FINAL REPORT

and Recommendations
From the Health Community
to The 101st Congress
and the Bush Administration

On the Occasion of the 25th Anniversary of the
Surgeon General's First Report on Smoking

TOBACCO USE IN AMERICA CONFERENCE

U.T.M.D. Anderson Cancer Center, Houston, Texas
January 27-28, 1989

FINAL REPORT

TOBACCO USE IN AMERICA CONFERENCE

Ellen McConnell Blakeman, Editor

Alan L. Engleberg, M.D., M.P.H., Scientific Editor

The final report of the Tobacco Use in America Conference was published by The American Medical Association. For additional single copies contact: The American Medical Association, Public Affairs Group, 1101 Vermont Avenue, N.W., Washington, D.C. 20005.

Acknowledgements

The Tobacco Use in America Conference was initiated by Congressman Michael A. Andrews of Texas and funded by the American Medical Association in cooperation with the University of Texas M.D. Anderson Cancer Center, Houston.

The conference was co-sponsored by the American Medical Association, the American Cancer Society, the American Heart Association and the American Lung Association.

Congressmen Richard J. Durbin, Illinois and Mike Synar, Oklahoma served as congressional co-sponsors and made invaluable contributions to the conference plans.

The sponsors extend their thanks to everyone who helped make the Tobacco Use in America Conference a success.

Special recognition is given to the workgroup leaders and Members of Congress who participated in the conference.

The sponsors express their gratitude to the Conference Planning Committee: Scott Ballin, American Heart Association; Alan Davis, American Cancer Society; Fran DuMelle, American Lung Association; Harry Holmes, Ph.D., University of Texas M.D. Anderson Cancer Center; John Hollar and Kim Koontz, staff to Rep. Mike Synar; David Kendall, staff to Rep. Michael A. Andrews; Susan Lightfoot, staff to Rep. Richard J. Durbin; John Madigan, American Cancer Society; Matt Myers, Coalition on Smoking OR Health; and John H. Scott, American Medical Association.

Special thanks goes to Bill Romjue, Administrative Assistant to Congressman Michael A. Andrews, for his leadership in planning the conference.

The sponsors also recognize several people for their extraordinary contributions to the workgroup papers: Mary Crane, American Heart Association; Cliff Douglas, Coalition on Smoking OR Health; Shirley E. Kellie, MD, American Medical Association; Angela Mickel, Tobacco-Free America; and Jonathan Slade, University of Medicine and Dentistry of New Jersey.

Thanks are extended to Jeff Rasco, Director of Conference Services at the M.D. Anderson Cancer Center and his fine staff, and Sharon Kremkau of the American Medical Association's Division of Meeting Services, for outstanding conference arrangements.

And special thanks to Pam Bauernfeind, staff of the American Medical Association's Department of Congressional Relations, whose hard work helped ensure the conference's success and to Mike Zarski with the American Medical Association's Department of Federal Legislation who made invaluable contributions to the planning of the conference and to the final report.

Table of Contents

Introduction

Prepared by:
Rep. Michael A. Andrews
U.S. House of Representatives
Charles LeMaistre, MD
President, M.D. Anderson
Cancer Center, Houston
Joseph Painter, MD, Vice-
Chairman, Board of Trustees
American Medical Association*

Twenty-five years ago the first Report of the Advisory Committee to the U.S. Surgeon General was issued on the impact of tobacco use on health. This 1964 report presented stark conclusions: that cigarette smoking causes lung cancer and is the most important cause of chronic bronchitis. The Report also linked smoking with emphysema and other forms of cancer.

The tobacco industry contested the report, arguing that there was no conclusive link between smoking and poor health. Yet while the "debate" raged, the evidence supporting that landmark report continued to mount.

Just three years later, in 1967, the late Dr. Luther Terry, then the Surgeon General, declared the "debate" closed:

> *There is no longer any doubt that cigarette smoking is* a direct threat to a user's health. There was a time when we spoke of the smoking and health controversy. In my mind, the days of argument are over.

With each passing year since 1964, the link between cigarette smoking and death and disease has become even more incontestible. Subsequent reports of the Surgeon General on the health consequences of smoking have shown unequivocally that, among many other things, cigarette smoking is the most important of the known modifiable risk factors for coronary heart disease; is a major cause of stroke; is a cause of disease, including lung cancer, in healthy non-smokers; and is a cause of fetal injury, premature birth and low birthweight in the case of smoking by pregnant women.

Much progress in curbing tobacco use has been made since 1964, but even more remains to be done. What crucial problems confront this nation about tobacco use today? What obstacles must be overcome to reduce the death and disease caused by tobacco use? And what strategies must be undertaken to eliminate the number-one preventable cause of premature death and disease in this country?

To answer these questions, the American Medical Association, the American Lung Association, the American Cancer Society, the American Heart Association, key members of Congress, and many other concerned citizens and organizational representatives came together in a remarkable two-day gathering early this year, The Tobacco Use in America Conference. Never before had such a broad-based coalition assembled to develop a common agenda to reduce the death and disease caused by tobacco.

The Conference achieved exceptional consensus on the scope, objectives and tactics for future tobacco-control efforts. The conferees agreed that in order to maintain current progress, decisive public policy action at the federal level must be combined with similar actions at the state and local levels, and that public policy must be developed in tandem with traditional public health initiatives. Only a comprehensive approach that recognizes the fundamental importance of public policy action will succeed.

The dominant issue of the conference was how to dramatically reduce smoking among *our nation's children*, young women, minorities and those Americans with fewer years of formal education. The recommendations of the conference call for developing more effective ways to work with these populations which have been so effectively targeted by *the tobacco industry.*

Another key concern reflected in the conference recommendations is the need for public policy-makers to recognize the powerfully addictive nature of nicotine. The conferees agreed nicotine addiction is a grave problem because it causes most tobacco users to become "hooked" before they are old enough to appreciate the health consequences of their actions. More than 90 percent of all tobacco users begin while teenagers or younger; 50 percent of high school seniors who smoke begin by the seventh and eighth grade; and 25 percent of all high school seniors who smoke begin before or during the sixth grade.

The major recommendations of the conference are:

- The U.S. Food and Drug Administration should be given authority over all tobacco products;
- Tobacco advertising and marketing must be severely restricted to eliminate its influence on our nation's children;
- Excise taxes and user fees on tobacco products should be increased to raise revenues and discourage use by children;
- The financial umbilical cord tying the federal government to the tobacco industry—Tobacco Price Support Program—should be severed to reduce tobacco's undue political influence on the federal decision-making process;
- Action is needed to protect non-smokers from involuntary smoking in public places, on trains, buses and planes, and in the workplace; and
- The federal government must eliminate the cynical inconsistency between its domestic health policy and the way in which it exercises its international trade leverage to open up tobacco markets in other nations thereby enabling American tobacco manufacturers to increase overall tobacco use in those countries.

The conference participants agreed that in order to implement their recommendations, the major health-related organizations must continue to work together in support of a united agenda. Collectively, the participating organizations can mobilize millions of citizens at the grassroots level to create a strong, coherent body able to more effectively influence and educate policy-makers throughout government.

In 1981 the first National Conference on Smoking or Health served as a catalyst for many of the public policy gains of the last decade. If the cooperation, unity, good sense and energy displayed at this year's Tobacco Use in America Conference translate into action, this conference, too, may serve as an important steppingstone towards achieving the Surgeon General's goal of a smoke-free society by the year 2000.

**Dr. Painter presided on behalf of all the conference sponsors: The American Medical Association, The American Cancer Society, The American Heart Association, and The American Lung Association.*

Tobacco Use: Women, Children and Minorities

Prepared by:
Shirley E. Kellie, MD, MSc
Dept. of Preventive Medicine
American Medical Association

Introduction

Tobacco use by women, children ad members of minority groups is unacceptably high in the United States. Potentially preventable morbidity and mortality from diseases associated with tobacco use in women and minorities populations are not declining at rates comparable to those in other groups. To better understand the problem of tobacco use by women, children and minorities, this background paper summarizes trends in tobacco use; the health consequences of smoking; and effective anti-tobacco interventions in women, children and minorities.

Tobacco Use

The incidence of smoking among men peaked at 54 percent in the mid-1950s, and declined to 32 percent in 1987. The highest rate of smoking in women—34 percent—occurred in 1966, and declined to 27 percent in 1987. Although fewer women than men smoke, the fastest growing segment of smokers is women under age 23. More than 80 percent of smokers start smoking before age 21.

Based on data collected in 1986 by the Office on Smoking and Health, more black men (32 percent) than white men (29 percent) smoke. A similar trend is noted in higher prevalence of smoking by black women (25 percent), compared with white women (24 percent). Data from the Hispanic Health and Nutrition Examination Survey conducted between 1982 to 1984, reveals that about 40 percent of Hispanic men smoke (Mexican-Americans, 43 percent; Cuban-Americans, 42 percent, Puerto Ricans, 40 percent). Smoking prevalence in Hispanic women is lower than that in white and black women, and ranges from 24 percent among Mexican-Americans and Cuban-Americans to 30 percent among Puerto Ricans.

There also appear to be specific cigarette brand purchasing patterns within minority populations. The available evidence indicates that the tobacco industry clearly recognizes the need to recruit additional smokers to insure its very survival and this had led to targeting of certain identified groups: women, children and minorities. These purchasing choices may reflect tobacco company marketing practices. For instance, 47 percent of Mexican-American men smoke Marlboro (Philip Morris) and 20 percent Winston (R. J. Reynolds); 30 percent of Mexican-American women smoke Marlboro, 20 percent Winston and 16 percent Salem. Use of menthol cigarettes is very common among blacks, with 76 percent reporting that they smoke that type of cigarette.

Based on data collected by the National Institute on Drug Abuse, smoking prevalence among high school seniors declined from approximately 28 percent in 1977 to 19 percent in 1987. The decline was rapid among both adolescent males and females between 1977 and 1981, and then leveled off between 1982 and 1987. Now, more adolescent females than males smoke, however the use of smokeless tobacco is highest in young boys.

Reliable national estimates of the prevalence of smoking among American Indians and Asian Americans are not available, and additional data regarding tobacco use are urgently needed for these groups. However, data from local surveys among these groups are available. Among American Indians, the highest smoking rates are seen in Northern Plains Indians (42 percent to 70 percent), with lower rates among Indians in the Southwest (13 percent to 28 percent). Smokeless tobacco products are reportedly used at high rates by adolescents of both sexes in Alaska and among Northern Plains Indians. Smoking rates among Asian Americans, based on data from local surveys in Hawaii, were 27 percent for both Hawaiians and Filipinos, and 23 percent for Japanese.

Health Consequences of Smoking

Women who smoke are at increased risk for the same tobacco-associated morbidity and mortality as men: cancer of the lung and other sites, cardiovascular disease, stroke and chronic obstructive lung disease. However, in addition, women who smoke cigarettes are at increased risk for adverse

reproductive outcomes and osteoporosis and its associated fractures, which lead to significant loss of function among older women.

Approximately one in ten women in the U.S. will develop breast cancer. In 1986, lung cancer mortality reached that of breast cancer mortality. 1988 data from the American Cancer Society shows that lung cancer deaths have surpassed breast cancer deaths, making lung cancer the leading cause of cancer deaths in women. Women who smoke have twelve times the rate of lung cancer as do nonsmoking women. Further, smoking accounts for approximately 41 percent of all coronary heart disease in women under age 65; women who smoke only one to four cigarettes per day have double or triple the risk for heart attacks than women who do not smoke.

The harmful effects of cigarette smoke to nonsmokers are well documented; exposure to environmental tobacco smoke is particularly detrimental to spouses and children of smokers as well. Spouses of smokers are at increased risk for lung cancer. Children of smokers have retarded development of lung function, and increased episodes of bronchitis and pneumonia during the first two years of life.

Women who smoke during pregnancy expose the developing fetus to serious health consequences, and have increased risk for delivering low-birthweight infants. Low-birthweight infants are five times more likely to die during the first year of life than are infants of normal birthweight. Women who smoke during pregnancy are also more likely to spontaneously abort, deliver prematurely, deliver a still birth or suffer premature rupture of the membranes.

Compared with whites, blacks experience significantly higher mortality from tobacco-associated diseases and disorders, including cancer, cardiovascular disease and infant death. Black men have a 20 percent higher mortality rate from heart disease, and 58 percent higher incidence of lung cancer than white men. Black women experience 50 percent more heart disease mortality, and higher rates of fetal death and low-birthweight babies than do white women. Rates of smoking-related cancers are particularly high among blacks. Estimates indicate that the incidence of lung cancer will increase by 31.8 percent in black men compared with 20.7 percent in white men from 1980 to 1990. During the same decade, estimates predict that the incidence of lung cancer will increase by 98.6 percent in black women and by 86 percent in white women.

American Indians have higher rates of cervical and stomach cancers (both of which are associated with smoking) than do whites, and the incidences of lung and oral cancers are increasing to levels observed in whites. There are considerable differences in tobacco-associated incidence and mortality rates among Asian Americans, including Japanese, Chinese, Filipinos, and Native Hawaiians. The incidence of lung cancer among Chinese and Native Hawaiian women is higher than in white women.

Intervention to Prevent Tobacco Use

Effectively intervening to prevent women, children and minorities from starting or continuing to use tobacco is extremely important. Anti-tobacco efforts may be either primarily *legislative* or *educational*. Current and proposed interventions in women, children and minorities include: bans on advertising and promotion; restrictions on children's access to tobacco products; increases in price of tobacco products; and educational efforts.

Advertising and Promotion

The tobacco industry claims that the intent of its advertising is to promote brand loyalty and brand switching. However, as Davis reports in an article in *New England Journal of Medicine*, "...Others believe that cigarette advertising may perpetuate or increase cigarette consumption by recruiting new smokers, inducing former smokers to relapse, making it more difficult for smokers to quit, and increasing the level of smokers' consumption by acting as an external cue to smoke."

The total expenditure for cigarette advertising and promotion in 1986 was $2.4 billion dollars. Recently, there has been an increase in outdoor advertising, and in 1985, expenditures for cigarette advertising accounted for 22.3 percent of total advertising expenditures ($945 million) in outdoor media.

Advertising of tobacco products, particularly cigarettes, glamorizes the product. In fact, these advertising techniques make tobacco products appealing to various groups including women and youth who may be struggling with problems of poor self-image. A number of cigarette brands have been introduced and have been reported to be marketed specifically to women. Cigarette advertising in women's magazines is growing. In 1985, eight women's magazines were among the 20 magazines receiving the most cigarette advertising revenue (*Better Homes and Gardens, Family Circle, Woman's Day, McCalls, Ladies' Home Journal, Redbook, Cosmopolitan* and *Glamour*).

Some cigarette brands are reported to be specifically promoted to blacks: Kool, Winston, More, Salem, Newport, and Virginia Slims. Advertising of cigarettes is heavy in black-targeted publications, such as *Ebony, Jet* and *Essence*. Cigarette advertising on small billboards, located close to streets, is increasingly common in low-income neighborhoods. In addition, cigarette cmpanies are major sponsors of athletic events, musical concerts and cultural events in black neighborhoods. A number of cigarette brands—Rio, Dorado, and L&M Superior—have been reported to be targeted to members of the Hispanic community. Cigarette companies increasingly sponsor entertainment events and advertise on small billboards in Hispanic communities.

While the tobacco industry denies that its advertising is targeted to children and adolescents, there is good evidence

that such advertisements do in fact reach youth. Some recurring themes in tobacco advertising, such as independence and sexual attractiveness, have particular appeal to children and adolescents. Cigarette advertising is very heavy in several magazines with large readerships among adolescents, such as *Glamour* (about one-quarter of readers are girls under age 18), *Sports Illustrated* (about one-third of readers are boys under age 18), and *TV Guide* (reaches approximately 8.8 million readers age 12 to 17).

Because of these concerns, many anti-tobacco advocates have supported federal legislation to ban all tobacco product advertising. This legislation has been opposed by some on the grounds that it would infringe upon First Amendment rights. However, others have argued that First Amendment rights may not apply to the advertising and promotion of products known to be harmful to health. Instead of a total ban on tobacco advertising, some have also proposed a "stepwise" elimination of advertising, beginning, for instance, with advertisements of tobacco which glamorize the products.

Access to Tobacco Products

A major contributor to tobacco use among children and adolescents is their relatively free access to purchase tobacco products. While 43 states have legislation establishing a minimum age of purchase for cigarettes, lack of enforcement is a very serious problem. In addition, a number of states require licenses to sell tobacco products, but this is generally for tax purposes and does not address the issue of enforcing the minimum age for purchasing tobacco products. Youth have access to cigarettes in vending machines, and at times through distribution of free samples by tobacco companies.

One anti-tobacco initiative recommended to restrict access of youth to tobacco products is to permit only over-the-counter sales of cigarettes. This measure could allow for the age of the purchaser to be verified by a responsible person, and if enforced could limit children's and adolescents' access to cigarettes.

Price of Cigarettes

Because adolescents generally have limited disposable income, their purchase of cigarettes is sensitive to increases in the price of cigarettes. Increasing cigarette prices by increasing excise taxes can reduce tobacco consumption in children and adolescents. Such taxes should be structured to increase and not decline with time.

Educational Interventions

Educational programs are appropriate for young people to prevent them from starting to smoke, or later to help smokers stop smoking. In either situation it is important that the educational services be individualized and relevant to meet the needs of the groups for whom they are provided. For example, a disproportionate number of smokers are now from lower educational, socioeconomic and minority groups, yet current anti-smoking educational materials are most used by those who are white and socioeconomically advantaged. Very few materials have been developed specifically for use with blacks or Hispanics.

Many women may not be aware of the consequences of smoking related to specific interactions between smoking and female physiology, such as increased risk for osteoporosis and the association between smoking and early onset of menopause. In addition, many young adolescent women ignore or do not recognize the harmful effects of smoking during pregnancy. Educational campaigns could include more information regarding the gender-specific harmful effects of smoking.

Summary of Workgroup Discussion

The available evidence indicates that the tobacco industry clearly recognizes the need to recruit additional smokers to insure its very survival and this has led to targeting of certain identified groups: women, children and minorities.

The tobacco industry's efforts may be blunted—even preempted—by specific actions to control access to tobacco and advertising of tobacco to women, children and minorities. Further, outreach programs aimed at these target groups may make them less vulnerable to pro-tobacco messages.

Access to tobacco products may be controlled in various ways. Options include: setting a federal minimum age for tobacco purchase with strong penalties for violation; instituting a federal ban on vending machine sales of tobacco; educating merchants about sales to minors; requiring a federal license for merchants to sell tobacco products, subject to revocation for sale to minors; banning distribution of free tobacco samples through the mail; prohibiting the sale of candy cigarettes; and an increase of excise taxes on tobacco products.

The frequency and content of tobacco advertising should be regulated. Options include: a total ban on advertising; a more limited ban on advertising and promotions to which a significant number of children are exposed; taxing cigarette advertising and promotion, and using the revenue for anti-tobacco activities; eliminating tax deductions for tobacco advertising; banning the use of the United States mail to distribute publications with current advertisements; making federal funds for mass transit contingent on no tobacco advertisements on vehicles; creating paid or public service announcements against tobacco directed to women, children and minorities; and having the federal government conduct a national survey to determine cigarette brand preferences of youth.

Outreach programs for women and minorities include: providing federal grants to minority health professionals and other organizations to support programs to prevent smoking and aid smokers to stop; providing federal government funding

for research on tobacco use in minority groups and women; increasing the budget for the Office of Minority Health for anti-smoking programs for minorities; encouraging women and minority groups not to purchase magazines which advertise tobacco products; developing alternative sources of support for youth and minority programs that now depend upon support from the tobacco industry.

A number of other initiatives can complete a comprehensive anti-tobacco campaign. They include: increasing the budget for the Office on Smoking and Health; requiring federally funded educational institutions to provide a smoke-free environment for children; appropriating additional federal funding for anti-smoking activities; including graphic pictures on cigarette package warning labels; eliminating any preemption clauses in federal legislation that might prevent states from taking more stringent action against the tobacco industry; tying anti-tobacco efforts with drug prevention efforts; and encouraging additional efforts by physicians to help prevent patients from starting to smoke and to help them stop.

Recommendations

For children:

1. Federal policy should establish, or provide incentives for states to adopt, age 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made, including meaningful penalties for violations.
2. The federal government should ban the sale of tobacco products through vending machines.
3. The federal government should ban the distribution of free samples of tobacco products through the mail, on public property and other places open to the public.
4. The federal government should require federally funded educational institutions to provide a smoke-free environment for children.

For women and minorities:

5. The federal government should increase federal funding for research on how to decrease tobacco use by minority groups and women.
6. Congress should fund a strong program of anti-smoking public service announcements, as well as a paid counter-advertisement campaign specifically directed to women and minorities.
7. Federal grants should be provided to minority health professional and other organizations to support programs to prevent tobacco use and to help smokers stop.

For all Americans:

8. Congress should eliminate the tax deduction for tobacco advertising and promotional expenditures.
9. Congress should increase the budget of the Office on Smoking and Health. In addition, the budget of the Office of Minority Health should be increased for anti-smoking programs targeting minorities.
10. Congress should provide additional federal funding for anti-smoking activities provided within existing federal public health programs serving women, children and minorities.

Nicotine Addiction

Prepared by:
John Slade, MD
St. Peter's Medical Center
University of Medicine &
Dentistry of New Jersey

Introduction

The Surgeon General's 1988 report, "Nicotine Addiction," concludes that cigarettes and other forms of tobacco are addicting, that nicotine is the addicting drug in tobacco and that the addictive process for nicotine is similar to that for drugs such as heroin and cocaine.

People who are in trouble in our society are especially likely to use tobacco. They may be attracted to tobacco because it literally makes them feel good about themselves—euphoric, relaxed, less anxious. Scientists now know that nicotine regularly causes addiction in the users of tobacco products. And like other addicting drugs, nicotine more and more is victimizing vulnerable groups, especially the poor, women, children and minorities.

Addiction to nicotine is the most common serious drug problem in the United States today. It is a complex disease with social, behavioral, physiologic and pharmacologic aspects. Like other addictions, it can be prevented and treated. However, at this time, adequate services are not available for the large number of people who may benefit from such therapy. Therefore, treatment services need to be expanded in number and in scope to provide help for highly addicted persons as well as those who suffer from psychiatric conditions or other drug problems which are complicated by nicotine addiction.

Products such as cigarettes and smokeless tobacco are nicotine delivery systems, and many other devices for administering nicotine are technically feasible. Nicotine itself can have harmful effects not only because it helps to maintain smoking and tobacco use. Therefore, our objective is to prevent and treat all forms of nicotine dependence.

Understanding Nicotine and Addiction

Classification

Nicotine is the active drug in tobacco. The 1988 Surgeon General's report reviews the extensive literature on nicotine and concludes that nicotine regularly causes a true drug addiction in a high proportion of regular tobacco users. Many professional societies, including the American Medical Association, the American Psychological Association and the American Medical Society on Alcoholism and Other Drug Dependencies, agree that nicotine causes addiction, also known as dependence. The American Psychiatric Association has classified tobacco dependence with other addictive diseases since 1980, and in 1987, changed the technical name of the condition from tobacco dependence to nicotine dependence.

In the 1950s, the World Health Organization classified tobacco use as an habituation. This classification was consistent with the belief at the time that drug addictions were manifestations of personality disorders and that in order to be considered addictive, a drug had to produce physical and psychological dependence. Under this paradigm, nicotine, cocaine, marijuana, and LSD were not thought to cause addiction, only habituation. This view is reflected in the 1964 Surgeon General's report.

Today, addictive diseases are no longer regarded as personality disorders. And, although recent research has clearly shown that nicotine produces a true physiologic dependence, this characteristic is no longer essential for classifying a drug as addictive. Instead, scientists define addiction in terms of certain behavioral interactions of an individual with a drug.

The primary criteria for a drug addiction used in the 1988 Surgeon General's report are:

—There is a highly controlled or compulsive pattern of drug use,
—Psychoactive or mood-altering effects are involved in the pattern of drug taking, and
—The drug functions as a reinforcer to strengthen behavior and lead to further drug ingestion.

Additional criteria used in the report are tolerance, physical dependence, continued use despite harmful effects, pleasant

(euphoric) effects, stereotypic patterns of drug use, relapse following drug abstinence and recurrent drug cravings.

All of these criteria apply to nicotine.

People use tobacco for the nicotine: nicotine-free products do not succeed in the marketplace. A major policy issue for the federal government is whether and how the Food and Drug Administration (FDA) or some other agency should regulate products which deliver nicotine. While the FDA has not asserted jurisdiction over traditional tobacco products (except in extraordinary circumstances), the 1988 report recommended that the federal government review new, alternative nicotine delivery systems for toxicity and addictive potential before they are marketed. It is time to develop a system of regulatory oversight for traditional tobacco products.

Health Complications

The 1989 Surgeon General's report estimates that in 1985, *one in six deaths in this country was caused by cigarettes.* These 390,000 deaths were distributed among the following terminal illnesses:

Diagnostic Category	*Deaths (thousands)*
Coronary Heart Disease	115
Chronic Obstructive Pulmonary Disease	57
Cerebrovascular Disease	27.5
Other Vascular and Pulmonary Diseases	45
Lung Cancer	106
Other Cancers	31.6
Infant and Neonatal Deaths	2.5
Lung Cancer in Nonsmokers	3.8
Deaths from Fires caused by Cigarettes	1.7
TOTAL	390.1

In addition to these diagnostic categories, there is substantial evidence that among nonsmokers, tobacco smoke pollution also causes deaths from coronary heart disease and cancers at sites other than the lung. In *Environment International*, J.A. Wells estimates the additional number of deaths among nonsmokers from tobacco smoke pollution at 43,000.

Determinants of nicotine addiction and recovery

Nicotine addiction occurs as the result of complex interactions of the drug nicotine with a specific individual living in a specific social and cultural context. For the most part, it is a pediatric disease: if an individual has not started to smoke by age 20, it is very unlikely he or she will ever become addicted to nicotine. On the order of three-fourths of children growing up in this country experiment with tobacco; about 70 percent of use has begun by age 15, half by age 13. Between one third and one half of those who experiment become chronic users; and most of these people are addicted to nicotine.

Table 35 (page 11) from the 1989 Surgeon General's report summarizes the pharmacologic, cognitive, personal and social factors involved in the onset of this disease, in its chronic stage, and in recovery from the addiction.

Typically, nicotine addiction develops over a period of several years from late childhood to early to mid-adolescence. There is evidence that most teenagers who smoke want to quit, and most make at least one serious attempt to do so in these early years of the disease. For adults, too, thoughts about quitting and attempts to stop smoking are common, although repeated failure makes many relatively reluctant to try yet again. Still, more than two-thirds of adults and adolescents who smoke would like to quit.

At the same time, people who smoke are highly conditioned to continue. This happens in part because the smoker perceives the pharmacologic effects of nicotine as positive. Thus, the person addicted to nicotine has lost control over his or her use of the drug, and truly free will is not operative. Thus, recovering from addiction involves a number of processes, including deconditioning, or unlearning all the associations with nicotine.

Social and cultural influences are important in starting and continuing smoking as well as in recovering from addiction. Some of these influences are the smoking behavior of people around the individual (the smoking status of peers and relatives have been specifically studied), availability of tobacco products, advertising and promotion of tobacco, public health messages about tobacco, counter-marketing and policies about where smoking is permitted, if at all, in public places, schools and workplaces. If we understand these influences, *we can begin to control the nicotine addiction* epidemic by adopting policies that encourage young people not to start smoking and support and encourage smokers of all ages to quit.

Most former smokers have quit smoking without formal treatment assistance. However, in many cases stopping smoking was associated with important personal or social changes in a person's life. (These are outlined in the section on nicotine and other addicting drugs.)

But for many people addicted to nicotine treatment is not only helpful, it is essential for them to become abstinent. *And treatment works. An extensive collection of scientific* literature is devoted to the treatment of nicotine addiction and documents a number of valid intensities and approaches to treatment from single brief encounters with a therapist and self-instruction courses to inpatient treatment programs and Smokers' Anonymous groups. Adjunctive drug therapy, such as with nicotine resin complex (Nicorette) along with behavior modification treatment is also proved to be useful for selected patients. Other drugs such as clonidine and some anti-depressants, and other forms of nicotine have also shown promise as adjunctive therapies in preliminary *studies.*

There are many settings in which treatment may be undertaken. Unfortunately, an important limiting factor is the lack

of health insurance reimbursement for stop-smoking services. The reimbursement issue is complicated by the fact that there are no formal standards for what constitutes acceptable therapy of this disease or for therapist training, and many proprietary clinics offer unproved remedies.

Comparisons with other addicting drugs

Data in the 1988 Surgeon General's report indicates that the use of nicotine shares many characteristics with the use of cocaine, opiates and alcohol. People who use any of these drugs in a sufficient dose can detect the presence of the drug by their subjective feeling state. The drugs produce effects regarded as pleasurable, and they all have been shown to be positive reinforcers in both animal and human studies. Place conditioning—the association of a specific environment with drug use, drug effects and/or drug withdrawal—is common to all four. Tolerance and withdrawal phenomena are regularly observed (physical dependence). Finally, each drug has been used in medicine as a therapeutic agent.

It is well known that many people have recovered from nicotine addiction without formal treatment. Tobacco industry spokespersons are particularly intrigued by this phenomenon, as though it suggests that nicotine does not cause addiction. However, so-called spontaneous remission is not unique to nicotine; it is also seen with other addictive diseases, including those related to alcohol and heroin. The 1988 report reviews many factors which are important motivators for spontaneous remission in all three conditions. These include health problems, social sanctions, significant others, financial problems, significant accidents, management of cravings, positive reinforcement for quitting, internal psychic changes and changes in lifestyle. In fact, the resolution of an addiction is seldom (if ever) a random event, stimulated merely by the freely exercised choice of the individual involved.

Nicotine addiction, alcoholism and psychiatric illness

There is a significant overlap between alcoholism and nicotine addiction. While less than 30 percent of the adult population smokes, around 80 percent of those presenting for treatment of alcoholism are also addicted to nicotine. Similar patterns are well known for other drug dependencies among both adults and adolescents. Patients in psychiatric hospitals and clinics also have high rates of nicotine addiction. Traditionally, there has been a profound reluctance on the part of clinicians to interfere with nicotine addiction in these settings; quitting has often been discouraged by those in authority. However, this approach lacks empirical support, and many experts question the special status nicotine addiction enjoys in these settings. The growing popularity of smoke-free hospitals, the increasing recognition that nicotine addiction shares much in common with other addictive disorders, and, especially, the enormous risk of morbid complications from smoking are bringing these issues into focus for both the mental health and the addiction treatment communities. Federal policy initiatives might help foster changes which will lead to nicotine addiction being treated as a primary problem in these patient groups.

Product liability

Tobacco product liability suits have been brought in recent years by individuals who have developed major complications from smoking such as lung cancer. Litigation has a number of benefits for the overall effort to control the nicotine addiction epidemic.

Liability suits typically claim that the plaintiff was addicted to tobacco, usually becoming addicted before the age of consent and before the legal age of sale. Although the plaintiff accepts some responsibility for smoking, the claim is that this responsibility should be shared with the tobacco company because of nicotine addiction, the inherently dangerous characteristics of the product and the company's behavior. The grounds available for pursuing these suits have been limited in many jurisdictions by court opinions that the Federal Cigarette Labeling Law pre-empts tort actions against cigarette companies. While this issue may yet be resolved by the judiciary, a clarification of the law by Congress—as has been done for smokeless tobacco—would facilitate the pursuit of these actions.

Need for Action

Nicotine addiction is the cause of the greatest epidemic of disease in this century. Its complications resulted in 390,000 deaths in 1985 alone. The disease is both preventable and treatable, and the federal government has many opportunities to control this deadly disease.

Summary of Workgroup Discussion

Nicotine causes an addictive disease in a high proportion of users. The disease typically beings in childhood or adolescence and continues through a large proportion of adult life. Personal, social and cultural factors act in conjunction with nicotine to produce the disease. Recovery is possible at any age or stage of the condition, and although a minority need specific clinical treatment, most can learn to not smoke with only general support from society. Because treatment services are not now available for the 40-million plus smokers who may want them, a major challenge facing public health is how to provide no-smoking support and how to minimize influences which encourage and sustain the addiction.

There are many opportunities for prevention and treatment of nicotine addiction. The 1988 Surgeon General's report has brought the fact of nicotine addiction into clear focus for policy makers for the first time. It is now time to explore the policy implications of nicotine dependence being an addictive disease.

Recommendations

1. Nicotine leads to more deaths than any other addictive drug in our country. Additionally, it is implicated in the development of other drug dependencies, it contributes to the severity of other addictions and it is often a complicating factor in treating these conditions. Therefore, *legislation should ensure that all programs for the prevention* and treatment of alcohol and other drug dependencies should address nicotine as well.
2. Preventing nicotine addiction is critical because the addiction which develops can be so strong. Prevention programs need to begin at the preschool age and should include education about the dangers of drug addictions in general and what these conditions are. Opportunities to begin the education exist in programs which target young children and pregnant women, such as the Special Supplemental Food Program for Women, Infants and Children (WIC), AID to Families with Dependent Children and Head Start.
3. Because nicotine is such a highly addictive drug, aggressive efforts to counter-market tobacco products are needed to help shift the momentum which initiates and sustains this disease.
4. Tobacco use and nicotine addiction are not a matter of free choice. Therefore, warning labels on tobacco products should not be construed as protecting tobacco manufacturers from product liability. Legislation which establishes labeling requirements for tobacco products should specify this.
5. *Tobacco product manufacturers' stated intent for their* products is to provide tobacco taste, pleasure and satisfaction. Pleasure and satisfaction are actually accomplished by producing changes in the structure and function of the body, including increasing nicotine receptors, modulating neurochemicals and activating nicotinic receptors. Therefore, new legislation should affirm FDA's authority to regulate existing tobacco products.
6. New nicotine delivery systems should be evaluated by the FDA for toxicity and addictive potential.
7. Because the addiction to tobacco is the greatest public health problem facing our nation, a portion of revenues from increased excise taxes on tobacco products sh d be devoted to countermarketing, public health promotion and research efforts to prevent and treat tobacco use. The use of tax money for anti-tobacco efforts should be clearly stated on package labels. In addition, increases in excise taxes on tobacco products are themselves an important part of a comprehensive program to control tobacco use: such taxes are known to reduce use, especially among the young. The same phenomenon is observed when the "cost" of heroin or cocaine is manipulated experimentally.
8. Current levels of funding to reduce tobacco use are inadequate considering the magnitude of the problem. Therefore, funding should be substantially increased.
9. Studies of the public's level of awareness of the enormity of nicotine addiction and its consequences should be conducted serially at the Federal level.
10. Treatment for nicotine addiction should be widely available and reimbursed by insurance carriers, including Medicare and Medicaid. Standards and guidelines for managing nicotine addiction ought to be developed as have been done for other diseases including alcoholism and other drug addictions.
11. The training of health professionals such as physi*cians, nurses, psychologists and counselors should* specifically include instruction and clinical experience with managing nicotine addiction.
12. Tobacco-free environments enhance efforts of those who have stopped using tobacco to remain abstinent, encourage current users to consider quitting and help discourage the young from beginning to experiment with nicotine. Further, tobacco-free schools, work*places, healthcare institutions and other facilities also* help prevent health problems caused by tobacco smoke pollution.
13. The behavioral and physiological processes of addiction begin with the first dose of nicotine, and the easy availability of tobacco products encourages use and promotes relapse to nicotine addiction. Therefore, access to nicotine delivery systems should be limited to those age 21 or over, free sampling of tobacco products should be banned and the locations where tobacco is sold should be sharply limited.

Determinants of smoking within each domain by stage

Domain	Stage		
	Onset/development	Regular use	Cessation
Pharmacologic processes and conditioning	Initial psychopharmacologic effects encourage transition from experimental to regular use	Numerous conditioned associations among smoking, environmental events, and pharmacologic effects of nicotine	Withdrawal symptoms and conditioned and reinforcing effects of nicotine encourage relapse
Cognition and decision-making	Poor awareness of long- and short-term health consequences and addictive nature of smoking Positive characteristics are attributed to smokers and smoking	Health consequences are minimized or depersonalized Positive characteristics are attributed to smokers and smoking	Increased awareness of smoking-related symptoms or illness Perceived benefits of cessation Belief in one's ability to stop
Personal characteristics and social context	Inclination toward problem behaviors Extraversion Peer and family norms and values support smoking Youth-oriented advertising	Stress/negative affect are reduced by nicotine Social acceptability and peer and family norms support continued smoking Cigarette marketing encourages and legitimizes smoking	Social norms and support for stopping and maintained abstinence Skills for coping with stimuli associated with smoking Economic, educational, and personal resources to minimize stress and maintain cessation

Federal Regulation of Tobacco Products

Prepared by:
Scott D. Ballin
Vice President, Public Affairs
American Heart Association

Introduction

In spite of the fact that tobacco products are responsible for more than 300,000 deaths each year—more deaths than from alcohol or drug abuse, accidents and suicides combined—tobacco products are the least regulated of all. The reasons for the lack of regulation are historical, economical, and political—not logical.

Tobacco regulations are a haphazard patchwork of incomplete and diminishing control. To date, only the Congress has had any clear authority to regulate these products for health and safety purposes. Attempts by the states in the late 19th century to regulate tobacco and cigarettes have all but disappeared as laws to ban cigarette sales have gradually been repealed. No federal laws have been enacted to take their place.

Regulating Components of Tobacco Products

Nicotine

The recent Surgeon General's Report, "Nicotine Addiction," notes that cigarettes and other tobacco products that contain nicotine are powerfully addictive. The National Institute of Drug Abuse calls cigarettes the most widespread form of drug abuse in the United States. Yet despite these conclusions, tobacco products and the nicotine in them are out of the control of any federal regulatory agency.

The Food and Drug Administration (FDA) regulates nicotine when it is sold as a drug, such as in Nicorette brand gum. This is a prescription drug manufactured by Lakeside Pharmaceuticals and is a drug therapy to help people quit the nicotine habit. To sell this product, Lakeside must adhere to all the regulatory standards required for new drugs, including the manufacturing, labeling, distribution, sale, and advertising requirements established under the Food, Drug and Cosmetic Act (FDCA).

Additives

Today's tobacco products are not the tobacco products of the past. They contain hundreds, if not thousands, of chemical additives used as flavors and fillers. No federal agency has any authority to require that these additives be disclosed or even removed if found to be harmful. Many of the additives used in tobacco products are suspected of being carcinogens or cocarcinogens. The FDA requires that food products list and ensure the safety of additives. In fact, the Delaney clause of the FDCA requires FDA to remove *any* additive from the market found to induce cancer. It seems ironic that for cigarettes, which cause an estimated 80,000 lung cancer deaths each year, the FDA is powerless to impose the same authority.

The 1984 Surgeon General's report sums up the problem of additives as follows:

> A characterization of the chemical composition and adverse biologic potential of these additives is urgently required, but is currently impossible. . . . With this lack of basic information and the usually prolonged latent period before manifestation of adverse effect of smoking, it is likely that a long time period will elapse before we know the hazards of the new cigarettes.

Testing and labeling of tobacco products for tar, nicotine, carbon monoxide and other constituents

Until 1988, the Federal Trade Commission (FTC) tested cigarettes for amounts of tar, nicotine, and carbon monoxide. But now the FTC laboratory is closed, and all testing is the responsibility of the tobacco industry.

While the FTC tested the cigarettes, the tobacco industry used the results for its own economic advantage in selling cigarettes. Cigarette manufacturers embarked on the so-called "tar wars," with each company trying to outdo the other by producing the lowest tar, but best-tasting cigarette

on the market. These marketing strategies (and the use of "federally" determined tar and nicotine levels) lull consumers of cigarettes into believing that low-tar and low-nicotine cigarettes are safer.

But, in addition to the tar and nicotine, tobacco smoke contains an estimated 4,000 constituents. None of these constituents are disclosed to the public, nor does the Public Health Service have any authority to ensure the safety or reduction of these constituents. The 1983 Surgeon General's report notes:

> A cigarette considered less harmful for cancer etiology might not reduce the risk of coronary disease. It appears a formidable task to develop a product that satisfies the smoker and does not increase disease risk exposure to carbon monoxide, cyanide, nitrous oxide or still unknown agents.

Interesting enough, as far back as 1959, Philip Morris was well aware of the problems of potential FDA regulation of its products. An internal Philip Morris document released in a tobacco litigation suit (Plaintiff's exhibit 323) notes "if the food and drug laws were ever applied to cigarettes certain constituents like arsenic and other insecticides and certain minor smoke constituents might have to be controlled."

Again, in 1963, in another internal memo (Plaintiff's exhibit 605) the Philip Morris research director notes, "We believe that the next medical attack on cigarettes will be based on the cocarcinogen idea. With hundreds of compounds in smoke this hypothesis will be hard to contest." In more than 20 years of anti-smoking activity, this is an area that is unresolved and unregulated.

Regulating Cigarette Sales and Promotion

Sale of Cigarettes to Minors

Although many states have laws that restrict the sale of cigarettes to minors (varying from no restrictions to age 21) these statutes are rarely enforced. Cigarettes and other tobacco products are readily obtained from vendors, as free samples, or uncontrolled vending machines. There are no federal restrictions on the sale and distribution of cigarettes sold in interstate commerce. Because the use of tobacco products is a national problem, and because almost all cigarettes and tobacco are marketed in interstate commerce, federal action to limit the accessibility of cigarettes to minors may be warranted.

Advertising

The advertising and marketing of cigarettes clearly requires federal regulation.

Without appropriate federal regulatory control, the tobacco industry will continue to advertise and promote their products with one goal—profits at the expense of health.

Regulating of Tobacco Products Under the Food, Drug and Costmetic Act

Expanded Definition of "Drug"

In 1906, Congress enacted the first federal food and drug law. The primary purpose of the Act was to ensure safety of products sold as foods and drugs. The Act defined "drug" very narrowly to include only those articles which were listed in the U.S. Homeopathic Pharmacopeia. Tobacco or cigarettes were not listed at that time.

Since 1906 the authority of the FDA has been expanded to include cosmetics and medical devices as well as food and drugs. All of the products covered by the Act are products that are either ingested by man, are applied to the skin, or implanted into the body. FDA regulation of these products not only covers the composition of the products, but also their *labeling, sale, distribution, advertising* and *promotion*.

In the 1930s Congress, concerned with an increasing number of ineffective, unsafe and dangerous products and devices appearing on the market, expanded the definition of "drug" under the Act. The Senate Committee Report accompanying the 1935 Act noted:

> The definition of "drug" has been expanded to include, first substances and preparations recognized in the Homeopathic Pharmacopeia of the United States; second devices intended for *use in the cure, mitigation, treatment or prevention of disease*; third substances, preparations and devices intended for diagnostic purposes, and fourth such articles other than food and cosmetics intended *to affect the structure or function of the body*. Such expansion of the definition of the term "drug" is essential if the consumer is to be protected against a multiplicity of devices and such preparations as "slenderizers," many of which are worthless at best and some of which are distinctly dangerous to health.

Court Tests

The expanded definition of "drugs" was applied against cigarettes in three court cases in the 1950s. In two of the cases relevant to FDA jurisdiction, the courts found that conventional cigarettes could be "drugs." The question of whether or not the FDA could assert jurisdiction hinged on whether or not the products were being sold as articles intended to either mitigate or prevent disease or intended to affect the function or structure of the body.

As the court in *U.S. v. 46 Cartons Fairfax Cigarettes* noted:

> If claimant's labeling was such that it created in the mind of the public the idea that these cigarettes could be used for the mitigation or prevention of the various named diseases, claimant cannot now be heard to say that it is selling only cigarettes and not drugs. . . The ultimate impression upon the mind of the reader arises from the sum total of not only what is said, but also all that is

2047393893

> reasonably implied. If claimant wishes to reap the reward of such claims let it bear the responsibility as Congress has seen fit to impose on it.

This was the first time that cigarettes were found to be subject to the FDA's jurisdiction because they were not sold "merely for smoking pleasure" but had other intended purposes. Because those cigarettes could not meet the statutory and regulatory requirements of the FDCA, they were removed from the marketplace.

The idea of classifying cigarettes as drugs has been reaffirmed by the FDA in testimony before Congress and more recently by the courts. In 1977, for example, in attempting to further clarify FDA's jurisdiction, Action on Smoking and Health (ASH) and others filed a petition with FDA seeking to classify all cigarettes as drugs under Section 201 (g)(C) as articles "intended to affect the structure or any function of the body of man or other animals." The premise on which the petition was filed was that because all cigarettes contain nicotine "they fall easily and squarely within the broad language of the act." FDA denied the petition—a decision upheld in court in 1980—and FDA Commissioner Donald Kennedy stated the petitioners had failed to establish an *intent* on the part of the manufacturer to sell a product which "affected the structure or function of the body." Specifically, the Commissioner wrote:

> Statements by the petitioners and citations in the petition that cigarettes are used by smokers to affect the structure or functions of their bodies are not evidence of such intent by the manufacturers or vendors as required under provisions of the FDCA.

However, in denying the petition, FDA did *not* say that cigarettes could not be classified as drugs under Sec. 201. The FDA merely said that in the case of *cigarettes in general*, petitioners failed to provide sufficient evidence to establish that manufacturers sell cigarettes with *an intention of affecting the structure or function of the body*.

In 1988 the Coalition on Smoking OR Health (American Cancer Society, American Lung Association, and the American Heart Association) filed a petition with FDA seeking to classify all low-tar and low-nicotine cigarettes as "drugs" under the Act. The Coalition's petition is based on a review of the advertising and marketing strategies of these products by the industry as well as evidence released as a result of the 1988 *Cipollone v. Liggett Group Inc.* liability case. It concludes there is a clear indication that the tobacco industry has marketed these products with the clear intention that by using low-tar and low-nicotine products a smoker can "mitigate" or "prevent" diseases associated with the smoking habit. A series of advertisements run by Vantage brand cigarettes such as this one in *Time* on January 8, 1973, blatantly indicated this intended purpose:

> For years, a lot of people have been telling the smoking public not to smoke cigarettes, especially cigarettes with high 'tar' and nicotine.... *Since the cigarette critics are concerned about high 'tar' and nicotine, we would like to offer a constructive proposal. Perhaps, instead of telling us not to smoke cigarettes, they can tell us what to smoke*. For instance, perhaps they ought to recommend that the American public smoke Vantage cigarettes... Vantage gives the smoker flavor like a full-flavor cigarette. But it's the only cigarette that gives him so much flavor with so little 'tar' and nicotine....

This petition is pending at the FDA.

Also in 1988, the American Medical Association and the Coalition on Smoking OR Health filed separate petitions seeking to classify the newly developed R. J. Reynold's cigarette-like device Premier as as drug under the FDCA. The arguments asking FDA to assert jurisdiction are based on a premise similar to the low tar and nicotine petition: that R. J. Reynolds is calling its new product "cleaner," one which "reduces the controversial compounds" and selling it as "safer," that is, designed to mitigate and prevent disease and to affect functions or structures of the body.

Defining when FDA can—or cannot—assert jurisdiction over cigarette-like products was further clarified in February, 1987. A manufacturer wanted to market a *non-tobacco* "cigarette-like device consisting of a plug impregnated with nicotine solution inserted with a small tube—corresponding in appearance to a conventional cigarette." FDA had no difficulty in classifying the product as a "drug." After reviewing promotional material as well as registration material filed with the Securities and Exchange Commission (SEC), the FDA reached the following conclusion:

> It is our position that Favor is a nicotine delivering system intended to satisfy a nicotine dependence and to affect the structure or one or more functions of the body.

While tobacco products can be deemed drugs under the FDCA where their marketing and sale meet the definitions under the Act, it remains unclear where FDA will draw the line in asserting its jurisdiction.

Masterpiece Tobacs is another case of FDA asserting jurisdiction over a product containing tobacco. The product was being sold in the form of a chewing gum. The manufacturer argued that because the product contained tobacco it was outside the FDA's jurisdiction. The FDA disagreed and ruled that the product was a "food" under the FDCA because that definition included "chewing gum." Because tobacco is a dangerous, unapproved substance for use in foods, the FDA ruled that the product was adulterated and could not be marketed for health and safety reasons.

Regulation of Tobacco Products Under Other Health and Safety Laws

Attempts to regulate tobacco and tobacco products under other federal health and safety statutes have not fared well. Of laws enacted since 1964 to regulate a variety of consumer products, the tobacco industry has been successful in having tobacco and tobacco products specifically exempted under:

- The Consumer Product Safety Act
- The Fair Labeling and Packaging Act
- The Federal Hazardous Substances Act
- The Controlled Substances Act
- The Toxic Substances Act

The Consumer Product Safety Act governs the safety of a large array of consumer products, but tobacco products are excluded. The Toxic Substance Act was enacted to ensure that authority existed to "regulate chemical substances and mixtures which present unreasonable risk of impairing health," but tobacco products are excluded. Despite its harmful effects on health and its addicting qualities, tobacco is excluded from the Controlled Substances Act. Despite Congress's desire to ensure that consumers are fully and adequately informed about the products they use, tobacco products are excluded from the Fair Labeling and Packaging Act.

One could reasonably argue that tobacco products would undoubtedly have been strictly regulated or even banned under these Acts if Congress had not provided the statutory exemptions.

New Regulatory and Legislative Options

Tobacco products are dangerous and addictive. It is only rational that at a minimum tobacco products be regulated in a manner similar to how other dangerous consumer products are regulated. Past attempts to bring tobacco under the jurisdiction of one or more of the federal health and safety agencies have failed. In recent years, however, new efforts to regulate tobacco have enjoyed increasing support inside and outside of Congress.

To develop strategies for regulating tobacco it is necessary to consider first, *the use of existing law*, and second, *legislative proposals that specify and designate an agency as responsible for regulating tobacco products*.

Existing Law

Over the years, Congress has effectively ruled out using major health and safety statutes to regulate tobacco products. The one narrow exception is with the FDA which has the authority to regulate:

> articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals, and articles (other than food) intended to affect the structure or any function of the body of man or other animals.

Applying these statutory provisions to tobacco products is only feasible when health claims are made, either directly or implied. Even then, if FDA fails to take any independent action, it is incumbent upon the private sector to initiate action through petitions. While it may have a positive outcome, the petitioning process—as is evident by FDA's failure to act on the RJR Premier cigarette and on low tar and nicotine cigarettes—can be long and tedious and may have to be resolved in the courts. But in the absence of clear-cut statutory authority to regulate tobacco for health and safety purposes, filing petitions asking FDA to apply its well-established regulatory muscle is one of the few available options.

In spite of obstacles, petitioning and demanding that the agency continue to define when it will and when it won't take jurisdiction over tobacco products is important to do. Each time a petition is considered, the public and Congress are reminded that while tobacco products remain the major preventable cause of death and disability, they also are the least regulated products.

Legislative Action to Regulate Tobacco Products

The Congress and the public are becoming increasingly aware that unlike other consumer products, no federal regulatory agency has any health and safety jurisdiction over tobacco products except in narrow exceptions outlined above.

During the 100th Congress numerous bills were introduced that would for the first time give a specific federal regulatory agency power over tobacco.

H.R. 2376 was introduced by Rep. Jim Bates (D., Cal.) to remove the statutory exemptions for tobacco and tobacco products from the Consumer Product Safety Act. The total regulatory ramifications of this approach are not clear, but at the extreme, could result in the product being banned. While logical, this approach may not be feasible at this time.

In September 1987, Rep. Bob Whittaker (R., Kan.) introduced legislation that would specifically give the FDA jurisdiction over all tobacco products. Because incorporating tobacco products under the definition of "food" or "drugs" could result in a total ban, the bill establishes a separate chapter of "Tobacco Products" under the FDCA. Thus, the product remains legal, but regulated. The bill is comprehensive in its scope giving FDA specific authority to regulate the *manufacture, distribution, sale, labeling, testing of chemical additives* such as *tar, nicotine* and *carbon monoxide and promotional activities*.

The debate over whether Premier should be declared a drug under the FDCA has drawn attention to the fact that tobacco products have escaped regulation, because of statutory and other legal loopholes. In discussing FDA's failure to act quickly against R. J. Reynold's Premier product, the Chairman of the House Subcommittee on Health and the Environment recently stated, "failure to act decisively will only

encourage the tobacco industry to exploit and widen loopholes in the federal law, thereby reversing the gains we have made."

In mid-1988, Rep. Thomas Luken (D., Ohio) introduced H.R. 5113. That legislation would ban all tobacco advertising; regulate the sale of cigarettes, except as over-the-counter products and where a sign has been posted stating that sale to minors is strictly prohibited; require that the Federal Trade Commission undertake responsibility for studying constituents of tobacco smoke and report to the Congress; allow for state actions to be brought against cigarette manufacturers; and require that cigarette packages carry warning labels stating that tobacco is addictive.

Both the Whittaker and Luken bills attempt to accomplish similar objectives using different federal regulatory agencies, the FDA and the FTC. It is important to note that these two members sit on committees and subcommittees that will ultimately make the decision about how tobacco is regulated. Rep. Luken chairs the Subcommittee on Transportation, Tourism and Hazardous Materials. Rep. Whittaker is the ranking minority member on that Subcommittee, and also sits on the Subcommittee on Health and the Environment as well.

Summary of Workgroup Discussion

Each year more than 300,000 people die as a result of cigarette smoking—an addictive habit which the Surgeon General of the United States has called the single most preventable cause of death and disability in the United States.

If cigarettes and tobacco products never existed and were developed today, they would be prohibited from being marketed on the sole basis of health and safety. Instead, however, we have a product class which remains virtually unregulated, enjoys special statutory exemptions from the very laws designed to protect the public from unsafe consumer products, and is advertised and promoted at a cost of over $2 billion a year.

Tobacco products are exempt from regulation under such laws as the Consumer Product Safety Act, the Federal Hazardous Substance Act, the Toxic Substances Act, and by administrative and judicial determination from FDCA. FDA acknowledges and the courts concur that tobacco products can in fact be regulated by the FDA if a determination is made that cigarettes meet the definitional requirements of "drugs" under the FDCA. However, FDA has been reluctant to use its discretionary authorities.

The Congress and the public are becoming increasingly aware that, unlike other consumer products, no federal regulatory agency has clear-cut jurisdiction over tobacco products. During the 100th Congress, numerous bills were introduced that would for the first time give a specific federal regulatory agency jurisdiction over tobacco.

In 1987, Rep. Bob Whittaker introduced legislation that specifically gives the FDA jurisdiction over all tobacco products. Because incorporating tobacco products under the definition of "foods" or "drugs" could result in a total ban, the bill established a separate Chapter, "Tobacco Products." Rep. Whittaker's bill adds a meaningful and useful provision to the FDCA *to give the FDA specific authority to regulate the manufacture*, distribution, sale, labeling, testing and disclosure of additives and other constituents, and promotion of all tobacco products.

A number of events have occurred over the past few years that underscore why the regulatory loopholes for tobacco need to be closed. In the spring of 1988, the Surgeon General released his report on nicotine addiction. In 1987, the FDA ruled that a non-tobacco, nicotine-containing cigarette called Favor was a drug under the Food Drug and Cosmetic Act. The FDA also ruled that a chewing gum containing tobacco was an adulterated food product and was therefore prohibited from sale. In 1988, the Coalition On Smoking OR Health and the American Medical Association filed petitions with the FDA to classify R. J. Reynold's smokeless cigarette, Premier, as a drug. A similar petition was filed by the Coalition on low-tar, low-nicotine cigarettes.

Recommendations

1. A separate chapter should be established under the FDCA to regulate the manufacture, sale, distribution, labeling, advertising, and promotion of tobacco products.
2. Under this chapter, a federal minimum age of sale of tobacco products should be set at 21, with the states given primary enforcement responsibility. However, if the FDA determines that such enforcement is not being carried out, then the Commissioner will have the authority to regulate the form, manner, and location of the sale of tobacco products.
3. Under this chapter, all tobacco sampling, distributing of discounted products and couponing would be prohibited.
4. Under this chapter, the FDA would require tha all additives in tobacco products be disclosed to the public and tested for health and safety reasons and that any additives found to be harmful be removed from the marketplace.
5. Under this chapter, the Commissioner will have the authority to require the disclosure of tar, nicotine, carbon monoxide and other harmful constituents, and the manner and means by which such disclosure is made.
6. Under this chapter, the FDA will have the authority to require any additional labeling for tobacco products, including the strengthening of existing language on present warning labels.
7. Under this chapter, all tobacco products will carry an additional label warning consumers of the addictive nature of tobacco and clearly stating that federal law prohibits the sale of tobacco to minors.

8. Under this chapter, the FDA will be given specific authority to regulate the advertising and promotion of tobacco products.
9. Under this chapter, the FDA will be given authority to regulate other nicotine-containing products as drugs.
10. Under this chapter, the Commissioner shall report to Congress and the Secretary on any other legislative recommendations that would further reduce the risk to health associated with the use of tobacco products. .

Cigarette Excise Tax

Prepared by:
David Kendall
Legislative Assistant
Congressman Michael A. Andrews
Mary Crane
Legislative Representative
American Heart Association

Introduction

The harmful effects of smoking are suffered by smokers and nonsmokers alike. Not only does smoking cause thousands of preventable deaths every year, it costs our economy billions of dollars in lost productivity and healthcare expenses.

A cigarette excise tax is one technique to discourage smoking by raising the price of cigarettes. Historically the tax has been successful in deterring smoking, but it hasn't kept pace with the cost of living or the actual financial burden smoking imposes on society.

Health Consequences of Smoking

Like all other tobacco-related legislation, the need for a cigarette excise tax can be traced to the harmful effect cigarette smoking has on the health of the American people. Overall, the total number of smoking-related deaths recorded annually is approximately 390,000 persons. But 390,000 deaths is just part of the equation; hundreds of thousands more suffer debilitating diseases caused, or complicated, by smoking. And when we consider the full extent of diseases, it becomes apparent why we need to pursue legislative efforts to discourage smoking.

For example, consider cardiovascular disease. According to the American Heart Association, cardiovascular disease has the deadly distinction of being the number one killer in the United States. In 1985, nearly one million Americans died from cardiovascular disease.

Smokers have more than twice the risk of heart attack as nonsmokers. Cigarette smoking is the most important risk factor for sudden cardiac death, increasing the smoker's risk by two to four times over that of the nonsmoker. A smoker who has a heart attack is more likely to die from it and is more likely to die suddenly (within an hour) than a nonsmoker. Cigarette smoking is responsible for 21 percent of deaths from coronary heart disease in the United States among men and is responsible for 40 percent of coronary heart disease deaths.

Surgeon General C. Everett Koop states, "Cigarette smoking should be considered the most important of the known modifiable risk factors for coronary heart disease in the United States."

Similar evidence exists regarding the relationship between cigarette smoking and cancer, the second most frequent cause of death in the United States. According to the American Cancer Society, if present trends hold, about 75 million Americans now living will eventually have cancer, or about 30 percent of the population. Over the years, cancer will strike in approximately three of every four families.

Cigarette smoking is responsible for 85 percent of lung cancer cases among men and 75 percent among women—about 83 percent overall. Smoking accounts for about 35 percent of all cancer deaths.

The American Cancer Society has noted that the higher incidence of cancer in men reflects the fact that in the past, more men than women smoked, and smoked more heavily. In recent years, however, the gap between male and female smoking has been narrowing. The unfortunate result is that in 1986 lung cancer surpassed breast cancer as the leading cancer killer among women.

Surgeon General Koop states, "There is no single action an individual can take to reduce the risk of cancer more effectively than quitting smoking, particularly cigarettes."

In addition, consider the statistics on the relationship between smoking and chronic obstructive lung disease. Citing a National Health Interview Survey, the American Lung Association estimates the prevalence of chronic bronchitis and emphysema to be 13.4 million. In 1986, 76,559 deaths were certified as due to chronic obstructive pulmonary disease (COPD) and allied conditions, making it the fifth leading

cause of death in the United States. According to the 1984 report of the Surgeon General, "The Health Consequences of Smoking: Chronic Obstructive Lung Disease," it is estimated that cigarette smoking accounts for 80 to 90 percent of COPD lung conditions.

For this reason Surgeon General Koop states, "Cigarette smoking is the major cause of chronic obstructive lung disease in the United States for both men and women."

Cigarette smoking is now implicated in other serious health problems. As reported in the 1989 Surgeon General's report, "Cigarette smoking is now considered to be a probable cause of unsuccessful pregnancies, increased infant mortality and peptic ulcer disease; to be a contributing factor for cancer of the bladder, pancreas and kidney; and to be associated with cancer of the stomach."

Financial Impact of Smoking

The most complete analysis of the financial impact of cigarette smoking was completed by the Office of Technology Assessment (OTA) in 1985. The analysis, "Smoking-Related Deaths and Financial Costs," reviewed a series of epidemiologic studies relating smoking to disease and numerous estimates of the costs of smoking-related disease. OTA is careful to point out that it was "conservative" in its choice of assumptions, stating, "The estimates presented... should... be considered minimum estimates."

OTA estimates cigarette smoking costs our economy $65 billion annually in healthcare and lost productivity costs. This figure includes:

- Smoking-related healthcare costs of $22 billion annually, or approximately six percent of gross national product (GNP). Seventy-five percent of these costs are incurred by those under the age of 65.
- Annual smoking-related healthcare expenditures by the federal government include $4.2 billion in Medicare and Medicaid payments, $210 million through the Department of Defense, and $400 million by the Department of Veterans Affairs.
- Annual smoking-related lost productivity costs of $43 billion. Lost productivity includes smoking-related absenteeism and disability.

In sum, the OTA concluded that each pack of cigarettes sold in the United States costs our economy about $2.17.

Health Implications of Increasing the Federal Excise Tax

An analysis by University of Michigan economist Kenneth E. Warner published in the *Journal of the American Medical Association* in February 1986 concludes that an increase in the federal cigarette excise tax would have the positive effect of discouraging tobacco use.

More specifically, Warner calculates that, "a 16-cent increase in the excise tax would encourage almost 3.5 million Americans to forego smoking habits in which they would engage if the tax were to remain at 16 cents per pack. This figure includes more than 800,000 teenagers and almost 2 million young adults aged 20 to 35 years."

A cigarette excise tax will also affect the incidence of cigarette smoking among the older adult population, though the impact will be far less dramatic. Because teenagers and young adults are more price sensitive than older persons, the greatest impact of an excise tax increase will be experienced by the former group.

A study of the impact of the 1983 increase in the federal cigarette excise tax published in 1987 by Jeffrey E. Harris, MD, PhD in Tax Policy and the Economy, noted, "During 1981-1986,... the real price of cigarettes increased by 36 percent. Concomitantly, per capita consumption declined by 15 percent."

As Harris observes, it is important to remember that the price increases of 1981-1986 were not solely due to an increase in the federal cigarette excise tax. Certainly, manufacturers also increased prices during this time frame. Yet, Harris emphasizes, it is equally important to know that during this same time period, cigarette manufacturers' advertising and promotional expenditures rose in real terms by nearly 20 percent. And real disposable personal income rose by 10 percent, yet tobacco consumption *still* declined. Harris concludes, "most of the decline during 1981-1984 could be explained on the basis of price increases alone."

The tobacco industry recognizes the impact of increased excise taxes on smoking. An August 1988 article in *The Washington Post*, "Canada Tries to Clear the Air," reports that a 25-cigarette pack, which cost $1.00 in 1980, now costs $3.00 because of increases in federal and provincial taxes. The taxes range from 82 cents in Alberta to $1.30 in Newfoundland. And, while the price has gone up, Canadian tobacco sales have fallen 23 percent over the past five years.

The article continues, and quotes Jacques Lariviere, spokesman for the Montreal-based Canadian Tobacco Manufacturers Council, who states, "The single most important factor in all of that has been the very dramatic increase in the retail selling price as a reflection of the equally dramatic increase in taxation."

History of Federal Cigarette Excise Taxes

A federal cigarette excise tax was first imposed during the Civil War. The first tax, imposed in June 1864 at a rate of 8 cents per pack of 20 cigarettes, increased to 10 cents per pack by March 1868. The rate declined, however, and by the turn of the century rested at about one cent per pack.

Since World War II, the federal cigarette excise tax has been increased twice. In 1951, the tax was increased from 7 to 8 cents per pack. In 1982, the Tax Equity & Fiscal Responsibility Act (TEFRA) temporarily increased the tax from 8 to 16 cents. Under TEFRA, the tax was scheduled to revert

to 8 cents on October 1, 1985. However, the 16 cent cigarette excise tax was made permanent by the Consolidated Budget Reconciliation Act of 1985 (P.L. 99-272) enacted on April 7, 1986. Interestingly, during the time period in which the cigarette excise tax doubled, the cost of living more than quadrupled.

On July 23, 1986, the Senate Finance Committee voted to increase the cigarette excise tax by 8 cents (to 24 cents per pack) as part of a budget reconciliation package. However, the House Committee on Ways and Means did not enact a similar proposal and a cigarette excise tax increase was not included in the final version of the 1986 Budget Reconciliation Act.

In the 100th Congress, several bills to increase the federal cigarette excise tax were introduced, all of which would have increased the excise tax by at least 16 cents—raising the tax from the current 16 cents to 32 cents per pack. A proposal to increase the tax by 25 cents per pack was introduced by Representative Michael A. Andrews (D., Tex.) in the second session of the 100th Congress.

The proposed increase in the federal cigarette excise tax has been opposed by the Coalition Against Regressive Taxation, a group of business interests—including representatives of the tobacco industry—who argue that increasing excise taxes is regressive. Their position is supported by a 1987 Congressional Budget Office (CBO) staff working paper, "The Distributional Effects of an Increase in Selected Federal Excise Taxes," which reviews the distributional effects, among income classes, of a simulated increase in certain federal excise taxes.

According to the analysis, "The average increase in taxes as a percentage of total income would be about twice as large (more than three times as large in the case of the tax on beer or tobacco) for families with incomes between $10,000 and $20,000 compared to families with incomes of $50,000 or more."

However, as the CBO noted, "Other excise taxes can be seen as compensation for the social costs that society in general ultimately bears because of certain activities. For example, the tax on tobacco products may offset some of the higher medical costs that smokers incur. . . ."

Many persons contend that compared to other tax alternatives, an increase in the cigarette excise tax is less regressive than many other options. For example, a cigarette excise tax increase would adversely affect far fewer individuals than would be affected by an increase in the gasoline excise tax or telephone excise tax, given the clear necessity of these latter two items in our current economy. Or, since the incidence of cigarette smoking is relatively low in the elderly population, an increase in the federal cigarette excise tax would adversely affect far fewer elderly than would a tax on Social Security income or additional catastrophic health insurance taxes.

What seems most important is that an increase in the federal cigarette excise tax will be regressive only among those who smoke. No one socioeconomic, racial, or population group will bear the burden of a cigarette excise tax increase to the exclusion of other groups. Only those individuals who choose to smoke will incur any additional cost.

In addition to the federal tax, state and local governments have enacted cigarette excise taxes. One notable, recent increase was in California. In 1988, Californians supported a ballot initiative to increase the state's cigarette excise tax by 25 cents, raising the tax from 10 to 35 cents. The measure was enacted with the support of 58 percent of the voters, despite a multi-million-dollar campaign opposing it.

Policy Options

Society in general, and Congress and the Administration in particular, have three decisions to make about cigarette excise taxes:

1. Should the federal cigarette excise tax be increased?
2. If so, by how much?
3. Should any of the revenues derived from a cigarette excise tax increase be dedicated?

Each of these questions will arise during the upcoming months, and the ramifications of each should be fully considered.

Should the federal cigarette excise tax be increased?

An increase in the federal cigarette excise tax will cause fewer individuals, particularly teenagers and young people to start smoking. In a nation that is increasingly concerned not only with the health of its citizens but also with spiraling healthcare costs, any action that may deter the single most preventable cause of death, cigarette smoking, should be encouraged.

However there are additional justifications. We know that the federal government is currently expending billions of dollars to treat the smoking-related illnesses of its citizens. We further know that doubling of the current federal cigarette excise tax—raising the tax from 16 to 32 cents—will generate an additional $2.9 billion in revenues annually to the federal government according to the Joint Committee on Taxation of the Congress. Considering our nation's staggering federal deficit and the smoking-related health care costs that the federal government is now bearing, a cigarette excise tax is justified.

One additional justification should also be explored. Members of Congress and the President are elected to represent the people. When the American people are asked how to reduce the federal deficit, they consistently and overwhelmingly call for increases in federal excise taxes. Consider the following polling data:

- In 1984 Americans were asked, "To reduce the size of the deficit, are you willing to see the Government raise

taxes on tobacco?" Increased taxes were supported by 77 percent of respondents according to *Time*, February 20, 1984.

- In 1986 Americans were asked, "Would you favor one of the following revenue hikes or would you rather consider some other way to raise money for the government instead?" Higher taxes on liquor and cigarettes were favored by 81 percent of respondents according to the *Los Angeles Times*, March 2, 1986.
- In 1987 Americans were asked, "I am going to mention some things that have been proposed to help balance the federal budget, and for each, please tell me whether you approve or disapprove of that proposal?" Raising taxes on liquor, beer and cigarettes were approved by 75 percent of respondents according to a *Washington Post*-ABC News poll, July 2, 1987.
- In 1988 the Gallup Organization polled Americans for their views on the federal budget deficit. Gallup reported, "Given a list of 20 deficit reduction measures, majorities favor only three—all tax hikes. . .61 percent support a tax increase on tobacco products."
- In a poll conducted immediately after the November 1988 general election, Media General-Associated Press found, "More than 7 in 10. . .approved of higher cigarette and alcoholic beverage taxes," according to the *Wall Street Journal*, November 28, 1988.
- In a report issued shortly after the November 1988 election, "Reclaiming the American Dream: Fiscal Policies for a Competitive Nation," the Council on Competitiveness, comprised of 157 chief executives from business, labor, and higher education, called for an increase in the federal cigarette excise tax upon noting that "the effective tax rates on cigarettes and alcohol have deteriorated significantly as a result of inflation."

Past political leaders have recognized the efficacy of increasing the federal cigarette excise tax. Former Presidents Gerald Ford and Jimmy Carter endorsed a cigarette excise tax increase in their 1988 report to the 41st president of the United States, "American Agenda." That report states, "Increases in revenues would reduce the amount of spending cuts necessary to reach budget balance by 1993. If revenues are to be raised, a case can be made for taxing consumption, especially increasing excise taxes on alcohol and tobacco to discourage their use. . . ."

Clearly the American people believe that a federal cigarette excise tax is justified. It is up to their representatives to act in a manner consistent with the peoples' wishes.

If a cigarette excise tax is justified, how much should it be increased?

If the cigarette excise tax is solely a health concern, then the tax should be increased to such level as would make the cost of cigarette smoking prohibitive. Perhaps a $5.00 or $10.00 increase would help achieve this goal. Political realities, however, suggest it is unlikely that such an increase can be enacted.

In recent years, attention has focused on doubling the current federal cigarette excise tax—raising the tax from its current level of 16 cents to 32 cents. The rationale for this increase is that it essentially adjusts the tax for the inflation that has occurred since the 1950s.

Beyond doubling the tax, there is also justification for an additional increase, given the smoking-related health care expenditures that the federal government must now make.

Federal cigarette excise tax increases in excess of 16 cents per pack are currently being discussed. Health considerations as well as economic considerations would appear to justify substantially larger increases.

Should any of the revenues derived from a cigarette excise tax be dedicated?

To date, all revenues received by the government from federal cigarette excise taxes have been dedicated to general revenues of the Treasury. No amounts are reserved in trust funds or set aside for specific programs.

Considering the current budget deficit, the need to find new sources of revenue to reduce the deficit, and the potential absence of funds to finance new or continuing programs, dedicating revenues from a cigarette excise tax increase might be justified.

Potential dedications of a federal cigarette excise tax include:

- Dedicate all new revenues to a trust fund to help reduce the federal deficit. In an excise tax increase proposal, include a provision to roll back the increase once the deficit is eliminated.
- Dedicate a portion of any increase to the Medicare and Medicaid trust funds to help reimburse those programs for costs incurred through the treatment of smoking-related illnesses.
- Dedicate a portion of an increase to fund the programs of the National Heart, Lung, and Blood Institute, the National Cancer Society, and the Office of Smoking and Health, all of which are federal entities concerned in part with addressing smoking-related health issues.
- Dedicate a portion of any increase to new federal education and health promotion efforts aimed at those sectors of society that have a higher incidence of smoking.

In the past, Congress has been hesitant to dedicate any portion of the federal cigarette excise tax. New political realities may, however, make this option far more attractive.

Additional Issues

Some additional issues cannot be ignored when examining a potential increase in the federal cigarette excise tax, including:

- Should the tax on tobacco products be recomputed as an ad valorem tax, meaning a percent of the retail price, rather than as an excise tax?
- How significantly will state revenues be affected by an increase in the federal cigarette excise tax?
- As the incidence of cigarette smoking continues to decline, what impact can be anticipated in terms of a projected loss of corporate revenues from tobacco companies?

Summary of Workgroup Discussion

The Tobacco Excise Tax Workgroup concludes that the overall benefits from an increase in the federal cigarette excise tax outweigh the disavantages for the following reasons:

1. It is a policy of the U.S. government to promote the health of the American people.
2. Cigarette smoking is the single most important preventable cause of death and disability in the United States today. Cigarette smoking accounted for an estimated 390,000 deaths in 1985 alone. Other forms of tobacco use contribute to death and disability in our country.
3. There is a broad consensus in our society that children should not smoke. This consensus cuts across all socioeconomic groups. Among high school seniors that smoke, nearly 60 percent report having smoked their first cigarette in eighth grade.
4. Cigarette price increases and enhanced educational efforts are important ways to reduce smoking by children.
5. Cigaretee smoking imposes enormous costs on society. The OTA estimates total healthcare costs and loss productivity to exceed $65 billion annually. This is a minimal accounting that does not reflect the pain and suffering inflicted on the victims of smoking-induced diseases and their families.
6. According to the Joint Committee on Taxation a 25 cent increase in Federal cigarette excise would raise $4.4 billion each year and $21.8 billion over five years.
7. The federal cigarette excise tax has been increased only once in 38 years. Cigarette taxes are a shrinking portion of the cost of a pack of cigarettes because cigarette companies have raised and continue to raise the price of their products.
8. Independent public opinion polls consistently show broad support for an increase in the cigarette excise tax.
9. The health consequences of cigarette smoking are far more regressive than the cigarette excise tax may be.

Recommendations

1. An increase in the cigarette excise tax should be enacted in the 101st Congress.
2. Any increase in federal cigarette excise tax should be accompanied by a similar increase in excise taxes on non-cigarette tobacco products.
3. Increased revenues from a cigarette excise tax could be used to finance education and counter-advertising to discourage children and people at high risk from smoking.

Protecting Nonsmokers

Prepared by:
Susan A. Lightfoot
Legislative Assistant
Rep. Richard Durbin
John M. Pinney, Exec. Director
Institute for the Study of Smoking
Behavior and Policy
Harvard University

Introduction

According to the Surgeon General, as many as 5,000 nonsmokers die each year of diseases caused by inhaling smoke released into the air by tobacco products. With the exception of asbestos, environmental tobacco smoke is responsible for more deaths than all other known airborne pollutants combined. Statistics also show that a woman who smokes during pregnancy places the health of her unborn child at risk of premature birth, low birthweight or perinatal death and the Surgeon General has reported that "involuntary smoking" can and does cause disease, including lung cancer, serious acute effects in otherwise healthy adults and severe respiratory problems in young children and infants.

While much is known about the adverse health consequences of tobacco use by smokers, more recent studies have shown a clear health danger to nonsmokers. As a result, the public policy debate has also begun to focus on the health and safety risks associated with exposure of nonsmokers to tobacco smoke. The nonsmoker's right to breathe clean air in the workplace, restaurants, public conveyances and other public places has resulted in a growing number of legislative initiatives on the federal, state and local levels.

Three major scientific reports have examined the link between involuntary smoking and health problems. The National Academy of Sciences (NAS) 1986 report, "Environmental Tobacco Smoke, Measuring Exposures and Assessing Health Effects," concludes that an increased risk of lung cancer due to exposure to environmental tobacco smoke (ETS) is biologically plausible. Moreover, children exposed to ETS from parental smoking, show an increased frequency of pulmonary symptoms and respiratory infections.

A second NAS report issued in August 1986, "The Airliner Cabin Environment—Air Quality and Safety," examined the issue of cigarette smoking aboard airplanes. This report recommends that smoking be banned on all domestic commercial flights to lessen irritation and discomfort to passengers and crew, reduce potential health hazards to cabin crew, eliminate the possibility of fires caused by cigarettes and bring the cabin air quality in compliance with established standards for other closed environments.

Finally, the 1986 Surgeon General's Report, "The Health Consequences of Involuntary Smoking," concludes that involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers. This report also states that simply separating smokers and nonsmokers within the same air space may reduce, but will not eliminate the exposure of nonsmokers to environmental tobacco smoke.

Actions Taken to Protect Nonsmokers—State and Local

Significant actions to protect nonsmokers from environmental tobacco smoke have been taken on the state and local levels. These actions are a good indication of the growing public sentiment toward protecting the health and safety of nonsmokers.

According to the October 1988 Tobacco-Free America report, "State Legislated Actions on Tobacco Issues":

> Forty-two states and the District of Columbia restrict smoking in some manner in public places. These laws range from simple, limited prohibitions, such as no smoking on a school bus while the bus is in operation (South Carolina), to comprehensive clean indoor air laws that limit or ban smoking in virtually all public places, including elevators, public buildings, health facilities, public transit, gymnasiums and arenas, retail stores, and educational facilities (Massachusetts). The most extensive clean indoor air laws include restaurants and private workplaces (Washington). Of the states that limit or prohibit smoking in public places, 25 have comprehensive clean indoor air laws; 31 require restrictions on smoking

in the public workplace, while 14 have extended those limitations to private sector workplaces.

Over the past two years, there has been a clear and dramatic increase in the number of cities and counties in the United States that have enacted local ordinances to limit smoking in public places. According to the Tobacco-Free America report, there are now nearly 400 city and county smoking control laws.

Public opinion polls are also showing an increase in support for smoke-free environments. For example, a 1986 survey conducted by the American Lung Association, American Cancer Society and American Heart Association found that Americans overwhelmingly favor "no smoking" sections in public places.

While the actions taken on the state and local levels to protect nonsmokers have increased, they impose inconsistent restrictions and limits. There are substantial gaps in the protections provided to nonsmokers in public places. In order to provide all nonsmoking Americans with equal protections, a more comprehensive smoking policy may be necessary. The federal government may play a role in developing such a uniform policy.

Federal Legislative and Regulatory Action

In 1987, Congress enacted an amendment offered by *Reps. Richard J. Durbin (D., Ill.) and C. W. (Bill) Young* (R., Fla.) and Senator Frank Lautenberg (D., N.J.), which prohibits smoking on commercial aircraft flights of two hours or less (H.R. 2890). The law went into effect on April 23, 1988 and will expire in two years unless extended by Congress; Rep. Durbin has already introduced legislation in the 101st Congress to make the two-hour airline smoking ban permanent (H.R. 160). Since the ban went into effect, the Federal Aviation Administration has documented only 18 enforcement actions against individuals violating the ban. The law also permanently prohibits tampering with aircraft smoke detectors and authorizes fines of up to $2,000 for violations.

Other bills introduced during the 100th Congress also dealt with smoking on airline flights. Reps. Oberstar (D., Minn.), Torricelli (D., N.J.) and Scheuer (D., N.Y.) introduced bills to ban smoking on *all* domestic commercial flights (H.R. 3377, H.R. 1078 and H.R. 432, respectively). The bills did not receive action but have been reintroduced in the 101st Congress as H.R. 598, H.R. 561 and H.R. 817, respectively. Also in the 100th Congress, Rep. Durbin introduced a bill (H.R. 5394) to ban smoking in all Medicare/Medicaid participating hospitals, which did not receive action before adjournment.

There has also been regulatory action taken recently to protect nonsmokers. In 1986, the Secretary of Defense initiated an "aggressive anti-smoking campaign" throughout *the Department of Defense and the Armed Services. The* General Services Administration, which controls one-third of all federal office space, issued regulations to increase protection for nonsmokers working in and visiting GSA-controlled buildings. The Secretary of Health and Human Services has taken a leadership role in establishing smoke-free HHS buildings. Most recently, the Department of Veterans Affairs announced plans to make the acute care sections of all VA hospitals and outpatient clinics smoke-free by mid-1989.

Policy Questions

From a public policy perspective, *smoking* and *involuntary smoking* are very different problems. To date, public policy has dealt primarily with *smoking*. Efforts to address the problems caused by cigarette smoking have focused on providing smokers with information about the dangers of smoking and encouraging them to quit. Parallel efforts work to convince nonsmokers to avoid starting to smoke.

But now the debate is broadened to include involuntary smoking. And the public policy response to involuntary smoking has to be very different from the response to smoking, because the risks of involuntary smoking result from the actions of others and are not necessarily self-imposed.

What then, are the policy questions and policy responses to consider on the issue of involuntary smoking? A 1987 report, "The Policy Implications of Involuntary Smoking as a Public Health Risk", propose these questions for debate:

- What role should the federal government play in protecting nonsmokers?
- What level of risk to nonsmokers should be tolerated? Should the policy goal be to totally eliminate exposure to tobacco smoke for those who do not smoke? Or, is it sufficient to eliminate exposure for those who receive the greatest exposure or for those who are at special risk?
- What can and should be done to protect children when they are in the care of institutions, such as daycare centers, schools and health care facilities?
- When should government intervene to protect the health of the nonsmokers and when should the private sector resolve this issue?
- Should smoking be banned in all public places? On all public conveyances? In schools? In hospitals?
- What role should existing regulatory mechanisms such as OSHA play, and at what level of government? Are new approaches and new laws needed?
- Who should be legally responsible for injuries suffered by nonsmokers from involuntary smoking?

It is obvious that the public policy debate must continue to address not only the dangers associated with smoking, but also the health and safety concerns of nonsmokers set forth *in reports issued by the Surgeon General and the National*

Academy of Sciences. Surgeon General Koop's final statement in his report, "The Health Consequences of Involuntary Smoking," provides us with a clear and concise message: "The right of smokers to smoke ends where their behavior *affects the health and well-being of others.*"

Protection of Nonsmokers—Summary of Workgroup Discussion

Involuntary smoking—the exposure of nonsmokers to environmental tobacco smoke—is a serious public health and safety problem. The Surgeon General of the United States has determined that involuntary smoking is a cause of disease, including lung cancer in healthy nonsmokers. It is estimated that involuntary smoking causes 2,400 excess lung cancer deaths each year. Environmental tobacco smoke has also been shown to be a significant health risk for infants and children. Finally, recent scientific evidence suggests that involuntary smoking contributes to substantial morbidity and mortality from heart and lung diseases among nonsmokers.

Given the nature and magnitude of the risks posed by involuntary smoking, *the federal government should play a significant role* in protecting nonsmokers, especially in circumstances and settings where federal funds are expended.

There has been significant progress at all levels to protect nonsmokers in public places, workplaces and other settings. However, *uniform protective policies and regulations need to* be adopted more rapidly to help eliminate exposure. There also is a need for increased public education about the health risks of involuntary smoking. Finally, all regulatory, educational and research activities would benefit from more extensive and effective coordination at the federal level. Congress can take the lead, for example, by imposing restrictions and creating incentives that will ultimately eliminate smoking in all federally supported or sponsored facilities, activities and programs.

Recommendations

1. The Congress should adopt the goal of eliminating smoking in all public transportation and transportation terminals. At a minimum, the 101st Congress should make permanent the ban on smoking on all flights scheduled for two hours or less and assure that newly constructed airline terminals provide separately ventilated nonsmoking areas, if smoking is allowed.
2. Congress should adopt the goal of eliminating smoking in all federal facilities. At a minimum, smoking should be permitted only to the extent that it does not endanger life or property or risk impairment of nonsmokers' health.
3. Congress should direct that a study be conducted to identify and assess the legislative and regulatory options for protecting nonsmokers in all workplaces. In addition, health and labor organizations should explore joint union-management approaches to protecting nonsmoking workers.
4. Congress should adopt the goal of eliminating smoking in all healthcare settings. To hasten achievement of this goal:
   - —The American Hospital Association (AHA) should study the experience of hospitals that have become smoke-free.
   - —The AHA, American Medical Association (AMA), the American Nurses Association, Coalition on Smoking OR Health and other health professional groups should intensify efforts to eliminate smoking in all healthcare facilities.
   - —Congress should enact legislation providing incentives through Medicare, Medicaid and other federal grant and payment programs to encourage healthcare facilities to eliminate smoking.
   - —*Healthcare facilities should be encouraged to* provide information and referral to stop-smoking services for all employees and patients.
   - —The Health Care Financing Administration should be directed to study the cost effectiveness of in-hospital stop-smoking services.
5. Congress should enact legislation to encourage elementary and secondary schools to adopt policies that:
   - —Prohibit smoking by students and the sale of tobacco products on school property or at school-sponsored functions.
   - —Encourage teachers and staff to be role models by refraining from smoking on school property or at *school sponsored functions.*
   - —Make stop-smoking information and services available for students.
   - —Require information on tobacco use to be included in all health curricula.
   - —Support joint efforts by organizations of teachers and staff and the AMA, PTA and health professionals and volunteers to encourage smoke-free schools.
6. *Congress should enact legislation to require that all* Head Start programs be smoke-free.
7. Congress should direct that the Special Supplemental Food Program fo Women, Infants, and Children (WIC) incorporate information on the risks of smoking, involuntary smoking and how to get stop-smoking help.

8. Congress should include in any day care legislation provisions to encourage such programs to be smoke-free.
9. Health professional and voluntary organizations should make increased efforts to inform and protect groups at high risk of exposure to environmental tobacco smoke.
10. Congress should explore ways to require that recipients of federal funds establish policies to protect nonsmoking workers and provide assistance to those who wish to quit.
11. Federal legislation on smoking should contain appropriate mechanisms to ensure that existing state or local laws that may be more strict and/or more broad are not preempted.
12. Congess should appropriate funds to support increased research on health and indoor environmental effects of tobacco smoke.
13. Congress should include in the Drug-Free Schools Act a requirement for education on the health and safety risks of smoking and involuntary smoking. Voluntary and professional groups should work with local nonsmoking groups to increase public education on involuntary smoking.
14. Congress should encourage development of model state and local laws to protect the nonsmoker in public and work places.
15. The Secretary of Health and Human Services should direct the existing Interagency Coordinating Committee on Smoking and Health to explore ways to improve coordination of federal regulatory, research and educational efforts on the protection of nonsmokers.

Tobacco Marketing and Promotion

Prepared by:
Matthew L. Myers
Staff Director
Coalition on Smoking OR Health
John Hollar
Legislative Director
Congressman Mike Synar

Introduction

What is the significance of advertising and promotion of tobacco products in the United States? What impact does advertising and promotion of tobacco products have on who smokes, who quits, how the media covers tobacco and health issues, how society views the use of tobacco products, and how the government responds to tobacco and health issues? To fully understand the role of tobacco advertising and promotion in the United States, these issues must be examined together, because the impact is cumulative.

Recently, much has been written about tobacco advertising and promotion. The Interagency Committee on Smoking and Health, for example, held three separate full-day sessions to explore the subjects. Kenneth E. Warner, Ph.D., published *Selling Smoke: Cigarette Advertising and Public Health*, with a superb summary of the background facts and questions raised by tobacco advertising and promotion. In addition, two days of hearings conducted by the Committee on Energy and Commerce of the United States House of Representatives in the summer of 1986 added close to a thousand pages to the literature. What follows is a brief synopsis of the current data and literature to help stimulate discussion and public policy analysis.

Nature, Extent and Effect of Tobacco Advertising and Promotion

How Much is Spent

In 1981 the Federal Trade Commission (FTC) found that cigarettes are the most heavily advertised and promoted product in the United States. In 1986 the six major cigarette companies spent close to $2.4 billion—or more than $6.5 million *a day*—on advertising and promotion. As Professor Warner notes in *Selling Smoke: Cigarette Advertising and Public Health*, annual expenditures on cigarette advertising and promotion equal almost $9.00 for every man, woman *and child* in this country.

Cigarette advertising and promotion expenditures have increased substantially over the last decade and continue to grow. In 1970—the year before cigarette ads were banned from television and radio—the tobacco industry spent $361 million on advertising and promotion. By 1979 tobacco industry spending on advertising and promotion exceeded $1 billion for the first time. Only five years later, in 1984, the tobacco industry's annual advertising and promotion budget exceeded $2 billion and only one year later, it jumped again to approximately $2.4 billion. In constant dollars, expenditures on the advertising and promotion of cigarettes have increased more than fivefold since 1971, when radio and television advertising was banned.

For perspective, contrast the tobacco industry's spending on *promoting* its products, with the $3.5 million annual budget of the *entire operation* of the Office on Smoking and Health in the Department of Health and Human Services.

How Tobacco Advertising and Promotional Expenditures are Spent

In 1987 Philip Morris and R.J. Reynolds (RJR) ranked first and fourth, respectively, among American magazine advertisers. Among newspaper supplement advertisers, RJR and Philip Morris ranked third and fifth, respectively. The top five outdoor billboard advertisers were all tobacco companies. And, as Philip Morris and other tobacco companies have diversified, their advertising clout has grown considerably. In 1987 the Philip Morris Companies became the leading national advertiser in the United States, ending Procter & Gamble's 24-year reign as the number-one advertiser.

Two other trends are noteworthy. First, as Professor Edward Popper testified in his June 4, 1986 presentation to the Interagency Committee on Smoking and Health, the tobacco industry has shifted an ever-increasing proportion of its advertising and promotional dollars into direct promotional activities. Today, domestic tobacco companies spend more on promotional activities than on advertising. In 1963, promotional

expenditures were less than 10 percent of the total cigarette advertising promotional budget; in 1963 they were more than 52 percent of the budget. This shift in emphasis to promotional expenditures has enabled the tobacco companies to target specific populations more precisely. Moreover, the promotions are usually designed to motivate consumer purchases by placing tobacco products directly in the hands of the consumer at minimal or no financial risk through free sampling and/or "couponing."

Tobacco promotion techniques also include sponsoring sporting, cultural and other special events. According to Dr. Popper, rock concerts, rodeos, skiing competitions and golf and tennis tournaments deliver the youth market to sponsoring tobacco companies, who reinforce their presence by putting their brand names on numerous promotional products such as T-shirts and hats.

The second recent trend is the increased attention paid by tobacco manufacturers to advertising and promotions directed toward blue-collar workers, women, minorities and children.

Since 1981 Philip Morris has annually published *A Guide to Black Organizations* filled with cigarette advertising featuring black models and distributed it to black politicians and other black leaders. As columnist Carl T. Rowan noted in 1986, "Wherever blacks are putting on a convention or other affair of consequence, R.J. Reynolds, Philip Morris, Brown & Williamson and the other companies are there, or trying to be, pushing cigarettes...." The companies also advertise heavily in black magazines and newspapers.

Cigarette ads account for more than 12 percent of total advertising in *Essence* magazine, which calls itself, "the magazine for today's black women." In January 1987, *The New York Times* noted that you can pick up any black publication and the same message is there, "beautiful black models, always enjoying themselves, smoking cigarettes and urging blacks to follow suit." The *Times* further noted that, "On street corners and in many inner cities, attractive young women tempt passers-by with free samples of popular brands or discount coupons."

A large share of contemporary cigarette advertising also is directed to women. An article in *Advertising Age* in 1981 bore the title "Women Top Cig Target." Another article in the same magazine two years later was entitled "Marketers Clamor to Offer Lady a Cigarette." In 1985 cigarette advertising contributed more than 10 percent of total advertising revenues for the *Ladies' Home Journal, McCalls, Redbook, Women's Day, Working Mother*, and more than nine percent of the total advertising revenue of *Better Homes and Gardens*.

Cigarette promotions targeted to women are not limited to suggestive print advertising. Is there a women alive who does not associate Virginia Slims with women's tennis? Considering that the first cigarette targeted solely at women was introduced in 1968, and that advertising targeted towards women skyrocketed over the next decade, it is no coincidence that the percentage of teenage girls who smoke nearly doubled from 8.4 percent in 1968 to 15.3 percent in 1979.

Tobacco Advertising and Promotion: Market Expansion or Brand Switching?

The tobacco industry claims that the $2.4 billion it spends each year is intended only to maintain brand share and that it does not help to attract new smokers, provide encouragement to current smokers not to quit, encourage quitters to relapse, or increase smokers' daily consumption. However, the evidence does not support the tobacco industry's claim.

Information on whether or not advertising and promotion affect consumption comes from a variety of different sources. First, the tobacco industry annually loses more of its customers than do the manufacturers of any other product. Since 1964 an average of 1.5 million Americans have quit smoking each year. In addition, cigarettes kill 390,000 smokers each year. Add to these figures the number of smokers who die of other causes, and it can be safely said that the tobacco industry has to attract more than two million new smokers a year just to maintain its market. Since over 90 percent of all new smokers are under the age of 20, this means that some 6,000 children and teenagers have to begin smoking each day in order for the tobacco industry to maintain the status quo.

Second, fewer than 10 percent of all smokers switch brands each year. Since there are only six major manufacturers of cigarettes in the United States and two of the manufacturers currently have about 75 percent of the total cigarette market, many, if not most, of those who switch brands change to another brand of the same company. At these rates, the tobacco industry is spending more each year for each person who switches than it makes.

Third, advertising campaigns targeted at women preceded and then accompanied the rapid spread of smoking among women. Similarly, recent advertising campaigns on behalf of smokeless tobacco products preceded and then accompanied the rapid increase in the use of smokeless tobacco products by teenagers. Certainly, there was more than one factor that influenced the growth in smoking by women; but the data suggest that the advertising campaign intended to, and succeeded, in exploiting this growth market. Likewise, the number of users of smokeless tobacco had long stagnated prior to a massive marketing effort by the United States Tobacco Company beginning in the early 1980s. Almost immediately, and for no other apparent reason, the use of smokeless tobacco products among teenagers in virtually every region of the country began to increase at an unprecedented pace.

Fourth, advertising experts agree that market expansion is a significant objective of advertising for virtually all products, even in mature markets. Emerson Foote, the founder of Foote, Cone & Belding and the former Chairman of the Board of McCann-Erickson, one of the world's largest advertising agencies, once observed,

"The cigarette industry has been artfully maintaining that cigarette advertising has nothing to do with total sales... This is complete and utter nonsense. The industry knows it is nonsense... I am always amused by the suggestion that advertising, a function that has been shown to increase consumption of virtually every other product, somehow miraculously fails to work for tobacco products."

This view is echoed by the testimony in 1986 of advertising executive Charles Sharp, a former vice president of Ogilvy & Mather, Inc., before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the U.S. House of Representatives. Mr. Sharp stated:

"A review of cigarette advertisements reveals that the industry communicates their message about smoking in a variety of attention-getting, frequently changing formats. The ads are rich in thematic imagery and portray the desirability of smoking by associating it with the latest trends in life-style, fashion and entertainment as well as associating smoking with youthful vigor, social, sexual and professional success, intelligence, beauty, sophistication, independence, masculinity and femininity. The ads are filled with exceptionally attractive, healthy-looking, vigorous young people who are both worthy of emulation, free of any concerns relating to health and who are living energetic lives filled with sexual, social and financial success and achievement.

"Why is this advertising approach significant? By depicting a product as an integral part of a highly desirable life-style and personal image, in addition to current users, an advertiser can attract individuals who do not currently use that product but who want to emulate that life-style and project a depicted image. Thus, ads which effectively associate smoking with the latest trends or ideas or with independence, sophistication, sexual, social or athletic success and happiness will attract smokers and nonsmokers alike who want to be like people in the ads."

Fifth, if advertising does not increase consumption, why would state tobacco monopolies advertise in countries where there is no competition? Nonetheless, at one time or another, a number of countries with state monopolies, such as Austria, Japan, South Korea, Thailand and Turkey, have engaged in widespread cigarette advertising.

Sixth, there has been a great deal of debate over what can be learned about the role of advertising from the international experience of countries that banned advertising and promotion after previously permitting it. While a number of free-market economies have enacted statutory bans on the advertising and/or promotion of tobacco, very few have effectively instituted total bans. Even fewer countries have combined those bans and/or restrictions with a comprehensive smoking-related program. Norway, Finland and, to a lesser degree, Sweden, provide the best examples of comprehensive anti-tobacco actions. In each of these countries, restrictions or an all-inclusive ban were accompanied by a variety of other actions, such as an increase in the excise tax on cigarettes, strengthened health warnings and/or increased educational activity.

The limitations of these data must be understood. Because multiple anti-tobacco actions accompanied the advertising ban, it is impossible to know the effect of the advertising ban alone; or even of the overall role of advertising and promotion in those countries. Nonetheless, the data from these countries show a positive correlation between eliminating advertising and promotion and a declining percentage of young people who smoke.

For example, in 1975 Norway banned all advertising of tobacco products, prohibited the sale of tobacco products to anyone under age 16, required that all packages be labeled with a symbol and health warning and began a vigorous nationwide educational campaign. Prior to these actions, per capita consumption of cigarettes in Norway was increasing steadily. The percentage of 13, 14 and 15 year-olds in Norway who smoked also rose steadily from 1963 to 1975. In contrast, in the decade after the advertising ban, per capita cigarette consumption dropped every year except one in Norway. Smoking among 14 year-olds, which had been on the increase prior to 1975, dropped from 17 percent to close to 10 percent after the ban took effect. Similarly dramatic declines in smoking occurred among 15 year-olds and among both males and females between the ages of 16 and 20 after the ban took effect. The data from Finland and Sweden are consistent with the Norwegian experience.

Finally, a number of formal analytical studies have sought to measure the effect of tobacco advertising and promotion These include regression analysis studies of the statistical relationship between advertising expenditures and cigarette consumption and survey studies of respondents' reaction to cigarette ads and their current and future smoking status. In *Selling Smoke*, Professor Warner notes that enough studies exist on both sides of the question to permit either side of the argument to appeal to scientific studies to bolster their case. Professor Warner concludes, however, that the more recent studies do tend to support the proposition that advertising encourages smoking.

Tobacco Marketing and Youth

The tobacco industry claims that its advertising has no impact on young people and denies any purposeful attempt to recruit young users. However, the industry's claims are contradicted by its own actions, including its targeted advertising and promotion and heavy use of image advertising in locations where the ads will be frequently observed by young people. Eight-five to 90 percent of all new smokers start before or during their teenage years. The age at which smoking

starts has declined over the past 25 years so that, now, children start smoking earlier than ever before, many before they leave the ninth grade.

William Meyers reports in his book, *The Image Makers*, how Philip Morris made Marlboro the number-one selling cigarette in this country. After interviewing top Philip Morris executives, Meyers found:

> "When [George] Weisman [a top executive at Philip Morris] assumed responsibility for Marlboro in the late 1950s, the always analytical executive, who wanted to learn more about the tobacco market, felt that a research study of American smoking habits was in order. The results of this investigation were fascinating. The one group of consumers that cigarette manufacturers had neglected was the impressionable young Emulators. In search of an identity, these post-adolescent kids were just beginning to smoke as a way of declaring their independence from their parents. But until now, marketers hadn't addressed their special needs. Weisman thought that if Marlboro could somehow appeal to them, then maybe the brand could be turned around and made profitable."
>
> "Jack Landry, a brilliant advertising mind at Philip Morris, was given the job of working with Leo Burnett to produce commercials that would turn rookie smokers on to Marlboro. . . At last, it latched onto the concept of a weathered-looking cowboy riding off into the sunset—a perfect symbol of independence and individualistic rebellion."
>
> "The Marlboro Man, as he was called, was an immediate hit. Insecure young adults flocked to the brand because they wanted to be as cool and confident as the cowboy—they, too wanted to be tough and free. Flushed with success, Landry expanded the scope of the ads with the unforgettable line, "Come to Marlboro Country." This wasn't an invitation to visit Wyoming or Colorado; it was a call to Emulators to get it together by smoking Marlboros. Landry's cowboy campaigns demonstrated the real power of psychological advertising. By 1976, the once floundering brand had become the best selling cigarette in America, and today it provides Philip Morris with close to four billion dollars a year in revenue."

Who smokes Marlboro today? More than 50 percent of teenage smokers smoke Marlboro. The efforts to attract insecure developing youngsters obviously worked.

Philip Morris knew what it was doing. Research conducted by William J. McCarthy and Ellen Gritz has examined the psychological and social factors which influence some teenagers to smoke. According to Dr. McCarthy, in testimony before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, "The child psychology literature provides strong reason to believe that the unique characteristics of adolescent development magnifies the effectiveness of some forms of cigarette advertising on these teens." Dr. McCarthy concluded:

> "To the degree that adolescents consciously tried to reduce the distance between their ideal self image and their own self images, and the scientific literature supports that they do, there is reason to conclude that the personality traits popularly imputed to cigarette smokers in cigarette advertisements are sufficiently alluring to induce adolescents to smoke.
>
> "In general, the personality and social variables which distinguish adolescent smokers from nonsmokers—risk taking, inpulsivity—are congruent with the images of independence, strength, maturity, and adventurous behavior portrayed in many cigarette advertisements.
>
> "For the typical teenager seeking to make his/her real self correspond more closely to his/her ideal self, the portrayal in cigarette ads of valued aspects of identity such as independence, social and physical attractiveness and confidence cannot fail to make cigarettes appear more attractive to teenagers than they would be without such associated imagery.
>
> "The data support the conclusion that smoking is a behavior for which there is 'a period of enhanced vulnerability' and that smoking onset occurs most often between the ages of twelve and sixteen."

In subsequent research, Drs. McCarthy and Gritz found that image-based cigarette ads do, in fact, have this effect. They also found that these image-based ads have the greatest impact on those children whose poor performance in school increases the distance between their ideal self-image and their current self-image. Dr. McCarthy further found that, "The evidence that advertisers use more image advertising with pictures of actors who appeal to a younger audience is so obvious that we hardly need statistics to describe the difference."

Indirect Role of Cigarette Advertising and Promotion

Tobacco advertising also appears to have substantial indirect effects. Studies have shown a relationship between media dependence on tobacco advertising revenue and coverage of smoking and health topics. Tobacco sponsorship of organizations and events appears to discourage those organizations from speaking out and educating their constituents about smoking and health. Cigarette advertising and promotion also seems to affect and/or promote an atmosphere in which tobacco use is legitimate, even wholesome, and certainly acceptable.

Cigarette advertising revenue and media coverage of smoking

Substantial evidence points to a link between a magazine or newspaper's dependence on cigarette advertising revenue

and the extent of its coverage of smoking and health issues. A decade ago, R.C. Smith wrote in the *Columbia Journalism Review* that "The record of national magazines that accept cigarette advertising . . . (is) dismal."

More recently, a number of studies have been done of the coverage of these issues in magazines for women. These studies found a significant inverse relationship between a magazine's dependence on cigarette advertising revenue to coverage of tobacco and health related articles. In one study of ten prominent women's magazines, four of the 10 magazines carried no anti-smoking articles in the entire 12-year period studied. By contrast, two prominent magazines which did not accept cigarette advertising ran 11 and five such articles, respectively, during the same period.

Other impartial studies have found a similar relationship. A 1986 survey by the American Council on Science and Health examined a group of 20 magazines. Of the magazines surveyed, four of the five rated best in terms of overall coverage of hazards of smoking and health did not accept cigarette advertisements. Among those who scored the worst in terms of covering the smoking and health issues were *Cosmopolitan, Redbook, Ladies' Home Journal*, and *Ms.*, all of which depend heavily on tobacco advertising.

Further, an increasing number of examples of censorship by magazines and newspapers have been reported by health writers who have prepared anti-tobacco articles. The censorship has been both partial and complete. In *Selling Smoke*, Professor Warner reports that Susan Otrie, a physician who writes a health column for *Cosmopolitan*, has stated that smoking is one subject for which the editors often "soften" their drafts. An investigative reporter for the television show "20/20" reported that a number of years ago, *Family Circle* asked him to write an article, but told him: "Don't write about cigarettes, it might offend advertisers." Other examples abound.

Thus, several noted observers have concluded that tobacco advertising directly and adversely affects the coverage of the tobacco and health issue. The irony is that tobacco advertising and promotion probably result in a more substantial infringement of free speech than would a ban or limitation on these activities.

Individual and Organizational Self-Censorship

The impact of tobacco advertising and promotional revenue sometimes takes another form. For years the professional women's tennis tour has been sponsored by Virginia Slims. While the health effects of smoking on women have been the subject of much study and concern during this period, no female tennis star has been willing to speak out. Self-censorship as the result of a dependence on tobacco sponsorship extends to other areas. For years the Kool Jazz Festival has been sponsored by the Brown & Williamson Tobacco Corporation. The tobacco manufacturers give substantial amounts of money to the Congressional Black Caucus, and the United Negro College Fund also receives thousands of dollars in contributions from R.J. Reynolds. The implications are troubling: Are these activities intended to—and are they successful—in causing organizations to take a less active role than they otherwise would in promoting health prevention and reduced smoking among their constituents?

Cigarette Advertising and the Smoking Environment

Professor Warner reports that tobacco advertising and promotion may have another effect in influencing our attitudes and behavior regarding its use. Tobacco advertising and promotion is ubiquitous. It portrays tobabbo use as an important part of the American way of life and as an integral part of social, athletic, financial and sexual success. The pervasiveness—and persuasiveness—of positive tobacco messages create an image that tobacco is, in fact, a legitimate, wholesome and healthy part of everyday life. After all, if tobacco use were so hazardous, would the federal government really permit it to be portrayed in such a positive light?

Current Restrictions and the Need for Further Governmental Action

Is additional governmental action necessary to limit the influence of tobacco advertising and promotion, or is a strategy that relies upon the status quo and voluntary self-regulation sufficient?

Current Legislation and Regulation Which Affects Tobacco Advertising and Promotion

What has the federal government done thus far to offset the impact of tobacco advertising and promotion? Are these actions adequate to cope with the issues noted above?

In 1964 there were no restrictions on tobacco advertising and promotion and few, if any, governmental efforts to educate the American public about the health hazards of smoking. In 1965 Congress rejected a proposal by the FTC to require detailed health warnings on all cigarette advertisements and packages and, instead, required only that all cigarette packages carry the following message: "Caution: Cigarette Smoking May Be Hazardous To Your Health." No warning was required on cigarette print ads. At the same time Congress pre-empted the FTC from taking further action for a period of five years.

In 1969 the FTC again proposed dramatically strengthening the health warning and expanding its coverage to include advertisements. Congress intervened to weaken and pre-empt the FTC proposal. In 1970 Congress amended the message on cigarette packages to read, "Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous To Your Health."

In 1970 Congress banned cigarette advertisements from

the broadcast media after January 1, 1971, but pre-empted the FTC from imposing any requirements on cigarette print ads for two years. In 1971 the FTC announced its intention to file complaints against the cigarette companies for failing to include a health warning voluntarily in their advertisements. Subsequent negotiations between the FTC and the six major tobacco manufacturers led to the execution of a consent decree by which the companies agreed to include the congressionally mandated package warning in their advertisements.

The ban on cigarette advertisements in the broadcast media was in part the result of the tobacco industry's own response to a 1967 decision of the Federal Communications Commission (FCC). At that time, the FCC determined that cigarette advertisements on the broadcast media involved public issues of a sufficiently controversial nature that they were subject to the Fairness Doctrine, and therefore the broadcast media had to provide opponents of tobacco products with a free opportunity for counter-advertising. By removing cigarette ads from the broadcast media, the requirement that the broadcast media provide free time for anti-smoking ads was also removed. Not surprisingly, in the aftermath of the broadcast ban the number of anti-smoking ads aired during prime time dropped dramatically.

Neither the FTC nor Congress took any further action to limit tobacco advertising or to require tobacco companies to do more to educate the American public about the health hazards of smoking. In 1981 the FTC issued a report which found that the then-existing health warning on cigarette ads and packs was inadequate and recommended that Congress take additional action to remedy the situation. In 1984 Congress enacted the Comprehensive Smoking Education Act, which replaced the single health warning on cigarette ads and packages with the four health warnings which now appear. A similar set of warnings was required for smokeless tobacco products by the Comprehensive Smokeless Tobacco Health Education Act of 1986.

Congress has otherwise imposed no restrictions on or other requirements which directly affect tobacco advertising and promotion. The Food and Drug Administration (FDA) takes the position that it has no authority over tobacco products or their ads as long as the ads make no health claims. The authority of the FTC over tobacco advertising and promotion is limited to enforcing the warning label legislation and to carrying out its traditional mandate to prohibit false and/or deceptive advertising. The current power of state and local governments to restrict tobacco advertising and promotion has been severely restricted by a provision included in a 1970 congressional act, which limits the power of state and local governments to impose additional restrictions on cigarette advertisements.

Self-Regulation

Voluntary self-regulation has not been successful in limiting the abuses of tobacco advertising and promotion. Neither the media nor the tobacco industry have demonstrated by their past acts that they are prepared to eliminate the negative consequences of tobacco advertising and promotion on their own.

Voluntary Self-Regulation By The tobacco Industry

The tobacco industry has neither developed nor given any indication that it will develop an effective self-regulatory mechanism to limit the harms posed by tobacco advertising and promotion. The few instances of voluntary self-regulation on the part of the tobacco industry have been a farce.

In 1964 the tobacco industry established its own "Cigarette Advertisers Code." In 1969 and again in 1981, the FTC evaluated the Code's effectiveness. On both occasions FTC found that the data amply demonstrated the "futility" of relying upon voluntary regulation to achieve any significant changes in the content and meaning of cigarette advertising.

Even a cursory comparison of the Cigarette Advertisers Code with current cigarette advertising practices demonstrates that the code serves no useful purpose. Consider the following passages from the so-called code adopted by the industry:

3. Cigarette advertising shall not suggest that smoking is essential to social prominence, distinction, success or sexual attraction, nor shall it picture a person smoking in an exaggerated manner.
5. Cigarette advertising shall not... show any smoker participating in, or obviously just having participated in, a physical activity requiring stamina or athletic conditioning beyond that of normal recreation.
7. Persons who engage in sampling shall refuse to give a sample to any person whom they know to be under 21 years of age or who, without reasonable identification to the contrary, appears to be less than 21 years of age.

Contrast these standards with the reality of the beautiful models in the Virginia Slims or Capri ads, and the sensuous women, the prosperous and handsome men, the mountain climbers, tennis players, football players and others, who appear in the ads for numerous brands today. It is apparent that the voluntary code serves only one purpose: to relieve the tobacco industry of any real responsibility toward consumers.

Self-Regulation By the Media

Few American newspapers on their own have decided not to carry tobacco advertisements because of the health consequences of smoking. An investigative report by Morton Mintz of the *Washington Post* found that in Canada,

newspapers that accounted for 20 percent of total weekday circulation had voluntarily stopped taking tobacco advertisements. In contrast, Mintz found that newspapers in the United States with a combined weekday circulation of only 0.6 percent had done so.

When questioned on their views about tobacco advertising, some representatives of the American print media state that as long as a product is legal to sell, it is not up to the news media to restrict advertising for that product. However, these same representatives fail to note that newspapers and magazines frequently decline advertising for other legal products for a wide variety of reasons, including the media's own perception of what is in good taste and what is consistent with a particular community's moral and social standards. Thus, many newspapers will not accept advertising for X-rated movies and, until recently, few members of the print media accepted advertisements for items such as condoms. Unfortunately, this same subjective discretion has not resulted in any significant limits being placed on ads for tobacco products.

Public Policy Proposals

Given the nature, extent and effect of tobacco advertising and promotion today, and the legislative, regulatory and educational efforts of the government and the private sector to date, the question is: What more, if anything, needs to be done? A number of public policy options have been raised and debated over the last several years, but none enacted into law.

These proposals offer various solutions. Some call for direct restrictions on tobacco advertising and promotion, ranging from a ban on all advertising and promotion, to restricting advertisements to tombstone ads, to enacting and enforcing some version of the industry's own advertising and sampling code, to simply expanding and/or strengthening the warnings which appear on tobacco advertisements and packages. Other advertising-related proposals, which would not necessarily involve any direct restriction on tobacco advertising and promotion, include expanding government-funded educational efforts and counter-advertising.

In addition, three other proposals have been seriously debated. They include eliminating the tax deduction for tobacco industry expenditures on tobacco advertising and promotion, eliminating the pre-emption of the authority of state governments to restrict advertising and promotion, and, finally, enacting legislation giving the FDA clear authority to regulate tobacco advertising and promotion.

Each of these proposals and their pros and cons are briefly discussed below.

Proposal Number One: Ban Advertising and Promotion

A ban on advertising and promotion would eliminate all advertising of any kind for tobacco products, including all billboards, print ads and utilitarian items, such as T-shirts and hats. It would also prohibit tobacco companies from sponsoring events such as rock concerts under their cigarette brand names. Organizations such as the American Lung Association, the American Heart Association, the American Cancer Society and the American Medical Association have endorsed a ban on advertising and promotion.

Legislation to ban all advertising and promotion of tobacco products was first introduced in Congress in 1986 by Rep. Mike Synar (D., Okla.) following the adoption of this proposal by the American Medical Association at its annual meeting in January 1986. Two days of hearings were held before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce on July 18 and August 1, 1986, where testimony was heard from 47 witnesses representing health groups and the tobacco and advertising industries. No further action was taken on the legislation during the 99th Congress.

Rep. Synar again introduced an advertising and promotion ban, H.R. 1272, at the beginning of the 100th Congress. Shortly thereafter, Rep. Bob Whittaker (R., Kan.) introduced a similar advertising ban, H.R. 1532, which differed primarily on enforcement provisions. The Subcommittee on Transportation, Tourism, and Hazardous Materials held a hearing on both bills on April 3, 1987. Two additional days of hearings were held on both measures before the Subcommittee on Health and the Environment on July 27 and 28, 1987, at which 32 witnesses testified. No further action was taken on either bill before the 100th Congress adjourned.

Pro

A tobacco advertising ban could have an impact on long-term consumption by reducing the number of smokers, particularly children and members of other groups which are the subject of the tobacco industry's targeted marketing efforts. A ban would not only eliminate the direct effects of tobacco marketing efforts, such as the lure of seductive advertisements and billboards, but the indirect effects as well, such as the inadequate coverage of the health consequences of smoking by advertising-dependent news media.

Recent U.S. Supreme Court decisions support the position that a legislatively mandated ban on tobacco advertising and promotion would probably be upheld as constitutional, if it was based on the government's desire to reduce the number of deaths caused by tobacco usage by reducing the number of smokers.

Con

Opponents of an advertising ban raise three principal objections: 1) an advertising ban is unconstitutional; 2) a ban would be ineffective in reducing the number of people who smoke; and 3) a ban would lead to bans on other consumer products. Each of these arguments is discussed below.

The debate over an advertising ban is made more complicated by several interested parties. The proposed ban engenders opposition by the media, which have become dependent upon tobacco advertising dollars and argue that they would be financially hurt by eliminating these revenues. Respected civil liberties organizations, such as the American Civil Liberties Union (ACLU), have expressed First Amendment concerns. Further, the proposed ban also engenders opposition by organizations, such as arts organizations, which receive substantial tobacco sponsorship dollars for their activities.

Tobacco Industry Argument 1: Constitutionality of an Ad Ban

Opponents of an ad ban argue that an advertising ban would violate the First Amendment. Many assert—without constitutional authority—the proposition that if a product is legal to sell, then it is unconstitutional to restrict advertising for that product. Indeed, the Supreme Court expressly rejected this point of view in *Posadas de Puerto Rico Associates v. Tourism Co. of Puerto Rico*, 106 S. Ct. 1968. In fact, for nearly 200 years the Court held that commercial speech was not entitled to *any* protection under the United States Constitution. It was not until 1975 that the Court for the first time held that the First Amendment did provide protection to some forms of commercial speech.

The Court in *Central Hudson Gas & Electric Corp. v. Public Service Commission*, 447 U.S. 557 (1980), established a four-part test for determining if commercial speech restrictions are constitutional. This test has subsequently been applied to every case involving commercial speech restrictions. The Court set forth the test, as follows:

> "[1] At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. [2] Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine [3] whether the regulation directly advances the governmental interest asserted, and [4] whether it is not more extensive than is necessary to serve that interest."

Six years later, in *Posadas de Puerto Rico Associates v. Tourism Co. of Puerto Rico, supra*, the Court provided clear guidance as to how it would apply the *Central Hudson* test to a tobacco advertising ban. In *Posadas*, the Court upheld a Puerto Rico statute which outlawed gambling advertisements aimed at Puerto Ricans. While the gambling advertisements concerned lawful activity and were not misleading, the Court found the *Central Hudson* test to be satisfied. The Court had "no difficulty in concluding that the Puerto Rican Legislature's interest in the health, safety, and welfare of its citizens constituted a 'substantial' governmental interest."

The Court found the third part of the test to be met simply because the advertiser chose to litigate the restrictions all the way to the Supreme Court. It noted that the advertiser would not have challenged the restrictions if they were not effective in discouraging gambling by Puerto Rican residents.

Finally, the Court found that the restrictions were no more extensive than necessary to advance the governmental interest, and thus met the fourth part of the *Central Hudson* test. The Court held that it was up to the legislature to determine whether the challenged restrictions were more effective than a less restrictive measure, such as a counter-speech requirement.

The Court's application of the Central Hudson test to gambling, an activity deemed harmful by the Puerto Rican legislature, provides a clear view as to how a tobacco advertising ban would be analyzed. The court specifically considered and rejected the argument that the legislature could not ban advertising for gambling because it involved a legal activity:

> "It is precisely because the government could have enacted a wholesale prohibition of the underlying conduct that it is permissible for the government to take the less intrusive step of allowing the conduct, but reducing the demand through restrictions on advertising."

There is no doubt that Congress could, if it wishes, constitutionally ban the sale of tobacco products. Thus, after *Posadas* there is little doubt that Congress could also constitutionally take the lesser step of banning the advertising that promotes the use of tobacco.

Significantly, in its opinion the Court gives a clear signal as to how a tobacco advertising ban would be viewed:

> Legislative regulation of products or activities deemed harmful, *such as cigarettes*, alcoholic beverages, and prostitution, has varied from outright prohibition on the one hand to legalization of the product or activity with restriction on stimulation of its demands on the other hand. To rule out the latter, intermediate kind of response would require more than we find in the First Amendment." (Emphasis added.)

Tobacco Industry Argument 2: Effectiveness of a Ban

To analyze the constitutionality of commercial speech restrictions, it is also necessary to determine whether the proposed restrictions would be effective, that is to reduce the number of persons engaging in an activity. In *Posadas*, however, the Court required little or no empirical evidence to establish the effectiveness of the advertising restrictions and instead gave great deference to the judgments of the legislature on the likely effects of its action. In both *Central Hudson* and *Posadas*, the Court accepted the logical assumption that advertising promotes consumption, and that restrictions on advertising have the reverse affect.

In the case of tobacco, however, proponents of an advertising ban will need to convince members of Congress of the likely impact of a ban in order to motivate Congress to act. There are two principal ways to demonstrate the link between tobacco advertising and tobacco consumption: first, by examining advertising expenditures and the demographics of smokers; and, second, by analyzing the experiences of foreign countries which have banned or limited tobacco advertising.

The tobacco industry asserts that the purpose of advertising is simply to maintain or increase market shares for individual brands. This notion is dispelled by a few simple facts about smokers. Approximately 390,000 Americans die each year as a result of smoking-related diseases. An average of 2.5 million Americans quit smoking each year. An additional 650,00 smokers die from other causes, so the industry must recruit two to 2.5 million new smokers each year simply to maintain its current market. To agree with the industry's market-share argument, one would have to believe that the tobacco industry would blithely accept a rapidly dwindling market of smokers.

While the total number of smokers is declining slightly, the decline is less than it would be if no new smokers took up the habit. Since 90 percent of all new smokers are under the age of 20, the vast majority of new recruits are children and teenagers.

Another way to gauge the effectiveness of tobacco advertising restrictions is to analyze patterns of smoking in foreign countries which have banned or restricted tobacco advertising. It is important, however, to recognize the limitations of any comparative analysis of foreign advertising and smoking trends. First, data is limited because few countries have established comprehensive advertising bans. Second, in those countries where advertising bans have been enacted, the bans often are not enforced. And, third, simply comparing U.S. smoking rates and initiation rates with those in foreign countries does not take into account the many social and cultural variables that influence smoking behavior.

Nonetheless, it is possible to conclude from the experiences of several countries, particularly in Scandinavia, that advertising bans as part of comprehensive tobacco and health programs have helped to reduce smoking rates. In the mid-1970s, Norway, Sweden, and Finland each enacted comprehensive smoking reduction programs. In Finland and Norway, tobacco advertising and promotion is completely banned and in Sweden severe restrictions are placed on tobacco advertising and promotion practices.

A decade of experience in these countries reveals that as part of a comprehensive anti-smoking effort, tobacco advertising and promotion bans are effective in reducing smoking rates, especially among young people. The data include:

- In Sweden, smoking rates among 16-year-old boys fell from 45 percent in 1974 to 33 percent in 1980. Among 16-year-old girls, smoking rates fell from 31 percent in 1974 to 21 percent in 1980.
- In Norway, two years after enactment of a comprehensive advertising and promotion ban, the smoking rate among 14-year-old boys was more than halved, from 19 percent to 8 percent.

Critics of the effectiveness of advertising bans cite several other western European countries such as France and Italy whose advertising restrictions are said to have been less effective. However, in both countries the bans go virtually unenforced and tobacco advertising is widespread.

Critics also cite several Eastern Bloc nations, such as Poland, Czechoslovakia and Rumania, where cigarette advertising has never been permitted, but smoking rates have increased. However, as Professor Kenneth Warner points out:

> "The fact of increasing smoking in countries lacking advertising says nothing about whether advertising influences consumption. It simply indicates that advertising is not the only cause of smoking, a premise that no one would challenge. . . . The appropriate question is how, if at all, the observed growth patterns would have been different if advertising had existed."

Tobacco Industry Argument 3: The Slippery Slope

Perhaps the favorite argument by opponents of a ban on tobacco advertising is that it will inexorably lead to bans on other consumer products—the "slippery slope." The premise is that if one action is taken, it will set off a chain of events that will inevitably lead to similar actions in situations which are not comparable or in which the action would be undesirable. The fallacy of this argument is that it presumes no intervening events between the favored and disfavored actions and no ability on the part of reasonable decisionmakers to draw rational lines.

In reality, one would expect Congress to apply the same scrutiny to any other proposed advertising restrictions as it has to tobacco advertising ban legislation. The proposed ban on tobacco advertising is clearly different from hypothetical bans on advertising sugar, salt, alcohol and fatty foods, which tobacco supporters claim to fear. Tobacco is the only product which is harmful to health when used as intended, and the death toll from tobacco use is qualitatively and quantitatively different from any other product.

Proposal Number Two: Eliminate Advertising Expense Deductions

Rep. Pete Stark (D., Cal.) and Sen. Bill Bradley (D., N.J.) in the 100th Congress introduced legislation, H.R. 1563 and S. 466, to deny tobacco companies a tax deduction for cigarette advertising expenses. H.R. 1563 was introduced on March 11, 1987 and had 24 cosponsors at the adjournment of the 100th Congress. S. 446 was introduced on February 3, 1987 and had five cosponsors. No hearings or markups were held during the 100th Congress on either bill.

Neither proposal would prohibit tobacco manufacturers from advertising, but both proposals would eliminate the manufacturers' privilege of deducting these expenditures from their taxes as tax-deductible business expenses.

Pro

The tobacco industry saves close to a billion dollars each year because its huge advertising and promotion budgets are tax-deductible. Removing this governmental privilege would substantially increase the cost of advertising and promotion and presumably, reduce tobacco manufacturers' financial incentive to spend so heavily. This proposal also relieves American taxpayers of some of the burden of subsidizing the tobacco manufacturers' marketing efforts.

Further, the Supreme Court has made it clear that a company does not have a constitutional right to such a tax deduction.

Con

Opponents of this legislation have argued that this approach is an unconstitutional restriction on free speech. The constitutional challenge to eliminating the advertising tax deduction has even less merit than the challenge to an outright advertising ban. Congress has broad latitude in establishing classifications within the tax code which confer benefits on some groups that are denied to others. As the Court stated in *Regan v. Taxation with Representation of Washington*. "This Court has never held that the Court must grant a benefit such as TWR claims here to a person who wishes to exercise a constitutional right.... We again reject the notion that First Amendment rights are somehow not fully realized unless they are subsidized by the state."

Opponents also argue that certain constitutional problems would be created because this legislation distinguishes between tobacco and other product advertisements. But under *Central Hudson* and *Posadas*, the Supreme Court has held that Congress may distinguish between various forms of commercial speech if its action furthers a substantial governmental interest. The purpose of these bills is to eliminate the taxpayer subsidy of tobacco marketing. While these proposals increase the practical cost of tobacco marketing, they impose no additional restrictions on what may be said in advertisements or where they may be placed. These proposals are intended to reduce the total amount of advertising, and thus reduce tobacco consumption.

In short, a tobacco manufacturer is not constitutionally entitled to deduct its expenditures on advertising and promotion.

Proposal Number Three: Tombstone Advertising

"Tombstone advertising" is an alternative to proposals to ban tobacco advertising or eliminate the tax deduction for tobacco advertising expenses. There are a variety of configurations of tombstone advertising, but the most common would prohibit the use of models, slogans, scenes or colors in tobacco advertisements or on tobacco packages. Only text would be permitted. Restricting tobacco advertising to tombstone advertising could also be tied to strict limits on tobacco promotions and brand-name sponsorship.

Pro

Many tobacco advertisements rely on slogans and images. By and large, these ads sell the potential smoker an image which he/she may wish to emulate. Studies demonstrate and advertising experts agree that this form of image advertising is most effective with young people, who are very image-conscious, see tobacco use as one way of being somebody they are not and pay little attention to advertisements that are primarily text oriented. Restricting tobacco advertising to tombstone ads would be an action designed to reduce the effectiveness of tobacco advertising with young people, by eliminating the form of advertising considered most persuasive with this group.

Thematic imagery ads are not just aimed at the young, but also at women and minorities. Strictly prohibiting the use of thematic imagery would dramatically alter tobacco industry marketing towards these groups as well.

Restricting tobacco advertising to tombstone advertising rather than enacting an outright ban may be perceived more favorably by those concerned about the First Amendment impact of an advertising ban. Tombstone advertising does not restrict what a tobacco manufacturer can say about its products in its ads nor does it limit the amount a manufacturer can spend to advertise. Thus, it is less likely to raise free speech concerns.

Because limiting tobacco advertising to tombstone advertising is a less extensive restriction than an outright ban, this proposal is less likely to be declared unconstitutional than an outright ban. Under *Central Hudson*, one criterion the Court sets in evaluating the constitutionality of a restriction on commercial speech is whether the restriction is no more extensive than necessary to serve the government's interest. In light of this and the Supreme Court's analysis in *Posadas*, there is good reason to believe the Court would uphold the constitutionality of either an outright ban or a restriction of tobacco advertising to tombstone advertisements.

Con

Unless a tombstone advertising policy also restricted promotional activities, its effectiveness could be limited. Cigarette marketing expenditures have steadily shifted from newspaper and magazine advertisements to promotional activities such as sponsoring events and providing free samples. Indeed, tobacco company expenditures for promotions now exceed expenditures on advertising. Some experts contend that promotional activities are more important than advertising in influencing smoking behavior.

Proposal Number Four: Enact a Version of Industry Advertising Code

The federal government could enact legislation modeled after the tobacco industry's voluntary advertising code, but with its most glaring weaknesses corrected. Among other things, the Code currently states that it prohibits advertising in publications directed at those under 21 years of age, the use of models under, or appearing to be under, 25 years of age, and advertisements suggesting that smoking "is essential to social prominence, distinction, success, or sexual attraction. . . ." To date, the tobacco industry has used its Code as a public relations gimmick, but has never seriously enforced or abided by its provisions.

Pro

The principal advantage of this approach is that it simply codifies and creates an enforcement mechanism for principles that the tobacco industry itself purports to have adopted. It would be difficult for the tobacco industry to claim the new Code represents governmental restrictions on commercial speech, if the Code is based on the industry's own attempt to eliminate abusive advertising practices.

Con

Codifying the industry's advertising guidelines, or any other code of conduct, would require Congress to establish relatively amorphous standards that might be difficult to enforce. For instance, what is a publication "directed primarily to those under 21 years of age"? How does one determine whether an actor appears to be under 25 years of age? Such a code would also likely permit the continued use of some of the marketing methods, such as the Marlboro man, which are most effective with young people.

And, as with tombstone advertising, enforcing a "voluntary" code without also restricting promotional activities would fail to address one of the principal marketing techniques of the tobacco industry. Banning promotional activity would have to be coupled with code restrictions.

Proposal Number Five: Develop a Mechanism to Fund and Produce an Effective Ongoing Counter-Advertising Program

Counter-advertising is often mentioned as an alternative or complement to restrictions on tobacco advertising. But to be effective means discouraging tobacco use. To be effective, counter-advertisements need to be professionally produced and placed frequently in often-seen media. This requires adequate funding to purchase advertising space and time on television and radio. The success of the program cannot depend on the media's good will in placing these ads for free.

Pro

Supporters of this approach point to the fact that anti-tobacco counter-ads run in the late 1960s—prepared as a result of applying the Fairness Doctrine to tobacco advertising on television and radio—accompanied a significant decline in tobacco consumption. Studies demonstrate that the counter-ads probably played an important role in reducing tobacco consumption during this period of time.

A major advantage of this option is that it involves no restrictions on speech. Thus, it obviates any argument of First Amendment concerns even by the most zealous supporters of the tobacco industry and the ACLU.

Con

The largest obstacle to creating an effective counter-advertising campaign is financing. In the late 1960s, counter-ads were broadcast on television and radio without charge, as required by the FCC. Today, an effective health campaign would require substantial funding to compete successfully against the $2.4 billion spent annually by the tobacco industry. Given the high federal budget deficit, it would be difficult to obtain an annual appropriation of this amount.

One funding option is to earmark a portion of the cigarette excise tax for this purpose. Each penny of the federal tax generates almost $300 million, so a relatively small increase dedicated to counter-advertising could provide measurable returns. H.R. 4740, introduced by Rep. Michael Andrews (D., Tex.) in the 100th Congress, would designate 10 percent of a proposed 25-cent excise tax increase to a "smoking cost recovery and education trust fund." This would raise about $400 million for counter-advertising and education.

Another funding option is to require that tobacco advertisers provide funds to purchase space for counter-ads on a proportional basis to their advertising expenditures. Or, this proposal might be combined with the proposal to eliminate the tax deductibility of tobacco marketing expenditures, and earmark a portion of the additional taxes received for counter-advertising.

Proposal Number Six: Eliminate the Federal Preemption of State Regulation of Tobacco Advertising

The Public Health Cigarette Smoking Act of 1969 prohibits states from enacting requirements or prohibitions based on smoking and health with regard to cigarette advertising or promotion. Repealing this clause would enable states to impose additional requirements and restrictions—including bans in appropriate circumstances—on tobacco advertising and marketing which take place wholly within their borders.

Pro

States should have the right to protect their own citizens; repealing this limitation would allow states to enact a variety of their own measures to discourage tobacco consumption within their jurisdictions.

Con

Opponents contend that repealing this provision would give states license to violate manufacturers' First Amendment rights and would create the possibility of 50 different states enacting 50 different sets of rules.

Proposal Number Seven: Enact Improved Warning Labels

The current warning labels required on tobacco products and advertisements were established by the 1984 amendments to the Federal Cigarette Labeling and Advertising Act. They were enacted because of the ineffectiveness of the then-existing warning label. Concerns have been raised about the effectiveness of the 1984 warnings as well, including the adequacy of the text of the current labels, the visibility of the warnings and the location of the current warnings.

Congress could amend the Act to require a different warning label format, content or location to help improve the labels' effectiveness on tobacco products and in tobacco ads. Information not now included could be added. For example, Rep. Jim Slattery (D., Kan.) and Sen. Bill Bradley (D., N.J.) introduced legislation in the 100th Congress to require, respectively, that tobacco products and advertisements carry a label warning that "Nicotine in cigarettes is an addictive drug" and "Smoking is addictive. Once you start, you may not be able to stop."

The Act could also be amended to require a "circle and arrow" format similar to that required on smokeless tobacco products packages and advertisements. This graphic device would make the current warning labels more visible. If this were done, the size of the circle and arrow and warning label print might both have to be increased.

Congress should also consider placing the warning label on the *front* of tobacco packages to improve the frequency with which they are seen. Moreover,the health warning on billboards should be made more prominent: to be effective, they must be legible from a distance, and at high speeds.

Pro

Improved health warnings can be enacted without appropriating substantial additional funds and without raising new First Amendment concerns. They also can be tailored to fill in specific gaps in consumer knowledge. Finally, the concept of a health warning is one legislators accept and, therefore, additional legislation might be easier to enact than other proposals.

Con

Questions are raised about the effectiveness of warning labels as a major component of an anti-tobacco effort. Whatever role warning labels may play in a comprehensive tobacco education program, the increased benefit of strengthening the current warnings is difficult to predict with certainty.

Warning labels have not served as an effective counterforce to the massive marketing efforts of the tobacco industry. Strengthening warning labels, if done in isolation, is unlikely to alter that situation. In addition, the current warning labels have become an impediment in resolving product liability lawsuits filed as a result of smoking related deaths and injuries of consumers. Simply improving the current warning system would also not alter that situation.

Proposal Number Eight: Authorize FDA to Regulate Tobacco Advertising

Federal laws and regulations of foods and drugs set very strict standards on how these products may be advertised and promoted. FDA has taken the position that it does not have authority over tobacco or tobacco advertising. Congress can remedy this by enacting appropriate legislation.

Pro

FDA regulations already contain dozens of restrictions on pharmaceutical advertising and promotion. These restrictions have in effect prevented pharmaceutical companies from advertising to consumers on television and radio, billboards and general circulation newspapers and magazines. Since tobacco and its components are more hazardous that many regulated drugs, the regulatory exemption of tobacco products is at best inconsistent. By providing the FDA with authority to regulate tobacco advertising, Congress could assure that a strict code is applied and avoid many of the difficulties in formulating new standards for tobacco advertising and promotion.

Con

Giving the FDA authority to regulate tobacco advertising and promotion will leave the degree of such regulation largely at the discretion of the federal agency. Regulation might increase or decrease based on the views of agency personnel at any given time.

Summary of Workgroup Discussion

The work group dealt with three key issues. First, to determine whether additional actions to control tobacco advertising and promotion are needed and, if so, what priority this public policy issue should be given in the near future. Second, to evaluate the available options for controlling tobacco marketing and to determine which are likely to be most effective, which are feasible to enact and what combinations of

actions, if any, should be recommended. Third, to develop strategies to see that policy recommendations are adopted.

Findings

1. There is sufficient evidence to conclude that tobacco *advertising and promotion*—
   a) Play a role in the decisions by young people to start smoking and make it attractive and socially acceptable to smoke;
   b) Encourage current smokers to keep smoking and ex-smokers to relapse;
   c) Adversely affect media coverage of tobacco-related health issues, as well as coverage of tobacco industry practices which inaccurately distort the relationship between tobacco and disease; and
   d) Adversely affect the willingness of individuals and organizations to speak out forcefully on tobacco-related issues.
2. More than 90 percent of new smokers are teenagers or younger. Fifty percent of high school seniors who smoke began by the 8th grade and 25 percent by the sixth grade.
3. Children are the most affected by tobacco advertising and promotion which, through models and imagery, associate tobacco use with adult behavior, sophistication, masculinity, femininity, and sexual, social, financial and athletic success, and those which associate tobacco use with sports and other youth-related activities through direct advertising and a wide variety of promotional practices.
4. Tobacco use is addictive and the younger one starts, the harder it is to quit.
5. Efforts to discourage tobacco use among children are inhibited by the combined effect of current advertising and promotional practices.
6. The recent report of the Surgeon General demonstrates that reductions in the smoking rate have been smallest among children, young women, minorities and those with fewer years of education—the very populations which have been the major targets of tobacco industry marketing efforts in recent years.
7. More needs to be done to educate children, young women, minorities and those with fewer years of education about tobacco, and discourage its use. The techniques used by the tobacco industry to entice these populations must be eliminated if we are to succeed.
8. The report of the Surgeon General demonstrates that action is needed *now* if we are to dramatically reduce smoking among young women, children, minorities and those Americans with fewer years of education.
9. Efforts to attack unacceptably high smoking rates must include increasing educational efforts and eliminating the advertising and promotional practices of the tobacco industry which affect these populations.
10. It is morally repugnant for American tobacco manufacturers to engage in advertising and promotion practices abroad that are prohibited in the United States.
11. The current warning labels on tobacco products and advertisements fail adequately to convey the dangers of smoking to potential and current smokers.

Recommendations

1. *Tobacco Health Education, Promotion and Advertising Campaign.*
   Legislation is needed to create a major, federally funded, long-term program of tobacco health promotion and advertising. The public service announcements of the late 1960s contributed significantly to the large decline in tobacco use in the late 1960s. Virtually all experts agree that a major anti-tobacco promotion and advertising campaign is one of the most effective ways to counter the billions of dollars spent by the tobacco industry to promote its products and to enable the public to have a more complete understanding of the hazards of tobacco use.
2. *Tombstone Advertising/Promotion Reform*
   The most effective methods used by the tobacco industry to reach targeted consumers are visual imagery in advertising and positive associations with sports and entertainment. A comprehensive approach to restrict the most effective means of attracting new smokers must include these steps:
   a) A limit on all remaining tobacco advertising to tombstone advertising, defined as, "No human figure or facsimile thereof, no brand name logo or symbol, and no picture other than the picture of a single package of the tobacco product being advertised displayed against a neutral background, shall be used in any tobacco product advertisement, provided that the product package displayed shall be no larger than the actual size of the product package and shall contain no human figure or facsimile thereof, no brand name logo or symbol and no pictures."

      The ads should be restricted to black print on white background, with type size and typeface in the ad identical to the size and typeface of the warning label. The tombstone restrictions also apply to all tobacco packages. The text on tobacco packages shall contain and be limited to brand

name, ingredients, tar, nicotine and carbon monoxide levels, corporate name and any other governmentally mandated information. The FTC has the authority or, if appropriate, the FDA, to restrict ads which are likely to be attractive to children, even if they include only texts.

b) A ban on all tobacco-related advertising in locations where sports are performed.

c) The elimination of brand name promotions including brand name sponsorships, free sampling, "couponing," the display of a brand name in connection with events open to the general public, the placement of brand names or logos on any consumer products, including but not limited to hats and t-shirts, as well as sports cars and other sporting equipment, and the payment of any money to any other person to engage in any practice prohibited by this provision.

3. *Improved Warning Labels on Tobacco Ads and Packages*
Current warning labels fail to convey in a meaningful way all of the dangers of tobacco use. The following changes should be considered:

a) Require warning labels to state that tobacco contains nicotine, and to convey the addictiveness of tobacco;

b) Require the FTC to conduct a study of the size, content, presentation and effectiveness of the current health warnings on tobacco products. As a result of this study, the FTC should recommend changes to increase the effectiveness of warning labels to communicate health information, discourage new users and encourage current tobacco users to stop. The FTC's recommendations shall become law unless vetoed by Congress and the President.

4. The right of state and local governments to regulate purely local advertising and promotional activities should be clarified through legislation.

U.S. Agricultural Policy on Tobacco

Prepared by:
Fran Du Melle, Director
Office of Government Relations
American Lung Association

Introduction

The federal government's policies on tobacco are inconsistent. On one hand, the government acknowledges that tobacco use is the single most preventable cause of death in the United States, and through the U.S. Public Health Service allocates funds for scientific research and public health education. On the other hand, policies of the U.S. Department of Agriculture (USDA) assure that federal assistance and tax dollars support the growth and use of tobacco products.

Legislation should be designed to eliminate the direct or indirect expenditure of any federal funds to support the growth of tobacco. Further, clear policies should be adopted within the USDA to eliminate management activities that encourage the growth or marketing of tobacco products. As proposals are developed to revise USDA's current tobacco policies, the economic welfare and well-being of the small family tobacco farmer should be carefully considered.

Tobacco Production

Tobacco was an especially important crop in the early history of the United States. Even though it no longer holds its once significant economic position, it is still a vital agricultural commodity in the major producing regions. Today, tobacco is produced in 21 states and Puerto Rico. Six states—North Carolina, Tennessee, Kentucky, Virginia, South Carolina and Georgia—account for 91 percent of the $1.9 billion in 1987 farm cash receipts from tobacco. Approximately 179,000 farms produce tobacco, harvesting an estimated 602,000 acres in 1987.

1988/89 U.S. tobacco production is approximately 10 percent more than that of 1987, due to additional acreage and higher yields. Although *production* is up, the 1988/89 tobacco *supply* is forecast to decline about eight percent, with decreases in all types of tobacco. Stocks entering the new marketing year are likely to equal 2.85 billion pounds, or about 14 percent less than last year. Approximately 65 percent of U.S.-grown tobacco is used for domestic manufacture and about 35 percent is exported.

The 1988 flue-cured crop is estimated at 780 million pounds, an increase of 13 percent over 1987. Beginning stocks were down 14 percent with the total supply at 2.27 billion pounds, or seven percent less than the previous year.

Flue-cured sales began July 26, 1988. By mid-September three-fifths of the anticipated marketings had been sold. Prices remained near last year's higher prices.

The 1988 burley crop is expected to be seven percent larger than the small 1987 crop. Because the 1987 crop was small, ending burley stocks are projected to be about 14 percent smaller than last year.

Tobacco 1965-1988

Year Average	Acreage Harvested (1,000s)	Yield/Acre (Pounds)	Production (Million lbs)
1965-69	942	1,958	1,845
1970-74	886	2,053	1,819
1975	1,086	2,008	2,182
1976	1,047	2,041	2,137
1977	966	1,982	1,914
1978	964	2,101	2,025
1979	827	1,845	1,527
1980	921	1,940	1,786
1981	977	2,113	2,064
1982	913	2,185	1,994
1983	789	1,811	1,429
1984	792	2,183	1,728
1985	688	2,197	1,512
1986	582	2,001	1,164
1987	587	2,028	1,191
1988*	621	2,101	1,304

*as of September 1, 1988

Tobacco Consumption

U.S. cigarette output is expected to increase from the 1987 level of 689 billion pieces because of increased exports. During the first seven months of 1988 cigarette exports increased 25 percent. However, while output is up, there is a downward trend in U.S. consumption. In fact, because of increased prices and the changing public attitude towards smoking, U.S. cigarette consumption may decrease by one and one-half percent, lowering per capita smoking from the 1987 rate of 3,196 cigarettes per year. See Table: Cigarettes: U.S. Output, Removals, and Consumption, 1979-88 on page 00.

The Tobacco Support Program

Significant federal regulation of agriculture began in the 1930s. The current tobacco program has its origin in the agricultural Adjustment Act of 1938, which provided for an average support price for each type of tobacco. The law made non-recourse government loans available through local cooperative associations to producers whose crops failed to bring a price from a private buyer above the support level. The government then charged interest on the loans while holding the tobacco until it could be sold profitably. Different classes of tobacco each had their own separately administered, but operationally similar, price support program. In addition to price supports, tobacco supply was also controlled through a national acreage allotment system. The Secretary of Agriculture would fix the total national acreage of tobacco every year. In the 1960s several changes were made in the supply control provisions for the intra-county lease and transfer of allotments for flue-cured tobacco and the institution of poundage quotas as a quantity restriction mechanism. These were the last major changes in tobacco programs until passage of the "No Net Cost" Act of 1982.

Costs of the pre-1982 tobacco programs were significant. For example, if a local cooperative was unable to sell the tobacco it held as collateral for unpaid loans, the federal government bore all losses. By April 1982, past losses totaled $57 million in unpaid loan principal. The government's method of charging and computing interest on loans also led to additional losses. Cooperatives were allowed to make loan payments on the principal first rather than on principal and interest. They also were charged below-market rates and the interest was not compounded. By the end of 1981, these loan policies had cost the federal government $591 million in interest losses. Moreover, the administration of the pre-1982 program was an additional cost: $13.1 million in 1981.

Under the threat of legislative dissolution of the tobacco program in 1982, Congress passed the "No Net Cost Tobacco Program Act." The legislation imposed an assessment on growers for every pound of tobacco marketed with the borrowed funds. The money raised by assessments would reimburse the government for any future financial losses from tobacco loans. In theory, except for administrative costs, the tobacco program was to be run at "no net cost" to the taxpayer. The administrative costs, however, are approximately $15 million annually.

In practice, "no net cost" hasn't stopped the red ink. For FY88, cumulative losses of loan principal will reach an estimated $505 million. Further, the estimated cumulative loss of loan interest will reach $319 million. The administrative cost of managing the entire price support program will be about $12.4 million in FY88. The cost of other tobacco-related activities of the USDA for FY88 include $0.2 million for development, maintenance, inspection, and grading standards for tobacco at auction markets; $0.8 million for market news reports on auction sales activity; $8.8 million for research and extension on tobacco production and marketing, and $4.9 million to subsidize producer premiums for all-risk crop insurance.

The grower assessment under the "no-net cost" legislation was not expected to ever exceed one to two cents per pound since past losses were low. However, loan prices were legislated higher than market prices in the late 1970s and early 1980s, resulting in a large increase in imported tobacco. Further, the statutory limits on marketing quotas could only be reduced so much each year. This allowed production which continuously exceeded utilization—and the surplus went under government loan. As stocks increased, so did the assessments until they reached 25 cents per pound for flue-cured and 30 cents per pound on burley in 1985.

The high assessments, declining market quota, and accumulating surplus tobacco stocks created a crisis for tobacco growers and the federal tobacco program. In early 1986 Congress enacted legislation as part of the Consolidated Budget Reconciliation Act to lower tobacco loan prices by approximately 26 cents per pound. At the same time, cigarette manufacturers agreed to buy over the next five years the surplus tobacco stocks at discount prices of up to 90 percent. The deep discounts on old surplus are expected to generate loan losses of $1 billion for U.S. taxpayers.

Ironically, as it operates today, the tobacco support program benefits least the people it was designed to assist: small family farmers. Instead, the greatest benefits of this program are shared by tobacco allotment holders, 74 percent of whom do not grow tobacco. Allotment holders charge the small family farmer who wants to grow tobacco large sums of money for permission to lease their allotment. About 84 percent of all family farmers rent allotments, a cost that can increase production expenses by 30 percent to 60 percent.

The federal price support program also impacts the ability of the American farmer to compete with foreign tobacco. As a result of high American prices created by the price support system, foreign-grown tobacco now comprises 35 percent of all tobacco used by American manufacturers overall and 33

percent of all tobacco used by American manufacturers in their cigarettes. In 1969, only nine million pounds of foreign tobacco were imported. By 1983, 240,000 metric tons were imported, an increase of 1,900 percent. See table: Estimated imports of flue-cured and burley tobacco, and domestic use, 1967-87, on page 00.

Congress and the federal government show no movement towards changing their inconsistent policies toward the support of tobacco production and marketing. In August 1988, the Drought Assistance Act was enacted, providing an estimated $2.9 billion in disaster payments for a wide variety of U.S. agricultural commodities, including tobacco, affected by adverse weather conditions. Under this act, payments are available to tobacco producers if production is reduced more than 35 percent because of drought, hail, excessive moisture, or related conditions. And, growers are eligible to receive a payment based on how much production falls below 65 percent of the expected level. For flue-cured and burley tobacco, the formula is based on the difference between production and effective quotas.

Deregulation of the Tobacco Support Program

As the summary of enacted legislation demonstrates, the tobacco program in the United States is composed of a few major provisions concerning the production and marketing of a variety of types of tobacco. There are also multiple minor provisions not reviewed. Deregulating the tobacco support program requires that all these provisions be repealed or significantly revised. The policy issue before the public health community should not be *whether* federal financial assistance to the tobacco support program should be ended, but rather *how* best to accomplish this task quickly and fairly. There are several options to reduce or eliminate the federal government's role—and its expenditures—for regulating the tobacco program.

Immediate Action

A. Use the annual budget and appropriations process to phase out these USDA expenditures for the tobacco support program:
   - developing and maintaining inspection and grading standards for tobacco auction markets;
   - publishing market news reports on auction sales;
   - subsidizing producer premiums for all-risk crop insurance.

B. Use the annual budget and appropriations process to redirect the USDA tobacco research and development activities towards crop options to replace tobacco.

Long-Term Action

A. Phase out budget support for administration of the no-net-cost program.

B. Phase out the price support and supply control/quota provisions for tobacco.

Long-term action to phase out or eliminate the federal tobacco program will have several impacts. The direct consequences include the loss of income for quota owners from the lease of allotments. However, eliminating costly allotment payments will benefit original, intended recipients of tobacco support programs and their heirs, the small family farmers.

Many observers speculate that the price of tobacco products will fall if federal support is phased out. They predict that lower prices will cause increases in the use of lower quality imports, in the use of all tobacco products, and in overall exports of tobacco products.

Since the primary objective of eliminating the federal support program is health related—to reduce consumption of tobacco products—attention should be given to the issue of tobacco use. Reduced costs will not necessarily increase use, because only three cents of the price of a package of cigarettes is the actual cost of tobacco. However, phasing out the tobacco support program should be accompanied by a comprehensive package of proposals to reduce the use of tobacco products.

Developing phase-out options should include careful consideration of the impact on the small family farmer. The number, size, and organization of tobacco farms is likely to change as a result of the program phase-out. This change, however, is not likely to be more dramatic than that which has occurred over the past 20 years as mechanized harvesting, bulk curing, and other technological innovations have made it possible to grow more and more tobacco on a single farm. Any phase-out program should include funding mechanisms to facilitate the farmer's transition away from federal support.

Summary of Workgroup Discussion

Tobacco agricultural interests continue to provide a political base for opposing strong public health policy responses to the use of tobacco products. It is, perhaps, the expenditure of U.S. tax dollars to support the growth of a crop which the Surgeon General has found responsible for 390,000 deaths each year, that has made the tobacco price support program so politically controversial and so vulnerable.

The health community believes strongly that all federal government policies related to tobacco must reflect the objective set by Surgeon General C. Everett Koop for a smoke-free society by the year 2000. The federal government cannot, therefore, continue policies and programs that encourage and promote the growth of tobacco.

While it is inappropriate to fund the tobacco price support program through general revenues, the health community finds nothing objectionable about requiring those who manufacture

or use tobacco products to fund the tobacco price support program through a system of user fees. Such a system also should fund all associated administrative expenses.

Any effort to reform the tobacco price support program must balance the concerns of the health community and the interests of the family tobacco farmer. Assistance should be made available to tobacco farmers who, for business or other purposes, elect to stop growing tobacco and to begin growing other crops. Such assistance should include direct grants or interest-free loans to cover income losses incurred during the transition period from tobacco to another crop and for capital expenditures necessary throughout the transition period.

The user fee mechanism can eliminate the health community's concern about using federal revenues to support the growth of tobacco, yet still provide tobacco farmers with a system for funding the tobacco price support program. This approach addresses both the current needs and provides an orderly transition to the growth of other crops.

Recommendations

1. ELIMINATE FEDERAL FINANCIAL SUPPORT FOR THE GROWTH OF TOBACCO. No federal expenditures should be permitted to pay for, administer or otherwise support the tobacco price support program. Further, no federal funds should be pledged to guarantee tobacco loans or the sale of tobacco for export. To the extent the program continues to exist, a system of user fees on tobacco manufacturers should be developed to replace federal financial support.
2. FEDERAL FINANCIAL ASSISTANCE SHOULD BE AVAILABLE FOR FARMERS WHO WISH TO STOP GROWING TOBACCO. A federally funded program should be created to provide financial assistance to tobacco farmers who are willing voluntarily to stop growing tobacco. Such an assistance program might be funded from a portion of revenues generated by the federal excise tax on cigarettes. Tobacco allotments owned by farmers who participate in the program would be retired, thereby decreasing the overall number of tobacco allotments and the total acreage devoted to the growth of tobacco.

Cigarettes: U.S. Output, Removals, and Consumption, 1979-1988

Year	Output	Removals Tax-exempt Taxable	Total	Exports	Shipments[1]	Overseas Forces[2]	Estimated Inventory Increase	Total U.S. Consumption[3]
				Billions				
1979	704.4	614.0	93.8	79.7	1.1	13.0	5.7	621.5
1980	714.1	620.5	94.2	82.0	1.1	11.1	2.3	631.5
1981	736.5	638.1	92.0	82.6	1.0	8.4	8.0	640.0
1982	694.2	614.1	82.1	73.6	1.0	7.5	-10.8	634.0
1983	667.0	597.5	69.7	60.7	.9	8.1	7.2	600.0
1984	668.8	597.8	67.1	56.5	.8	9.8	8.8	600.4
1985	665.3	595.0	66.5	58.9	.7	6.9	9.5	594.0
1986	658.0	583.1	74.3	64.3	.8	9.2	10.9	583.8
1987[4]	-689.4	577.2	111.3	-100.2	.8	10.3	14.6	-575.0
1988[5]	-705.0	563.0	125.0	-115.0	.8	7.2	9.1	-567.0
				Year Ending June 30				
1979	707.0	615.2	92.2	78.8	1.2	12.2	12.1	616.0
1980	697.0	605.8	93.2	82.9	1.0	9.3	-7.2	622.0
1981	727.8	631.4	92.0	83.0	.9	10.1	5.9	637.0
1982	721.5	632.2	86.8	78.8	.8	7.2	5.1	635.7
1983	678.4	603.3	75.3	65.5	.8	9.0	6.2	620.0
1984	661.5	596.6	65.0	56.4	.8	7.8	5.8	600.0
1985	665.4	595.4	66.3	55.8	.8	9.7	8.8	598.0
1986	662.0	589.2	70.3	62.2	.8	6.9	8.8	589.0
1987[4]	667.1	579.4	90.2	78.9	.8	10.5	11.9	580.0
1988[5]	702.8	571.3	122.3	112.1	.8	9.4	10.9	572.0

[1]To Puerto Rico and other U.S. possessions
[2]Includes ship stores and small tax-exempt categories
[3]Taxable removals, overseas forces, inventory change and imports
[4]Subject to revision
[5]Estimated

Compiled from reports of the Bureau of Alcohol, Tobacco, and Firearms and the Bureau of the Census.

Estimated U.S. Imports of Flue-Cured and Burley Tobacco, and Domestic Use, 1969-1987

(Farm-sales weight)

Year Beginning July 1	Flue-cured				Burley			
	Imports[1]	Domestic Disappearance	Total Use	Imports' Share of Total	Imports[1]	Domestic Disappearance[2]	Total Use	Imports Share of Total
	Million pounds			Percent	Million Pounds			Percent
1969	5.7	645.9	651.6	0.9	3.3	507.1	510.4	0.6
1970	10.6	640.1	650.7	1.6	3.2	503.0	506.2	0.6
1971	11.2	662.5	673.7	1.7	4.6	515.2	519.8	0.9
1972	12.7	664.2	676.9	1.9	8.9	543.5	543.5	1.6
1973	20.4	703.4	723.8	2.8	30.7	533.1	563.8	5.4
1974	23.1	652.3	675.4	3.4	47.7	518.8	566.5	8.4
1975	24.4	670.6	695.0	3.5	46.7	510.1	556.8	8.4
1976	30.8	634.0	664.8	4.6	37.9	489.6	527.5	7.2
1977	55.0	608.2	663.2	8.3	85.4	494.8	580.2	14.7
1978	60.1	584.1	644.2	9.3	89.1	502.8	591.9	15.1
1979	84.8	563.1	647.9	13.1	113.6	498.5	612.1	18.6
1980	72.7	529.4	602.1	11.7	136.9	477.6	614.5	22.3
1981	63.3	488.8	552.1	11.5	109.7	463.9	463.9	19.1
1982	103.1	478.5	581.6	17.7	141.3	444.1	585.4	24.1
1983	94.4[3]	441.6	536.0	17.6	135.0[3]	388.7	523.7	25.8
1984	120.1[3]	454.2	574.3	20.9	163.8[3]	402.6	566.4	28.9
1985	151.0[4]	476.5	627.5	24.1	137.8[4]	425.0	562.8	24.5
1986	176.6[4]	479.6	656.2	26.9	120.4[4]	401.7	522.1	23.1
1987	209.7[4]	541.0	750.7	27.9	162.4[4]	460.0[5]	622.4	26.1

[1]Imports for consumption (duty paid) of leaf, scrap, and manufactured or unmanufactured (beginning 1980), prorated according to reported stocks of imported flue-cured and burley.
[2]Marketing year beginning October
[3]General imports adjusted for stock change
[4]Volume inspected by Agricultural Marketing Service adjusted for stock change
[5]Estimated

The International Marketing of Tobacco

Prepared by:
Gregory N. Connolly DMD, MPH
American Cancer Society
Dir., Div. of Dental Health
Dir., Office of Non-Smoking *and Health*
Massachusetts Department of Public Health

Introduction

The United States is the world leader in promoting international health. As a nation we have worked aggressively to eliminate infectious diseases, malnutrition and use of addictive drugs. We have also made significant progress in implementing measures to control tobacco use within our own borders, and are in an ideal position to assist other countries in adoption of similar measures.

In practice, however, the United States' tobacco trade policy actually *encourages* the proliferation of tobacco use in other countries. Using the threat of trade sanctions, the U.S. Trade Office helps open up new marketing opportunities overseas for our tobacco companies that are losing business at home. Thanks to our own trade policy, U.S. cigarette exports have doubled since 1983, with 100 billion sent to foreign countries last year. In fact, the United States is the *world's leading* cigarette exporter.

The United States cannot be Number 1 in world health and Number 1 in cigarette exports. Our own tobacco policy may reverse all the gains we have made in promoting world health. Our own tobacco policy makes an hypocrisy of our efforts to curb international trade in addictive drugs.

As the leader of the free world, the U.S. must adopt a new tobacco policy to prevent the expansion of tobacco marketing; assure that people, regardless of their country of origin, are adequately warned of the dangers of tobacco use; and encourage the worldwide adoption of measures that will curb tobacco consumption. A new tobacco policy will require that new legislation be passed by Congress and new international health programs be implemented by the Administration.

Background Information

An estimated one billion persons worldwide smoked five trillion cigarettes in 1986, resulting in 2.5 million deaths attributed to smoking. By the year 2000, the number of deaths are expected to rise to four million annually. While smoking rates are declining in developed nations at a rate of 1.5 percent per year, they are rising 2 percent a year in developing countries. According to the World Health Organization (WHO), progress made in curbing deaths from malnutrition and infectious diseases in developing nations will be lost to deaths caused by smoking unless tobacco consumption is curbed.

There are a number of reasons why smoking is increasing in developing countries. Tobacco production creates agricultural and manufacturing jobs and generates substantial tax revenue. As nations progress economically consumers have more disposable income to purchase luxury items such as cigarettes; stresses brought on by urbanization and industrialization may also increase consumer demand for nicotine. And considering the long expoure time needed for smoking-induced diseases to occur, countries have little incentive to address future health problems caused by tobacco use.

The international marketing efforts of the world's six transnational tobacco companies (TTCs) also help create demand. These companies produce approximately 40 percent of the world's cigarettes—and up to 85 percent of cigarettes if production by nations with state-owned tobacco monopolies and centrally planned economies are excluded. The industry is highly concentrated with little real competition occurring between the six. The TTCs effectively control 85 percent of the tobacco leaf sold on the world market and in doing so, indirectly determine the price of the cigarettes. The six act as an oligopoly dividing the world's cigarette markets with the European firms dominating Africa and the United States companies, Latin America. All six are currently expanding their market operations in the newly developed countries and less developed countries of Asia.

If the companies are able to gain free access to Asia, they will likely capture large shares of that market. The companies have developed highly effective promotional and advertising programs which very persuasively promote tobacco use in countries where the health risks of smoking are not well

known. The companies have also amassed large amounts of capital from sales at home to use in developing new markets overseas.

In 1985, in the book, *Transnational Corporations and the International Cigarette Industry: Profile, Progress and Poverty*, P.L. Shepherd analyzed how the TTCs penetrated the closed cigarette markets of Latin America in the 1960s and how they eventually acquired the former state companies. The push into Latin America in the 1960s came in direct response to the decline in United States smoking rates that followed publication of the first Surgeon General's report on smoking and health. Liberalization, making the cigarette market more competitive, also allowed the TTCs to dominate South America. Smoking rates rose in response to the increased marketing of tobacco and the public health suffered. By the early 1980s diseases caused by smoking in Brazil rivaled the magnitude of diseases caused by infectious disease and malnutrition.

History is repeating itself today: Smoking rates are falling again in the United States and companies are looking abroad for new smokers to replace those who quit at home. The new targets are the closed cigarette markets of Japan, Korea, Taiwan, Thailand, and China. Many of the same strategies used to open the markets of South America are being used again. But this time, there is a new twist: the United States is using governmental trade threats to force resistant countries to remove tobacco trade restrictions. It is interesting to compare the experience of opening up Latin America in the 1960s to what is occurring in the Far East today.

Opening a Closed Market, Then and Now

Marketing and Manufacturing Agreements

Countries have uniformly resisted entry into their markets by multinational tobacco companies. Many less developed and newly developed countries chose to operate closed cigarette markets dominated by a state-owned tobacco monopoly. This decision is based on the belief that scarce consumer capital should not leave the nation for purchase of a foreign cigarette—a nonessential, luxury item. State-owned monopolies dominated Latin America until the 1960s and still do today in many Far East nations. Some countries protect their monopolies from foreign competition by banning sale of foreign cigarettes, which is the case in South Korea, Columbia, Thailand, and Nigeria. However, it is more common—and equally effective—for countries to place high tariffs on imported cigarettes and their distribution and advertising.

In the absence of competition, the vast majority of state tobacco monopolies advertise and promote smoking at a minimum level. They also generally produce a harsh, less "flavorful" cigarette which uses locally grown tobacco. Both factors tend to minimize smoking. The incidence of smoking in many of these countries is similar to that found in the United States 30 years ago. High smoking rates are found among adult males and low rates among females and adolescents. For example, in Japan and China smoking rates among men are 60 percent and 80 percent, respectively, and among women, 12 percent and 6 percent. Per capita consumption is also lower than in more competitive markets with 900 cigarettes consumed per person per year in China, 1,500 in Taiwan and 1,700 in Korea. The United States rate is 2,600 cigarettes consumed per person per year.

The TTCs have two objectives when entering a closed market. The first is to remove laws that prohibit sale of foreign cigarettes and other protectionist measures such as tariffs or restrictions on marketing. The second is to expand marketing opportunities by repealing laws that limit Western-style advertising or securing guarantees that such advertising can be used.

In his analysis, Shepherd found that the multinationals can gradually penetrate a closed market by entering into a series of manufacturing arrangements with the national company. Through this process, the multinationals progressively gain more control over the market until they dominate it. The first step is to secure a licensing arrangement with the state firm to sell international brand name cigarettes. This "foot in the door" approach is tolerable to local policymakers since local leaf is used in cigarettes which are produced by the national company. Such an arrangement does not threaten local farmers or other tobacco workers. Joint manufacturing ventures between the state company and multinationals usually follow. These arrangements give the multinational a firm foothold and in exchange for the agreements, the TTCs give advanced agricultural and manufacturing technology to the local company. At the same time the TTCs push the local governments to denationalize the state tobacco monopoly and form a private firm. This action removes any residual sentiment that the government may have had for protecting the national company and sets the stage for future acquisition of it.

The decision to lift trade barriers or denationalize a state company rests with the local governmental or legislative officials who face strong internal economic and political pressure not to do so.

In negotiations with foreign officials, the TTCs argue that opening the market is in the nation's economic and health interest. The TTCs say that competition will make the state company more competitive. They also promise to introduce modern tobacco growing and agricultural techniques, thus improving the tobacco industry. This concept is being widely pushed by multinationals throughout the Far East today, particularly in China and Korea.

However, Shepherd found these arguments to prove false in Latin America. Rather than the state monopoly becoming more competitive in an open market, the vast majority of Latin firms were seriously weakened by the multinationals.

Based on the economies of scale, the locals were unable to compete with the intensive advertising and short-term predatory pricing practices of the TTCs. By 1976, the TTCs had formed 12 subsidiaries in 17 Latin American countries. These subsidiaries controlled 90 percent or more of the market share in their respective countries and the vast majority of them were acquisitions of former national companies.

The multinational companies also tell foreign officials that an open market will shift consumer preference to "safer" Western-style low tar/low nicotine brands. Two recent Surgeon General's reports found that smokers receive only marginal benefits from smoking these brands. In fact, many smokers just smoke more often or inhale more deeply to compensate for the lower yield. A 1988 analysis of Marlboro and Winston light cigarettes sold in the Philippines found their tar and nicotine content to be 50 percent higher than that of the same brands sold in the United States.

Shepherd observes that the multinationals use their international brands as a lure to gain a foothold in the market. According to him, the TTCs promote the sale of contraband international cigarettes to help stimulate local demand. The loss of tax revenue from bootlegging serves as an added incentive for local governments to legalize the sale of foreign brands. This tactic is still being used today. Sales of contraband cigarettes are a major problem throughout all of the markets of Asia, particularly in the closed market of China, Korea and Thailand. Brands such as Marlboro and Camel convey powerful images of Western life style and success. Smoking these brands conveys status to many citizens of a less-developed or newly developed country. In the long run, however, Shepherd found that these brands don't capture a major portion of the market. After the multinational acquires the local firm, national brands continue to be popular and remain a large portion of the market.

Government Contracts

The companies also use other strategies to remove barriers to entry. According to a 1976 Security and Exchange Commission Report, Philip Morris and R.J. Reynolds made $2.8 million in "questionable payments" in their Latin American Operations in the 1970s. In at least seven countries payments were made to government officials to secure favorable agreements relative to their market operations.

Civil servants in newly developed countries of the Far East are not as susceptible to this type of influence peddling, so the TTCs have changed their tactics. In 1986 and 1987, United States companies asked key members of the United States Congress to pressure trade officials of Korea, Taiwan, Japan and Thailand to open their cigarette markets. The Congressmen threatened these countries with passing protectionist United States trade legislation unless tobacco trade barriers were removed. Similar threats by four United States Senators were made against Hong Kong in 1986 when that government proposed a ban on smokeless tobacco. The only manufacturer of that product was the United States Tobacco Company.

Administration officials have also been involved. In 1985, Michael Deaver, former chief of staff to President Reagan, was paid $250,000 by Philip Morris to secure trade concessions from Korea on cigarettes. Michelle Laxalt, daughter of then-Senator Paul Laxalt was also hired by Philip Morris. Richard Allen, former United States national security director, was hired to do the same by R.J. Reynolds. At a meeting with the President of Korea, Mr. Deaver said he would take care of pending United States protectionist legislation that would hurt Korea's textile industry if Korea opened its market to United States cigarettes. A few months later the President vetoed the protectionist Jenkins Thurmond Textile bill and Korea unilaterally opened its market.

Another strategy to force opening of the market is to use retaliatory trade threats by the United States government. In 1984, the United States Congress amended Section 301 of the 1974 Trade Act to allow the president to conduct investigations of alleged unfair trade practices against the United States' products by foreign countries. Under pressure from the United States Cigarette Export Association, which represents Philip Morris, R.J. Reynolds and Brown and Williams, the United States government conducted three investigations on unfair tobacco trading practices of Japan, Taiwan and Korea.

In 1984, Korea had a law prohibiting sales of foreign cigarettes and both Taiwan and Japan had high tariffs on imported brands and restrictions on their distribution and advertising. Between 1985 and 1988, the United States' Trade Representative (USTR) threatened these nations with sanctions on goods they exported to the United States unless United States cigarette companies were given free access to their markets. No other United States agricultural product received the same attention and all three nations capitulated to the United States' demands. Japan and Korea were also pressured to denationalize their tobacco companies. Japan did so and Korea is committed to following suit. Trade threats by the United States were also used to expand advertising and promotional opportunities. Both Taiwan and Korea were pressured by USTR to repeal their restrictions on cigarette advertising and even to allow television advertising. The countries refused to permit television advertising but bowed to the pressure and did allow print advertisements.

Advertising

United States companies contend that their intention in the Far East is to encourage Oriental smokers to switch to their brands and not to target nonsmokers. Shepherd found that following entry into Latin America, the TTCs greatly expanded promotion and advertising. In Argentina, per capita advertising expenditures rose 30 percent from 1968 through

1975. As a consequence, per capita cigarette consumption rose an average of 6.4 percent each year from 1966 to 1975—almost three times more than the 2.4 percent annual rate increase reported for the years prior to TTC entry.

The same is occurring in Asia today. Two years after TTC entry into Japan, there is a tenfold increase in the number of television advertisements for cigarettes. Cigarette ads now rank number two on Japanese television in terms of total minutes of air time. Japanese retail sites selling cigarettes have also been greatly expanded, particularly vending machines. In Taiwan hundreds of small shops are contracted by United States companies to both sell their brands and serve as sidewalk advrtisements for cigarettes.

Beginning in 1986, product promotions, something rarely done by Oriental monopolies, were introduced on a wide scale. Now, it is common to see young women giving away free samples on the streets of Tokyo. In Taiwan young people received free disco tickets in exchange for empty American cigarette packages. Multinational tobacco companies also sponsor motorcycle racing events and dance troupes in China.

Commercials for Virginia Slims cigarettes began airing on Tokyo television in 1987. Similar targeting of nonsmoking women is being done in Taiwan and Hong Kong. Considering the relatively low smoking rates among Oriental women, ads targeted to women give a clear signal that the multinationals' actual intent is to convert nonsmokers. Recent data shows sharp increases in smoking among urban Oriental women. The effect of the marketing is already being seen. One 1987 study found Japanese female college students to be four times as likely to smoke than their mothers.

In Taiwan, cigarette consumption was declining until the entry of the Western companies. Taiwan consumption rose 4 percent in 1987. Korea's consumption also rose 2 percent. In Japan, a decline in consumption that preceded the entry of the United States firms has been halted. Foreign companies which before had virtually no cigarette market share now hold 11 percent of Japan's market and 22 percent of Taiwan's. Within a few years foreign companies are expected to control 20 percent to 30 percent of the markets of these countries as well as Korea.

These statistics demonstrate that the health and economic claims made by the multinationals to justify opening a closed market are fallacious. Opening the closed cigarette markets in the Far East will likely result in increased consumption among current smokers and in many nonsmoking women and adolescents starting to smoke.

Controlling Worldwide Expansion

What can be done to curb multinational tobacco companies from further expanding their influence worldwide? Shepherd argues that a decaying state-owned monopoly is just "what the doctor ordered" and keeping the market closed is good medicine for any national tobacco control program.

But unfortunately, as long as smoking rates continue to decline in the developed countries and the United States continues to incur high trade imbalances with the newly developed countries in the Far East, considerable pressure will be placed on countries with closed markets to open them. It is likely that national monopolies will be dismantled worldwide. Thailand is under pressure by the United States to open its market. Joint ventures in China may only be the beginning of multinational dominance of that country. And if the Korean and Japanese companies are able to become competitive and learn how to make and market cigarettes the way they learned to make cars, the health of the world will suffer immeasurably.

The Sixth World Conference on Smoking and Health held in Japan in 1987 took note of this problem and recommended that tobacco not be used as trade leverage. The General Agreement on Tariffs and Trade (GATT)—an international agreement which nations use to resolve trade disagreements—currently includes tobacco. United States and international health and religious organizations should petition member nations of GATT to remove tobacco from the list of trade items. This is justified based on the heavy toll that tobacco takes on human life worldwide. Other international economic developmental agencies such as the World Bank, International Monetary Fund and FAO should also be called upon to exclude tobacco or tobacco products from their program activities and should fund activities to curb tobacco use.

It is evident that the United States tobacco trade policies promote world smoking. Public opinion can and should be tapped to change U.S. policies. For example, tobacco is still eligible for support in the "Food for Peace Program" but, in response to public concern in the United States, the Department of Agriculture has decided not to allow tobacco in the program. Similar pressure could be used to influence United States trade officials not to use 301 trade sanctions to force unwanted American cigarettes onto friendly nations.

Governments in the Far East are to be blamed for their failure to aggressively address the smoking problem. Certainly, their neglect is due in large part to concern about the economic implications of controlling tobacco. But foreign countries can still institute policy actions that protect the public health. The first option is to prohibit all forms of tobacco marketing and advertising. This action would prevent the multinationals from capturing a large segment of the existing market, but more importantly prevent the TTCs from marketing to nonusers of tobacco such as women and adolescents. Foreign governments can also take a second action, to increase cigarette excise taxes. The tax would have the public health benefit of curbing smoking and replace revenue lost to the multinational company.

Citizen-based antismoking groups in the United States and other industrialized countries have been highly effective. These groups are not influenced by governmental officials

and have successfully used the issue of nonsmokers' rights and lawsuits against tobacco manufacturers to change public attitudes. Over time, United States government policy has been influenced by these groups. As American tobacco companies export Western cigarettes, activists in the United States should export the American antismoking movement.

There are fledgling consumer-based antismoking groups in Japan, Taiwan and Korea. Until recently, these groups were perceived as fringe elements in the conformist societies of the Far East. However, United States trade pressure has sparked charges of cigarette dumping and neocolonialism. The antismoking groups have been able to link their messages with the public anger about the U.S. actions. The antismoking movement has become a national cause in Taiwan and Korea. In many respects, the United States governmental pressure has backfired and given legitimacy to the fledgling antismoking groups.

The groups have been successful. Smoking is banned on many Japanese railroads and the Taiwanese Ministry of Health is proposing to ban smoking in public places. Laws are pending in Taiwan and the Philippines to ban all forms of tobacco advertising. A class action suit on behalf of ten Filipino children was filed in a Manila court in 1987 against two United States multinational companies. The plaintiffs claim that Philip Morris and R.J. Reynolds fail to provide the same level of protection to Filipino children as to American children, specifically, warning labels on print ads and packages and no television advertising. The failure of the TTCs to place health warning labels on cigarettes sold in many poor countries makes them vulnerable to future product liability.

In combination, these actions provide hope for curbing world smoking—hope for the billions of children in the world who are at risk of becoming 21st-century customers of the six multinational tobacco companies.

Summary of Workgroup Discussion

United States tobacco trade policies have enabled it to become the world's leading cigarette exporter. And, in addition to export dominance, U.S. trade policies allow United States tobacco companies to virtually control domestic tobacco farming and production in many developing countries.

As a result, United States tobacco companies are more than replacing smokers who are quitting in developed countries with new smokers in developing countries. In large part, these new smokers are women and children. While this may be good for the tobacco companies, it is bad public policy for the United States.

The United States tobacco trade policy is bad because it has the potential to reverse all the gains we have made in promoting world health. It makes a mockery of our claim to be the world's leader in health. It is grotesquely inconsistent with our efforts to curb international trade in addictive drugs. And, the gains made from tobacco have hurt export opportunities of other United States goods and have caused serious harm to the image of the United States overseas.

As a leader of the free world, the United States must adopt a new policy that prevents the world smoking epidemic from expanding. The United States government's roles is to promote the health of the American people and to serve as a positive example to the rest of the world in the active support of world health. To that end, a new tobacco policy should be based on the following general principles:

- The United States government and U.S. health organizations, along with international health organizations, should encouarge worldwide adoption of effective smoking prevention and control measures. Together, these groups should collect data on mortality and disease related to worldwide tobacco use.
- Tobacco should not be used as trade leverage.
- All people regardless of country of residence should be warned of the dangers of tobacco.
- Efforts should be made to discourage international development agencies from introducing and supporting tobacco growth, production, marketing, and sales as an economic strategy.

All nations in the world should be encouraged to adopt policies that curb the reckless and irresponsible promotion and advertising of tobacco products.

Such a policy requires that we pass new legislation, implement new international health programs, develop international collaborative health projects between U.S. health agencies and their international counterparts and launch advocacy and public education programs to regain our leadership in world health.

Recommendations

I. Legislative Recommendations

1) Congress should pass legislation to prohibit the USTR, the Departments of State and Commerce, or any other agency of the United States government from actively encouraging, persuading or compelling any foreign government to expand the marketing of tobacco products whether it be by repealing of laws restricting marketing practices or securing agreements to introduce new measures or expand current ones. This applies to the promotion, advertisement, distribution and taxation of tobacco products.
2) Congress should pass legislation requiring any manufacturer who sells tobacco products in the United States to place the same health warning labels that are required in the United States on advertisements and packages sold abroad unless more stringent health disclosures are required. Manufacturers should also be required to disclose the tar and nicotine content of brands if the level is different from the same brand

sold in the United States. Nothing in this recommendation should be construed as preempting any local law or regulation including product liability of the tobacco manufacturer and seller.

3) Congress should restrict the use of United States funds by international trade and monetary agencies such as the World Bank and International Monetary Fund from being used to provide financial or technical support for tobacco agriculture of manufacture.
4) Congress should significantly increase United States funding for smoking control activities for WHO and work with it to establish an international data base and clearinghouse on tobacco control.

II. Regulatory Recommendations:

1) The Surgeon General in his capacity as the Government's chief international health officer should devote an upcoming Surgeon General's report to the world health consequences of smoking.
2) The General Accounting Office should undertake a study on the economic costs and benefits to the United States of the export of tobacco. The study should include analyses of the past activities undertaken by the USTR to determine if tobacco products have been accorded preferential treatment. Other areas to be studied include an environmental impact study on the use of pesticides, deforestation and other environmentally destructive practices for the growth of tobacco. In addition, the study should include the financial implications of reducing tobacco exports on American farmers.
3) The National Institutes of Health should establish a collaborative project with other nations to gather health data on the consequences of worldwide tobacco use.

III. Public Education:

1) A world conference should be held on the world health consequences of tobacco use. The conference should encourage foreign health experts and government representatives to participate.
2) A clearinghouse should be established as a corporate entity and in collaboration with voluntary health agencies, professional groups, the United States Public Health Service, Pan American Health Organization and the World Health Organization to provide relevant data on health, economic, environmental and social impacts related to worldwide use of tobacco.

wholesale sales price to retailers, manufacturer's invoice price, or price at which the tobacco entered the state. Alabama and Arizona base their smokeless tobacco excise taxes on the weight of the tobacco package, which may vary. Two states, Alaska and Iowa, increased their smokeless tobacco excise tax rates in 1988.

- **Age Restrictions on Sales of Tobacco Products**—Forty-three states and the District of Columbia restrict the sale of tobacco products to minors. South Dakota imposes this restriction only on smokeless tobacco products. This year only the state of Wisconsin approved legislation to prohibit the sale of tobacco products to children by setting the age of a minor at 18. On July 1, 1989, it will no longer be legal in Wisconsin to sell tobacco products to persons under age 18, nor will it be legal for one under age 18 to purchase such products. Six states—Kentucky, Louisiana, Missouri, Montana, New Mexico, and Wyoming—have not yet acted to prohibit the sales of tobacco products to young persons. (See Attachment E).

Restrictions on Distribution of Tobacco Product Samples

U.S. cities have taken the lead in restricting the distribution of tobacco product samples. Since 1979, 12 cities banned the distribution of tobacco product samples. One city, New Orleans, prohibits the distribution to minors only.

States have been slower than cities in addressing the issue of tobacco samples. While many limit access of tobacco products to minors by prohibiting sales or furnishing, only 10 states have taken action to restrict the distribution of free samples. Minnesota is the only state that totally bans the distribution of cigarettes, smokeless tobacco products, cigars, pipe tobacco or other tobacco products suitable for smoking. Kansas prohibits the distribution of sample cigarettes. Georgia, Indiana, Louisiana, Maine, New Hampshire, Rhode Island, Utah and Wisconsin ban the free distribution of tobacco product samples to minors only.

Restrictions on Selling Tobacco Products in Vending Machines

Thirteen states regulate the sale of tobacco products in vending machines. Only one, Colorado, bans the sale of smokeless tobacco products in vending machines. Nine states—Colorado, Georgia, Hawaii, Indiana, Massachusetts, Minnesota, Rhode Island, Virginia and Wisconsin—require owners, operators and/or supervisors of tobacco vending machines to post signs stating that minors are prohibited from making a purchase from that machine. Five states—Alaska, Idaho, Maine, New Hampshire, and Utah—require that placement of vending machines be placed in supervised areas to deter use by minors. Wisconsin prohibits vending machines from being placed within 500 feet of a school.

Licensing Requirements

Forty-six states and the District of Columbia require parties that sell tobacco products to be licensed. Iowa, Kentucky, South Dakota and West Virginia do not require any such licensing. Licensing regulations vary among states, and range from requiring only distributors to have licenses (California) to requiring wholesalers, distributors, manufacturers, and retailers to obtain licenses (Delaware). The licensing law in Nebraska includes a penalty for any such licensee who furnishes tobacco products to minors, and may revoke the license for subsequent offenses.

Recent Actions: November 1988 Ballot Initiatives

- **California—Proposition 99**

  California voters accepted a 25 cents increase in the cigarette excise tax by approving Proposition 99 by a 58 percent majority. In addition to increasing the cigarette excise tax, the initiative set an excise tax on smokeless tobacco products. Beginning January 1, 1989, cigarettes will be taxed at 35 cents per pack, and an excise tax of 41.67 percent of the wholesale price will be imposed on smokeless tobacco products. The expected $660 million additional revenue will help fund tobacco education, health care for the indigent, tobacco-related medical research and wildlife protection.

The tobacco industry spent nearly $15 million on an intense radio and television advertising campaign in an attempt to defeat the measure. In contrast, proponents of the measure, the "Coalition for a Healthy California," spent $1.5 million.

- **Oregon—Measure 6**

  Measure 6 would have banned smoking in virtually all indoor work areas, including private homes used as offices and enclosed places frequented by the public. If passed, it would have been the toughest smoking-control law in the country—but it was defeated by a 61 percent to 39 percent margin.

The tobacco industry spent more than $3 million in casting the campaign against Measure 6 as a question of "personal liberties," instead of a public health issue. Proponents of the initiative spent only $55,000 and despite the loss, viewed it as a valuable opportunity to educate the public about the hazards of environmental tobacco smoke.

Coordinated Grassroots Efforts to Influence Federal Legislation

During the 1980s, several significant federal tobacco-control laws were enacted, including the Comprehensive Smoking Education Act of 1984, which required rotating warning

labels on cigarette packages and advertisements; the Consolidated Budget Reconciliation Act of 1985, which established a permanent 16 cents per pack federal cigarette excise tax; and the Comprehensive Smokeless Tobacco Health Education Act of 1986, which banned smokeless tobacco advertising on radio and television.

It was not until 1987 that an organized grassroots lobbying effort emerged as a factor influencing federal tobacco control legislation. At that time, a proposal by Rep. Richard Durbin (D., Ill.) to ban smoking on domestic airline flights of two hours or less was attached to the FY88 Transportation Appropriations bill. Under the aegis of the Coalition on Smoking OR Health—American Cancer Society (ACS), American Heart Association (AHA), and American Lung Association (ALA)—for the first time multiple health, consumer and union organizations united to form the Ad Hoc Clean Indoor Air Lobby Group to see this measure through the Congress and ensure its enactment.

The Ad Hoc Clean Indoor Air Lobby Group consists of more than 25 organizations, including the American Association of Flight Attendants, the American Medical Association (AMA), and members of the sponsoring group, the Coalition on Smoking OR Health. To help secure passage of the Durbin proposal, the group coordinated lobbying strategy, conducted attitude surveys, sponsored a lobby day in Washington, D.C. and energized its state and local volunteers and staff. Plans are already underway to seek a permanent extension of the law.

Need for Action

Clearly a majority of the efforts in the tobacco-control movement have been concentrated in the state and local arenas. This is due to several factors:

- The tobacco industry has less influence with local lawmakers than with national lawmakers. The political consequences of supporting tobacco-control measures are less for local lawmakers who are not as dependent on the financial contributions of special-interest groups or political action committees to win reelection.
- There is a strong national, cultural tie with tobacco in the United States, dating back to the first settlers of this country. For instance, tobacco financed the American Revolution and was this country's first cash crop. Moreover, tobacco use has been socially acceptable, and legal, for centuries.
- Federal government policies, such as tobacco price supports, and powerful Congressional opponents of tobacco-control laws deter efforts to pass such laws.

Our goal should be to unify our state and local members into a national grassroots lobbying network. By creating such a structure, we can profit from the vast experience of the local coalitions and gain the ability to mobilize instantly. A coordinated advocacy campaign, one that becomes self-sufficient over time, will enhance our effectiveness and influence change.

Existing Options for Building a Network

Numerous groups on the national, state and local level are in place and working on tobacco-control issues. They might be organized into a united lobbying entity with a national and local presence.

Major National Health and Health Advocacy Organizations

Aside from the Coalition on Smoking OR Health, no real cooperative effort exists to affect tobacco-control legislation. Although there are numerous organizations committed to health promotion and disease prevention that have actively lobbied on tobacco issues, they have done so separately and at their own pace. Examples of the national agencies and advocacy groups that could join with ACS, AHA, and ALA to form a national tobacco-control alliance are listed below:

ACTION ON SMOKING AND HEALTH
ADVENTIST HEALTH NETWORK
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF OTOLARYNGOLOGY
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AMERICAN ASSOCIATION OF RETIRED PERSONS
AMERICAN CHIROPRACTIC ASSOCIATION
AMERICAN COLLEGE OF CARDIOLOGY
AMERICAN COLLEGE OF CHEST PHYSICIANS
AMERICAN COLLEGE OF PREVENTIVE MEDICINE
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA
AMERICAN DIABETES ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
AMERICANS FOR NONSMOKERS' RIGHTS
AMERICAN PUBLIC HEALTH ASSOCIATION
AMERICAN SOCIETY OF INTERNAL MEDICINE
ASTHMA AND ALLERGY FOUNDATION
CONSUMER FEDERATION OF AMERICA

State Networks

- **Tobacco-Free America (TFA) Legislative Clearinghouse**
  The TFA Legislative Clearinghouse is the primary information bank and advisory resource to the state and local coalitions of ACS, AHA, and ALA, as well as to government agencies, private corporations and individuals and the media. This clearinghouse monitors state and local tobacco-related legislation and regulations and analyzes trends and effects of the information collected. Information compiled by TFA is used to advise and assist coalitions, agencies and individuals in formulating and implementing strategies

for getting involved in tobacco-related legislative initiatives.

- **Smoking Control Advocacy Resource Center (SCARC), The Advocacy Institute**
  SCARC serves as a national support system and communications network for the tobacco-control movement. Primarily, SCARC assists in the strategic use of the mass media as a resource to advance the anti-tobacco cause.
- **Nonsmoker's Rights Groups**
  Americans for Nonsmokers' Rights (ANR), state nonsmokers' rights groups (NSRs), and local Groups Against Smoking Pollution (GASP).

ANR is the only national antismoking group solely devoted to restricting smoking in public places. However, there are numerous independent state and local organizations devoted to the rights of and protections for nonsmokers, such as New Jersey GASP and the New York-based Anti-Smoking Educational Service.

Summary of Workgroup Discussion

In the 1980s, the leadership of the major voluntary health associations and the AMA joined with nonsmokers' rights groups and tobacco-control activists to build a national movement to support the enactment of appropriate tobacco-control policies at the federal, state and local levels. This movement recognized not only the threat of smoking as the nation's number one preventable public health problem, but the organized, resourceful, unflagging political resistance of the tobacco lobby.

If the tobacco-control movement is to achieve its public policy goals in the last decade of the 20th century, its efforts must be strengthened. The material and human resources dedicated to the cause must be greatly increased, and the commitment of both professional staff and volunteers must be further encouraged, supported and rewarded. The movement needs both professional advocacy resources and dedicated, trained, empowered volunteers.

It needs coordinated strategic planning; interactive communications networks; mutual support at the local, state, national, and international levels; and advocacy training and skills building.

A national tobacco-control grassroots lobbying network should include:

- Coordinated communications system within and among national, state, and local networks
- Coordinated communications system for legislative action
- Complete, A to Z, lobbying strategy that can effectively compete with the economic power of the tobacco industry
- Media strategy that uses all forms of broadcast and print media
- Media relations training to assure that comprehensive, compelling messages are delivered.
- Coalition-building techniques

Recommendations

1. The leadership of each sponsoring organization should act internally to raise the level of commitment to tobacco-control advocacy. They should consider allocating greater financial resources and hiring professional lobbyists and organizations at local, state and national levels.
2. Turf battles, institutional rivalries, bureaucratic resistance and institutional inertia must be transcended in the common pursuit of the overriding public goal.
3. The staff and resources of the national organizations should be dedicated to the political education, recruitment, confidence-building and institutional recognition of their volunteer members who can advocate tobacco control policies at each level of government.
4. National and state coalitions should be strengthened with added financial resources, aggressive outreach to new and potential alliances, professional lobbying staffs, and greater strategic planning and communications capability. (See Attachment F.)
5. Training in advocacy skills, especially in lobbying techniques, media relations and coalition building should be made a priority for professional staff and volunteers of each sponsoring organization.
6. *Systematic and coordinated efforts should be made to* track and anticipate tobacco industry lobbying strategies, and to pre-empt or counteract them.
7. A national campaign to "de-legitimatize" and expose the tobacco lobby should be launched as a major underpinning for tobacco-control policy initiatives. Corporations, trade associations, legislators and government officials who collude with the tobacco lobby must *be held publicly accountable.*
8. All tobacco-control advocates should have ready access to essential information sources. To this end, a national interactive communications program should be developed. Furthermore, national and state legislative clearinghouses and data banks should be strengthened and made readily available to advocates at all levels of government.
9. "Citizen spark-plugs"—effective advocates—should be encouraged, supported and rewarded as valued "public citizens" and the heart of the smoking-control movement.
10. A task force should be convened immediately by the conference sponsors to develop both short-term and long-term plans for implementing the above recommendations.

ATTACHMENT A

STATES WITH LAWS THAT LIMIT SMOKING IN PUBLIC PLACES (43)

ALASKA
ARIZONA
ARKANSAS
CALIFORNIA
COLORADO
CONNECTICUT
DELAWARE
DISTRICT OF COLUMBIA
FLORIDA
GEORGIA
HAWAII
IDAHO
INDIANA
IOWA
KANSAS
KENTUCKY
MAINE
MARYLAND
MASSACHUSETTS
MICHIGAN
MINNESOTA
MISSISSIPPI
MONTANA
NEBRASKA
NEVADA
NEW HAMPSHIRE
NEW JERSEY
NEW MEXICO
NEW YORK
NORTH DAKOTA
OHIO
OKLAHOMA
OREGON
PENNSYLVANIA
RHODE ISLAND
SOUTH CAROLINA
SOUTH DAKOTA
TEXAS
UTAH
VERMONT
WASHINGTON
WEST VIRGINIA
WISCONSIN

STATES WITH COMPREHENSIVE CLEAN INDOOR AIR LAWS (25)

ALASKA
CALIFORNIA
COLORADO
CONNECTICUT
FLORIDA
HAWAII
IDAHO
IOWA
KANSAS
MAINE
MASSACHUSETTS
MICHIGAN
MINNESOTA
MONTANA
NEBRASKA
NEVADA
NEW HAMPSHIRE
NEW JERSEY
NORTH DAKOTA
OKLAHOMA
OREGON
RHODE ISLAND
UTAH
WASHINGTON
WISCONSIN

STATES WITH LAWS RESTRICTING SMOKING IN PUBLIC WORKPLACES (31)

ALASKA
ARIZONA
CALIFORNIA
COLORADO
CONNECTICUT
FLORIDA
HAWAII
IDAHO
INDIANA
IOWA
KANSAS
MAINE
MARYLAND*
MASSACHUSETTS
MICHIGAN
MINNESOTA
MONTANA
NEBRASKA
NEVADA
NEW HAMPSHIRE
NEW JERSEY
NEW MEXICO
NORTH DAKOTA
OHIO
OKLAHOMA
OREGON
RHODE ISLAND
UTAH
VERMONT
WASHINGTON
WISCONSIN

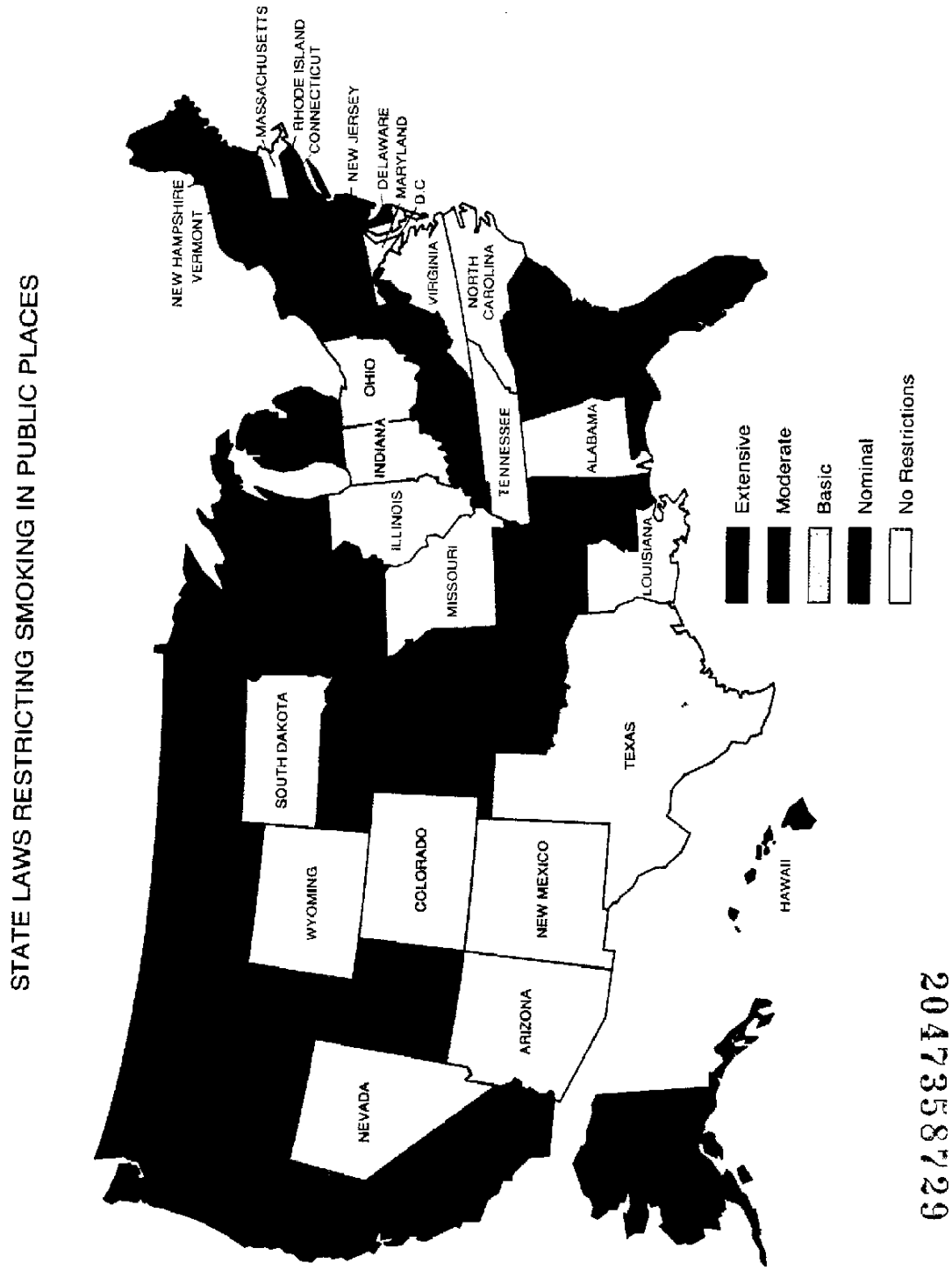
STATES WITH LAWS RESTRICTING SMOKING IN PRIVATE WORKPLACES (14)

ALASKA
CONNECTICUT
FLORIDA
IOWA
MAINE
MINNESOTA
MONTANA
NEBRASKA
NEW HAMPSHIRE
NEW JERSEY
RHODE ISLAND
UTAH
VERMONT
WASHINGTON

*By Executive Order

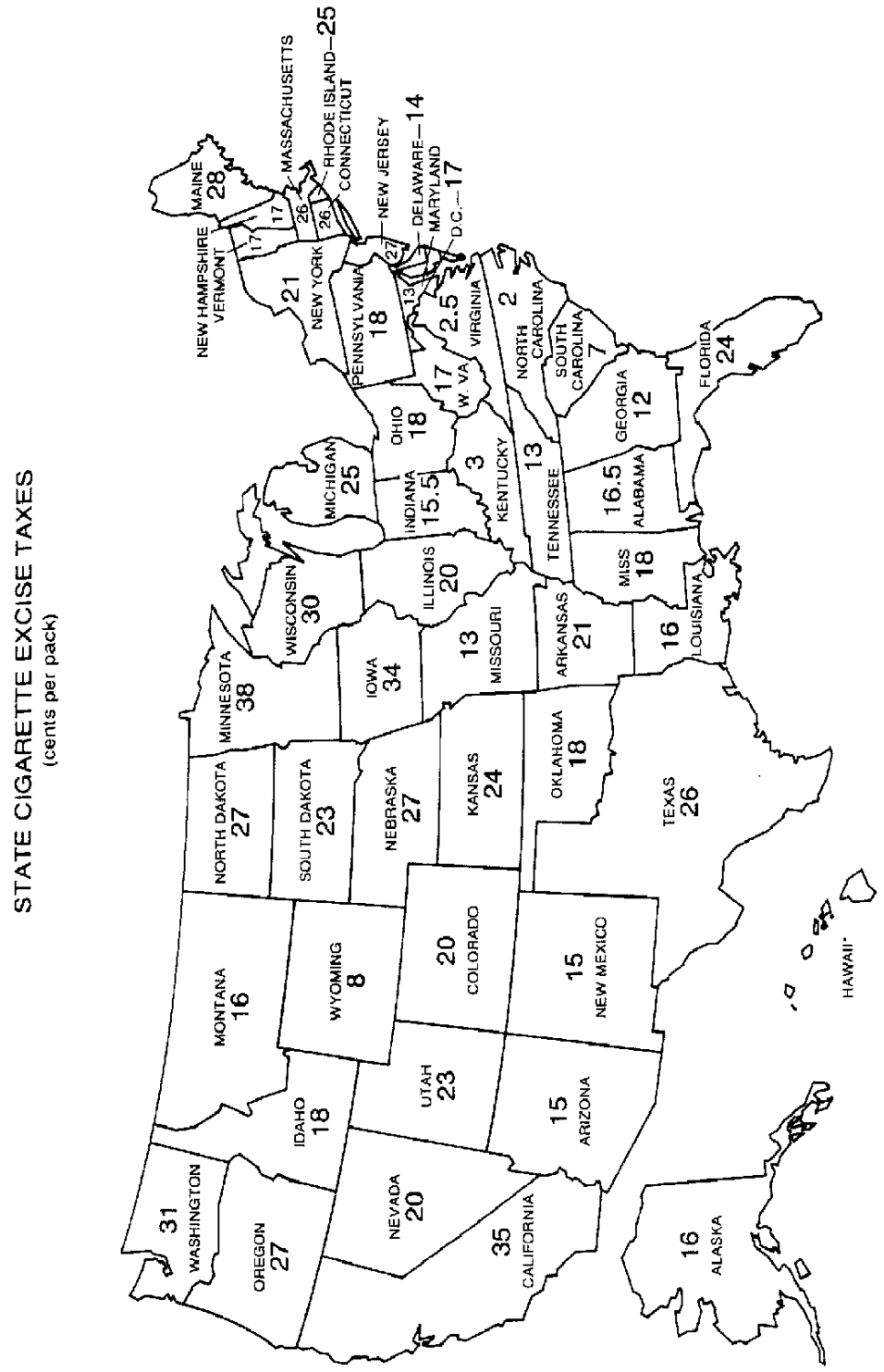
2047358728

ATTACHMENT B



2047358729

ATTACHMENT C



2047358730

ATTACHMENT D

STATE SMOKELESS TOBACCO EXCISE TAXES

CHEWING TOBACCO AND SNUFF

STATE	TAX	STATE	TAX
AL	Tax based on weight[1]	MT	12.5% of wholesale price
AK	25% of wholesale price	NE	15% of purchase price
AZ	$.02/ounce	NV	30% of wholesale price
AR	16% of manuf. inv. price	NH	None
CA	41.76% of wholesale price[2]	NJ	None
CO	20% of manuf. price	NM	25% of wholesale price
CT	None	NY	None
DE	15% of wholesale price	NC	None
DC	None	ND	20% of wholesale price
FL	25% of wholesale price	OH	None
GA	None	OK	30% of wholesale price
HI	40% of wholesale price	OR	35% of wholesale price
ID	35% of wholesale price	PA	None
IL	None	RI	None
IN	15% of wholesale price	SC	5% of manuf. price
IA	19% of wholesale sales price	SD	None
KS	10% of wholesale price	TN	6% of wholesale price
KY	None	TX	28.125% of manuf. price
LA	None	UT	35% of manuf. sales price
ME	45% of wholesale price	VT	20% of distributor price
MD	None	VA	None
MA	25% of wholesale price	WA	64.9% of wholesale price
MI	None	WV	None
MN	35% of wholesale price	WI	20% of wholesale price
MS	15% of manuf. list price	WY	None
MO	None		

[1]Chewing Tobacco: ¾ cents/ounce or fraction thereof.
Snuff: (a) 5/8 ounces or less, ½ cent;
(b) Over 5/8 ounce not exceeding 1-5/8 ounces, 1 cent;
(c) Over 1-5/8 ounces, not exceeding 2½ ounces, 2 cents;
(d) Over 2½ ounces, not exceeding 3 ounces; 2½ cents;
(e) Over 3 ounces, not exceeding 5 ounces (cans, packages, gullets), 3 cents;
(f) Over 3 ounces, not exceeding 5 ounces (glasses, tumblers, bottles), 3½ cents;
(g) Over 5 ounces, not exceeding 6 ounces, 4 cents;
(h) One cent additional tax for each ounce or fraction part thereof over 6 ounces.

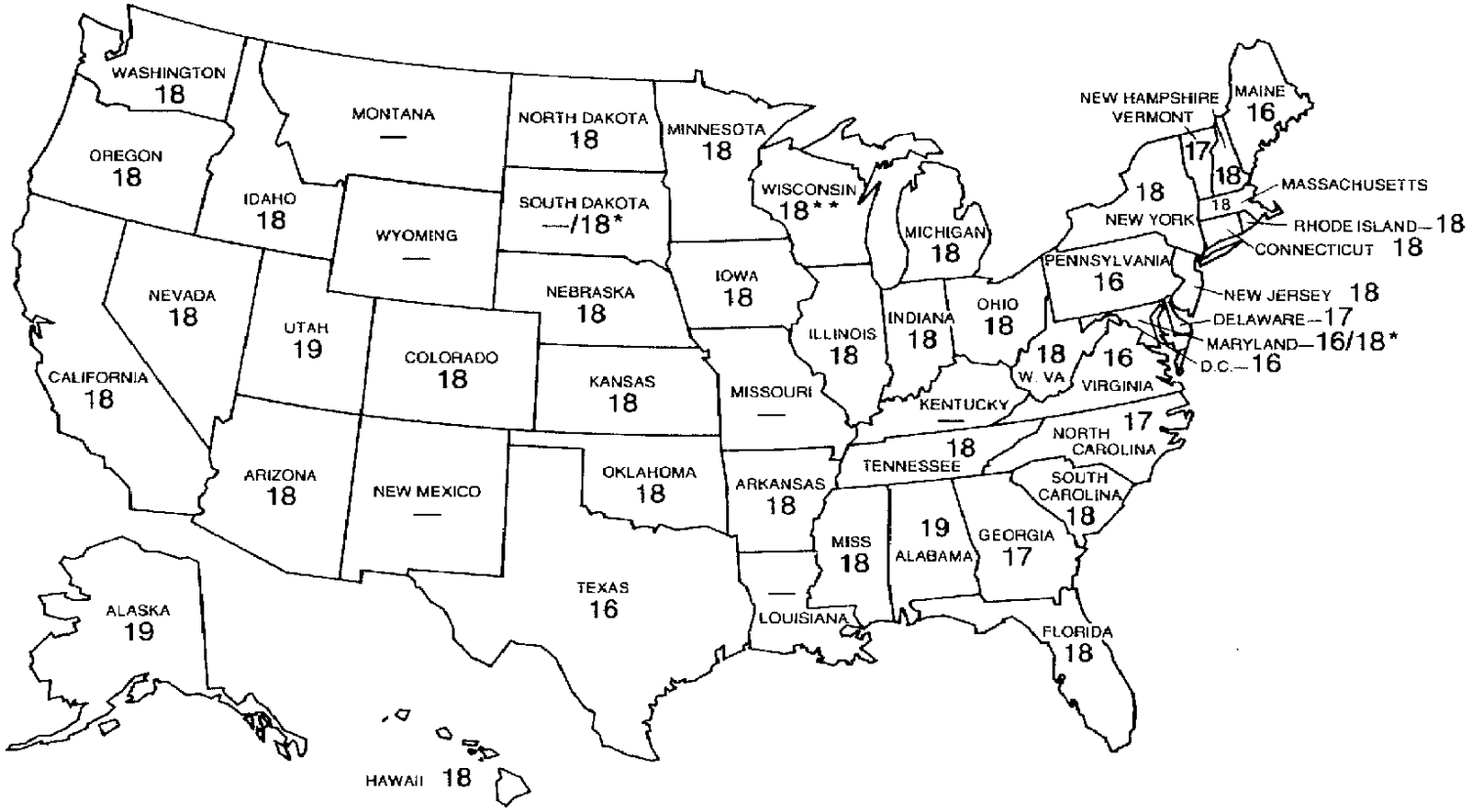
[2]Effective January 1, 1989.

Sources:
State Departments of Revenue, Bureaus of Tobacco and Miscellaneous Taxes, 1988.

The Tax Burden on Tobacco: Historical Compilation, Vol. 22, The Tobacco Institute, 1987.

2047358731

STATE AGE RESTRICTIONS FOR SALES OF TOBACCO PRODUCTS



*Cigarette/Smokeless
**7/1/89

2047358732

ATTACHMENT F

SUGGESTED TARGET GROUPS FOR OUTREACH

1. Older Americans
2. Educational groups
3. Youth groups
4. Non-tobacco related businesses
5. Unions
6. Health professionals' groups
7. Minority groups
8. Smokers for tobacco control
9. Religious organizations
10. State and local governments
11. Unlikely allies
12. Other professional associations
13. Political parties
14. Sports organizations
15. Womens' gropus
16. Celebrities
17. Arts and cultural communities
18. Farmers
19. Civic and community organizations
20. Fire fighters
21. Consumers groups
22. Environmental groups
23. Insurers
24. Victims

References

Altman DG, Foster V, Rasenick-Douss L, Tye JB. Reducing illegal sales of cigarettes to minors. *JAMA*. 1989; 261:80-83.

Anonymous. $4M Worth of Smokes Seized. *Hong Kong Standard*; November 24, 1988.

Anonymous. Asian Markets Open to U.S. Cigarettes. *Tobacco Observer*. 1987; 12:1.

Bruneman K, American Health Foundation. Personal communication to G. Connolly. May, 1988.

Centers for Disease Control. Cigarette smoking among blacks and other minority populations. *Morbid Mortal Week Rep*. 1987; 36:404-407.

Centers for Disease Control. Cigarette smoking in the United States. *Morbid Mortal Week Rep*. 1987; 36:581-585.

Chandler WU. Banishing Tobacco. *Worldwatch Paper 68*. Washington, DC: Worldwatch Institute; 1986.

Cipollone v. Liggett Group Inc., et. al, CA 83-22864 (SA) (U.S. District Court DNJ, 1988). Plaintiff's Exhibit 605.

Connolly GN. The American Liberation of the Japanese Cigarette Market. *World Smoking and Health*. 1988; 13:20-25.

Connolly GN, Walker BW. Restrictions on Importation of Tobacco by Japan, Taiwan, South Korea. *New England Journal of Medicine*. May 28, 1987; 316:1416-1417.

Davis RM. Current trends in cigarette advertising and marketing. *New England Journal of Medicine*. 1987; 316:725-732.

Davis RM, Jason LA. The distribution of free cigarette samples to minors. *A J Prev Med*. 1988; 4:21-26.

DiFranza JR, Norwood BD, Garner DW, Tye JB. Legislative efforts to protect children from tobacco. *JAMA*. 1987; 24:3387-3389.

Federal Trade Commission. *Report to Congress Pursuant to the Federal Cigarette Labeling and Advertising Act, 1986*. Washington, DC: Federal Trade Commission; May 1988.

Harris, Jeffrey E., The 1983 Increase in the Federal Cigarette Excise Tax, *Tax Policy and the Economy*, Vol. 1, M.I.T. Press, 1987.

Interagency Committee on Smoking and Health: The impact of cigarette smoking on minority populations. *National Advisory Committee Proceedings*; March 31, 1987.

Jameson S. Cigarette Issue Riles South Koreans. *Los Angeles Times*; October 22, 1986.

Office of the U.S. Trade Representative. *The President's Trade Policy Statement: An Update*. Washington, DC: Office of the U.S. Trade Representative, Executive Office of the President; 1986.

Schmeisser P. Pushing Cigarettes Overseas. *New York Times Magazine*; July 19, 1988.

Shepherd PL. *Transnational Corporation and the International Cigarette Industry: Profits, Progress and Poverty*. South Bend, Indiana: University of Notre Dame Press; 1985.

Stebbins KR. Tobacco or Health in the Third World: A Political Economy Perspective with Emphasis on Mexico. *International Journal of Health Services*. 1987: 17:521-537.

Taylor P. *The Smoke Ring*. New York: Mentor Press; 1988.

Tobacco Products Litigation Reporter. 3.357, 1988. Published in Boston. Plaintiff's Exhibit 323.

United States Cigarette Export Association. *301 Submission Tobacco Products Japan*, Memorandum to Office of the United States Trade Representative. Washington, DC; November 11, 1985.

United States Department of Agriculture. *World Tobacco Situation*. USDA/FAS. FT6-88, June, 1988.

United States Public Health Service. *Smoking and Health. Report of the Advisory Committee to the Surgeon General of the Public Health Service*, Center for Disease Control. (PHS) 1103, 1964.

United States Department of Health and Human Services. *Report of the Secretary's Task Force on Black and Minority Health*. Washington, DC: United States Department of Health and Human Services, Public Health Service, Office of Minority Health. 1985-1986.

United States Department of Health and Human Services. *The Health Consequences of Smoking: Cardiovascular Disease. A Report of the Surgeon General*. The United States Department of Health and Human Services, Public Health Service, Office on Smoking and Health. DHHS Publication (PHS) 84-50204, 1983.

United States Department of Health and Human Services. *The Health Consequences of Smoking: Chronic Obstructive Lung Disease: A Report of the Surgeon General*. The United States Department of Health and Human Services, Public Health Service, Office on Smoking and Health. DHHS Publication (PHS) 84-50205. 1984.

United States Department of Health and Human Services: *The Health Consequences of Involuntary Smoking: A Report of the Surgeon General*. United States Department of Health and Human Services, Public Health Service, Centers for Disease Control, Office on Smoking and Health, DHHS Publication No. (CDC) 87-8398, 1986.

United States Department of Health and Human Services. *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General*. United States Department of Health and Human Services, Public Health Service, Centers for Disease Control, Office on Smoking and Health. DHHS Publication No. (CDC) 88-8406, 1988.

United States Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General*. United States Department of Health and Human Services, Public Health Service, Centers for Disease Control, Office on Smoking and Health. DHHS Publication No. (CDC) 89-8411, Prepublication Version, January 11, 1989.

United States v. Michael K. Deaver, CR 87-0096, (U.S. District Court CDC, 1987).

Warner KE. Smoking and health implications of a change in the federal cigarette excise tax. *JAMA*. 1986; 225:1028-1032.

Warner, KE. *Selling Smoke: Cigarette Advertising and Public Health*. Washington, DC: American Public Health Association, 1986.

Conference Participants

Workgroup Leaders

Tobacco Use: Women, Children and Minorities

Congressman James H. Scheuer
U.S. House of Representatives
Washington, DC 20515

Lonnie Bristow, MD
Member, Board of Trustees
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Ronald Davis, MD, Dir.
Office on Smoking and Health
Department of Health & Human Services
5600 Fishers Lane
Rockville, MD 20857

Nicotine Addiction

Edwin Fisher, Jr., PhD
Dept. of Psychology, 215 Eads Hall
Washington University
One Brookings Drive
St. Louis, MO 63130
American Lung Association

Jack Henningfield, PhD
Addiction Research Center
National Institute on Drug Abuse
4940 Eastern Avenue
Baltimore, MD 21224

Federal Regulation of Tobacco

John Oates, MD, Prof. & Chairman
Dept. of Medicine-Vanderbilt University
Medical Center North B 3218
School of Medicine
Nashville, TN 37232
American Heart Association

Senator Jeff Bingaman
The United States Senate
Washington, DC 20510

William T. McGivney, PhD, Dir.
Div. of Health Care Technology
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Tobacco Excise Tax

Congressman Michael A. Andrews
U.S. House of Representatives
Washington, DC 20515

Jeffrey E. Harris, MD, PhD
Dept. of Economics, Bldg. E52-171
Massachusetts Institute of Technology
Cambridge, MA 02139

Protecting Non-Smokers

Congressman Richard J. Durbin
U.S. House of Representatives
Washington, DC 20515

John M. Pinney, Exec. Dir.
Institute for the Study of Smoking Behavior and Policy
Harvard University, JFK School of Govern.
79 John F. Kennedy Street
Cambridge, MA 02138

Tobacco Marketing and Promotion

Congressman Mike Synar
U.S. House of Representatives
Washington, DC 20515

Kenneth Warner, PhD
Dept. of Public Health Policy & Admin.
School of Public Health
University of Michigan
1420 Washington Heights
Ann Arbor, MI 48109-2029
American Heart Association

Tobacco Agricultural Policy

James A. Swomley
Managing Director
American Lung Association
1740 Broadway
New York, NY 10019

International Trade

Congressman Chester G. Atkins
U.S. House of Representatives
Washington, DC 20515

William M. Tipping, Exec. V.P.
American Cancer Society
1599 Clifton Road, N.E.
Atlanta, GA 30329

William R. Hendee, PhD, V.P.
Science & Technology Group
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Gregory N. Connolly, DMD, MPH
Massachusetts Dept. of Public Health
150 Tremont Street
Boston, MA 02111
American Cancer Society

Grassroots Lobbying

Michael Pertschuk, Esq.
Advocacy Institute
1730 Rhode Island Ave., NW, Suite 600
Washington, DC 20036

Bill Albers
Albers and Company
1731 Connecticut Avenue, NW
Washington, DC 20036

Additional Congressional Participant

Congressman Thomas A. Luken
U.S. House of Representatives
Washington, DC 20515

Speaker

Alan Blum, MD
Doctors Ought to Care
Baylor College of Medicine
5115 Loch Lomand
Houston, TX 77096

Congressional Staff Participants

The United States Senate

Carrie Billy
Office of Senator Jeff Bingaman
Washington, DC 20510

Joy Silver
Office of Senator Frank Lautenberg
Washington, DC 20510

Sharon Waxman
Office of Senator Frank Lautenberg
Washington, DC 20510

Wyn Froelich, MD, JD
Senate Labor and Human Resources Committee
Washington, DC 20510

Louise Little
Senate Labor and Human Resources Committee
Washington, DC 20510

Mona Sarfaty, MD
Senate Labor and Human Resources Committee
Washington, DC 20510

U.S. House of Representatives

Dave Kendall
Office of Representative Michael Andrews
Washington, DC 20515

Joey Giamfortone, Project Director
Office of Representative Michael Andrews
Washington, DC 20515

Deborah Matthews, Press Secretary
Office of Representative Michael Andrews
Washington, DC 20515

Bill Romjue
Office of Representative Michael Andrews
Washington, DC 20515

Jim Kessler
Office of Representative Chester C. Atkins
Washington, DC 20515

Susan Lightfoot
Office of Representative Richard J. Durbin
Washington, DC 20515

Jean Perih
Office of Representative Don Ritter
Washington, DC 20515

Greg Hodur
Office of Representative James Scheuer
Washington, DC 20515

Anne Zeppenfeld
Office of Representative Pete Stark
Washington, DC 20515

John Hollar
Office of Representative Mike Synar
Washington, DC 20515

Kaye Drahozal
Office of Representative Bob Whittaker
Washington, DC 20515

Ben Cohen
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Participant Roster—Tobacco Use in America Conference

Joseph Ainsworth, MD
U.T.M.D. Anderson Cancer Center
Box 43 1515 Holcombe
Houston, TX 77030

C.R. Allen, MD
AAPHP
P.O. Box 171438
Arlington, Texas 76003

David Altman
Stat/Stanford University
201 Congo Street
San Francisco, CA 94131

Lynn Artz
Office of Disease Prevention
2132 Switzer Boulevard
330 C Street, S.W.
Washington, D.C. 20201

Virginia Bales
Center for Disease Control
1600 Clifton Boulevard, 3 RM 117
Atlanta, GA 30333

Dan Ballard
Clark Thomas Winters
Newton
70 Lavaca, Suite 1300
Austin, TX 78701

Scott Ballin
American Heart Association
1250 Connecticut Avenue, N.W.
Suite 360
Washington, DC 20036

Ross Bannister
American Lung Association
777 Post Oak Boulevard #222
Houston, TX 77056

Flavia Bare
American Cancer Society
3000 United Founders Boulevard
Oklahoma City, OK 73112

Patrick Baum
Houston GASP, Advisory Board
1945 West Lamar
Houston, TX 77019

Karl E. Bauman, Prof.
University of North Carolina at Chapel Hill, CB 7400
Chapel Hill, NC 27516

Mary Berger, PhD, MD
American Heart Association
10 Suburban Drive
West Orange, NJ 07052

Robert Bernstein, MD
Commissioner Health
State of Texas
1100 W 49th Street
Austin, TX 78756

Erwin P. Bettinghaus, Dean
Michigan State University
286 CommArts Building
East Lansing, Michigan 48824

Holis Bivens
M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

Kay Bonham
Delta Airlines
855 Augusta, #57D
Houston, TX 77057

Cheryl Brown
American Association of Respiratory Care
11030 Ables Lane
Dallas, TX 75229

Toni Brown
American Lung Association
9735 Main Street
Fairfax, VA 22031

Kathy Bryant
American College of Obstetricians/Gynecology
409 12th Street, S.W.
Washington, DC 20024

David Burns MD
UCSD Medical Center
225 W. Dickinson Street
San Diego, CA 92103-1990

Marilyn B. Byrd
7411 Park Place Boulevard
Houston, TX 77087

Lynda Calcote
3499 Santa Monica
Abilene, TX 79605

E. L. Calhoon, MD
Box 70
Beaver, OK 73932

Craig Campbell
P.O. Box 27227
Houston, TX 77227-7227

Susan Campbell
American Academy of Pediatrics
1331 Pennsylvania Avenue, N.W. #721N
Washington, DC 20004-1703

Robert Caraway, Jr., MD
2100 Regional Med Drive
Wharton, TX 77488

Reginal Carlson
New Jersey Gasp
105 Mountain Avenue
Summit, NJ 07901

Julia Carol
Americans for Nonsmoking Rights
2054 University Avenue, Ste. 500
Berkeley, CA 94704

David Carr
M.D. Anderson Cancer Center
1515 Holcombe
Houston, TX 77030

Robert M. Chamberlain, PhD
U.T. M.D. Anderson Cancer Ctr.
1515 Holcombe Blvd.
Houston, TX 77030

Portia S. Choi, MD, MPH
Los Angeles County Health Services
612 West Shorb Street
Alhambra, CA 91803

Paul Cinciripini, PhD
University of Texas Medical Branch
Behavioral Medical Laboratory RT D-29
Galveston, TX 77550

Anna Clapper
American Lung Association
12104 Camelot Place
Oklahoma City, OK 73120

Tom Clapper
American Lung Association
12104 Camelot Place
Oklahoma City, OK 73120

Betty Cody
University of Texas
M.D. Anderson Cancer Center
1515 Holcombe
Houston, TX 77030

Joel Cohen
University of Florida College of Business
Gainesville, FL 32611

Neil Collishaw
Department of National Health and Welfare
Ottawa, Canada KLA OL2

Marianne Corr
1450 G Street, N.W.
Washington, DC 20005

Jay Cox
American Lung Association
1740 Broadway
New York, NY 10019

Mary Crane
American Heart Association
1250 Connecticut Avenue, N.W. #360
Washington, DC 20036

K. Michael Cummings, MD
Roswell Park Memorial Institute
666 Elm Street
Buffalo, NY 14263

William Darity, PhD
School of Health Sciences
University of Massachusetts
Amherst, MA 01003

Alan Davis
American Cancer Society
316 Pennsylvania Avenue, SE, #200
Washington, DC 20003

Richard Daynard
TPLR, Inc.
Box 1162 Back Bay Annex
Boston, MA 02117

Karen Deasy
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

William de Groot
Professor
University of Texas Medical Branch
Galveston, TX 77051

Chris Deputy
American Lung Association
P.O. Box 7065
Richmond, VA 23221

2047358738

Jo Deutsch
Association of Flight Attendants
1625 Massachusetts Avenue, N.W.
Washington, D.C. 20036

Clifford E. Douglas, Esq.
Assistant Director
Coalition on Smoking OR Health
1607 New Hampshire Avenue, N.W.
Washington, D.C. 20009

Fran Du Melle
American Lung Association
1029 Vermont Avenue, N.W.
Washington, D.C. 20005

Jim Dunne
Houston GASP
11835 Cedar Pass
Houston, TX 77077

Catherine Edwards, PhD
Texas Medical Association
1801 N Lamar
Austin, TX 78701

Michael Ericksen, ScD
M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, TX 77030

Virginia Ernster, PhD
University of California Dept. of Epidemiology
Box 0560
San Francisco, CA 94143

Richard Evans, PhD
University of Houston
Houston, TX 77204-5341

Harmon Eyre, MD
American Cancer Society
University of Utah
50 N Medical Drive
Salt Lake City, UT 84132

Leland Fairbanks, MD
Arizonans Concerned About Smoking
1866 E. Vinedo Lane
Tempe, AZ 85284

Betty Jean Farb
P.O. Box 4509
McAllen, TX 78502

Steve Fenoglio
Clark Thomas Winters
Newton
700 Lavaca, Suite 1300
Austin, TX 78701

Donald Fernbach, MD
Baylor College of Medicine
6021 Fannin
Houston, TX 77030

David B. Ferris
Friends of Austin Nonsmoker
5603 Chadwyck Drive
Austin, TX 78723

June Ferris
Texas Department of Health
Office of Smoking and Health
1100 W 49th
Austin, TX 78756

David Fine
Southwestern Bell
1667 K Street, N.W., Ste. 1000
Washington, DC 20006

Paul Fischer, MD
Medical College of Georgia Family Medicine
Augusta, GA 30912

James Forde
California Black Health Network
6069 Rancho Mission Road
San Diego, CA 92108

Harold Freeman, MD
American Cancer Society
Harlem Hospital
135th and Lenox
New York, NY 10583

Margaret Garland
American Lung Association
93 Cumberland Road
Burlington, VT 05401

J. Greg Getz
Adj Associate Professor
University of Houston
Department of Psychology
Houston, TX 77004

Charles Gibson
Texas Association of Nonsmokers
5201 S. 7th
Abilene, TX 79605

Jan Gibson
Texas Association of Nonsmokers
5201 S. 7th
Abilene, TX 79605

K.H. Ginzel, MD
University of Arkansas
Dept. of Pharmacology
4301 W Markham
Little Rock, AR 72205

George Gitlitz, MD
5 Riverside Drive
Binghamton, NY 13905

Stanton Glantz, Ph.D.
Medical Center Hospital of Vermont
Burlington, VT 05401

Alexander Glassman, MD
New York State Psychiatric Institution
722 W. 168th Street
New York, NY 10032

Jerome Goldstein, MD
American Academy of Otolaryngology
1101 Vermont Avenue, N.W., Suite 302
Washington, D.C. 20005

Jose Gonzalez
Laredo Webb County Health Dept.
P.O. Box 2337
Laredo, TX 78041

Margarita Gonzalez
Texas Medical Association
1801 N. Lamar Boulevard
Austin, TX 78701

Nell Gottlieb
American Heart Association
104 West 32 Street
Austin, TX 78705

Reginald M. Greff
Houston Health Department
7411 Park Place, #200
Houston, TX 77087

John Guyton, MD
Methodist Hospital Department of Medicine
6565 Fannin
Houston, TX 77030

Nancy Hailpern
American Cancer Society
316 Pennsylvania Avenue, SE, #200
Washington, DC 20003

Edwin B. Hutchins, PhD
Program Director
Carter Center
1989 North Williamsburg Drive
Decatur, GA 30033

Lovell A. Jones, MD
U.T.M.D. Anderson Cancer Center
1515 Holcombe
Houston, TX 77030

Walter F. Leavell, MD
President
Charles Drew
University Med & Science
1621 E 120th Street
Los Angeles, CA

M. Arnita Hannon
American Lung Association
1029 Vermont Avenue, NW
Washington, DC 20005

Robert Harmon, MD
Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102

Joyce Hartman, Director
Houston Behavioral Center
1200 Post Oak Blvd., #342
Houston, TX 77056

Lawanda Hartman
American Cancer Society
P.O. Box 140435
Austin, TX 78714-0435

Kerry Harwood, MSN, RN
Johns Hopkins Oncology Center
2221 Chesterfield Avenue
Baltimore, MD 21213

Rick Hay, MD
American Heart Association
20 N. Wacker, Suite 1240
Chicago, IL 60606

Rebecca Herron
American Lung Association
3520 Executive Center Drive
Austin, TX 78731

Robert C. Hickey, MD
Association of American Cancer Institutes
1515 Holcombe Blvd., Box 59
Houston, TX 77030

Glenn Hildebrand
American Cancer Society
P.O. Box 2061
Oakland, CA 94604

David Hill
Canadian Cancer Society
99 Bank Street
Ottawa, Ontario K1P 6C1
CANADA

Chesley Hines, Jr., MD
American Coll. Gastro.
1514 Jefferson Highway
New Orleans, LA 70121

Russell Hinz
American Lung Association
8 Mountain View Avenue
Albany, NY 12205

Con Hitchcock
Public Citizen Litigation Group
2000 P Street, NW, Suite 700
Washington, DC 20036

Harry Holmes, PhD
Assistant to the President
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

Tom Houston, MD
DOC
3243 E. Murdock
Wichita, KS 67208

Lois Hoyt
American Academy of Family Physicians
600 Maryland Avenue, SW
Washington, DC 20024

John Hughes, MD
University of Vermont
Dept. of Psychology
1 South Prospect Street
Burlington, VT 05401

John Hughes, MD
Vercellino GI Cancer Inst.
7000 Fannin, Suite 1240
Houston, TX 77030

Susan Islam
American Cancer Society
1180 Avenue of Americas
New York, NY 10036

Sharon Jaycox
American Lung Association
1740 Broadway
New York, NY

Lynn Jones
American Hospital Association
840 N. Lake Shore Drive
Chicago, IL 60611

William Kane, PhD
American College of Preventive Medicine
1015 15th Street, NW, Suite 043
Washington, DC 20005

Shirley Kellie, MD
Senior Scientist
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Karen Kitchens, MA
University of Texas, Medical Branch
Behavioral Med. Lab. RT D-29
Galveston, TX 77550

Rear Adm. Harold Koenig
Dep. Cmdr. Health Care Operations (MEDCOM-03)
Naval Medical Command
Washington, DC 20372

Lynn Kozlowski, MD
Addict Research Foundation
33 Russell Street
Toronto, Ontario M5S 281
CANADA

Ken Kyle
Canadian Cancer Society
77 Metcalfe Street
Ottawa, Ontario K1P 5L6
CANADA

Diana Lamberson
Texas Medical Association
1801 N. Lamar Blvd.
Austin, TX 78701

John Langdon
University of Central Florida
Student Health Service
Orlando, FL 32816

Lynn Lapitsky, MA
University of Texas, Medical Branch
Behavioral Med. Lab RT D-29
Galveston, TX 77550

Charles LeMaistre, MD, President
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

Edward Lichtenstein, PhD
Oregon Research Institute
1899 Willamette
Eugene, OR 97401

Scott Lippman, MD
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd., Box 80
Houston, TX 77030

John Lore, MD
St. David Community Hospital
919 E 32nd Street
Austin, TX 78705

John Lukeman, MD
1515 Holcombe Blvd.
Houston, TX 77030

Henry Macintosh, MD
American College of Cardiology
P.O. Box 95000
Lakeland, FL 33804-5000

Kenneth MacKenzie
IT Corp
10910 Braesforest
Houston, TX 77071

Mary MacKenzie
Hotelier, Inc.
10910 Braesforest
Houston, TX 77071

John Madigan
American Cancer Society
316 Pennsylvania Avenue, SE, #200
Washington, DC 20003

Diane Maple
American Lung Association
1029 Vermont Avenue, NW
Washington, DC 20005

Susan H. Mather, MD
Veterans Administration
12144 Long Ridge Lane
Bowie, MD 20715

Owen McCrory
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

Deborah McLellan
American Public Health Association
10115 15th Street, NW
Washington, DC 20005

Ed McMahon
216 7th Street, SE
Washington, DC 20003

Donald Meade
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd., Box 153
Houston, TX 77030

R. E. Mecklenberg
National Cancer Institute
12304 Rivers Edge Drive
Potomac, MD 20854

Martin Meltz, PhD
7703 Floyd Curl Drive
San Antonio, TX 78284

Angela Mickel
Tobacco-Free America
1029 Vermont Avenue, NW, #710
Washington, DC 20005

Henry Miller, Esq.
Clark, Gagliardi & Miller
99 Court Street
White Plains, NY 10601

Sherry Milligan
American Association Respiratory Care
11030 Ables Lane
Dallas, TX 75229

Betty Moore
Caring for Nonsmokers
7022 S. Janmar
Dallas, TX 75230

D. L. Moore
Executive Director, TCC
105 Riverside
Austin, TX 78759

Cindy Morgan
American Cancer Society
P.O. Box 9863
Austin, TX 78766

Alfred Munzer, MD
Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912

Leigh Anne Musser
Community Education Specialist
U.T. Health Science Ctr.-Educ. Svcs.
P.O. Box 20036
Houston, TX 77225

Matthew Myers, Esq.
Coalition on Smoking OR Health
1607 New Hampshire Ave., NW
Washington, DC 20009

Claudia Nadig
State Senator Cyndi Taylor Krier
P.O. Box 12068
Capitol Station
Austin, TX 78711

Mohan Nadkarni
Public Citizen Health Research Group
2000 P Street, NW
Washington, DC 20036

W. James Nethery
Coalition Healthy Californians
999 N. Tustin
Santa Ana, CA 92705

Guy Newell, MD
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

Linda Nichols
American Lung Association
3520 Executive Center Drive
Austin, TX 78731

Sam Nixon, MD
University of Texas
Health Science Center
P.O. Box 20367
Houston, TX 77225

Anne Marie O'Keefe
Advocacy Institute
1730 Rhode Island Avenue, NW
Suite 600
Washington, DC 20003

Joseph T. Painter, MD
Board of Trustees
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Guadalupe Palos, RN
1511 Christa Lane
South Houston, TX 77587

Joe Patterson
American Cancer Society
3340 Peachtree Road, NE
Atlanta, GA 30326

Terry Pechacek
National Cancer Institute
9000 Rockville Pike
Bethesda, MD 20892-4200

Mark Pertschuk
Americans for Nonsmokers Rights
2054 University Ave., Suite 500
Berkeley, CA 94704

Mike Pertschuk
Advocacy Institute
1730 Rhode Island Avenue, NW
Suite 600
Washington, DC 20003

Billy Philips, PhD
Univeristy of Texas Medical Branch
1100 Mechanic Street
Galveston, TX 77550

Ed Pitt, Dir. Health
National Urban League
500 East 62nd Street
New York, NY 10021

Edward Popper, DBA
67 Eldredge Avenue
East Greenwich, RI 02818

Nita Pyle
American Lung Association
777 Post Oak Blvd., Suite 222
Houston, TX 77056

Amelie Ramirez
U.T. Health Science Center
7703 Floyd Curl Drive
San Antonio, TX 78284

James Reich
American Lung Association
7616 LBJ Freeway
Dallas, TX 75251

James Repace
U.S. Environmental Protection Agency
Washington, DC 20460

John W. Richards, Jr., MD
Medical College of Georgia
Augusta, GA

Robert Robinson, DR PH
Fox Chase Cancer Center
430B Rhawn Street
Philadelphia, PA 19111

Clarence Robison, MD
American Cancer Society
3000 United Founders Blvd.
Oklahoma City, OK 73112

G.A. Robison
University of Texas
P.O. Box 20708
Houston, TX 77225

Amy Roome
American Heart Association
1700 Rutherford Lane
Austin, TX 78759

Jed Rose, PhD
V.A. Medical Center
Bldg. 29, Room 206
Los Angeles, CA 90073

Jack Roth, MD
UT M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030

David Sachs, MD
Smoking Cessation Research Institute
750 Welch Road
Palo Alto, CA 94304-1509

Susan Schoenmarklin
American Cancer Society
5555 Frantz Road
Dublin, OH 43017

Dr. Charlotte R. Scott
Jowers Center
S.W. Texas State University
San Marcos, TX 78666-4616

John H. Scott
Assistant Director
Dept. of Congressional Affairs
American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005

John Seffrin, PhD
Indiana University, HPER 116
Bloomington, IN 47405

Iris R. Shannon
President
American Public Health Association
1015-15th Street, N.W.
Washington, DC 20005

Charles Sharp
12400 Wilshire
Los Angeles, CA

Donald Shopland
National Cancer Institute
9000 Rockville Pike
Bethesda, MD 20892

Barbara Silvestri-Dore
Chicago Lung Association
1440 W. Washington
Chicago, IL 60607

Carol Sipfle
Smoking Intervention
1025 Ashworth Road, #410
West Des Moines, IA 50265

John Slade, MD
N.J. Comm. on Smoking & Health
166 Montgomery Road
Skillman, NJ 08558-9642

Susan Yale Smith
California Medical Association
P.O. Box 7690
San Francisco, CA 94120

Madeliene Solomon
American Heart Association
20 N. Wacker Drive, Suite 1240
Chicago, IL 60606

Roy Spezia
Clark, Thomas, Winters & Newton
700 Lavaca, Suite 1300
Austin, TX 78701

James Stacey, Director
Media and Information Service
American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005

Dr. R. Craig Stotts
GASP
4827 Travis
Galveston, TX 77551

Barbara Sunderland
21 Briar Hollow Lane
Houston, TX 77027

Ed Sweda, Esq.
GASP
25 Deaconess Road
Boston, MA 02115

Gayle Thomas
Texas Medical Association
1801 N. Lamar Blvd.
Austin, TX 78701

Ron Todd
Texas Department of Health
1100 W. 49th
Austin, TX 78756

Robert S. Toth, MD
American College of Legal Medicine
7070 Edgewater Drive
Willis, TX 77378-9185

W. E. Townsley
STAT-Attorney
3550 Fannin Street
Beaumont, TX 77701

Joe Tye
STAT
78 Colton Place
Longmeadow, MA 01106

Louise Villejo
UT M.D. Anderson Cancer Center
1515 Holcombe Box 21
Houston, TX 77030

DeDe Vinson
Potter-Randall County Medical Society
P.O. Box 50008
Amarillo, TX 79159

Edgar Vovsi
American Heart Association
1181 N. Dirksen Parkway
Springfield, IL 62708

M. Jeanne Weigum
ANSR
1647 Laurel
St. Paul, MN 55104

Raymond Weisberg, MD
American Cancer Society
1734 Gough Street
San Francisco, CA 94109

Joseph Weller
American Lung Association
Portland, Oregon 97205

Patrick Wells, PhD
Texas South Univresity
College of Pharmacology
3100 Cleburne Street
Houston, TX 77004

Leonard Wheat
American Dental Association
1111 14th Street, NW
Washington, DC 20005

Judith Wilkenfield
FOTOCO
601 Pennsylvania Avenue, NW
Washington, DC 20580

John S. Zapp, DDS
Director
Division of Government Affairs
American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005

Mike Zarski
Department of Federal Legislation
American Medical Association
434 North Dearborn Street
Chicago, IL 60610

Philip Zbylot, MD
Utah Health Science Center
Austin, TX 78712

Karen Zielaski
Nonsmokers, Inc.
P.O. Box 12666
Tucson, AZ 85732

Leslie Zoref, PhD
Oregon Research Institute
1899 Williamette
Eugene, OR 97401