive tobacco use prevention and control programs.

Developing Extensive and Extended Mass Media Campaigns

Campaigns are mass media interventions of an extended duration that use brief, recurring messages to inform and motivate individuals to remain tobacco free and to avoid exposure to ETS. Mass media campaigns should be combined with other interventions, such as increases in the excise tax on tobacco products, school-based education, or other community programs.

Campaigns that are combined with other activities to reduce tobacco use are effective in (1) reducing consumption of tobacco products, and (2) increasing cessation among tobacco users. Studies observed a median decrease in tobacco initiation of 8.0 percentage points in people exposed to the campaign compared with groups not exposed. Studies evaluating the effectiveness of mass media campaigns in reducing tobacco consumption in statewide populations (as measured by statewide sales of cigarettes) found a median decrease of 15 packs per capita per year.

Smoking Bans and Restrictions

Policies to reduce smoking indoors reduce exposure to ETS. They can also result in both a reduction in the number of cigarettes smoked each day and an increase in the number of smokers who quit. Smoking bans prohibit smoking entirely. Smoking restrictions limit smoking, but not completely, allowing smoking in designated areas, at designated times, or under certain other conditions.

Studies that evaluated the effect of smoking bans in workplaces observed an average reduction in exposure to components of ETS (e.g., nicotine vapor) of 72 percent. Smoking bans

were more effective in reducing ETS exposures than were smoking restrictions. Smoking bans were effective in a wide variety of public and private workplaces and health care settings. Studies evaluating smoking bans also observed reductions in the amount of cigarettes consumed by smokers.

Provider Education and Self-Reminder Systems

Efforts to increase the number of people who stop using tobacco include an education program for providers, so that they can help their patients quit tobacco use ("provider education"), prompting health care providers to identify and to discuss with tobacco-using patients the importance of quitting ("provider reminder"), and self-help materials for patients interested in quitting ("patient education"). While these interventions implemented alone have limited effectiveness, studies have shown that a combination of the three is successful in helping smokers to quit. These programs are applicable in different populations, with different forms of tobacco, and in different settings (including Health Maintenance Organizations, private practices, physician training programs, and public health, primary care, internal medicine, and family medicine clinics).

Based on the studies reviewed by the task force, when interventions that include a provider reminder system and a provider education program were implemented, on average the number of patients who received advice from a provider to quit tobacco use was 20 percentage points higher, and the number of patients who quit tobacco use was 4.7 percentage points higher. For interventions including patient education, provider reminders, and provider education, provider advice to quit increased by 22 percentage points, and the number of patients who quit increased 5.7 percentage points.

Providing Telephone Counseling and Support Services

These programs, including one run in Kansas by KDHE, are organized efforts to help tobacco users quit and not start using tobacco again. They provide one or more sessions of telephone counseling or assistance, usually delivered by trained counselors. These telephone sessions are often combined with other efforts, such as distribution of materials about quitting,

formal individual or group counseling, or nicotine replacement therapies (including patches or gum).

Findings from the task force were that studies demonstrated small, but consistent increases in the number of tobacco users who quit when these supportive services are implemented together with other interventions, such as other educational approaches or medical therapies. On average, the quit rate after these interventions increased by 2.6 percentage points (a 41 percent improvement).

There are many different approaches to the use of telephone support. To be effective, programs should at least give tobacco users the option to call for help and should distribute printed materials about quitting tobacco use.

At the end of 2003, the Kansas Department of Health and Environment started the Kansas Tobacco Quitline. The Quitline, operated through a contractor, attracts up to 600 callers every month. The number of clients seems to fluctuate in relation to the intensity of advertising and marketing activities (another indication of the importance of integrating multiple approaches for a successful tobacco control program).

The CDC's Best Practices for Comprehensive Tobacco Control Programs

The CDC has an important role in funding many state-based tobacco control activities and in identifying how funds should be used. In 1999 the CDC published its *Best Practices for Comprehensive Tobacco Control Programs.* This document provides states with recommended strategies and funding levels for effective programs to prevent and reduce tobacco use, eliminate the public's exposure to secondhand smoke, and identify and eliminate disparities related to tobacco use and its effects among different population groups.

The CDC endorses the use of the evidence-based interventions recommended by the Task Force on Community Preventive Services, and it suggests that those interventions be part of comprehensive tobacco control programs that include the following nine components:

- Community programs
- Chronic disease programs (e.g., heart disease prevention, cancer registries) to reduce the burden of tobacco-related disease
- School programs
- Enforcement of existing policies
- Statewide programs
- Counter-marketing
- Cessation programs
- Surveillance and evaluation
- Administration and management

The CDC estimates that the annual costs to implement all of the recommended program components range from $7 to $20 per person in small states (populations under 3 million) and from $5 to $16 per person in large states (population over 7 million). A more detailed description of the nine program components is in appendix 2.

Healthy People 2010 Objectives

Healthy People 2010 is a set of health objectives for the nation to achieve over the first decade of the new century. These objectives serve as the basis for the development of state and community public health plans. Healthy People 2010 was developed through a broad consultation process by the Healthy People Consortium, consisting of more than 400 national membership organizations, all state and territorial health departments, and key national associations of state health officials working to advance health.

There are 21 objectives that address the use of tobacco products, most of which are broken down into smaller components. A full list is included in appendix 3. The most noticeable objective is probably to reduce cigarette smoking by adults aged 18 years and older to 12 percent. In 2003, Utah was the first and only state that met this objective. While the prevalence of smoking nationwide has decreased, the rate of decline is not rapid enough for the country to reach this objective. The CDC comments that unless states expand cessation and other tobacco

control and tobacco prevention efforts, the Healthy People 2010 goal of reducing smoking prevalence to less than 12 percent will not be achieved.

TOBACCO CONTROL PROGRAMS IN KANSAS AND OTHER STATES

Kansas Programs

Kansas has a variety of tobacco control programs both at the state and local level. A detailed list of the major Kansas state and local programs is in appendix 4. While most of these programs appear to embrace some of the components and evidence-based interventions recommended by the CDC and the Task Force on Community Preventive Services, the project team could not identify any programs in the state that include all those components into one comprehensive intervention.

The Kansas Department of Health and Environment runs the Tobacco Use Prevention Program, which provides resources and technical assistance to community coalitions on tobacco control activities. The budget for this program in FY 2004 was about $2.2 million, mostly from federal and private foundations' grants. The program has been in existence for about 12 years and employs 12 people. This program also includes the Kansas Tobacco Quitline described earlier in this document.

The Tobacco Free Kansas Coalition is a group of more than 125 organizations and individuals working together to reduce tobacco use. Members span numerous counties across Kansas and disseminate media campaign resources developed by the CDC.

Among local initiatives, the Central Kansas Foundation of Salina was selected in 2001 to receive a $500,000 grant from KDHE (funded through the MSA funds) to conduct a comprehensive community-based tobacco use prevention program, perhaps the largest local tobacco control program in the state. The grant was renewed in 2002 and in 2003 for an additional $500,000, and in 2004 for $750,000. This money represents the only allocation of Kansas MSA funds towards tobacco use prevention.

Finally, as mentioned in the section dealing with legal issues, several localities in Kansas have approved (and others are considering) smoking restrictions or bans in public places. In the absence of a legal initiative from state legislators, it is likely that local ordinances will continue to play an important role in community-based clean air activities.

Neighboring States

The amount of state funding for tobacco prevention programs in surrounding states varies from zero in Missouri to $4.8 million in Oklahoma. These numbers represent a relatively small portion of the CDC minimum recommended amounts of funding to tobacco control programs. Kansas is second to the last in achieving the CDC recommended level of funding. The following table compares tobacco revenues and prevention expenditures by state.

Table 2. **Expenditures* for tobacco-prevention programs and annual tobacco revenues in Kansas and surrounding states – Fiscal Year 2005****

State	Tobacco Prevention Spending	Total Annual State Revenues from Tobacco	Prevention Spending as % of Tobacco Revenues	CDC Minimum Prevention Spending Target	Tobacco Prevention Spending % of CDC Minimum
CO	$4.3	$221.1	1.9%	$24.5	17.5%
KS	$0.75	$170.6	0.4%	$18.1	4.1%
MO	$0.0	$243.9	0.0%	$32.8	0.0%
NE	$2.9	$105.8	2.7%	$13.3	21.8%
OK	$4.8	$290.2	1.7%	$21.8	22.0%

* Include only state government funding

**All amounts are in millions of dollars per year

Most neighboring states have programs similar to those implemented in Kansas. Some key tobacco control initiatives in neighboring states are described below.

Colorado

The Colorado Department of Public Health and Environment created a publication entitled Colorado Tobacco Settlement Times to serve as a forum to share news about state's tobacco

education and prevention activities. It can be view at http://www.cdphe.state.co.us/pp/tobacco/Publications/TobaccoSettlementTimes/March2003.pdf. Also, Colorado has both a telephone quit line and a Web-based quit service.

Missouri

The Missouri Foundation for Health (http://www.mffh.org/tobinit.pdf), a non-profit foundation with the goal of improving the health of the people in Missouri communities, identified tobacco use as a major health issue, and developed a Tobacco Prevention and Cessation Initiative to support direct program implementation, policy development activities, and evaluation. Missouri also has a statewide Tobacco Steering Committee.

Nebraska

Tobacco Free Nebraska (http://www.hhs.state.ne.us/tfn/03TFNSnapExec.pdf) is a comprehensive tobacco control program that targets youth prevention, cessation, eliminating secondhand smoke exposure, and disparities related to tobacco use and its effects among different population groups. In 2000, the Nebraska State Legislature appropriated additional Tobacco Settlement funds to support statewide prevention and cessation efforts.

Oklahoma

In 2000 Oklahoma's constitution was amended by a vote of the people, to place a portion of each year's tobacco settlement payments into an endowment trust fund, called the Oklahoma Tobacco Settlement Endowment Trust (http://www.tobaccosettlement.state.ok.us/programs/tobaccouse.html). The trust funds programs in the following five areas: clinical and basic research and treatment; cost-effective tobacco prevention and cessation programs; programs designed to improve the health of Oklahomans or to enhance the provision of health care services, with particular emphasis on such programs for children; educational programs and services for the benefit of the children of Oklahoma; and programs designed to enhance the health and well-being of senior adults.

Success Stories in Other States

Most states have implemented tobacco control programs that include one or more of the recommended best practice interventions. Some states have been considered as models for the success of the comprehensive programs that they implemented. A review of some successful state programs is contained in appendix 5.The experience in these states demonstrated some important points:

- When adequately funded, comprehensive state tobacco prevention programs quickly and substantially reduce tobacco use.
- State tobacco prevention programs must be insulated against the attempts to reduce program funding.
- The programs' funding must be sustained over time.
- When program funding is cut, progress in reducing tobacco use diminishes.

EMERGING ISSUES AND RESEARCH GAPS IN TOBACCO CONTROL

Research Gaps

Despite the tremendous progress in knowledge achieved during more than 50 years of research in the effects of tobacco and on strategies to limit its consequences, there remain several areas in which our understanding is incomplete.

At a level of basic research, our understanding of the mechanisms by which tobacco-related diseases occur needs to improve. For example, over the past 40 years, for reasons still unknown, the type of lung cancer caused by smoking has changed (from squamous carcinoma to adenocarcinoma). Also, important questions remain on how smoking interacts with other cardiovascular risk factors. Furthermore, there seem to be important differences in the effects caused by smoking among population groups that are still not fully understood. Answers to these and other questions could provide important assistance in developing targeted, effective control programs.

More research is needed on how changing tobacco products affect human health. Tobacco products different from ordinary cigarettes are imported from Indonesia, India, and other

Southeast Asia countries. Some of them are flavored, and their exotic appearance and taste may attract in particular young smokers wishing to experiment. The content of these products is often unknown, but in many cases they seem to have higher concentration of tar, nicotine, and carbon monoxide. In additions, there are several products marketed as potentially reduced exposure products that promise to decrease the amount of nicotine and tar delivered. Smokers may be attracted to these with the expectation to reduce their health risk and be deterred from quitting, but the evidence of risk reductions is still lacking.

Important questions are still open also about tobacco control strategies. For example, anti-tobacco marketing is one of the strategies accepted as effective in reducing tobacco consumption, but we know little about what characteristics make social marketing campaigns more or less successful. How big must the campaign be? How long must it run? What themes are more effective? What is the required intensity? How do these and other characteristics affect the effectiveness of a campaign in different population subgroups?

Regarding community-wide strategies, while there is an agreement that the best results are achieved when multiple strategies are combined in a comprehensive program, it is largely unknown what intervention components contribute most to the effectiveness of multi-component interventions, and what combinations of components are more successful.

Finally, more research is also needed to better understand what motivates smokers who want to quit to take advantage of some of the interventions known to be effective in reducing tobacco consumption. Smokers who are trying to quit do not seem to generate as much demand for these services as one could expect, and identifying factors that can increase that demand in different population segments could have important effects on cessation rates.

Smokeless Tobacco

The use of smokeless tobacco has been promoted by some as a safer alternative to cigarette smoking. In reality, smokeless tobacco is a significant health risk and is not a safe substitute for smoking cigarettes. Smokeless tobacco is a known cause of human cancer, as it increases the risk of developing cancer of the oral cavity. Oral health problems strongly associated with smokeless

tobacco use are leukoplakia (a lesion of the soft tissue that consists of a white patch or plaque that cannot be scraped off) and recession of the gums. Smokeless tobacco use can lead to nicotine addiction and dependence.

Smokeless tobacco use has increased over the past decades, and is a particular concern among adolescents. It is estimated that nationwide 11 percent of male and 2 percent of female high school students use smokeless tobacco. In Kansas, the use of smokeless tobacco among male high school students is estimated at more than 14 percent, higher than the national average. Adolescents who use smokeless tobacco are more likely to become cigarette smokers.

The use of smokeless tobacco has not been studied and reported as extensively as cigarette smoking. Smokeless tobacco use is increasing and seems to be particularly high among high school males in Kansas; this is likely to become an increasing focus of interventions for tobacco control programs in the near future, particularly for early prevention interventions.

U.S. Department of Justice Lawsuit

In September of 1999, the federal government through the US Department of Justice (DOJ) filed a landmark racketeering complaint against tobacco companies for numerous illegal and harmful practices, including marketing to children, concealing the health effects of smoking, and obscuring information about the addictiveness of nicotine. The Department of Justice is seeking $280 billion in past profit, $9 billion for smoking cessation programs, and changes in the ways tobacco companies produce and market their products.

The trial began on September 21, 2004, and is expected to last for several months. A decision in favor of the DOJ may have severe financial consequences on the tobacco industry, whose current net worth is estimated at $89 billion less than what is being sought in damages. The risk of bankruptcy for some of the major tobacco companies has induced some states to explore the option to securitize, or sell to investors, future tobacco settlement payments for a smaller, up-front payment. Preliminary ruling during the trial indicates that it is unlikely that the requests from the DOJ will be accepted. This is the most expensive case ever undertaken by the DOJ, costing approximately $135 million to date.

CONCLUSIONS

Today there are more former smokers than current smokers, and per-capita consumption of cigarettes has decreased by over 50 percent since the publication of the first Surgeon General's report on smoking and health in 1964. The majority of men smoked in 1964 and smoking was allowed almost everywhere, while today there is an unprecedented level of activities to achieve clean indoor air quality. Some key results of four decades of research and efforts to reduce tobacco use are:

- Almost 4,000 Kansans die every year as a result of smoking. Smoking harms nearly every organ of the body, causing disease and reducing the health of smokers in general.
- The only way to reduce the risk of smoking is to quit smoking and not to be exposed to environmental tobacco smoke.
- Smoking starts young—most adult smokers start before they are 18 years old. Over 20 percent of Kansas high school students smoke cigarettes.
- There are 14 evidence-based recommendations and 9 best practices for comprehensive tobacco control programs that have been proven through multiple studies to be effective in reducing tobacco consumption. This study could not identify any programs in Kansas that includes all the recommended prevention components.
- Despite the massive influx of money generated through the Master Settlement Agreement, most states are using only a small proportion of these funds for tobacco control activities. Kansas ranks among the states spending the lowest level of funding for tobacco control programs.

There has been a tremendous progress achieved in the field of tobacco control. Despite this impressive progress, smoking remains the leading preventable cause of disease and death in the United States. Future reduction in morbidity, mortality, and economic costs of tobacco use will require a continued and sustained effort and allocation of resources.

APPENDIX A

TOLL OF TOBACCO IN KANSAS

The Toll of Tobacco in Kansas*

Tobacco Use in Kansas

High school students who smoke	21.1%(35,400)
Male high school students who use smokeless or spit tobacco	14.5% (females use much lower)
Kids (under 18) who become new daily smokers each year	6,700
Kids exposed to secondhand smoke at home	161,000
Packs of cigarettes bought or smoked by kids each year	8.9 million
Adults in Kansas who smoke	22.1% (436,500)

Nationwide, youth smoking has declined since 1997, but remains at high levels. The 2003 Youth Risk Behavior Surveillance (YRBS) found that 21.9% of U.S. high school kids smoke and 11.0% of high school males use spit tobacco. U.S. adult smoking has decreased gradually since the 1980s, and 22.5% of U.S. adults (about 45 million) currently smoke.

Deaths in Kansas From Smoking

Adults who die each year from their own smoking	3,800
Kids now under 18 and alive in Kansas who will ultimately die prematurely from smoking	57,000
Adults, children, & babies who die each year from others' smoking (secondhand smoke & pregnancy smoking)	340 to 620

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined -- and thousands more die from other tobacco-related causes -- such as fires caused by smoking (more than 1,000 deaths/year nationwide) and smokeless tobacco use. No good estimates are currently available, however, for the number of Kansas citizens who die from these other tobacco-related causes, or for the much larger numbers who suffer from tobacco-related health problems each year without actually dying.

Smoking-Caused Monetary Costs in Kansas

Annual health care costs in Kansas directly caused by smoking	$724 million
- Portion covered by the state Medicaid program	$153 million
Residents' state & federal tax burden from smoking-caused government expenditures	$487 per household
Smoking-caused productivity losses in Kansas	$741 million

Amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, spit tobacco use, or cigar and pipe smoking. Other non-health costs from tobacco use

include residential and commercial property losses from smoking-caused fires (more than $500 million per year nationwide); extra cleaning and maintenance costs made necessary by tobacco smoke and litter (about $4+ billion nationwide for commercial establishments alone); and additional productivity losses from smoking-caused work absences, smoking breaks, and on-the-job performance declines and early termination of employment caused by smoking-caused disability or illness (dollar amount listed above is just from productive work lives shortened by smoking-caused death).

Tobacco Industry Influence in Kansas

Annual tobacco industry marketing expenditures nationwide	$11.45 billion
Estimated portion spent for Kansas marketing each year	$126.3 million

Published research studies have found that kids are three times more sensitive to tobacco advertising than adults and are more likely to be influenced to smoke by cigarette marketing than by peer pressure, and that one-third of underage experimentation with smoking is attributable to tobacco company advertising.

Source: National Center for Tobacco-Free Kids. Retrieved November 25, 2004 from
http://www.tobaccofreekids.org/reports/settlements/TobaccoTollPrint.php3?StateID=KS

APPENDIX B

THE CDC'S BEST PRACTICES FOR COMPREHENSIVE TOBACCO CONTROL PROGRAMS

Best Practices for Comprehensive Tobacco Control Programs, August 1999*

Executive Summary

Tobacco use is the single most preventable cause of death and disease in our society. Most people begin using tobacco in early adolescence, typically by age 16; almost all first use occurs before high school graduation. Annually, tobacco use causes more than 430,000 deaths and costs the Nation approximately $50–$73 billion in medical expenses alone. Data from California and Massachusetts have shown that implementing comprehensive tobacco control programs produces substantial reductions in tobacco use.

The goal of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use by

- Preventing the initiation of tobacco use among young people.
- Promoting quitting among young people and adults.
- Eliminating nonsmokers' exposure to environmental tobacco smoke (ETS).
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

In this guidance document, CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon "best practices" determined by evidence-based analyses of comprehensive State tobacco control programs. Evidence supporting the programmatic recommendations in this guidance document are of two types. Recommendations for chronic disease programs to reduce the burden of tobacco-related diseases, school programs, cessation programs, enforcement, and counter-marketing program elements are based primarily upon published evidence-based practices. Other program categories rely mainly upon the evidence of the efficacy of the large-scale and sustained efforts of two States (California and Massachusetts) that have been funding comprehensive tobacco prevention and control programs using State tobacco excise taxes.

Based upon this evidence, specific funding ranges and programmatic recommendations are provided. The local analysis of each State's priorities should shape decisions regarding funding allocations for each recommended program

---

* Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999. Accessed on November 23 2004 at http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestprac-execsummay.htm.

component. The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors. Although the type of supporting evidence for each of the recommended nine program components differs, evidence supports the implementation of some level of activity in each program area. In general, States typically have selected a funding level around the middle of the recommended ranges. Current allocations range from $2.50 to over $10; however, no State is currently implementing all of the recommended program components fully. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller States (population under 3 million), $6 to $17 per capita in medium-sized States (population 3 to 7 million), and $5 to $16 per capita in larger States (population over 7 million).

The best practices address nine components of comprehensive tobacco control programs:

I. Community Programs to Reduce Tobacco Use (Base funding of $850,000–$1.2 million per year for State personnel and resources; $0.70–$2.00 per capita per year for local governments and organizations).

Local community programs cover a wide range of prevention activities including engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others; and promoting governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, provide coverage for treatment, and achieve other policy objectives. In California and Massachusetts, local coalitions and programs have been instrumental in achieving policy and program objectives. Program funding levels range from approximately $1.00 per capita in California to over $2.50 per capita in Massachusetts.

II. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases ($2.8 million–$4.1 million per year).

Even if current tobacco use stopped, the residual burden of disease among past users would cause disease for decades to come. As part of a comprehensive tobacco control program, communities can focus attention directly on tobacco-related diseases both to prevent them and to detect them early. The following are examples of such disease programs and recommended funding levels:

- Cardiovascular disease prevention ($500,000 for core capacity and $1–$1.5 million for a comprehensive program).
- Asthma prevention (base funding of $200,000–$300,000 and $600,000–$800,000 to support initiatives at the local level).
- Oral health programs ($400,000–$700,000).
- Cancer registries ($75,000–$300,000).

III. School Programs ($500,000–$750,000 per year for personnel and resources to support individual school districts; $4–$6 per student in grades K–12 for annual awards to school districts).

School program activities include implementing CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, which call for tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services; implementing evidence-based curricula identified through CDC's Research to Classroom Project; and linking school-based efforts with local community coalitions and statewide media and educational campaigns. Oregon has developed a new funding model for school programs based upon CDC's guidelines and experience in California and Massachusetts. At an annual funding level of approximately $1.60 per student, Oregon was able to provide grants to approximately 30% of their school districts. Assuming 100% coverage of school districts using a funding model similar to the Oregon model, $4–$6 per student in grades K–12 should be budgeted.

IV. Enforcement ($150,000–$300,000 per year for interagency coordination; $0.43–$0.80 per capita per year for enforcement programs).

Enforcement of tobacco control policies enhances their efficacy by deterring violators and by sending a message to the public that community leaders believe that these policies are important. The two primary policy areas that require enforcement activity are restrictions on minors' access to tobacco and on smoking in public places. State efforts should be coordinated with Food and Drug Administration (FDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) Federal programs. California and Massachusetts have addressed enforcement issues as part of community program grants. Florida has taken a more centralized approach by using State Alcoholic Beverage Control Officers to conduct compliance checks with locally recruited youth in all regions of the State.

V. Statewide Programs (Approximately $0.40–$1 per capita per year).

Statewide projects can increase the capacity of local programs by providing technical assistance on evaluating programs, promoting media advocacy, implementing smokefree policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to racial, ethnic, and diverse communities can help eliminate the disparities in tobacco use among the State's various population groups. Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform their membership about tobacco control issues and encourage their participation in local efforts. Both California and Massachusetts have awarded grants to statewide organizations, businesses, and other partners that total about $0.40 to $1.00 per capita per year.

VI. Counter-Marketing ($1–$3 per capita per year).

Counter-marketing attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a State, region, or local community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising at the State and local level; media advocacy and other public relations techniques using such tactics as press releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Counter-marketing activities can promote smoking cessation and decrease the likelihood of initiation. They also can have a powerful influence on public support for tobacco control interventions and set a supportive climate for school and community efforts. Counter-marketing campaigns are a primary activity in all States with comprehensive tobacco control

programs. With funding levels ranging from less than $1.00 per capita up to almost $3.00 per capita, the campaigns in California, Massachusetts, Arizona, and Florida have been trendsetters in content and production quality.

VII. Cessation Programs ($1 per adult to identify and advise smokers about tobacco use; $2 per smoker to provide brief counseling; and the cost of a full range of cessation services including pharmaceutical aids, behavioral counseling, and follow up visits ($137.50 per served smoker covered by private insurance; $275 per served smoker covered by publicly financed insurance).

Strategies to help people quit smoking can yield significant health and economic benefits. Effective cessation strategies include brief advice by medical providers, counseling, and pharmacotherapy. In addition, system changes (e.g., tobacco-use screening systems, clinician training, and insurance coverage for proven treatments) are critical to the success of cessation interventions. State action should include establishing population-based treatment programs such as telephone cessation helplines; covering treatment of tobacco use under both public and private insurance; and eliminating cost barriers to treatment for underserved populations, particularly the uninsured. No State currently is fully implementing the Agency for Health Care Policy and Research smoking cessation guidelines. Massachusetts and California are implementing the basic recommended elements. The complete recommended program is being implemented in several large health maintenance organizations around the country.

VIII. Surveillance and Evaluation (10% of total annual program costs).

A surveillance and evaluation system monitors program accountability for State policymakers and others responsible for fiscal oversight. Surveillance is the monitoring of tobacco-related behaviors, attitudes, and health outcomes at regular intervals of time. Program evaluation efforts build upon surveillance systems by linking statewide and local program efforts to progress in achieving intermediate and primary outcome objectives. Experience in California, Massachusetts, and other States has demonstrated that the standard public health practice guideline of devoting 10% of program resources to surveillance and evaluation is a sound recommendation. State surveillance efforts should be coordinated with Federal tobacco surveillance programs such as SAMHSA's National Household Survey on Drug Abuse.

IX. Administration and Management (5% of total annual program costs).

An effective tobacco control program requires a strong management structure to facilitate coordination of program components, involvement of multiple State agencies (e.g., health, education, and law enforcement) and levels of local government, and partnership with statewide voluntary health organizations and community groups. In addition, administration and management systems are required to prepare and implement contracts and provide fiscal and program monitoring. Experience in California and Massachusetts has demonstrated that at least 5% of program resources is needed for adequate staffing and management structures.

APPENDIX C

HEALTHY PEOPLE 2010 OBJECTIVES

Healthy People 2010 Objectives—Tobacco Priority Area

27-1 Reduce tobacco use by adults.

- 27-1a Reduce cigarette smoking by adults aged 18 years and older to 12%.
- 27-1b Reduce spit tobacco use by adults aged 18 years and older to 0.4%.
- 27-1c Reduce cigar use by adults aged 18 years and older to 1.2%.
- 27-1d Reduce use of other tobacco products by adults aged 18 years and older (Developmental).

27-2 Reduce tobacco use by adolescents.

- 27-2a Reduce use of tobacco products in past month by students in grades 9 through 12 to 21%.
- 27-2b Reduce use of cigarettes in past month by students in grades 9 through 12 to 16%.
- 27-2c Reduce use of spit tobacco in past month by students in grades 9 through 12 to 1%.
- 27-2d Reduce use of cigars in past month by students in grades 9 through 12 to 8%.

27-3 Reduce the initiation of tobacco use among children and adolescents (Developmental).

27-4 Increase the average age of first use of tobacco products by adolescents and young adults.

- 27-4a Increase the average age of first use of tobacco products by adolescents aged 12 to 17 years to 14 years of age.
- 27-4b Increase the average age of first use of tobacco products by young adults aged 18 to 25 years to 17 years of age.

27-5 Increase smoking cessation attempts by adult smokers to 75%.

27-6 Increase smoking cessation during pregnancy to 30%.

27-7 Increase tobacco use cessation attempts by adolescent smokers to 84%.

27-8 Increase insurance coverage of evidence-based treatment for nicotine dependency.

- 27-8a Increase insurance coverage of evidence-based treatment for nicotine dependency by managed care organizations to 100%.
- 27-8b Increase insurance coverage of evidence-based treatment for nicotine dependency by Medicaid programs in States and the District of Columbia to 51%.
- 27-8c Increase insurance coverage of evidence-based treatment for nicotine dependency by all insurance providers (Developmental).

27-9 Reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%.

27-10 Reduce the proportion of nonsmokers exposed to environmental tobacco smoke to 45%.

27-11 Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events to 100%.

27-12 Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas to 100%.

Healthy People 2010 Objectives—Tobacco Priority Area (Continued)

27-13 Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.

- 27-13a Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in private workplaces in all 51 jurisdictions.
- 27-13b Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public workplaces in all 51 jurisdictions.
- 27-13c Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in restaurants in all 51 jurisdictions.
- 27-13d Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public transportation in all 51 jurisdictions.
- 27-13e Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in day care centers in all 51 jurisdictions.
- 27-13f Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in retail stores in all 51 jurisdictions.
- 27-13g Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas on Tribal properties (Developmental).
- 27-13h Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in U.S. Territories (Developmental).

27-14 Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.

- 27-14a Increase the number of jurisdictions with a 5% or less illegal sales rate to minors in all 51 States and the District of Columbia.
- 27-14b Increase the number of jurisdictions with a 5% or less illegal sales rate to minors in all U.S. territories.

27-15 Increase the number of States and District of Columbia that suspend or revoke State retail licenses for violations of laws prohibiting the sale of tobacco to minors to 51.

27-16 Eliminate tobacco advertising and promotions that influence adolescents and young adults (Developmental).

27-17 Increase adolescents' disapproval of smoking.

- 27-17a Increase 8th grade adolescents' disapproval of smoking to 95%.
- 27-17b Increase 10th grade adolescents' disapproval of smoking to 95%.
- 27-17c Increase 12th grade adolescents' disapproval of smoking to 95%.

27-18 Increase the number of Tribes, Territories, and States and the District of Columbia with comprehensive, evidence-based tobacco control programs (Developmental).

27-19 Eliminate laws that preempt stronger tobacco control laws in all states.

27-20 Reduce the toxicity of tobacco products by establishing a regulatory structure to monitor toxicity (Developmental).

27-21 Increase the average Federal and State tax on tobacco products.

- 27-21a Increase the average Federal and State tax on cigarettes to $2.00.
- 27-21b Increase the average Federal and State tax on spit tobacco to (Developmental).

APPENDIX D

TOBACCO CONTROL PROGRAMS IN KANSAS

SYNOPSIS OF CURRENT KANSAS TOBACCO INITIATIVES

Kansas Endowment for Youth (KEY) Fund

The Children's Initiatives Fund (CIF) was created to fund programs promoting the health and welfare of Kansas children with money from the Kansas tobacco settlement. The settlement payments are placed in the KEY fund. A large portion of those funds is transferred to the CIF. The initial transfer in FU 2001 was $30,000,000. It increased to $40,000,000 in FY 2002 and $45,000,000 in FY 2003. The transfer is statutorily increased by 2.5 percent each year following FY 2003. The transfer for FY 2004 was $46,125,000. Expenditures from the CIF are recommended by the Governor and approved by the Legislature. The fund is administered by the Children's Cabinet, a 15-member committee consisting of ex officio members, and appointees of the Governor and Legislature. The Cabinet is responsible for initiating audits and reviews of the programs receiving CIF funding.
http://www.brendalandwehr.org/voters/62003AccentChildren.pdf

Kansas Department of Health and Environment

The Tobacco Use Prevention Program provides resources and technical assistance to community coalitions for development, enhancement, and evaluation of state and local initiatives to prevent morbidity and mortality from tobacco use addiction. This program receives funding from the Centers for Disease Control and American Legacy Foundation, and focuses on four priority areas: 1) Preventing the initiation of tobacco use among young people; 2) Promoting quitting among young people and adults; 3) Eliminating nonsmokers' exposure to environmental tobacco smoke; and 4) Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.
http://www.kdhe.state.ks.us/tobacco/tobacco_facts.html

Kansas Tobacco Quitline is a personalized telephone counseling service available for tobacco individuals seeking help with cessation.
http://www.kdhe.state.ks.us/tobacco/images/quitline_card.jpg

TASK

TASK, which is a statewide youth movement against tobacco use, promotes tobacco free teens by uniting communities to create one strong voice standing against the tobacco industry. Initially formed in 1998 as an offshoot of the Tobacco Free Kansas Coalition, this organization has evolved into an independent entity involved with Kansas teen tobacco prevention. During 2000 and 2001, more than 122,000 young rural and urban Kansans were involved in youth tobacco prevention activities. Students from 43 schools attended the 2002 "Manipulate This" Youth Summit sponsored by TASK **http://www.kstask.org/**

The Tobacco Free Sports (TFS)

The KDHE Tobacco Use Prevention Program is available to provide technical assistance to sports leagues or teams working to develop tobacco free policies. The TFS program promotes a

tobacco free lifestyle for young athletes by providing educational opportunities and assuring the existence of tobacco free environments during sporting events. The Kansas TFS program is a grant-funded project that began in 1998 as a soccer program and had grown to encompass all sports.

The TFS programs offers competitive mini-grant opportunities to support activities where youth are coached by tobacco free leaders and education is provided about the negative effects of tobacco on health and athletic performance. Any event supported by the program must be tobacco free, including all sponsors (coaches), athletes, and spectators. **http://www.kdhe.state.ks.us/tobacco/tob_free_sports.html**

Kansas Department of Social and Rehabilitation Services (SRS)

As part of its prevention services, most SRS's Regional Prevention Centers offer tobacco cessation programs to their clients. In 2002, SRS awarded a number of community grants that had initiatives focusing on tobacco cessation. Some of these included:

Community Awareness Team, Colby, Involves all segments of the community, especially youth, in the Communities That Care process; supports cross-age teaching projects, youth development approaches as an alternative to drug involvement, parent education, Project Prom, SADD, and a tobacco cessation program for youth and adults.

Ellis County Community Partnership, Hays, Supports the community mobilization plan and seven subcommittees such as the Advocacy Coalition for Teens youth group; the alternative activities committee's drug-free events; the policy committee's recommendations for environmental change; the Opportunities for Kids Committee; the communication committee's media campaign; the tobacco committee's cessation programs and awareness campaigns; the family education's committees parent education program; and the YouthFriends mentoring program.

Project Freedom, Leavenworth/Atchison, Focuses on youth ages seven to 12 and supports Students Uniting with Caring Communities for Educational Excellence and Development (SUCCEED), Big Brothers and Sisters, Teen Baseline, teen tobacco cessation classes, Cops in Shops and STOP, the Parent Connection, 4H Y-TEACH youth-led initiatives, and community mobilization.

Tobacco Free Kansas Coalition, Inc.

The Tobacco Free Kansas Coalition, Inc. is a group of more than 125 dedicated organizations and individuals working together to reduce the prevalence of tobacco use addiction and to assist Kansans in avoiding the negative health and economic impacts of tobacco use. Members span numerous counties across Kansas. As part of their unified message, the Tobacco Free Kansas Coalition is urging its members to use the media campaign resources already developed by US Centers for Disease Control and Prevention. **http://www.tobaccofreekansas.org/**

Media Campaign Resource Center (MCRC)

MCRC is a clearinghouse funded by the US Centers for Disease Control and Prevention. The MCRC licenses and maintains an inventory of existing tobacco control advertisements developed by a number of US states, organizations and federal agencies.
http://www.cdc.gov/tobacco/mcrc/index.htm

Campaign for Tobacco-Free Kids

The Campaign for Tobacco-Free Kids is a national organization, which compiles information on a state-by-state basis. The Campaign is fighting to free America's youth from tobacco and to create a healthier environment. It is the nation's largest non-governmental initiative ever launched to protect children from tobacco addiction and exposure to secondhand smoke. Their web site offers today's tobacco news, action alerts, kid's corner, calendar, information about your state, research, Attorney General's agreement, links to other useful sites, plus more.
http://tobaccofreekids.org/

Kansas Family Partnership

The Kansas Family Partnership coordinates the Red Ribbon Campaign and SADD (Students Against Destructive Decisions) program for Kansas, helping Kansas youth choose healthy, tobacco-free lifestyles. The Partnership also provides Kansans with free tobacco prevention printed materials and video loans through their RADAR (Regional Alcohol and Drug Awareness Resources) Network. **http://www.kansasfamily.com/**

SADD (Students Against Destructive Decisions)

Originally, the mission of the SADD chapter was to help young people say "No" to drinking and driving. Today, that mission has expanded. Students have told us that positive peer pressure, role models and other strategies can help them say "No" to more than drinking and driving. And that is why SADD has become a peer leadership organization dedicated to preventing underage drinking and drug use by focusing attention on the potentially life threatening consequences of destructive decisions involving issues such as not wearing a safety belt, smoking, steroid use, violence, sexually transmitted diseases and suicide.
http://www.kansasfamily.com/Pages/0200sadd.html

Sunflower Foundation: Health Care for Kansans

The American Legacy Foundation, was established to reduce tobacco use in the United States and is setting in motion a new legacy through a public education campaign driven by a single premise: Promoting Tobacco Free Generations. For the past few years Kansas benefited from Legacy Foundation funding, which was awarded to the Tobacco Free Kansas Coalition, and in turn used to provide grants to youth in TASK.

This past year in an effort to provide more community focus and accountability, the Legacy Foundation changed its grant making mechanism by offering asking local philanthropies to match its grants for maximization and sustainability of tobacco prevention activities. The

Sunflower Foundation responded to the Legacy Foundation's Request for Proposal and was awarded an 18-month grant in the amount of $150,000—the Sunflower Foundation has matched that amount with $350,000. These funds will be used to sustain and expand the TASK initiative in Kansas, as well as fund additional projects that support community-based tobacco use prevention and control efforts as part of the Sunflower Foundation's Strengthening Tobacco Use Prevention and Control initiative. The Sunflower Foundation is looking for additional stakeholders in the state with whom to partner on this important issue.
http://www.americanlegacy.org/americanlegacy/skins/alf/home.aspx
http://www.sunflowerfoundation.org/flash/

Central Kansas Foundation of Salina

In 2001 the Central Kansas Foundation of Salina was selected through a competitive grant process as the recipient of a $500,000 grant to conduct a comprehensive community-based tobacco use prevention program. This program includes community programs to reduce tobacco use, school programs, media/counter-marketing, enforcement, quit smoking programs, and evaluation of results. The grant was renewed in 2002 and in 2003 for an additional $500,000.
http://www.c-k-f.org/index.html

American Lung Association of Kansas

The American Lung Association provides tobacco-related information on programs, press releases and articles, legislative advocacy, and links to other sites. Freedom from Smoking® is an adult tobacco cessation program, sponsored by the American Lung Association, that works! Currently there are 15 sites in Kansas where this program is available: Abilene, Coffeyville, Concordia, Emporia, Garden City, Junction City, Olathe, Overland Park, Meade, Ness City, Salina, Seneca, Stockton, Topeka and Wichita. **http://www.kslung.org/**

American Heart Association of Kansas

Has risk assessment of your 10-year coronary heart disease risk. Assesses blood pressure, cholesterol, smoking, and diabetes.
http://www.americanheart.org/presenter.jhtml?identifier=3018961

American Cancer Society - Heartland Division

This organization serves Kansas, Missouri, Nebraska, and Oklahoma.

Kansas Health Foundation

The Kansas Health Foundation is committed to social marketing campaigns as well as funding grants that address prevention and the reduction of tobacco use. **http://www.kansashealth.org/**

APPENDIX E

SUCCESS STORIES IN OTHER STATES

CAMPAIGN for TOBACCO-FREE Kids®

COMPREHENSIVE STATEWIDE TOBACCO PREVENTION PROGRAMS EFFECTIVELY REDUCE TOBACCO USE

Smoking and other tobacco use can be effectively reduced through public education efforts, counter-marketing, community and school-based programs, helping smokers quit, and strictly enforcing laws that establish smoke-free areas and restrict youth access to tobacco products. But research and experience also shows that these individual elements work much more effectively when they are all integrated into a comprehensive program.[1] States that have implemented comprehensive tobacco control programs have achieved significant reductions in tobacco use among both adults and youth.

The experiences in California, Massachusetts, Florida, and other states establish the following key points:

- When adequately funded, comprehensive state tobacco prevention programs quickly and substantially reduce tobacco use, save lives, and cut smoking-caused costs.
- State tobacco prevention programs must be insulated against the inevitable attempts by the tobacco industry to reduce program funding and otherwise interfere with the programs' successful operation.
- The programs' funding must be sustained over time both to protect initial tobacco use reductions and to achieve further cuts.
- When program funding is cut, progress in reducing tobacco use erodes, and the state suffers from higher levels of smoking and more smoking-caused deaths, disease, and costs.

A 2003 study published in the *Journal of Health Economics* provides powerful evidence of the effectiveness of comprehensive tobacco prevention programs. The study found that states with the best funded and most sustained tobacco prevention programs during the 1990s – Arizona, California, Massachusetts and Oregon – reduced cigarette sales more than twice as much as the country as a whole (43 percent compared to 20 percent). This study, the first to compare cigarette sales data from all the states and to isolate the impact of tobacco control program expenditures from other factors that affect cigarette sales, demonstrates that the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales would have declined by 18 percent instead of nine percent between 1994 and 2000 had all states fully funded tobacco prevention programs.[2]

Unfortunately, many states faced with budget difficulties have recently made the penny-wise but pound-foolish decision to slash the funding of even the most effective tobacco control programs, which will cost lives and money.[*]

Program Success – California

In 1988, California voters approved Proposition 99, a ballot initiative that increased state cigarette taxes by 25 cents per pack, with 20 percent of the new revenues (over $100 million per year) earmarked for health education against tobacco use. California launched its new Tobacco Control Program in Spring 1990. Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in funding, the program has still reduced tobacco use substantially.

[*] This factsheet focuses on the extensive public health benefits obtained by state tobacco prevention programs. Other Campaign factsheets show that these programs also reduce smoking-caused costs, including those incurred by state Medicaid programs. See, e.g., *Comprehensive Statewide Tobacco-Prevention Programs Save Money*, http://tobaccofreekids.org/research/factsheets/pdf/0168.pdf.

- Since the passage of Proposition 99, between 1987 and 2002, cigarette consumption in California has declined by 62 percent, compared to just 36 percent for the country as a whole.[3] Even after the tobacco industry's successful efforts to reduce the state's tobacco prevention funding, cigarette consumption still declined more in California than in the rest of the country.[4]

- In the 10 years following the passage of Proposition 99, adult smoking in California declined at twice the rate it declined in the previous decade.[5]

- According to the California Student Tobacco Survey, from 1996 to 2003, smoking declined by more than 60% among eighth grade students and by more than half among tenth grade students. From 2000 to 2003 alone, smoking prevalence decreased by more than 30 percent among twelfth grade students.[6]

- From 1988 to 2003, adult smoking in California decreased from 22.8 percent to 16.2 percent, resulting in over one million fewer smokers.[7]

- More than 1.3 million Californians have quit smoking because of the California Program.[8]

- While teenage smoking increased significantly throughout the country from 1990 to 1993, smoking among California teenagers remained constant.[9] Similarly, from 1992 to 1994, the significant nationwide increase in youth smoking rates was slowed significantly in California as a result of the combined effect of the state's tax increase and a strong tobacco control program.[10]

- 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 reduction was independent of the decreases in consumption brought about by the tax increase.[11]

- The proportion of California tobacco retailers who failed compliance checks for selling tobacco products to minors decreased from 52 percent in 1994 to 19.3 percent in 2002.[12]

- The proportion of California's indoor workers exposed to secondhand smoke at work was cut in half, falling from 29 percent in 1990 to less than 12 percent in 1996.[13]

- The proportion of California children and adolescents exposed to secondhand smoke in the home decreased from 29 percent in 1992 to 13 percent in 1996.[14]

The California tobacco control program produced much larger smoking reductions in the early years, when it was funded at its highest levels, than during subsequent years, when the state cut its funding. For example, when California cut the program's funding in the mid 1990s, its progress in reducing adult and youth smoking rates stalled, but it got back on track when program funding was partially restored.[15]

Program Success -- Massachusetts

In 1992, Massachusetts voters approved a referendum that increased the state cigarette tax by 25 cents per pack. Part of the new tax revenues was used to fund the Massachusetts Tobacco Control Program (MTCP), which began in 1993. As in California, despite some reductions in funding encouraged by the tobacco industry, the program has achieved considerable success. Data from 2000 demonstrate success in reducing tobacco use among both children and adults.

- Massachusetts cigarette consumption declined by 36 percent between 1992 and 2000, compared to a decrease of just 16 percent in the rest of the country (excluding California).[16]

- From 1995 to 2001, current smoking among Massachusetts high school students dropped by 27 percent (from 35.7% to 26%), while the nationwide rate dropped by 18 percent (34.8% to 28.5%)[17]

- Other surveys also show youth tobacco use declining at a faster rate in Massachusetts than nationally. Between 1996 and 1999, smoking among Massachusetts 8th and 10th graders declined by 40 percent and 27 percent, respectively. Nationally, the declines were just 17 percent among 8th graders and 16 percent among 10th graders. Among 12th graders, smoking in Massachusetts declined by 15 percent during this time period, while nationally, it actually increased by 2 percent. [18]

- Between 1993 and 2000, adult smoking prevalence dropped from 22.6 percent to 17.9 percent, resulting in 228,000 fewer smokers.[19]

- Those who smoke in Massachusetts are smoking less. From 1993 to 2000, the average number of cigarettes smoked by adult smokers declined more than 20 percent from 19.7 cigarettes per day to 15.2 cigarettes per day. Between 1993 and 2000, the percent of pack a day or more smokers dropped from 26 percent to 16 percent.[20]

- Among Massachusetts smokers who try to quit, the success rate has increased from 18 percent in 1993 to 25 percent in 2000.[21]

- Between 1990 and 1999, smoking among pregnant women in Massachusetts declined by more than 50 percent (from 25% to 11%). Massachusetts had the greatest percentage decrease of any state over the time period (the District of Columbia had a greater percent decline).[22]

- Between 1993 and 2000, the use of spit (smokeless) tobacco by Massachusetts high school males has declined by over 50 percent (from 17.0% to 7%).[23]

- The proportion of state tobacco retailers found making illegal sales to youth during compliance checks fell from 48 to only 11 percent, between 1993 and 2000.[24]

- Exposure to environmental tobacco smoke (ETS) decreased among Massachusetts workers, from 44 percent reporting exposure in 1993 to 29 percent in 2000.[25]

- An analysis of national data on youth smoking showed that, between 1992 and 1994, the national increase in youth smoking rates was slowed significantly in Massachusetts as a result of the combined effect of a tax increase and a strong tobacco control program.[26]

Despite the considerable success achieved in Massachusetts, funding for the state's tobacco prevention program has been cut by 95 percent - from a high of approximately $54 million per year to just $2.5 million in FY2004. These drastic reductions in the state's investments to prevent and reduce tobacco use will translate directly into higher smoking rates, especially among kids, and more smoking-caused disease, death, and costs. In fact, a study released by the Massachusetts Association of Health Boards shows that the Massachusetts program funding cuts have already been followed by an alarming increase in illegal sales of tobacco products to children.[27]

- Between 2002 and 2003, cigarette sales to minors increased by 74 percent, from 8 percent to 13.9 percent in communities that lost a significant portion of their enforcement funding.

- Over the same time period, cigarette sales to minors increased by 98 percent in communities that lost all of their local enforcement funding.

Program Success – Maine

In 1997, Maine increased its cigarette excise tax and used a portion of those funds to establish a comprehensive tobacco prevention program known as the Partnership for a Tobacco-Free Maine. Maine has subsequently augmented its program with proceeds from the 1998 state tobacco settlement, which also resulted in a further increase in cigarette prices (the state also raised cigarette taxes again in 2001, to $1.00 per pack). As a result, Maine today is one of only four states that funds tobacco prevention programs at levels recommended by the CDC. Prior to launching this effort, Maine had one of the highest youth smoking rates in the country. Now, it has one of the lowest.

- Smoking among Maine's high school students declined a dramatic 48 percent between 1997 and 2003, falling from 39.2 percent to 20.5 percent. Smoking among Maine's middle school students declined by 59 percent, from 21 percent to 8.7 percent, over the same time period. [28]

Program Success – Mississippi

Mississippi, the first state to file and settle its lawsuit against the tobacco companies, launched a youth-driven comprehensive tobacco prevention program in 1999. The results after two years of implementation are very promising.

- Between 1999 and 2002, smoking among public middle school students declined by 48 percent, from 23 percent to 11.9 percent. Smoking among public high school students declined by 29 percent, from 32.5 percent to 23.1 percent over this same time period.[29]

- In just one year, between 1999 and 2000, smoking in Mississippi declined by 10 percent among public high school students and by 21 percent among public middle school students. The declines in smoking were even greater for African-American students in Mississippi's public schools. Smoking declined by 31 percent among African-American middle school students and by 20 percent among African-American high school students.[30]

- Youth involved in Frontline, Mississippi's teen advocacy group, helped enact state legislation banning all tobacco use on school grounds and at all school events.[31]

Program Success -- Florida

With funding from its 1997 settlement with the tobacco industry, the state of Florida funded a comprehensive tobacco prevention modeled on the programs in California and Massachusetts but targeted at youth. This innovative program that actively involved youth in its design and implementation produced substantial early success in preventing and reducing smoking among kids.[32]

- In the first three years of the Florida program, from 1998 to 2001, current smoking declined by 47 percent (from 18.5% to 9.8%) among middle school students and by 30 percent (from 27.4% to 19%) among high school students, resulting in almost 75,000 fewer youth smokers.

- Similarly, the proportion of Florida middle school students who had EVER smoked a cigarette declined from 43.6 percent in 1998 to 32.1 percent in 2001, while the proportion of high school students who had ever smoked declined from 68.1 percent in 1998 to 53.7 percent in 2001.

- The proportion of "committed never smokers" rose from 38.9 percent in 1998 to 53.6 percent in 2001 among middle school students and from 25 percent in 1998 to 41.8 percent in 2001 among high school students.

Despite the program's steady success, the Florida legislature and governor have cut its funding in every year since the program's inception, with particularly deep cuts occurring in FY2002. These cuts have not only stopped the program's early progress but begun to reverse it, especially among younger kids, who are not only entering the most vulnerable years for starting to smoke but who are now receiving a weak, watered down version of the state program's efforts to help protect them from becoming addicted smokers.

- After several years of consistent progress in reducing youth smoking rates, in 2001 the declines in smoking among middle school students stopped. In 2002, current smoking among middle school students remained stagnant (at 9.2 percent).

- Even more foreboding, increases in smoking between 6th and 7th grades and between 7th and 8th grades reached record high levels in 2001. More recent data indicate that increases in current

smoking between sixth and seventh grade persisted in 2002. The same pattern occurs for students transitioning from between seventh and eighth grade over the same time period.

- After increasing steadily between 1998 and 2000, the percentage of middle school students who were "committed never smokers" remained unchanged between 2001 and 2002. Similarly, the percentage of Florida high school students who were committed never smokers rose to 41.8% in 2001, but remained virtually unchanged at 43.2% in 2002.

In 2003, Florida's governor and legislature virtually eliminated this highly successful program and eliminated any opportunity to evaluate the full impact of the drastic reductions in funding.

Program Success -- Oregon

Using revenue from a tobacco tax increase, in 1997 Oregon implemented a Tobacco Prevention and Education Program (TEPP) modeled on the California and Massachusetts programs.

- Between 1996 (when Oregon began its program) and 2002, tobacco consumption decreased by 30 percent.

- Between 1996 and 2002, smoking declined by 51 percent among Oregon 8th graders and by 29 percent among Oregon 11th graders.

- From 1996 to 2002, adult smoking in Oregon decreased 12 percent (from 23.4 % to 20.4%), resulting in 75,000 fewer smokers.

- From 1996 and 2002, smoking by pregnant women dropped by 27 percent (from 17.8% to 13%).

- From 1996 to 2002, the proportion of Oregon retailers who sold tobacco to minors decreased by 59 percent (from 39% to 16%).[33]

Program Success – Arizona

In 1994, Arizona voters passed the Tobacco Tax and Health Care Act, which increased the state sales tax on tobacco and funded a comprehensive Tobacco Education and Prevention Program. This program, launched in 1996, has significantly reduced smoking in Arizona, as outlined below.[34]

- From 1996 to 1999, adult smoking prevalence declined by 21 percent, from 23.1 to 18.3 percent.

- During this same time period, some of the largest declines in smoking were among persons of low income (31.2% to 22.8%) and low education (29.3% to 16.2%), thus decreasing disturbing disparities in smoking rates.

- Arizona residents also reported an increased proportion of health care providers who asked about smoking and advised patients to stop (25.1% to 36.7%) between 1996 and 1999.

Program Success –Minnesota

With funding from its settlement with the tobacco industry, the Minnesota Department of Health created a youth tobacco prevention program in 2000. The program, called Target Market, includes advertising, public relations, and a grassroots movement to educate Minnesota teens about tobacco use and the targeting of youth by tobacco companies. After just one year, the program had significant impacts on teen attitudes that are often precursors to changes in smoking behavior.[35] There is also evidence that tobacco use among kids has declined in Minnesota.[36]

- Between 2000 and 2002, current cigarette use declined by 21 percent among middle school students and by 11 percent among high school students. Additionally, current use of any tobacco product

declined by 11 percent among both high school and middle school students over this same time period.

- The proportion of Minnesota teens (12-17 year olds) who believe cigarette companies try to get young people to smoke increased between 2000 to 2001 from 52 to 66 percent. Just as important, the proportion who think they can fight back against tobacco companies increased from 42 to 57 percent.

- The proportion of kids who are annoyed by tobacco companies targeting kids and who are angry about the money they make off kids also increased significantly between 2000 and 2001.

- The proportion of Minnesota teens who ever used tobacco declined from 37 percent in 2000 to 32 percent in 2001.

- Pre and post survey results also found that the proportion of Minnesota teens who are committed never smokers increased 46 percent to 55 percent.

Although Minnesota's program was successful right from the start, program funding was reduced from $23.7 million to $4.6 million in July 2003, and the Target Market campaign, the linchpin of the program, was eliminated. Just six months afterward, awareness of the Target Market campaign among 12-17 year olds had already declined from 84.5 percent to 56.5 percent and youth susceptibility to smoking increased by 22 percent.[37] As more time passes, the situation will likely get much worse – unless program funding is restored.

Program Success – An Experiment in Texas

Rather than using settlement money to fund a comprehensive statewide tobacco prevention program, the state of Texas decided to use a small portion of its tobacco settlement money to test tobacco prevention interventions of varying intensity and comprehensiveness across fourteen locations in the state. The experiment included fourteen combinations of three media campaign levels and five community program options to test which combinations were most effective. Not surprisingly, this experiment found that the largest effects on both youth prevention and adult cessation occurred in those areas that combined higher level media campaigns with community interventions.

- Among sixth graders, the target of the effort, tobacco use was reduced by 60 percent in the areas with high level media campaigns and multiple school/community efforts. In other areas with lower level media campaigns or fewer school/community efforts, the declines ranged from 24 percent to 44 percent.[38]

- The adult program focused mainly on cessation rates of current smokers. The highest rate of cessation, nearly 14 percent, was in the area with high level media campaigns and cessation service delivery. There was less change (11 percent) in the area with a low level media campaign and cessation services. Areas that had media campaigns alone without cessation services and no media or cessation services had the lowest cessation rate (8 percent and 5 percent, respectively).[39]

Program Success – Indiana

In 2000, Indiana implemented a comprehensive tobacco prevention and cessation program with revenue received from the state's tobacco settlement. Indiana's program is modeled after other comprehensive programs that have been successful in reducing tobacco use. Indiana's program includes public education, a counter-marketing campaign, community and school-based programs, and enforcement initiatives.[40] Recent data indicate that this comprehensive approach is working.[41]

- Between 2000 and 2002, smoking among high school students declined by 26 percent, (from 31.6 percent to 23.4 percent).

- Smoking among middle school students declined by 12 percent, from 9.8 percent to 8.6 percent, over this same time period.

The Campaign for Tobacco-Free Kids. November 2, 2004 / Meg Gallogly

Related Campaign Fact Sheets (available at www.tobaccofreekids.org)

---

[1] See, e.g., Inst. of Medicine & National Research Council, *State Programs Can Reduce Tobacco Use*, Nat'l Academy of Sciences, 2000; U.S. Department of Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*, 2000; Wakefield, M & Chaloupka, F, Effectiveness of comprehensive tobacco control programs in reducing teenage smoking in the USA," *Tobacco Control* 9:177-186, Summer, 2000.

[2] Farrelly, M.C., et al., "The impact of tobacco control program expenditures on aggregate cigarette sales: 1981-2000." *Journal of Health Economics* (22) 2003 843-859.

[3] *Current Tobacco Use and Statistics;* California Department of Health Services/Tobacco Control Section, March 2003. http://www.dhs.cahwnet.gov/ps/cdic/ccb/TCS/documents/Consumption.pdf

[4] Pierce, JP et al., "Has the California Tobacco Control Program Reduced Smoking?" *Journal of the American Medical Association*, September 9, 1998. Volume 280, No. 10.

[5] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3,1998.

[6] California Department of Health Services, Tobacco Control Section, executive Summary of the Final Report, In-School Evaluation of Tobacco Use Prevention Education in California 2001-02. http://www.dhs.ca.gov/tobacco/documents/ietp01-02.pdf

[7] *Current Tobacco Use and Statistics;* California Department of Health Services/Tobacco Control Section, May 2004 http://www.dhs.ca.gov/tobacco/documents/PressRelease5-26-04.pdf

[8] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3, 1998.

[9] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996,* University of California, San Diego, 1998.

[10] Chaloupka, F & M Grossman, *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*

[11] 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.

[12] California Youth Tobacco Purchase Surveys, conducted by the California Department of Health services, Tobacco Control Section, 1994-2002. In *California Tobacco Control Update 2002;* CA Department of Health Services, Tobacco Control Section, November 2002. http://www.dhs.cahwnet.gov/tobacco/documents/TCSupdate.PDF

[13] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* University of California, San Diego; 1998.

[14] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War,* 1998.

[15] Pierce, J.P. , et al., "Has the California Tobacco Control Program Reduced Smoking?," *JAMA* 280(10): 893-899, September 9, 1998.

[16] Abt Associates Inc, *Independent Evaluation of the Massachusetts Tobacco Control Program, Seventh Annual Report - January 1994 to June 2000.*

[17] *Massachusetts Youth Risk Behavior Survey: 2001*; *National Youth Risk Behavior Survey*.

[18] MA Data: Health & Addictions Research, June 2000. National data are from the Monitoring the Future Survey.

[19] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[20] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[21] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[22] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[23] Common Wealth of Massachusetts, Dep't of Education. *Massachusetts Youth Risk Behavior Survey: 2001*, January, 2002.

[24] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[25] Abt Associates Inc, *Seventh Annual Report - January 1994 to June 2000.*

[26] Chaloupka, F & M Grossman, *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*

[27] Sbarra, Cheryl, Massachusetts Association of Health Boards, Abstract, March 2004. http://www.mahb.org/tobacco/sales%20to%20minors%20study%20abstract.pdf

[28] *Maine 2003 Youth Risk Behavior Survey*, Maine Department of Human Services, October, 2003.

[29] *Mississippi 2002 Youth Social Climate Survey of Tobacco Control,* Mississippi State Social Science Research Center, April 2003. http://www.ssrc.msstate.edu/socialclimate/components/Social%20Climate%20Reports%20and%20Presentations/pdf3%20YSCS-TC%206-19.pdf

[30] *Mississippi 2000 Youth Tobacco Survey*; Mississippi State Department of Health; Volume I, June 2000.

[31] *Clearing the Air: A Newsletter from the Partnership for a Health Mississippi*; August 2000

[32] Florida Department of Health, *2002 Florida Youth Tobacco Survey*, Volume 5, Report 1; May, 2003.

[33] Oregon Tobacco Facts. Tobacco Prevention and Education Program; Oregon Health Division, March 2003.

[34] CDC, "Tobacco use Among Adults - Arizona, 1996 - 1999," *MMWR* May 25, 2001: 50(20);402-406.

[35] Ergo International, *Target Market Campaign Evaluation: Pre/Post Research Results*, Minnesota Department of Health, August 2001.

[36] Minnesota 2002 Youth Tobacco Survey, Minnesota Department of Health, December, 2002

[37] CDC, "Effect of Ending an Antitobacco Youth Campaign on Adolescent Susceptibility to Cigarette Smoking – Minnesota, 2002-2003," *MMWR* 53(14):301-304, 2004. http://www.cdc.gov/mmwr/PDF/wk/mm5314.pdf

[38] University of Texas - Houston. *Texas Tobacco Prevention Initiative: Media Campaign and Community Program Effects Among Children and Adults*, January 2001.
[39] University of Texas - Houston, January 2001.
[40] Indiana Tobacco Prevention and Cessation, Annual Report, 2001-2002, http://www.in.gov/itpc/Images/annual.pdf.
[41] Youth Tobacco Survey, 2000 and 2002. http://www.in.gov/itpc/files/research_52.pdf