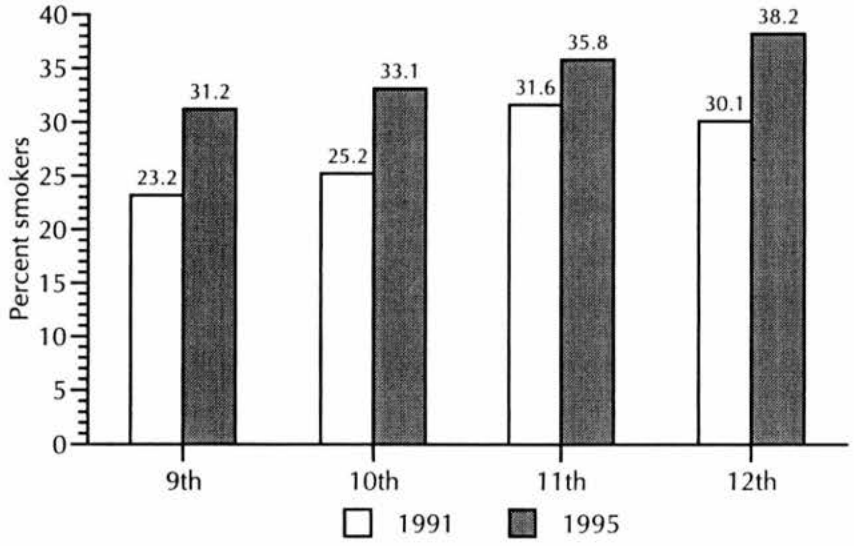
Tobacco: Background

Targeting Tobacco Use:

The Nation's Leading Cause of Death

AT-A-GLANCE
1998

Cigarette Smoking Anytime in the Past 30 Days,* by Grade in School—United States, 1991 and 1995



*Smoking one or more cigarettes during the previous 30 days.
Source: CDC, Youth Risk Behavior Surveillance System.

"Today, nearly 3,000 young people across our country will begin smoking regularly. Of these 3,000 young people, 1,000 will lose that gamble to the diseases caused by smoking. The net effect of this is that among children living in America today, 5 million will die an early preventable death because of a decision made as a child."

Donna E. Shalala, PhD
Secretary, U.S. Department of Health and Human Services
Testimony before the Senate Labor and Human Resources Committee, September 25, 1997

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Tobacco Use in the United States

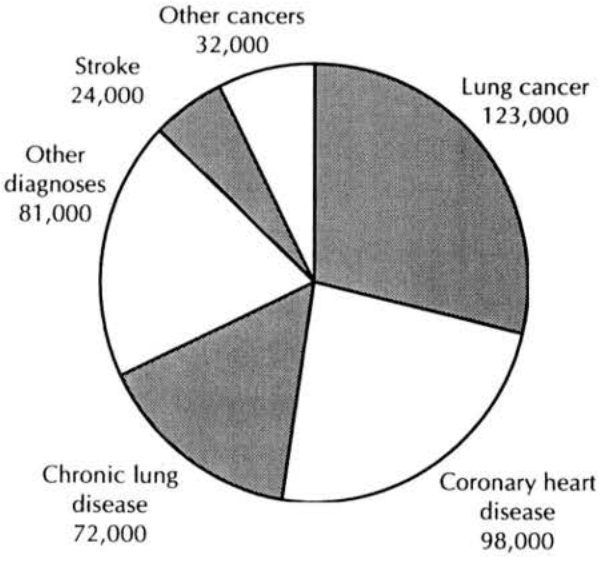
An estimated 47 million adults in the United States smoke cigarettes, even though this behavior will result in death or disability for one out of every two regular users. Tobacco use results in more than 430,000 deaths each year, or one in every five deaths. Paralleling this enormous health burden is the economic burden of tobacco use: more than $50 billion in medical expenditures and another $50 billion in indirect costs.

Since the release in 1964 of the first Surgeon General's report on smoking and health, the scientific knowledge about the health consequences of tobacco use has greatly increased. It is now well documented that smoking can cause chronic lung disease, coronary heart disease, and stroke, as well as cancer of the lung, larynx, esophagus, mouth, and bladder. In addition, smoking is known to contribute to cancer of the cervix, pancreas, and kidney. Researchers have identified more than 40 chemicals in tobacco smoke that cause cancer in humans and animals. Smokeless tobacco and cigars also have deadly consequences, including lung, larynx, esophageal, and oral cancer.

In 1996, smoking-related illnesses cost the nation more than $100 billion.

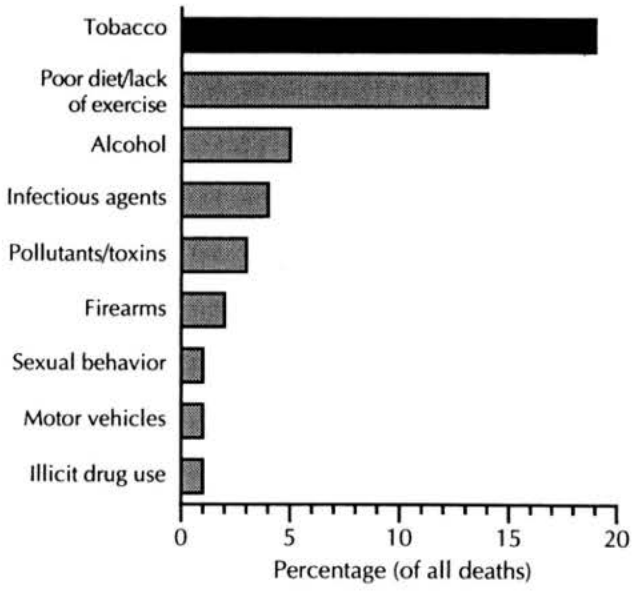
The effects of smoking don't end with the smoker. Women who use tobacco during pregnancy are more likely to have adverse birth outcomes, including babies with low birthweight, a leading cause of death among infants. The health of nonsmokers is adversely affected by environmental tobacco smoke (ETS). Each year, exposure to ETS causes an estimated 3,000 nonsmoking Americans to die of lung cancer and causes up to 300,000 children to suffer from lower respiratory tract infections. Evidence also indicates that ETS increases the risk of coronary heart disease.

430,000 Annual Deaths Attributable to Cigarette Smoking—United States, 1990–1994



Source: CDC, *MMWR* 1997;46:448–51.

Actual Causes of Death, United States, 1990



Source: McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA* 1993; 270:2207–12.

A Comprehensive, Broad-Based Approach to Tobacco Control

In the past, helping people quit smoking was the primary focus of efforts to reduce tobacco use. This strategy has been a critical one, since smoking cessation at all ages reduces the risk of premature death. In recent years, the focus of tobacco control has expanded to include strategies to prevent individuals from ever starting to smoke. Reaching young people early is important because the decision to use tobacco is nearly always made in the teenage years, and about one-half of young people who take up smoking continue to use tobacco products as adults. A more extensive strategy also includes efforts to protect people from exposure to ETS.

A broad-based spectrum of federal, state, and local government agencies, professional and voluntary organizations, and academic institutions have joined together to advance the elements of a comprehensive approach to tobacco use, including:

- Prevention (reducing minor's access and promoting school health education).
- Restriction of advertising and promotion of counteradvertising.
- Treatment of nicotine addiction.
- Reduction of exposure to ETS.
- Product regulation.
- Economic deterrents.

Tobacco use causes about one of every five deaths in the United States and is the single most preventable cause of death and disease in our nation.

CDC's Tobacco Control Framework

With fiscal year 1998 appropriations of $28.4 million, the Centers for Disease Control and Prevention (CDC) organizes and supports numerous activities that address key components for reducing tobacco use. Through collaboration with the states, with national, professional, and voluntary organizations, with academic institutions, and with other federal agencies, CDC leads and coordinates strategic efforts to prevent tobacco use among young people, promote smoking cessation, and reduce exposure to ETS. Designed to reach multiple populations, these activities target high-risk groups, such as young people, racial and ethnic minority groups, blue-collar workers, persons with low income, and women.

Building Capacity to Conduct Programs

CDC strengthens national tobacco control efforts through its strategic partnerships with all states, U.S. territories, and national organizations.

Through its IMPACT (Initiatives to Mobilize for the Prevention and Control of Tobacco Use) program, CDC provides limited funding to 32 states and the District of Columbia to implement state tobacco control programs. CDC provides extensive technical assistance and training through site visits, workshops, and teleconferences on planning, developing, implementing, and evaluating tobacco control programs.

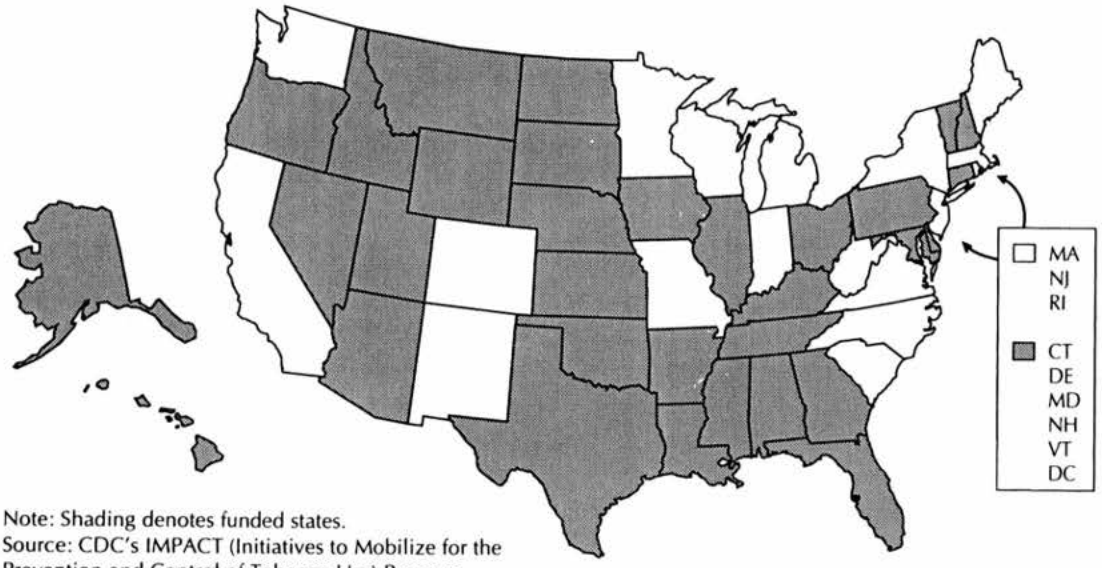
CDC also supports and actively collaborates with a variety of national organizations (for example, the National Medical Association and the National Association for African-Americans for Positive Imagery) to ensure the participation of diverse community groups, coalitions, and community leaders in tobacco control efforts.

Expanding the Science Base

CDC strengthens and expands the scientific foundation for tobacco-use prevention and control by examining trends, patterns, health effects, and the economic costs associated with tobacco use. For example:

- The Surgeon General's reports on the health consequences of tobacco use document comprehensive, scientific information on cigarette smoking and smokeless tobacco use. Recent reports have addressed tobacco use among adolescents and among special populations.
- CDC's *Morbidity and Mortality Weekly Report* (*MMWR*) serves as a major outlet for surveillance data and research findings on tobacco use. Topics include state laws on tobacco use and trends in smoking initiation among young people.

States Funded by CDC's IMPACT Program—Fiscal Year 1998



Note: Shading denotes funded states.
Source: CDC's IMPACT (Initiatives to Mobilize for the Prevention and Control of Tobacco Use) Program.

- CDC's Smoking-Attributable Mortality, Morbidity, and Economic Cost (SAMMEC) software, a computer program designed to estimate deaths, disease impact, and costs related to smoking, provides essential information to state tobacco control programs and for Surgeon General's reports, *MMWR* articles, and responses to public inquiries.
- CDC's state-based State Tobacco Activities Tracking and Evaluation (STATE) System is a comprehensive surveillance system that tracks legislative, programmatic, and epidemiologic data that will be used for reporting on current status and trends. The system will also be able to answer state-specific queries and generate reports on topic areas of particular interest to individual states.
- CDC's Air Toxicants Laboratory is developing and applying laboratory technology to further public health efforts to prevent death and disease resulting from smoking and use of smokeless tobacco products, as well as from ETS. Specific areas of interest are tobacco additives, toxic chemicals in cigarette smoke, and biological monitoring to assess exposure to harmful substances in tobacco products.

Communicating Information to the Public

CDC serves as a primary resource for tobacco and health information. In this role, CDC develops and distributes important information about tobacco and health to the public and other interested groups nationwide. For example:

- CDC responds to a diverse audience and to as many as 60,000 inquiries each year, through a variety of channels, including brochures, fact sheets, articles, and video products—many available through a toll-free dissemination service. In addition, CDC provides the public with ready access to tobacco use prevention information through a World Wide Web site on the Internet.
- Responding to a call from the Secretary of Health and Human Services, CDC developed the Secretarial Initiative: Reduce Smoking Among Teens and Preteens. Through partnerships with other federal, state, and local agencies, key tobacco control messages will be communicated through a variety of avenues, including the media, schools, and communities. The themes being highlighted are:

  Promote positive alternatives to tobacco use—for example, through the "Smokefree Kids and Soccer" campaign.

  Empower young people—for example, through the "MediaSharp" media literacy program.

Deglamorize tobacco use through the entertainment industry—for example, through spokespeople such as the popular music group Boyz II Men.

Involve parents and families through innovative activities to reduce tobacco use.

Implement a paid counteradvertising campaign—for example, through the Media Campaign Resource Center.

- Through the Media Campaign Resource Center, CDC develops and distributes high-quality materials to help states promote a smoke-free climate. These media-related materials include brochures, magazines, videos, fact sheets, and news articles. The Media Campaign Resource Center also provides information on how to work with various media outlets, how to promote counteradvertising, and how to place information with the media.

Reaching Young People Through Schools

The key to reducing adult tobacco use is to prevent children from using tobacco. CDC's support of coordinated health programs in schools is pivotal to its tobacco control framework.

- CDC has established a national framework to support coordinated school health programs. With fiscal year 1998 funding of $9.9 million, CDC directly supports 15 states to provide coordinated health programs in schools. Such programs are targeting high-risk health behaviors among young people, with a heavy focus on tobacco use. CDC also collaborates with more than 30 professional and voluntary organizations to assist schools and agencies serving youth in developing model policies and guidelines to help states implement effective school health programs.
- With the Research to Classroom project, CDC works with evaluation and programmatic experts to identify curricula that have credible evidence of reducing health risk behaviors among young people. CDC then provides resources to ensure that the interventions, including training, are available nationwide for schools interested in using them.

Facilitating Action Through Partners

CDC works with state health departments, other federal organizations, and professional, voluntary, academic, medical, and international organizations to reduce tobacco use. For example:

- CDC supports the Interagency Committee on Smoking and Health and cosponsors the annual Tobacco Use Prevention Summer Institute.
- CDC is the lead agency for the Healthy People 2000/2010 national objectives on tobacco use. This role includes monitoring the nation's progress toward reaching the year 2000 and 2010 targets for tobacco use. The objectives include topics such as youth and adult prevalence, reduction of tobacco-related disease, state clean indoor air legislation, ETS exposure, and cessation treatment.
- CDC collaborates with the National Association of County and City Health Officials, the National Association of Local Boards of Health, the National Council of State Legislators, and the Association of State and Territorial Health Officials in the coordination and promotion of tobacco prevention and control activities.
- Through an agreement with the World Health Organization (WHO), CDC serves as the only U.S. Collaborating Center for Smoking and Health and as the catalyst for communication between all nine Collaborating Centers and the six WHO Regional Offices. CDC prepares and implements international and regional studies, as well as epidemiologic research, and provides health education and other assistance to help international organizations and other countries reduce tobacco use.

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Robert Wood Johnson Foundation and Boston University School of Medicine Working Group: Creating Statewide Tobacco Control Programs after Passage of a Tobacco Tax

Supplement to Cancer

Designing an Effective Statewide Tobacco Control Program–Massachusetts

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OVERVIEW. Smoking-related illnesses kill > 10,000 Massachusetts residents each year and cost hundreds of millions of dollars of public and private expenditures for health care. To combat this public health problem, in 1992 Massachusetts voters approved a referendum question calling for an increased excise tax on tobacco products, with the revenue supporting a Health Protection Fund. Approximately 40% of the fund is used to finance the Massachusetts Tobacco Control Program (MTCP), administered by the Massachusetts Department of Public Health. During the first 3 fiscal years (FY), the MTCP budget has averaged just over $40 million annually, declining during that period from approximately $43 million in FY 1995 to < $37 million in FY 1997. *Cancer* 1998;83:2722–7.

The Massachusetts Tobacco Control Program (MTCP) is designed to curtail tobacco-related health risks for the people of Massachusetts in three key ways:

- Persuading and helping adult smokers to stop smoking.
- Preventing young people from starting to use tobacco and reducing their access to tobacco.
- Protecting nonsmokers by reducing their exposure to environmental tobacco smoke (ETS).

MTCP activities began in October 1993 with a major media campaign designed to provide information regarding the negative health effects of smoking and influence public attitudes toward smoking. The Massachusetts Tobacco Media Education Campaign, administered by the advertising agency Arnold Communications, produces television, radio, newspaper, and billboard advertising and conducts public relations events throughout the state synchronizing media themes and programmatic activities to maximize outcomes.

In late 1993 and early 1994, MTCP began funding community-based services throughout the Commonwealth. Local programs are at the center of the MTCP. Each program plays a unique role; working together they are promoting policies and providing services that are changing community attitudes toward smoking and people's smoking behaviors. To date, MTCP has funded > 400 local programs throughout the Commonwealth. Some important changes occurred in the model, productivity, and outcome measures in the summer of 1997 when the Department of Public Health conducted a public rebid of services.

Massachusetts is a "home rule" state and emphasis is placed on

Presented at the Robert Wood Johnson Foundation and Boston University School of Medicine Working Group: Creating Statewide Tobacco Control Programs after Passage of a Tobacco Tax, Waltham, Massachusetts, October 3–4, 1997.

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community education and local participation in policy initiatives. There are two types of programs that promote local policy change in Massachusetts' cities and towns: 1) Community coalitions engage in grass roots community education and mobilization, raising public awareness regarding the health issues related to tobacco use, the strategies used by the tobacco industry to promote use, and the importance of tobacco control laws and regulations. They also play a lead role in assisting all local tobacco control programs to plan and coordinate their activities to utilize resources efficiently and maximize the effect of initiatives. 2) Boards of health and health department programs primarily are funded to enact and enforce local ordinances and regulations designed to make it harder for youth to buy tobacco products from retail establishments and vending machines and to protect the public from ETS.

Another major area of activity for MTCP programs is the implementation of smoking intervention strategies designed to engage high risk populations in the process of changing group norms that support tobacco use; prevent or interrupt habituated use among risk-taking youth; and identify smokers, motivate them to quit, and provide smoking cessation services when needed. There are four program types used to achieve these outcomes: 1) Institutional casefinding programs implement models designed by health and human service providers to identify smokers within their existing client or patient population. Models are based on the National Cancer Institute 4A's: they "Ask" about smoking behavior at appropriate opportunities; "Advise" all smokers to stop; "Assist" the smokers with quitting and "Arrange" follow-up visits. Smoking cessation specialty services are agency-based and offer structured individual and group counseling to assist smokers to quit and prevent relapse. These programs frequently target comorbid populations such as substance abusers and promote nicotine replacement therapy. 3) Innovative outreach and intervention programs reach at-risk populations at home, at public events, and in other public settings with creative smoking intervention strategies responsive to the particular needs of the target population. Strategies may include educating community leaders and engaging them in health promotion and tobacco control policy-related activities. 4) Innovative intervention for risk-taking youth programs are structured, youth skill-building programs that foster youth leadership in tobacco control. Structured program experiences include activities such as designing and conducting attitude and behavior surveys; community mapping of industry advertising practices; developing, passing, and enforcing a tobacco control regulation or law; and media advocacy. Programs also offer smoking cessation and relapse prevention interventions for youth to prevent or interrupt habituated use.

Several program support services and other statewide initiatives also were undertaken early in the development of MTCP to train a new cadre of tobacco control professionals, provide culturally relevant educational materials to the public, and educate local cities and towns regarding tobacco control legal and policy issues that may effect their residents. For example, ten Regional Prevention Centers and the Tobacco Control Statewide Training Center provide technical assistance and training to local tobacco control programs, regional Steering Committees, and public schools.

An example of a cooperative effort of three statewide projects is the Community Assistance Statewide Team. Two trade associations and a legal policy project collaborate to assist cities and towns in their efforts to enact laws and regulations. The Massachusetts Association of Health Boards, Massachusetts Municipal Association, and the Tobacco Control Resource Center at Northeastern Law School play an important technical assistance role to municipalities as tobacco control laws and regulations are introduced in their communities.

The Smoker's Quitline (1-800-TRY-TO-STOP), managed by the American Cancer Society, provides public information and self-help materials, referrals, and counseling to smokers who want to quit and the Tobacco Education Clearinghouse develops and distributes educational materials on smoking, chewing tobacco, and ETS.

Building a Social Movement Using Boundary-Crossing Networks

MTCP is organized to facilitate communication within geographic areas, across agency and program boundaries. These boundary-crossing networks combine public and private sector entities in new collaborative models that achieve and sustain tobacco control initiatives in communities, the workplace, and educational and healthcare settings (Fig. 1).

Local programs are organized into six regional networks that meet monthly. Regional meetings are convened by the MTCP Regional Field Director. They are conducted in both large and small group formats, broken down by geographic subareas or by provider type. Regional meetings serve as a forum for regional action planning, information dissemination, provider collaboration, identification of "best practices," and training.

Each regional network is guided by a Steering Committee. Steering Committees work on goal align-

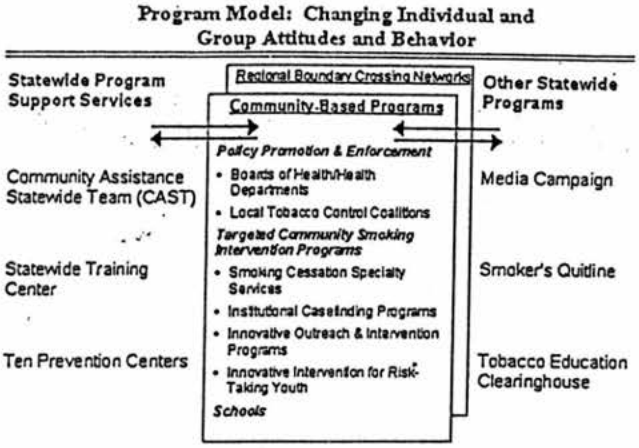


FIGURE 1. Program model using boundary-crossing networks.

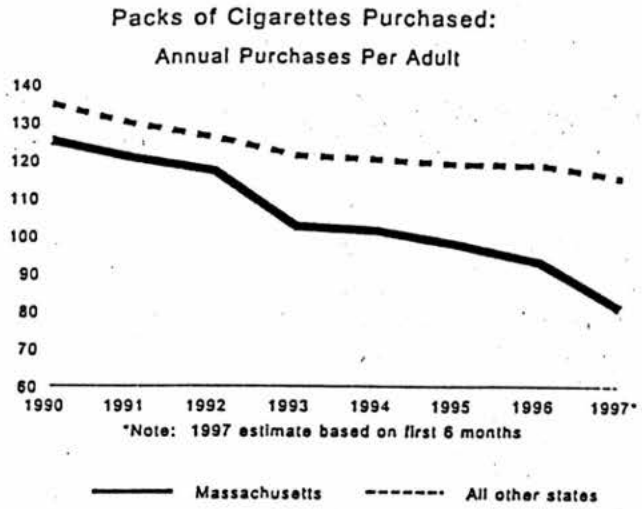


FIGURE 2. Graph showing decline in cigarette purchases in Massachusetts starting in 1992 when Question 1 was passed.

ment, strategic planning, regional public relations campaigns, and quality improvement. Steering committees are comprised of representatives from local and regional programs; managers representing other segments of the Department's public health service system, such as substance abuse services; and representatives from the American Cancer Society and the Department of Education.

Achieving Desired Outcomes: The Independent Evaluation of the Massachusetts Tobacco Control Program

To learn more about the program's effectiveness, the Department of Public Health commissioned several research and evaluation efforts, including an overall evaluation by Abt Associates Inc., a national policy research firm headquartered in Cambridge. The overall evaluation draws on data and analyses from a variety of sources to describe MTCP activities and assess their results. The evaluation results summarized in this article cover approximately 3.5 years of program activity, through June 1997.

This year's Annual Report finds continued progress. Tobacco consumption continues to decline faster in Massachusetts than elsewhere. Adult smokers are smoking less than they did before the program began, and the number of smokers appears to be shrinking. Youth smoking trends, although not declining as everyone desires, are more favorable in Massachusetts than in the nation as a whole. Nonsmokers' exposure to environmental tobacco smoke has been reduced. Merchants are complying better with the prohibition on tobacco sales to minors. These and other key results are summarized in the following excerpts from the Fourth Annual Report Summary, prepared by William Hamilton of Abt Associates, Inc.

Cigarette consumption in Massachusetts has fallen by 31% since 1992, when Question 1 was passed. Tobacco Institute data show a steep drop in purchases, from 117 packs per Massachusetts adult in 1992 to 81 packs in 1997. For the remainder of the U. S., cigarette consumption declined 8% during the same period (Fig. 2).

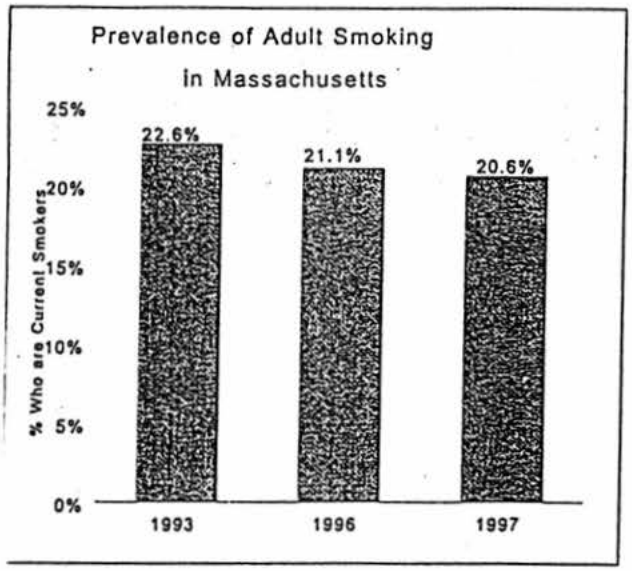
Those who smoke are smoking less. In statewide surveys, the average smoker in 1996–1997 reported smoking 16 cigarettes per day. This represents a 20% reduction from the average of 20 cigarettes reported in 1993.

The number of adult smokers slowly is declining. The surveys show a slow but steady decline in the proportion of adults who smoke. The 1993–1997 difference implies a reduction of approximately 90,000 smokers, although this estimate is within the survey margin of error (Fig. 3).

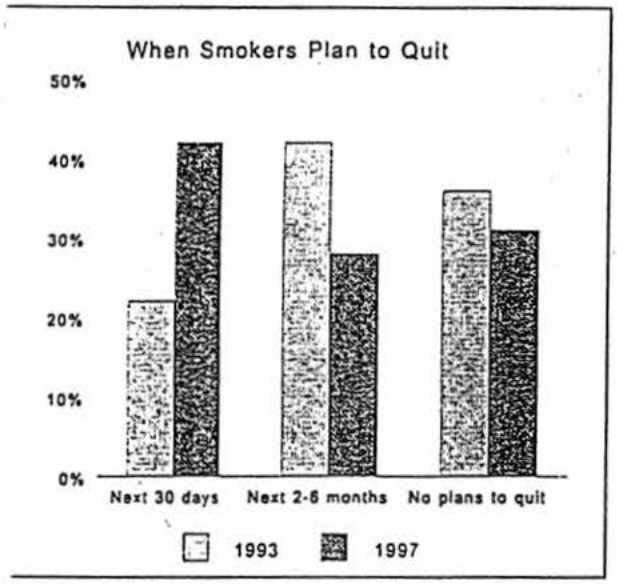
More smokers are planning to quit soon. Among smokers interviewed in the 1997 survey, 42% planned to quit within the next 30 days. This is nearly double the rate reported in 1993, when 22% planned to quit within the next 30 days (Fig. 4).

The surveys also suggest that more people are trying to quit, and more are succeeding. Among people who had smoked within 1 year before the 1997 survey 54% quit for at least 1 day during the year and 14% were nonsmokers at the time of the interview. Both figures are higher than those found in the 1993 survey.

The rate of youth smoking grew less in Massachusetts than elsewhere. Among Massachusetts students in Grades 7–12, smoking rates were nearly the same in



IGURE 3. Bar graph showing steady decline in the number of adult smokers Massachusetts.



GURE 4. Bar graph showing increase in numbers of Massachusetts okers planning to quit between 1993 and 1997.

96 (31%) as in 1993 (30%). In contrast, nationwide uth smoking rates grew substantially during that riod. Massachusetts smoking rates have grown less an national rates for Grades 8, 10, and 12, the only oups that can be compared directly.

uth use of smokeless tobacco has declined. Only 4.5% Massachusetts youth in Grades 7–12 reported using okeless, or "spit," tobacco in the month before the 96 interview. This striking decline from the rate of

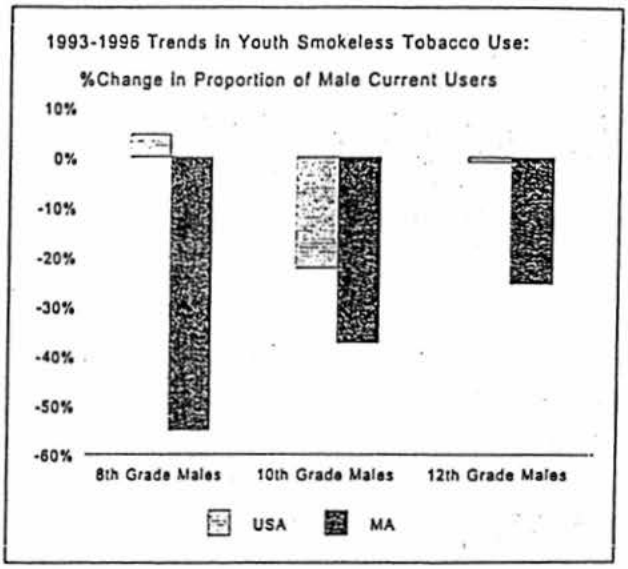


FIGURE 5. Bar graph showing trends in use of smokeless tobacco in youths in Grades 8, 10, and 12 in Massachusetts compared with the U. S. as a whole. MA: Massachusetts.

8% reported in 1993 is much larger than the reduction observed nationwide (Fig. 5). Massachusetts excise tax hikes, which brought the tax to 75% of the wholesale price by 1996, doubtless account for much of the reduction in use.

Merchants are complying better with laws prohibiting sales to minors (Fig. 6). MTCP-funded local Boards of Health monitor and enforce laws against selling tobacco products to youths age < 18 years. Often working in conjunction with young participants in the Youth Tobacco Education and Leadership Programs, Boards have conducted > 21,000 underage buying attempts in which youth ages < 18 years attempt to purchase cigarettes and report on the results. When illegal sales occur, Boards may issue citations, which can lead to fines or license suspensions.

As monitoring has become more intense and citations more frequent, merchant compliance has improved dramatically. By April–June 1997, only 8% of all underage attempts to purchase cigarettes resulted in a sale. This is far less than the 48% violation rate observed as testing got under way in March–May, 1994.

Workers are less exposed to ETS. MTCP programs help employers establish policies restricting smoking in the workplace. To date these programs have provided information or technical assistance to > 1800 worksites, nearly 500 of which are known to have implemented new policies. More than 70,000 employees are affected by these new protections (see next page).

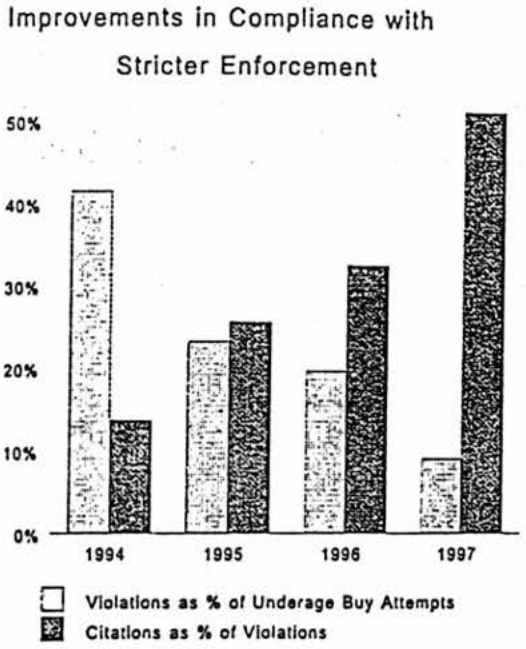


FIGURE 6. Bar graph showing improved merchant compliance with stricter tobacco control enforcement in Massachusetts.

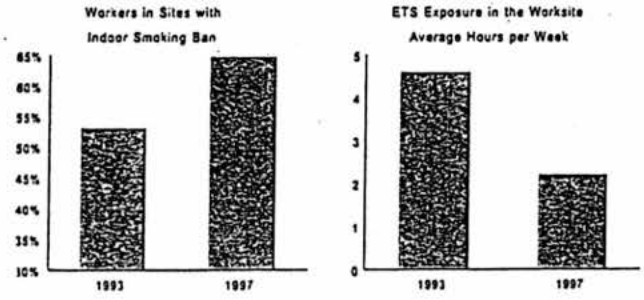


FIGURE 7. Bar graph showing reduction in workplace exposure to environment tobacco smoke (ETS) in Massachusetts between 1993 and 1997.

As a result of such activities, the percentage of workers in sites that ban indoor smoking climbed from 53% to 65% between the 1993 and 1997 surveys. Average ETS exposure at work has decreased from 4.5 to 2.2 hours per week (Fig. 7).

The number of Massachusetts residents protected by local environmental tobacco control and youth access provisions has grown dramatically since Question 1 was passed in 1992. The population covered of cities and towns with each type of provision has more than quadrupled over that period, and some types of provisions now cover > 67% of all residents of the commonwealth (Fig. 8).

Restaurant patrons are better protected from secondhand smoke, and restaurant business has not been

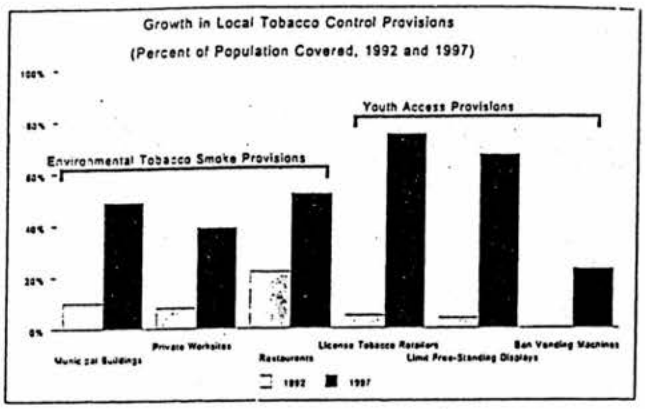


FIGURE 8. Bar graph showing growth in local tobacco control provisions in Massachusetts by the percent of the population covered in 1992 and 1997.

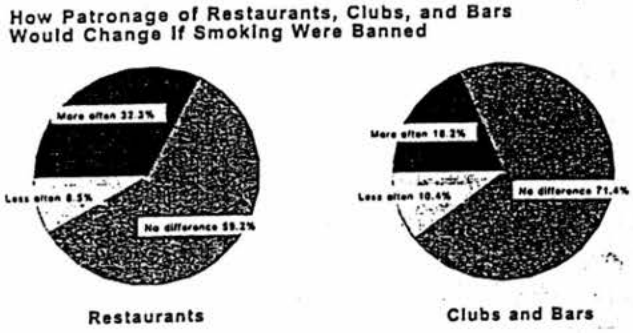
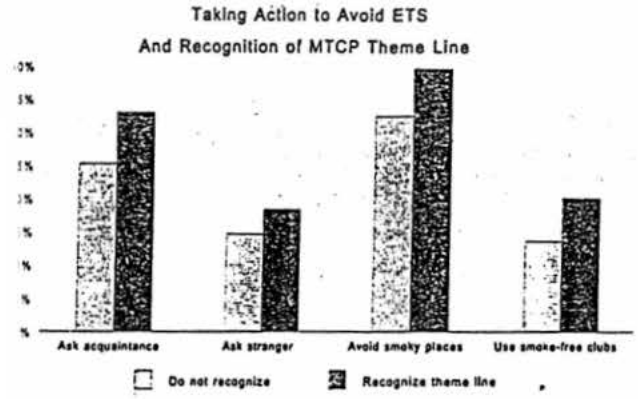


FIGURE 9. Graph showing expected changes in patronage of restaurants, clubs, and bars in Massachusetts if smoking were banned.

harmed. Since the MTCP local programs began promoting local ordinances and provisions restricting smoking in restaurants, the population covered by such provisions has more than doubled. In fact, nearly 1 million Massachusetts residents now live in cities or towns with complete bans on smoking in restaurants. Two separate analyses have found that the adoption of smoking restrictions definitely has not harmed restaurant business, and most likely has helped it. One analysis found that Massachusetts towns adopting highly restrictive policies showed an increase in restaurant receipts of 5.5–8.6% above predicted levels. A second analysis estimated that the number of restaurant jobs increased or remained unchanged. Both are consistent with the statements of survey respondents, who say they would use restaurants and bars more–not less–if they had smoking bans (Fig. 9).

The MTCP campaign helps individuals take action to avoid exposure. Increasing awareness of ETS has been one goal of the media campaign. Survey results indicate that people who recognize the campaign theme line, "It's time we made smoking history," more often



GURE 10. Bar graph showing how media campaign has made Massachu-tts residents more aware of environmental tobacco smoke. ETS: environ-ntal tobacco smoke; MTCP: Massachusetts Tobacco Control Program.

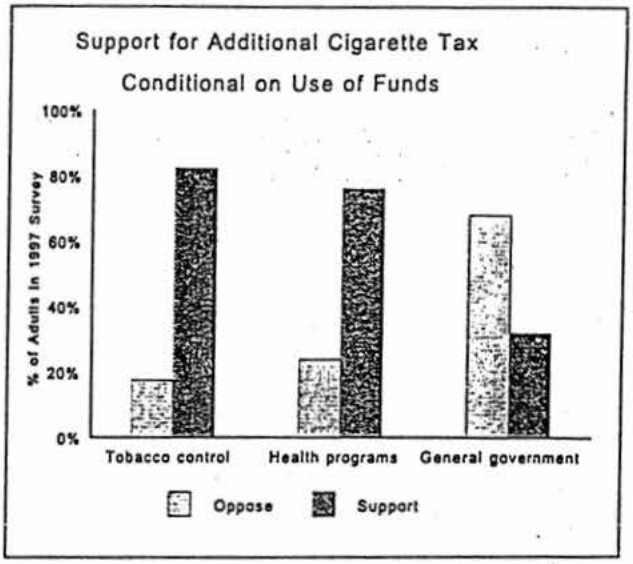


FIGURE 11. Bar graph showing strong support for tobacco control measures among Massachusetts residents, specifically support for an additional cigarette tax provided the funds are used for tobacco control and other health programs.

k acquaintances or strangers not to smoke and avoid aces in which they would be exposed to too much condhand smoke (Fig. 10).

iblic support for tobacco control remains strong in assachusetts. Surveys consistently have found strong ajorities favoring any additional taxes on cigarettes, ovided that the proceeds are used for tobacco con-l or other health programs. The pattern continued er the increased excise tax took effect in October 96; the percentage of respondents supporting an ditional excise tax in 1997 is nearly identical to that 1996 (Fig. 11).

gnificant new legislation shows continued public d political support for tobacco control. The legis-ion includes: 1) the first law in the nation requir-disclosure of cigarette nicotine levels and addi-es; 2) the first law in the nation requiring estment of tobacco company stocks and bonds m state pension funds; 3) A 25-cent increase in cigarette excise tax, making Massachusetts' total arette excise tax the second highest in the nation; d 4) A smoking ban in the State House and other te government buildings. Massachusetts was the h state to bring suit against the tobacco industry to recover the cost of Medicaid claims for treating tobacco-related illnesses.

MTCP effects reach beyond Massachusetts. As one of the first comprehensive state tobacco control programs, the MTCP has been studied by many other states, and a number have adopted or replicated program elements. For example, television spots developed for the Massachusetts media campaign have been used in 20 other states.

Massachusetts' tobacco control initiatives have been covered extensively in the national media as well. Hearings on the Tolman amendment were covered by the primary news programs on the American Broadcasting Company (ABC), the Columbia Broadcasting System (CBS), the National Broadcasting Company (NBC), the Cable News Network (CNN), and National Public Radio. In addition, MTCP personnel and activities have been featured on the television programs "60 Minutes," "20/20," "48 Hours," and "Good Morning America."

Has the California Tobacco Control Program Reduced Smoking?

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Context.—Comprehensive community-wide tobacco control programs are considered appropriate public health approaches to reduce population smoking prevalence.

Objective.—To examine trends in smoking behavior before, during, and after the California Tobacco Control Program.

Design.—Per capita cigarette consumption data (1983-1997) were derived from tobacco industry sales figures. Adult (≥18 years) smoking prevalence data were obtained from the National Health Interview Surveys (1978-1994), the California Tobacco Surveys (1990-1996), the Current Population Surveys (1992-1996), and the California Behavioral Risk Factor Survey and its supplement (1991-1997). Trends were compared before and after introduction of the program, with the period after the program being divided into 2 parts (early, 1989-1993; late, 1994-1996).

Main Outcome Measures.—Change in cigarette consumption and smoking prevalence in California compared with the rest of the United States.

Results.—Per capita cigarette consumption declined 52% faster in California in the early period than previously (from 9.7 packs per person per month at the beginning of the program to 6.5 packs per person per month in 1993), and the decline was significantly greater in California than in the rest of the United States ($P<.001$). In the late period, the decline in California slowed to 28% of the early program so that in 1996 an average of 6.0 packs per person per month were consumed. No decline occurred in the rest of the United States, and in 1996, 10.5 packs per person per month were consumed. Smoking prevalence showed a similar pattern, but in the late period, there was no significant decline in prevalence in either California or the rest of the United States. In 1996, smoking prevalence was 18.0% in California and 22.4% in the rest of the United States.

Conclusions.—The initial effect of the program to reduce smoking in California did not persist. Possible reasons include reduced program funding, increased tobacco industry expenditures for advertising and promotion, and industry pricing and political activities. The question remains how the public health community can modify the program to regain its original momentum.

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EARLY PUBLIC HEALTH approaches to reducing population smoking prevalence emphasized interventions aimed at individual smokers.[1] However, the results of numerous studies indicated that too few individuals were reached for such a strategy to effect a measurable reduction in population smoking prevalence.[2] The varied successes of several comprehensive, community and statewide tobacco control programs[3-7] led to this approach being widely recommended as the most appropriate way to reduce tobacco use in the United States.[2,8] Starting in 1989, the California Tobacco Control Program introduced the use of increased tobacco excise taxes to continuously fund a large, coordinated statewide effort to reduce the health costs associated with smoking.[9]

The voter initiative that led to the California Tobacco Control Program clearly specified that the program take a multipronged or "shotgun" approach to reducing smoking. In addition to imposing an additional tax ($0.25 per pack), the initiative mandated funding for mass media antitobacco campaigns, local health agencies to provide technical support and monitor adherence to antismoking laws, community-based interventions selected by a competitive grants process, and enhancement of school-based prevention programs. Additionally, it mandated that the program's effectiveness be evaluated.[9] In this article, we report the longer-term evidence that the California Tobacco Control Program affected smoking behavior.

One problem with assessing the effectiveness of tobacco control programs funded by cigarette taxes is that funding for evaluation research, including population surveys of smoking behavior, becomes available only after the first intervention (imposition of the tax) has occurred. In the United States, surveillance surveys have rarely had designs that provide precise enough estimates of smoking behavior at the state level to allow a sensitive assessment of changes in trends.[10] The research challenge is to reach valid conclusions from the analysis of preprogram trends derived from one set of surveys and postprogram trends from different surveys. Fortunately, another source of data is available from the collection of cigarette excise taxes. All states have such taxes, and the sales reporting methods for tax assessment are uniform. If there is no major change in the average level of consumption per smoker, trends in smoking prevalence should mirror trends in cigarette sales, which would increase the confidence in conclusions based on either analysis.

In this article, we assess trends in per capita cigarette consumption and adult smoking prevalence in California compared with the rest of the United States. The only previous report of the longer-term impact of a statewide tobacco control program indicated that the program

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had an overall impact during its first year of operation.[5] However, the magnitude of this initial effect was not maintained over the next 4 years. A different pattern was observed for men and women; the rate of decline (trend) in smoking was greater only in men in the second period than it was in the preprogram period.[11] If the later trend is not larger than the preprogram trend, then the program can be considered to have lost its effect. Should an ongoing tobacco control program lose its effect, a careful examination of the possible reasons is essential so that appropriate revitalization measures can be taken. Also, it must be considered that counterstrategies used by the tobacco industry may play a role in diminishing a program's effectiveness.

METHODS

Cigarette Sales (Consumption)

The Tobacco Institute reports on monthly tax payments from all packs of cigarettes removed from wholesale warehouses to retail outlets for sale within each state.[12] Data from February 1983 through March 1997 are included in the present analysis. We estimated per capita consumption for a given state in any given year using census estimates for the state population aged 18 years and older. Decade census population data were assummed to reflect the population on April 1, 1980, and April 1, 1990. Supplemental estimates reported from the Current Population Surveys were assumed to reflect the population as of July 1 of each year.[13,14] To obtain monthly estimates of state populations, we interpolated regression lines fitted to the yearly census data. Since retail outlets appear to stock up in the last month of both the fiscal and calendar years, we removed this source of variation by considering bimonthly averages (for December-January, February-March, etc). The per capita consumption represents the average number of packs removed from wholesale warehouses during a 2-month period divided by the population estimate for the midpoint of the particular time interval. To further deseasonalize the data so that trends over time become more apparent, we applied the SABL procedure (available in the statistical package S-plus[15]) to the bimonthly data. The SABL procedure provides robust estimation of seasonal and trend components of a time series, possibly in the presence of nonadditive effects.[16] This procedure was used for both California and the rest of the United States to produce smoothed time-series trend lines indicating changes over time.

A piecewise linear spline regression model was applied to the bimonthly raw data to further quantify trends. Indicator variables were included to account for the effects of the 6 bimonthly time points. This model allows for changes in the slope at defined points of time.[17,18] The first cut point was defined as January 1989, when the additional excise tax was imposed in California. The deseasonalized trends suggested that a second cut point occurred in California in mid-1994 and in the rest of the United States in mid-1993, so January 1994 was used to make the analyses consistent. A 2-tailed statistical test yielded a P value for differences in slope from one period to the next. Also, from computed SEs for the piecewise slopes, a z statistic could be computed to assess (2-tailed) differences in slopes between California and the rest of the United States.

Smoking Prevalence

Surveys.—Smoking prevalence estimates were obtained from several different population-based surveys conducted nationally and in California.[19-25] These differed considerably in the methods used, including sample selection, survey mode (face-to-face or telephone), smoking status questions, respondents (self or proxy[20]), and sampling variability. These issues made combining all the survey estimates and examining trends over time problematic. Therefore, the data from each survey type were first examined separately to establish that they were not contradictory to each other; then they were combined in an analysis similar to the one used for per capita consumption.

Since 1965, the National Health Interview Surveys (NHIS) have been the surveillance system of choice for smoking prevalence in the United States.[10,19] Although the NHIS provide only estimates at the regional level, California is the largest state in the Western region. Thus, the NHIS sample sizes for California smoking prevalence estimates are reasonably large. The 1978-1994 NHIS were used for an initial assessment of preprogram and postprogram smoking prevalence trends in California and the rest of the United States. The NHIS conducted before 1978 were excluded, either because they did not include persons as young as 18 years (1976 and 1977 surveys) or because smoking status information was missing for more than 1.5% of respondents (1974 survey). The 1992 NHIS was excluded because it was cancelled suddenly at the midpoint of fieldwork with unknown consequences to response rate and representativeness. The paucity of data points after the start of the California Tobacco Control Program results in insufficient statistical power to precisely evaluate changes in trend or to compare California with the rest of the United States. Nevertheless, we used the piecewise linear regression approach to determine whether these data appeared consistent with the postprogram change in slope identified from the per capita consumption data.

Since 1989, there have been several large-scale population surveys conducted

Table 1.—Survey Data Used for Analysis of Smoking Prevalence (Samples Sizes and Response Rates)*

	NHIS†		CTS	BRFS/CATS	CPS	
Year	California	United States–California	California	California	California	United States–California
1978	1178	10 399	...	...	...	...
1979	2578	21 535	...	...	...	...
1980	1112	9303	...	...	...	...
1983	2309	20 109	...	...	...	...
1985	3572	30 058	...	...	...	...
1987	5064	39 059	...	...	...	...
1988	5030	39 203	...	...	...	...
1990	4898	36 206	65 139 (75)‡	...	...	...
1991	5747	39 029	...	2995 (60)§	...	...
1992	...	...	21 872 (73)	3982 (62)	(September) 8081	97 856 (89)‖
1993	2668	18 360	63 269 (70)	7371 (60)	(January) 8272	96 831 (89)
1993	...	...	...	...	(May) 8151	96 769 (86)
1994	2382	17 356	...	8169 (62)	...	...
1995	...	...	...	8207 (53)	(September) 5966	77 570
1996	...	...	78 337 (53)	8165 (49)	(January) 5780	69 375
1996	...	...	...	...	(May) 6041	70 164

*NHIS indicates National Health Interview Surveys; CTS, California Tobacco Surveys; BRFS, Behavioral Risk Factor Surveys; CATS, California Adult Tobacco Surveys; and CPS, Current Population Surveys. Ellipses indicate data not applicable. Numbers in parentheses are response rates in percent, where available.

†Although not published, the NHIS claim a response rate exceeding 86%.

‡For CTS, this is the number of screening interviews completed as a percentage of all households targeted (including telephone numbers for which it was unknown whether the number was that of a residence or a business).

§For BRFS/CATS, this is the product of the household response rate (see CTS) and the interviewee response rate.

‖For CPS, this is the percentage of respondents targeted for smoking supplement interviews for whom the interview was completed. For smoking status, the response was higher because proxy information is included.

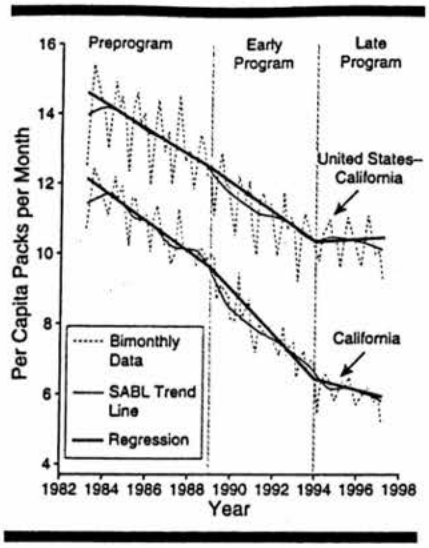

Figure 1.—Trends in monthly per capita adult (≥18 years) cigarette consumption in California and the rest of the United States.

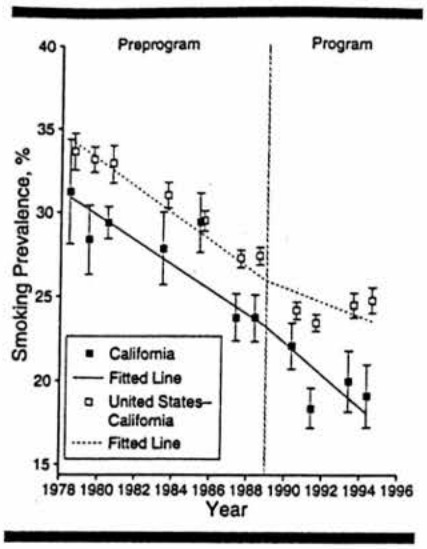

Figure 2.—Trends in adult (≥18 years) smoking prevalence in California and the rest of the United States from National Health Interview Surveys data. Error bars indicate SEs.

Table 2.—Summary of Decreases in per Capita Cigarette Consumption*

	California		Rest of the United States	
Period	Rate of Decline, Pack (SE)	Packs/mo	Rate of Decline, Pack (SE)	Packs/mo
Pre-1989 (preprogram)	−0.42† (0.03)	9.7	−0.36 (0.02)	12.5
1989-1993 (early period)	−0.64‡§ (0.03)	6.5	−0.42 (0.03)	10.4
1994-1996 (late period)	−0.17†§ (0.07)	6.0	0.04§ (0.06)	10.5

*The per capita adult (≥18 years) cigarette consumption in December 1998, December 1993, and December 1996 were estimated from piecewise linear model.
†$P<.01$, California vs the rest of the United States.
‡$P<.001$, California vs the rest of the United States.
§$P<.001$, change from previous period.

in California on a periodic basis. The California Tobacco Surveys (CTS) were the largest of these and specifically funded to evaluate the California Tobacco Control Program. To date, they have been conducted in 1990, 1992, 1993, and 1996. The CTS are random-digit–dialed telephone surveys of households in California.[20,21] A brief screening interview was conducted with a household adult to enumerate all residents and to obtain demographic information, including age and smoking status. Both self and proxy data from the screening interview were included. The Behavioral Risk Factor Surveys (BRFS) have been conducted in California every year since 1984.[22] Beginning in 1991, the sample size was increased, and quality control procedures were established (using California Tobacco Control Program funds) to make this survey a potentially useful tool for assessing trends. Beginning in 1993, a special smoking supplement (modeled after the CTS), the California Adult Tobacco Surveys (CATS), was attached to the BRFS.[23] Finally, the national Current Population Surveys (CPS),[24,25] conducted in September 1992, January and May 1993, September 1995, and January and May 1996, were designed to provide state-specific estimates. The 1985 and 1989 CPS also had smoking-status questions, but these data were missing from more than 1.5% of respondents, so they were not included in our analyses. The various surveys with sample sizes and response rates (if known) are summarized in Table 1.

Smoking Status.—Respondents to all surveys were asked if they (or the person they were responding for) had smoked at least 100 cigarettes in their lifetime and whether they smoked now. In a few of the more recent surveys (NHIS since 1993, CPS since 1992, and BRFS/CATS since 1994), respondents were asked if they currently smoked "everyday," "some days," or "not at all." The everyday and some days smokers were considered to "smoke now." The CTS computed smoking prevalence based on the smoke now question. The other surveys also required that smokers report smoking at least 100 cigarettes in their lifetimes before being asked the current smoking question.

Weighting and Variance.—Survey weights, provided with each of the data sets, were constructed to account for the probability that an individual is sampled and to adjust for differential nonresponse using poststratification procedures. The poststratification procedures for the various surveys were based on different demographic subgroups, and population totals for these subgroups were from different years. Because the demographics of the population changed between 1978 and 1996, data from each survey were standardized (direct method for weighted prevalence) according to sex, age (18-29, 30-39, 40-49, 50-59, and ≥60 years), race (white, nonwhite), and educational level (no college, some college). Variance estimates were generated for each estimate (data available from the authors) so that 95% confidence intervals could be computed and so that rates of change in prevalence estimated from each survey during the postprogram period could be evaluated (data available from the authors).

Finally, once it was established that trends from the various surveys were not contradictory, all the data were combined into one piecewise linear regression analysis, using the same model form as for the per capita consumption data. This analysis, though still problematic for all the reasons discussed above, provides a summary of the prevalence trends that can be examined against the per capita consumption data.

RESULTS

Per Capita Cigarette Consumption

Figure 1 shows the bimonthly raw data, the SABL deseasonalized trends, and the fitted trends from the piecewise linear model for monthly per capita cigarette consumption in California and the rest of the United States. Before the California Tobacco Control Program began, the annual rate of decline in monthly per capita cigarette consumption was −0.42 pack, which was significantly ($P<.01$) more rapid (more negative) than the rate of decline of −0.36 pack in the rest of the United States. From January 1989 through December 1993, the annual rate of decline in monthly per capita consumption increased significantly (became more negative) in California, from −0.42 to −0.64 pack ($P<.001$) or by a factor of 52%. There was a slight but insignificant increase in the rate of decline during this period in the rest of the United States. The rate of decline was significantly ($P<.001$) greater in California (by a factor of 52%) than in the rest of the United States during this period. These results are summarized in Table 2. From January 1994 through December 1996, the annual rate of decline in monthly per capita consumption changed significantly ($P<.001$) in California to −0.17 pack, which was only 28%

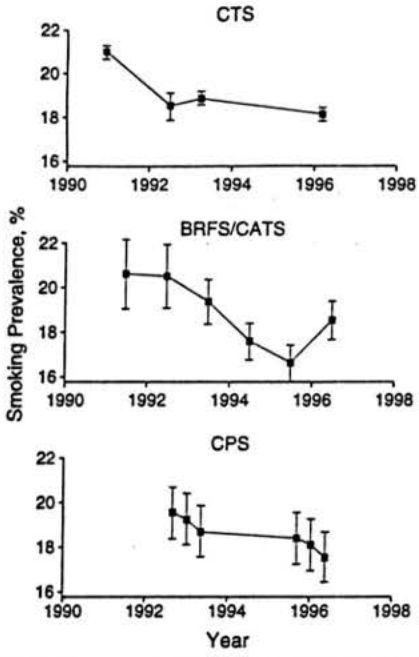

Figure 3.—Top, Trends in adult (≥18 years) smoking prevalence in California from California Tobacco Surveys (CTS) data. Middle, Behavioral Risk Factor Surveys and California Adult Tobacco Surveys (BRFS/CATS) data. Bottom, Current Population Surveys (CPS) data. Error bars indicate 95% confidence intervals.

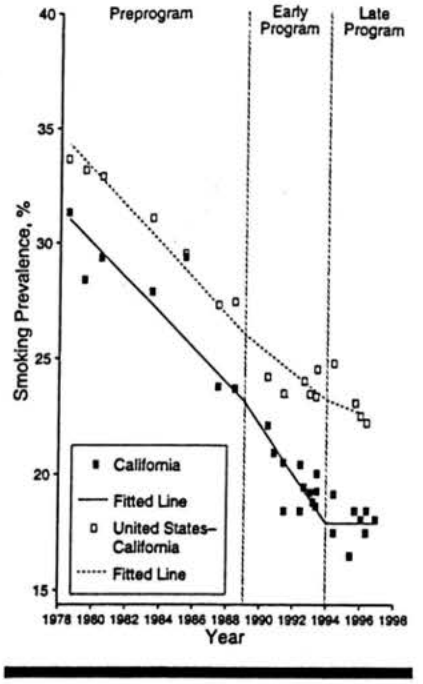

Figure 4.—Trends in adult (≥18 years) smoking prevalence in California and the rest of the United States computed from all survey sources combined.

Table 3.—Summary of Decreases in Smoking Prevalence*

	California		Rest of the United States	
Period	Rate of Decline, % (SE)	Smoking Prevalence, %	Rate of Decline, % (SE)	Smoking Prevalence, %
Pre-1989 (preprogram)	−0.74 (0.12)	23.3	−0.77 (0.09)	26.2
1989-1993 (early period)	−1.06†‡ (0.17)	18.0	−0.57 (0.14)	23.3
1994-1996 (late period)	0.01‡ (0.21)	18.0	−0.28 (0.26)‡	22.4

*Adult (≥18 years) smoking prevalence in December 1998, December 1993, and December 1996 were estimated from piecewise linear model.
†$P<.05$, California vs the rest of the United States.
‡$P<.001$, change from previous period.

of the rate of decline identified for January 1989 through December 1993 and only 40% of the preprogram rate of decline. In the rest of the United States, the annual rate of change in monthly consumption halted altogether (only 0.04 pack), which was a significant change from the earlier period ($P<.001$). The rate of decline in California, although considerably diminished, was still significantly ($P<.01$) greater than the essentially zero decline in the rest of the United States for this period.

In December 1988, before the California Tobacco Control Program began, monthly per capita cigarette consumption, 9.7 packs, was less than the 12.5 packs for people in the rest of the United States, by a factor of 22%. In December 1996, the per capita consumption of 6.0 packs was 43% less than the 10.5 packs seen in the rest of the United States.

Cigarette Smoking Prevalence

Change From Preprogram.—The NHIS data from California and the rest of the United States are presented in Figure 2. The rate of decline in California before the start of the California Tobacco Control Program was −0.72% (SE, 0.19%) per year, which was not statistically different from the rate of decline in the rest of the United States, which was −0.79% (SE, 0.10%) per year. After 1988, the rate of decline in California increased (more negative) to −0.98% (SE, 0.35%) per year. This 36% increase in the rate of decline was not statistically significant because there were too few estimates to provide sufficient precision. In the rest of the United States, the rate of decline was −0.42% (SE, 0.20%) per year, but the decrease (less negative) from the earlier rate of decline was also not statistically significant. The overall rate of decline in the rest of the United States from 1978 to 1994 was −0.67% (SE, 0.07%) per year, and in California it was −0.79% (SE, 0.11%) per year.

Changes During Program Period.—Figure 3 gives the standardized smoking prevalence estimates with 95% confidence intervals from the various surveys conducted in California in the postprogram period. The top panel presents CTS estimates. The decline (±95% confidence interval) from 20.9% ± 0.5% in 1990 to 18.9% ± 0.5% in 1993, −0.85% ± 0.30% per year, was significantly greater ($P<.001$) than the rate of decline of −0.22% ± 0.17% per year from 1993 to a prevalence of 18.1% ± 0.4% in 1996.

The middle panel of Figure 3 shows the standardized smoking prevalence estimates from the BRFS/CATS. In 1991, the prevalence estimate was 20.5% ± 1.6%, which decreased to 17.6% ± 0.8% by 1994; this represents a rate of decline of −0.99% ± 0.59% per year. By 1996, the prevalence estimate was 18.5% ± 0.9%, which was a rate of increase of 0.47% ± 0.60% per year from 1994. The difference between the rate of decline in the early period and the rate of increase in the later period was statistically significant ($P<.001$).

The bottom panel of Figure 3 shows the standardized CPS data for California. For example, smoking prevalence was 18.7% ± 1.1% in May 1993 and 17.5% ± 1.1% in May 1996, which represented a rate of change of −0.39% ± 0.55% per year, which was not statistically different from zero.

In summary, the CTS data indicate a slower rate of decline in the later period as compared with the earlier period, the BRFS/CATS indicate a decline in the early period and an increase in the later period, and the CPS showed no significant change in the later period.

Combined Analysis.—Since data from the California surveys did not contradict the observation that a decline occurred in the early period that was not maintained later, the data from all of them, including the NHIS, were combined into a single analysis similar to the one performed on the per capita cigarette consumption data. Figure 4 shows all the data points and the resulting fitted regression lines, and Table 3 presents the rates of decline and prevalence estimates derived from the model. Before the California Tobacco Control Program began in 1989, smoking prevalence declined at about the same rate in California (−0.74% per year) and the rest of the United States (−0.77% per year). The rates of decline were not statistically different, but prevalence in California was below that for the rest of the United States. The rate of decline increased (became more negative) significantly

Table 4.—Funding for the California Tobacco Control Program and the Advertising and Promotion of Cigarettes in California*

Budget Category	1989-1990	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	Total, 1989-1996
Expenditures Targeted at Tobacco Use in California, $ Millions[31]								
	Fiscal Year							
Mass media	14.3	14.3	16.0	15.4	12.9	12.2	6.6	91.7
Local lead agency	35.6	35.4	14.5	17.8	13.5	16.4	10.2	143.4
Competitive grants	3.3	49.7	1.1	27.5	15.1	10.9	9.7	117.3
Local schools	32.6	32.6	24.3	23.3	19.6	16.8	15.3	164.5
Actual Totals	**85.8**	**132.0**	**55.9**	**84.0**	**61.1**	**56.3**	**41.8**	**516.9**

Budget Category	1989	1990	1991	1992	1993	1994	1995	Total, 1989-1995
Expenditures by the Tobacco Industry in California, $ Millions[32]								
	Calendar Year							
Advertising	111	114	112	99	94	89	82	701
Incentive to merchants	100	102	116	151	156	168	187	980
Promotional items	122	149	207	252	332	210	201	1473
Other	28	34	31	22	22	17	19	173
Totals	**361**	**399**	**466**	**524**	**604**	**484**	**489**	**3327**

*Data are from Balbach et al[31] and the US Federal Trade Commission.[32] Dollar amounts are not adjusted for inflation.

($P<.001$) in California after the program began, whereas in the rest of the United States it did not. As a result, the rate of decline from 1989 through 1993 was significantly greater ($P<.05$) by a factor of nearly 90% in California (−1.06% per year) than in the rest of the United States (−0.57% per year). After 1993, the rate of decline in California and in the rest of the United States was not significantly different from zero, and in both instances, the change in the rate of decline was significantly less ($P<.001$) than in the preceding period. Obviously, these late program trends were less than the preprogram rates of decline.

From the fitted model (Table 3), adult smoking prevalence in December 1988 was 11% lower than in the rest of the United States, and by December 1996 it was 20% lower.

COMMENT

Analysis of trends in per capita cigarette consumption indicates that the start of the California Tobacco Control Program in 1989 was associated with a 50% more rapid rate of decline that was unique to California. After 1993, the rate of decline in per capita consumption in California slowed to less than one third of the rate observed from 1989 through 1993 and to less than one half of the rate of decline observed before the program began. However, this post-1993 rate of decline was still significantly more rapid in California than in the rest of the United States, for which the decline in consumption halted.

The smoking prevalence trends from the combined survey data are fairly consistent with the changes observed in per capita consumption. The initiation of the program was associated with a 36% increase in the rate of decline of smoking prevalence, which was nearly twice the rate of decline identified for the rest of the United States. However, from 1994 through 1996, there was no identifiable decline in smoking prevalence either in California or the rest of the country. In California, smokers may be reducing their consumption rather than quitting, while it appears that in the rest of the United States they are doing neither.

It is important to the future of tobacco control in general and to the California Tobacco Control Program specifically to hypothesize why the loss of the early program success occurred. Additional analyses will be required to fully understand the influences of various factors. Did the program lose its effectiveness because it failed to introduce new and innovative approaches to interest the population in tobacco control, or did it suffer from countermeasures used by the tobacco industry? The fact that the tobacco industry lowered prices for premium brands of cigarettes in 1993[26] could be at least partly responsible. Also, it is possible that lower funding for the Tobacco Control Program or increased expenditures by the tobacco industry for advertising and promotion played a role. Finally, the tobacco industry engaged in a variety of political activities, which may have influenced the level of commitment of the state administration and legislature to the California Tobacco Control Program. These possibilities will be examined in some detail below.

There were several tobacco control strategies that were emphasized during the early phase of the California Tobacco Control Program. One was support for the adoption of ordinances at the local level that restricted or banned smoking in indoor workplaces and public places. The percentage of indoor workers reporting smoke-free workplaces increased during the early years of the program but continued to increase even more later.[21] California Assembly Bill 13 was enacted in January 1994, and it prohibited smoking statewide in 1995 in all indoor workplaces except bars, taverns, and casinos. If smoke-free workplaces encourage smokers to reduce their consumption or quit, the effect on per capita consumption and prevalence should have been evident throughout the entire program period. Another important element of the very early California Tobacco Control Program was a well-funded and effective media campaign.[27] Antismoking television ads focused on the duplicity of the tobacco industry and the dangers of secondhand tobacco smoke. Funding for the media campaign was vetoed by the governor in 1992 and later restored,[28] but it was reinstated at a lower level than previously (Table 4). Also, the administration has been accused of "watering down" the antismoking advertising.[27]

Economic theory and empirical data have suggested that cigarette price is a major determinant of smoking behavior.[10,29] However, recent data suggest that when tobacco control programs are in place, the price elasticity of demand may be altered (S. Emery, E. A. Gilpin, J. P. Pierce, unpublished data, 1998).[30] In 11 of the 14 states that participated in the American Stop Smoking Intervention Study (ASSIST), where there was a decrease in the real price of cigarettes from 1992 to 1994 (which spanned the date when the tobacco companies lowered the price of cigarettes), per capita cigarette consumption did not increase as economic theory would predict.[30] In the remaining 3 ASSIST states, the increase in consumption was very minimal. In the non-ASSIST states (excluding California), all showed a decrease in the real price of cigarettes from 1992 to 1994, and over half showed the expected increase in per capita consumption. A recent analysis of changes in cigarette price and per capita consumption in Cali-

fornia showed that when the excise tax increase went into effect the percentage change in per capita consumption (12.2%) closely matched what economic theory would predict from the resultant change in cigarette price (11.8%) (S. Emery, E. A. Gilpin, J. P. Pierce, unpublished data, 1998). The increased tax was the first element of the California Tobacco Control Program implemented, and as additional programs were introduced, the expected relationship between price and consumption disappeared. Importantly, per capita consumption decreased 8.5% from 1993 to 1994, when the price decrease would have predicted a 4.9% increase. The price of cigarettes has remained stable from 1993 through 1996. These results suggest that price alone cannot be responsible for the loss of effect of the California Tobacco Control Program.

The level of funding for the California Tobacco Control Program has varied over the course of the program.[31] Expenditure data for the Health Education Account (which funds the Tobacco Control Program) are shown in Table 4 (top) for the line items of mass media, local lead agencies, competitive grants and school programs, and other expenses.[31] The funds allocated for administration and evaluation, which averaged about 5% of the total budget each year, are not included. There is variation over time, which suggests that money from 1 year was brought forward to the next, particularly in the category of competitive grants. From fiscal year 1989-1990 to fiscal year 1992-1993, the average annual expenditure was $85.5 million, or $3.35 per capita per year (considering a population of 25.5 million people in California >12 years old). However, beginning with fiscal year 1993-1994, there was a marked reduction in program funding. The annual average was $53.0 million, or $2.08 per capita, which was a reduction of 40% from the early years of the program. This reduction in the level of effort aimed at reducing smoking in California is a possible explanation for the loss of program effect.

Concurrent increases in the amount of money the tobacco industry spent to promote cigarette use may have exacerbated the problem. The lower portion of Table 4 shows the estimated amount spent for each of several line-item categories as reported to the Federal Trade Commission.[32] Traditional print media and billboard expenditures constitute the advertising category. We combined the categories for "coupons," "retail value added," and "specialty item distribution" into one category labeled "promotional items." The category "incentives to merchants" includes the Federal Trade Commission category that they designate as "promotional allowances," which covers expenditures to encourage wholesalers and retailers to stock and promote particular cigarette brands. We assumed that the tobacco industry did not specifically target California with its marketing dollars and that California received a share of the industry's national promotion and advertising effort in proportion to its population (approximately 10%). This assumption is likely to be conservative, since the tobacco industry may have specifically increased their promotional efforts in California to counteract the Tobacco Control Program when there were early indications that it was having an impact.[7,33] Furthermore, the data on expenditures for advertising and promotion are for manufactured cigarettes only and do not include other tobacco products, such as cigars. The amount spent on advertising has decreased over time, but the amount spent on incentives to merchants has increased markedly, as has the budget allocation for promotional items. From 1989 to 1993, it is estimated that the tobacco industry spent an average of $437 million annually, or $17.14 per capita, in California; thereafter, it spent an average of $525 annually, or $20.59 per capita, an increase of 20% from the earlier period. In the earlier period, the industry outspent the program by approximately $5 to $1 ($17.14 to $3.35 per capita), and in the period from 1993 to 1996, it outspent the program by nearly $10 to $1 ($20.59 to $2.02 per capita).

The cuts made by the administration and legislature in the California Tobacco Control Program budget appeared to be about the same in each budget category of the Health Education Account, except in 1995-1996, when the expenditure for the media program was halved. The decision by the administration to divert funding for the program could not have been justified on the basis that the program was considered to be performing above expectations. The 1993 interim assessment of the program suggested that since early indications demonstrated that the program was having an effect on smoking behavior, this effect needed to be increased by 50% more in order for the program to meet its goal for the year 2000.[34] The goal was to decrease adult smoking prevalence by 75% within a 12-year period. Further, the decision to reduce expenditures for the program was made in the face of active lobbying by health advocacy organizations and lawsuits against the administration brought by the American Lung Association, Americans for Nonsmokers' Rights, the American Cancer Society, and the American Heart Association.

Recently, a set of internal memoranda from the Tobacco Institute surfaced. These internal memoranda, written in 1990, outlined a strategic plan for combatting the California Tobacco Control Program.[35] The plan called for lobbying the California legislature to intervene, encouraging and supporting minority organizations to oppose the program, convincing the health services director to pull or modify media messages that reflected poorly on the industry, and encouraging the governor to intercede against the program. There is evidence that these strategies were used and met with some success. As mentioned previously, the governor initially vetoed the media budget in 1992, although he reconsidered following significant public pressure.[28] Antismoking media funding was reduced by 50% for 1995-1996, and anti-industry media spots were short-lived.[27] Furthermore, tobacco industry campaign contributions to legislature candidates, other elected officials, political parties, and political party committees totaled over $1.5 million in 1995-1996; this was a 70% increase compared with the level of such contributions in the 1993-1994 election cycle.[31] On a per legislator basis, members of the California legislature received twice as much money as did members of the US Congress, even though California is not a tobacco-producing state.[31] The slowing of the decline in smoking in recent years may well be a result of these political counterstrategies by the tobacco industry.

The California Tobacco Control Program has confirmed findings from earlier studies[3-7] that large health promotion programs can have a major influence on smoking behavior. Similar programs have been initiated in Massachusetts (1993), Arizona (1995), and Oregon (1996). Furthermore, the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention have provided limited support for the development of similar tobacco control programs in other states.[36,37] Only the relatively well-funded Massachusetts program[38] has been in effect long enough to potentially confound the results of our analyses. However, Massachusetts represents a small percentage of the US population, so it was not surprising that a reanalysis of the data without it did not change the results.

In conclusion, the California Tobacco Control Program clearly lost its original positive effect on reducing smoking, which must be of considerable concern to the public health movement. In this article, we have discussed some of the factors that might have been associated with the loss of effect. The Tobacco Institute memoranda[35] revealed that the

tobacco industry decided early on to actively oppose any potentially effective tobacco control efforts. Traynor and Glantz[39] and Heisner and Begay[40] have outlined the political difficulties faced in developing and maintaining an effective tobacco control program in such a climate. Despite active industry opposition and political influences, it is urgent that the public health community determine how the California Tobacco Control Program can be modified to regain its original momentum.

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General Statement

As the nation=s prevention agency, the Centers for Disease Control and Prevention (CDC) is responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. In its half-century of successes working with partners across the nation and the world, CDC has been a leader and pioneer in detecting and investigating health problems, conducting research to enhance prevention, developing and advocating sound health policies, implementing prevention strategies, promoting healthy behaviors, fostering safe and healthy environments, and providing leadership and training in public health. At home and abroad, CDC has consistently recouped the nation=s investment, saving lives and dollars.

As part of a global partnership, CDC played a major role in the worldwide eradication of smallpox in 1977 and, as a partner in immunization campaigns, is leading the global effort to eradicate polio.

As our nation approaches the next century, CDC has embarked on efforts to confront new public health challenges. New and drug-resistant forms of infectious diseases now threaten the health of Americans. Tobacco use causes about one of every five deaths in the United States, costing the country more than $100 billion annually in medical expenditures and indirect costs. Violence, another highly preventable public health problem, continues to endanger young Americans; homicide is the second leading cause of death for people between the ages of 15 to 24 and the *leading* cause of death for African-Americans in this age group. We must also be prepared to respond quickly to reduce the consequences of biological, chemical, and radiological terrorism.

Finally, the country=s public health structure - the people, science, and systems that protect the country from disease - must be strengthened. For example, the country needs an enhanced national surveillance system that can quickly identify infectious disease outbreaks or bioterrorist attacks. A number of CDC=s laboratory, office, and scientific support buildings, many of which are more than 30 years old, are outdated and do not provide a safe, up-to-date working environment. Without a national disease monitoring system and a strong laboratory and scientific infrastructure at CDC, the country will not able to protect its citizens from the deadly threat of infectious diseases and environmental exposures.

CDC established the National Breast and Cervical Cancer Early Detection Program in 1990, a program which delivers critical screening services to undeserved women. Through March 1998, CDC provided more than 1.7 million screening tests.

To meet these challenges, CDC has identified four priorities to guide our actions as we move into the 21st century:

- $ Strengthen Science for Public Health Action
- $ Collaborate with Health Care Partners for Prevention
- $ Promote Healthy Living at Every Stage of Life
- $ Work with Partners to Improve Global Health

CDC requests additional funding that allows the agency to carry out these priorities, and thus meet America=s new public health challenges.

Strengthen Science for Public Health Action

CDC is committed to strengthening science for public health action. CDC=s scientific endeavors are designed to respond to a clear public health need, and address the nation=s **C** and the world=s **C** pressing public health problems. CDC will continue to work with partners to build and maintain the public health infrastructure so that cutting-edge science is translated into practical public health programs.

Approximately 85 percent of CDC=s Clifton Road Campus laboratory capacity is 35+ years old and lacks modern mechanical, electrical, plumbing, fire and life safety systems.

Unfortunately, America=s public health infrastructure--the people, science, and systems that braid together to form a protective bulwark against disease and disability--has weakened. A variety of pressures at federal, state, and local levels over the past two decades have decreased the ability to address current problems and respond to new crises and emerging health threats.

To address this issue, CDC requests funding to complete the following activities:

$ construct needed national laboratory facilities to replace the unsafe and antiquated structures currently in use;

$ improve public health preparedness at the federal, state, and local levels of government to respond to the threat posed by biological, chemical, or radiological terrorism;

$ increase food safety by building a national early warning system for hazards in the food supply;

$ build the national and state capacity needed to respond quickly to the threat of emerging infectious diseases;

$ develop and implement a national Hepatitis C public information campaign in partnership with medical professionals and public health departments;

$ develop a health statistics system for the 21st century that is capable of meeting increased demands for information and that makes data more readily available to users through the Internet and other state-of-the art means;

$ fill occupational safety and health research gaps in the National Occupational Research Agenda (NORA), a landmark national consensus on the research needed to control workplace hazards.

These initiatives will allow CDC to strengthen the public health infrastructure so that the agency can translate the latest science into beneficial public programs.

Collaborate with Health Care Partners for Prevention

CDC and those involved in health care delivery**C**including State and local health departments, academia, medical and managed care organizations, Medicare and Medicaid, and large corporations that buy health care for employees and their families**C**have similar interests in prevention. This represents a tremendous opportunity to improve health and prevent disease. CDC will capitalize on this opportunity by striving to work with public and private sector partners in carrying out its programs.

As part of this commitment, CDC will engage in the following efforts:

$ expand injury prevention research and implement youth violence prevention programs through state and local health departments and medical professionals;

- $ enhance services to prevent violence against women; discover evaluate and communicate what works; monitor the problem; and lead a national effort to change social norms in partnership with the domestic violence, law enforcement and medical communities;

- $ establish a Center for Bio-ethics in Research and Health Care at Tuskegee University in collaboration with academia and the medical community;

Promote Healthy Living at Every Stage of Life

It is more important than ever to help avert the burdens of preventable disease and disability, at every stage of life. To do that, CDC must think of people=s entire lives, how and where they live Cand look for points at every stage of life to interject prevention. Given that race, ethnicity, and socioeconomic inequalities correlate with persistent health disparities, it also means that the agency must act to improve the health of undeserved populations.

Research has demonstrated that poor health is not an inevitable consequence of aging and that it is never too late to make healthy lifestyle choices. CDC can play a crucial role in the promotion of healthy living through its national leadership role. As part of this effort, CDC requests funds to carry out the following initiatives:

- $ expand programs, surveillance, and research efforts aimed at addressing the health problems of racial and ethnic minorities;

- $ develop a comprehensive tobacco control strategy designed to prevent and reduce tobacco use among youth and adults;

- $ eliminate syphilis in the United States within the next decade by enhancing surveillance and identifying critical prevention opportunities;

- $ increase the number of people who know their HIV infection status, particularly among those at high risk for infection and within communities of color; and

- $ expand vaccinations to include all susceptible children through 18 years of age.

Work with Partners To Improve Global Health

Today, with health disparities among developed, newly developed, and developing nations ever more glaring, and with disease just a plane ride away, CDC must work more closely with global partners to help shape the science, design the policy, and provide the support to promote global public health.

CDC staff extend the horizon of medical science, provide developmental assistance to populations, and serve to protect the health of America=s citizens. No other governmental agency offers comparable service to ensure the health of the world=s population - thereby protecting the health of American people.

As part of these efforts, CDC requests funding to carry out the following activities:

- $ lead global polio elimination efforts by targeting immunization and surveillance activities toward war torn countries in Africa;
- $ disseminate Abest practices@ for tobacco control to international partners.

> ADistinctions between domestic and international health problems are losing their usefulness and are often misleading... The direct interests of the American people are best served when the United States acts decisively to promote health around the world.@ (Institute of Medicine report, America=s Vital Interest in Global Health, 1997)

Public Health National Surveillance System

CDC monitors health status and trends by providing financial support and leadership for the development of public health surveillance systems. Development and implementation of an integrated National Electronic Disease Surveillance System at CDC will begin. This system will collect and analyze epidemiological information on the occurrence of communicable diseases and is a critical missing link in the nation's public health infrastructure.

Examples of CDC supported surveillance systems are: laboratory-based electronic surveillance of infectious diseases in every state to allow for early identification of unusual events and to detect increases by real-time analysis of data from clinical and public health laboratories; and provider-based sentinel networks which are sufficient in number and sensitive enough to detect unusual events. Data from all surveillance systems for infectious and toxic agents are collected, linked and analyzed in real-time (at the time of initial collection) to support early detection of agent releases, exposures, and outbreaks. These various surveillance systems are not independent of one another but combine to form a network of passive and active systems supported by a strong infrastructure collecting health information from all levels and passing back analyzed data which can take the form of health alerts of a possible outbreak of E.coli or a recommendation to increase the emphasis on adult influenza immunization. Funds requested in the FY 2000 budget are essential to maintaining this critical public health effort. Actual requests for funding support for surveillance are found in several places within this overall budget presentation.

In 1997, laboratory surveillance systems in Colorado identified a food borne outbreak involving hamburger patties contaminated with *E. coli* 0157:H7. Twenty-five million pounds of ground beef were recalled, and a potential nationwide outbreak was averted.

The Public Health Response to Terrorism

CDC will provide support to prepare the federal, state and local public health infrastructures to detect and effectively respond to threats posed by bioterrorism. CDC will focus on building upon the essential role that public health plays in the emergency response to terrorism through efforts that: 1) reinforce systems of public health surveillance to ensure rapid detection of unusual outbreaks; 2) build epidemiologic capacity to investigate and control health threats from such events; 3) enhance public health laboratory capability to diagnose the illness and identify etiologic agents most likely to be used in bioterrorist events; 4) develop and coordinate communications systems with other government agencies and the general public to disseminate critical information and allay unnecessary fear; and 5) create a special stockpile of pharmaceutical antidotes, antibiotics and/or vaccines that will be readily available in the locations in which they would be needed. This increase of $118 million is in the Public Health and Social Services Emergency Fund (PHSSEF).

Public health surveillance systems will be able to rapidly recognize unusual events that may be caused by terrorist uses of infectious or chemical agents.

FY 2000 BUDGET REQUEST

CDC is requesting a total program level of $3,116,163,000 including $2,820,440,000 in budget authority. The FY 2000 budget request includes program increases of $252,417,000 in budget and program authority offset by Health Statistics savings created by shifting from budget authority to 1% Evaluation funds ($26,780,000), a decrease of $2,717,000 in Physicians= Compensation Allowance for a net increase of $177,920,000 in budget authority. The budget request of 7,631 FTEs reflects an increase of 109 FTEs above the FY 1999 Appropriation. These additional FTEs are essential to implementation of the programmatic increases reflected in the FY 2000 Budget Request.

Included in this request are increases for fifteen (16) programmatic high priority programs and decreases in four (4) other areas. This budget represents a 6.7 percent increase over the FY 1999 Appropriation. This

request also reflects a program level decrease of $12,000,000 for the Agency for Toxic Substances and Disease Registry (ATSDR).

The 16 programmatic increases in the FY 2000 budget are as follows:

I. Strengthen Science for Public Health Action ($94 million and 80FTEs)

Construction of the Clifton Road, Building 17, Phase II, Edward R. Roybal Infectious Disease Research Lab ($22 million and 0 FTEs)

This critically important lab project was divided into two phases several years ago. Phase I is currently under construction. Phase II construction will cost $33 million, and will house approximately 128 scientific staff in addition to the 250 scientists housed in Phase I. The scientists will support infectious disease outbreak investigations, emerging infectious disease research, and laboratory systems being developed to respond to bioterrorism. In FY 99, CDC received $11,000,000 for phase II, leaving a balance of $22,000,000 to be funded in FY 2000.

PUBLIC HEALTH SURVEILLANCE INITIATIVE

$65 million (with $20 million from the PHSSEF) is provided for a new public health electronic disease surveillance initiative at CDC to integrate the surveillance systems used to detect incidents of iinfectious diseases, foodborne illness, and bioterrorism and consolidate the disparate funding streams for these activities.

The current surveillance systems for infectious diseases, food safety and bioterrorism are largely independent. Furthermore, many local and state health departments do not communicate regularly with the local medical community (e.g., physicians, hospitals, laboratories, and managed care organizations). An individual physician might miss a disease outbreak that a state or local health department epidemiologist could easily detect. This electronic disease network will provide a communication link between the local, state and national public health community and the medical community to improve the ability to rapidly detect communicable diseases.

Bioterrorism Surveillance-
Emergency Preparedness and Response ($20 million and 20 FTES)

This bioterrorism component of the Infectious Diseases Initiative builds on the epidemiologic and laboratory enhancements for emerging diseases, focusing on targeted bioterrorism and unknown threat agents, including weapons of mass destruction (WMD). It also complements the PHSSEF Bioterrorism Initiative by strengthening surveillance through a national network of State/major metro area laboratories for early identification and characterization of disease outbreaks and by establishing an Emergency Response Unit which can be deployed to provide rapid field assessments in the event of a suspected release of a biological agent.

National Food Safety Initiative ($10 million and 10 FTEs)

CDC will increase its capacity to identify new foodborne hazards and characterize the risk posed by those hazards, increase the speed with which the presence of hazards in foods can be determined and controlled, and increase the accuracy and timeliness of public health data needed for food safety control programs. More specifically this initiative will expand the scope of the CDC/FDA/ USDA Active Foodborne Disease Surveillance Program; develop and standardize new and rapid diagnostic techniques and molecular sub-typing (Afingerprinting@) of foodborne pathogens; conduct detailed analyses of the economic impact of foodborne outbreaks; and design distance-based educational and training programs for foodborne illnesses for school personnel, practicing health professionals and those in training at the State and local levels.

> The Council for Agricultural Science and Technology has estimated that as many as 9,000 deaths and 6.5 to 33 million illnesses in the United States each year are food related.

Preventing Emerging Infectious Diseases ($10 million and 15 FTEs)

CDC will continue to implement programs to build core epidemiology and laboratory capacity domestically by providing financial and technical assistance to 10 additional state and large local health departments for enhanced surveillance and response to emerging diseases. This initiative stresses the need for developing emergency preparedness at all levels of government for an organized, rapid, and effective response in the event of pandemics (global epidemics), such as influenza, and large-scale disease outbreaks or natural disasters. CDC will also focus on the growing problem of antimicrobial resistance by investigating, monitoring, and establishing surveillance for antimicrobial use, resistance, and related risk factors.

To prevent the next influenza pandemic, skilled epidemiologists, strong public health laboratories, and coordinated communications and disease reporting systems will be required.

Hepatitis C. ($5 million and 5 FTEs)

Chronic liver disease is the tenth leading cause of death among adults in the United States and it is estimated that 40-60% of chronic liver disease is caused by hepatitis C virus (HCV). Approximately 4 million Americans are infected with HCV. Most of these chronically infected persons are not aware of their infection. CDC will develop and pilot test strategies to identify, test, and refer persons at risk for HCV as part of the *National Prevention and Control Plan for Hepatitis C Virus.* Development and implementation of a national HCV information and education campaign targeted to at-risk populations and health care professionals and implementation of HCV prevention demonstration projects in select high prevalence states or major cities will be initiated.

Hepatitis C virus-related acute and chronic liver disease causes 8,000-12,000 deaths annually and the medical and work loss costs are estimated to exceed $600 million annually.

Health Statistics for the 21st century ($15.0 million and 30 FTEs)

CDC will continue to improve its statistical systems to provide information to guide critical health and health policy decisions by adapting existing surveys, improving the underlying methodological and analytic infrastructure, and developing new, targeted data collection mechanisms to meet new data needs. **The National Health Interview Surveys** will be continually adapted to address current data needs, serve as a sampling "nucleus" for integrated health surveys, and will begin the process of a fundamental redesign that will be required as a result of the decennial census. **The National Health and Nutrition Examination Surveys** will continue full field operations with new, state-of-the-art medical and communications technology to improve quality and speed results. **The National Health Care Surveys** will address new approaches to monitoring the health care delivery system, including organizational and financial arrangements of providers, as part of a public/private effort to address major data gaps in this area. Finally, new resources will enable CDC to help States implement a major revision to the international coding system for mortality, and to assist States in moving to electronic systems that will lead to further improvements in quality and timeliness.

National Occupation Research Agenda ($12.0 million and 0 FTEs)

The National Occupational Research Agenda (NORA), developed with more than 500 public and private partners, represents a landmark national consensus on what research needs to be done to control occupational hazards causing illness, injury, death, and their related economic and social burden . NORA has successfully expanded the breadth of the scientific and academic community now engaged in occupational safety and health. CDC, together with three institutes of NIH, has announced a request for grant applications (RFAs) targeting 11 of 21 NORA priority areas. The challenge now is to support and maintain the renewed interest among academicians in conducting occupational health research. Currently, 15 university-based, academic occupational health Education and Research Centers (ERCs) work with regional business partners to conduct research, training, and outreach. ERCs will work with these partners to develop and evaluate the effectiveness and costs of worksite interventions for small businesses. The programs would then work with CDC and other partners to promote the use of cost-effective interventions.

Each year, occupational hazards inflict 6,500 deaths from injury, 13.2 million nonfatal injuries, 60,300 deaths from disease, and 862,200 illnesses. Work-related illnesses, injuries, and disabilities cost the U.S. more than $171 billion each year in lost wages, lost productivity, health care and other costs.

II. Collaborate with Health Care Partners for Prevention ($14.9 million and 7 FTEs)

SAFE U.S.A. ($1.9 million and 2 FTEs)

CDC will support the expansion of the National Electronic Injury Surveillance System of the Consumer Product Safety Commission to collect information on all traumatic injuries seen in a nationally representative sample of emergency departments. This snapshot of emergency department visits for injuries will supplement existing systems to track deaths and hospitalizations at a national level.

Violence Against Women: Enhancing Services and Changing Social Norms ($11.0 Million and 4 FTEs)

CDC will provide leadership and the necessary tools to shape significant change by providing more services to women in existing and underserved locations, evaluate existing services as well as the linkages between child welfare/child protective services and the domestic violence service system, conduct biannual surveys of violence against women that would collect detailed information on special populations, such as adolescents, elders, pregnant and working women. CDC will also assess the usability of data from other sources, such as criminal justice data, and work to establish linkages between health, social services, criminal justice, state domestic violence and sexual assault coalition data.

More than 85% of the approximately 5,000 girls and women murdered each year are killed by someone they know. More than half the killers are intimate partners: husbands and ex-husbands, boyfriends and former boyfriends.

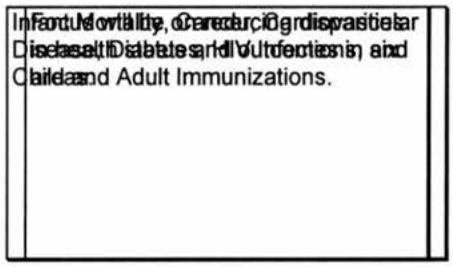
Tuskegee- Center for Bioethics ($2million and 1 FTE)

As part of the Presidentɛs apology for the Tuskegee study on May 16, 1997, a commitment was made to establish a Center for Bioethics in Research and Health Care at Tuskegee University. This initiative will support a public museum and the development of curriculum and related training/outreach materials, as well as securing a director and support staff to operate the Center.

III. Promote Healthy Living at Every Stage of Life ($ 126.5 million and 31 FTEs)

Demonstrations to Address Health Disparities ($25.0 million and 15 FTEs)

CDC will support community based research/demonstrations of prevention and service delivery interventions that show promise in eliminating health disparities in the six goal areas shown below. This will enable different racial and ethnic communities to evaluate the effectiveness of science-based interventions that will improve health status at the community level. Model interventions, grounded in emerging research findings, will allow applicants to adapt promising approaches to their specific communities and health problems. The model interventions that will be examined will be specific to the six disparity reduction goals, and applications will be sought from a diverse range of communities so that the efficacy of specific interventions can be evaluated in both rural and urban areas, and in different cultural settings. A rigorous evaluation strategy will be employed to assure that policy makers can rely upon the results of these demonstrations to make decisions about the expansion and/or redesign of the Department=s current programs. This initiative is part of a DHHS-wide effort which will contribute to the President=s Initiative on Race.



Approximately 665,000 AIDS cases have been reported to the CDC, and approximately 400,000 people have died.

Preventing Tobacco Use Nationwide ($27.0 Million and 7 FTEs)

CDC will provide support in five areas. This will include expanding support to states and local health and education agencies to address tobacco use. CDC will work to: 1) implement Abest practices@ and evidence-based approaches learned from the National Cancer Institute=s ASSIST, CDC=s IMPACT programs, and other state tobacco control programs; 2) support a nationwide public-information campaign to deglamorize tobacco use, especially among young people, and for multiple strategies that address the psychosocial factors related to tobacco use; 3) enhance surveillance systems to monitor tobacco use, especially among youth and special populations; 4) expand research on the health risks of nicotine, additives, and other potentially toxic compounds in tobacco through investigation of additives; and 5) promote public policies that provide a clear message commensurate with the public health harm caused in the United States and worldwide by tobacco use, including policy research and diffusion of best practices globally.

Every day, 3,000 young people become regular smokers in the United States.

Syphilis Elimination ($5 million and 4 FTEs)

While the rates for syphilis have declined for all racial and ethnic groups, the 1997 primary and secondary rate for African Americans of 22.0 cases per 100,000 was 44 times greater than the rate for White Americans.

CDC will address syphilis elimination in the United States as outlined in CDC=s report to Congress, AElimination of Syphilis from the United States@ by assisting State and local health departments and community level partners throughout the U.S. through a multi-systems approach, which will include involving communities in the development and implementation of syphilis elimination plans, enhanced syphilis surveillance, outbreak response preparedness, and identification of critical prevention opportunities (e.g., correctional facilities, drug treatment centers, community based organizations). CDC currently anticipates that it may take a decade to achieve elimination given adequate resources. Syphilis, a relatively rare disease, has the potential of becoming an extremely rare health event in the future.

AKnow your HIV Status@ Campaign ($9.5 million and 5 FTEs)

Advances in HIV prevention and treatment make it more important than ever before for people to learn their HIV status. HIV testing provides a critical avenue to reach individuals at risk with prevention counseling and services, as well as to link infected individuals with needed care. This campaign will aim to increase the number of people who know their HIV infection status, particularly among those at high risk for infection

and within communities of color; develop appropriate referrals and prevention/care interventions for those infected; and decrease the stigma associated with HIV infection. Outreach projects in a variety of settings, including basic social systems (such as businesses, religious organizations, schools, etc), medical institutions and criminal justice facilities will be initiated.

Section 317 Vaccine Purchase ($60.0 million and 0 FTEs)

The Advisory Committee on Immunization Practices (ACIP) continues to recommend new and combined vaccines and expand current recommendations to further protect the health of our nation=s children. Changes in FY 2000 include licensure and subsequent recommendation for routine use of rotavirus vaccine. Other recent immunization schedule changes include routine use of varicella vaccine and catch-up vaccinations for hepatitis B and the second dose of MMR for adolescents who have not previously received the complete series. The ACIP has also recommended catch-up of all children kindergarten through 12th grade who had not previously received a second dose of MMR. More recent changes include expanding coverage for varicella vaccine to include susceptible children through 18 years of age and expanding coverage for hepatitis B vaccine to include all children through 18 years of age.

Widespread use of the rotavirus vaccine is expected to prevent 1.5 million cases of rotavirus diarrhea, up to 55,000 hospitalizations and 20-40 deaths annually.

IV. Work with Partners To Improve Global Health ($17 million and 15 FTEs)

Global Polio Eradication ($17.0 and 15 FTEs)

CDC will assist in bringing to a successful conclusion the global polio eradication effort by targeting immunization and surveillance activities toward the most difficult and war torn countries in Africa. Adequate surveillance for acute flaccid paralysis has not been established or maintained in many polio-endemic countries. Assistance will include training, operational research, assignment of short- and long-term consultants to WHO and national EPI offices to ensure capability to gather and analyze evaluation data.

PHYSICIAN COMPENSATION ALLOWANCE

The FY 2000 budget for HHS includes a physician compensation payroll policy of 6 percent growth per year. In effect, the policy guideline means that physician payroll in HHS would be held to 6 percent annual growth in FY 2000 and future years.

CHIEF FINANCIAL OFFICER (CFO) FY 1997 AUDIT REPORT

During FY 1998, CDC welcomed the opportunity to address the issues identified in our first audit **B** the FY 1997 audit. Despite challenges, including the fact that the FY 1997 audit was not completed until midway through FY 1998, CDC managed to address many of the audit issues. CDC expects that several issues will be resolved entirely including the reconciliation of personal property records to the general ledger, the monitoring of all Single Audit reports from grantees, and segregating data base administration and financial accounting system duties. CDC made significant progress on several other issues. For instance, CDC worked closely with HHS staff to develop a suitable methodology for accruing year-end grant expenses. The auditors are currently reviewing that methodology. CDC has also made progress in the area of reimbursable accounting. CDC will not be certain of the audit issues that remain until the audit opinion is received in February 1999. The agency continues to welcome the opportunity to improve accounting practices. CDC management remains committed to obtaining a clean audit opinion and firmly believes that it is important to follow proper accounting procedures and principles.

YEAR 2000 COMPLIANCE STATUS

CDC=s Year 2000 project is proceeding on schedule. All 229 major information systems have been remediated and greater than 90% have been independently validated and verified and placed into production operation. Work proceeds on assessing and remediating devices with embedded microchips including the IT infrastructure, laboratory equipment, PCs and servers, telecommunication devices, building and facility infrastructure. Agency funding in FY 2000 will be used for final phases of Year 2000 preparation including implementation of certain portions of the agency=s contingency plan, such as conducting extensive testing on January 1, 2000 and taking emergency actions to address any problems found.

CONCLUSION

CDC=s FY 2000 budget represents an effort to confront new public health challenges. CDC will continue to focus on new priority areas as they emerge thus continuing to be a leader and pioneer in improving public health at home and across the globe.

ALCASE

Tobacco Statement

The new decision by many states to agree to the settlement proposal by the US tobacco companies disturbs many of us who are concerned about lung cancer.

From the very beginning, the words "lung cancer" have been missing from the discussions. Maybe this is because the tobacco company executives have yet to admit that their products cause lung cancer and other tobacco-related illnesses.

I think it is primarily because there is a great need to keep lung cancer as the invisible disease.

As long as people with lung cancer aren't diagnosed in early stages, they can continue to be sent home to die, having been offered little or no treatment. Although in many cases the cost of treating early stage disease is less than treating advanced stage, the erroneous idea that early diagnosis will be more costly prevails. Is this, then, why in all of the discussions, federally and within the states that have settled, the words "lung cancer" fail to be mentioned?

Is this why other cancers are receiving dollars from settlements or from tobacco tax resources, while lung cancer receives nothing?

And, how much of our government's unwillingness to fund lung cancer research and early screening programs is because we as a nation foster the image that people with lung cancer caused their own disease and don't deserve early diagnosis or curative treatment?

We suggest that each and every one of you become an activist. Find out what is happening in your state, both to tobacco taxes collected and settlement dollars that will be distributed in the future. Write to your legislators at the state and federal levels.

Only when all of us become a major voice, demanding early screening and more research dollars for lung cancer, will there be any change.

My deepest gratitude to each of you who have helped ALCASE and the cause of lung cancer awareness and survivor support. It means so much to so many!

Peggy McCarthy, volunteer Executive Director

Cynthia Dailard 09/22/98 04:41:17 PM

Record Type: Record

To: Cynthia A. Rice/OPD/EOP, Nicole R. Rabner/WHO/EOP

cc:

Subject: California Tobacco Tax Initiative

Los Angeles Times, September 22, 1998

California voters appear ready to sanction casino-type gambling on the state's Indian lands and slap more tax on cigarettes to pay for early childhood development programs, according to a new Los Angeles Times poll.

At the same time, voters are less clear on whether they will grant themselves a utilities rate cut and force utilities to bear the full cost of debts associated with energy deregulation.

In partisan races, at least two incumbent Republicans, Secretary of State Bill Jones and Insurance Commissioner Chuck Quackenbush, face potentially strong challenges by, respectively, Democrats Michela Alioto and Diane Martinez.

Two Democratic state officeholders, Controller Kathleen Connell and state schools chief Delaine Eastin, are having an easier time against, respectively, Republicans Ruben Barrales and Gloria Matta Tuchman.

Three other statewide contests--for lieutenant governor, attorney general and treasurer--are essentially dead even.

However, typical for this stage of the campaign, these so-called down-ballot races are drawing little notice, as are the other nine largely uncontroversial and even arcane initiatives on the Nov. 3 ballot.

Asked their motivation for going to the polls, 35% of registered voters cited the assortment of statewide contests, 32% said there is no one thing to spur them to vote and 18% cited the closely matched governor's race between Republican Dan Lungren and Democrat Gray Davis.

The highest-profile initiative on the ballot and the one most familiar to registered voters was Proposition 5, dealing with Indian gaming. The focus of tens of millions of dollars of TV advertising, the measure would amend California law to allow casino-type gambling on Nod totribal lands.

After hearing a description of the measure, 57% of registered voters supported Proposition 5, 28% were opposed and 15% were undecided. Seventy-two percent of those who said they have visited an Indian casino supported the initiative, as did 52% of those who have never been.

Similarly, 71% of frequent gamblers and 63% of occasional gamblers backed the measure, as did 57% of those who rarely gamble and 51% who abstain.

"The pro-Proposition 5 forces, basing their arguments on economic development and Indian self-sufficiency, have clearly

done the better job so far of making their case," said Susan Pinkus, director of the Times Poll.

Also winning early voter support is Proposition 10, which would raise cigarette taxes 50 cents a pack to finance early childhood development programs. After hearing a description of the measure, 54% of registered voters backed it, 35% were opposed and 11% were undecided.

Voters were more evenly divided on Proposition 9, the electric utilities initiative. The measure would rewrite the state's electricity deregulation law to require a 20% rate cut and prevent utilities from charging customers $28 billion for the cost of nuclear plants and long-term purchase contracts.

After hearing a description of the measure, 36% of registered voters supported Proposition 9, 21% were opposed and 43% were undecided.

In the partisan contests, much seems to depend on who turns out on Nov. 3--an uncertain guess, given the current unsettled political climate. Moreover, most of the candidates on both sides--including incumbents--are largely a mystery to voters at this point.

In the race for lieutenant governor, state Assemblyman Cruz Bustamante (D-Fresno) leads state Sen. Tim Leslie (R-Tahoe City) 29% to 22% among registered voters. Among likely voters, however, the race was a statistical tie, with Leslie at 29% and Bustamante at 28%.

Similarly, in the race for attorney general, state Sen. Bill Lockyer (D-Hayward) leads Chief Deputy Atty. Gen. Dave Stirling, the GOP nominee, 31% to 25% among registered voters, but they are virtually tied, 31% to 30%, among likely voters.

In the race for treasurer, the contest is even among both registered and likely voters. Among registered voters, Democrat Phil Angelides has 27% support to 25% for state Assemblyman Curt Pringle (R-Garden Grove.) Pringle was slightly ahead among likely voters, 30% to 27%.

Two Republican incumbents could face tough reelection fights, depending on turnout.

Insurance Commissioner Quackenbush was essentially tied with state Assemblywoman Martinez (D-Monterey Park) among registered voters, 36% to 35%, but led by 42% to 34% among likely voters.

At the same time, Secretary of State Jones drew 28% to Alioto's 30% among registered voters, but held a 34% to 29% lead among likely voters.

Two incumbent Democrats, Controller Connell and Supt. of Public Instruction Eastin, were more comfortably ahead in their reelection bids.

Connell led San Mateo County Supervisor Barrales 38% to 22% among registered voters and 40% to 27% among likely voters. Eastin led Santa Ana teacher Matta Tuchman 24% to 10% among registered voters and 27% to 11% in the race for the nonpartisan office.

The Times Poll interviewed 1,651 Californians, including 1,270 registered voters, by telephone Sept. 12-17. Among them, 684 were deemed likely to vote. The margin of sampling error is plus or

minus 3 percentage points for registered voters and 4 percentage points for likely voters.

Cynthia -- August 24

Here is the Executive Summary of John Pierce's report on the California tobacco-control program, along with his upcoming September 9 JAMA article (embargoed), which summarizes the findings of the California study regarding adults. Pierce is currently negotiating with JAMA regarding an article on teens in California, so he has no idea when or whether the teen article will be published.

The California report looked at two periods in California -- from 1989-93, and 1993-96. Before 1993, the tobacco industry outspent the state by a ratio of 5:1. After 1993, that ratio rose to 10:1, due to reduced state spending on tobacco control efforts, and increased industry spending. The report indicated that during the initial period, there was a major decline in smoking rates, which tapered off during the latter period. Specifically, the report found:

Adult Smoking

- In 1989-93, adult smoking rates (prevalence and consumption) declined over 50% faster than previously, and over 40% faster than the rest of the country. In 1993-96, consumption slowed to only 34% of the rate of decline in the first period, and prevalence to only 15% of the earlier rate. In 1996, adult smoking prevalence was 18.1%.

Teen Smoking

- Adolescent (12-17 years) smoking prevalence remained stable during the first period, but increased 26.3% during period 2 to 12% in 1996. It is estimated that adolescent smoking rates will continue to rise through 1999.

ETS Exposure

- From 1990-96, the proportion of workers exposed to secondhand smoke decreased from 29% to 11.7% (a decrease of 60%). By 1996, over 90% of indoor workers had a smokefree workplace, compared to 35% in 1990 (an increase of 160%). Among children and adolescents, exposure to ETS in the home decreased from 29% in 1992 to 13% in 1996, a reduction of 55%.

-- Cynthia D.

UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

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TO: Cynthia Daillard
Fax: (202) 456-7431

FROM: Christine Hayes
Cancer Prevention and Control Program
University of California, San Diego
Telephone: (612) 622-1731, Ext. 1728
Fax: (612) 622-1745

SUBJECT: Executive Summary for Tobacco Control in California: Who's Winning the War? (evaluation of the California Tobacco Control Program, 1989-1996)

DATE: August 21, 1998

NUMBER OF PAGES (including cover sheet): 8

Cynthia:

At the request of Dr. John Pierce, I have attached a copy of the Executive Summary of the 1989-1996 evaluation report on the California Tobacco Control Program. If you do not receive all of the pages (pages I-i through I-vii) or have any questions, I can be reached via telephone at (619) 622-1731, Ext. 1728 or via e-mail at chayes@ucsd.edu.

PREFACE

The California Department of Health Services contracted with the University of California, San Diego, to conduct a series of California Tobacco Surveys and to provide an independent and scientific assessment of the progress of the California Tobacco Control Program. Any interpretations of data or conclusions expressed in this report are those of the authors and may not represent the views of the State of California.

A primary goal of the Tobacco Control Program is to reduce smoking among California adults and adolescents. Assessment of Program progress in meeting this goal involves an examination of trends in per capita cigarette consumption and smoking prevalence. Program effects must be distinguished from differences resulting from changes in the demographic profile of the California population. Standardized prevalence estimates were computed to adjust for demographic changes. An effective program would lead to a more rapid decline in smoking than existed previously or that occurred in the rest of the United States. Moreover, the effect should persist over time.

The analysis considered two periods in the Tobacco Control Program, suggested by changes in per capita cigarette consumption trends, standardized adult smoking prevalence estimates from the California Tobacco Surveys, and the relative level of funding for the Program and what the tobacco industry spends to promote smoking. Before fiscal year 1992-1993, the ratio of spending was 5:1 in favor of the tobacco industry and subsequently it was 10:1. The higher ratio resulted from reduced funding for the Tobacco Control Program and increased tobacco industry expenditures.

The first part of this executive summary presents a brief overview of the main evaluative outcomes relative to the California Tobacco Control Program: smoking behavior and exposure to secondhand tobacco smoke. Following this brief overview, trends in smoking behavior are discussed in more detail. Finally, other important findings, including those relating to secondhand smoke, are summarized under the five main tobacco control strategies identified by the Tobacco Education, Research, and Oversight Committee (TEROC).

OVERVIEW

The trends in per capita cigarette consumption and adult smoking prevalence indicate that the introduction of the California Tobacco Control Program led to an acceleration of the rate of decline in smoking, but that this effect was not maintained between 1993 and 1996.

Over the course of the Program, there has been a continued major decline in the level of exposure to secondhand tobacco smoke among Californians.

TRENDS IN SMOKING BEHAVIOR

In Period 1, from the start of the Program in January 1989 through June 1993, adult (18+ years) smoking prevalence and per capita cigarette consumption declined over 50% faster than previously, and over 40% faster than in the rest of the United States.

In Period 2, July 1993 through December 1996, the rate of decline in per capita cigarette consumption and adult prevalence slowed, consumption to only 34% of the rate of decline in Period 1, and prevalence to only 15% of the Period 1 rate. In Period 2, California no longer showed a greater rate of decline in prevalence than the rest of the United States. However, per capita cigarette consumption was constant in the rest of the United States. The 1996 California Tobacco Survey estimated that adult smoking prevalence was 18.1%.[1]

Adolescent (12-17 years) smoking prevalence in California remained stable in Period 1, but it increased 26.3% during Period 2 to 12.0% in 1996.[2] A detailed analysis of California data suggests that adolescent smoking prevalence will continue to increase through 1999.

Between 1993 and 1996, California smokers made considerable progress towards future successful cessation by decreasing consumption levels and increasing their quitting activity. A strong motivational tobacco control program may produce another major reduction in smoking prevalence.

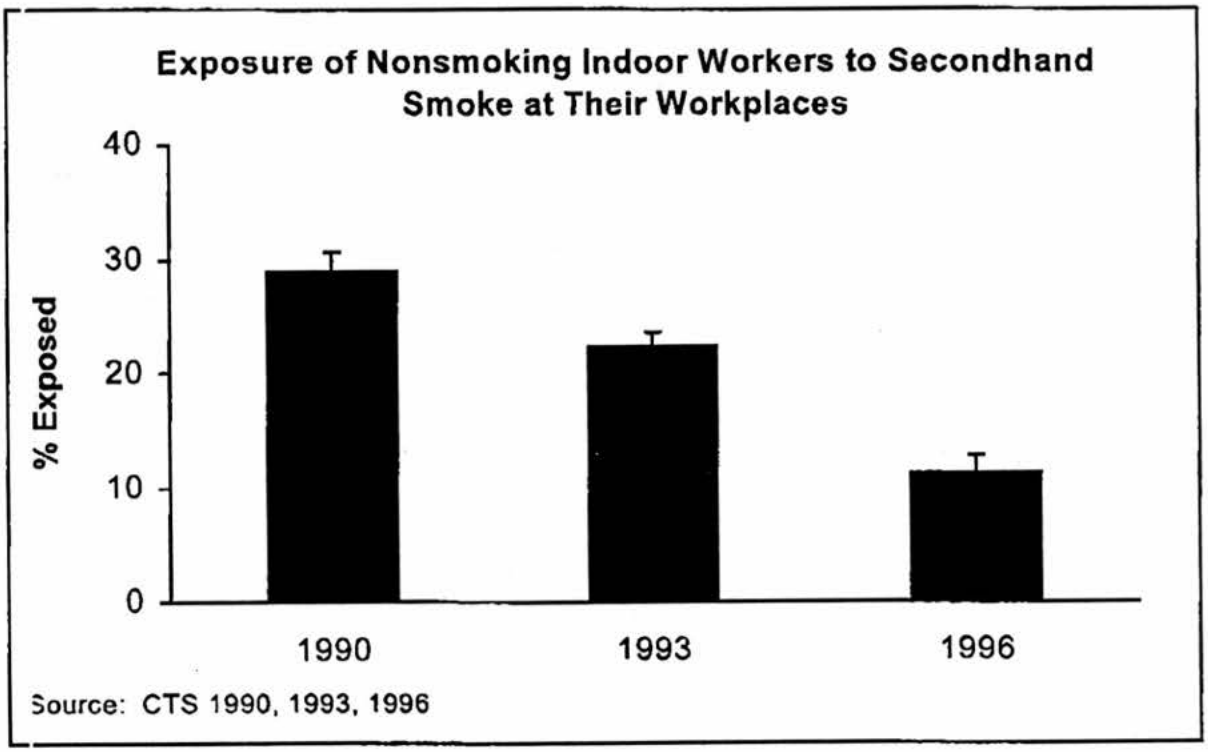
---

[1] The adult prevalence estimates from the California Tobacco Surveys were: 22.2% in 1990, 20.2% in 1993, and 18.1% in 1996. The standardized estimates were: 20.9% in 1990, 18.9% in 1993, and 18.1% in 1996.

[2] The adolescent smoking prevalence estimates from the surveys were: 9.2% in 1990 and 1993, and 12.0% in 1996. The standardized estimates were: 9.4% in 1990, 9.5% in 1993, and 12.0% in 1996.

EFFECTIVENESS OF CALIFORNIA TOBACCO CONTROL STRATEGIES

STRATEGY 1: PROTECT CALIFORNIANS FROM SECONDHAND SMOKE



- From 1990 to 1996, the proportion of indoor workers exposed to secondhand tobacco smoke at work decreased from 29% to 11.7%, a reduction by a factor of nearly 60%. (KF* 4.3)

- By 1996, over 90% of indoor workers had a smokefree workplace, compared to 35% in 1990, an increase by a factor of nearly 160%. (KF* 4.2)

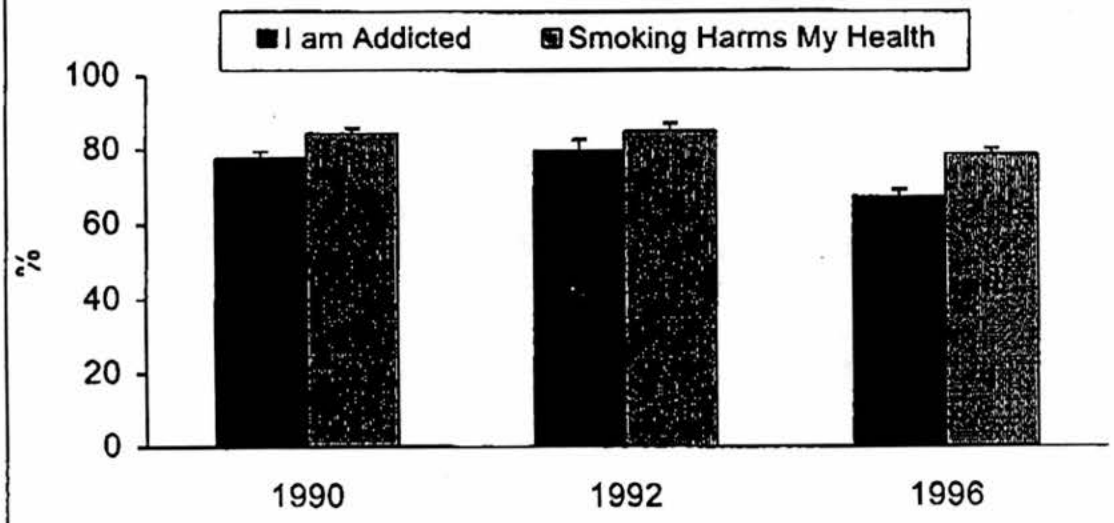
- Among California children and adolescents, exposure to secondhand tobacco smoke at home decreased from 29% in 1992 to 13% in 1996, a reduction by a factor of 55%. (KF* 2.11)

KF* = Key Findings, found on pages II-i to II-xvi.

EFFECTIVENESS OF CALIFORNIA TOBACCO CONTROL STRATEGIES

STRATEGY 2: TO EMPHASIZE THE ADDICTIVE NATURE OF TOBACCO, ITS HARMFUL HEALTH EFFECTS AND ITS UNATTRACTIVE FEATURES

Change in Beliefs about Addiction and Harm from Cigarettes among Current Smokers



Source: CTS 1990, 1992, 1996

- The percent of California smokers who believe they are addicted to smoking decreased significantly by a factor of 13% between 1990 and 1996, from 78% to 67%. The percent who agreed with the statement, "smoking is harming my own health," also decreased significantly, by a factor of 7%, from 84% in 1990 to 79% in 1996. (KF* 12.5a and 12.5b)

- However, the percent of California smokers who consume less than 15 cigarettes/day increased significantly by a factor of 26%, from 43.6% in 1990 to 55.1% in 1996. (KF* 6.5) Lighter smokers may be less likely to feel addicted or that they are harming their health.

- In 1996, 2.7% of California adults (>25 years) were "hard core" smokers; this represents less than 10% of all smokers. (KF* 6.1) This finding indicates that further significant decreases in smoking prevalence are possible.

KF*= Key Findings, found on pages II-i to II-xvi.

EFFECTIVENESS OF CALIFORNIA TOBACCO CONTROL STRATEGIES

STRATEGY 3: TO COUNTER EFFORTS OF THE TOBACCO INDUSTRY AND OTHERS TO PROMOTE TOBACCO USE

EFFECTIVENESS OF TOBACCO INDUSTRY ADVERTISING AND PROMOTION ACTIVITIES

- Between 1993 and 1996, receptivity to tobacco advertising and promotional activities increased among California teens. The percentage of teens owning a tobacco promotional item increased significantly, from 8.9% to 13.5%. (KF* 5.7)

- 34% of adolescent experimentation with cigarettes in California can be attributed to tobacco industry advertising and promotional activities. In 1996, over 200,000 California adolescents experimented with smoking; 68,000 did so because of tobacco industry advertising and promotions. (KF* 9.3)

- The marketing of cigars as symbols of sophistication and power is associated with significant increases in cigar use among California adults, from 2.5% in 1990 to 4.9% in 1996. Furthermore, in 1996, one in four teenage boys reported experimenting with cigars. (KF* 13.1 and 13.3)

EFFECTIVENESS OF THE TOBACCO CONTROL PROGRAM COUNTER-MARKETING

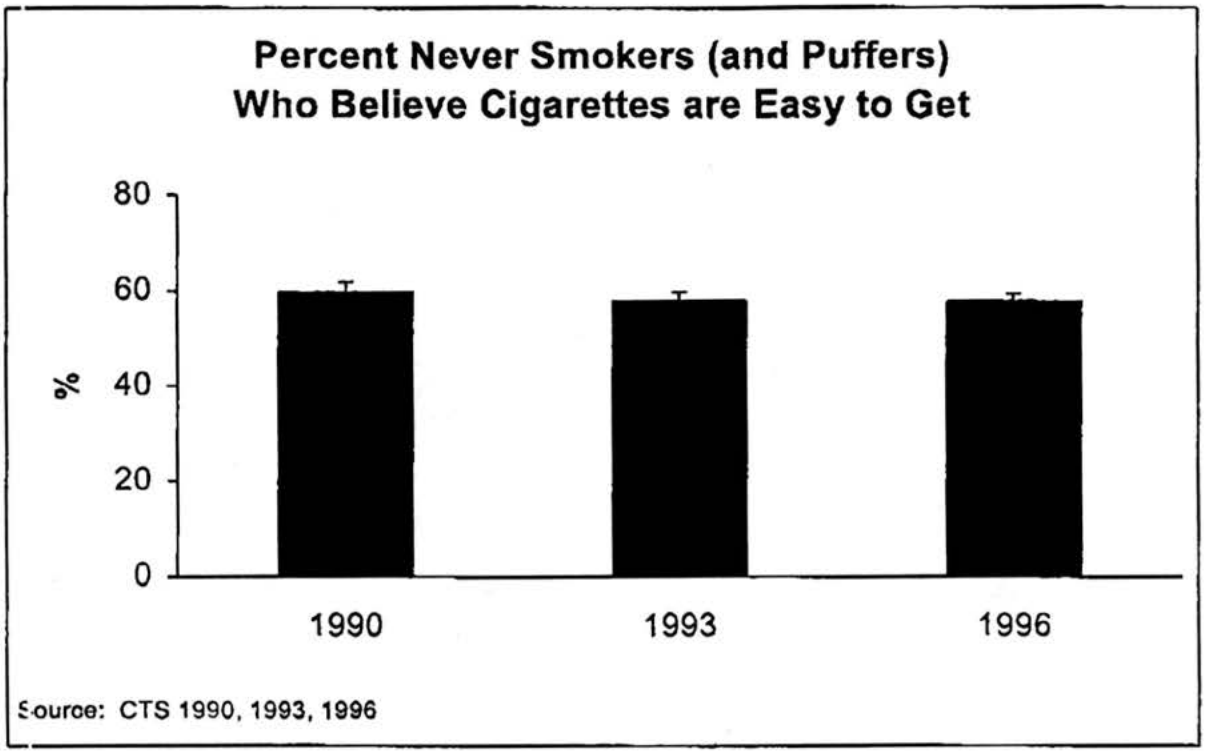
- In 1996, adults who recalled the media campaign were more likely to agree with messages used in the campaign. (KF* 9.9)

- Although inconsistently in the field, the mass media campaign was effective in getting smokers to seek help to quit. (KF* 9.6 and 9.7)

KF*= Key Findings, found on pages II-i to II-xvi.

EFFECTIVENESS OF CALIFORNIA TOBACCO CONTROL STRATEGIES

STRATEGY 4: WORK TO ELIMINATE THE AVAILABILITY OF TOBACCO PRODUCTS TO CHILDREN AND TEENS

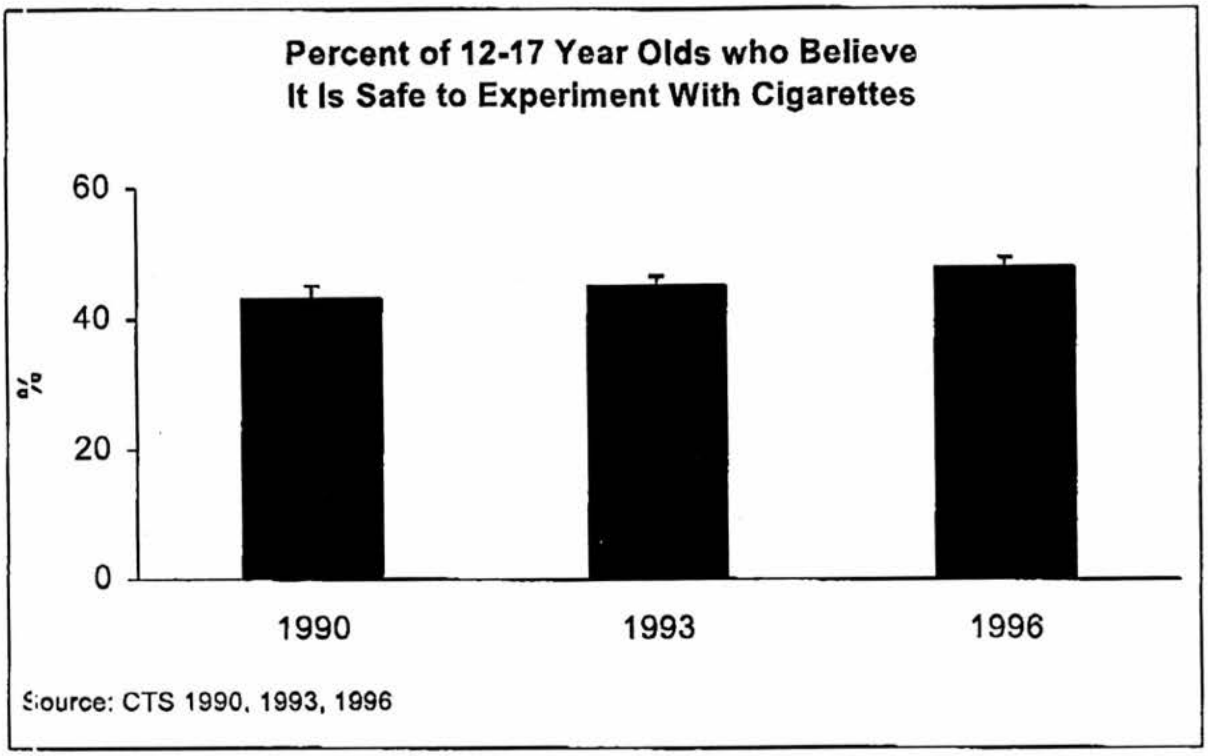


- Between 1990 and 1996, the percent of California teens who had either never smoked or only puffed on a cigarette believed cigarettes were "easy to get" did not change. In 1996, 57.8% of these teens held this belief. (KF* 10.2)
- In 1996,[1] 51.5% of teens believed it would be easy to buy a pack of cigarettes. (KF* 10.3)
- In 1996,[1] only 16% of teens who had ever smoked—or less than 5% of all teens—reported that they usually buy their own cigarettes. Another 20% reported that they usually ask someone else to buy cigarettes for them, and 58% reported that others usually give them the cigarettes they smoke. (KF* 10.1)

KF*= Key Findings, found on pages II-i to II-xvi.
[1] Data only available from the 1996 CTS.

EFFECTIVENESS OF CALIFORNIA TOBACCO CONTROL STRATEGIES

STRATEGY 5: TO PROVIDE YOUTH WITH TOBACCO-RELATED INFORMATION AND SKILLS



- In 1996, nearly half (48%) of teens (12-17 years old) believed it is safe to experiment with cigarettes, significantly more than the 43% who held this belief in 1990. (KF* 5.6)
- In 1996, fewer adolescents (41%) reported that teen smokers adhered to smokefree school policies than in 1990 (46%). (KF* 11.1)
- In 1996[1], the majority of students (57%) do not think that current health education classes are effective in dissuading adolescents from smoking. (KF* 11.6)
- Between 1993 and 1996, the percentage of 12-14 year old never smokers who were susceptible to smoking increased by a factor of 22%, from 34.5% to 42%. (KF*5.1)

KF*= Key Findings, found on pages II-i to II-xvi.
[1] Data only available from the 1996 CTS.

California in the early period than previously, and over 50% faster than in the rest of the United States. In the later period, the decline in California slowed to less than 30% of the early Program rate, and it ceased in the rest of the United States. Smoking prevalence showed a similar pattern, but in the later period, there was no significant decline in prevalence either in California or the rest of the United States.
>
>Conclusions. The initial effect of the Program to reduce smoking in California was subsequently lost. Possible reasons include reduced Program funding and increased tobacco industry expenditures for advertising and promotion and industry pricing and political activities. Urgent review by the public health community is needed so that the Program can be revitalized.
>

John Pierce <jppierce @ ucsd.edu>
08/21/98 01:49:22 PM

Record Type: Record

To: Cynthia Dailard/OPD/EOP

cc:
Subject: California Tobacco Control Program Evaluation

>Date: Tue, 18 Aug 1998 11:58:18 -0500
>To: cynthia_Daillard@opd.eop.gov
>From: John Pierce <jppierce@ucsd.edu>
>Subject: California Tobacco Control Program Evaluation
>X-Attachments:
I:\PASS2\REPORT96\FINAL-DECEMBER\KeyFind-ExecSum-Preface\Backup of
F_Pref&ExecSum(p1)jpp.wbk;
I:\PASS2\REPORT96\FINAL-DECEMBER\KeyFind-ExecSum-Preface\F_newExec_se.doc;
>
>Cynthia,
>
>Attached please find a copy of the executive summary which is in two word files. The first is the preface and the overview on prevalence and the second is the other main findings which include figures. The abstract for the JAMA paper on Sept 9 follows in this e-mail. Please note that this abstract is not for circulation and is embargoed by JAMA until Sept 8 at 10am. You do understand that our insistence on not altering the science led to the termination of our State contract to evaluate the campaign.
>
>John
>
>ABSTRACT for JAMA Sept 9 paper
>
>Context. Comprehensive community-wide tobacco control programs are considered appropriate public health approaches to reduce population smoking prevalence.
>
>Objective. To examine trends in smoking behavior before and following the California Tobacco Control Program, funded by a tobacco excise tax increase passed by voters in 1988 (Proposition 99).
>
>Design. Trends in per capita cigarette consumption and adult (18+ years) smoking prevalence for California were compared to those in the rest of the U.S. Per capita consumption (1983-1997) is from tobacco industry sales and population census figures. National and statewide population surveys provided the prevalence estimates (1978-1996). Trends are compared both before and after the Program began, with the post-Program period divided into two parts (early: 1989-1993, late: 1994-1996).
>
>Results. Per capita cigarette consumption declined over 50% faster in

California in the early period than previously, and over 50% faster than in the rest of the United States. In the later period, the decline in California slowed to less than 30% of the early Program rate, and it ceased in the rest of the United States. Smoking prevalence showed a similar pattern, but in the later period, there was no significant decline in prevalence either in California or the rest of the United States.
>
>Conclusions. The initial effect of the Program to reduce smoking in California was subsequently lost. Possible reasons include reduced Program funding and increased tobacco industry expenditures for advertising and promotion and industry pricing and political activities. Urgent review by the public health community is needed so that the Program can be revitalized.
>

California Children and Families Initiative

Rob Reiner, Chair

YES ON PROPOSITION 10 FACT SHEET

OVER A DECADE OF RESEARCH PROVES COST-EFFECTIVE INVESTMENTS IN CHILDREN AND ANTI-SMOKING PROGRAMS SAVE DOLLARS AND LIVES

- Early and comprehensive prenatal care saves $3 for every one dollar invested. *(U.S. House Select Committee on Children, Youth and Families, 1990, Brown and English 1994)*

- Every dollar invested in childhood immunizations saves, on average, $10 in costs for hospitalizations and other treatments. *(U.S. House Select Committee on Children, Youth and Families, 1990, Brown and English, 1994)*

- For each dollar spent for substance abuse treatment services, more than $11 are saved in social costs. *(U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, 1994)*

- Treatment of substance abusers in the California public system in 1991 saved $1.4 billion in reduced criminal activity and health care utilization over a two-year period - a 7 to 1 ratio of benefits to costs. (Report submitted to the State of California Department of Alcohol and Drug Programs, 1994; U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, 1994)

- High quality pre-school programs for at-risk children have demonstrated lasting benefits and a significant return on investment. A twenty-two year, longitudinal study of one such program found a net savings of $7.16 - including lower costs related to reduced special education and welfare costs and higher future worker productivity - for every dollar invested. *(U.S. Select Committee on Children, Youth and Families, 1990, High Scope Educational Research Foundation, 1993)*

- A study published by the Families and Work Institute showed that an investment of $10,000 per year for one child yields an estimated minimum savings to society of approximately $100,000 per child. These savings are reflected in reduced spending on special education, welfare and juvenile crime. *(Rethinking the Brain: New Insights Into Early Development, Appendix B)*

- The cost of providing smoking cessation help to the estimated 350,000 pregnant smokers seen in public health clinics would be approximately $1.75 million compared with an estimated $37 million in excess low birth weight costs, producing a cost-benefit ratio of $1 to $21. *(U.S. Select Committee on Children, Youth and Families, 1990)*

- California employers absorb more than $860 million each year in lost productivity due to smoking-related illnesses. *(California Department of Health Services)*

- Ten years ago, California voters approved Proposition 99, a twenty-five cent tax on cigarettes. Smoking decreased in California by one-third. Experts predict an additional decrease in smoking by 25 percent or more as a direct result of Proposition 10. According to studies by the National Cancer Policy Board and others, the decline is likely to be the greatest among teenage smokers who are the most sensitive to price increases.

California Children and Families Initiative, a Project of Forum for Early Childhood Development

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LEVEL 1 - 1 OF 1 STORY

NPR

SHOW: NPR ALL THINGS CONSIDERED (NPR 8:00 pm ET)

SEPTEMBER 22, 1998, TUESDAY

Transcript # 98092214-212

TYPE: PACKAGE

SECTION: News; Domestic

LENGTH: 1341 words

HEADLINE: California Anti-Tobacco

BYLINE: Robert Siegel, Washington DC; Mandalit delBarco, Lo

HIGHLIGHT:
NPR's Mandalit delBarco reports that California's anti-smokin advertising campaign was once a model for the nation, but critics say the rhetorical teeth have been taken out of the ads so as not to offend business. In turn, the rate at which Californians quit smoking has slowed.

BODY:

ROBERT SIEGEL, HOST: For the past decade, California's anti- smoking campaign has been a model for the rest of the country. The centerpiece of that campaign was a series of hard-edged television and radio ads aimed at stripping away smoking's glamorous image.

Some anti-tobacco activists say over the past few years those ads have become far tamer and far less effective in turning people away from smoking.

This month, state Senator Diane Watson held a hearing to look into those allegations.

From Los Angeles, NPR's Mandalit delBarco has the story.

MANDALIT DELBARCO, NPR REPORTER: One TV ad produced in 1990 for the state of California may be one of the most memorable anti-smoking commercials ever made.

(BEGIN AUDIO CLIP OF TV AD)

UNKNOWN ACTOR: Gentlemen, gentlemen, the tobacco industry has a very serious multi-billion dollar problem...

DELBARCO: It's supposed to depict tobacco company executives sitting around a smoke-filled boardroom.

UNKNOWN ACTOR: Every day, 2,000 Americans stop smoking. Another 1,100 also quit, actually, technically, they die. That means that this business needs 3,000 fresh new volunteers every day. So forget about all that: heart disease, cancer, emphysema, stroke stuff. We're not in this business for our health...

LAUGHTER

DELBARCO: By all accounts, the early commercials were hard hitting and confrontational. The first six years of the department's media campaign were deemed a success. Tobacco consumption in California reportedly dropped 43 percent. Nearly 2 million Californians quit smoking and cigarette sales dropped by more than a billion packs.

Those same successful ads air in other states today, courtesy of the Centers For Disease Control. But they're no longer played in California, which infuriates anti-smoking advocates like Dr. Stan Glance, (ph) who is a professor of medicine at the University of California, San Francisco. STAN GLANCE, PHYSICIAN, PROFESSOR, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; I mean, it was the biggest, most successful tobacco control program in the world. And it was the model for everywhere else. And they've wrecked it.

DELBARCO: The 'they' Dr. Glance refers to is Governor Pete Wilson and his administration. Glance is a member of the state's oversight committee that monitors the state's tobacco education program. During the hearing, he cited a newly published study in the "Journal of the American Medical Association" that shows that the slowdown in the decline of smoking coincided with efforts to weaken anti-smoking campaigns.

GLANCE: They used to run an aggressive program. When they stopped running it, the program stopped working. In 10 years, we could have essentially eliminated tobacco as a public health problem in California, had the Wilson administration not tied the hands of the advertising agency and the other public health advocates of the state.

DELBARCO: Glance refers to a policy change in 1994, the year Governor Pete Wilson ran unsuccessfully for president. That same year, funding for the anti-tobacco campaign was cut. Health and Welfare Secretary Sandra Smoley also banned the use of the words "tobacco industry" or "addiction" in the state's anti-smoking commercials.

Today, money earmarked for the media campaign has been restored, but the ad agency is now forbidden to use other words and images. That's what health department deputy director James Straton (ph) testified before State Senator Diane Watson.

DIANE WATSON (D), STATE SENATOR, CALIFORNIA: Are there specific words or themes or images which the department prohibits in its advertising? Yes, no?

JAMES STRATON, DEPUTY DIRECTOR, CALIFORNIA HEALTH AND WELFARE DEPARTMENT: Secretary Smoley has indicated...

WATSON: Yes, no?

STRATON: Yes.

WATSON: OK, now can you talk about them?

STRATON: Yes.

WATSON: All right, would you explain now what words cannot be used, or themes that cannot be used.

STRATON: Secretary...

WATSON: Can you talk about those?

STRATON: Yes.

WATSON: OK, thank you. STRATON: Secretary Smoley has expressed a distaste for calling people liars and to...

WATSON: All right, so the word "liar" cannot be used. All right, that's one. OK. I understand.

STRATON: OK. She has also expressed a concern about directly attacking and vilifying tobacco industry executives because she thinks it sends a basic anti-business message.

DELBARCO: Straton denied the policy has anything to do with support for the tobacco industry. In fact, he says while cigarette advertising in California has increased, the department's anti-smoking ads have begun new, more sophisticated messages about second hand smoke and manipulating young people into smoking.

STRATON: They're very tough. They're very direct. They name the tobacco industry and the specific things that they're doing that are wrong and need to stop.

DELBARCO: A commercial last year featured a woman who was still addicted to smoking despite the illness it caused her. She takes a puff of a cigarette through her voice box, a hole in her throat.

Another brand new TV ad depicts a beautiful woman at a black tie party who becomes disinterested in a sophisticated man when a cigarette suddenly goes limp.

(BEGIN AUDIO CLIP FOR TV AD)

UNKNOWN ACTRESS: Now that medical researchers believe cigarettes are a leading cause of impotence...

DELBARCO: Dr. Straton says this is the type of message that works today.

STRATON: Calling attention to young macho men that think smoking is cool and sexy will cut to the heart of the sophisticated image that the tobacco industry

is trying to convey. And people will certainly think twice before smoking.

DELBARCO: During the legislative hearing, the maker of those ads said they tried an even stronger approach, but the health department rejected 80 percent of their ideas.

CHRISTINE STEEL (ph), AD AGENCY EXECUTIVE: We feel we developed incredibly strong work and presented that work and then it wasn't approved. It wasn't really anything on our end that we believe we could do better.

DELBARCA: Christine Steel and Joel Hochberg (ph) of Asher & Partners Advertising were rather guarded with their answers. They're still under contract with the health department and are prohibited from talking about ads that haven't made it on the air.

But Senator Watson continued to probe. WATSON: If you had the kind of openness, could your ads have been more expansive and been more effective?

JOEL HOCHBERG, ADD AGENCY EXECUTIVE: We believe so, yes.

STEEL: Definitely.

DELBARCO: Dr. Straton says some of their ideas were rejected because they were over the top. For example, one ad would have show an pile of dead bodies representing people killed by cigars and cigarettes.

STRATON: For a state health department to do a television ad that would depict something that gruesome would be an inappropriate use of taxpayer dollars.

DELBARCO: Straton says there's simply a difference of opinion between the health department and anti-smoking advocates about how best to counter tobacco messages. During the hearing, Senator Watson said she would begin drafting legislation to make sure California's anti-smoking program is scrutinized for its effectiveness.

Mandalit delBarco, NPR News, Los Angeles.

This is a rush transcript. This copy may not be in its final form and may be updated.

TO PURCHASE AN AUDIOTAPE OF THIS PIECE, PLEASE CALL 888-NPR-NEWS

LANGUAGE: ENGLISH

LOAD-DATE: September 22, 1998

PROPOSITION 10

Date: July 19, 1998

State and County Early Childhood Development Programs. Additional Tobacco Surtax. Initiative Constitutional Amendment and Statute.
Proponent: Rob Reiner

BALLOT LABEL

STATE AND COUNTY EARLY CHILDHOOD DEVELOPMENT PROGRAMS. ADDITIONAL TOBACCO SURTAX. INITIATIVE CONSTITUTIONAL AMENDMENT AND STATUTE.

Creates state and county commissions to establish early childhood development and smoking prevention programs. Imposes additional taxes on cigarettes and tobacco products. Fiscal Impact: New revenues and expenditures of $400 million in 1998-99 and $750 million annually. Reduced revenues for Proposition 99 programs of $18 million in 1998-99 and $7 million annually. Other minor revenue increases and potential unknown savings.

SUBJECT TO COUR
ORDERED CHANGE

Proposition 10
State and County Early Childhood Development Programs.
Additional Tobacco Surtax.
Initiative Constitutional Amendment and Statute.

Yes/No Statement

- A YES vote on this measure means: Excise taxes would be increased on cigarettes by 50 cents per pack and on other tobacco products by the equivalent of $1 per pack. The increased revenues would primarily fund early childhood development programs administered by a new state commission and county commissions.

- A NO vote on this measure means: Excise taxes on cigarettes and other tobacco products would not be increased and, therefore, these new revenues would not be raised for early childhood development programs.

SUBJECT TO COURT ORDERED CHANGES

BALLOT PAMPHLET SUMMARY INFORMATION

Argument In (favor) against (circle one) proposition 10.

Text (50 words) of summary argument:

Provides child immunizations, health care, nutrition services, domestic violence prevention and treatment for pre-school children. *Doubles* dollars available for anti-smoking education. Funds Breast Cancer research. Endorsed by: American Cancer Society, California School Boards Association, teachers and children's advocates. *Don't be fooled by tobacco industry lies.* Vote YES on 10.

"Whom to Contact for More Information".

California Children and Families Initiative
Rob Reiner, Chair
1875 Century Park East, Suite 300
Los Angeles, CA 90067
Phone: 1-800-847-4743 or 213-627-5140 or 310-285-2328
FAX: 213-627-5709 or 310-205-2721
E-Mail: children98@aol.com
WEBSITE: http://www.children98.org

SUBJECT TO COUR
ORDERED CHANGE

Ballot Measure Summary Arguments - CON

Committee Against Unfair Taxes – No on Proposition 10

Opposed by California education officials and taxpayer advocates. *Amends Constitution* to keep funds from California's schools. *Duplicates existing programs for children and families.* Creates huge new bureaucracy; *59 new commissions, thousands of new bureaucrats and over 500 political appointees* to spend millions of taxpayer dollars with no independent oversight.

[redacted] P. 1

[redacted]

SUBJECT TO COUR
ORDERED CHANGES

[redacted]

Carol,

Barry Cadden just called me and asked me to send the following information over to you for the [redacted] section of the ballot pamphlet.

Who to contact for No on Proposition 10:

Committee Against Unfair Taxes
555 Capitol Mall, Suite 600
Sacramento, CA 95814
916-446-6667
www.defeatprop10.com

PROPOSITION 10
State and County Early Childhood Development Programs. Additional Tobacco Surtax. Initiative Constitutional Amendment and Statute.
Proponent: Rob Reiner

Date: July 17, 1998

SUBJECT TO COUR
ORDERED CHANGES

BALLOT TITLE AND SUMMARY

STATE AND COUNTY EARLY CHILDHOOD DEVELOPMENT PROGRAMS. ADDITIONAL TOBACCO SURTAX. INITIATIVE CONSTITUTIONAL AMENDMENT AND STATUTE.

- Creates state commission to provide information and materials and to formulate guidelines for establishment of comprehensive early childhood development and smoking prevention programs.
- Creates county commissions to develop strategic plans with emphasis on new programs.
- Creates trust fund for these programs. Funding for state and county commissions and programs raised by additional $.50 per pack tax on cigarette distributors and equivalent increase in state tax on distributed tobacco products.
- Funds exempt from Proposition 98 requirement that dedicates portion of general tax revenues to schools.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact:

- Raises new revenues of approximately $400 million in 1998-99 and $750 million annually thereafter for the California Children and Families First Program, to be allocated primarily to new state and county commissions for early childhood development programs.
- Results in reduced revenues for Proposition 99 health care and resources programs of about $18 million in 1998-99 and $7 million annually thereafter.
- Results in increased state General Fund revenues of about $2 million in 1998-99 and $4 million annually thereafter. Results in increased county General Fund revenues of about $3 million in 1998-99 and $6 million annually thereafter.
- Potential unknown long-term savings in state and local health, education, and other programs.

ANALYSIS BY THE LEGISLATIVE ANALYST

SUBJECT TO COURT ORDERED CHANGES

Legislative Analyst's Office
July 17, 1998 (12:55PM)
FINAL

Proposition 10
State and County Early Childhood Development Programs.
Additional Tobacco Surtax.
Initiative Constitutional Amendment and Statute.

Background

Early Childhood Development Programs. Currently, state and local governments administer a variety of early childhood development programs, such as the Head Start Program, the State Preschool Program, and the Early Mental Health Initiative. In general, these types of programs focus on the social, emotional, and/or cognitive development of young children.

Tobacco Taxes. Current state law imposes an excise tax on cigarettes, which amounts to 37 cents for each pack. Of this amount, 25 cents is allocated to the Cigarette and Tobacco Products Surtax Fund (established by Proposition 99 of 1988), 10 cents is allocated for state General Fund purposes, and 2 cents is allocated to the Breast Cancer Fund. Cigarette and Tobacco Products Surtax Fund monies are earmarked for programs to reduce smoking, to provide health care services to indigents, to support tobacco-related research, and to fund resources programs (primarily in the Departments of Fish and Game and Parks and Recreation). The Breast Cancer Fund supports research and services related to breast cancer.

Current state law also imposes an excise tax on other tobacco products—such as cigars, chewing tobacco, pipe tobacco, and snuff. This excise tax is equivalent to the excise tax on cigarettes (if both taxes were calculated as a percentage of the wholesale costs of these products). All of these tax revenues are allocated to the Cigarette and Tobacco Products Surtax Fund for Proposition 99 programs.

Cigarette and tobacco product taxes are administered by the State Board of Equalization. In 1997-98, these state excise taxes generated about $450 million for Proposition 99 programs, $33 million for the Breast Cancer Fund, and $165 million for the General Fund.

In addition to the state excise tax, there is currently a *federal* excise tax on cigarettes of 24 cents per pack, as well as federal excise taxes (in varying amounts) on other tobacco products.

Proposal

Revenues

This measure imposes an additional excise tax on cigarettes of 50 cents per pack. The total state excise tax, therefore, would be 87 cents per pack.

The measure also increases the excise tax on other types of tobacco products—such as cigars, chewing tobacco, pipe tobacco, and snuff—in two ways:

- The measure imposes a *new* excise tax on these products that is equivalent (the same percentage in relation to the wholesale costs of these products) to a 50 cent per pack tax on cigarettes.

- Under current law, any increase in the tax on cigarettes automatically triggers an increase in the tax on other tobacco products. As a result, the measure increases the *existing* excise tax on these products by the equivalent of a 50 cent per pack increase in the tax on cigarettes, in addition to the amount above.

Thus, the measure increases the excise taxes on other tobacco products in total by the equivalent of a $1 per pack increase in the tax on cigarettes.

The measure requires that the revenues generated by the *new* excise taxes on cigarettes and other tobacco products be placed in a new special fund—the California Children and Families First Trust Fund. These revenues would:

- Fund early childhood development programs (described below).

- Offset revenue losses to Proposition 99 health education or research programs and Breast Cancer Fund programs. (As discussed in more detail later in this analysis, the revenue losses are the result of decreased sales due to the excise taxes imposed by this measure.)

The revenues resulting from the increase in the *existing* excise tax on other tobacco products would be placed in the Cigarette and Tobacco Products Surtax Fund (for Proposition 99 programs).

The additional excise tax on cigarettes would begin January 1, 1999. The increase in the excise tax on other tobacco products would begin July 1, 1999.

Expenditures

The measure establishes the California Children and Families First Program to promote and develop early childhood development programs. The program would be funded by the revenues resulting from the increased tax on cigarettes and other tobacco products. The new program would be carried out by state and county commissions.

State Commission. The measure creates a new state commission—the California Children and Families First Commission—which would be responsible for administration of the early childhood development program. The commission would be composed of seven voting members (appointed by the Governor, the Speaker of the Assembly, and the Senate Rules Committee) and two ex officio nonvoting members.

The commission would develop statewide program guidelines, distribute educational materials, provide technical assistance to the county commissions, and conduct research and evaluations of early childhood development programs. The program guidelines must address parenting education and related support services; the availability and provision of high quality, accessible, and affordable child care; and the provision of specified types of child health care and prenatal and postnatal maternal health care services.

Twenty percent of the available revenues would be allocated to the state commission, to be spent for the following purposes:

- *Mass Media Communications.* Six percent for mass media communications to the general public related to: methods of child nurturing and parenting which encourage proper childhood development; the selection of child care; health and social services; the prevention of tobacco, alcohol, and drug use by pregnant women; and the detrimental effects of secondhand smoke on early childhood development.

- *Education.* Five percent for the development of educational materials and parental and professional education and training.

- *Child Care.* Three percent for programs related to the education and training of child care providers and the development of educational materials and guidelines for child care workers.

- *Research.* Three percent for early childhood development research and for evaluating such programs and services.

- *Administration.* One percent for the administrative functions of the California Children and Families First Commission.

- *General Purposes.* The remaining 2 percent may be used for any of the specific purposes described above, except for the administrative costs of the commission.

County Commissions. Eighty percent of the available revenues would be allocated to counties that create county commissions (consisting of five to nine members appointed by the county board of supervisors) to implement programs in accordance with strategic plans to support and improve early childhood development in the county. The formula for allocating these funds is based on the number of births in each participating county. The strategic plans must be consistent with guidelines adopted by the state commission. Two or more counties could form a joint county commission, adopt a joint county strategic plan, or implement joint programs, services, or projects.

The measure requires that funds be used to supplement and not replace existing service levels. In addition, the measure amends the California Constitution to provide that (1) the new tax revenues shall not be considered General Fund revenues for the purposes of determining the level of funding to be provided for public schools pursuant to Proposition 98 of 1988, and (2) the appropriation of revenues from the additional taxes imposed by the measure shall not be subject to the existing state or local appropriations limits. (Current law places limits on the level of certain appropriations made by the state and local governments.)

Fiscal Effect

New Revenues and Expenditures—The California Children and Families First Trust Fund. The measure would raise revenues of approximately $400 million in 1998-99 (half year) and about $750 million in 1999-00 (first full year), and slightly declining amounts annually thereafter, for the new California Children and Families First Trust Fund.

This estimate assumes that the distributors of cigarettes and other tobacco products would likely pass the full amount of the tax increase along to consumers in the form of higher prices. This, in turn, is likely to cause a decrease in taxable sales within the state for two reasons:

- First, it would result in a decrease in consumption of tobacco products within the state.
- Second, it is likely to result in some increase in out-of-state sales of tobacco products, some of which would be subsequently brought back into the state, and would not be taxed

This decrease in sales would reduce revenues from existing state excise taxes on tobacco products for the Breast Cancer Fund and the Cigarette and Tobacco Products Surtax Fund.

Most of the revenues generated by this measure would be available to fund the costs of the California Children and Families First Program. This includes the administrative costs for the new state and county commissions and the costs of program activities. Additionally, a small amount of the new revenues (less than 1 percent) would be used to offset revenue losses to the Breast Cancer Fund. Also, about 2 percent of the new revenues would be used to offset losses to the Cigarette and Tobacco Product Surtax Fund in 1998-99, and less than 1 percent in subsequent years, as discussed below.

Other Costs. The State Board of Equalization would incur administration and enforcement costs, related to the additional excise taxes, of about $800,000 in 1998-99, $850,000 in 1999-00, and $600,000 annually thereafter. These costs would be reimbursed out of the proceeds of the new taxes.

Effect on Cigarette and Tobacco Products Surtax Fund Revenues. The measure would result in a decrease in revenues to the Cigarette and Tobacco Products Surtax

SUBJECT TO COURT ORDERED CHANGES

Fund (Proposition 99). The decrease is due to two offsetting factors. First, to the extent that the measure results in a reduction in overall tobacco product sales, it would *decrease* the revenues resulting from the existing excise taxes on these products. Second, the measure would *increase* the revenues resulting from the *existing* excise tax on other tobacco products (cigars, snuff, etc.) that are allocated to the Cigarette and Tobacco Products Surtax Fund. As noted above, this occurs because the measure triggers an increase in this existing excise tax.

The measure requires that the revenue losses to Proposition 99 health-related education and research programs be offset by revenues resulting from the new excise taxes established by this measure. However, revenue reductions to Proposition 99 health care and resources programs would not be offset. We estimate net revenue losses of about $18 million in 1998-99 and $7 million annually thereafter for Proposition 99 health care and resources programs.

Effect on the State General Fund and Local Tax Revenues. The measure would result in a net increase in state General Fund revenues of about $2 million in 1998-99 and $4 million annually thereafter. These net increases are due to the measure's effect on: (1) sales tax revenues (which increase because the measure would increase the price of tobacco products) and (2) existing cigarette excise tax revenues (which would decrease due to reduced sales). Also, there would be a net increase in local government sales tax revenues of about $3 million in 1998-99 and $6 million annually thereafter.

Potential Long-Term Savings. The use of tobacco products has been linked to various adverse health effects by the United States Surgeon General and numerous scientific studies. The state and local governments incur costs for providing (1) health care for low-income persons and (2) health insurance coverage for state and local government employees. Consequently, changes in state law that affect the health of the general populace—and low-income persons and public employees in particular—would affect publicly funded health care costs. To the extent that this measure results in a decrease in the consumption of tobacco products, it would probably reduce state and local health care costs over the long term. The magnitude of these savings is unknown.

Due to the potential effects of the additional expenditures on early childhood development programs, the measure also could result in state and local savings over the long term in programs such as special education. The amount of such potential savings is unknown.

YES on Proposition 10
Ballot Argument For
400 Words

PROPOSITION 10 WILL GIVE OUR YOUNGEST CHILDREN THE HEALTHY FOUNDATION THEY NEED TO SUCCEED – IN SCHOOL AND IN LIFE.

Scientific evidence proves that the care a child receives from the prenatal through the first years of life is critical to the child's brain growth and development. It has a profound effect upon whether the child will become a productive, well-adjusted adult.

Billions are spent on remedial education and social services for children after they enter school. For too many children, this is too late.

PROPOSITION 10 WILL PROVIDE COMPREHENSIVE, INTEGRATED SERVICES FOR PRE-SCHOOL CHILDREN INCLUDING:

- Child immunizations, vision and hearing tests
- Prenatal and postnatal maternal and infant nutrition services
- Domestic violence intervention, prevention and treatment
- Treatment for children suffering from problems related to drug and alcohol abuse
- Child care, health care and social services not provided by existing programs

PROPOSITION 10 WILL MORE THAN DOUBLE CALIFORNIA'S ABILITY TO EDUCATE THE PUBLIC TO STOP SMOKING.

Smoking by pregnant women threatens the health and normal development of children. Smoking during pregnancy accounts for an estimated 20-30 percent of pre-term deliveries and increases the risk of sudden infant death syndrome.

Proposition 10 will more than double the dollars available for California's anti-smoking mass media campaign with a special emphasis on stopping smoking by pregnant women and parents of young children. It will also protect funding for breast cancer research.

SUBJECT TO COURT ORDERED CHANGES

SUBJECT TO COURT
ORDERED CHANGES

PROPOSITION 10 IS FOR LOCAL CONTROL -- NOT BIG GOVERNMENT.

80% of the money will go directly to counties. A local commission including experts in health care, education and child care will spend the money on programs that meet the priorities of parents in each community.

20% of the money will go to statewide programs including anti-smoking and parental education programs.

PROPOSITION 10 FUNDS ARE AUDITED ANNUALLY TO ASSURE ACCOUNTABILITY.

Section 130150 of the initiative requires an annual audit by the state and county commissions which must include "... the manner in which funds were expended, the progress toward and achievement of program goals and objectives, and the measurement of specific outcomes through appropriate reliable indicators ..." THESE AUDITS WILL BE MADE PUBLIC.

PROPOSITION 10 IS ENDORSED BY LEADING HEALTH CARE, CHILD CARE, EDUCATION AND COMMUNITY GROUPS INCLUDING:

American Cancer Society, California Division
American Heart Association of California
American Lung Association of California
California Medical Association
California School Boards Association
California Consortium To Prevent Child Abuse
California Child Care Resource and Referral Network
California Association of Catholic Hospitals
National Council of Jewish Women
National Black Child Development Institute
Los Ninos Child Development Center
Asian Family Resource Center

PROPOSITION 10 IS ENDORSED BY LEADERS FROM BOTH POLITICAL PARTIES.

Los Angeles Mayor Richard Riordan, Republican
San Francisco Mayor Willie Brown, Jr., Democrat
Businessman and Former Congressman Mike Huffington, Republican
U.S. Senator Barbara Boxer, Democrat

Proposition 10 is opposed by the tobacco industry, their front groups and the politicians who follow their agenda. A YES VOTE ON PROPOSITION 10 IS A VOTE FOR OUR CHILDREN AND AGAINST THE TOBACCO INDUSTRY.

/s/

Rob Reiner
~~Founder and~~ Chairman
I Am Your Child Campaign

Alan Henderson, Dr PH
President
American Cancer Society,
California Division

John D'Amelio
President
California School Boards Association

SUBJECT TO COURT ORDERED CHANGES

Rebuttal Argument from the Committee Against [illegible] Proposition 10

PROPOSITION 10

Proposition 10 is a badly flawed initiative. Its language provides for no specific Early Childhood Development programs. Instead it creates 59 NEW STATE AND COUNTY COMMISSIONS, which in turn are AUTHORIZED TO SPEND HUNDREDS-OF-MILLIONS OF NEW TAX DOLLARS ON UNSPECIFIED NEW SOCIAL PROGRAMS.

Proposition 10 AUTHORIZES THE CREATION OF OVER 500 NEW POLITICAL APPOINTEES AND COULD LEAD TO A STAFF OF 8000 to serve them. Proposition 10 even exempts the staff and employees of these new commissions from California's civil service laws. This initiative is A DREAM COME TRUE FOR AMBITIOUS POLITICIANS AND THEIR POLITICAL OPERATIVES: THOUSANDS OF NEW PATRONAGE JOBS AT TAXPAYERS EXPENSE!

PROPOSITION 10's "SELF-AUDITING" PROVISION ALLOWS THESE POLITICAL APPOINTEES TO AUDIT THEMSELVES; *WITHOUT ANY INDEPENDENT OVERSIGHT.* THEY ARE ACCOUNTABLE TO NO ONE!

PROPOSITION 10 DEPRIVES BREAST CANCER RESEARCH AND TEEN SMOKING PROGRAMS OF MILLIONS OF DOLLARS. The Legislative Analyst's official fiscal analysis estimates Proposition 10 would wipe out millions in funds annually for health care programs such as breast cancer research.

Proposition 10 even goes to the extreme of exempting itself from the constitutional requirements of Proposition 98 that 40% of new tax dollars fund schools. The net effect is THAT PROPOSITION 10 RAISES $700 MILLION IN NEW TAXES, YET CALIFORNIA'S SCHOOLS DON'T GET THEIR FAIR SHARE!

Proposition 10 amounts to ONE OF THE LARGEST TAX INCREASES ON POOR PEOPLE IN ~~THE HISTORY OF CALIFORNIA~~ CALIFORNIA, WITH NO GUARANTEES THAT ANY OF THIS MONEY WILL END UP IN OUR COMMUNITIES. Vote no to more wasteful government.

William Campbell
President Emeritus, California Manufacturers Association

Francesca Felizzatto
School Teacher

Ramon Rodriguez
Small Business Owner

SUBJECT TO COURT ORDERED CHANGES

California education officials, taxpayer advocates and leading government watchdogs have determined that Proposition 10 is not what it claims to be. Proposition 10 is *harmful* to California's schools and *actually takes money away from* existing state programs that benefit children and families. It raises *hundreds of millions in new taxes, creates a massive new state bureaucracy*, but *spends almost all of the new money on programs that have nothing to do with smoking or tobacco related issues.*

PROPOSITION 10 CREATES A NEW STATE COMMISSION, AND 58 SEPARATE COUNTY COMMISSIONS. Thousands of new bureaucrats, controlled by over 500 new political appointees, would spend millions of new tax dollars on new programs that have nothing to do with anti-smoking or breast cancer research programs.

Proposition 10 directs millions of new tax dollars to UNSPECIFIED Child Development programs; GRANTING OPEN-ENDED AUTHORITY TO BUREAUCRATS AND POLITCAL APPOINTEES TO SPEND MILLIONS WITHOUT ANY OUTSIDE CONTROL.

PROPOSITION 10 REDUCES MONEY FOR BREAST CANCER RESEARCH. Proposition 10 would *divert current tobacco tax revenue that funds critical research on breast cancer* at the University of California and *turn it over to new bureaucracies that have nothing to do with tobacco issues.*

PROPOSITION 10 HURTS CURRENT PROGRAMS TO COMBAT TEEN SMOKING. Proposition 10 would actually take money away from Proposition 99 tobacco tax programs that fund anti-tobacco advertising, designed to curb teen smoking. If passed, Proposition X would raise millions in new tobacco tax dollars, yet it would actually *decrease* the amount of money spent to stop children from smoking.

PROPOSITION 10 ROBS FUNDING FROM CALIFORNIA'S SCHOOLS. PROPOSITION 10 ACTUALLY *AMENDS THE CONSTITUTION* IN ORDER TO CIRCUMVENT PROPOSITION 98. Proposition 98, approved by voters, ensures California schools receive a fair share of all state revenues in order to meet their basic funding needs. Despite the huge tax increases, Proposition 10 *explicitly exempts any of the new money from going to California schools.* UNDER PROPOSITION 10, CALIFORNIA SCHOOLS GET NOTHING FROM THIS NEW TAX.

SUBJECT TO COURT ORDERED CHANGES

PROPOSITION X EXEMPTS ITSELF FROM THE CONSTITUTIONAL LIMIT ON STATE SPENDING. Proposition X shields its massive bureaucracies from constitutional limits on all state spending. By amending the constitution, Proposition X purposefully avoids the constitutional spending limit previously approved by California voters. Proposition X will result in UNCONTROLLED SPENDING, WITH TAXPAYERS LEFT TO PAY THE BILL.

PROPOSITION X UNFAIRLY TARGETS POOR TAXPAYERS AND MINORITY TAXPAYERS. Proposition X is a *regressive tax that singles out poor and minority Californians* to pay the greatest share of the cost of this new government bureaucracy. Like any tax on business, this tax is passed on to the consumer. *So poor people are going to pay disproportionately more* for the thousands of new bureaucrats and their programs that have nothing to do with stopping smoking or breast cancer research.

Proposition X is a sham. It's bad for California's families, bad for California's children, bad for California's taxpayers and bad for California's schools. Taxpayer advocates, educators, and healthcare professionals urge you to VOTE NO ON PROPOSITION X.

Jane Armstrong
State Chairman, Alliance of California Taxpayers & Involved Voters

Helena Rutowski
Member, Westminster School Board

Dr. Ken Williams
Family physician

SUBJECT TO COURT ORDERED CHANGES

Rebuttal Argument For Proposition 10

THE TOBACCO INDUSTRY IS FUNDING THE CAMPAIGN AGAINST PROPOSITION 10.

Official reports list the opposition as "sponsored by tobacco companies," including Philip Morris, RJ Reynolds, Lorillard Tobacco and Brown & Williamson. Smoking decreased 32% in California after voters approved a 25 cent tobacco tax in 1988. That is why Big Tobacco opposes Proposition 10.

Their arguments are false and misleading. Here are the facts:

PROPOSITION 10 MORE THAN DOUBLES THE FUNDING AVAILABLE FOR ANTI-TOBACCO ADVERTISING AND ALSO HELPS FIGHT TEEN SMOKING. The National Cancer Policy Board says increasing the price of cigarettes is "the single most effective way" to reduce teen smoking. The American Lung Association and The American Heart Association endorse Proposition 10.

PROPOSITION 10 ALLOCATES MONEY SPECIFICALLY FOR BREAST CANCER RESEARCH. The American Cancer Society endorses it.

PROPOSITION 10 DOES NOT TAKE ONE PENNY FROM OUR SCHOOLS. The organization representing every local school board and the California Teacher's Association endorse Proposition 10.

PROPOSITION 10 IS A BIG BENEFIT FOR TAXPAYERS. A Families and Work Institute study showed that every dollar spent on early childhood programs can save taxpayers up to seven dollars in remedial education, welfare and juvenile crime.

THE TOBACCO COMPANIES DON'T CARE ABOUT MINORITIES, THE POOR OR ANYONE BUT THEMSELVES. They advertise heavily to minority and low income youth. The result – 45,000 African-Americans die annually from smoking related diseases and smoking among Latino teens is skyrocketing.

WHO DO YOU BELIEVE? The tobacco industry or anti-smoking, healthcare, child care and education leaders. Please vote YES.

/s/

C. Everett Koop, M.D.
Former Surgeon General of the United States

Delaine Eastin
Superintendent of Public Instruction

Alan Henderson, Dr PH
President, American Cancer Society, California Division

SUBJECT TO COURT ORDERED CHANGES

CALIFORNIA CHILDREN AND FAMILIES INITIATIVE

Chair, Filmmaker Rob Reiner

Co-Chair Committee

U.S. Senator Barbara Boxer

Mayor Willie L. Brown, Jr. *Mayor Richard J. Riordan*

Businessman Ron Burkle

Businessman and Former U.S. Congressman Michael Huffington

Vice Chair Committee

Assemblyman Robert Hertzberg *Businessman Steven Soboroff*

Endorsements

Former Surgeon General C. Everett Koop

California State University Chancellor
Charles B. Reed

U.S. Representative Robert Filner
U.S. Representative George Miller
U.S. Representative Esteben Torres
U.S. Representative Henry Waxman

Senator John Burton, President Pro Tem
Senator Tom Hayden
Senator Betty Karnette
Senator Jack O'Connell
Senator Byron Sher
Senator Diane Watson

Assembly Speaker Antonio Villaraigosa
Assemblywoman Elaine Alquist
Assemblyman Michael Sweeney
Assemblywoman, Speaker Pro Tem,
Sheila Kuehl

Vice Chair, Board of Equalization,
Johan Klehs
Los Angeles County Board of Supervisors
Edythe Alff

Herb Alpert, Musician
Carol A. Berman
Stephen Bing, Investor
Frank Biondi, MCA
Eli Broad, Sun America, Inc.
Susie Tompkins Buell, President,
Espirit Clothing
E. Blake Byrne, President, Argyle Television
Allyson and Alan Caso
Bob Daly, Chairman and Co-CEO,
Warner Bros. and Warner Music Group
Marvin Davis, The Davis Companies
Lauren Donner
Michael Douglas, Actor-Producer
Victoria A. Dutton
The Contra Costa Times
Donna Crowden
Lauren Donner, Producer
David Geffen, Principal, DreamWorks SKG
Walter Gerken
Lisa Goodman
Gale Grunert
Margie Higgins
Dustin Hoffman, Actor
Alan Horn, Chairman and CEO
Castle Rock Entertainment
Claudia Jardot
Mary Ellen Kasdan, Producer

Reid and Margaret Kathrein,
Attorneys at Law
Jeffrey Katzenberg, Principal,
DreamWorks SKG
Michael King, Kingworld
Phyllis Klein
Norman Lear, Chairman,
Act III Communications
Bill Lerach, Milberg, Weiss, Bershad &
Lerach, LLP
Irena and Michael Medavoy,
Phoenix Pictures
Mary Mendoza
Ronald Meyer, Universal Studios
Ken Moelis, Donaldson, Lufkin &
Jenrette, Inc.
Cheri Morgan
Peter Morton, Hard Rock Hotel
Jerry Moss, Alamo Sounds
Lesley Chase Oliver
Morris Ostin, Dreamworks Records
Michael Ovitz, Investor
Jerry Perenchio, Chartwell Partners
Carl Reiner, Director - Writer
Victoria Rowell, Television Star and
Former Foster Youth
Haim Saban, Fox Kids Worldwide
Jay Sandrich, Television Director

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Martin Shafer, Co-Founder and President, Castle Rock Pictures
Andrew Scheinman, Co-Founder and Producer Castle Rock Entertainment
Tom Scott, Businessman
George Shapiro, Manager
Diane Lander Simon, Live! Magazine
Steven Spielberg, Principal, DreamWorks SKG
Jake Steinfeld, Body by Jake
Jeff Tarango, Tennis Star
Jim Wiatt, President and Co-Chairman, ICM
Robin Williams, Actor
Stephanie E. Williams, Soap Star and Foster Mother
Bud and Cynthia Sikes Yorkin, Yorkin Productions
Gail Zappa, ICA
George Zimmer, The Men's Warehouse

Associations and Community-Based Organizations

4-H Afterschool Child Care Program
AARP
American Cancer Society, California Division
American Heart Association, Western States Affiliate
American Heart Association, Greater Los Angeles Affiliate
American Lung Association of California
Asian Family Resource Center
Asian Health Center
Nora J. Baladerian, Ph.D., Director of Counseling Center of West L.A.
Bethlehem Children's Center
Buckingham Nannies
California Association of Catholic Hospitals
California Child Care Health Program
California Child Care Resource and Referral Network, Patty Siegel, Director
California Child Development Administrators' Association
California Conference of Local Health Officers
California Consortium to Prevent Child Abuse
California Correctional Peace Officers Association
California Council of Community Mental Health Agencies
California Medical Association
California State University Faculty Association
Castle Amusement Park
Child Care Coordinating Council of San Mateo County
Child Care Law Center
Children's Council of San Francisco
Children's Institute International
The Children's Preschool Center, Palo Alto
Choices
Claremont United Church of Christ Early Childhood Center
Colusa County Tobacco Education Program
Early Head Start
Educational Enrichment Systems, Inc.
El Nido Family Centers
Families and Schools Together, Lynn McDonald, Ph.D., Director
Family Helpline
Family Service Agency of Marin
Family Service Council of California
Frank D. Lonteman Regional Center
Fresno City College Child Development Center
Good Beginnings Nursery School and Day Care
The Grace Homes
High Desert Child Abuse Prevention Council
Inter Agency Council on Child Abuse and Neglect
Aggie Jenkins, Children's Advocacy Council of Riverside
Dr. Kerby T. Alvy, Center for the Improvement of Child Caring
Kids Turn, San Diego
Lead Safe California
Leap . . imagination in learning
Lincoln Child Center
Live Oak Child Development Program
Logan Heights Family Health Center
Los Angeles City Commission for Children, Youth and Their Families
Los Angeles Children's Museum
Los Angeles County Children's Planning Council
Los Angeles County Commission for Children and Families
Los Angeles Unified School District
Los Ninós Child Development and Family Program
Mary Beth Phillips, Founder of the Trustline Registry
Mental Health Association of California
Morey Avenue School Early Childhood Development Center
National Black Child Development Institute
National Council of Jewish Women
Northeast Valley Health Corporation
National Council of Jewish Women, Los Angeles
Project A.R.I.S.E. c/o Sonrise Community Outreach, Inc.
The Rainbow School at Escondido Village
St. Joseph Health System
Saint Vincent's Day Home
San Francisco Parenting Skills Program
San Diego Association for the Education of Young Children
San Jose School Health Centers
Santa Barbara Community College Children's Center
Seneca Center Residential and Day Treatment Center
Dr. Sidney Smith, CHDP Director
TFT Today, Incorporated
Trauma Foundation, San Francisco
Valley Resource Center
Walden Family Services
WestEd Center for Child and Family Studies
Westside Children's Center
Wu Yee Children's Services
YWCA Of North Orange County Child Development Center

(partial list)

Smoking causes illness and death ... Even among infants

Smoking During Pregnancy Accounts for:

- An estimated 20 to 30 percent of low birth weight babies.
- Up to 14 percent of preterm deliveries.
- Maternal smoking has been linked to asthma among infants and young children.
- Increased risk of sudden infant death syndrome (SIDS).
- Secondhand smoke is responsible for between 150,000 and 300,000 lower respiratory tract infections in infants and children under 18 months of age annually.
- Secondhand smoke results in between 7,500 and 15,000 hospitalizations each year.

Sources: *American Lung Association*
American Cancer Society
Environmental Protection Agency

California Tobacco Statistics

- In 1996 alone, cigarette makers spent more than $400 million to market, advertise and promote their products.
- Children are the industry's prime targets as 90 percent of today's smokers become addicted by the time they are 19.
- The Centers for Disease Control and Prevention estimates that 1,446,550 children in California under 18 are expected to become smokers. Of this number, 462,896 will die of smoking related illnesses.

California cigarette taxes are 21st in the country, lower than Michigan, Oregon, New York and Texas. The last significant increase was in 1988 when voters approved Proposition 99, a 25 cent per pack tax to fund anti-smoking and health care programs.

Smoking has decreased by one-third as a direct result of this tax and the programs it funded.

The California Children and Families Initiative will fund a new statewide multi-media campaign to inform pregnant woman about the negative effects of smoking while pregnant. It will also provide smoking cessation assistance for pregnant women and parents of young children who want to quit smoking.

The price increase in cigarettes brought about by the new tobacco tax will reduce smoking by an additional one-third or more, saving countless lives.

"The opportunity for a parent and child to form secure healthy attachments is the most important thing that will ever happen to a child in his or her life. Forming healthy attachments between a parent and child builds a sense of lifetime belonging to family. This bonding gives a child the foundation for a positive life. Absent healthy attachments, a child can fall prey to school failure, drug addiction, juvenile crime, premature sexual activity, and welfare dependency."

— Rob Reiner, Chair
March 23, 1998 Fresno, California

Recent studies on brain development by the *Carnegie Institute of New York, Baylor School of Medicine* and the *California Research Bureau* have proven that a child's experiences in the first years of life have a profound impact on educational, social and economic outcomes.

The brain begins to develop inside the mother's womb, forming billions of neurons or nerve cells. Neurons produce long stemmed axons that connect with other neurons. These brain connections shape the baby's entire personality and determine how well he or she will perform in school and later life.

A child's brain grows to approximately 90 percent of its adult size in the first three years. Children who lack proper nutrition, health care and nurturing during this time do not develop the social, motor and language skills needed to enter school healthy and ready to learn.

In one study, imaging techniques were used to compare the brain of a normal three year old child who received proper care and nurturing with the brain of a child who was the product of extreme neglect and abuse. When the brain images were placed side by side, one showed a perfectly formed brain with all the gray matter filled in while the other showed a brain about two-thirds the size with black crevices where gray matter should be. Brain specialists examined these images and, not knowing their source, assumed the smaller brain was that of a person afflicted with the deteriorating effects of Alzheimer's disease.

Pregnant women who smoke or abuse alcohol and drugs threaten the normal brain development of their children. Child abuse, domestic violence and extreme neglect also produce physical symptoms of brain damage that may never be repaired.

A Rand Corporation Study determined that 90% of the billions of dollars spent on education, health care and social services for children are spent after children enter school at age five. For too many children, this is simply too late.

These are the children we lose to gangs and drugs. We taxpayers foot the bill for welfare, law enforcement and prisons. The California Children and Families Initiative will make a substantial investment in our children early, when it will do the most good.

Q1: Why impose another state tax on cigarettes?

A: Three reasons:

1. California has not significantly increased the state tax on cigarettes since the voters passed Proposition 99, ten years ago. The twenty-five cent tax increase contained in this initiative raised the price of cigarettes and cut cigarette smoking by nearly a third.

2. Cigarette smoking is a leading cause of cancer and other health problems, including those that inhibit the healthy development of children.

3. According to the National Cancer Policy Board, there is strong evidence supporting a direct correlation between raising the cost of a pack of cigarettes and a decrease in consumption of cigarettes, especially among teenagers.

Q2: How will the money from the cigarette surtax be collected?

A: A special account, the California Children and Families Trust Fund Account, will be set up within the State Treasury to collect and hold for disbursement all revenue generated by the Cigarette and Tobacco Products Surtax.

Q3: Does the California Children and Families Act of 1998 affect the funding for anti-smoking programs funded by Proposition 99 and/or the Breast Cancer Fund, two measures that were previously voted into law to raise funds to combat the negative effects of smoking and smoking related diseases?

A: No. The initiative specifically protects funding for these programs by requiring money from the new initiative to first be used to offset any decrease in funds that might occur as a result of a decrease in cigarette consumption. The State Board of Equalization will, within one year, determine the effect of imposing additional taxes on cigarettes as well as the increase or decrease in the level of consumption of cigarettes and the amount of money generated by the tax.

The State Board of Equalization will transfer from the California Children and Families Trust Fund accounts whatever funds are necessary to offset revenue decreases in programs that support Proposition 99 and the Breast Cancer Fund.

This reimbursement will occur annually if necessary.

Q4: How will the $700 million in cigarette surtaxes for the California Children and Families Initiative be allocated?

A: Every fiscal year, after determining the level of smoking consumption and whether or not Proposition 99 and the Breast Cancer Fund need reimbursement, the funds for the California Children and Families Act will be allocated as follows:

- Prop 99 anti-smoking programs and the Breast Cancer Fund will be reimbursed an estimated 35 million dollars..

  Twenty percent of the balance will be appropriated to the State Commission for statewide expenditures. This money will then be allocated as follows:

- Six percent will fund a statewide multimedia campaign designed to encourage pregnant women and parents of young children to stop smoking.
- Five percent will be used for parenting education and training and the development of educational materials and technical support for the local county commissions.
- Three percent will be allocated for education and training of child care providers, the development of educational materials and guidelines for child care workers.
- Three percent will be directed to research and development that identifies the best practices for early childhood development programs.
- One percent will be used for administrative functions of the state commission.
- Two percent will be set aside in a special subaccount and made available for approved expenditures.

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None of this money will be used for administrative purposes.

The remaining eighty percent of the revenue in the California Children and Families Trust Fund Account shall be given directly to county commissions that adopt and submit a county strategic plan for providing health care and other revenues to pre-school children. The money will be used to provide the direct services deemed necessary by the local county commissions.

Q5: Who will administer the California Children and Families Trust Fund Account and the California Children and Families Program at the state level?

A: A seven member commission will be appointed by the California Governor, State Rules Committee and Assembly Speaker to provide oversight and technical assistance to the 58 local county commissions.

Q6: What kinds of programs will be eligible for funding at the county level?

A: The initiative will:

- Fund a creation of a comprehensive and integrated delivery system of information and services to promote early childhood development
- Provide funds to existing community based centers or establish new centers that focus on parenting education and family support services
- Educate Californians via a statewide multimedia campaign on the importance of early child development and the dangers of smoking by pregnant women and parents of young children
- Provide assistance to pregnant women and parents of young children who want to quit smoking
- Establish programs designed to help pregnant women and parents of young children who smoke quit smoking
- Create education and training programs on the avoidance of tobacco, drugs and alcohol during pregnancy
- Provide prenatal and postnatal maternal and infant nutrition services
- Fund child immunizations
- Provide training for parents and child care providers in child care skills
- Provide treatment for children suffering from problems related to drug and alcohol abuse
- Fund domestic violence intervention, prevention and treatment
- Fund child development, health care and social services not provided by existing programs
- Create additional quality child care

Q7: Who will administer the California Children and Families Initiative at the county level?

A: The Board of Supervisors from each county will appoint a five to nine member County Children and Families Commission.

The Commission will include: A county health officer, representatives of local medical, pediatric or obstetric communities, representatives of local school districts and a member of the county board of supervisors.

The County Children and Families Commission is responsible for developing and adopting a county strategic plan that promotes the improvement of early childhood development.

Q8: Will a special formula be used to specifically determine how much money each county will receive?

A: Yes. Funds allocated to each county commission will be based on the proportion of the number of births that occur within the county relative to statewide births.

Q9: Is the program audited?

A: The commission must prepare and present to the Governor and the Legislature an annual audit that includes reports from each individual county commission. The audit will be available to the public.

The California Children and Families Act of 1998 will create an annual funding stream of $700 million by adding an additional 50 cents per pack tax to cigarettes. The revenue will be used for the following:

- Creation of a comprehensive and integrated delivery system of information and services to promote early childhood development
- Providing funds to existing community-based centers or establishing new centers that focus on parenting education and family support services
- Educating Californians via a statewide multimedia campaign on the importance of early childhood development and the dangers of smoking by pregnant women and parents of young children
- Providing assistance to pregnant women and parents of young children who want to quit smoking
- Designing and implementing programs to help pregnant women and parents of young children who smoke quit smoking
- Education and training on the avoidance of tobacco, drugs and alcohol during pregnancy
- Prenatal and postnatal maternal and infant nutrition services
- Child immunizations
- Child care skills for parents and child care providers
- Treatment for children suffering from problems related to drug and alcohol abuse
- Domestic violence intervention, prevention and treatment
- Child development, health care and social services not provided by existing programs
- Creation of additional quality child care

California is losing hundreds of millions of dollars in federal funding for these kinds of programs because we do not have matching funds. The initiative will provide these matching funds, adding up to 700 million federal dollars to the $700 million generated by the initiative.

Tobacco Technical Assistance
June 9, 1999 (includes additional options, not sent, underlined)

Below are several approaches that would reduce youth smoking and raise revenue for health-related programs in FY 2000. All estimates are preliminary.

Payments Per Child Smoker

Industry-Wide
Tobacco companies would pay per-child payments based on the number of children smoking nationwide. Alternatives include:

- A one-time payment of $2,150 per child raises about $7.3 billion in FY 2000, less about $1 billion in lost excise tax revenues, for a net revenue effect of $6.3 billion. This payment amounts to 37 cents per pack; because such payments would be nondeductible for the companies, retail prices would go up by 55 cents per pack. The Administration's budget included an excise tax increase of 55 cents per pack.

- A one-time payment of $1,200 per child raises about $4.4 billion in FY 2000, less about $600 million in lost excise tax revenues, for a net revenue effect of $3.8 billion. This payment amounts to 22 cents per pack; because such payments would be nondeductible for the companies, retail prices would go up by 33 cents per pack.

- A one-time payment of $900 per child raises about $3.4 billion in FY 2000, less about $500 million in lost excise tax revenues, for a net effect of $2.9 billion. This translates into 17 cents per pack in payment, and a 26-cent increase in retail prices.

Company-Specific
Each tobacco company would pay a per-child payment based on the number of children smoking its brands of cigarettes nationwide.

- A one-time payment of $1,000 per child raises about $3.8 billion, translating into a 19 cents per pack payment.
- A one-time payment of $750 per child raises about $2.9 billion, and translates into a 15 cents per pack payment.

Acceleration of Excise Tax Increase

The 1997 Balanced Budget Act raised the tobacco excise tax 10 cents per pack effective January 1, 2000 and another 5 cents effective January 1, 2002. Accelerating the scheduled 15 cent tobacco tax increase, so that it takes effect in FY 2000, would add about $1.1 billion in FY 2000. (The revenue would be slightly less if coupled with the industry payment because the payment would increase cigarette prices, reducing cigarette consumption as well as the revenue raised by the accelerated excise tax.) This proposal was included in the Administration's FY 2000 budget.

PRESIDENT CLINTON:
FIGHTING FOR LEGISLATION TO REDUCE TEEN SMOKING

June 19, 1998

"Some have suggested that Congress should now just get in line and do what the tobacco lobby wants them to do... and appear to be passing a bill that will reduce teen smoking, that everybody knows will not have very much influence... We're going to stick with the children and their future...and keep working, to get a bill that will increase the price of cigarettes enough to deter smoking, that will have strong advertising restrictions, that will have strong access restrictions, that will invest in public health and do something honorable for tobacco farmers."

President Bill Clinton
June 19, 1998

President Clinton is committed to passing landmark tobacco legislation that will reduce teen smoking and benefit the health and well-being of our children. The Senate's refusal to vote on this important legislation is a vote against our nation's families and children. The President will not accept scaled down legislation which does not seriously address the problem of teen smoking, but merely serves to give cover to members of Congress.

ON WEDNESDAY JUNE 17TH, THE SENATE REFUSED TO VOTE ON A BILL TO REDUCE TEEN SMOKING. The President supported legislation introduced by Senator John McCain (R-AZ) that contained the strongest anti-youth smoking provisions in our history -- legislation that would cut youth smoking in half over the next five years. When Senators could have sided with families and children, a minority of Senators chose instead to side with the tobacco industry, and blocked a vote on this important legislation.

WEDNESDAY'S DECISION WAS A VOTE AGAINST FAMILIES AND CHILDREN. The President worked in good faith with Senators who expressed concern about tobacco legislation and accepted Republican changes. Every major amendment to the tobacco bill was proposed by a member of the Republican majority. Tobacco legislation was voted out of Committee by a 19-1 margin; however, when the measure came to the Senate floor, many Republicans who had voted for the bill in committee switched their vote. In doing so, these Senators voted against:

- A law that would help save an estimated 1 million lives over the next five years by cutting youth smoking in half over the next five years;
- A tax cut to eliminate the marriage penalty for couples making less than $50,000 a year, and increased funding for anti-drug measures;
- Caps on attorneys for lawyers involved in tobacco litigation.

THE PRESIDENT IS IN GOOD COMPANY. The President stands with leading public health organizations -- the American Heart Association, American Lung Association, and the American Cancer Society -- in calling for tobacco legislation that actually helps reduce teen smoking. That is why the President will not accept scaled down tobacco legislation that has no real chance of saving the lives of young people, but instead is simply intended to save the political lives of members of Congress.

THE TOBACCO LOBBY VS. CHILDREN AND FAMILIES. The Senate's vote and the lobbying effort by the tobacco industry, which spent $40 million to defeat this measure, will not reduce the President's resolve or effort to pass tobacco legislation. The facts are clear: Smoking kills -- 3,000 children every day start smoking and 1,000 of those children will die early as a result. Instead of supporting a plan to reduce teen smoking, the Senate sided with the tobacco lobby. The Senators who blocked this vote are on the wrong side of this issue, and they are out of step with the communities and families of this country.

A STRATEGIC PLAN FOR REDUCING YOUTH SMOKING. For the last three years, the President has worked tirelessly to reduce teen smoking. The President has stated that tobacco legislation must meet 5 objectives: 1) a reduction in youth smoking by raising the price of cigarettes by up to $1.10 over 5 years, with additional surcharges on companies that continue to sell to kids; 2) full authority for the Food and Drug Administration to regulate tobacco products; 3) changes in the way the tobacco industry does business, including an end to marketing and promotion to kids; 4) progress toward other public health goals, including biomedical and cancer research, a reduction of second-hand smoke, promotion of smoking cessation programs and other urgent priorities; and 5) protection for tobacco farmers and their communities.

PRESIDENT CLINTON:
STANDING UP FOR CHILDREN AND FAMILIES

June 18, 1998

"Today, like every other day, 3,000 children start to smoke, and 1,000 of them will have their lives shortened because of it. If more members of the Senate would vote like parents rather than politicians, we could solve this problem and go on to other business of the country."

President Bill Clinton
June 17, 1998

Yesterday, a bipartisan majority of the Senate signaled its readiness to vote on meaningful tobacco legislation to reduce teen smoking, but were blocked by a minority of Senators. President Clinton is committed to passing this important legislation, and will continue to fight for the health and well-being of our children.

A STRATEGIC PLAN FOR REDUCING YOUTH SMOKING. For the last three years, the President has worked tirelessly to reduce teen smoking. The President has stated that tobacco legislation must meet 5 objectives: 1) a reduction in youth smoking by raising the price of cigarettes by up to $1.10 over 5 years, with additional surcharges on companies that continue to sell to kids; 2) full authority for the Food and Drug Administration to regulate tobacco products; 3) changes in the way the tobacco industry does business, including an end to marketing and promotion to kids; 4) progress toward other public health goals, including biomedical and cancer research, a reduction of second-hand smoke, promotion of smoking cessation programs and other urgent priorities; and 5) protection for tobacco farmers and their communities.

THE SENATE REFUSED TO VOTE ON A BILL TO REDUCE TEEN SMOKING . The President supported legislation introduced by Senator John McCain (R-AZ) that contained the strongest anti-youth smoking provisions in our history and would cut youth smoking in half over the next five years. Yesterday, when Senators could have sided with families and children, a minority of Senators chose instead to side with the tobacco industry, and blocked a vote on this important legislation.

THE PRESIDENT WORKED COOPERATIVELY WITH CONGRESS TO PRODUCE STRONG LEGISLATION. In order to get a tough anti-smoking bill, the President was willing to accept a tax cut to eliminate the marriage penalty for couples making less than $50,000 a year, and increased funding for anti-drug measures. The President earlier worked to secure several improvements to the tobacco legislation, including stronger lookback surcharges, stronger environmental tobacco smoke protections, and substantial funding for public health and research as well as for states and tobacco farmers.

THE TOBACCO LOBBY VS. CHILDREN AND FAMILIES. The Senate's vote, and the lobbying effort by the tobacco industry, which spent $40 million to defeat this measure, will not reduce the President's resolve or effort to pass tobacco legislation. The facts are clear: Smoking kills -- 3,000 children every day start smoking and 1,000 of those children will die early as a result. Instead of supporting a plan to reduce teen smoking, the Senate sided with the tobacco lobby. The Senators who blocked this vote are on the wrong side of this issue, and they are out of step with the communities and families of this country.

Tobacco Policies in the FY 2000 Budget

Every day, 3,000 children become smokers -- 1,000 have their lives shortened because of it. Almost 90 percent of adult smokers began smoking by age 18 and today, 4.5 million children aged 12 to 17 -- 37 percent of all high school students -- smoke cigarettes. Tobacco is linked to over 400,000 deaths a year from cancer, respiratory illness, heart disease and other problems.

The 1998 State tobacco settlement was an important step in the right direction, but more must be done to protect our children and hold the tobacco industry accountable. The Budget therefore mentions the following tobacco policies: 1) price increase; 2) FDA authority; 3) public health investments; 4) tobacco-related Federal health cost litigation; 5) farmers; and 6) recoupment negotiations, as discussed below:

(1) Raising the Price of Cigarettes to Discourage Youth Tobacco Use

Last year, the President called for an increase of $1.10 per pack to help cut youth smoking in half. This year, we can build on price increases already agreed to between the tobacco companies and the States and those already legislated by the Congress.

The FY 2000 Budget contains three revenue components:

- A 55 cents per-pack increase to be collected through tobacco excise taxes.

- Acceleration of the BBA's 15 cents excise tax. The 1997 Balanced Budget Agreement (BBA) raised the excise tax 10 cents per-pack effective January 1, 2000 and another 5 cents effective January 1, 2002, for a cumulative 15 cent increase. The FY 2000 Budget accelerates the effective date of this entire tax by one year, effective October 1, 1999.

- The BATF excise shift. Treasury assumes that revenues will be lower than we estimated in 2000 because smokers will stock up in FY 1999, before the 70 cent total price increase takes effect. The stocking up effect reduces 2000 revenues, but increases 1999 revenues by $304 million. To capture the 1999 revenues for use in 2000, Treasury came up with an excise tax shift. The shift loses money in 1999 and gains in 2000, more or less canceling out the stocking up effect. Note that the shift applies to all excise taxes collected by BATF, not just tobacco.

Federal Receipts Raised from Tobacco Excise Taxes (in billions)

Year	1999	2000	2001	2002	2003	2004	00-04
55 cents	.165	6.525	6.426	6.426	6.418	6.400	32.195
BBA 15 cent	.139	1.081	0.679	0.163	-----	-----	1.923
Shift BATF	-.381	.381	----	----	-----	-----	.381
Net Receipts	**-.077**	**7.987**	**7.105**	**6.589**	**6.418**	**6.400**	**34.499**

In FY 2000, these revenues are attributable to tobacco-related health care costs in the following Federal programs (as displayed in Table S-___).

Federal Program	Tobacco-Related Costs (in billions)
Veterans' Affairs	4.0
OPM FEHB[1]	2.2
Department of Defense	1.6
Indian Health Service	0.3
TOTAL	**$8.0**

The programs above are funded in the Budget and funding is not contingent upon tobacco receipts.

(2) Re-Affirm Full FDA Authority to Regulate Tobacco Products

The Administration will again support legislation that confirms the FDA's authority to regulate tobacco products in order to halt advertising targeted at children and to curb minors' access to tobacco products.

(3) Support Public Health Initiatives To Curb Tobacco Use

The Budget includes $122.2 million **additional** funds for tobacco-related activities in CDC, FDA, VA, and ATF:

- $27 million for expanding CDC's existing State-based tobacco prevention activities. The FY 2000 increases brings CDC's tobacco budget to $101 million, $73 million (+37%) above FY 1999.

- $34 million for FDA's outreach and enforcement activities. FDA's increase doubles its tobacco budget to $68 million.

- $56 million for a smoking cessation program in VA for any honorably discharged veteran who began smoking in the military.

- $5.2 million for enhanced enforcement at ATF to prevent evasion of tobacco taxes.

1/ OPM Federal Employee Health Benefits Program figure includes the total premium costs, and is not broken down by enrollee share (28%) and Federal share (72%).

(4) Lawsuits to Recover Tobacco-Related Federal Health Care Costs

The FY 2000 Budget proposes $20 million for the Department of Justice to finance costs incurred in preparing and bringing litigation against tobacco companies for tobacco-related Federal health costs. The Justice Department has concluded that there are viable legal grounds to recover tobacco-related health care costs and is forming a task force to make decisions on the litigation. The Justice Department has noted two possible theories on which to proceed -- the Medical Care Recovery Act and the Medicare Secondary Payer Act -- but the eventual litigation could rely on additional theories as well.

(5) Protecting Farmers and Farming Communities [Note: the FY 2000 budget does not include additional funds for tobacco farmers].

States, farmer, and industry representatives recently produced a $5 billion agreement to provide financial assistance to tobacco farmers and their communities. This Administration supports this agreement and remains committeed to protecting tobacco farmers and their communities. The Administration will work with all parties, as needed, to ensure the financial well-being of tobacco farmers, their families, and their communities.

(6) Claiming the Federal Share of State Tobacco Settlements

Since U.S. taxpayers paid a substantial portion of the Medicaid costs that were the basis for the State settlement with the tobacco companies, Federal law requires that the Federal Government recoup its share. However, the Administration will work with the States and the Congress to enact tobacco legislation that, among other things, resolves these Federal claims in exchange for a commitment by the States to use tobacco money to support shared national and State priorities which reduce youth smoking, promote public health and children's programs, and assist affected rural communities.

The amounts below represent the estimated Federal share (roughly 57 percent) of tobacco industry payments under the State Attorneys General Settlement Agreement.

Year-by-Year Forgone Recoupment (in billions)

Year	2000	2001	2002	2003	2004	2001-04
Non-Recoupment	0.0	4.6	4.7	4.8	4.8	18.9

Table S–8. TOBACCO LEGISLATION

(In billions of dollars)

	Estimate				
	2000	2001	2002	2003	2004
Receipts:					
55 cent per pack increase [1]	6.9	6.4	6.4	6.4	6.4
Accelerate BBA 15 cent increase	1.1	0.7	0.2	.....	.....
Total	8.0	7.1	6.6	6.4	6.4
Tobacco-Related Health Care Costs in Federal Programs:					
Veterans	4.0	4.0	4.0	4.0	4.0
Federal Employees Health Benefits Program	2.2	2.3	2.5	2.7	2.9
Department of Defense	1.6	1.7	1.7	1.7	1.8
Indian Health Service	0.3	0.3	0.3	0.3	0.3
Total	8.0	8.2	8.5	8.7	8.9
Memorandum:					
Estimated effects of recoupment policy	.....	–4.6	–4.7	–4.8	–4.8

[1] Includes accelerated date for BATF excise tax ($381 million into 2000).

Teen Smoking Fact Sheet

Teen Smoking is a Major Problem in this Country

- 4.5 million children ages 12-17 are current smokers.[1]

- Every day, more than 3000 young people become regular smokers in this country,[2] and 1000 will die prematurely from smoking-related diseases as a result.[3]

- In 1996, 66 percent of the 1.8 million Americans who became regular smokers were under the age of 18 (1.2 million).[4]

- Almost 90 percent of adult smokers began at or before age 18.[5]

Tobacco Use by Teens is On the Rise

- Cigarettes: Smoking among high-school seniors is at a 19-year high -- 36.9 percent and since 1991, past-month smoking has increased by 35 percent among eighth graders and 43 percent among tenth graders.[6] Daily smoking among high school seniors dropped slightly between 1997 and 1998, from 24.6 to 22.4 percent.[7]

- Smoking rates among high school students rose by nearly a third between 1991 and 1997, from 27.5 percent to 36.4 percent.
  - Cigarette smoking was highest among white students (39.7 percent), rising by 28 percent from 1991 (30.9 percent).
  - While the level of cigarette smoking among African-American students was lower than for white students, the rate increased by 80 percent between 1991 and 1997 for African-American students (from 12.6 percent to 22.7 percent).
  - Smoking among Hispanic students rose 34 percent, from 25.3 percent in 1991 to 39.7 percent in 1997.[8]

- Between 1988 and 1996, the number of children who became regular smokers increased by 73 percent, and this increase resulted in 1.5 million more children becoming regular smokers over the eight year period.[9]

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[1] "National Household Survey on Drug Abuse: Population Estimates 1997", Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[2] "Incidence of Initiation of Cigarette Smoking -- United States, 1965-1996", *Mortality and Morbidity Weekly Report*, vol. 47, no. 39, Centers for Disease Control and Prevention, October 9, 1998.

[3] John Pierce, et al., "Trends in Cigarette Smoking in the United States, Projections to the Year 2000", *Journal of the American Medical Association*, vol. 261, pp. 61-65, 1989.

[4] "Incidence of Initiation of Cigarette Smoking -- United States, 1965-1996".

[5] "Preventing Tobacco Use Among Young People--A Report of the Surgeon General, 1994", Centers for Disease Control and Prevention.

[6] Monitoring the Future Study, University of Michigan, 1997.

[7] Monitoring the Future Study, University of Michigan, 1998.

[8] "Tobacco Use Among High School Students -- United States, 1997", *Morbidity and Mortality Weekly Report*, vol. 47, no. 12, Centers for Disease Control and Prevention, April 3, 1998.

[9] "Incidence of Initiation of Cigarette Smoking -- United States, 1965-1996".

- Cigars: One in five high school students (22 percent) smoked cigars within the past month. 31.2 percent of male high school students smoked cigars within the past month, compared with 10.8 percent of female students.[10]

- Smokeless Tobacco: Almost one in ten (9.3 percent) of high school students used smokeless tobacco within the past month. White male students were significantly more likely to use smokeless tobacco products than any other group of high school students (20.6 percent).[11]

- Tobacco Products: Overall, 42.7% of high school students used tobacco products in the previous month (cigarettes, cigars, or smokeless tobacco) -- this represents nearly half of male high school students (48.2 percent) and more than a third of female students (36 percent).[12]

Many Teens are Addicted to Tobacco[13]

- Teenagers find it difficult to quit smoking -- 86 percent of teens who smoke daily and try to quit are unsuccessful.

- Teenagers underestimate the addictiveness of nicotine -- 75 percent of daily smokers who expect to quit are still smoking five years later.

- Casual smokers become hooked -- 42 percent of young people who smoke as few as three cigarettes per month go on to become regular smokers.

Teen Smoking is Associated with Other High-Risk Behaviors

- Adolescents (ages 12-17) who are current smokers are 12 times as likely to use illicit drugs and 23 times as likely to drink heavily as non-smoking youths.[14] Seventy-four percent of youths who had smoked marijuana in their lifetime tried cigarettes first.[15] Smoking is associated with a host of other risk behaviors, such as fighting and engaging in unprotected sex.[16]

December 18, 1998

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[10] "Tobacco Use Among High School Students -- United States, 1997".

[11] "Tobacco Use Among High School Students -- United States, 1997".

[12] "Tobacco Use Among High School Students -- United States, 1997".

[13] "Selected Cigarette Smoking Initiation and Quitting Behaviors Among High School Students -- United States, 1997", *Morbidity and Mortality Weekly Report*, vol. 47, no. 19, Centers for Disease Control and Prevention, May 22, 1998.

[14] "National Household Survey on Drug Abuse: Population Estimates 1997", Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[15] "National Household Survey on Drug Abuse: Population Estimates 1995", Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

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

	McCain Manager's Amendment	McCain as Amended	Hatch	Settlement
Lookback Surcharges -- Industry	$80 million for each percentage point missed for the first five points missed, $160 million for each percentage point missed (for 6-10 points missed), $240 million for each percentage point missed (for 11 points or more missed). Penalties are capped at $4 billion per year.	$40 million for the first five percentage points by which the industry misses the youth smoking reduction target, and $120 million for each point missed thereafter. Penalties are capped at $2 billion. (Durbin amendment).	Years 1-5: $100 million for each percentage point missed for the first five points missed, $200 million for each percentage point missed (for 6-10 points missed), $300 million for each percentage point missed (for 11 or more points missed). Penalties are capped at $5 billion per year. After year 5: $250 million for each percentage point missed for the first five points missed; $500 million for each percentage point missed for 6 points missed or above. Penalties are capped at $10 billion per year. The proposal's so-called "double-counting adjustment" means that the actual surcharges imposed are in most years substantially below the amounts per percentage point presented (e.g., the effective charge is about $140 million per point, not $500 million). Companies may have these surcharges abated if they acted in good faith and complied with the law.	$80 million for each percentage point by which the industry misses the youth smoking reduction target. Penalties are capped at $2 billion annually. Companies may have these surcharges abated if they acted in good faith and complied with the law.

	McCain Manager's Amendment	McCain as Amended	Hatch	Settlement
Lookback Surcharges -- Company Specific	$1000 per teen by which the company misses its youth smoking reduction target. This figure (which is equivalent to about $64 million per percentage point) represents twice the forgone profits of hooking a teen. No cap on penalties.	$80 million per percentage point for the first 5 percentage points, and $240 million per percentage point thereafter. This figure represents approximately 2.5 times the forgone profits for the first five percentage points, and about 7.5 times the forgone profits for the next 19 percentage points. Penalties are capped at $5 billion. (Durbin amendment.)	None.	None.
Youth Smoking Reduction Targets	Reduce youth smoking by 60% over 10 years.	Reduce youth smoking by 67% over 10 years.	Reduce youth smoking by 60% over 10 years.	Reduce youth smoking by 60% over 10 years.

Gave Harkin

Tobacco Technical Assistance
June 8, 1999

Below are several approaches that would reduce youth smoking and raise revenue for health-related programs in FY 2000. All estimates are preliminary.

Payments Per Child Smoker

Tobacco companies would pay per-child payments based on the number of children smoking nationwide. Alternatives include:

- A one-time payment of $1,200 per child raises about $4.4 billion in FY 2000, less about $600 million in lost excise tax revenues, for a net revenue effect of $3.8 billion. This payment amounts to 22 cents per pack; because such payments would be nondeductible for the companies, retail prices would go up by 33 cents per pack.

- A one-time payment of $900 per child raises about $3.4 billion in FY 2000, less about $500 million in lost excise tax revenues, for a net effect of $2.9 billion. This translates into 17 cents per pack in payment, and a 26-cent increase in retail prices.

Acceleration of Excise Tax Increase

The 1997 Balanced Budget Act raised the tobacco excise tax 10 cents per pack effective January 1, 2000 and another 5 cents effective January 1, 2002. Accelerating the scheduled 15 cent tobacco tax increase, so that it takes effect in FY 2000, would add about $1.1 billion in FY 2000. (The revenue would be slightly less if coupled with the industry payment because the payment would increase cigarette prices, reducing cigarette consumption as well as the revenue raised by the accelerated excise tax.) This proposal was included in the Administration's FY 2000 budget.

McCain

Possible Uses of Tobacco Legislation Receipts

(In Billions of Nominal Dollars– FY99-03 Unless Noted)

		Budget	Compromise $	Compromise %	Year 1 FY99	Year 2 FY00	Year 3 FY01	Year 4 FY02	Year 5 FY03	Proposed Manager's Amendment FY99-03	FY99-08	FY99-23	Allocation within Accounts Min. %	Min. $ 5 Yrs	Max. %	Max. $ 5 Yrs
RECEIPTS																
Gross Payments		95														
Net Receipts 1/		66	62	100%	15.4	11.0	12.5	12.8	13.8	65.5	142.7	460.4				
Initial Payment, net (Excluded from formula)			7													
USES																
Health & Health-Related Research		21.1	13.5	22%	3.4	2.4	2.8	2.8	3.0	14.4	31.4	101.3				
NIH		17.0			2.6	1.7	2.0	2.3	2.5	11.1			*75%*	*10.8*	*80%*	*11.5*
NSF Biomedical/Basic Research		2.9			0.1	0.1	0.1	0.1	0.1	0.4			*1%*	*0.1*	*5%*	*0.7*
Clinical Cancer Trials		0.8			0.2	0.3	0.3			0.8			*9%*	*0.8*	*9%*	*0.8*
CDC/AHCPR		0.4			0.5	0.4	0.4	0.4	0.5	2.2			*12%*	*1.7*	*18%*	*2.6*
													93%	*13.5*	*108%*	*15.6*
Public Health		9.5	13.5	22%	3.4	2.4	2.8	2.8	3.0 #	14.4	31.4	101.3				
Cessation		5.3			1.0	0.7	0.8	0.8	0.9	4.3			*25%*	*3.6*	*35%*	*5.0*
Indian Health Service		0.1			0.2	0.1	0.1	0.1	0.2	0.7			*3%*	*0.4*	*7%*	*1.0*
Prevention & Education (Prev., Advertising, Surveys)		3.0			1.9	1.4	1.6	1.6	1.7	8.3			*50%*	*7.2*	*65%*	*9.4*
State Prevention		0.4								2.7			30%	2.2	35%	3.3
Counter-Advertising		2.4								2.7			30%	2.2	35%	3.3
International		0.3			0.2	0.2	0.2	0.2	0.2	1.1			10%	0.7	15%	1.4
Surveys (Minimum Allocation)					*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.8*			*10%*	*0.7*	*12%*	*1.1*
													80%	5.8	97%	9.1
Licensing & Enforcement (FDA, Licensing, Anti-Smuggling)		1.2			0.7	0.5	0.6	0.6	0.6	2.9			*17.5%*	*2.5*	*22.5%*	*3.2*
FDA (Minimum within Sub-account)		*1.2*			*0.1*	*0.2*	*0.3*	*0.3*	*0.3*	*1.2 (non-add)*			*96%*	*13.8*	*130%*	*18.7*
State Funds, Direct		26.4	25.0	40%	6.2	4.4	5.0	5.1	5.5	26.2	57.1	184.1				
Unrestricted	41%	10.7		50%	3.1	2.2	2.5	2.6	2.8	13.1						
Specified	59%	15.7		50%	3.1	2.2	2.5	2.6	2.8	13.1						
					2.5	4.2	6.2	8.3	10.5							
Farmers & Farm Communities	28.5	0.5	10.0	16%	2.5	1.8	2.0	2.0	2.2	10.5	22.8	28.5				
Compensation		3.0		4%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Other Research (Climate Change, NASA, etc)		5.1		2.3%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Other/Medicare 2/		0.0	7.0	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	45.1				
TOTAL USES		66	69	111%	15.4	11.0	12.5	12.8	13.8	65.5	142.7	460.4				
FUNDS REMAINING (DEFICIT)		0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				

42ND STORY of Level 1 printed in FULL format.

The Washington Post

November 20, 1998, Friday, Final Edition

SECTION: OP-ED; Pg. A29

LENGTH: 774 words

HEADLINE: Desperate for a Deal

BYLINE: C. Everett Koop; David Kessler

BODY:

Big Tobacco once again has met with several state attorneys general behind closed doors. The public, especially public health experts, once again was specifically excluded from complicated negotiations. The public once again has been presented with the details of a proposed tobacco "settlement." And we are expected to believe that the tobacco industry is not once again up to its old tricks?

After failing to buy special protections from Congress, Big Tobacco is back to courting the attorneys general. Believing that anyone will sell his virtue if the price is right, the highly profitable tobacco industry is offering several states billions of dollars to gain protection and privileges that no honest business would be granted. Big tobacco is desperate for a deal, but why?

The tobacco industry wants to limit the public's knowledge of its chicanery. Each lawsuit that actually goes to trial means that more secret documents become public, shedding more light on what this greedy, lying industry does to the nation's health. In addition, the industry knows that when increasingly incriminating information becomes part of the public domain, other states' chances of getting more money become better. Any attorneys general who decide to reject the settlement and push on with their cases in court are likely to not only recoup more of their states' money but also make more of big tobacco's misdeeds public.

We wonder why no one stops to think about why Big Tobacco has so much money. For decades the industry has bought special privileges and protections that have allowed it to charge dearly for a cheap product. Profits are huge because costs are transferred to the public. Other companies have to pay for damages from defective products, even when defects were not intended, but Big Tobacco has the taxpayer paying. You pay more than $ 2 for every $ 1 Big Tobacco makes.

The desire of all negotiating parties for complete secrecy is a clear sign that the public will suffer substantial losses in the terms, just as it would have under the June 20, 1997, terms. Imagine the public and media outrage if Congress suddenly decided that all legislative hearings were now to be conducted in secret. The industry wants to surprise the public with only one day of

headlines so that a complete, thoughtful, and sound review is not feasible. Apparently, the negotiating parties are going to ignore state Administrative Procedures Acts requiring public review and comment of usually at least 30 to 60 days before adoption of major policies. The blinding amount of money offered, even though it represents not even half of what is needed for just compensation, is supposed to hide this obligation.

The parties involved made a deal without public review of compromises that the attorneys general as elected officials made for the citizens of their state. And those attorneys general who have not already signed on have only a matter of days to make this decision, a deadline imposed by the tobacco industry because it knows that if there is proper public inspection and debate on the settlement the public will be outraged.

And what is the industry proposing? Cents on the dollar, compared with states that settled their cases individually; no provision for federal regulation of an addictive drug; stunningly weak restrictions on advertising; increased roadblocks to the federal government to increase cigarette taxes; improper immunity for an industry that still has not admitted its misdeeds.

Big Tobacco should not be protected from suits by aggrieved individual citizens, groups and organizations. Full disclosure must continue. Liability should not be capped. Community laws should not be preempted by either states or federal law, nor co-opted by an illegitimate, closed-door agreement between attorneys general and Big Tobacco.

Some have called this a "milestone" in the war against tobacco, implying that Congress will take up the issue again. But this agreement would in fact mark one of the last miles in this long war. The settlement sends a signal to Congress that the states accept the industry's group settlement as acceptable punishment, thereby stunting further federal legislation. And the more states accept the settlement, the stronger that destructive signal will be.

Any attorney general who buys into the industry's lies is changing the health of Americans for the worse. This settlement might be quick, but it is no fix.

C. Everett Koop was surgeon general of the United States from 1981 to 1989. David Kessler was commissioner of the Food and Drug Administration from 1990 to 1997.

LANGUAGE: ENGLISH

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SEPTEMBER 8, 1998, TUESDAY

SECTION: IN THE NEWS

LENGTH: 8345 words

HEADLINE: NATIONAL PRESS CLUB LUNCHEON WITH
FORMER SURGEON GENERAL C. EVERETT KOOP
FORMER FDA COMMISSIONER DAVID KESSLER
MODERATOR: DOUG HARBRECHT
1:01 PM EDT

BODY:
MR. HARBRECHT: Good afternoon and welcome to the National Press Club. This is our 90th anniversary year. My name is Doug Harbrecht. I'm president of the National Press Club and Washington news editor of Business Week magazine, a McGraw-Hill Companies publication.
I'd like to welcome Club members and their guests in the audience today, as well as those of you watching on C-SPAN or listening to this program on National Public Radio.
Before introducing our head table, I would like to remind our members of some upcoming speakers. Tomorrow we'll hear from David Komansky, chairman and CEO of Merrill Lynch & Company. He will be followed by Richard Riley, secretary of Education, on September 15th. Randy Tate, executive director of the Christian Coalition, will be speaking on September 16th; and William Ivey, chairman of the National Endowment for the Arts, on September 17th. Then, former Secretary of State James Baker speaks about his experiences during the cold war, as well as what's ahead for the world now, on September 13th. And Ted Forstmann, venture capitalist and founder of the Children's Scholarship Fund, speaks on September 28th.
Transcripts and audiophiles of National Press Club luncheons will be posted this afternoon at our Web site at npc.press.org. To purchase audio and videotapes, please call 1-888-343-1940.
If you have any questions for our speakers today, please write them on the cards provided at your table and pass them up to me. I will ask as many as time permits.
I'd now like to introduce our head table guests and ask them to stand briefly when their names are called. Please hold your applause until all head table guests have been introduced.
From your right, Richard Kiehl, chief tobacco reporter, Bloomberg News; Ira Teinowitz, Washington bureau chief, Advertising Age; the Honorable Henry A. Waxman from California; Dr. -- I'm sorry, skipping our speaker for just a moment, Joan Cassedy, president of King Publishing Group and member of the Speakers Committee who arranged today's lunch -- skipping over our other speaker for a minute -- Kay Kahler Vose, director of communications for Campaign for Tobacco-Free Kids and former president of the National Press Club; and Saundra

Torry, reporter for the Washington Post. (Applause.)
Our speakers today are two of the most distinguished advocates for and protectors of American public health and safety of this century. That's a tall order, comparing them with such public health legends as Walter Reed and Jonas Salk, but the respect is well deserved.
Dr. C. Everett Koop, following a distinguished career as a surgeon and educator, became a household name when, just a month after being formally sworn in as surgeon general of the United States, he issued the most unequivocal indictment of cigarette smoking ever issued by the Public Health Service. He called the risks associated with smoking, and I quote, "the most important public health issue of our time." And this was just one month into the job.
Dr. Koop earned a reputation as a skilled clinician, brilliant researcher and outstanding surgeon during his lengthy career. It's hard to believe now, but when he was named surgeon-in-chief at Children's Hospital in Philadelphia in 1948, at the ripe age of 32, many of the surgical procedures performed on newborns resulted in a mortality rate as high as 95 percent. Dr. Koop is credited with helping to significantly lower those statistics by improving pre- and post-operative care for children and by developing dozens of new surgical and diagnostic procedures, some of which corrected birth defects that had heretofore been considered un-correctable. He established the nation's first neonatal intensive surgical unit, as well as a total-care pediatric facility at Philadelphia Children's Hospital.
But outside of his undeniably impressive professional medical career, Dr. Koop invoked considerable controversy by espousing his personal views against abortion on lecture platforms and in his books. Thus, his nomination as surgeon general drew an avalanche of opposition, not only because of his stance on abortion but also because of his lack of specialized training in public health, and even his age. At the time he was over the age limit of 64 established by law in 1944.
But North Carolina Senator Jesse Helms no less sponsored an amendment to an unrelated bill that then passed the Senate, clearing the way for his confirmation hearings and subsequent appointment as the first full-time surgeon general in over a decade.
Since he left in 1989, he has continued to be a force for public health and health education on many fronts, from his office as senior scholar of the C. Everett Koop Institute at Dartmouth, including his own Web site, www.drkoop.com.
Also with us today is Dr. Koop's workaholic equal, Dr. Kessler, a generation younger but in many ways cut from the same cloth. He is a pediatrician and lawyer by training, and is now dean of the Yale School of Medicine.
Dr. Kessler was at 39 years old the youngest commissioner of the Food and Drug Administration since 1912, when he was appointed by President Bush in 1990. He too became a household name shortly after his appointment when he boldly ordered US marshals to seize 24,000 gallons of orange juice from a warehouse because the manufacturer had labeled it fresh when it really was from concentrate.
Dr. Kessler took on as a priority a complete overhaul of the FDA, when had become a beleaguered agency with claims of mismanagement and scandal. He is widely credited with reorganizing and streamlining the agency, notably improving the talent at the top. But his effort to impose serious new regulations on tobacco was one of his boldest moves.
Under his leadership, the FDA fought hard to regulate nicotine as a drug and to stop smoking among children by placing new restrictions on tobacco advertisements and vending machines. President Clinton, who had re-appointed Dr. Kessler, supported the FDA's proposals to regulate tobacco sales and marketing aimed at youth. A war ensued between the FDA and the tobacco industry. Just

last month the Fourth Circuit struck down the FDA's jurisdiction over tobacco, ruling that Congress had not intended for FDA to have jurisdiction.

I'm sure our speakers will be addressing that topic today, but the war is certainly not over.

Dr. Koop will address us first today on the topic "The Tobacco Scandal: Where is the Outrage?" Let's have a warm National Press Club welcome for Dr. Koop. (Applause.)

DR. KOOP: Thank you very much, ladies and gentlemen.

I was invited to speak here today and when I heard that Dr. Kessler was also going to be present, I presumed the subject would be tobacco. But I am not going to give you a blow-by-blow description of the tobacco wars. I think you know that history probably as well as anyone, and several of you are probably already writing books on the subject. Instead, I would like you to consider the anatomy of a scandal, and I'm not talking about the scandal that springs most readily to people's minds. I'm talking about a scandal that really involves the entire nation and especially Washington.

This is scandal of some in Congress trading public health for PAC money and believing slick ads of the tobacco industry. This is a scandal of senators, well over half voting yes but still losing. This is scandal of some hiding from the potential to save lives and choosing instead to posture. This is a scandal of politics for sale, and to my dismay, some Republicans going to the highest bidder.

If outsiders were to visit this land their conclusion would have to be that the enormity of the burden of tobacco, the metastasis of this malignancy tobacco industry, and of the failure of Congress to respond to it, all constitute a scandal that should have pushed Monica Lewinsky to page 7 of the second section. (Laughter.) Instead, this is now mostly a silent scandal, press and public alike sort of saying politics as usual, and the politicians saw their duty and did not do it, so what else is new?

I, however, want you to consider anew the disgraces of the tobacco wars and ask you, where is the outrage? Let's start with a factual description of the problem.

Based on the calculations of the finest statistical minds in the world and the World Health Organization, they have predicted that by 2025, 27 years from now, 500 million people worldwide will die of tobacco-related disease. That's a numbing figure. It is too large to take in, so let me put it in other terms for you. That's a Vietnam War every day for 27 years. That's a Bhopal ever two hours for 27 years. That's a Titanic every 43 minutes for 27 years.

If we were to build for those tobacco victims a memorial such as the Vietnam Wall, it would stretch from here 1,000 miles across seven states to Kansas City. And, if you want to put it in terms per minute, there's a death 1.7 seconds, or about 250 to 300 people, since I began to speak to you this afternoon.

These unnecessary deaths are a disgrace, but there is the outrage? A Vietnam a day should produce more than a press conference from the House and a filibuster in the Senate. But let's go from facts to behavior. Bhopal and the Titanic were accidents. Tobacco deaths are not. They are the predictable result of malignant industry that manipulates, packages, advertises and sells its product at every corner of the globe. By any reasonable standard, tobacco executives understand and know the consequences of their acts -- that is, they know that they will and are causing disease and death. But they stood in front of Congress and swore under oath that their products were not addictive or dangerous and that they had not marketed to children.

After the decades of the industry hiding its lies and its misdeeds, some brave

and diligent people showed us the facts. Skip Humphrey, for example, the attorney general of Minnesota, and his colleagues really pursued the truth with admirable tenacity. They exposed some of the most incriminating evidence of lying, deceit and suppression of science ever. And we learned that the industry was marketing to children as young as 13, that it was really spiking their product to achieve greater addictiveness, and that it was covering up the truth about a range of diseases from infant morality to cancer.

We have also learned that the industry recently paid scientists thousands of dollars to write letters to the editors of prominent publications to question the link between environmental tobacco smoke and lung cancer and to undermine the 1993 Environmental Protection Agency findings.

This included one former NIH cancer researcher who was paid $20,000 over seven months to write to the lay and professional press. And when questioned he replied, "Are you getting paid for what you're writing? We're all out there working."

Where is the outrage?

The Congress is threatening to bring down the government over testimony about a blue dress. And yet it seems that perjury about addicting children and tampering with evidence on airborne cancer is of no interest to them. And there's not only the perjury of the tobacco industry that should be viewed as a scandal, there's the question of tainting the entire legislative process.

Maybe my story should be called "Dr. Smith Goes to Washington." But I never really believed that politics are corrupt or that politicians are for sale. But when I look at the lobbying effort of the tobacco industry over the past year, I have to wonder if that's still true in its entirety.

The industry hired one lobbyist for every two members of Congress. The major manufacturers spent over $30 million in lobbying fees last year alone, a number that does not include the millions in campaign contributions or the billions spent on advertising grass roots and front organizations. The number of tobacco lobbyists on the Hill was obscene. But it was not the quantity, it was the quality of such lobbyists that was a stroke of genius on the part of the tobacco industry. As one anti-tobacco Republican senator confided to me, "Do you have any idea how difficult it is to be faced by a former colleague now lobbying for tobacco? I try not to take all his calls but I do have to take some of them."

Moreover, it is not just influencing peddling at work here, there are also donations to think about, donations that abounded to those who confirmed and contributed to the demise of tobacco legislation. Even if the donations are not in the form of cash, the Congress can also look forward to some other kind of in-kind donations and help from the tobacco industry in the form of advertising.

Let me ask you, when the McCain bill is long dead, why does the tobacco industry keep running the ads against it?

Is it to pay back loyal supporters? Senator McConnell, the chief opponent of campaign finance reform, said that the ads would be generally helpful to the people that decided to kill this bill as a big tax increase on working Americans.

Or is it as Kathleen Hall Jamieson of the Annenberg Public Policy Center says, to provide political protection to those in Congress who decide to stick with the industry?

Or is it to keep the Democrats at bay, defending themselves during the upcoming campaign? Or is to help the Republicans who are in power?

And the answer, I think, is all of the above. And my thanks go to Dick Pullman (sp) of the Philadelphia Inquirer, who put that together so nicely.

But don't think it stops there. In addition to the Congress, the tobacco

industry wines and dines state legislatures, giving them everything from lavish dinners to trips to the Kentucky Derby and Nascar (sp) races.

Since many states have even looser restrictions on campaign donations than does the Congress, as hard as that may be realize, the industry is also undoubtedly helping them out with elections as well.

But where is the outrage about that?

This Congress is holding the attorney general in contempt over memos about the building from which a fund-raising call came. But no one seems to be troubled by lobbying federal and state officials, a mob of lobbyists, stacks of campaign cash, ongoing targeted ads and dirty boxes. That I suppose is business as usual in defending the right to sell cancer to unknowing and immature minors.

When I came to Washington as the solicitor general-designate, I thought that health should be nonpartisan and that I would maintain that position. I'm proud to say that I did. I was appointed to my post by a Republican president and I served him for seven years and then his successor for one year more; that's two full four-year terms. I'm still a registered Republican, but I have to admit a certain shame when I say that because of some Republican behavior on tobacco legislation.

Let me quickly say that I do not mean this as a blanket statement about all Republicans because there are people like Senators McCain, Chafee, Specter, Gregg, Frist and so on, and Congressman Hansen and a dozen of his colleagues, all have been strong Republican leaders in the fight against tobacco, as have a handful of others in this Congress; and to them we owe a great debt.

But we have to admit that it was the Republican Party that defeated the McCain tobacco bill in the Senate and that prevented the Hansen bill from even being discussed in the House.

As a Republican, I find it hard to understand why the Republican Party has been so opposed to comprehensive tobacco legislation.

They say that they are against drugs, but tobacco contains a dangerous addictive drug, perhaps the most addictive of them all, and that is also a gateway drug to the others that give them so much concern.

They claim to be pro-life. Tobacco causes spontaneous abortion, prematurity and low birth weight. In addition to the 430,700 tobacco- related deaths last year, we know that that year also probably saw between tens of thousands and 100,000 newborn babies die before birth. New data also shows that permanent fetal brain damage and disabilities are caused by tobacco, such as disabilities such as attention deficit syndrome, hyperactivity and so on.

The GOP says it is for protecting children. But they must not think that preventing the addiction of children to a life of bondage to tobacco and premature death comes under the category of child protection.

And finally, Republicans are, of course, pro-family. And yet nearly half a million families are disrupted every year by a tobacco- related death alone. And moreover, many times that number are disrupted by tobacco-related illness and disabilities.

But where is the outrage?

My party splits bitterly over who is sufficiently pro-life, pro- child, pro-family. But the leadership of the Republican Party avoids all mention of its links with the tobacco industry and tobacco money.

I am not proud of that and I think many other Republicans, like me, who are truly anti-drug, pro-life, pro-child and pro-family, would not be proud of it either.

During this battle of the tobacco wars, no sustained outrage ever developed. There were early victories such as overturning the middle- of-the-night $50

billion theft in the balanced budget bill and reversing the cut in FDA enforcement funding. But confusion, distractions, resignation to politics as usual and plain old apathy took over. And instead of a public that demanded contrition, an apology from the tobacco, regulation of corporate misdeeds and jail terms for some, there has been a resurgence of arrogant dishonesty on the part of the tobacco industry.

Having used their money and lying advertising campaign to defeat the best tobacco legislation in the history of this country, the industry can now sit back and watch its profits grow, as Medicare, Medicaid, Veterans Affairs, private health insurance and public hospitals pay the real price of their products.

Outrage is an endangered quality in America, not only about tobacco but also about a variety of other issues that even just a few decades ago would have produced moral indignation.

But outrage about tobacco need not become extinct. I believe that the press was quite effective in its reporting on the tobacco wars. Ironically, the paid ads in print on radio and on television undermined much of what the message was that you were reporting, but the reporting was generally comprehensive and very thoughtful.

So, if you don't mind my saying so, it is up to you, the press, to keep outrage from becoming extinct. This country and the public health community in particular need you now as never before. Please continue to be advocates for the public health. The public health folks do not have the resources to counter the sheer volume of industry propaganda, and we must rely on you for the so-called free media to make the system honest.

Let me make a few requests of you.

First, keep up a steady reminder on the effects of tobacco. Do not be numbed by the numbers. Remind everyone that 1 in every 5 deaths in the United States is tobacco-related, that nicotine is a very addictive drug, and that no form of tobacco is safe.

Remember, too, that the real issue is the addiction of children. Do not be sidetracked into meaningless discussions about the free choice of adults, when 90 percent of smokers start before they are 18. And do not make criminals of kids; punish the seller and not the buyer.

And don't forget that most smoking adults really want to quit. Push for more scientifically sound programs to help them and for more research to understand why they became addicted.

Remind the public that no amount of money is worth giving away the basic rights of citizens and states. Other companies have to pay the cost for their dangerous products and they include it as part of the prices that they charge. The tobacco industry has so much money because it avoids paying for the damage its products cause.

And never underestimate the tobacco industry. It is a social disease as dangerous as any malignancy and it metastasizes more rapidly.

As I close, forgive me if I as a physician have been using the analogy of the attack of a malignancy on its victim. In medicine when we say malignancy we usually mean a tumor. And when we may victim, we are talking about the patient. In my analogy, the patient is society and the tumor is the malignant industry of tobacco.

Let me tell you some of the characteristics of a malignancy. It is unbridled in its growth. It uses great energy at the expense of its victim. It grows rapidly in secret before a sign or symptom makes it evident. When it has done its damage locally, it metastasizes and spreads to distant sites. It can be

controlled by surgery, my favorite method treatment because that means the malignancy is disposed of. But it also responds to other therapy such as radiation and chemotherapy.

But the good news is that progress is being made is understanding malignancy and there is hope for successful new prevention and new treatment. This analogy comes to life with a few examples. Tobacco has grown without control in this country because of a network of special legislative exceptions and protections. The tobacco industry draws on the energy of society, forcing taxpayers to pay for its medical and social costs. The tobacco industry has acted in secrecy, corrupting the normal ways of doing business. After many years of deception, it has finally been recognized by the illnesses that it causes. And the tobacco industry has metastasized to every corner of the globe, using practices even more reprehensible than those that are used in America.

The tobacco industry perhaps could once have been controlled by surgery. But after waiting 200 years, such therapy is out of the question for now. It might gradually respond to such other therapies such as radiating light on its misdeeds and holding the industry responsible for its actions.

Finally, there is hope that this base of experience we've had in fighting this battle of the tobacco wars, we can move forward in the next Congress to make progress in the prevention and treatment of this social cancer.

The ladies and gentlemen of the press, if this sounds to you like a plea, it is. We have tried lots of approaches and they have not worked. And now I think it might be up to you.

In my contacts with some of you, the press, I occasionally get notes that I cherish. One recently came from a reporter whose name I will not mention. As you folks say, I have to protect my sources. He said, "I can only share your outrage with the outcome of the proposed tobacco legislation in Congress. It was emblematic of a degree of Capitol Hill corruption and of disdain for health, safety and life itself. It beats anything I have known in my entire career as a Washington reporter."

I hope that some of you here today feel the same way that that gentleman does and act accordingly. Please go out there and create some outrage.

Thank you. (Applause.)

DR. KESSLER: Thank you, Dr. Koop, for your eloquence this afternoon.

What Congress has done this year on tobacco legislation is a national disgrace. This Congress has abdicated its responsibility. And as a result, it has continued to expose tens of thousands of children to a lifelong burden of addiction and many to a premature death.

The last few months have not been a good time for the public health community. But more importantly, it is not has been good for the public health of this country. The tobacco industry is winning more battles than it is losing. It seems that almost everyone in Washington has been on the tobacco industry's payroll of late -- lawyers, pollsters, lobbyists and advertisers. A minority of senators almost gleefully killed the McCain bill, which had a majority of members supporting it. And the recent round of judicial opinions have favored the tobacco industry.

Am I concerned? No, not really.

Let me tell you why not.

The basic fact is that nothing that has occurred over the past few months can change what we now know. The scientific evidence today is incontrovertible. Where we once saw tobacco products as things that people smoked and chewed for pleasure, we now know that nicotine is an addictive drug. Where the industry was once able to argue that smoking is a matter of choice for adults to make, we

now know, as the industry has known, that smoking begins in childhood. Where we once saw tobacco products as natural agricultural products, we now know that the levels of nicotine in those products have been manipulated to deliver optimal doses of an addictive drug. And we now know that for years the tobacco industry has targeted young people.

That's the record. No amount of money, lawyers or lobbyists or advertisers can change that record.

The industry gets indignant at comparisons of nicotine to morphine, cocaine or heroin. But the science doesn't lie. Nicotine's effect on the brain is like any other addictive drug. And it's not just that the product is addictive. It also kills. That is why the day of reckoning for the tobacco industry will come -- maybe not this year, maybe not even next, but it will come.

Nicotine is an addictive drug and a deadly product. It is a fact with which we as a country will ultimately confront. And because it is children who are becoming addicted as children, I am convinced that we as a country will deal with this deadly product.

The problem with the settlement was just that: it was a settlement. The industry has for years wanted to achieve one thing: to make cigarettes less controversial. The industry wanted peace. It is wrong to reach a settlement with someone who is selling an addictive drug and a deadly product.

I am actually optimistic. The way the Congress killed the McCain bill was so blatant that it is hard to believe that they can live with the consequences of their actions. One day -- maybe in this Congress, maybe in a future Congress -- a majority leader or speaker of the House will wake up one morning and look himself in the mirror and say that enough is enough. We have seen it happen with industry whistle- blowers; they live in a world shaped by denial. One day a leader in Congress will say to himself that it is no longer right for the Congress to come down on the side of the tobacco industry. I am not holding my breath, but it will happen. It will happen because a majority leader or a speaker is not going to want to admit that he has fronted, consciously or not, for an industry that has addicted so many.

I am confident that the Fourth Circuit will be reversed. Respectfully, they got it wrong. They got it wrong because they didn't recognize one major fact: nicotine is an addictive drug. The two judges who voted against FDA argued that tobacco products fit the definition of "drug" only mechanistically. They are wrong -- seriously wrong. It is as if the decision were written years ago when our knowledge about nicotine's pharmacological activities were kept as top secrets with in the companies, when all the public knew was that cigarettes were smoked for pleasure, or what the cigarette companies called "satisfaction." Cigarettes are smoked to satisfy an addiction.

The two judges in the Fourth Circuit didn't understand the science. They didn't understand the record. The record today is there for everyone to see. The Fourth Circuit also made certain other fatal errors. They misconstrued the rules of statutory construction. They misinterpreted the holdings of the Supreme Court in the Chevron (sp) case. Would anyone seriously take the position that each time a new product is synthesized or a new medical device is invented Congress needs to enact specific legislation governing the regulation of those products? Of course not. Agencies are assigned general regulatory responsibilities over types of products. NISTA has authority over motorized vehicles. The FDA has responsibility over any mechanical object that carries people into flight. OSHA regulates everything that might pose a threat to workers. FDA has responsibility over drugs. No amount of tortured legal reasoning can get around that fact.

As Judge Hall said in the dissent, the administrative record in this case is a

perfect illustration of why an agency's opportunity to adopt a new position should remain open. The crux of the panel's majority's ruling is that Congress has made it clear that the FDA has no authority over tobacco products. Nothing -- nothing in the federal Food, Drug and Cosmetic Act says that. Under no rule of statutory construction that I know of can you reach that opinion from the words of the statute.

There is also one other interesting problem with the Fourth Circuit's opinion: If Congress were unequivocal in saying that FDA doesn't have the authority to regulate tobacco products, why did Congress appropriate millions of dollars to the agency to do so? To quote Judge Hall, "Under the facts found by the FDA during the rule- making process, it is now a scientific certainty that nicotine is extremely addictive, and that a large majority of tobacco users use the product to satisfy that addiction." He went on, and I quote, "Even more important to my mind is the new evidence that the manufacturers design their products to sustain such addiction," end of quote. Our scientific understanding today of nicotine addiction makes it imperative for the FDA to regulate tobacco products. With absolute certainty I can predict that there will come a time when the Congress finally comes to grips with the terrible toll that nicotine and the deadly carcinogens in cigarettes have had on millions of families.

The tobacco companies may be able to buy vast amounts of influence here in Washington and state capitals around the country. They've proven that they're willing to spend millions of dollars to get what they want. But they can't buy the facts or the science.

And the science on cigarette carcinogens and nicotine's devastating effect on the brain is incontrovertible fact. Science does not wait on politicians or campaign ads or judicial fights or public policy skirmishes. And the science on cigarettes and nicotine is unfolding at a pace never seen in this country. These are facts that the tobacco companies have fought for years -- for decades -- to obscure.

Some in the Congress and the courts have yet to recognize it. Nicotine is a drug of abuse. It is delivered to the body very effectively by the cigarette. All that remains to be seen is whether Congress and the courts will let FDA to its job. With every ounce of energy, Dr. Koop and I are committed to seeing to it that in the end the public health will prevail. Thank you. (Applause.)

MR. HARBRECHT: Doctors, would you both please -- could you -- Dr. Kessler please? We're going to have some questions here from the audience I'd like to ask you. We can alternate or whoever wishes to answer can do so.

Both of you have addressed the issue of not accepting an imperfect settlement. But looking back, was it wrong not to agree to the terms the attorneys general negotiated? Wouldn't it have been better to pass a bill and then push for more, as opposed to getting nothing and still pushing for the whole loaf?

DR. KOOP: Well, the settlement really was a settlement. It was something that was devised by the tobacco industry, and the attorneys general of the several states, and one lone representative of the world of public health. Many of the things in it were illegal. And what they asked Congress to do is to ratify what they had decided to do in private. And even the people who did not behave as we think they should in Congress said this is not what the Constitution demands; this is not what Congress does; it doesn't just ratify private agreements made in secrecy behind closed doors.

What the McCain bill was -- initially -- was a gift to the tobacco industry, just like the settlement was. But then conscientious people in Congress amended it until it became good tobacco legislation. And that's what the Republican

Party killed.
DR. KESSLER: I think the settlement, if it was enacted into legislation, would years from now be looked upon as one of the major mistakes in the public health arena. The industry wanted peace. They wanted to reduce the level of controversy around that product. They wanted immunity for its past deeds. It would have been wrong to do that.
MR. HARBRECHT: Looking ahead now, will you support the soon-to- be-released new attorneys general settlement? And what motivation is there now for Congress to act on tobacco? Do you think Congress will do anything meaningful to regulate tobacco either this year or next year?
DR. KESSLER: I have very good friends who are attorney generals who do a wonderful job. But it is time for members of Congress who pass the laws of this land to step up to the plate. The last time I checked, the attorney generals don't enact legislation. They act when there is a vacuum, when there is a void in national leadership. And right now there is that void.
DR. KOOP: I think one of the most telling things that happened about the present so-called settlement is that Attorney Harshberger of Massachusetts, who has always been one of those who put public health first, finally walked out on the talks, because there were no public health provisions.
MR. HARBRECHT: This is for Dr. Kessler. Dr. Kessler, you don't really believe that the Court of Appeals ruled in favor of the tobacco industry because of the money spent by the industry to protect its interests, do you?
DR. KESSLER: I believe the Court of Appeals got the law wrong. They viewed tobacco as the way it was viewed decades ago. They didn't understand the basic fact, that nicotine is an addictive drug. They didn't understand the science. When you look at the score card, there is no question that the industry is ahead, because it had two votes in the Court of Appeals. And so far when you really add it up you have one Court of Appeals judge and one District Court judge siding with the FDA; one Court of Appeals judge and a District Court judge, who was sitting on the Court of Appeals for that hearing, siding with the industry. I certainly encourage the Fourth Circuit as a whole to review that decision. I think that would be the right thing to do.
MR. HARBRECHT: This is for Dr. Koop. When you ask where is the outrage regarding the deceptive practices of the tobacco industry, do you blame the press, or do you accept the premise that the American people just doesn't get outraged by scandals like the tobacco companies' practices?
DR. KOOP: No. I thought I made it very clear that I didn't blame the press. I thought they were overshadowed by a $30 million campaign, just as they were getting to the height of their reporting. And I pled with them to go back to their responsible reporting and keep the public informed. But you have to recognize that there is in this country, as I said, a growing lack of interest in things that used to make us outraged. There is apathy -- it is not just about tobacco. And I think that all of us forgot about this. I remember just a year ago this week talking to President Clinton, who had not included the exposure of documents in the five points that he said must be in any legislation that he would sign. And I told him that if he would encourage the exposure of the documents then being considered in the Minnesota trial that the public would be so outraged that they would force Congress to do the right thing. He agreed with that, as did the first lady in that conversation, but we were wrong about it. I think Skip Humphrey was wrong. And it's not our fault, I think, that we misunderstood the American public. They just don't get as excited about things as they used to. Because if there's ever anything you want to get excited about, it's the malignancy of the tobacco industry.
MR. HARBRECHT: Well, gentlemen, the strategy now -- will you now set aside the

push for federal legislation, the push for state law? Should the strategy be to push in the courts? What do you think is the best way to go?

DR. KESSLER: These are chapters. These are chapters in the history of tobacco control. The courts still have their work before them. There is the issue of whether the Fourth Circuit will hear the case on Bonk (sp), whether ultimately the Supreme Court will take certiorari. There is Department of Justice investigation underway.

Look, we're in this for the long term. This is a chipping away. This doesn't happen overnight. And if this Congress doesn't have the courage to stand up to this industry, one day there will be a Congress that will do it. Unfortunately we may have to wait. We are not going away. We are going to see this to the end.

MR. HARBRECHT: Dr. Koop, as a matter of passing interest, what fuels your passion on this particular issue?

DR. KOOP: Everything. I think that when I came to Washington the smoking issue was on my desk, and I found I was supposed to deliver a report every year to Congress on smoking and health. And I did eight of those. I'm very proud of them, because three of them anyway were the basis that led to the necessity for a settlement on the part of the tobacco industry.

But I think that what happened to me was that I changed from being just a health officer interested in the health of 250 million people to a health officer who was enraged that this country permitted an industry to pull the wool over the eyes of Congress, state legislatures and the public. What the tobacco industry has done to 450,000 people a year is beyond belief. If this were any other thing except tobacco, it couldn't happen.

Suppose you went to bed tonight and knew nothing except what Dr. Kessler said a few minutes ago, that some people liked to smoke and some people got into the habit of doing it, but you didn't know anything about the health effects or about addiction. And for the first time tomorrow morning you saw 450,000 people died last year from tobacco, there would be a revolution in this country that nobody in public health knowing these things had done anything about it. And that's how I feel about Congress. They've -- the tobacco industry has hidden behind the Food, Drug and Cosmetic Act for so long that it is nauseating. They said -- and Congress agreed with them -- that tobacco is not a food -- I agree with that -- it's not a drug -- that's wrong -- and it's not a cosmetic -- that's right. But it is also a device.

So I was annoyed about tobacco and its minions behind able to sell a drug that was addictive, just as addictive as heroin and cocaine. And think about the difference. All the things that Congress worries about -- cocaine, heroin, LSD and those things -- if you take every single death in this country that comes from drugs, it comes to 20,000. It's a lot of deaths -- but it's nowhere near a half a million.

MR. HARBRECHT: Dr. Gary Bauer of the Religious Right has called the McCain tobacco bill -- which you were no fans of -- but he called it "fascism." Do either of you know why the religious community has been largely silent against tobacco companies?

DR. KOOP: I haven't the slightest idea, except that they rise to social issues very slowly. In the Protestant church especially, and then to some degree the Roman Catholic Church as well, they confuse something with what used to be called the social Gospel. There was either straight Christian theology or reform Christian theology, and then there was very liberal Christian theology, which was social theology. And I think that's what keeps them from getting

involved in this. But when they do get involved they're very effective. And I can only hope that they will begin to see some of these things.
Not understanding what Bauer means about being fascistic just adds to hundreds of things I don't understand about Bauer. (Laughter.)
MR. HARBRECHT: What are your opinions, please, of the vast and some would say excessive contingency fees that would have been paid to lawyers in the tobacco settlement? Dr. Kessler, wearing your attorney hat, what is your opinion of the legal fees?
DR. KESSLER: I was greatly troubled by those fees. Certainly the state are entitled to settle their cases. I understand that. Certainly lawyers invest their time and resources. But this shouldn't be about windfalls, this shouldn't be about contingency fees, this shouldn't be about money. This is about public health. And that's why it's absolutely necessary. Some day someplace, when there is the will to do it, that Congress not pass a settlement -- not pass a deal -- but pass what it is supposed to pass, and that is legislation. MR. HARBRECHT: An individual responsibility question: Should individuals who have smoked for years then suffered lung cancer be able to recover money from tobacco companies? Do individuals have any responsibility to know the results and choose for their own behavior?
DR. KOOP: Well, Dr. Kessler created a sound bite several years ago which was very true and very telling when he said that smoking was a pediatric disease, what he meant by that was that 90 percent of smokers in America today who are adults, and have the ability to make reasonable judgments, became addicted to nicotine when they were still children. And I think all of us agree that there comes an age below which you can expect children -- minors, innocent juveniles -- to make life-long decisions, especially about something as difficult as an addictive drug. And so there is a sense in which individual responsibility is wiped out when you are dealing with an addictive drug.
I am sure every one of you here -- maybe some of you yourself -- know what tremendous hold an addictive drug has upon an individual. It isn't something that you sit down and say on a given evening, "Gee, I shouldn't be smoking because it's not good for my health -- so I'll stop tomorrow." You might stop tomorrow, but you have to do it about six different times over the course of five years before it really takes on.
And so to talk about individual responsibility, when you're really talking about children who were seduced by lies into smoking, is not really talking about a reasonable choice of adults at all.
DR. KESSLER: Let me tell you where I think the dam may break. In front of a jury the fact that you, the tobacco industry, fooled me into smoking -- most people aren't going to buy that. Now, there are enough documents now available to see the extent that the industry went to try to create this, quote, "open controversy," to create doubt, to try to fool people. But I think in the end jurors can go either way, either the corporate misconduct or the individual responsibility.
Where I think the dam will break, where I think this country draws the line, is not that you, tobacco industry, fooled me, a 65- year-old person, into smoking -- that's not where it's going to happen. What's going to happen is that you, the tobacco industry, targeted my children; my children became addicted. That I believe is the case the industry will lose every time.
MR. HARBRECHT: Dr. Koop, you referred to improper practices abroad as being worse than in the U.S. What did you mean by that, and why is smoking even more rampant in Europe, Asia and elsewhere? It is rather shocking by the way. And what effect does our anti-smoking campaign have on smoking issues internationally? What can be done to -- what can be done globally to cut down

on tobacco use? That's for both gentlemen. DR. KOOP: I think that if we had been able to pass the McCain bill, that would have been the best thing the United States could have done for the international problem about tobacco, because they would have shown other industrialized nations, and then the Third World, what a template might be to go after the tobacco companies. But we didn't do that, and therefore now stuck with this malignant metastases going all over the world.

Some of the things that are worse abroad than they are here -- first of all, there is no surgeon general's warning on tobacco, as inadequate as they might be in our own country. There is at times more nicotine in the cigarettes sent abroad, and there's many times as more tar in the cigarettes sent abroad. In addition to that, their marketing practices are very reprehensible. They will go into a Third World country, offer them -- altruistically supposedly -- free tobacco plants to start an industry. And after they grow tobacco they will show them how to build a little cigarette company and get the people smoking their cigarettes. And they say the reason you should do that is so you can have an excise tax, and you'll make money on it. And then as soon as they get the population addicted, they import Marlboros into that country, and nobody wants the rotten cigarette that is made by the local people.

So everything that they do is designed to dupe people, to take them into a situation where they don't understand either the health problems or the addictiveness. And that's why I think you could easily say that the practices abroad are worse than they are here. This is nothing new. I think the worse part about it all is that for many years the efforts of the tobacco industry were aided and abetted by the White House in the form of the United States Trade Representative. And the things that we have done in Taiwan, in South Korea and in Thailand are extraordinarily criminal in my opinion. The last public utterance that I made the day before I retired as surgeon general was to say that I thought one of the most reprehensible things that this country did was to export disease, disability and death, aided by the United States Trade Representative, to the Third World.

DR. KESSLER: Two hundred and fifty million children alive today around the globe will die of smoking-related illnesses. Fifty million children alive today in China will die from tobacco products. I have real concerns in 20 years what those countries will think of us, of this country, what effect it will have.

MR. HARBRECHT: Well, doctors, it really is an honor to have you here today. I have some things here before I ask our final question today. First, certificates of appreciation -- Dr. Koop, Dr. Kessler -- for coming today. Thank you very much. We have copies of the -- our 90th anniversary history book -- the reliable source, of which both you gentlemen, being reliable sources today, thank you so much for coming. And of course the National Press Club mug. (Applause.)

I have a final question for both of you today. I remember growing up, and when Roger Maris was going for 61 home runs and the shocking pictures in the newspapers of Roger Maris smoking a cigarette after every game, or every time he hit a home run. What role do you think sports stars could play in dissuading teens from smoking? And have you tried to establish a network of sports stars against smoking?

DR. KOOP: I think that sports figures could do a tremendous amount by being positive instead of negative role models. The other problem is not just smoking, but it's the malicious practice that many baseball players, especially pitchers have, of chewing smokeless tobacco. And some of you may remember just a few years back the young lad named Marcey (sp), who was on the front page of

most papers, dying with the hugely expanded head with all kinds of tubes coming out of him. And I talked to his mother, and she said, "I begged him not to use tobacco in any form, but especially not to chew it. And he said, 'Mom, you know, if there was anything wrong with tobacco there'd be a label on the can saying not to do it.'" This was the day before we had labels on cans of chewing tobacco. And he said, "Besides that, do you think all those baseball players would be so stupid to chew tobacco if it was going to endanger their health?" Sean Marcey (sp) died. And if there is one man that should deserve a tremendous amount of credit in this country, and that's Greg Conley (sp), who is a dentist and very active in the Department of Health in the State of Massachusetts, and he has carried on a one-man campaign to convince baseball players to switch from chewing tobacco to bubble gum. And you watch next season when the pitchers go out on the mound they'll be chewing, and some of them will blow bubbles. But it takes only about two weeks, and they go back to tobacco again. Hence you will believe that this stuff is really addictive.

DR. KESSLER: We've created images in this country -- almost a century's worth -- fueled by the advertising and promotional themes that the companies and their advertisers have dreamt up. That's what we are talking about reversing. It's not going to happen overnight. Those images that were created led young people, baseball players, actors -- make them believe that there was something cool, there was something sexy about smoking those products.

Today now we know that it was all -- unfortunately it was all manipulation. If you read those documents and you understand the lengths the industry went. Tell a young person when they think it's cool, when they think it's adventuresome, that they think it is an act of rebellion. Nothing rebellious about it -- they're simply being manipulated. But it's going to take time to change that -- those images.

MR. HARBRECHT: Well, doctors, I'd like to thank both of you very much for coming today. And I'd like to thank National Press Club staff members Kate Goggin, Joanne Booze, Pat Nelson, Melanie Abdow Dermott and Howard Rothman, for organizing today's lunch. Ladies and gentlemen, thank you very much for coming.

(Applause.)

END

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